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

This inspection was an announced comprehensive inspection of health care services at HMP Liverpool between 9 and 12 October 2018.

Spectrum Community Health C.I.C. (Spectrum) had commenced providing health and social care services at HMP Liverpool on 1 April 2018, after the previous provider withdrew from the prison health contract. We found that Spectrum had made good progress during their first six months in improving health services for prisoners in several key areas. CQC do not currently rate services provided in prisons.

We announced this inspection on the 14 September 2018, to follow up the previous areas of concern we identified in September 2017 and to determine how Spectrum had taken action to address the risks they had inherited.

Spectrum had subcontracted several aspects of health service provision to meet the needs of prisoners. However, the service was branded one health service: "Better Health Liverpool", which was the joint name of health services at HMP Liverpool. Spectrum had worked with its key health partners to introduce a comprehensive governance framework for the service. We found a service where health providers worked together with the prison to deliver improved health services.

At this inspection we found:

- The registered provider had implemented a robust governance process, which was clear about the risks and pressures within the service but there remained areas where ongoing improvement was required.
- Spectrum had focused on recruiting, supporting and developing staff and managers with a range of organisational and professional development initiatives to improve the focus on safe and effective patient care.
- There was work ongoing in developing staff records and local training systems.
- There had been significant staffing challenges in April 2018, as the provider had inherited shortfalls in staffing across the service. Progress had been made in most areas, with some regular agency staff covering vacancies in the primary health care services.
- The final primary care structure and recruitment was due to be completed by the end of October 2018. This was crucial to developing the effectiveness of the primary health team and patient experience. Supporting patients with long-term conditions remained an area for improvement.
- Arrangements to support prisoners arriving at the prison, including initial and secondary screening and oversight of substance misuse prescribing had been improved since April 2018, however further improvements were required to ensure patients experiencing alcohol withdrawal on arrival were safe.

There remained areas where the provider needs to take further action to improve services:

Key findings

The provider must:

- Ensure overnight observations for patients undergoing alcohol detoxification are undertaken, recorded and monitored.
- Ensure that patient records are accurate, fit for purpose and person centred.
- Ensure that staff records include all relevant information including training and supervision.

There were also areas where the provider should make further improvements, these are:

- Ensure effective prioritisation and monitoring of patients with long term conditions awaiting reviews and ensure that vulnerable and older patients receive care that meets their needs.
- Complete the introduction of new structures and staffing arrangements to deliver effective primary care services.
- Ensure all appropriate managers are involved in investigating incidents and complaints and have access to relevant information to develop learning and service improvement.
- Develop the audit programme to include clinical, patient outcome, therapeutic medicines audits and monitoring of missed doses.
- Ensure that all aspects of medicines are monitored through regular medicines management meetings, including the tracking system for hand written prescriptions.
- Ensure that complaints are accurately recorded and that robust quality assurance informs service improvement.
- Ensure the availability of more comprehensive information and engagement with prisoners to improve their understanding of the health care services offered at HMP Liverpool.

Our inspection team

Our inspection team comprised of four health and justice inspectors, a GP specialist professional advisor who has experience of working in prison health, a CQC pharmacy specialist inspector who has knowledge of prison health, a health and social care inspector from Her Majesty's Inspectorate of Prisons (HMIP) and a CQC Health and Justice Inspection Manager.

The inspection was announced on 14 September 2018 and we requested a range of documentary evidence be submitted to review prior to the inspection site visit. During the inspection we:

- Spoke with senior health and prison leaders, managers, health and prison staff and patients.
- Reviewed patient clinical records, appointments and access to the service.
- Observed care and treatment.
- Reviewed systems and procedures.
- Reviewed staff records.
- Observed multi-disciplinary meetings.

Background to HMP Liverpool

HMP Liverpool is an adult male local prison, located in the Walton area of Liverpool.

At the time of our inspection, the reduced population was around 700 prisoners, owing to ongoing refurbishment of much of the prisoner accommodation. The normal capacity was 1,300 prisoners, the vast majority of prisoners held there were from the local area and wider north west.

