HMP Stafford

Quality 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.

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Overall summary

We carried out a scheduled inspection at HMP Stafford between 8 and 19 February 2016 jointly with our partner inspectorate Her Majesty's Inspectorate of Prisons (HMIP) under our joint memorandum of understanding. The inspection identified a number of areas which required improvement by the healthcare provider at that time. As this was a joint inspection, the full comprehensive report can be found on the HMIP website:

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

Health services at HMP Stafford are commissioned by NHS England. In April 2016, the contract for the provision of healthcare services at HMP Stafford transferred to Care UK Clinical Services Ltd (Care UK). CQC appraised Care UK of the concerns identified during the inspection in February 2016 so that they could address these within the new service provision.

This inspection was a desk-based review carried out in January and March 2017 to confirm that the new provider

Summary of findings

had made improvements in the areas which were identified in February 2016 as concerning. This report covers our previous inspection findings and also additional improvements made since our last inspection.

Our key findings were as follows:

- The provider had increased the provision and scope of dental care so that access and treatment were equivalent to that in the community.
- Significant improvements had been made around management of medication which reduced the risks identified in the February 2016 inspection.
- The new contract had led to increased primary mental health care staffing and staff were now accessing supervision. There remained two Registered Mental Nurse (RMN) vacancies at the time of the follow up inspection, which were being recruited for. A range of innovative service improvements and pilot studies were under way to improve patient pathways for patients with long term conditions including dementia, though the provider was aware that further work was required to ensure community equivalent care was provided for the population.

There remained areas of practice where improvements had not yet been fully embedded which the provider should continue to address.

In particular, the provider should:

- Continue to roll out the in possession medication risk assessment care arrangements for individual patients with specific needs to ensure medication is administered appropriately and safely.
- Complete the work commenced on long-term condition pathways to bring this service in line with community health care services.
- Introduce effective succession management arrangements to improve timeliness of recruitment and reduce impact of staff turnover.

Summary of findings

The five questions we ask 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 21 June 2016. We found that the areas of concern identified in February 2016 had been addressed.

The arrangements for safe management of medicines had been reviewed and significantly improved to protect patients.

Dental x-ray equipment and emergency equipment was now appropriately checked to ensure it was safe for use.

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 21 June 2016. We found that the areas of concern identified in February 2016 had been addressed.

Specifically, person centred care around dental care and access to appointments was now compliant with regulations.

The provider had worked hard to develop training and skills within the nursing team, as well as improving patient pathways for long-term conditions including dementia. There was more work to do in this area.

Are services caring?

We did not inspect this key question during this desk top inspection.

Are services responsive to people's needs?

We did not inspect the responsive 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 21 June 2016. We found that the areas of concern identified in February 2016 had been addressed.

Are services well-led?

We did not inspect this key question during this desk top inspection.

Summary of findings

Areas for improvement

Action the service SHOULD take to improve

- Continue to roll out the in possession medication risk assessment care arrangements for individual patients with specific needs to ensure medication is administered appropriately and safely.
- Complete the work commenced on long-term condition pathways to bring this service in line with community health care services.
- Introduce effective succession management arrangements to improve timeliness of recruitment and reduce impact of staff turnover.

HMP Stafford

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection was completed by a CQC health and justice inspector who had access to specialist advice.

Background to HMP Stafford

HMP Stafford operates as a Category C adult male prison for approximately 750 sex offenders. The population was noted in the joint inspection report in February 2016 as being much older than in the past which had presented challenges to the health care provision.

Health and social needs of the population included dentistry; personal care; dementia care; substance misuse; palliative care; primary and secondary mental health and a range of long-term conditions as well as routine primary medical care.

Health care services are commissioned by NHS England. In April 2016, subsequent to the February joint inspection, and following an NHS procurement process, Care UK Clinical Services Limited (Care UK)commenced a new contract for the provision of healthcare services at HMP Stafford. Care UK have sub-contracting arrangements in place for some healthcare services including a dental care provider who is registered with CQC to provide services at HMP Stafford.

