HMP Woodhill

Quality 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.

Contents

Overall summary

We undertook a focused inspection on the 20 and 21 September 2017 under Section 60 of the Health and Social Care Act 2008. The purpose of the inspection was to follow up on a Requirement Notice that we issued following a previous focused inspection in September 2016 and to check that the provider was meeting the legal requirements and regulations associated with the Act.

Our key findings were as follows:

- The trust was focused on increasing staffing levels and had implemented a rolling recruitment programme. To ensure a range of services were provided to patients,

Summary of findings

managers at the trust had reviewed the service and recruited a number of associate mental health practitioners to provide group work and one to one therapies.

- Joint working between partner agencies had developed since our previous inspection and was fully embedded across healthcare services.
- Prisoners could now self-refer to mental health services.
- Patients we spoke with were positive about their contact and experience of healthcare services within HMP Woodhill.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We did not inspect the safe key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notice issued in September 2016.

- The trust was focused on increasing staffing levels and had a rolling recruitment programme. To ensure a range of services were provided to patients, managers at the trust had reviewed the service and recruited a number of associate mental health practitioners to provide group work and one to one therapies.

Are services effective?

We did not inspect the effective key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notice issued in September 2016.

- Joint working between partner agencies had developed since our previous inspection in September 2016 and was fully embedded across healthcare services within the prison.

Are services caring?

We did not inspect the safe key question in full at this inspection.

- Patient care plans did not fully reflect the level of support they received from healthcare staff.

Are services responsive to people's needs?

We did not inspect the responsive key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notice issued in September 2016.

- Prisoners could now self-refer to mental health services.
- Patients with complex health care needs received a coordinated and responsive service from a range of health care partners.

Are services well-led?

We did not inspect the well-led key question in full at this inspection.

- Oversight of improvements was monitored through a range of quality improvement arrangements which supported the trusts vision and strategy to deliver high quality care and promote good outcomes for patients.

Summary of findings

- Staff we spoke with told us they felt supported by management, they felt involved and were consulted in regard to day to day delivery of the service.
- Governance arrangements ensured consistency of service delivery including the identification and management of risk through regular internal audits.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- The trust should develop the overall quality of care plans so that they fully reflect the level of staff interventions undertaken with patients. This will ensure that nursing staff meet patients health and care needs in a consistent way.

HMP Woodhill

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC health and justice inspector, accompanied by a second health and justice inspector and an inspector from the CQC's mental health inspection team.

Background to HMP Woodhill

HM Prison Woodhill is a Category A male prison, located in Milton Keynes, England and can accommodate up to 819 prisoners. The prison holds remand and sentenced prisoners aged 18 and above. In addition, Woodhill is one of the eight national high security prisons, holding category A prisoners, some in the "Closed Supervision Centre". Central and North West London NHS Foundation Trust (CNWL) provides a full range of primary health and mental health, including emergency response services, first night assessments and prescribing services to the prison population at HMP Woodhill.

Why we carried out this inspection

We undertook a focussed inspection on the 20 and 21 September 2017 under Section 60 of the Health and Social Care Act 2008. The purpose of the inspection was to follow up on a Requirement Notice that we issued following a previous focused inspection in September 2016 and to check that the provider was meeting the legal requirements and regulations associated with the Act. Following the 2016 inspection we asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting at that time. At our previous inspection in September 2016 we found that the trust was focused on promoting good outcomes for patients who used healthcare services within HMP Woodhill. When we undertook a follow up inspection on the 20 and 21 September 2017 we looked at this again to ensure ourselves that the trust remained committed to improving outcomes for prisoners.

The full comprehensive report on the November 2016 inspection can be found on our website at http://www.cqc.org.uk

How we carried out this inspection

Before our inspection we reviewed a range of information that we held about the service. We asked the provider to share with us a range of information which we reviewed as part of the inspection. We spoke with staff and sampled a range of records. We were on site for two days and during the inspection we looked at provider documents, patient records, spoke with healthcare staff, prison staff and people who used the service.

