HMP Liverpool

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.

Overall summary

We carried out an announced focused inspection of healthcare services provided by Spectrum Community Health C.I.C (Spectrum) at HMP Liverpool between 2 – 6 September 2019, alongside a comprehensive joint inspection of health and social care services at the prison with Her Majesty's Inspectorate of Prisons (HMIP).

During a comprehensive inspection by CQC in October 2018, we found that the quality of healthcare provided by Spectrum at this location did not meet the fundamental standards. We issued a Requirement Notice in relation to Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

We do not currently rate services provided in prisons.

At this inspection we found:

- Improved arrangements to monitor patients withdrawing from alcohol or other substances, including the development of a clearer care pathway and evidence of more consistent observations to ensure patients' safety.
- Staff able to access to a good range of training and regular supervision which was usually completed promptly and accurately recorded.
- Evidence of detailed care plans which were personalised and reflected patients' individual needs and preferences, particularly for patients with long-term health conditions.

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

- Governance processes recently developed to support and monitor the safe care and treatment of substance misuse patients should be fully embedded.
- All health staff should receive regular individual supervision in line with the provider's policy.

Our inspection team

Our inspection team was led by a CQC health and justice inspector. Two health and social care inspectors from HMIP also contributed to our findings.

Before this inspection we reviewed a range of information that we held about the service. Following the announcement of the inspection we requested additional information from the provider, which we reviewed.

During the inspection we asked the provider to share further information with us. We spoke with healthcare staff, prison staff, commissioners, and people who used the service. We also observed multidisciplinary meetings, reviewed systems and procedures, and sampled a range of patient clinical records.

Background to HMP Liverpool

HMP Liverpool, known locally as Walton prison, is a category B local prison with a capacity of 1300 serving the Merseyside area. The prison holds remanded and sentenced adult male prisoners. At the time of our inspection, the prison had a reduced population of 684 prisoners because of ongoing refurbishment work.

Spectrum is commissioned by NHS England as the lead health provider at HMP Liverpool, operating with partner providers under the branding Better Health Liverpool.

Spectrum is registered with the CQC to provide the following regulated activities at HMP Liverpool: Treatment of disease, disorder or injury, Diagnostic and screening procedures, and Personal care.

The report from CQC's comprehensive inspection in October 2018 can be found at:

https://www.cqc.org.uk/sites/default/files/new_reports/AAAH8357.pdf

Are services safe?

Risks to patients

At our last inspection, we found that overnight observations of patients undergoing alcohol detoxification was not consistent. Prisoners accommodated on the first night prison wing were not routinely monitored over night by healthcare staff. Only 10 out of 49 patients treated for alcohol dependency had received recorded overnight observations between June and September 2018.

During this focused inspection, we found that arrangements to monitor patients detoxing from alcohol or other substances had improved and high-risk patients were now managed safely:

- The provider had recently developed a draft treatment pathway with the prison to ensure that prisoners with substance misuse problems and those withdrawing from alcohol and other substances were located on A wing, the dedicated drug treatment unit, wherever possible. The pathway was intended to ensure that health and prison staff were aware of these prisoners' needs and could adequately monitor and support them if they were located elsewhere in the prison.
- Two inpatient beds were designated to accommodate prisoners with complex substance withdrawal needs.
- The prison had recently installed new observation hatches on cell doors on A wing. Health staff told us they could now clearly observe prisoners who were withdrawing.
- Prisoners withdrawing from alcohol and other substances received regular observations to ensure their safety regardless of their location. Health staff completed physical health observations twice daily and monitored prisoners three times during the night.
- Out of 12 patients that we reviewed who had recently received treatment to help them withdraw from alcohol and other substances, 10 patients had regular daily and nightly observations recorded in their clinical record. One patient had refused to engage with staff, although their clinical record evidenced appropriate actions taken to ensure their safety. One patient had gaps in their regular observations, which had been raised as an incident on the Datix incident reporting system.
- Health staff routinely raised a Datix incident if prisoners withdrawing form alcohol or other substances were not appropriately located or could not be accesses, to ensure this could be formally investigated.
- Health staff used a ledger on the SystmOne electronic clinical record to track patients requiring observations during the day and overnight.
- Health staff responsible for monitoring prisoners who were withdrawing from alcohol and other substances had received additional training for monitoring physical health observations and opiate withdrawal symptoms.
- Service managers had improved oversight of substance use patients' care. The provider had recently started auditing patient care records, including completion of observations and overnight monitoring. Audit results that we reviewed indicated overnight observations were now being completed routinely.
- Prisoners withdrawing from alcohol and other substances were reviewed during a daily safety meeting to ensure staff had completed required observations and that these prisoners were receiving appropriate clinical support.
- The provider was developing an electronic template to promote consistency in recording overnight observations of prisoners withdrawing from alcohol and other substances.

Are services effective?

Effective staffing

At our last inspection, we found that recording systems were not sufficiently up to date to reflect all staff supervision and training. Compliance with mandatory training requirements was low.

During this focused inspection, we found that the provider now maintained accurate records in respect of staff training and supervision. Staff had improved access to a good range of training and regular supervision, which was usually completed promptly and accurately recorded:

- Staff compliance with mandatory training had increased to around 91%, which was a significant improvement on our previous inspection findings.
- Service managers regularly monitored and reported on staff completion rates for mandatory training packages through the electronic staff record.
- Access to regular individual supervision had improved, particularly for primary care staff, although further work was required to ensure all health staff had equal access to regular supervision in line with the provider's policy.
- The provider had improved local systems to monitor staff supervision compliance, and periodically reported compliance rates in a quality submission to NHS England to provide assurances around performance.
- Local records of individual staff supervision were now up to date, although further work was ongoing to incorporate this information into the electronic staff record.
- Agency staff could access the regular supervision available to substantive staff, and a range of training, including immunisation and vaccination training.
- Health staff could access weekly group reflective practice sessions to support them in their roles.
- Most staff told us that they could now access more regular supervision and sufficient non-clinical time to complete mandatory training requirements.

Are services caring?

Involvement in decisions about care and treatment

At our last inspection, we found that care planning was inconsistent. Some patient records were limited to "generic" blank care plans which meant they were not accurate and did not reference discussions with the patients.

During this focused inspection, we found evidence of detailed care plans which were personalised and reflected patients' individual needs and preferences:

- All patients with an identified long-term health condition attended a clinic with a specialist nurse to discuss their needs and care preferences. The nurse completed and shared with each patient a personalised care plan which reflected their discussion, in line with national guidance.
- Ten patients that we reviewed with long-term health conditions including diabetes, hypertension and epilepsy all had care plans in place which were personalised and evidenced discussion with the patient around their preferences. The patients had all received a copy of their care plan.
- The specialist nurse had implemented an emergency care plan for epileptic patients which included information around emergency medication. With patient consent, relevant information was shared with prison staff to help support health needs.
- One patient who had received palliative care had a detailed care plan in place including details of external specialist care and advanced care planning reflecting the patient's preferences.
- The provider conducted regular audits to monitor the consistency and quality of care plans for patients with long-term health conditions, inpatients, and substance misuse patients. Audit results that we reviewed indicated positive levels of compliance.

Are services responsive to people's needs?

We did not inspect the responsive key question as part of this focused inspection.

Are services well-led?

We did not inspect the well-led key question as part of this focused inspection.