How we carried out this inspection

We carried out a desk-based focused inspection of HMP Stafford Health Care between 31 January 2017 and 10 March 2017. The provider and NHS England submitted a range of documentary evidence to show the improvements had been made and how performance was now being monitored.

We spoke with the NHS England commissioners for these services and held a telephone conference with the healthcare team comprising of Care UK Clinical Services Limited (Care UK) and dental service managers for HMP Stafford.

Evidence reviewed included:

- An updated action plan from Care UK for HMP Stafford
- A report on a Health and Justice Clinical Quality Visit to HMP Stafford carried out by NHS England
- A comprehensive update on progress and complaints management monitoring from Care UK for HMP Stafford and redacted details of compliments to the healthcare team.
- Copies of prisoner council meetings.
- Details of current waiting times in January 2017 for health services.
- An update on dental service provision.
- Audits on dental care and oral health advice.
- Relevant training and supervision records for staff.
- Details of controlled drugs stock monitoring and medicine destruction records.

We reviewed the evidence submitted, the concerns identified in February 2016 and requirement notices issued to the previous provider and made an assessment against our regulations.

Are services safe?

Our findings

At our previous inspection in February 2016, we found a range of concerns around medicines management and clinical equipment.

These arrangements had significantly improved when we undertook a follow up inspection in January and February 2017.

Overview of safety systems and process

At the inspection in February 2016, we found concerns with:

- The prescribing formulary and management of in-possession medication.
- Delays in supply of prescribed medication.
- Unsafe management of medicine arriving into the prison.
- Inadequate storage space, over-ordering to compensate for supply delays, poor stock management and reconciliation of medication.
- Medicine fridges not being suitably monitored and staff not fully trained in use of thermometers.
- Medication for destruction stored on the floor in two rooms.
- Limited medicines administration times encouraged the inappropriate use of medicines.
- Dental x-ray and emergency medical equipment checks was inconsistent and did not ensure it was suitable for use.

During this inspection we found that the provider had now adopted the new formulary on prescribing in custody although the electronic patient record system had not yet been fully updated to reflect this.

Healthcare staff carried out individual in-possession medication risk assessments for all newly received prisoners and were using a new standardised template. Completion of this template was being audited by Care UK Clinical Services Limited (Care UK) monthly.

A new system had been introduced for receiving medication into the prison which ensured it arrived and was collected promptly and transferred safely to the healthcare department.

Care UK had centralised the system for ordering and monitoring prescription requests to the pharmacy. Stock was appropriately managed and there were fewer incidents of medication delays.

Training had been provided for staff in the correct use of refrigerator thermometers and new procedures ensured that medication was being stored according to national guidance.

Procedures had been implemented to ensure that medication was disposed of promptly in line with guidance. Stock was stored and disposed of in appropriate containers. Controlled drugs were destroyed on the premises using denaturing kits. Copies of the destruction registers showed that this was managed appropriately.

Care UK had increased GP sessions at HMP Stafford, which gave more continuity of GPs and oversight of prescribing had improved to reduce the numbers of men being issued prescribed medication inappropriately. Where possible in-possession risk assessments were carried out; slow release medication prescribed or individual care plans were put into place to ensure that medication could be prescribed and administered in line with national guidance.

Appropriate radiation checks had been carried out on the x-ray equipment in the dental suite and a system of regular checks had been introduced on emergency equipment. Further improvements were planned with the upgrading of the dental suite which would include a controlled drugs cabinet.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection in February 2016, we found that staffing in primary mental health care was insufficient to meet the needs of the population. There were no staff experienced in the delivery of dementia care and treatment and too few nursing staff trained in the management of long-term conditions, minor injury and illness. Not all staff were accessing appropriate clinical supervision.

