HMP Durham

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 responsive to people's needs?	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 Spectrum Community Health C.I.C. (Spectrum) at HMP Durham to follow up on requirement notices issued after our last inspection in November 2021.

At the last inspection, we found the quality of healthcare provided by Spectrum at this location required improvement. We issued Requirement Notices in relation to Regulation 12, Safe care and treatment and Regulation 17, Good governance.

The purpose of this inspection was to determine if the healthcare services provided by Spectrum were meeting the legal requirements of the requirement notices that we issued in March 2022, and to determine if the provider was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that prisoners were receiving safe care and treatment.

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

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At this inspection we found:

- Staff identified any urgent clinical need during the reception screening process.
- Overnight safety checks were carried out and recorded.
- Patients with long-term conditions were identified and offered appropriate care.
- The staffing of healthcare teams had improved and recruitment was ongoing. Waits for a GP appointment were much shorter.
- Staff took appropriate action when patients did not attend to collect their medicines.
- The service was responsive to patients' needs and anything urgent was prioritised.
- There was increased capacity within the healthcare leadership team.
- Governance processes relating to record keeping and monitoring of waiting lists and triage of patient applications had improved.

Our inspection team

Our inspection team was comprised of two CQC health and justice inspectors.

How we carried out this inspection

We conducted a range of interviews with staff and accessed patient clinical records on 27 & 28 September 2022. We conducted searches of the electronic records of patients who had been identified as having missed doses of medicines and patients with long-term conditions such as diabetes.

Before this inspection we reviewed a range of information that we held about the service including notifications and action plan updates. Following the announcement of the inspection we requested additional information from Spectrum which we reviewed.

During the inspection we spoke with:

- Two nurses
- One advanced nurse practitioner
- One GP
- Three healthcare support workers
- One pharmacist
- The head of healthcare
- The deputy governor of HMP Durham
- Three prison officers.

We also spoke with NHS England & Improvement (NHSE/I) commissioners and requested their feedback prior to the inspection. We spoke with three patients and observed lunchtime medicines administration. We also accessed the electronic patient record system (SystmOne).

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

- Audits relating to medicines
- Medicines missed dose reports
- Policies and procedures relating to medicines and reception screening processes
- The process for triaging patient applications for healthcare appointments
- Information relating to recruitment
- Staff rotas
- The provider's action plan submitted after the previous inspection.

Background to HMP Durham

HMP Durham is a Category B reception prison which receives men from courts across the north region. The prison is in the city of Durham and accommodates up to 1001 prisoners. The prison is operated by His Majesty's Prison and Probation Service.

Health services at HMP Durham are commissioned by NHSE/I. The contract for the provision of healthcare services is held by Spectrum. Spectrum is registered with CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Our previous comprehensive inspection was conducted jointly with Her Majesty's Inspectorate of Prisons (HMIP) in November 2021 and published on the HMIP website on 11 March 2022. We found a breach of Regulation 12, Safe care and treatment and Regulation 17, Good governance.

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-durham-5/

Inspected but not rated

Are services safe?

Safety systems and processes

At our last inspection we found that patients' immediate healthcare needs were not always identified when they first arrived at the prison. There were issues with patients arriving at the prison later in the day which meant there wasn't enough time to complete a full healthcare screen. Whilst this issue persisted, improvements had been made by the provider to ensure that any urgent needs were identified, and safety measures put in place.

Depending upon their time of arrival at the prison, most patients received a full healthcare screening to identify any immediate needs such as support with alcohol withdrawal. The screening was jointly carried out by an advanced nurse practitioner (ANP), healthcare support worker and a mental health nurse. This process ensured that patients were signposted to the various healthcare services available and medicines were prescribed and provided to the patient quickly.

Some patients required overnight safety checks, such as anybody undergoing withdrawal from alcohol or other substances. Healthcare staff and prison officers told us that these checks were carried out and we saw records confirming this on SystmOne.

Should a patient not receive the full healthcare screening on arrival at the prison, this was prioritised for the following morning. Urgent, same day appointments were available with the GP and ANP should a patient need to be seen quickly. Applications that were made by patients to see a healthcare professional were triaged by a clinician in order to identify potentially urgent matters.

How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?

At our last inspection, staffing vacancies placed pressure on primary care staff and meant that there were long waits for a routine GP appointment. Patients with long-term conditions such as asthma did not always receive appropriate care due to ongoing staffing challenges. Since the previous inspection the provider had continued to advertise and recruit into vacant positions. New staff had started in various roles such as nurse, pharmacy technician and the newly created deputy head of healthcare position. In order to build resilience into the staffing team the provider had also expanded the pool of bank staff who could cover shifts when required.