We carried out an announced focused inspection of HMP Liverpool in September 2017, alongside a comprehensive joint inspection with our partner inspectorate Her Majesty's Inspectorate of Prisons (HMIP) under our joint memorandum of understanding. The inspection identified areas which required improvement by the healthcare provider at that time.

The joint comprehensive inspection report can be found on the HMIP website:

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

Health care services at HMP Liverpool are commissioned by NHS England. The contract for the provision of healthcare services transferred to Spectrum Community Health C.I.C. (Spectrum) on 1 April 2018. Spectrum is registered with CQC to provide the regulated activities of Diagnostic and Screening procedures, Treatment of disease, disorder or injury and Personal care at HMP Liverpool. In May 2018 CQC appraised Spectrum of the concerns identified during the previous inspections so that they could address these within the new service provision.

Spectrum had subcontracted the provision of mental health, psychosocial substance misuse, general practitioner and dental services but retained overall contractual responsibility.

Are services safe?

The provider had a clear joined up approach to safety with its partner providers and prison management.

Safety systems and process

- The provider had introduced a range of policies, procedures, monitoring and meetings to embed safety into the service and promote effective partnership working. Healthcare staff worked closely with the prison to safeguard vulnerable prisoners, contributing to the prison Assessment, Care in Custody and Teamwork (ACCT) process. Safeguarding and preventing radicalisation were key priorities for staff training.
- The agreement to remove the healthcare inpatient cells from the prison's certified normal accommodation meant healthcare staff had clear clinical admission criteria for the inpatient unit and could work collaboratively with prison managers to ensure those prisoners most in need of inpatient support for health needs were located there.
- A comprehensive health screening was carried out by nurses when prisoners arrived in reception. This included a review of physical, mental, social care and substance use needs. This was followed up by a secondary health screening within seven days. The completion of the second health screening had improved over six months from an average of 59% between April and June 2018, to 97.8% in September 2018.
- GPs saw patients identified with complex health needs as part of the reception process and prescribed medicines including for detoxification and substance misuse dependency. All detoxification and prescribing for these patients was then remotely reviewed by a specialist substance misuse clinical lead the following day. A substance misuse nurse reviewed patients after five days and 13 weeks. This ensured that potential clinical risks were identified.
- Health care staff contributed to the prison process for monitoring prisoners at risk of self-harm or suicide, Assessment, Care in Custody and Teamwork (ACCT). When a prisoner was supported through an ACCT, a mental health nurse reviewed their risk assessment for managing their medicines independently (in possession). This was a good system, but did not take into consideration that where a vulnerable prisoner was sharing a cell and might have access to another prisoner's prescribed medicines.

Risks to patients

- The provider had identified staffing levels, particularly around substance misuse as a risk to patients and had promptly reviewed the staff in the substance misuse teams. The substance misuse service had since been fully recruited to, with one clinical manager still to commence.
- The agreed staffing profile for the main primary care service was being finalised during our inspection, recruitment was ongoing. Medication administration and long-term condition clinics were examples of where low staffing impacted on risks to patients.
- A focus on patient safety had underpinned the service transition from the previous provider, with staff being supported to develop their clinical skills and knowledge to improve patient care and safety. Several regular agency staff had been used to support the service as part of the transition and there had been ongoing recruitment of nursing staff since April 2018 to fill gaps.
- The inpatient staffing included a mix of primary care nurses and health care support workers who monitored and supported patients with physical health conditions and mobility issues, as well as mental health nurses.
- A recent improvement ensured that a GP attended the weekly multi-disciplinary ward round. Other staff attending these meetings included mental health staff, including psychiatrists, occupational therapists, ward staff, mental health nurses and prison management.
- There were regular reviews in place for patients who had been placed on medicines for treating withdrawal from alcohol and other substances. The provider had agreed with the prison and NHS England (NHSE) that two inpatient beds would be designated to accommodate patients undergoing alcohol detoxification so that overnight observations could be made. However, of 49 prisoners who had been treated for alcohol detoxification since June 2018, only 10 had been held in the inpatient unit. Prisoners who were accommodated in the first night prison wing were not monitored over night by healthcare staff. This was discussed with the clinical leads during the inspection who considered the risks and implemented additional nightly checks by healthcare staff, although these were not fully embedded. Further work was required in partnership with prison managers to ensure all patients were monitored overnight.

