Care Quality Commission

City Health Care Partnership CIC - HMP Hull

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 effective?	**Inspected but not rated**	
Are services well-led?	**Inspected but not rated**	

Overall summary

We carried out an announced focused inspection of healthcare services provided by City Health Care Partnership CIC (CHCP) at City Health Care Partnership CIC – HMP Hull in response to a specific incident and lack of evidence that the provider had taken appropriate action to protect patients in their care. The purpose of the inspection was to determine if the healthcare services provided by CHCP were 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.

During this inspection we acknowledged that the restricted prison regime introduced as a result of Covid-19 impacted significantly on care delivery at times.

We took account of the exceptional circumstances arising as a result of the pandemic when considering how we carried out this inspection. We therefore undertook some of the inspection processes remotely and spent less time on site. The provider consented to our remote activity to reduce inspection activity carried out on site and minimise infection risks due to the coronavirus pandemic.

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:

- Patients with long-term conditions were not being cared for safely in line with national guidance.
- Medicines were not being managed safely. In particular, prescribing was not following national guidance to ensure patient safety was not compromised by their medicines.
- Staff had completed additional training on supporting patients with diabetes care.
- The provider actively monitored risks at the location and had quality assurance arrangements in place, but these had not led to improvements in care.
- Service staffing levels had decreased significantly during 2020 which was impacting on patient care.
- The coronavirus pandemic had affected the service significantly, leading to high staff absence at times and delaying newly recruited staff from taking up post.
- There was currently no diabetes pathway in place and local operating procedures had not been formally approved or implemented.
- Patients with long term conditions had not received reviews in line with national guidance.
- Clinical care did not always follow national guidance and oversight of clinical care was not consistent.
- Governance systems and processes were insufficiently embedded to assess, monitor and improve the quality and safety of patient care.

Due to the risks to patients identified during this inspection, we wrote to the provider with immediate concerns that needed to be addressed. We were assured by the evidence received that the provider had addressed the issues sufficiently and further improvements would be made in a timely manner.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care. (please see the specific details on action required at the end of this report).

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

- Continue to review and improve systems to ensure patient care is safe and follows national guidance.

Our inspection team

Our inspection team was led by a CQC health and justice inspector supported by a second CQC health and justice inspector and a GP specialist professional advisor (GP SPA).

How we carried out this inspection

We conducted a range of interviews with staff and accessed patient clinical records remotely between 30 November 2020 and 22 December 2020. We carried out a shortened site visit on 2 December 2020. We conducted searches of patients prescribed high risk medicines and sampled 25 patient records.

Before this inspection we reviewed a range of information that we held about the service including the action plans in response to significant incidents. Following the announcement of the inspection we requested additional information from City Health Care Partnerships CIC (CHCP) which we reviewed.

. During the inspection we spoke with:

- Five nurses
- One health care assistant
- Two administrative staff and the practice manager
- One GP and one psychiatrist
- Three quality and governance staff from CHCP within the location and the wider governance team
- The local operational manager
- The general manager
- The head of medicines services and senior pharmacy technician for the service.

We also spoke with NHS England commissioners and CHCP senior leaders.

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

- Audits including those relating to diabetes care and medicines
- Quality assurance and governance meetings records
- CHCP transformation plans and meeting minutes
- Root cause analyses and learning from incidents
- Local procedures and draft standard operating procedures
- Workforce reports throughout 2020
- Staff training and supervision matrices
- Staff newsletters
- Service risk register and action plan trackers
- Notes from daily handover meetings and team meetings
- Spreadsheets showing secondary care appointments, and continuity of care

Background to City Health Care Partnership CIC - HMP Hull

HMP Hull is a local male adult Category B prison serving the East Yorkshire area. The prison is in the city of Hull and accommodates over 1,000 prisoners. Approximately one third of the population may be on remand, or awaiting sentence resulting in a high turnover of prisoners each month. The prison is operated by Her Majesty's Prison and Probation Service.

Data published in the Health and Social Care Needs Assessment in October 2019 (HSCNA) showed that around 42% of prisoners had resided at HMP Hull for over six months. The HSCNA identified that the numbers of patients residing at HMP Hull diagnosed with diabetes was above expected prevalence (6.3% actual against expected prevalence of 3.9%). The average age of the population had also increased, in 2016, 24% of the population was over 45 years old, in 2019 this had increased to 28%.