Evidence reviewed included:

- We reviewed the providers updated action plan January 2017
- Minutes of the WQIG (Woodhill Quality Improvement Group) Progress Report 10 January 2017
- Minutes of the WQIG (Woodhill Quality Improvement Group) Progress Report 2 May 2017
- Minutes of the Interagency Integrated Clinical Governance Meeting Group HMP Woodhill for February, March and April 2017
- Northamptonshire & Milton Keynes Prison Healthcare Partnership Board 7 October 2017

Detailed findings

- Minutes from the Offender Care Service Transformation Board May 2017
- Task Force Action Plan March 2017
- A CNWL Recruitment Position Paper September 2017
- CNWL DNA (Did Not Attend) Policy June 2017
- Local Operation Procedure – Roles and Responsibilities for Attendance at ACCT reviews (January 2017)
- Joint policy for dual diagnosis
- Audit Report Primary Mental Health Group Interventions Aug 2017
- Local Operating Procedure – Admission and Discharge from Clinical Assessment Unit

We reviewed the evidence submitted against the concerns identified in September 2016 and the requirement notice that was issued following the inspection and made an assessment against our regulations. At this inspection we found the provider was no longer in breach of the regulations.

Are services safe?

Our findings

At our previous inspection in September 2016 we had concerns regarding staffing levels. These arrangements had significantly improved when we undertook a follow up inspection on the 20 and 21 September 2017.

Monitoring risks to patients

- At our previous inspection in September 2016 we reported that both the primary healthcare and mental health teams had experienced staffing shortages for a significant length of time. The mental health team was providing a 'crisis' service. Whilst we were assured that patients in crisis were seen promptly, we were concerned that patients with low level mental health needs did not have access to a full range of therapeutic activities, including group work and one to one work.
- Following our previous inspection the trust developed a divisional workforce strategy to focus on the recruitment of nursing and health care staff at the prison, part of which included a dedicated offender care human resources recruitment manager. This resulted in an apprenticeship scheme which commenced in September 2017, healthcare assistants supported to develop by undertaking nurse associate training and the creation of associate mental health practitioner posts.
- At this follow up inspection in September 2017 we found that the overall number of qualified staff had not changed and in response to a national difficulty to recruit band 5 nurses the trust had reviewed its position. The outcome of the review resulted in the appointment of four mental health associate practitioners whose role included providing group and one to one work with patients. This role was also extended to link in with smoking cessation programmes.
- At our previous inspection we found that six monthly reviews of patients who were subject to a Care Programme Approach (CPA) under the Mental Health Act 1983 did not take place. The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. At this follow up inspection we found that CPA reviews were consistently taking place and managers monitored these on a monthly basis.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in September 2017 we found that a number of new initiatives for responding to patients with complex needs had been put in place; however we did not have the opportunity of assess the effectiveness of these arrangements.

We found that these arrangements were effective and fully embedded across the service when we undertook a follow up inspection on the 20 and 21 September 2017.

Management, monitoring and improving outcomes for people

- At our previous inspection weekly meetings between the mental health team and substance misuse teams had been a recent development and patients known to both teams were discussed. However, we were unable to fully test the effectiveness of these meetings. Staff we spoke with during this focused inspection confirmed that the joint working arrangement worked well and provided an opportunity for staff to monitor and review patients' progress and concerns. The joint working arrangments were effective and ensured good outcomes for patients.
- Additionally daily lunch time staff meetings took place where patients were discussed. These meetings were attended by primary care and mental health nurses.

Similarly a weekly complex cases meeting was held, to discuss patients with significant health care needs with input from various health care professionals. It had been recognised that there was a need for all service providers involved with the patient to meet periodically to discuss and review the patient's care.

