Bridgewater CHCFT HMP Wymott

Inspection report

Wymott Prison
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall summary

The five questions we ask and what we found

Are services safe?

- Information provided by the trust showed that not all primary health care staff had completed safeguarding training appropriate to their role. Neither had a sufficient number of staff completed either basic life support training or intermediate life support training commensurate with their role.
- The availability of chaperones during examinations and intimate examinations was not advertised or promoted in healthcare literature or on information boards located within the healthcare centre.
- Treatment rooms on wings and those located in the healthcare centre did not meet infection prevention standards. Whilst the trust is not directly responsible for the cleaning of treatment areas as these are the responsibility of the prison, nurses told us that they did what they could to ensure areas were as clinically clean as possible by wiping down areas in which they treated prisoners and/or administered medicines.
- The risks to patients were not adequately identified, managed or monitored, for example, primary health care managers did not keep accurate records of clinics cancelled, which impacted on their ability to adequately monitor and review service delivery. An exception to this was in respect of dental services, where we found that health and safety policies and risk assessments were up to date and reviewed regularly to help manage potential risks.
- Emergency medical equipment was available but staff did not regularly complete daily checks of emergency bags and records of such checks were not maintained in accordance with local policy. This meant that the safety of patients requiring an emergency response and/or treatment could be compromised.
- The arrangements for managing medicines did not keep patients safe.
- There was a system in place for recording and acting on significant events. However, we were not assured that all significant incidents, with the exception of those reported by dental staff, were reported and appropriate action was taken to ensure patient safety.
- There was no evidence of learning from adverse events and the subsequent dissemination of information to improve safety across primary health care services.
- Dental decontamination procedures were appropriate and all necessary equipment used in the process was available to clinical staff.

Are services effective?

- Not all prisoners received a secondary health assessment within the first seven days of their reception into HMP Wymott, which compromised their safety and wellbeing. Healthcare assessments within the first few days in prison are crucial in identifying prisoners' healthcare needs, providing treatment and keeping people safe.
- Healthcare staff did not always ensure that prisoners received a continuous supply of prescribed medicines. Reviews of prescribed medicines did not happen with sufficient regularity.
- The dentist confirmed they referred prisoners to specialists in primary and secondary care when treatment was needed and monitored urgent referrals with colleagues from primary health care services to make sure they were dealt with promptly.
- Care and treatment for prisoners with long term conditions (LTC) was effective and supported by a dedicated LTC nurse.
- Prisoners' attendance at healthcare appointments was monitored monthly and analysed for trends. Prisoners who did not attend healthcare appointments were followed up by nurses.
- The supervision and management of social care provision at the prison was unclear. Care planning for prisoners in receipt of a social care package was not consistent and care plan reviews did not take place regularly.
- Supervision arrangements for all members of the staff team were insufficient.

Are services caring?

- Primary healthcare staff including dental staff spoke to prisoners in a respectful and caring manner.
- Clinic room doors remained open during nurse-led consultations and conversations could be heard by other staff including prison staff and other prisoners passing through the health care reception area. This practice compromised patient confidentiality.
- Prisoners told us their requests to meet privately with a nurse to discuss their health concerns were not met.

Are services responsive to people's needs?

Overall summary

- The healthcare centre was small with insufficient treatment rooms to meet the needs of the prison population; however this was not the direct responsibility of the trust.
- Prisoners were not always able to access primary health care and treatment within acceptable timescales, Clinics were cancelled and/or oversubscribed.
- Prisoners sometimes received their medicines late.
- Prisoners were supported to attend external hospital appointments.
- Information on how to complain was publicised on most wings and in the healthcare centre.

Are services well-led?

- Senior managers within the trust were not sufficiently focused on staff development and/or service development and because of this lack of focus, improvements were not sustained. There were inadequate processes in place for providing all staff with the development they need, including supervision, training and support.
- Some healthcare staff told us that healthcare managers were not always visible and they did not effectively work with front line staff. Despite the varying views of staff, most were optimistic about achieving change and improvements, though not enough staff had been consulted and involved in plans for the future.
- Systems and processes to support good governance and management of the service were limited at local level and this impacted on overall effectiveness of the service. The exception being dental services which were managed effectively by the trusts dental network.
- Health care managers did not routinely share learning from incidents with primary healthcare staff in order to make improvements.
- Governance checks were not undertaken to ensure that equipment in emergency bags was monitored and fit for purpose.
- Measures to monitor primary health care services, including checks of fridge temperatures and the clinical environment, were poorly implemented.
- Quality assurance processes for dental services including audits of care records, radiographs and infection prevention and control were effective.
- Induction for permanent and agency primary health care staff was not a priority and many staff had not had a formal induction, missing a crucial opportunity to help all staff understand the trust's vision and values
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. However, many were less confident that action would be taken in response to their concerns.

Key Findings

The areas where the provider **must** make improvements are:

- The provider must ensure that staff receive the support, training, professional development, and supervision that are necessary for them to carry out their role and responsibilities.
- The provider must ensure that people who use the service receive safe care and treatment and prevent avoidable harm or risk of harm by making sure equipment used is safe, medicines are available and supplied in sufficient quantities.
- The provider must ensure that people using the service receive appropriate person-centred care and treatment that is based on an assessment of their needs and preferences.
- The provider must ensure that they employ effective governance arrangements, including assurance and auditing systems or processes to support, assess, monitor and drive improvement in the quality and safety of the services. Systems and processes must assess, monitor and mitigate any risks relating to the health, safety and welfare of people using the service.
- The provider must maintain accurate, complete and detailed records in respect of each person using the service and records relating the employment of staff and the overall management of the regulated activity.