Health services at HMP Hull are commissioned by NHS England. The contract for the provision of healthcare services is held by City Health Care Partnership CIC (CHCP). CHCP is registered with CQC to provide the regulated activities of diagnostic and screening procedures, personal care, surgical procedures and treatment of disease, disorder or injury.

Our previous comprehensive inspection was conducted jointly with Her Mastery's Inspectorate of Prisons (HMIP) in April 2018 and published on HMIP website on 7 August 2019. We found breaches of Regulation 9, person-centred care and Regulation 17, good governance.

CQC conducted a focused inspection in March 2019 of aspects of service provision under Regulation 9, person centred care and Regulation 17, good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Previous breaches of Regulations had been addressed during this inspection. The report from this inspection can be found on our website at:

https://api.cqc.org.uk/public/v1/reports/2bdd3753-59c3-4028-863f-4ae2339b5e06?20190401235021.

Are services safe?

We did not look at all aspects of this key question during this focused inspection.

Safety systems and processes

Local managers had improved systems around reception screening to ensure appropriate referrals were made for mental health, substance misuse and long-term condition clinics. We saw evidence that these referrals were made in our sample of patient records.

Administrative staff had improved the arrangements to monitor all referrals to outside health services and followed up appropriately where appointments were not received.

Risks to patients

During our remote searches of the patient clinical record system, we identified that the provider did not have effective systems, practices and processes to keep people safe. The provider did not have an effective system for ensuring that Medicines and Healthcare Regulatory Agency (MHRA) and patient safety alerts were received and actioned. We also saw that not all clinical observations or test results were followed up when they were outside of normal expected limits. This meant, in some instances, action was not taken; for example, in supporting patients with diabetes to achieve their target HbA1C levels.

Our remote sample of records and the searches we conducted demonstrated that clinical risks to patients were not always being identified and action was not being taken to reduce these risks.

We found one occasion when a patient experienced chest pains and/or raised blood pressure where tests were not carried out to rule out potentially serious conditions and appropriate follow up care did not take place. This placed patients at risk of serious harm from complications related to their conditions.

Within the sample of records reviewed for patients identified as having atrial fibrillation, a heart condition that causes an irregular and often abnormally fast heart rate, we identified that patients were not consistently being assessed for risk in line with national guidance.

Information to deliver safe care and treatment

The provider had introduced a process in October 2020 to ensure action was taken when a patient returned from hospital without a discharge summary (discharge summary is a clinical report prepared by a hospital healthcare professional at the end of a hospital stay to share information about care and treatment). However, not all nurses we spoke with were aware of the system, which meant we were unable to verify if missing discharge summaries were followed up consistently.

We identified that there was a backlog of clinical letters which had not been scanned and coded into patient records, some of which were three months old. There were also over 30 pathology results allocated to a GP who no longer worked at the location. Patient records were therefore not complete which meant there was a risk that important clinical information would not be available to staff when required. Following our inspection, CHCP assured us that each result had been checked and reviewed by a second doctor.

Appropriate and safe use of medicines

Are services safe?

We saw evidence in patient records of clear action being taken where patients with diabetes who had unstable blood sugars received support to manage their medicines. However, we also saw evidence where some patients with known abnormal readings were not followed up appropriately to ensure their medicines were prescribed and monitored safely.

Our sample of patient clinical records identified that several patients who were prescribed high risk medicines were not being appropriately monitored to ensure they were not adversely affected by the medicines, placing them at potential clinical risk.

During our inspection, we brought one patient to the provider's attention due to the level of risk from gaps in provision of their medicine. The provider assured us pharmacy staff would review the patient's medicines promptly to mitigate the risks.

Not all patients prescribed combinations of medicines which could have harmful interactions were monitored in line with national guidance to reduce the risk of potential complications

A MHRA drug safety alert was issued in February 2019 regarding the use of a new group of medicines used for treating type 2 diabetes. Our sample of patient records demonstrated that the requirements of MHRA drug safety alerts were not always followed.