Are services safe?

- Arrangements were in place to follow up where patients failed to attend GP appointments or to collect their medicines. This meant that patients who might be vulnerable or unwell were identified promptly and appropriate support was put in place.
- Not all risks for patients who were bed bound had been fully addressed. Some could not access or use emergency call buttons. Access arrangements and safeguarding for one patient was under discussion by health, prison management and the local authority at the time of our inspection.
- The local Spectrum management team had recently completed a draft business continuity plan which was to be shared with partner providers to inform a single healthcare continuity plan. This provided clear actions for healthcare staff in the case of incidents, and highlighted those which would be dependent on existing prison service continuity arrangements.
- Staff had completed basic life support training and had access to appropriate emergency equipment and medicines. GPs on duty would also attend emergencies until 9pm each night. There were nurses on duty overnight who could attend medical emergencies and had completed intermediate life support training.
- Prison and healthcare staff had access to out of hours advice through the national 111 system.
- Local managers received copies of Medicines and Healthcare products Regulatory Agency and patient safety alerts, and kept a monitored log of those which required action. There was also a clear system in place which would enable medicines to be administered in any failure of the electronic clinical record system.

Information to deliver safe are and treatment

- There was a single shared electronic patient clinical record which all health staff used.
- There were effective staff handovers twice daily so staff were clearly aware of individual needs and safety issues. There were also regular multi-disciplinary meetings which prisons staff attended to enable a shared approach to safe care and treatment.
- A weekly safeguarding meeting ensured that health and prison managers were clear about risks to individual prisoners and relevant support and observation was put into place. It was not clear whether all health staff had received safeguarding training and training in the completion of the ACCT documentation.
- Referrals for further treatment included all the necessary information. GPs and Advanced Nurse Practitioners reviewed test results daily and arranged relevant follow up care including referrals to secondary care.

Safe and Appropriate use of medicines

There were a range of processes in place to ensure safe management of medicines. These included:

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  - Reconciliation of medicines within 72 hours of prisoners' arrival in the prison, by the pharmacy team.
  - The pharmacist checked the summary care records for patients who arrived the previous night to check for potential adverse medicines interactions.
  - Monitoring of medicines storage and transportation, including refrigerator temperatures and audits.
  - Management of drug alerts with appropriate action taken where required.
  - Patient identity was checked prior to medicines being given out.
  - All medicines prescribing and administration was recorded clearly in patient clinical records.
  - Patients prescribed four or more medicines were highlighted for medicines use reviews.
  - A stock of commonly-prescribed medicines was held in the prison reception so that patients could receive their medicines promptly.

- There had been occasions when a prisoner had been unexpectedly discharged from the prison to a court hearing and subsequently released directly from court, without their prescribed medicines. Where possible, these patients were contacted, and advised that a prescription had been left for them at the prison gate to avoid the risk of their health being detrimentally affected.
- There were areas of medicines management where systems and procedures required further development. These included:

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  - Some prescription-only medicine boxes such as inhalers were not being individually labelled when they were issued to patients, which was not in line with legal labelling standards.
  - No record was kept of the placement and rotation of analgesic patches prescribed for patients.
  - Liquid medicines which had been opened were not labelled with the opening or revised expiry dates.

Are services safe?

- Only one medicines management meeting had taken place since April 2018.
- There was no recording or monitoring of the occasions when a prisoner reported that his prescribed medicines had been stolen.
- The a log of FP10 hand written prescriptions was incomplete as two of these had been used with no records kept of who had issued them to which patients.

Track record on safety

- Spectrum had worked with their partner providers to ensure that the service was safe and that all incidents were reported, investigated and reviewed.