The areas where the provider **should** make improvements are:

- The provider should provide information about the availability of chaperones to people using the service.
- The provider should ensure that all clinical areas, in which primary healthcare nursing staff provide treatments and medicines, meet infection prevention standards and do not compromise patient safety.
- The provider should establish arrangements to effectively support multi-disciplinary review of people with complex needs who use the service.

Overall summary

- The provider should ensure that people who use the service have information on how to escalate their concerns if they are dissatisfied with how their complaint had been managed.

Our inspection team

Our inspection team was led by a CQC health and justice inspector, accompanied by two CQC health and justice inspectors, a CQC hospitals inspector, a CQC pharmacist specialist, a healthcare inspector from Her Majesty's Inspectorate of Prisons (HMIP) and a dental specialist adviser (SpA).

We do not currently rate services provided in prisons.

Background to Bridgewater CHCFT HMP Wymott

HM Prison Wymott is a Category C men's training prison, located in the village of Ulnes Walton, in Lancashire, England. The prison is operated by Her Majesty's Prison and Probation Service. It accommodates up to 1176 adult male prisoners.

Bridgewater Community Healthcare NHS Foundation Trust has been commissioned by NHS England to provide primary health care services, including GP and dental services to the prison population at HMP Wymott, since April 2017. The trust is also commissioned by Lancashire County Council to provide social care services within the prison. The trust is registered with CQC to provide the regulated activities of Diagnostic and screening procedures and Treatment of disease, disorder or injury at the prison.

Our last joint inspection with HMIP was in October 2016. At the time of that inspection healthcare services were provided by another registered provider. The joint inspection report can be found at:

Why we carried out this inspection

We announced our intention to undertake a comprehensive inspection of health care services provided by Bridgewater Community Healthcare NHS Foundation Trust on the 2 July 2018. The inspection took place from the 17 July 2018 to the 20 July 2018.

In July 2017 we received approximately 30 concerns, including whistle blower alerts, safeguarding concerns and complaints from prisoners about the care they had received.

Since July 2017 we have monitored the performance of the service at HMP Wymott through regular engagement meetings, through discussions with NHS England and our attendance at Quality Risk Summits. Risk summits provide a mechanism for key stakeholders from various organisations to come together to share and review information when a serious concern about the quality of care provided by a service provider has been raised and agree any actions needed. As a result of the risks identified, NHS England funded a 'Turnaround team', to support healthcare services provided by the service in the prison from September 2017.

In March 2018, we received information from NHS England that suggested the improved quality of healthcare services was not being sustained.

A further two complaints were received in December 2017, and one in June 2018.

Following a review of the information and intelligence we held, we identified three areas of concern - medicines management, access to GP services and the management of long term conditions. We asked the trust to submit an action plan detailing how they intended to respond to these areas of concern and improve the safety and quality of healthcare service at HMP Wymott. The trust submitted an action plan to us on the 17 July 2018.

We subsequently decided to inspect healthcare services provided by the trust at the prison to determine if the trust was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008, and that prisoners were receiving safe care and treatment.

Our key findings were as follows

- Primary healthcare staff were not effectively deployed across the service to meet the needs of the people using the service.
- Primary health care staff were not sufficiently trained, supervised and supported by senior health care and health care managers.
- Care and treatment was not always provided to people who use the service and care records were not accurately maintained and kept up to date.
- Person-centred care and treatment was not consistently delivered.
- There was an absence of effective governance systems that supported service development, including an absence of effective monitoring systems to mitigate risks to people who used the service.

How we carried out this inspection

Before this comprehensive inspection we reviewed a range of information that we held about the service.

During the inspection we asked the provider to share with us a range of information which we reviewed. We spoke with healthcare staff, prison staff and people who use the service, and sampled a range of records.

Are services safe?

Safety systems and processes

- The service had safeguarding systems in place, with a named nurse for safeguarding adults, a strategic lead for safeguarding and a director for safeguarding. However, we found that not all staff had completed safeguarding training appropriate to their role. We found that 36% of staff, including nursing staff, health care assistants and social care support staff had not completed safeguarding level 2 children, and 32% had not completed training in safeguarding level 2 adults.
- Despite some primary health care staff not completing safeguarding training, those staff we spoke with were able to describe how they would identify and report a safeguarding concern. Staff demonstrated a good understanding of their responsibilities regarding safeguarding and understood the trust safeguarding policy and how this could be implemented alongside prison safer custody mechanisms.
- We were told that prisoners could request a chaperone to be present during examinations, including intimate examinations. However, this was not advertised or promoted in healthcare literature or on information boards located within the healthcare centre. Chaperones protect both patients and staff and their role is to assist GP consultations and nurse-led clinics. Prisoners did not request this because they were unaware that chaperones were available.
- Treatment rooms on wings and those located in the healthcare centre did not meet infection prevention standards. We observed several treatment areas with dirty unsealed floors and one with detritus strewn on the floor. The trust shared with us an audit of clinical treatment areas dated 8 July 2018. The audit showed that most clinical areas, including a GP treatment room, three healthcare-based treatment rooms, and treatment areas on nine wings, all failed to meet infection prevention and control standards and all areas were assessed as requiring immediate action.
- The trust is not directly responsible for the cleaning of treatment areas as these are the responsibility of the prison. Her Majesty's Prison and Probation Service (HMPPS) contracts a private company to undertake cleaning at HMP Wymott, and we were told that there were ongoing discussions with the company about the quality of service provided. We observed varying levels of cleanliness across all treatment areas and rooms. There were no monitored cleaning schedules in treatment areas and nurses told us that they did what they could to ensure areas were as clinically clean as possible by wiping down areas in which they treated prisoners and/or administered medicines. Soap dispensers and handtowels were available in most rooms, but several staff told us these had only been installed just prior to our inspection.
- A dental audit showed that the dental area fully met infection prevention standards.