During this inspection we identified several significant risks to patient care and therefore wrote to City Health Care Partnership (CHCP) with the immediate concerns which needed to be addressed. The provider took immediate action for patients where we had identified risks and has provided evidence to CQC of how they will continue to improve safe care. The provider has submitted an action plan to CQC and will work to regularly provide CQC and NHS England commissioning managers with updates on progress against the action plan.

Lessons learned and improvements made

CHCP had a quality and clinical governance team who worked closely with local leaders. We reviewed minutes of quality meetings which clearly demonstrated understanding of improvements required following incidents.

Whilst we saw clear evidence that some improvements had been implemented, such as additional training for staff in diabetes care and insulin management, there were also actions which had not been embedded. For example, CHCP identified a range of risks in 2019 following a significant incident but had not fully implemented required actions to improve patient safety.

The provider had identified the need to deliver improved staff development and support to ensure care was safe. Some actions had not been implemented due to the impact of the coronavirus pandemic on the service and staffing levels.

Are services effective?

We did not look at all aspects of this key question during this focused inspection.

Effective needs assessment, care and treatment

City Health Care Partnership (CHCP) had identified in 2019 that a pathway for diabetic patient care was required, but this had not been established. An outline of what would be included in the pathway was provided as evidence for this inspection. Patients who arrived at HMP Hull previously diagnosed with long term conditions including diabetes were placed on a waiting list for a long-term condition clinic. Although CHCP were following primary care prioritisation guidance regarding the provision of long-term clinics, no clinics had been held since March 2020 and there was no systematic approach to ensuring the effective review and monitoring of individual risk.

Care was not always being provided in line with NICE guidance. For example, of 52 patients on the diabetic register, 15 (29%) had not had blood sugar monitoring to identify the risk of developing associated complications in line with NICE guidance. This meant the patient's average blood sugar levels could not be determined to identify any risk of the development of diabetic related complications. Action to support patients with reducing any risks could not therefore be taken.

We found that patients diagnosed with diabetes had not received annual urine testing to identify early signs of kidney disease.

A diabetic specialist nurse (DSN) from a community clinic had provided short training sessions in October 2019 and February 2020 to support clinical staff with the care and management of patients with diabetes. The DSN had also supported regular specialist diabetic clinics within the prison until February 2020, when the outreach clinic was stopped by the community health partner due to Covid-19. Support from the diabetic specialist team had been made available remotely however, as an interim arrangement during the pandemic. We saw evidence in one patient's clinical record of advice being sought from the community diabetic specialists around unstable blood sugar monitoring. However, other patients were still awaiting specialist input.

Care was not always taking place in line with local operating procedures or NICE guidance for other long-term conditions including asthma, chronic obstructive pulmonary disorder (COPD), heart failure, epilepsy and chronic kidney disease (CKD). We reviewed the registers of patients with these conditions and identified that 136 patients required annual reviews of their conditions. We saw that 87 patients had resided at HMP Hull for more than 12 months, of which 37 (43%) had not received a review of their condition in the last 12 months, 27 of whom, (31%) had not had a review for more than 18 months. None of the 49 patients who had arrived at HMP Hull between June and December 2020 had received a review of their condition to ensure their care was effective. CQC acknowledged that Covid-19 had impacted on the delivery of health care services within the prison, and some patients accounted for in the above data had only recently transferred to the prison. However, many patients were not being cared for in line with guidance.

The provider had commenced working with a provider of clinical templates (used in electronic patient record systems to ensure care is carried out in accordance with national guidance) to pilot how these could be used in the prison environment, having recognised that they needed to improve effective care.

Monitoring care and treatment

CHCP had redeployed clinical staff who usually worked within quality and audit teams as a result of the pandemic. Staff had carried out a range of audits, though some auditing had been postponed due to the coronavirus pandemic.

Are services effective?

