Bridgewater CHCFT HMP Risley

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

This inspection was an announced focused inspection carried out on 3 May 2017. The purpose of the inspection was to confirm that the service provider, Bridgewater Community Healthcare NHS Foundation Trust had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) between 20 and 23 June 2016 and in the Requirement Notice that we issued on the 14 December 2016. This report covers our findings in relation to those requirements.

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 at this inspection.

Are services effective?
We did not inspect the effective key question at this inspection.

Are services caring?
We did not inspect the caring key question at this inspection.

Are services responsive to people's needs?
We did not inspect the responsive key question at this inspection.

Are services well-led?
We did not inspect the well-led key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 14 December 2016.

- Governance arrangements had significantly improved and partnership working was effective.
- Patient access to GP clincs and waiting times were effectively monitored. Staffing levels and skills mix were reviewed to ensure that patient need was met.
- A clinical check had been introduced since our last inspection and this provided improved governance around prescribing.
- The trust actively engaged and worked in partnership with health and well-being advisors.

Bridgewater CHCFT HMP Risley

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was led by a CQC health and justice inspector, accompanied by a second health and justice inspector.

Background to Bridgewater CHCFT HMP Risley

HMP Risley is a category C training and resettlement prison for around 1,110 adults. It is located near Warrington in Cheshire, between Liverpool and Manchester. Bridgewater Community Healthcare NHS Foundation Trust provide the majority of health care services at the prison including, primary health care, dental services and GP services. The location, Bridgewater CHCFT HMP Risley is registered to provide the regulated activities of, diagnostic and screening procedures, surgical procedures and treatment of disease, disorder or injury.

CQC inspected healthcare services at the prison in partnership with Her Majesty's Inspectorate of Prisons from 20 - 23 June 2016. We found the provider, Bridgewater Community Healthcare NHS Foundation Trust was in breach of the regulations and we issued a Requirement Notice. We asked the provider to make improvements and we followed up on their progress during a focused inspection on 3 May 2017.

During this focused inspection, we found the provider had made significant improvements, had taken necessary action and was meeting the regulations.

Why we carried out this inspection

We undertook a focused inspection of Bridgewater CHCFT HMP Risley on 3 May 2017. This inspection was carried out to review in detail the actions taken by the provider to improve the quality of care and to confirm that the provider was now meeting legal requirements.

The inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-risley/

How we carried out this inspection

We carried out a focussed inspection of HMP Risley on 3 May 2017. Before our inspection we reviewed a range of information that we held about the service. We asked the provider to share with us a other information which we reviewed as part of the inspection. During the inspection we spoke with a range of healthcare staff and the prison's governor.

Evidence reviewed included:

- An updated action plan from Bridgewater Community Healthcare NHS Foundation Trust
- A report on a quality visit to HMP Risley carried out by NHS England on 31 January 2017.
- Minutes of monthly staff meetings.
- Updated medication risk assessments.
- Evidence relating to patient medicine use reviews.

Detailed findings

- Staffing rotas
- Clinic waiting lists.
- Minutes of the medicines management committee meetings.

Are services safe?

Our findings

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

Are services effective?

(for example, treatment is effective)

Our findings

We did not inspect the effective key question at this inspection.

Are services caring?

Our findings

We did not inspect the caring key question at this inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect the responsive key question at this inspection.

Are services well-led?

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

Our findings

We did not inspect the well-led key question in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued on 14 December 2016.

Governance arrangements

- At our previous joint inspection with HMIP in June 2016 we had concerns that governance systems to monitor the effectiveness and quality of service provision were not robust. We found that local monitoring arrangements did not ensure safe and effective service delivery. We found governance arrangements had significantly improved when we undertook a follow up inspection on 3 May 2017.
- We saw that a range of meetings were held which various health care partners attended. These included a monthly GP operational meeting, bi-monthly medicines management meetings, which looked at prescribing data, incident reporting and controlled drugs and a monthly strategic management meeting was held which all health care partners attended with representation from the prison. Collectively these provided effective oversight of health care provision within the prison.
- Previously we were concerned that access times to GP clinics were not sufficiently monitored and patients waited a long time to see a GP. At our inspection in May 2017 we found that patients had good access to GP services and access to timely appointments. We were told that three GP sessions had been cancelled in recent weeks due to industrial action by prison staff; this coupled with the impact of the use of Novel Psychoactive Substances (NPS), commonly referred to as 'Legal highs') within the prison meant further demands were made of GP services and the trust managed this appropriately. GP waiting times were monitored by the trust and additional appointments were facilitated by providing extra GP sessions. An advanced nurse practitioner had been recruited and there were plans to develop the use of nurse clinics to assist with the demand for GP appointments.
- Previously we were concerned that in-possession risk assessments were not routinely updated. In- possession medication means that where possible, prisoners are given autonomy and responsibility for the storage and administration of their medication, dependent on individual risk assessments. Since our last inspection the trust had reviewed its in-possession risk assessment. At the time of our inspection all in-possession risk assessments had been updated.
- Previously we were concerned that formal patient medicine reviews were not completed. During our focused inspection in May 2017 we found robust monitoring of medicines management. Medicines management meetings were held regularly and the trust had appointed a lead pharmacist and a number of pharmacy technicians. This ensured effective systems were in place and patients' medicines were regularly reviewed. A clinical check had been introduced since our last inspection and this provided improved governance around prescribing.

Seeking and acting on feedback from patients, the public and staff

- At our previous joint inspection with HMIP in June 2016 we were concerned that although there was a system in place to gather the views of patients after they had left the prison, there was no established system to gather the views of patients who received services from health care. There was no effective patient forum in place and information for patients about healthcare services was limited. During our focussed inspection on the 3 May 2017, we found that the trust was actively engaged and worked in partnership with health and well-being advisors from the local council.
- The trust in partnership with the local authority had plans to develop a new patient forum. Plans included working with trained representatives from the prisoner population with a focus on developing a range of mechanisms to capture patient feedback.
- The provider told us that since our last inspection a patient survey had been carried out and analysis of this was taking place at the time of our visit.
- We saw that prisoners had access to a range of health care information. The health care information booklet that provided detail on what services were available had been reviewed and updated.
- The trust attended quarterly Queensland meetings. Queensland meetings are prison led meetings which prisoners can attend and where they discuss issues that

Are services well-led?

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

directly effect them, including health care services. We saw minutes from these meetings where prisoner representatives discussed issues specific to health care services provided at the prison.

- In June 2016 there was limited evidence available that demonstrated how the views of staff were sought in respect of how the service was run and how operational arrangements were communicated to staff. At our follow up inspection we found that monthly full staff meetings took place. This offered staff the opportunity to contribute to discussions regarding the day to day running of the services as well as being involved in planning how the serviced was to meet the needs of patients. As a result of such discussions with staff, staffing levels were reviewed and staffing levels were increased at weekends and evenings. The trust had a monthly bulletin which was shared with all staff employed across the trust.
- At our previous joint inspection with HMIP in June 2016 we had concerns that staffing levels were not sufficiently monitored to ensure that patients needs were met in a timely way. At our follow up inspection we found that staff rotas were completed monthly, the review of staffing also included the skills mix of the team and considered which staff were on duty and lead responsibilities for nurse clinics. The use of agency and bank staff was considered as part of the review. Regular agency staff were used and there was an ongoing recruitment programme and an advanced nurse practitioner had been recruited. Collectively these actions provided effective monitoring of staffing levels and this ensured that patients health care needs were met.