Risks to patients

- The risks to patients were not adequately identified, managed or monitored, for example, managers did not keep accurate records of clinics cancelled, which impacted on their ability to adequately, monitor and review service delivery.
- However, an exception to this was in respect of dental services, where we found that health and safety policies and risk assessments were up to date and reviewed regularly to help manage potential risks. Safe systems were in place to support the reporting of faults and hazards and we saw that these were acted on in a timely way. Control of Substances Hazardous to Health (COSHH) risk assessments and product safety data sheets were in place.
- We saw copies of staff duty rotas for May, June, and July 2018, which showed the number of staff on duty. During the inspection nursing staff told us about low staffing levels on 28 June 2018, with one nurse and one health care assistant on duty. We cross-referenced this with the staff rota for June 2018. The rota confirmed that one agency nurse and a health care assistant were on duty on the 28 June 2018, along with the head of health care and a practice manager who was a Band 7 nurse. The rota confirmed that one agency nurse and a health care assistant were on duty on the 28 June 2018, along with the head of health care and a primary healthcare manager.
- On the 31 July 2018 we received information from an anonymous source that the service was understaffed,

clinics were cancelled due shortage of staff, and medicines were not administered safely. We asked the trust to investigate these allegations and report the outcome to us. The trust investigated and reported that healthcare was sufficiently staffed on the 31 July 2018.

- The trust told us that they were aware that there was not enough permanent nursing staff employed across the healthcare service. They told us that the current staff group was made up of 80% agency staff and 20% permanent staff. At the time of the inspection the service had five nursing staff vacancies and one vacancy for an advanced nurse practitioner. The trust had successfully recruited three nurses who were going through security vetting procedures and had a rolling recruitment process in place and was reviewing their current service model, which included considering the recruitment of other healthcare professionals. Regular agency nurses were used to fill vacancies and permanent nurses and other healthcare staff told us this assisted with continuity of patient care.
- Emergency equipment was available, but regular checks of emergency bags were not consistently completed and records maintained, which meant that the safety of prisoners requiring an emergency response and/or treatment could be compromised. Reviews of emergency bags were not completed daily in line with the trust's policy.
- Following our inspection the trust sent us copies of 26 emergency bag equipment daily checklists in respect of 10 prison wings. We found gaps in the recordings of 18 of the records we reviewed, which meant that daily checks of emergency equipment were not happening consistently and in line with the trust's policy. The dates on some records had been changed, and in some instances the wrong date had been recorded. Governance systems did not ensure that these checks happened.
- Other medical equipment used in health care, for example, pulse oximeters, had been tested and were safe to use.
- The majority of staff including nursing staff, pharmacy technicians, healthcare assistants and social care support workers had not completed life support training commensurate with their role. We found that 95% of nursing staff and pharmacy technicians had not completed basic life support training and no nursing staff and pharmacy technicians had completed intermediate life support training. This put prisoners requiring emergency treatment and care at risk. However, all dental staff including a dentist, dental nurses and a dental therapist had completed training in emergency resuscitation and basic life support training.
- We saw up to date servicing documentation for all dental equipment used and dental staff carried out checks in line with the manufacturers' recommendations. Suitable arrangements were in place to ensure the safety of the X-ray equipment. A radiation protection file was in place.

Information to deliver safe care and treatment

- Where prisoners were known to other healthcare providers within the prison, for example, mental health services, information needed for their ongoing care was shared appropriately.
- The prison held weekly complex case review meetings to discuss prisoners with multiple needs, including health care needs. These meetings were led by prison governors. However, representatives from the primary healthcare service did not attend these meetings which meant that staff may not be aware of important information about their patients. Specific health-led multidisciplinary meetings did not take place.

Appropriate and safe use of medicines

- We looked at the systems in place for medicines management within the prison. We looked at medicines optimisation, storage, and administration. We found that the arrangements for managing medicines did not keep people safe.
- Medicines were administered to prisoners by nursing staff and pharmacy technicians. We observed the process for the administration of medicines, which was in line with trust policy. We saw areas of good practice where pharmacy technicians' roles had been developed to assist with medicines administration. A clear competency framework and assessment was in place to ensure the technicians could complete this task safely. However, this was facilitated at a trust level and not by local operational management, to whom pharmacy technicians were directly accountable. This meant that the healthcare operational staff could not be assured of individual technician's skills or competencies.
- The process for recording and administration of controlled drugs kept people safe. Records were reviewed on a frequent basis and stock balance checks had been performed and recorded accurately.

Are services safe?