Audits had been developed using NICE guidance. Our inspection identified that audits were not undertaken in a timely manner and did not cover all clinical requirements of national guidance. For example, an audit of diabetic care was carried out in October 2020 despite several incidents relating to diabetic patient care in 2019. The audit of diabetic care in October 2020 identified gaps in care and treatment. For example:

- None of the insulin dependent diabetic patients' records had a set review frequency or recall dates indicated within their care management plan.
- None of the records contained completed blood sugar monitoring level monitoring.
- 61% of insulin dependent diabetic patient records indicated a referral to a specialist diabetic nurse was required.
- There was no evidence that clinical staff had accessed the diabetes care action plan and were aware of the improvements required.

We also found that there was insufficient oversight of audits and audit findings did not lead to enough improvement. For example:

- Several audits had been conducted by the pharmacy team. Six of these showed that compliance with the audit criteria was 100%, despite each containing one or two indicators being marked as non-compliant. One two-cycle audit of medicines management had shown some improvement with outstanding actions clearly identified.
- An audit of patient records reviewed seven records for HMP Hull and HMP Humber. This was a sample size of 3.5% of the joint prison population. It was not clear how actions had improved patient care.

Effective staffing

The service had high staffing vacancies, particularly in the primary care and leadership teams. CHCP had identified staffing capacity as a risk in August 2020, and immediately bought in two managers to support the team and commenced further recruitment. However, staffing levels had decreased between January and September 2020 across all teams, but in particular primary care and leadership.

The provider had made changes in the senior leadership team within the prison during early 2020. However, these changes had occurred immediately prior to the coronavirus pandemic. This impacted upon recruitment and led to further vacancies.

March 2020 onwards saw significant changes in healthcare delivery due to more restrictive prison regimes. Staff we spoke with during the inspection described significant challenges around staffing and during the coronavirus pandemic, with large numbers of staff unwell or isolating due to the virus during November and December 2020.

CHCP had identified the need to increase staff skills and training in 2019. A transformation plan had been agreed to develop nurses who had worked within the prison environment for several years to become more aligned with community practice nursing and clinical skills. This had included development of a skills passport for both nurses and health care assistants, online diabetes training on insulin management and national early warning score (NEWS2, a template for taking clinical observations to monitor patient risk).

Local leaders had worked with the Nursing and Midwifery Council and put support plans in place for some nurses identified as needing further support with their clinical skills and knowledge of diabetes care.

Are services effective?

All staff identified as requiring undertaking the Safe use of Insulin eLearning module during 2019 had completed this by July 2020. The community diabetes specialist nurse had facilitated a training session in October 2019 on diabetes care for staff, which was repeated in February 2020. Attendance was not recorded, so it was not possible to confirm how many staff had received additional training or that staff records were complete and up to date.

All staff received a corporate four-day induction before staring their substantive role. However, two staff told us they had not received an induction when they started their clinical, on-site role which reflected the staffing pressures at the time.

We reviewed staff supervision and found that this had not been embedded into the service. CHCP advised us their supervision policy required four supervision sessions per year. Some of the staff we had interviewed said they had not previously had supervision, though this had recently begun. For 22 primary care staff we saw evidence that only eight had received supervision between April and August 2020 and seven between September and December 2020. Five healthcare staff returned from long term sickness absence between July and September, there was no evidence of supervision or support when they returned. Eight primary care staff had received no supervision since April 2020.

Evidence showed that within the mental health, drug and alcohol reduction team and, pharmacy and admin teams, supervision had been taking place more consistently through a combination of team meetings and individual supervision.

Coordinating care and treatment

The service had worked with a diabetic specialist nurse who had held clinics at HMP Hull until March 2020. We saw evidence in some patient records that, where the diabetic specialist nurse had recommended tests in line with NICE guidance, these were not carried out.

For some patients with identified diabetic risks since March 2020, there had been remote communication with the local community endocrine team for advice and guidance. However, there were eight patients on a waiting list for diabetic specialist input including one patient who had been waiting for over 12 months. Following the inspection CHCP assured us patients with urgent needs would be referred to the GP for review.

Consent to care and treatment

Our sample of patient records identified that whilst patients were asked to sign a consent form (confirming patient consented to healthcare contacting community healthcare professionals to request community records and liaising with other healthcare providers where required) during their reception screening, these were not always correctly filled in or signed by a nurse, so it was not clear what had been agreed to by the patient.

Are services well-led?

We did not look at all aspects of this key question during this focused inspection.

