Cumbria Partnership NHS Foundation Trust

Haverigg Prison

Inspection Report

HMP Haverigg
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Overall summary

This inspection was an announced focused inspection carried out in January 2018 to confirm that the provider had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection between 3 and 6 April 2017.

The April 2017 comprehensive inspection was carried out in partnership with Her Majesty's Inspectorate of Prisons (HMIP) under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions in accordance with our published methodology. CQC issued one Requirement Notice under regulation 12 of the Health and Social Care Act to Cumbria Partnership NHS Foundation Trust. This can be found in Appendix 2 of the joint inspection report. The joint inspection report can be found at:

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

This focused inspection report covers our findings in relation to those aspects detailed in the Requirement Notices dated 28 July 2017 and the joint HMIP/CQC report recommendations that related to healthcare delivery. We do not currently rate services provided in prisons.

Our key findings were as follows:

- The provider had taken steps to ensure that medicines were managed safely for patients.
- Patients with long-term conditions were now identified and followed up in a timely and systematic manner.
- Embedding a positive focus on staff training and development had led to improved staffing levels.
- A range of continuous improvements had been made to improve patient care and monitoring of safety and quality.

The action taken by the provider ensured that patients were receiving safe and effective treatment.

Summary of findings

The five questions we ask about services 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 identified as requiring improvement in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 16 August 2017.

We found that the areas of concern identified in April 2017 had been addressed.

Medicines were managed and administered safely and segregated patients were seen appropriately by healthcare.

Are services effective?
We did not inspect the effective key question in full at this inspection. We inspected only those aspects identified as requiring improvement in the joint inspection report published by Her Majesty's Inspectorate of Prisons on 16 August 2017.

We found that the areas of concern identified in April 2017 had been addressed.

A range of staff had completed training in the management of long-term conditions and developed a range of care pathways to improve patient care.

Are services caring?
We did not inspect this key question during this focused follow up inspection.

Are services responsive to people's needs?
We did not inspect this key question during this focused follow up inspection.

Are services well-led?
We did not inspect the well-led key question during this follow up inspection.

However, during this inspection, we saw evidence to show how the provider had continually improved the service including improving quality and governance.

The governor of HMP Haverigg had recently nominated the healthcare team for a regional prison award.

Haverigg Prison

Detailed findings

Background to this inspection

HMP Haverigg is a category C male training prison situated in West Cumbria. At the time of the last inspection, HMP Haverigg was holding around 300 adult male prisoners, less than half its previous population following a decision by the then National Offender Management Service (now known as Her Majesty's Prison and Probation Service (HMPPS)) to close two accommodation units because the safety of prisoners living there could not be assured. The population remained around 300 during this follow up inspection.

CQC inspected this location with HMIP between the 3 and 6 April 2017. We found evidence that fundamental standards were not being met and one Requirement Notice was issued in relation to Regulation 12, Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We subsequently asked the trust to make improvements regarding this breach. We checked these areas as part of this focused inspection and found that the provider had addressed the issues identified that fell within their control and remit.

Health services at HMP Haverigg are commissioned by NHS England. The contract for the provision of primary healthcare services at HMP Haverigg is held by Cumbria Partnership NHS Foundation Trust. This report covers our findings in relation to those aspects detailed in the Requirement Notice issued to Cumbria Partnership NHS Foundation Trust (CPFT) in July 2017, and recommendations in the joint report specific to CPFT. We do not currently rate services provided in prisons.

We carried out a focused follow up inspection of Haverigg prison during January 2018. We did not visit the prison on this occasion because we were able to gain sufficient assurance through the documentary evidence provided and a telephone conference with relevant staff.

Are services safe?

Our findings

At our previous inspection in April 2017, we found a number of breaches of regulation in relation to the safe management of medicines, wider concerns around medicines management and with the application of the trust's zero tolerance to abusive behaviour policy.

The concerns we found in April 2017 were:

- Medicines were not always managed safely. We observed medicines being removed from packaging and transported insecurely to the segregation unit.
- Nurses were administering medication without legal authorisation. On one occasion this included high risk medication where a clinical assessment of relevant test results was not carried out.
- A patient in the segregation unit was not being reviewed daily by primary care staff in line with prison guidance.