- Medicines were administered in accordance with the prison's daily regime and the storage of medicines on the wings was secure. However, we saw examples where prisoners had run out of medicines as the processes to ensure prescribed medicines were available for prisoners were not effective. For example, one prisoner on a specialist medicine had waited eight days for this medicine to be delivered. This delay posed a risk to the prisoner's health and wellbeing.
- When medicines were required urgently staff had access to prescriptions which could be dispensed at external pharmacies (FP10). During the inspection we asked what procedures were in place for the use and tracking of FP10 prescription pads. This information could not be supplied at the time of the inspection. However, on the 31 July 2018 we received a prescription tracking form from the trust. The form lacked detail, contained inaccuracies and information was missing, it was not dated and there were no signatures or dates recorded to indicate when the prescriptions had arrived at the prison. This did not assure us that safe processes were in place to ensure the secure management of prescription pads.
- Nursing staff told us they had access to a range of approved patient group directions (PGD) for the administration of some medicines. PGDs are written instructions to assist competent healthcare staff in the supply or administration of medicines to patients, usually in planned circumstances. We reviewed a range of PGDs prior to the inspection; however we did not see individual signature sheets signed by staff to confirm that they were competent to administer these medicines. Following the inspection, the trust sent us a copy of one signed PGD for a member of nursing staff. This evidence confirmed that a range of PGDs were available to staff.
- The safe transportation of medicines through the prison was not assured. In addition, there was no system in place to track medicines which left the storage area for transportation to the wings. Transportation of medicines received from the external pharmacy to the medicines room within healthcare was unsafe in particular as medicines were transported into the healthcare reception area and no security was provided.
- The recording of medicine fridge temperatures was an area of concern. We could not be assured that medicines held within fridges were fit for purpose or that medicines administered had been effective due to a lack of monitoring and recording of temperatures. On the day of inspection, the maximum temperature of the healthcare centre fridge was above the required safe range. We reviewed the records for May 2018. We asked for additional evidence of fridge temperature records but these records were not available. Following our inspection, the trust sent us 14 sets of records, which included five records of room temperatures where fridges and other medicines were stored. We found gaps in the recordings of 13 sets of these records, which meant that daily checks of fridge temperatures and room temperatures were not consistently undertaken and governance systems did not ensure that these took place.
- During the inspection we found 71 flu vaccinations that had expired in June 2018, stored in a fridge in healthcare. Senior healthcare staff took immediate action and removed the vaccines from the fridge.
- We were concerned that the temperature of a fridge used to store vaccinations was not sufficiently monitored. We asked the trust to take immediate action to ensure the integrity of any medicines stored in this fridge and to consider if they needed to share our findings and concerns with Public Health England (PHE). PHE provides detailed guidance on vaccination storage, ordering and handling of vaccinations. On the 21 September 2018 the trust sent us information which demonstrated they had taken action in response to our findings.
- The trusts in possession policy stated that, as part of the reception process, prisoners should sign a compact agreement (document signed by the prisoner detailing the rules regarding holding medicines in possession) for those who were permitted to hold medicines in their possession. We looked at 18 records of new reception prisoners who held medicines in possession and found that eight did not have signed compact agreements. Further, evidence of in-possession risk assessments being completed as part of the reception screening was not present in eight of the 18 records. We could therefore not be assured that prisoners who currently had medicines in their possession had been fully risk assessed, or understood their responsibilities.
- We observed medicines administration on wings across the prison and had no concerns about the safety of the service provided by nursing staff and pharmacy technicians. Nurses and pharmacy technicians told us

that prison officer supervision of medicine queues was variable and they were concerned as this provided the opportunity for medicines to be diverted between prisoners.
- Emergency drugs used in dentistry were stored appropriately and dentists could prescribe medicines to prisoners who received dental treatment.

Track record on safety and lessons learned and improvements made

- Risks to primary healthcare services were not effectively managed. The exception being for dental services which held a separate risk register. The trust was in the process of reviewing its risk register for the five prison locations to which it provided healthcare services. It was anticipated that this would improve understanding of the risks at each prison location. The current risk register identified 17 risks specific to HMP Wymott, including, the completion of mandatory training, including safeguarding, which was first, identified in August 2017 and last reviewed in June 2018. Despite the inclusion of mandatory training on the risk register, a significant number of staff had still not completed training relevant to their role.
- There was a system in place for recording and acting on significant events. However, we were not assured that all significant incidents were reported and appropriate action was taken to ensure patient safety. We found that reporting processes at local level were variable and it wasn't clear if all incidents were reported, or escalated to the trust if they were significant.
- Staff knew how to report incidents both internally and externally and understood they had a duty to raise concerns and report incidents and near misses. However, staff did not do this consistently, for example, when fridge and room temperatures in clinical rooms were out of range, there was no evidence of staff escalating this for advice or investigation.
- There was no evidence of learning from adverse events and the subsequent dissemination of information to improve safety across the service. We reviewed incident reports where lessons learnt were identified and reviewed minutes of two team meetings. There was no evidence in any documents that learning from significant events had been shared with staff. Staff told us that they did not receive feedback from incident reports they submitted which meant there were missed opportunities to learn from events and improve outcomes for prisoners.
- The trust had an escalation procedure that identified potential safety issues at the service and this linked in with the trust's business continuity plan. Escalation procedures assisted staff in identifying if a key, 'red flag', had been triggered, for example, if staffing levels were insufficient to meet the demands of patient care. The procedure identified a number of potential 'red flags', including, 'medications not available for administration', and the 'inability to deliver planned clinic sessions'. During the inspection we were made aware of a patient who had been without their medicines for eight days. The provider had not raised this as an incident and had not shared this with partner organisations.
- We found that dental staff, recorded incidents and there was clear documented evidence of learning from events and the subsequent dissemination of information to improve safety across the service.

