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Angela Dixon
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30 April 2024

Dear Angela

RE: Follow up Inspection at HMP Addiewell

I am writing to thank you and your staff for their contribution and assistance with the unannounced follow up inspection at HMP Addiewell between 17-18 April 2024. We were aware of the considerable effort made by staff to welcome and assist us and I would be grateful if you could pass on our thanks to all involved.

Inspection findings

We were pleased to see that there has been progress made against 23 recommendations following the full inspection to HMP Addiewell in November 2022. We recognise some recommendations remain in the early stages of implementation.

We were encouraged to see the number of staffing vacancies had greatly reduced and that the improved staffing levels have had a positive impact on reducing waiting times, particularly for patients referred to the mental health and addictions team.

Whilst several recommendations have been met, as evidenced during the inspection, 16 remain outstanding. In addition to the outstanding recommendations during our inspection process, our team onsite raised several concerns with the management team which related to the following:

- **Triage process -** At the time of inspection referrals to the mental health and addictions team were managed electronically. Inspectors were told that whilst referrals were generally discussed with a registered nurse, most nurses did not have access to the electronic system which meant that the initial screening of referrals was undertaken by a healthcare support worker. Whilst we recognise some steps have already been taken to address this, we are concerned about a lack of a formalised process to ensure triaging of referrals are managed consistently and by a registered nurse. This would ensure that there is a consistent risk-based approach to prioritising referrals and identifying staff responsible for this role.

- **Risk assessments -** Inspectors were not assured all patients on the mental health caseload had an up to date risk assessment recorded on an agreed standardised tool, stored within patient care records for staff to access. We were concerned that there was a lack of a consistent approach to the management of individual patient risk assessments.

- **Leadership and Oversight –** We recognize that there has been a new leadership structure at HMP

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Addiewell since the last full inspection in 2022. However, a number of previous recommendations remain unmet with the addition of four new recommendations as a result of this follow up inspection. Several of our recommendations highlighted a gap in the oversight and governance of systems and processes relating to patient care and safety. Whilst inspectors recognise the priority to recruit new staff and the process for developing and ratifying new procedures can be lengthy, we remain concerned that there was a lack of oversight in a number or areas, including:

- **Governance -** Inspectors were not assured that there is an effective system in place to monitor the quality and completion of risk assessments and care plans despite this being highlighted as a recommendation in the previous reports. Inspectors were advised that external auditors had been requested to provide assurance on the quality and completion of risk assessments. However, there was also no evidence of internal assurance activities taking place with regards to this.
- **Caseload management -**The initial inspection highlighted a lack of oversight of the caseloads for patients receiving care from the mental health and addictions teams. Whilst a caseload management system was in place, it was not up to date, therefore there was no robust process in place for identifying patients on the caseloads.
- **Staff support/induction -**Staff morale appeared to have improved, however inspectors were not assured that all new staff were receiving up to date inductions and appropriate information to support them to deliver care.

To allow full consideration of our concerns we request a new action plan with the outstanding and new recommendations to reflect the findings from the onsite inspection.

Please provide this electronically to our confidential mailbox: his.prisoninspect@nhs.scot **by 15 May 2024**. Following receipt of the completed action plan we will review it as part of our risk assessment process and will notify you of the next steps.

If we can be of any further assistance, please let us know.

Yours sincerely

Sophie Dias Cavaco
Lead Inspector

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