

HMP High Down

Inspection report

Highdown
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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 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 Central and North West London NHS Foundation Trust (CNWL) at HMP High Down on 23 and 24 May 2022. This was in response to a focused inspection carried out in June 2021 when we found the quality of care required improvement. We issued a Requirement Notice in relation to Regulation 17: Good governance. Systems and processes did not always ensure the maintenance and quality of care.

The purpose of this focused follow up inspection was to determine if the healthcare services provided by CNWL were now meeting the legal requirements of the above regulation, under Section 60 of the Health and Social Care Act 2008.

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:

- Systems for monitoring storage temperatures of medicines were effective.
- Systems for checking items stored in emergency bags were effective.
- Medicines administration was undertaken in line with policies and procedures.
- A monthly missed dose report enabled analysis and service improvements to be implemented.
- There was a high number of vacancies in the physical health care team, however, there was a consistent team of bank and agency staff.
- Safe staffing levels were reviewed on a daily and weekly basis, however, there was not an effective system to readily report on the number of unfilled shifts over time.
- There was a system in place to monitor the use of, and response to, 'Tasks' within the electronic patient record system in line with agreed processes and procedures.
- Compliance with secondary health screenings within seven days was good and systems enabled a further health screening appointment to be routinely offered when an initial appointment had been missed.
- Waiting lists were continuously reviewed to enable patients with the highest need to be prioritised for care and treatment.
- Staff received adequate mentoring for their role.
- Most, but not all staff received supervision in line with the provider's policy.
- Newly appointed staff received an induction and most, but not all, staff felt supported in their roles.
- Systems were not effective in ensuring the management of patients with long-term health conditions.

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

- Ensure systems and processes are effective in ensuring patients with a long-term health condition receive an annual review in line with National Institute for Health and Care Excellence (NICE) guidance.

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

- Monitor unfilled shifts on a consistent basis to support with identifying gaps in service provision.
- Engage with Her Majesty's Prison and Probation Service (HMPPS) to ensure the consistent supervision of medicine queues to reduce the risk of diversion.
- Ensure systems and processes monitor that identified actions are implemented following clinical audit.
- Ensure staff receive supervision in line with policy and procedures.

Our inspection team was led by a CQC health and justice inspector supported by two CQC health and justice inspectors.

How we carried out this inspection

Overall summary

We accessed patient clinical records during our onsite visit on 23 and 24 May 2022. We conducted searches for patients who had been identified as having specific long-term conditions, such as diabetes and epilepsy, and sampled several patient records.

Before this inspection we reviewed a range of information that we held about the service including information we had requested from the provider in support of our inspection.

During the inspection we spoke with healthcare staff, prison staff, commissioners, people who used the service, and sampled a range of records.

We also reviewed documents that included:

- Medicines missed dose report
- List of patients with an outstanding annual medication review
- Clinical incident data including those relating to medicines
- Policies and procedures relating to medicines
- Information relating to the staffing model, vacancies and recruitment
- Staff supervision and induction compliance data
- Medicines mandatory training compliance data
- Secondary health screening compliance data
- Minutes of governance and quality assurance meetings
- Minutes of medicines governance meetings
- Staff meeting minutes
- Clinic information including cancelled clinic data
- Care plan audit data
- Mental health case load data
- Monthly management check list including fridge temperatures and emergency equipment checks
- Medications administered report

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

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Background to HMP High Down

HMP High Down had been rerolled from a Category B local prison to a category C training prison in 2022 and, at the time of our inspection, initial plans had just been implemented to support the change in function. The prison is near Banstead in Surrey and holds approximately 1,150 convicted and remanded men. The prison is operated by Her Majesty's Prison and Probation Service.

Central and North West London NHS Foundation Trust (CNWL) is the health provider at HMP High Down. The trust is registered to provide the following regulated activities at the location: Treatment of disease, disorder or injury and Diagnostic and screening procedures.