Infection control dentistry

- The dental service had an infection prevention and control policy in place which followed guidance in The Health Technical Memorandum 01-05: Decontamination in primary care dental practices (HTM01-05) published by the Department of Health.
- Decontamination was carried out in a separate treatment room. Instruments were noted to be clean, appropriately stored and stamped with the date to reprocess. Decontamination procedures were appropriate and all necessary equipment used in the process was available to clinical staff.
- Evidence confirmed that all clinical dental staff had completed infection prevention and control training relevant to the service and equipment that was in use.
- We saw cleaning schedules for the dental surgery, which was clean on the day we inspected. Prisoners we spoke with told us the surgery was always clean.
- The dental treatment room met infection prevention standards. We saw a copy of the latest Infection Prevention Audit dated May 2018 which assessed the standard to be 100% complaint with infection prevention. We looked at the arrangements that were in place for safe dental care and treatment, including risk assessments. A sharps procedure was in place and staff

followed relevant safety laws when using needles and other sharp dental items. Staff confirmed that only dentists were permitted to assemble, re-sheath and dispose of needles.

Are services effective?

Effective needs assessment, care and treatment

- Despite arrangements being in place to assess prisoners' immediate and ongoing healthcare needs at the point of reception into the prison, we found that not all prisoners received a more detailed secondary health assessment within seven days of their reception into the prison. Health care assessments within the first few days in prison are crucial in identifying prisoners' healthcare needs, providing treatment and keeping people safe.
- We were made aware of a prisoner who had not had a healthcare reception assessment when they first came into the prison, and neither had they had a secondary health assessment. The prisoner arrived at the prison on the 3 July 2018 and there was no record of them having had an initial health assessment. The prisoner was scheduled to have a second health assessment on the 9 July 2018, this also had not happened. Care records showed that the prisoner was not rebooked for any further assessment.
- We asked the trust to provide information on the number of secondary health screens completed between April and June 2018. They told us that between April – June (3 months) there were 237 new receptions to the prison and only 38 received a secondary health assessment, however it was not clear what percentage of these prisoners were still in the prison seven days later.
- The dentist confirmed they referred prisoners to specialists in primary and secondary care when treatment was needed. These included referrals to oral cancer specialists under the national two week wait arrangements in accordance with 2005 NICE guidance. The dentist monitored urgent referrals with colleagues from primary healthcare services to make sure they were dealt with promptly.

Monitoring care and treatment

- Care and treatment for patients with long-term conditions was effective. Long-term conditions (LTC) were managed by a dedicated LTC nurse who had been in post since December 2017. We found evidence of patient-centred care plans for prisoners who had a diagnosed condition that were reviewed regularly, and referrals on to other services and specialists as required.
- Social care was provided by the trust in partnership with Lancashire County Council. Four full-time and one part-time social care support worker posts were funded by the council to provide personal care to 19 prisoners. A social worker from the council visited prisoners who were in receipt of a care package on a weekly basis. However, the overall supervision and management of social care provision at the prison was unclear. We found that care planning in respect of prisoners in receipt of a social care package was not consistent and reviews of care plans did not take place regularly. Care support staff did not always maintain a record of their input and contact with a prisoner and risk assessments for these prisoners were not completed.
- Care planning arrangements did not ensure that prisoners' health care needs were effectively monitored and met. We reviewed the care plan for a prisoner with leg ulcers, which indicated daily dressing changes were required; the care plan had not been updated since September 2017. Nursing staff told us they thought the dressings should be changed every two to three days. We observed that these dressings had in fact not been changed for 11 days. We saw a referral and photographs had been sent to the tissue viability nursing service, requesting specialist advice.
- Prisoners' attendance at healthcare appointments was monitored monthly and analysed for trends. Healthcare staff worked closely with prison staff to ensure prisoners attended healthcare appointments. Prisoners who did not attend healthcare appointments were followed up by nurses to find out why they had not attended an appointment.
- Staff did not use the computer appointments ledger consistently or accurately. We found many historic appointments left open and others not updated. There was no monitoring of these processes by healthcare managers. This potentially impacted on the validity of reported non-attendance rates.
- We reviewed the care records of a prisoner with diabetes who told us they did not always get their prescribed medicines. We saw that in March 2018 the prisoner did not receive their insulin for three days and in June 2018; they did not receive their insulin for two days.
- A prisoner told us that they had not been issued with their prescribed specialist medicine for a total of eight days. We asked healthcare managers to provide us with a report concerning this incident. This report demonstrated a number of concerns and issues with regard to the process for identifying and ordering specific medicine, including the action staff are expected to take when medicines were unavailable. We

found that healthcare staff had not taken action promptly to ensure that a prescription was issued by the external specialist prescriber and the patient received their medicines.

- There was no medicines optimisation service at the prison. Following reception into prison, reconciliation of prisoners' medicines did not occur. Reauthorisation of prescriptions was completed by the GP. However, medicines reviews by the GP did not regularly happen. We found an example of one prisoner who was admitted to hospital from prison and upon discharge from hospital was prescribed gabapentin for epilepsy in April 2017. A formal review of his care and treatment did not take place until June 2018 and the prisoner was found not to have epilepsy, and the medication was subsequently stopped. Development was required around medicines reviews, particularly for prisoners prescribed strong pain relief medicines.
- The dental service kept dental care records containing information about the patients' current dental needs, ongoing treatment and medical histories. Dental records were detailed and comprehensive.