Leadership capacity and capability

There had been several leadership changes over the previous two years which had been identified by NHS England commissioners as an improvement requirement. There was a clear understanding from local and senior leaders of the challenges they faced, but there remained shortages within the operational leadership team.

A new quality lead and clinical lead had recently taken up post and staff felt some of the changes were beginning to impact positively.

We saw evidence of senior leadership involvement and understanding of the challenges faced by the staff providing health services within the prison environment. This included a general manager routinely working within the prison to increase management oversight.

Whilst the leaders we spoke with had clear knowledge of the concerns and capability to see through changes, the capacity to deliver the required changed remained limited due to vacant posts.

Vision and strategy

The vision and strategy set out by City Health Care Partnership (CHCP) was clear. There was work underway to stabilise the leadership and embed the vision and strategy.

We saw that some recent daily handover meetings had tried to inform staff of strategic direction. However, attendance at meetings had been reduced to minimise the risk of infection during the recent coronavirus outbreak, and staff advised us they did not have enough time to read all the information which was being shared by email.

Culture

The provider had recognised there were some cultural issues and was trying to address these through increased development, skills and support.

Staff told us they felt that the clinical lead and quality lead were beginning to make a difference, though they still felt the pressure from staff vacancies and coronavirus absence.

Governance arrangements

There was a strong governance structure built in to the CHCP provision and the recent addition of a local governance and quality lead within the prison healthcare team. However, risks identified were not acted upon in a timely way and there was insufficient clinical oversight of monitoring arrangements and patient care, so risks to patients had not been fully identified and acted upon.

We reviewed a range of audits and reviews for different aspects of care and found that incomplete audits or incorrect scoring had not been identified by CHCP governance oversight. There was limited cyclic audit activity to demonstrate improvements made.

Are services well-led?

Clinical staff we spoke with were unaware of any audits, and some could not advise of any learning from serious incidents which had been used to improve patient care.

Managing risks, issues and performance

The risk register for the location identified both long term condition management and staffing as risks for the service. CHCP was sighted on risks and the need to increase staffing and staff skills, however recruitment challenges for CHCP and the Humber region, alongside the significant coronavirus outbreak within the Humber area and within the prison impacted upon the provider's ability to address risks in a timely way.

Engagement with patients, the public, staff and external partners

The local team informed us that they had been requesting patient feedback throughout year, however few forms were being returned. The provider recognised they needed to make changes to improve patient engagement.

There were several peer support workers who were trained to give some health and wellbeing advice and support to patients, however, following significant prison regime reductions and the need to prevent virus transmission, their roles had been reduced during the pandemic.

Continuous improvement and innovation

Our remote samples of patient clinical records identified a range of significant risks which we bought to the attention of the provider during the reporting process. We asked the provider to take action to reduce the risks to patients and they incorporated this into their continuous improvement process.

The provider has set in place arrangements to update NHS England commissioners and CQC of their progress against their service improvement plan.

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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **There were no effective systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:** • There were no effective systems to identify and manage the use of high-risk medicines. • There was no effective system to ensure that MHRA alerts were used to ensure that patient care was being improved. **Systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided were not effective. In particular:** • The system to ensure that pathology results were reviewed by a clinician and available to staff within patient records was ineffective. • Absence of discharge summaries was not always followed up when patients returned from hospital. • Oversight of audits was not effective. • Audit processes were not always effective in identifying risks to patients. • Actions to mitigate identified risks had not been effectively implemented to improve the service. • Staff supervision was not taking place in line with the organisational policy. • Monitoring of care for patients with long-term conditions was not identifying care and treatment that was not in line with local operating procedures or national guidance. **The provider did not maintain securely an accurate, complete and contemporaneous record in respect of**

This section is primarily information for the provider

Requirement notices

each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. In particular:

- Letters regarding patient care and treatment rationale and decisions were not always recorded contemporaneously.
- Patient consent forms were not filled in completely.

The provider did not maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. In particular:

- Records of staff attending local training sessions.

The provider did not seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular:

- Where specialist clinicians gave advice regarding additional tests which should be carried out in line with national guidance, this advice was not used to improve the service.