Lessons Learned and improvements made

- Staff had access to the electronic incident reporting system, and incidents were reported and reviewed by relevant managers. There had been a range of support and training since April 2018 for staff around incident reporting and learning from incidents.
- The service had developed the analysis of incidents, improving the identification of themes, and introducing a "Learning Round Up" bulletin for staff. Managers had identified a trend of duplicate prescribing of opiate substitute treatment within patient records. This was discussed in detail with prescribers and acted upon to stop it from recurring, although pharmacy staff had not been involved.
- There was effective monitoring of actions stemming from deaths in custody, including those prior to 1 April 2018 when the provider commenced the new contract. Management had identified clear goals to change practice and worked closely with prison service managers to highlight and mitigate risks. Training had been provided for staff to embed good practice, including awareness of coroner enquiries and clinical record keeping.
- Staff confirmed that they had the opportunity to discuss incidents and share learning at team meetings and during supervision. Managers told us that staff responding to patients' verbal complaints had identified areas for improvement, and informed the patient with an apology. However, these were not being routinely recorded for monitoring and shared learning.

Are services effective?

Effective needs assessment, care and treatment

- There was evidence of clear use of clinical best practice throughout the service. For example, the Advanced Nurse Practitioners (ANPs) who undertook long-term condition reviews with patients were referring to clinical knowledge summaries during consultations and in their clinical records. The guideline for the clinical management of adult drug and alcohol dependence at HMP Liverpool was based on best practice and reflected recent updates, including the recent increase in prescribing psychoactive drugs known to have a tradeable value, and the risks of polypharmacy.
- For patients who required wound care, there was evidence of assessing the need and completing an evidence based care plan in patient clinical records. Likewise, for patients accommodated in the inpatient unit, the quality of health needs assessment and care planning was good.
- There was effective partnership working with the local authority to identify and assess patients who had disabilities or social care and complex needs. Assessments were carried out by a social worker, although arrangements between the provider, local authority and prison had not been formalised and there was limited access to community occupational therapy assessment. There was not yet access to a dietician; this service was currently being procured. Care plans were in place for patients in receipt of social care.
- Telephone translation services were available and used when required. A communication plan had been put into place previously for a patient who had a hearing impairment, and advocates were regularly involved in multi-disciplinary meetings and care planning to ensure that services took the needs of vulnerable men into consideration.

Monitoring care and treatment

- Managers used a range of national monitoring processes to review the service and patient outcomes.
- The main health outcome quality measures which Spectrum reported on to NHSE through contract meetings were the Health and Justice indicators of Performance (HJiP).
- Between April to September 2018 there had been an increased uptake across most blood borne virus testing including Hepatitis C and HIV. The numbers of patients referred to a secondary hepatology service had also significantly increased.
- The HJiP data demonstrated a sustained improvement in clinical drug treatment outcomes. All patients had received a five-day review after the commencement of substitute prescribing since August 2018. The percentage of patients whom received a 13-week review had increased from 20% in April 2018 to 100% since July 2018.
- Long-term conditions were monitored through the national Quality and Outcomes Framework (QOF, a framework originating in GP practices to monitor the management of patients with long-term conditions). The prison had achieved 93.5% compliance.
- The pharmacist used the electronic clinical record to run a variety of reports about prescribing and medicines optimisation. These included high risk medicines and the use of nutritional supplements. These demonstrated that medicines effectiveness was being used to inform and develop services.
- Staff recorded missed doses and follow up action was taken, but there was no review of this in relation to missed critical medicines.
- Spectrum had completed audits on infection prevention and control, patient safeguarding, care planning, reception and inpatient mattress suitability, and had plans to develop the audit programme to include the substance misuse service.
- Infection prevention and control had been prioritised after the initial audit showed deficiencies and improvements were being monitored.
- There were regular quality visits by NHS England and strong working with the local commissioning team to improve overall service quality,

Effective staffing

- The provider had made a range of professional training and accreditation available to staff since commencing the contract in April 2018, with further development planned. This included:
- ▪ The Royal College of General Practitioners (RCGP) certificate in the management of drug misuse in secure environments for substance misuse staff.

