# Trust Headquarters, 350 Euston Road

## Inspection report

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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 rating for this location | Inspected but not rated |
| Are services safe? | **Inspected but not rated** |
| Are services well-led? | **Inspected but not rated** |

# Overall summary

We carried out an announced follow up inspection of healthcare services provided by Central and North West London NHS Foundation Trust (CNWL) at HMP Downview on 7 December 2022. This was in response to a His Majesty's Inspectorate of Prison's (HMIP) joint inspection carried out in July 2021 when we found the quality of care needed improvement. We issued a Requirement Notice in relation to Regulation 17: Good governance. There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular: Patient applications to see a healthcare professional were not triaged by clinically qualified staff. There was no oversight of patients who were waiting to see the GP. There was insufficient oversight of the electronic task system with over 450 tasks open at the start of the inspection.

The purpose of this focused inspection was to determine if the healthcare services provided by CNWL were now meeting the legal requirements of the above regulation, under Section 60 of the Health and Social Care Act 2008.

At this inspection we found the required improvements had been made and the provider was meeting the regulations. The requirement notice was lifted.

## Our inspection team

The inspection was carried out by two CQC health and justice inspectors.

**How we carried out this inspection**

Before this inspection we reviewed some information that we held about the service including notifications and action plan updates. We conducted a range of interviews with staff on the day of our visit on 7 December 2022.

During the inspection we spoke with healthcare staff including the head of healthcare.

We accessed patient clinical records during our onsite visit on 7 December 2022. We conducted searches of patients who had been placed on a GP waiting list, and reviewed the electronic task system.

We asked the provider to share a range of evidence with us. Documents we reviewed included:

- Staff organogram.
- Planned versus number of actual staff on shift over each week in August, September, October and November 2022. (Outlining number of unfilled shifts).
- Copy of most recent patient record audit and associated action plan.
- Number of nurse-led clinics held and number of nurse-led clinics cancelled by healthcare or the prison April to November 2022.

## Background to Trust Headquarters, 350 Euston Road

HMP Downview is a closed women's training prison and young offender institution (YOI) in Sutton, Surrey, for women aged 18. The prison is operated by His Majesty's Prison and Probation Service.

Central and North West London NHS Foundation Trust (CNWL) is the health provider at HMP Downview. The trust is registered to provide the following regulated activities at the location: Treatment of disease, disorder or injury and Diagnostic and screening procedures.

The last HMIP comprehensive inspection was in July 2021 and was published on the HMIP website in October 2021 when we found not all fundamental standards were being met in relation to Regulation 17: Good governance. The inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-yoi-downview-2/

Inspected but not rated

# Are services safe?

We did not look at all aspects of this key question during this focused inspection.

**Systems were effective in ensuring the assessment, monitoring and management of risks to patient safety.**

During the July 2021 HMIP joint comprehensive inspection, we found not all patient applications to see a healthcare professional were triaged by a clinically qualified member of staff.

- During this follow up inspection, we found this practice had stopped and that only a clinically qualified staff member triaged healthcare applications.
- Healthcare applications were collected each day from the wings and a clinically qualified member of staff triaged each application. Each patient was added to an appropriate waiting list, according to their assessed level of clinical need. Patients requiring urgent care were allocated a same day appointment with the GP.
- Following the change in practice, monthly audits were initially completed to ensure an appropriately trained member of staff was triaging all healthcare applications. There was 100% compliance in an audit undertaken in October 2021, and we found this process was now embedded in practice.
- Triage refresher training had also been delivered in September 2022 to ensure the consistent prioritisation of clinical need. This training was also delivered to bank and agency staff.

During the July 2021 HMIP joint comprehensive inspection, we found there was no oversight of patients waiting to see a GP. During the inspection, 39 patients were on the GP waiting list and had been waiting up to 3 weeks and 4 days. These patients did not have GP appointments booked despite records indicating that there were available appointments in 3 days. Nurses were allocated to oversee the list and the appointments schedule. However, low staffing levels meant this task had not been completed.