Effective staffing

- Staff had protected time to complete mandatory training; however despite this a training matrix demonstrated that the uptake of some mandatory training by staff was poor. For example, not all staff had completed training in safeguarding children, safeguarding adults, duty of candour and basic life support and/or intermediate life support. Social care support workers had not completed the majority of their required mandatory training. It was unclear how the trust and healthcare managers assured themselves that staff members were sufficiently skilled to carry out their roles.
- The trust had a clinical supervision policy that applied to clinical staff and non-registered staff who had a clinical role and/or worked in a clinical area. Medical, dental, nursing and allied health professionals fell within the scope of the policy. Models of clinical supervision included one to one supervision, group supervision and 'network' supervision. Clinicians were expected to access clinical supervision four times a year. Health care staff, including nurses, pharmacy technicians, healthcare assistants and social care support workers told us they did not receive regular formal one to one managerial or clinical supervision.
- Supervision arrangements for all members of the staff team were insufficient. During the inspection we asked to see supervision records for six nurses, two healthcare assistants, two social care support workers and three pharmacy technicians. This information was not provided. Following the inspection we received nine records of group clinical supervision sessions, which had been attended by nurses and pharmacy technicians. We did not see any evidence that healthcare assistants and social care support workers received supervision. It was unclear how the trust and healthcare managers assured themselves that staff members were appropriately supervised, monitored and supported to carry out their roles.

Coordinating care and treatment

- Healthcare staff worked together and with other health and social care professionals effectively to deliver care and treatment. Care records showed that healthcare staff from different organisations, for example, GPs and mental health workers, had been involved in assessing, planning and delivering coordinated care and treatment. However, we found instances when poor communication did not support positive outcomes for prisoners. For example, we found a prisoner who had been seen by a diabetic specialist in November 2017 and was recommended for further blood test monitoring. However, healthcare staff did not follow this up and none of the required tests had been undertaken.

Helping patients to live healthier lives

- Health promotion was a developing picture following the appointment of a dedicated health promotion nurse who had been in post since February 2018 and worked across two prisons. Their role included working with individual patients to advise on health improvement, for example, obesity, diet, diabetes and some communicable diseases.
- The health promotion nurse had started to work with gymnasium staff and the catering department within the prison in respect of individual prisoners who needed calorie rich diets to assist them to gain weight, or to maintain energy levels. They also had plans to promote health campaigns on the wings, including hepatitis immunisation and influenza vaccination in September 2018, in line with the Health Promotion UK calendar of events.

Are services effective?

- Dental staff were familiar with the 'Delivering Better Oral Health toolkit', which is an evidence based toolkit used to support dental teams in improving their patient's oral and general health. We were told that the practice provided preventative care, advice and support to patients. There was limited information on oral health displayed in the healthcare centre, although prisoners had access to good range of oral health education leaflets. Prisoners told us that dentists advised them on how to improve oral health, relating to smoking and diet.

Consent to care and treatment

- Primary health care clinicians obtained consent to care and treatment in line with legislation and guidance. They understood the requirements of the legislation and guidance when considering consent and decision making. Clinicians worked on the basis of having obtained implied consent. The dentist told us they gave patients information about treatment options and the risks and benefits of these so they could make informed decisions.
- Nurses, pharmacy technicians and other healthcare staff supported patients to make decisions about care and treatment. The majority of staff had completed training in the Mental Capacity Act 2005 with the exception of social care support staff. Staff, including dental staff were aware of the Mental Capacity Act 2005 and their responsibilities under the act when treating adults who may not be able to make informed decisions.

Are services caring?

Kindness, dignity, respect and compassion

- We observed some positive and respectful interactions between healthcare staff and prisoners during the inspection. However, the majority of prisoners we spoke with had a negative perception of their contact and experience of health care services.
- We observed social support staff acting in a kind and caring way to prisoners located on I wing. Prisoners in receipt of care packages told us that staff treated them respectfully, including knocking on cell doors before entering.

Involvement in decisions about care and treatment

- Some prisoners who received social care support held copies of their care plans; others told us they had declined a copy. Care plans in relation to prisoners with long-term conditions demonstrated clear patient involvement.
- Some prisoners we spoke with felt involved in planning their care, others felt they had little involvement. Others said that the quality of care delivered depended on staff availability.
- Staff did not always communicate clinical decisions adequately to patients. In one case, a prisoner had been administered medicine for anaemia despite being told by the GP that his blood test results were clear the previous month, and could not gain clarity on the issue from healthcare staff. Staff did not consistently help prisoners to understand their treatment or involve them in in decisions about their care and treatment.
- Language Line was available and used to assist communication during consultations for prisoners whose first language was not English.
- We saw that dental staff provided prisoners with information about relevant treatment options to help them make informed choices. A prisoner told us that dental staff were helpful when they were in pain or discomfort.