  - Support for the Advanced Nurse Practitioners to attend Masters courses.
  - Dry Blood Spot testing training for healthcare assistants (HCAs).
  - Phlebotomy and electrocardiogram training for HCAs.
- Managers were sourcing training for staff in long term-condition management and end of life care. Staff and managers acknowledged that there was further work required to ensure all staff had completed sufficient training for their roles.
- Increased emphasis had been placed on delivering organisational change to help improve managers' skills and to support staff in working within a changing environment. The development of reflective practice sessions and professional skills had supported clinical staff in their roles.
- The recording system was not sufficiently up to date to evidence all staff supervision and training. There remained some staff and managers who did not have access to the system.
- Completion of the Spectrum mandatory training packages was low, at 43% although records from the previous provider had not yet been incorporated into the Spectrum employee record system, so training records did not yet reflect all staff training. Managers were working to incorporate legacy records and ensure that staff had sufficient non-clinical time allocated to complete their mandatory training.
- The provider was working to ensure that supervision and appraisal to support effective clinical care was embedded into the service and recorded in the employee record system. Most staff we spoke to advised that they had received supervision, although this had only commenced recently. Staff also told us they had the opportunity for group supervision discussions at team meetings. The appraisals system had been introduced, around 80% of staff had had their first appraisal discussion.

Coordinating care and treatment

- The range of multi-disciplinary meetings to ensure patient care was safe evidenced how providers were working together to provide effective care. Staff from all teams and prison staff attended the variety of internal healthcare meetings. Likewise, healthcare teams were present at a wide number of relevant prison facilitated meetings including those focusing on drug strategy and security.
- The provider had introduced community link roles for substance misuse, which facilitated partnerships with community substance misuse providers. A range of peer led support groups were available to prisoners. Substance misuse staff worked closely with the prison's offender management unit staff and there were joint working protocols in draft form for release pathways. A prison officer had recently joined the substance misuse team to improve the coordination of patients being supported with drug and alcohol issues.
- There was clear understanding of risks to patients of polypharmacy and drug seeking behaviour although no pain management pathway had yet been introduced. Nurses challenged drug seeking behaviour appropriately.
- For prisoners who had restricted mobility, there was clear evidence of shared personal evacuation plans with prison staff should an emergency require it. An integrated pathway between the inpatient unit and the primary care team in the main prison ensured transferring prisoners experienced continuity of care.

Helping patients to live healthier lives

- A range of health promotion and wellbeing activity was taking place, led by health care or prison staff. Plans were in place to coordinate and link this more closely together.
- The main waiting room had limited health promotion material on display.
- Prisoner wellbeing representatives had been involved in developing a health newsletter which they had just begun to distribute.
- During our visit World Mental Health Day was celebrated, led by the mental health team. This was a healthcare wide event to raise the profile of mental health concerns and the support available.
- Smoking cessation therapy was available; the prison had been smoke free since September 2017.
- Prisoners had access to all national screening programmes including bowel cancer, abdominal aortic aneurism (AAA) and diabetic eye screening. In response

to a low uptake of bowel cancer screening, staff had begun to visit eligible prisoners in their cells, offering further information and support. This had improved uptake, although numbers remained low.

- NHS health checks were available and conducted by trained health care assistants but uptake was variable and staff were considering how this could be improved. Prisoners were offered dried blood spot testing and treatment for blood borne viruses.
- Weekly vaccination and immunisation clinics offered an appropriate range for a population with health inequalities where some may not have engaged with community health services consistently. The provider had recognised the low uptake, so was due to commence a joint research project on the uptake of national screening programmes with Public Health England.
- A good range of therapy groups were facilitated by the substance misuse team, including relapse prevention, smart recovery, foundations of change and access to peer led support groups such as AA.
- Work was in progress to develop wellbeing plans for all inpatients to support them to increase their emotional resilience. During the inspection the prison formally re-opened J wing as a wellbeing unit, which had been closed for refurbishment.

Consent to care and treatment

- Staff conducting initial health and social care screening asked patients for consent for sharing their personal information with health partners.
- There was evidence in the patient record system that treatment information had been explained to patients as part of the consent process.

Are services caring?

Kindness, respect and compassion

- During the inspection we saw staff treating patients with compassion and nurses responding kindly to patients in distress and ensure appropriate care was given in private.
- The service had received 11 compliments since April 2018, many of these recognised the care and compassion which patients felt staff had showed to them.
- The prison had demonstrated that the service met the Dying Well in Custody Charter through self-evaluation. A family member of one terminally ill patient had attended multi-disciplinary meetings, and after his death had complimented the prison and health staff on their care.