Our last CQC focused inspection was in June 2021 when we found not all fundamental standards were being met in relation to Regulation 17: Good governance. The inspection report can be found at

<https://api.cqc.org.uk/public/v1/reports/490ac9d8-cfb0-4679-a769-f66176ce6768?20211011164306>

Our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) was in January 2018. During this inspection, we found that the fundamental standards were being met. The inspection report can be found at:

<https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-high-down-2/>

Are services safe?

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

Safety systems and processes

The provider ensured that equipment was safe and maintained.

At our last inspection, we found that systems for ensuring the recording and monitoring of the contents of emergency bags, such as through the completion of a management audit tool and additional spot checks, had not been embedded in practice. At this inspection, we found improvement and a monthly management audit was completed for each house block/area and that most daily checks had been recorded to ensure equipment was consistently checked. Monthly training on emergency bag contents and completion of checklists was introduced as standard refresher training from August 2021.

Risks to patients

Systems were mostly effective to ensure the assessment, monitoring and management of risks to patient safety.

At the time of our June 2021 focused inspection, there was a vacancy rate of 36% in the primary care team and one vacancy in the mental health team. During this follow up inspection, we found deterioration in that there was a vacancy rate of 46% in the primary care team and an increased number of vacancies in the mental health team. There were two assistant psychologist vacancies in the mental health team with a third assistant psychologist reporting they were leaving the service imminently. The provider acknowledged the assistant psychologists had not received clinical supervision in line with policy due to staff sickness. A service review was in progress to address this alongside a review of mental health provision in general in line with the re-role of the prison and imminent changing profile of the populations' needs.

The provider continued to hold recruitment days in an effort to fill vacancies, however, staffing deficits impacted on wait times for mental health provision and the consistent delivery of nurse-led clinics. For example, wait lists for psychology one-to-one intervention were 44 weeks; and 20 and 18 nurse-led clinics were cancelled in March and April 2022 respectively. There were three mental health nurses in the service and staff reported this was not enough with one nurse stating '...we feel overwhelmed ...there aren't enough of us we don't get time to focus on patients'.

At our previous inspection in June 2021, we found there had been three heads of healthcare since September 2019 and a period of four months from December 2020 to April 2021 when temporary senior leadership cover was in place which meant staff had experienced much change. During this inspection, a substantive head of healthcare (HoHC) had been in post for approximately ten months and they had also worked alongside the previous interim HoHC prior to stepping into the role. Staff told us they felt supported and that changes in the management team were 'good' and that morale had improved. Furthermore, staff from the primary care team reported they had an appropriate level of mentoring to ensure they were confident in undertaking the full range of tasks required.

At the time of our last inspection, there was 67% compliance with supervision that was not in line with policy; however, the pandemic had increased clinical need and staff sickness had also impacted on its delivery. At this inspection we found improvement however, the delivery of supervision was not consistent. For example, compliance was 82.5% (April 2022), 87.2% (March 2022), 73.5% (February 2022), and 53.3% (January 2022) respectively; the trust confirmed lower compliance was at a time of a surge in Covid-19.

Are services safe?

At the time of our last inspection, not all patients were followed up to offer a further secondary health screening appointment if they missed the initial appointment. At this inspection we found a new system had been implemented to ensure patients were routinely offered a further opportunity to attend a secondary screening appointment. For example, there was 95.1% compliance with patients receiving a secondary screening within seven days during May 2022, and the trust confirmed that all but one patient received a screening albeit outside of this timeframe.

At our last inspection we found routine appointments to see a GP were between two and four weeks which we assessed as being in line with community provision and, at the time of this inspection, wait times were similar which was reasonable. Patients requiring urgent care were seen as required. Progress had been made to reduce waiting lists for an annual medication review at the last inspection and, at this inspection, we found a new system had ensured patients were booked on to the GP routine wait list for their review that had been effective in minimising the risk of delay.

Improvement plans in the management of waiting lists had been initiated at the time of our last inspection and work had been ongoing to review and clear waiting lists. At this inspection, GP waiting lists were regularly reviewed, and nurse-led clinics were held on each of the house blocks to manage minor ailments and conditions. A registered nurse triaged patients to ensure they were prioritised for treatment according to clinical need and were seen by a GP as required.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

At our June 2021 focused inspection, we found some patient recording systems required review to support with the analysis of patient information to inform service improvements. For example, there was not a system in place to appropriately analyse the data from a missed dose report or ensure that patients who missed doses were followed up.