Privacy and dignity

- We saw clinic room doors open during nurse-led clinics, and consultations could be heard by staff including prison staff and other prisoners passing through the reception area. We brought this to the attention of senior managers, but no rationale for this practice was shared with us. We observed that the practice of leaving doors open during appointments continued throughout the inspection. Periodically we saw that screens had been placed across doorways to obscure patients undergoing treatment.
- We observed that the door of the dental clinic room was closed at all times whilst patients were receiving treatment. This maintained patient dignity and afforded them appropriate respect whilst undergoing treatment. This enabled staff to discuss confidential information with prisoners without conversations being overheard.
- Some prisoners commented positively that staff including dentists and dental nurses, were friendly, caring and respectful.
- Processes for informing prisoners of scheduled healthcare appointments did not ensure patient confidentiality. Healthcare appointment slips, including for GP and nurse- led clinics were put under prisoners' cell doors. Appointment slips included details of the clinic which a prisoner was attending. They were not put in an envelope or concealed in any way to maintain patient privacy and confidentiality.
- We found other instances were prisoners' confidentiality had been compromised or had the potential to be compromised. Prisoners told us their requests to meet privately with a nurse to discuss their health concerns were not met and they had to discuss highly personal information in close proximity of medicines hatches and in ear shot of other prisoners and prison staff.

Are services responsive to people's needs?

Responding to and meeting people's needs

- The healthcare centre was small with insufficient treatment rooms to meet the needs of the prison population. A lift was available to assist prisoners with mobility problems to access treatment rooms, including the dental suite.
- The service did not always deliver healthcare services in a way that met prisoners' healthcare needs and within acceptable timescales. We were made aware of several incidents where prisoners had waited up to two hours to be seen at a nurse-led clinic. Clinics were oversubscribed and not effectively managed. Prisoners were returned to their wings to enable staff to issue medicines. Prisoners told us about the frustration of sitting around for hours waiting to be treated only to be sent back to the wing without being treated. They told us that communication and information about appointments was poor.
- Prison officers told us that treatment cancellations often meant that prisoners returned to their cells feeling frustrated, and officers were left to manage prisoners' adverse reactions to cancelled appointments.
- Healthcare staff reported that a number of clinics had been cancelled in recent months due to staffing shortages. We reviewed electronic records used to schedule clinics and patient appointments, which confirmed that many clinics had not happened. The recording around this and reasons for cancellation were unclear. Managers were unable to provide us with accurate figures about recent clinic cancellations, and were not monitoring this effectively. We found that prisoners were not routinely re-booked a further appointment when a clinic was cancelled, leading to delays in patient care. Healthcare managers were unable to provide us with accurate figures about clinic cancellations.
- Prison officers told us they were concerned that prisoners held in the segregation unit were not visited by a member of healthcare staff on a daily basis. It is a prison requirement that a member of healthcare staff must assess the physical, emotional and mental wellbeing of prisoners and if there are any clinical reasons to advise against the continuation of segregation. We found that GP visits were consistently happening as required, three days per week. However registered nurses were not attending on all other days. For example, we found three occasions in July 2018 when healthcare staff had not visited prisoners held in the segregation unit. Visits not completed by healthcare staff put prisoners held in segregation at risk by not assessing and responding appropriately to their changing healthcare needs.

Timely access to care and treatment

- Healthcare appointment application forms were available on wings and prisoners knew how to request an appointment. Non-attendance rates were being monitored but the clinic ledger was being used to provide this information and this was frequently not completed correctly which meant that data was not reliable. Some patients commented about the extended time it took to access nurse clinics, the GPs and dental services.
- The dental service was committed to seeing patients experiencing pain on the same day and kept some appointments free for same day care.
- Some treatment rooms were shared with other healthcare providers. We saw that two nurse-led clinics were scheduled on one day of the inspection; however, these clinics did not take place. We were told that this was because two treatment rooms were not available. We observed two nurses undertaking an ECG on one prisoner in one treatment room, which was not the best use of a qualified nurse's time. Resources were not effectively managed to ensure clinics took place and patients had prompt access to assessment, care and treatment.
- Prisoners were supported to attend external hospital appointments. The number and reasons for non-attendance at hospital appointments was monitored and analysed monthly for patterns and/or trends. Reasons for non-attendance varied. Sometimes prisoners refused to attend hospital appointments, or appointments were cancelled by the hospital and rearranged. Prison officers supported prisoners' attendance at hospital appointments and the prison prioritised these accordingly. Prisoners told us that access to hospital appointments was good, but earlier in the year had been affected by inclement weather conditions.

L istening and learning from concerns and complaints

- Information on how to complain was publicised on most wings and in the healthcare centre. Healthcare complaint forms were available on the wings. However,

Are services responsive to people's needs?

the poster "how to complain", was not visible on one wing location and easy read versions of complaints information was not available. Prisoners we spoke with knew about the complaints procedure, however, several told us they did not have confidence that their concerns would be listened to.

- Complaints and concerns were responded to appropriately and in a timely manner. Responses to complaints were satisfactory, though we did not have access to the original complaint. Responses did not include information on how a prisoner could escalate their concerns if they were dissatisfied with how their complaint had been managed. A lead dental nurse was responsible for responding to complaints about the dental service, the majority of which were about waiting times to access care and treatment.

Are services well-led?

Leadership capacity and capability

- Primary health care leaders had the capacity and skills to deliver high-quality, sustainable care, including processes to develop leadership capacity and skills amongst its staff group. However, the trust was not sufficiently focused on staff development and/or service development and because of this lack of focus, improvements were not sustained.
- Healthcare staff told us that healthcare managers were not always visible and they did not always work effectively with front line staff. Though some staff told us since the appointment of the associate chief nurse they felt better supported and listened to. However, other staff told us they felt disengaged from the trust
- Dental services were managed separately to primary health care services and came under the management of the trust's dental network. Dental staff were supported by an external operational manager who undertook regular visits to the prison dental service to review aspects of the service provided.