Involvement in decisions about care and treatment

- We saw many good quality care plans, with clear involvement of patients in their care. GP patient consultations during the reception process were person centred and a substance misuse five-day review gave the opportunity for patients to discuss their treatment, and request specific help for release planning.
- However, we also saw a number of blank generic care plan templates had recently been added to patient electronic clinical records without consultation with patients.
- Ward reviews provided evidence of care being planned in line with patients' wishes and how consent was taken into consideration.
- Staff described how families had been involved in prisoners' care (with their consent), although these had not been formally recorded. Effective partnership working with prison enabled healthcare staff to involve families in patients' care and release planning arrangements.
- On arrival at HMP Liverpool, most patients' medicines were destroyed. Although they were informed about this, there was no evidence in clinical records that their permission was sought.
- The substance misuse staff included questions about release planning in their initial interviews and five-day reviews with prisoners. This allowed men to request specific release support which was then incorporated into treatment planning.
- Patients were informed of all clinical test outcomes. Patients with positive test results were offered appropriate treatment.

Privacy and dignity

- Consultation room doors were closed during consultations and patients could access nurses for confidential advice at medicine administration times.
- Patients could submit applications and complaints to healthcare through a confidential system, and appointment slips were sent out in sealed envelopes.
- Staff took a collaborative approach to ensuring that emotional and social needs were addressed. We saw engagement with occupational therapists who supported patients in the inpatient unit, discussions over how family issues in the community might impact upon treatment, and how treatment might impact upon family relationships.

Are services responsive to people's needs?

Responding to and meeting people's needs

- A health and social care needs assessment for HMP Liverpool had been published in November 2017. Spectrum was clearly sighted on the needs identified in this document. This had been used to inform service development and the local action plan reflected progress.
- A good range of nurse led clinics were available including:
  - NHS Health Checks
  - Wound care
  - Phlebotomy
  - ECG (electro cardiogram for heart concerns).
  - Long-term condition reviews
  - Vaccinations and immunisations
- Patients with long-term conditions and requiring medicines were seen by the GP on reception. However, there were 135 patients on the waiting list for nurse led long-term condition clinics, and an average of six patients had been seen per week over the preceding eight weeks, which meant waiting times were too long.
- There were over 100 prisoners in the prison aged over 50 at the time of our inspection. One older patient had been admitted to hospital as an emergency twice in the last four months and whilst he was seen by the GP upon his return from hospital there was no evidence his care was being coordinated to ensure all his needs were met. There was no effective prioritisation of these patients. Spectrum recognised these needs
- The pharmacy could provide weekly blister packs of medicines where men were assessed as requiring support to take their own medicines daily.
- There was a range of patient group directions in place for nurses to administer medicines such as vaccines, which were signed and authorised by a manager during the inspection visit. However, the supply and administration of commonly used over the counter remedies was restricted to mild pain relief, which was a lost opportunity.
- Prisoners who required secondary care were referred externally. Most appointments were provided within community equivalent timescales. The number of prison provided officer escort slots did not fully meet the needs of the reduced population; however, clinicians were actively involved in prioritising patients whose needs were most urgent.
- Administrative staff clearly recorded all appointments and reasons for cancellations and this was being monitored by health and prison management regularly.
- A good range of visiting external services included sexual health, physiotherapy, podiatry, diabetic eye screening and diagnostic services. Low attendance at some of these clinics was being reviewed.
- The prison was responsible for the therapeutic environment of the inpatient unit. Partnership working between all healthcare providers and the prison under Better Health Liverpool had led to an improved inpatient regime.

Timely access to care and treatment

- A clear application and urgent referral process for appointments was in place. Applications for routine appointments were added onto waiting lists and prioritised by clinicians.
- For urgent care, nurses triaged patients immediately, and could access either urgent GP appointments, or request emergency services.
- Access to GP appointments was good and included a specialist substance misuse GP available three times a week. The reported waiting time to see a GP for routine care was 12 days in September 2018 and same day for urgent care.
- Although many patients we spoke to during the inspection were positive about access to healthcare, some also said they waited too long to see a GP.
- There remained a high number of patients who did not attend their appointments. This had been an ongoing concern for health and prison management and there was significant partnership working underway to monitor this, identify and remove barriers to prisoners not attending healthcare appointments, which would also reduce waiting times.
- There was work ongoing through consultation meetings to inform prisoners more about access to healthcare services. Further work was required to align service access with prisoner expectations and reduce non-attendance.
- In response to patient consultation, posters showed the main primary care clinic times, but prisoners were not given comprehensive written information about how to access primary health services when they arrived at HMP Liverpool.
- Information on access to substance misuse and mental health services was available.