Patients with long-term conditions were identified during their initial reception screening and booked into appropriate clinics as required. Staff maintained registers of patients with various conditions such as asthma and diabetes and had set recalls on SystmOne so that any patients requiring a review would be booked an appointment. We also saw that patients received medicines required to manage their condition and additional health checks, such as diabetic foot checks were carried out.

Information to deliver safe care and treatment

We reviewed the care plans of patients with various long-term conditions, such as diabetes, hypertension and chronic obstructive pulmonary disease (COPD). These provided the essential information required to support staff in understanding what care and support patients needed.

Staff maintained records using SystmOne for each patient when they came into the prison and recorded interactions such as when a patient attended an appointment or received medicines. The records we saw were completed in detail which clearly explained what care and treatment had been offered and provided.

Inspected but not rated

Are services safe?

Appropriate and safe use of medicines

At our last inspection we found that when patients did not attend for their medicines this was not followed up by staff to understand the reasons for non-attendance. During this inspection we found that improvements had been made and there were now robust systems in place to follow up with any patients not attending to collect their medicines.

We observed medicines administration at lunchtime and saw there was a poster prominently displayed reminding staff of the steps to take when patients did not attend for their medicines. Staff followed this for three patients who did not attend and spoke with a prison officer who collected the remaining patients. Staff told us that this was now routine practice and they were aware of the process to follow.

Pharmacy staff ran a weekly report from SystmOne which identified those patients who regularly did not collect their medicines. Action was taken to contact patients to understand the reasons for this and if any changes were required to support their wellbeing. Where required, patients were booked an appointment with the GP, ANP or pharmacist to discuss their medicines and if any alternatives could be provided.

Inspected but not rated

Are services responsive to people's needs?

Timely access to services

At the last inspection there were extended waits for a routine GP appointment, due to difficulties in securing GPs to cover the contracted number of sessions as well as a lack of oversight of waiting lists. Changes had been made to the way in which applications to see the GP were processed, with clinicians triaging new applications on a daily basis and booking appointments directly into the appropriate clinic, rather than adding patients to a waiting list.

Some issues were dealt with immediately without the need for a face to face appointment which further reduced waiting times for patients. At the time of the inspection the waiting time for a routine GP appointment was eight days and routine ANP appointments were available within four days. Urgent appointments were available every day. Patients arriving at the prison with substance misuse needs would be seen by a GP quickly to review any medication and ongoing treatment plans.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

At the last inspection the head of healthcare was covering clinical shifts, often at short notice, which meant there was not always sufficient leadership capacity available to provide strategic oversight of the service. Ongoing staff recruitment had led to a more stable staffing pool which meant the head of healthcare had more capacity for the managerial and strategic elements of their role. There had also been investment in developing the knowledge and skills of the staff team as well as empowering staff to take appropriate decisions. This further reduced pressure on the head of healthcare as staff told us they felt more confident and supported.

The provider had recently appointed to a newly created deputy head of healthcare role and the successful candidate was due to take up post imminently. All of the staff we spoke with were positive about the leadership shown and felt that the improvements had been driven by clear leadership. We also received positive feedback about the working relationships between healthcare staff and prison staff, both at a managerial and operational level.

Governance arrangements

At our last inspection we found that the systems to triage patient applications and monitor waiting lists for the GP were not effective. This had led to patients experiencing extended waits to see the GP and some patients remaining on the waiting list even after they had left the prison. At this inspection we saw the provider had taken action and the wait for a routine GP appointment was much shorter at eight days. Applications for appointments were triaged on a daily basis and, should a GP appointment be required, these were booked rather than allocating the patient to a waiting list. Some issues were dealt with immediately by the ANPs where possible which meant patients didn't have to wait for an appointment. Waiting lists and clinic schedules were regularly reviewed and any patients that had since left the prison were removed to free up appointment slots for others.

At the previous inspection medication administration records were not always completed and governance systems had not addressed this issue. Regular audits of these records were now being carried out and, where required, action was being taken to resolve these issues. The records we reviewed were fully completed with reasons clearly stated for patients who had not attended for their medicines.

Appropriate and accurate information

At the last inspection staff were not always completing medication administration records. This meant it was not possible to determine if patients had attended for their medicines and what the reasons were for non-attendance. During this inspection we sampled patient records and noted that record keeping had improved and the records we reviewed were completed as required. The head of healthcare told us that they had reiterated to staff the importance of keeping accurate records.