These arrangements had significantly improved when we undertook a follow up inspection in January 2018.

Safe and appropriate use of medicines

During this inspection we found that the trust had improved procedures in relation to administration and transportation of medication and also worked with prison management and pharmacy colleagues to develop safer storage and delivery of medicines for patients in the segregation unit. There was work ongoing to develop a dedicated healthcare room in the segregation unit to further improve patient care.

A review of prescribing and out of hours access to medicines had also taken place, with clear standard operating procedures and patient group directions in place for medicines which nurses might need to administer.

The trust's medicines optimisation team made regular visits to the prison and supported the healthcare team to improve medicines safety.

Safe care for segregated patients

Subsequent to the inspection in April 2017, the trust reviewed its zero tolerance to abusive behaviour policy and replaced posters with behaviour expectation posters.

Local management had implemented a new protocol to ensure that all prisoners held in segregated conditions were seen and reviewed daily by primary care staff. We were unable to review clinical records during this desk top review, but new arrangements assured us that all patients held in segregation were seen daily by a nurse in line with this policy.

To deter abusive behaviour toward healthcare staff when administering medicines and when visiting patients in the segregation unit, work was also underway implement a pilot scheme of key healthcare staff wearing body worn cameras after completing the relevant prison training programme. Consideration had been given to maintaining patient confidentiality, and body worn cameras would only be worn by staff working in areas which experienced high levels of threatening and abusive behaviour.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

At our previous inspection we found that patients with long-term conditions were not all receiving reviews of their conditions and care planning was not well embedded.

During this focused inspection we found that the provider had introduced systems to ensure that patients with long-term conditions were identified upon arrival at the prison and a review of their condition was carried out. Nurses worked closely with GPs to improve the care for these patients.

A range of guidance documents and templates had been developed to improve consistency and ensure that all nurses were following best practice in supporting patients with long-term conditions.

Effective staffing

The trust had arranged additional training for nurses including respiratory conditions and tests, so that appropriate assessments and diagnosis of patients with respiratory conditions could be carried out.

Staff training had been given significant focus by management. Courses in minor illness, major injury, triage management, burns management and blood borne viruses had taken place.

A number of staff had undertaken advanced life support training, with further staff identified to attend this course. This was particularly important at HMP Haverigg due to its isolated location and the length of time it could take for ambulances to arrive.

Coordinating care and treatment

The trust had developed a standard operating procedure for working with local accident and emergency teams and to improve information sharing when patients attended accident and emergency departments for treatment.

Helping patients to live healthier lives

The trust had developed improved national screening pathways for retinal screening; bowel screening and abdominal aortic aneurism (AAA) with a number of staff attending an update training session.

The local team had also made ongoing improvements to the blood borne virus pathways, and worked closely with North Manchester General Hospital. HMP Haverigg had the highest referral rate for Hepatitis C treatment across northwest prisons, despite having the lowest prison population. A range of visits and specialist support was available to patients with blood borne viruses through this partnership working arrangement.

Are services caring?

Our findings

We did not inspect this key question during this focused follow up inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect this key question during this focused follow up inspection.

Are services well-led?

Our findings

We did not inspect this key question during this focused follow up inspection. However, during this inspection, we saw evidence to show how the provider had continually improved the service.

Continuous improvement and innovation

The trust had reviewed its staffing model and introduced several new roles. This included two new Band 6 nurses, and a quality and safety lead. This role linked into wider trust governance meetings which ensured that service quality and safety at HMP Haverigg were aligned with wider trust procedures and monitoring.

Local staff had reviewed the local complaints monitoring process so that the timeliness of complaints responses could be monitored.

The wider trust patient experience team had committed to undertake quality audits of the complaints process at HMP Haverigg, the first was due in March 2018.

Local teams had continued to develop templates in the patient electronic record system to improve the quality of record keeping and the consistency of patient care.

The governor of HMP Haverigg had recently nominated the trust healthcare team for a north west regional award for their partnership working with the prison to recognise the communication and innovation which was consistently demonstrated to improve patient care and support the prison staff in caring for prisoners safely.