Are services responsive to people's needs?

Listening and learning from concerns and complaints

- The management of complaints was coordinated by Spectrum in line with a recently agreed Better Health Liverpool partnership process. Prisoners had good access to 'Have your say about our services' forms, which were managed confidentially.
- All complaints, compliments and suggestions and response letters were logged. Administrative staff filtered out inappropriately used forms (such as appointment requests) to support accurate recording.
- However, the categorisation of complaints was inconsistent, which had an impact on analysis.
- Better Health Liverpool had received 112 'Have your say' forms since 1 April 2018, of which 15 were compliments or suggestions for service improvements. All 97 complaints had been resolved locally, although an escalation was available should patients be dissatisfied with responses.
- Common themes were: access to medicines, staff attitude, and access to treatment or services. Managers were conducting some trend analysis reporting to the monthly Risk and Quality Group. Concerns raised verbally were not being recorded, which was a missed opportunity to inform service improvement.
- The pharmacist had not been involved in responding to complaints which related to medicines management and prescribing.
- Some learning from complaints was now being shared with staff through the "Learning Round Up" monthly newsletter, although not all staff appeared aware of complaints and trends.
- Individual complaints were forwarded to the appropriate team leader who met with complainants promptly to discuss the issues raised and agree a resolution. These meetings were followed up with a letter confirming the outcome of the discussion.
- The complaints log showed that most responses were produced within the stated timeframe.
- Staff had received complaints management training and had access to template response letters to support consistently good practice. However, we found some variation in the quality of response letters, including whether they addressed all the concerns raised by the complainant.
- There were no formal processes in place to monitor the timeliness, or quality of complaints responses, which Spectrum acknowledged as an area for improvement.

Are services well-led?

Leadership capacity and capability

- There was clear investment in ensuring local and organisational leaders were visible within the service. During the initial staff consultation meetings the contact details for senior Spectrum staff were shared.
- Spectrum was committed to a matrix management approach within the prison environment and a range of organisational development and training was underway to support local leaders.
- Regular support visits by senior leaders from the Better Health Liverpool partners took place during the transition and transformation phase of the new contract. Spectrum had also introduced support for local managers which was ongoing.
- Spectrum recognised that partnership working with the prison needed to develop as part of the service improvement, and through the Better Health Liverpool partnership, had part-funded an operational prison management role to support the development of health and social care services.
- We saw that senior health care managers were also members of the prison senior management team and there were more effective working relationships between prison and health staff than we had seen in 2017.

Vision and strategy

- Spectrum Community Health C.I.C. had worked closely with partners to develop Better Health Liverpool as the single identified brand for all health and social care services within the prison. There was a clear vision to which all partners were signed up to, and had been communicated to staff.
- Three challenging priorities had been identified and formed the basis of ongoing management and governance structures:

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  - Developing an operating model to deliver the requirements of the services specification
  - Staff fully engaged and clinically effective in their roles
  - Service users who are involved and feedback "an excellent experience of care".

Culture

- Staff and managers were positive about how they had been supported by Spectrum since April 2018. Senior leaders saw organisational development support for local staff and leaders including change management, reflective practice and continuous professional development as instrumental to cultural change.
- Sickness absence had impacted upon support for local clinical leaders. An interim clinical lead had been in post for around two months, and there was further work required to implement a clear, locally-owned clinical leadership structure.
- An example of a pragmatic partnership approach to service development was the introduction of a single incident reporting system; to maintain use of the existing system via the subcontractors' provision rather than introduce the system used by Spectrum.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Staff and managers were aware of the requirements of the duty of candour, further work was required to fully embed this locally.