- During this inspection, we found a new governance system had been introduced to ensure there was consistent oversight of GP waiting lists. Daily, weekly and monthly checks were undertaken by a healthcare lead to ensure patients were seen in a timely and safe way.
- Patients were triaged daily by a clinically trained member of staff before they were placed on the GP waiting list. The primary care lead reviewed the GP waiting list on a weekly basis to ensure the daily checks had been completed accurately. On a monthly basis, the GP waiting lists were reported to the senior management team for additional oversight to enable any concerns to be addressed.
- Staff knew the patients at the prison well and further health information was collected through patient observations and discussions at every opportunity. Any noted concerns were shared within the team which would result in a patient's healthcare appointment being brought forward if required.
- At the time of our inspection, there was one patient on the GP waiting list. This represented a significant improvement to the previous inspection. The next available routine appointment was on 23 December 2022 which, at just over 2 weeks, was good. We reviewed 7 patient records who had GP appointments on 7 December 2022 and found their wait times had been similar, at around 2 weeks. One patient had received an appointment with 48 hours. This demonstrated the triage system was safe and effective.

During the July 2021 HMIP joint comprehensive inspection, we found there was insufficient oversight of the electronic task system with over 450 open (unactioned) tasks at the start of the inspection. This meant there was a risk that a request for a review of a patient's treatment and care would not be actioned in a timely way.

- During this inspection, we found significant improvement in that there were 62 open tasks, 9 of which were dated between 1 November 2022 and 5 December 2022. Most open tasks had been created in the previous 48 hours. We reviewed a sample of open tasks and found there were no outstanding urgent requests for treatment and care. Some tasks were duplicates, whilst others had been actioned and their closure had been overlooked.

Inspected but not rated

# Are services safe?

- Staff were allocated daily to review tasks in each team, and open tasks were reviewed weekly by clinical leads to ensure they were actioned as required.
- A local operating procedure had been introduced following the previous inspection that set out the process for task management. We found most tasks were managed in line with the guidance; however, some 'housekeeping' was required to close a small number of tasks that, while not urgent, had been overlooked.
- Compliance with task management was monitored at the monthly health and justice senior management team meeting.

During the July 2021 HMIP joint comprehensive inspection, we found that approximately 25% of patients missed their GP appointment because of a lack of officers to escort them.

- During this inspection, we found improvement and that a review with the prison had been undertaken to increase attendance at healthcare appointments. Routine GP appointments were now booked 'wing by wing' which was more effective in ensuring prison officers were available to take people to appointments. During November 2022, there were 36 out of 320 (11%) missed appointments due to patients not being escorted to the healthcare department. Whilst this represented improvement, leaders told us they continued to work with prison staff to increase attendance.

During the July 2021 HMIP joint comprehensive inspection, we found that low staffing numbers meant there had not been consistent oversight of the GP waiting list. Furthermore, the head of healthcare was required to complete clinical tasks at times and it was not clear why gaps had not been filled by bank or agency staff.

- During this inspection, we found improvement in that data confirmed staffing was 87% and 97% above minimum required staffing levels in October and November 2022 respectively. There were some vacancies across the service; however, leaders told us vacant shifts were mostly covered by bank and agency staff and data we reviewed confirmed this.

Inspected but not rated

# Are services well-led?

**Leadership capacity and capability**

At the previous HMIP joint comprehensive inspection we found leaders had not always filled vacant shifts by recruiting bank and agency staff. The head of healthcare was required to undertake clinical work which compromised the consistent oversight of the service. Prison officer staffing gaps had also meant the escorting of patients to their healthcare appointments was not always prioritised and 25% of appointments were missed.

At this inspection we found:

- A new head of healthcare had been recruited since the previous inspection and there were very few shifts that had not been filled by bank or agency staff.
- CNWLs relationship with prison managers was good and processes had been revised to manage escorting patients to their healthcare appointments. Attendance had significantly increased since the previous inspection.

**Governance arrangements**

At the previous HMIP joint comprehensive inspection we found patient applications to see a healthcare professional were not triaged by clinically qualified staff. There was no oversight of patients who were waiting to see the GP; and there was insufficient oversight of the electronic task system with over 450 tasks open at the start of the inspection.

At this inspection we found:

- All healthcare applications were triaged by a clinically qualified member of staff.
- There was consistent oversight of patients waiting to see a GP to ensure they were seen in a timely way and according to their clinical need.
- Revised governance processes ensured there was effective oversight of the electronic task system.