Effective staffing

- Previously we reported that staff had the skills, knowledge and experience to deliver effective care and treatment to the prison population at HMP Woodhill. However, reduced staffing levels meant they could not to provide a full range of services specifically in relation to providing group work and one to one support for patients with primary mental health needs.At this inspection we found that the introduction of mental health associate practitioners meant that patient groups were happening, as were one to one therapy sessions with patients.Some interventions provided included, group relaxation, anxiety management, coping with trauma and one to one sessions as appropriate.
- The mental health associate practitioners also held weekly drop in surgeries on each wing and had been used to support prisoners on smoking cessation programmes since the 4 September 2017 when the prison became non-smoking. These developments ensured that patients had improved access to therapies and other support.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

- Patients we spoke with were positive about their contact and experience of healthcare services within HMP Woodhill. They told us they received good information on healthcare services and how to access them when they first came into the prison, including mental health services. They told us that nursing staff were helpful and approachable.

Care planning and involvement in decisions about care and treatment

- We reviewed a sample of patient care records including care plans. We found that care plans were in place for prisoners with long-term conditions, and for those who required mental health support. However care plans did not fully reflect the level of support and interventions from staff that patients received and required further development.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection in September 2016 we had concerns that prisoners could not make direct referrals for mental health support services, which could be a potential barrier or deter prisoners from seeking help.These arrangements had significantly improved when we undertook a follow up inspection on the 20 and 21 September 2017.

Responding to and meeting people's needs

- As previously reported in 2016, prisoners continued to receive a comprehensive physical and mental health assessment, known as a 'health screen' within 24 hours of their reception into the prison. At this focused inspection we found responsive healthcare assessments continued to take place within 24 hours of a prisoner's reception into the prison This ensured that prisoners' physical and mental health needs were comprehensively assessed at the earliest opportunity, care and treatment plans put in place, risks assessed and monitored.
- The mental health team now undertook timely, responsive reviews of all patients who were subject of a Care Programme Approach (CPA).

Access to the service

- Previously we reported that prisoners could not self-refer to the mental health team, but had to request a referral through their relevant wing based nurse. We questioned the appropriateness of this and it's potential to act as a barrier or deter prisoners from asking to see a mental health practitioner. The trust took on board our concerns and reviewed their service model.As a consequence of this prisoners can now refer directly to the mental health team.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

- At our previous inspection in September 2016 we found that the trust was focused on promoting good outcomes for patients who used healthcare services within HMP Woodhill. When we undertook a follow up inspection on the 20 and 21 September 2017 we found that the trust remained committed and consistent in its vision that prisoners accessed effective and responsive health care services.
- Oversight of improvements was monitored through a range of quality improvement arrangments including the offender care transformation meetings, risk management and at a local level through weekly and daily clinical patient focused discussions.

Governance arrangements

- Since our last inspection the trust remained proactive in its attempts to recruit staff from various clinical backgrounds to meet the needs of patients. Managers held fortnightly divisional workforce meetings that monitored recruitment and vacancies ensured health care services were sufficiently staffed.
- Audits of clinical practice continued to be undertaken and used to monitor quality and make improvements to service delivery, for example, monitoring missed patient appointments.
- Arrangments continued to be in place for identifying, recording and managing risks.At our previous inspection the development of the 'Interagency Integrated Clinical Governance Meeting' had been a new initiative and we were unable to test its impact. The Integrated Clinical Governance Meeting, which is attended by all healthcare providers within the prison, NHS England commissioners and the governor for HMP Woodhill had until recently met on a monthly basis and now met quarterly.It provided an overarching prison response to deaths in custody and ensuring the safety of prisoners as a joint prison response between the prison and healthcare partners.
- The trust continued to record and monitor all incidents and actions to address identified risks on a monthly basis; thus retaining an effective overview of the service.

Leadership and culture

- Clear leadership structures continued and staff we spoke with told us they felt supported bymanagement, they felt involved and were consulted in regard to day to day delivery of the service.

Continuous improvement

- There was a focus on continuous learning and improvement across healthcare services within the prison.
- Audits and daily reports were produced to check that all prisoners received good, effective and responsive care.
- The trust in consultation with its partner agencies was currently reviewing the patient pathway for patients with complex care needs, including those who had a dual diagnosis .
- The thorough assessment of a prisoner's health and emotional well being at their point of reception into the prison provided a basis for assessing and managing prisoners at risk during early days in custody and meeting their long term care and treatment needs.