Governance arrangements

- The provider had introduced a comprehensive governance structure for Better Health Liverpool in partnership with health providers which had oversight of the whole prison health and social care service.
- The prison governor and prison management were active partners in the governance and monitoring of the service.
- Safety and performance were continuously monitored, including some audits on service quality.
- The early indications showed positive progress that these governance mechanisms would support continual improvement, however, there was further work required to fully embed effective governance in all aspects of the service. We were unable to confirm the effectiveness of these new arrangements at the time of our inspection.

Managing risks, issues and performance

- A risk register for Better Health Liverpool had been developed and reviewed since April 2018. Risk issues were raised by all health partners and reviewed jointly.
- A quality improvement plan (QIP) comprised a quality plan, external recommendations, death in custody actions, safeguarding, infection prevention and control and medicines management. This facilitated good oversight of service improvement, although it incorporated more than 250 actions, which presented its own monitoring challenges.

Are services well-led?

Appropriate and accurate information

- Quality and operational information was used to ensure and improve performance. Patient views were considered as part of the performance information.
- The provider had introduced IT systems to monitor performance and improve the quality of care although further work was required to fully embed these into service provision.
- Spectrum submitted data and notifications to NHS England and CQC as required and was clear of communication arrangements with other external stakeholders.

Engaging with patients, the public, staff and external partners

- Two separate patient engagement meetings were in place to gain patient feedback; the inpatients forum and the Better Health Liverpool user voice meeting, both of which ran monthly.
- Patient suggestions were leading to changes in service and ongoing improvement. For example, prisoners had requested two additional peer led support groups which were due to commence.
- Posters displaying healthcare clinics had been provided following a user voice meeting. A positive initiative was the inclusion of a prisoner on a recent staff interview panel.
- A range of staff consultation events had been held in April and June 2018. Staff told us they felt confident raising concerns with, or challenging their managers.
- A culture of care barometer survey for staff had been carried out, and recent analysis had led to recommendations for further support for staff and managers.
- The service was transparent, collaborative and open with stakeholder about performance. NHS England had undertaken regular quality visits since Spectrum commenced in April 2018 and feedback on progress was positive.
- There was a high level of external scrutiny of the service, and a range of other partners had visited to review progress.

Continuous improvement and innovation

- Continuous improvement underpinned the health and social care provision. Some of the areas where this was most evident included:
- - Improved standards of professional and clinical knowledge.
  - The introduction of clinical admissions criteria and a clinically-led service in the inpatient unit.
  - The introduction of evidence-based care provision, national clinical guidance and best practice to develop the substance misuse service,
  - The introduction of a recovery focused substance misuse service with a range of short and long-term interventions to support the varied population.
  - The ongoing workforce transformation and support for staff development.
- Ongoing service development to improve care further was underway. For example, the blood borne virus testing was to move from the primary care nursing team to the substance misuse team. This would both free up further primary care nursing time but also develop harm minimisation and psychosocial support and treatment for patients.
- The new structure for the primary care team was in the final stages of approval, and included a new pathway from reception through to primary care, with initial long-term condition needs identified and managed as part of the reception process.
- This was also intended to ensure that needs were met in relation to older patients, dementia and national screening programmes.
- Through partnership working, wing based treatment rooms were to be introduced as part of the prison wide accommodation refurbishment programme to improve access to services. Ongoing discussion and consideration was in progress to ensure services could be facilitated on prison wings.
- Plans for primary care and substance misuse teams to introduce nurse-led services, were intended to better reflect community health services. Work was under way developing the advanced nurse practitioner and substance misuse pathways to ensure they reflected best practice.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met. The registered person did not effectively assess, monitor and mitigate risks relating to the health, safety and welfare of prisoners. Overnight observations of patients experiencing alcohol detoxifications was not consistent. Only 10 out of 49 patients treated for alcohol dependency had received overnight observations between 25 June 2018 and 21 September 2018. The registered person did not maintain accurate and contemporaneous records in respect of each service user. Some patient records were limited to “generic” blank care plans which meant that patient records were not accurate and did not reference discussions with the patients. The registered provider had not maintained accurate records in relation to persons employed in the carrying on of the regulated activity. Staff training records did not adequately reflect training completed by staff prior to the their transfer to Spectrum. Records showed 43% compliance with Spectrum mandatory training requirements. Records of individual staff supervision were not fully up to date.