Vision and strategy

- Despite the varying views of staff, most were optimistic that change and improvements were achievable. Individual staff we spoke with understood the vision and strategy of the trust to deliver high quality, sustainable care to the prison population, but trust-level commitment and support was felt to be lacking.
- Induction for permanent and agency primary health care staff was not a priority and many staff had not had a formal induction, missing a crucial opportunity to help all staff understand the trust's vision and values. It was unclear how senior health care managers assured themselves that staff were sufficiently informed to carry out their role. Similarly, supervision arrangements for all staff members were insufficient. Effective oversight of staff supervision and arrangements for supervision was absent throughout the service.

Culture of the organisation

- Staff we spoke with told us they could raise concerns and were encouraged to do so. Whilst they felt confident to raise issues with line mangers, they were less confident that action would be taken in response to their concerns.
- We found many incidents had not been reported, for example, daily tests of equipment and fridge monitoring were not routinely completed and staff did not report these omissions.
- Some staff told us that they didn't feel listened to and involved in the day to day management of the service. Staff spoke of feeling undervalued and not appreciated.
- Senior management had not consulted staff on proposed changes to the service model and plans for developing the service. Healthcare staff needed better support to have a stronger voice across the organisation.

Governance arrangements

- Systems and processes for learning and continuous improvement were firmly embedded across the trust's dental services directorate. There was a focus on continuous learning and improvement; this was done through the use of the trusts learning 'Hub', to which all trust employees had access to, newsletters and reviews of patient complaints. Learning was shared and used to make improvements.
- The dental service gathered appropriate information through their quality, performance and contract reporting arrangements. The information was used to monitor the service and trends, and provide an overview of quality performance issues. The information was regularly reviewed to inform service delivery and ongoing development.
- However, for primary health care services we found systems and processes to support good governance and management of the service were limited at local level and this impacted upon their overall effectiveness. For example, processes for providing all staff with the development they needed, including supervision were not embedded across the service. Staff meetings did not take place on a regular basis.
- Managers were frequently involved in delivering patient care. Whilst staff valued this practical support it was to the detriment of effective leadership.
- Health care managers did not routinely share learning from incidents with primary healthcare staff in order to make improvements. Primary health care staff told us that they did not receive feedback from incident reports they submitted which meant there were missed opportunities to learn from events and improve outcomes for prisoners.

Are services well-led?

- Whilst mandatory training was recorded and monitored, the uptake by staff was poor; for example, with found a number of primary healthcare staff had not completed safeguarding training relevant to their role. It was difficult to understand how healthcare managers assured themselves that staff members were sufficiently informed to carry out their roles and duties. The uptake of mandatory training by dental staff was exemplary.
- Regular checks of emergency equipment bags were not consistently completed and records maintained. Additionally, no governance checks were undertaken to ensure that equipment was monitored and fit for purpose. This meant that the safety of prisoners requiring an emergency response and/or treatment could be compromised.

Managing risks, issues and performance

- Processes for managing risks, issues and performance were not fully effective. Monitoring systems did not support processes to identify, understand and address risks, including risks to patient safety. There was limited evidence of management oversight or monitoring in a number of key areas, including cancelled primary health care clinics.

Appropriate and accurate information

- The service gathered information through their quality, performance and contract reporting arrangements, including, serious incidents, such as medication errors and prescribing trends of tradeable medicines. We were told that this information was used to monitor the service, identify trends and provide an overview of quality performance issues. However, it was not clear how this information was used to develop and improve outcomes for prisoners who used primary health care services.
- The service submitted data or notifications to external organisations as required.

Engagement with patients, the public, staff and external partners

- It was evident that engagement with patients had not been a priority for primary healthcare services. Limited action had been taken to involve patients, staff and external partners in delivering high-quality sustainable services.

Continuous improvement and innovation

- Systems and processes for learning and continuous improvement were in place. However, learning from reported incidents was not effective or sufficiently embedded across primary health care services, but was firmly established across dental services. A dental network newsletter was sent out to dental staff on a quarterly basis, which included updates on the MCA code of practice and safety updates. Lessons learnt were published and shared with all dental staff on a monthly basis and included topics such as needle stick injury and steps to take should instruments break during treatment.
- We attended three primary health care staff handover meetings. We observed that handover meetings were not always well managed and lacked structure, clear purpose and accountabilities.
- Dental quality assurance processes including audits of care records, radiographs and infection prevention and control were effective.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use the service did not always receive person-centred care and treatment. Care plans were not consistently reviewed and/or updated to reflect changes in peoples care needs. People were not always involved in planning their care and treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Peoples' privacy was not maintained at all times when attending clinic appointments. Clinic doors did not remain closed during consultations which compromised people's dignity.All reasonable efforts had not been made to make sure that discussions about care treatment and support took place privately. All reasonable efforts had not been made to ensure that people receive invitations to clinic appointments in a way that does not breach their patient confidentiality.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided to people who use the service in a safe way. Risk assessments were not available for those prisoners with complex health needs. Risk assessments for people who held medicines in-possession were not always completed. Regular checks of emergency bags were not consistently completed and records maintained.Daily checks of fridge

This section is primarily information for the provider

Requirement notices

temperatures were not always undertaken. Medicines were not supplied in sufficient quantities to ensure the safety of people who used the service and to meet their needs.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes to support good governance and management of the service were limited and under developed at local level and this impacted upon their overall effectiveness of the service. Those that existed needed further development.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Healthcare staff did not always receive appropriate support, training, professional development and supervision necessary to enable them to carry out their duties.