During this inspection, we found significant improvement in that the provider produced a missed drug report each month that was included as a standing agenda item on the medicine's optimisation meeting. The findings from the report were analysed and any themes and trends were targeted to support with service improvement; for example, in addressing areas where a higher number of patients did not attend (DNA) to receive their prescribed medication.

Appropriate and safe use of medicines

During our focused inspection in June 2021 we found some concerns within medicines management processes that indicated that the provider's policies and procedures were not always adhered to. During this inspection we found improvement in that:

- Systems for monitoring the storage temperatures of medicines were now effective in ensuring their suitability for use. For example, management audits and regular spot checks were undertaken, and we observed one fridge was checked daily during May 2022 in a treatment room on one house block.
- Staff consistently checked prisoner IDs before administering medicines.
- Controlled drugs (CDs) were administered in line with policies and procedures, and CD records were complete. However, staff had to wait for a second checker to arrive at times from another wing which increased the risk of a patient's medication being delayed.
- Most prescribed medicines were available as required for administration.
- A new system had been implemented to store prescribed medicines which reduced the risk of error.

Are services safe?

- Where medicines administration took place by one member of staff in an area where patients queued at two separate hatches, the administrator was required to move from one area of the room to another to administer medicines; this raised the risk of error.
- Some staff responded to prisoner's requests for a healthcare appointment/form, for example, during medicines administration which presented the risk of loss of concentration and error.
- One patient was asked to self-administer an injection at the hatch in view of other patients which did not ensure their privacy and dignity.
- Some medicines queues were disorderly and there was a high level of noise, such as on house block 6, which could present a risk of distraction. Officer observation was also inconsistent which raised the risk of diversion. It was noted however, it was the first day officers had supervised medicines administration queues following a move to the new prison regime.
- There was 100% compliance with medicines management competency workbooks and drug calculation assessments as of May 2022. There was also a rolling programme of medicines management modular training provided by pharmacy staff, and the ongoing monitoring of training records which included compliance by bank/agency staff.
- Learning from medicines incidents were shared electronically and at staff briefings.

Are services effective?

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

Effective needs assessment, care and treatment

During our June 2021 focused inspection, we found that the management of patients with long-term health conditions was underdeveloped and not systematic. Whilst most patients requiring treatment for long-term health conditions had a care plan in place, these had been recently added to the patient records and were not individualised to inform their ongoing care. Furthermore, there was no evidence that patients were involved in their care planning which meant there was a risk they may not be supported to manage their own care and treatment. Patients with long-term health conditions were not sufficiently monitored to ensure the care and treatment they received met their needs.

During this inspection, we found ongoing concerns in the management of patients requiring treatment for long-term health conditions. Staff told us that, following the pandemic, there remained some areas that required 'catch up' and gaps in staffing meant some nurse-led clinics were cancelled. For example, seven long-term conditions clinics were cancelled in March and April 2022 respectively. There had been no respiratory or asthma nurse-led clinic since before the coronavirus pandemic as there was not a suitably trained nurse in the team to deliver the care and treatment. Patients were booked to see the GP for an annual review of their long-term condition. A community diabetic nurse specialist visited the prison to review patients with diabetes, however staff told us they had not been for 'at least a month' and staff were not sure as to the reason for their absence.

We asked the provider for a report of the number of patients with a long-term health condition who were eligible for, and those who had received or were outstanding an annual long-term health condition review in line with NICE guidance. The trust reported there was 'no easy way' to report on data around annual reviews and that data had to be compiled by a manual 'trawl' of the data. This meant we were not assured systems and processes were effective in ensuring annual long-term conditions reviews took place as required. Furthermore, data confirmed 16 out of 31 (52%) patients had not received an asthma annual review, and 6 out of 19 (32%) patients had not received an annual diabetes review. The provider told us some of these reviews were recently out of date and that a further patient had refused to engage, however; there was a risk that patients were not receiving the right medication or the best possible care.

A review of the electronic patient record system found that two out of five patients on the asthma long term conditions register did not have a care plan in place, however, they had arrived at the prison in April and May 2022 respectively. Two out of two patient records reviewed with epilepsy had a care plan in place, however, one was overdue a review from September 2021.

At the last inspection we found that whilst the provider had a clinical audit cycle process in place, some audits, such as those related to care planning, had not resumed due to the need to prioritise the direct provision of patient care and treatment during the pandemic. At this inspection we found a care plan audit had been recently implemented and, of ten care plans audited during April 2022, nine had a care plan that had been personalised in place. However, there were no comments made regarding the patient without a care plan, for example, to evidence if they were high risk or otherwise, and no associated action plan to address the gap. There was therefore no audit trail to capture that the care plan had been completed with the patient to ensure they received treatment and care in accordance with the plan.

Are services responsive to people's needs?

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

During our June 2021 focused inspection, we found that management of tasks on the electronic clinical recording was not effective in ensuring they were actioned in a timely way. This increased the risk that patients' immediate health needs may not be met. There was a high number of open tasks that increased the likelihood that a request for clinical action would not be responded to in a timely way.

At this inspection we found significant improvement in that a new system had been implemented to monitor open tasks that were reviewed weekly by clinical leads to ensure they were actioned as required. Additionally, we found there were 14 open tasks allocated to pharmacy as at 24 May 2022, of which two were in progress, which was positive.

Are services well-led?

Leadership capacity and capability

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

At our focused inspection in June 2021, we found there had been inconsistency within the leadership team. There had been three heads of healthcare since September 2019 and a period of four months from December 2020 to April 2021 when temporary senior leadership cover was provided from the Health and Justice Services Directorate to backfill sick leave. This meant that, whilst the provider had ensured continuity in leadership, staff had experienced ongoing change.

During this inspection, a substantive head of healthcare (HoHC) had been in post for approximately ten months and they had also worked alongside the previous interim HoHC prior to stepping into the role. All staff we spoke with spoke highly of the HoHC and the support they provided. As of April 2022, the provider also confirmed the leadership team was fully recruited to across the service. This represented significant improvement.

Whilst staffing remained a key concern, leaders continued to closely monitor staffing levels and undertake recruitment campaigns in an effort to fill vacancies. Nevertheless, the provider did not have an effective system for capturing the number of unfilled shifts over a period of time to inform analysis/planning, however, they informed us a report was being devised to capture this going forward.

Staff gaps continued to impact on wait times and the delivery of nurse-led clinics at times, for example, clinics were cancelled on occasion when there was a need to prioritise essential services such as medicine administration. Despite vacancies, staff morale had mostly improved in primary care with some staff describing a 'friendly and open environment' and others discussing the progress and change that had been made. Not all staff in the mental health team described morale as high, with some reporting workload demand and inconsistent supervision as impacting on their resolve.

Governance arrangements

During this inspection we found a number of service improvements had been implemented to improve performance; however, there remained some gaps in service provision where governance processes required strengthening to ensure the ongoing delivery of safe and effective care.

Systems and processes revised since our previous inspection that were effective in ensuring:

- The consistent monitoring of the storage temperatures of medicines.
- Systems for checking items stored in emergency bags were consistently followed.
- Medicines administration was consistently undertaken in line with policies and procedures.
- The recording of missed dose incidents supported the analysis of information to enable service improvements.
- That 'Tasks' within the electronic patient record system were monitored and action was taken in line with agreed processes and procedures.
- That a further health screening appointment was routinely offered when an initial secondary health screening appointment had been missed.
- That waiting lists were continuously reviewed to enable patients with the highest need to be prioritised for care and treatment.
- That staff received adequate mentoring for the tasks required in their role.

Governance systems that were not always effective in ensuring:

Are services well-led?

- The management of patients with long-term health conditions was in line with national guidance.
- That supervision was always delivered in line with the provider's policy.

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 CQC (Registration) Regulations 2009 Notification of death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act 1983 How the regulation was not being met: The systems and processes designed to enable 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 were not used effectively. In particular: Guidance was not always followed to ensure the effective management of patients with long-term health conditions.