Effective staffing

Since the contract had changed in April 2016, the provision of primary and secondary mental health care had been merged with psycho-social support for substance misuse. There was now 100% protected time for primary mental health work and support ranged from low level to full care programme approach treatment. There were now two Registered Mental Health Nurses (RMN) who had caseloads of approximately 30 men each. However, recruitment was ongoing for two further RMNs to complete the team.

One-to-one and group work interventions were delivered tailored to the needs of the population, these included current courses in emotional regulation and anxiety management.

Care UK Clinical Services Limited (Care UK) had worked had to develop a pathway of care for patients with suspected dementia and in January 2017, a consultant in dementia care held an assessment clinic for four patients at HMP Stafford. However, it had taken longer to arrange this than patients in the community would have experienced.

Additional training had been provided for the nursing team in minor illness and suturing to improve first level nursing care.

With respect of long-term conditions, the GP had held diabetes clinics with hospital-based staff via telemedicine and a long term condition nurse had held a clinic to conduct annual reviews for patients with learning disabilities. There had been staffing changes and Care UK were now recruiting a nurse to coordinate long-term condition management throughout the local cluster of prisons. There was also ongoing work to draw on the skills and experience of clinical staff in other prisons through the teleconferencing technology.

Within the HMP Stafford complement, there was one nurse able to review chronic heart disease; one spirometry and a new nurse with diabetes care training about to commence work.

This inspection reviewed the registers of patients with long-term conditions and noted that whilst some improvements had been made, performance in quality and outcomes framework for these long-term conditions still required further improvement. The healthcare team shared details of individual complex cases where partnership working with the prison and social care providers had led to good/better quality shared care for particularly unwell patients. At the time of the follow up inspection, four men were receiving social care support and additional late visits at 9.30pm had recently been introduced. Discussions were also taking place over attendance of district nurses at times when healthcare staff were not on duty.

Whilst clear progress had been made with regards to staffing skills in long-term condition management, there remained work to be done to ensure that the range of complex medical needs of the HMP Stafford population were adequately met.

Details of supervision for staff were provided which demonstrated that all clinical staff were now accessing appropriate clinical supervision.

Are services caring?

Our findings

We did not inspect this key question during this desk top inspection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

During the inspection in February 2016, we found that the range of dental care and treatment as well as access to urgent and routine dental treatment were not equivalent to NHS dental care in the wider community:

- Dental waiting times for both urgent and routine treatment were too long and not equivalent to those in the community.
- Prioritisation of dental appointments was ineffective, resulting in delays for patients in clinical need
- The range of dental care and treatment provided did not reflect NHS care and treatment in the wider community

These arrangements had significantly improved when we undertook a follow up inspection in January and March 2017. Care UK Clinical Services Limited had sub-contracted the dental care and the new provider had increased the range of care and treatment to be more in line with dental care in the wider community.

Responding to and meeting people's needs

During the inspection in February 2016, staff described the service as providing urgent care and treatment only. Patient records reflected this. Some longer treatments, including dentures and dental bridges, were not being provided and oral health advice was very limited.

During this inspection we found that all treatments were offered in line with NHS and current guidance including crowns, bridges, dentures, root canal treatments and oral health advice. Audits were carried out by the dental provider to monitor the oral health advice given, the most recent audit in February 2017 showed 100% achievement on oral health advice being given.

Access to the service

At the inspection in February 2016, we found that the dental services provided were not consistently meeting the needs of the prison population. Access to dental services was poor. Dental waiting times for both urgent and routine treatment were too long and not equivalent to those in the community. Prioritisation of dental appointments was ineffective, resulting in delays for patients in clinical need.

During this follow up inspection we found that access to dental services had been improved. For example, the provider showed that waiting times for urgent dental care was generally two days and for routine dental care it was five days. The provider had worked with NHS England to provide additional dental services prior to taking over the contract and had increased the numbers of sessions and range of dental staff available. A triage system was also in place which ensured appropriate prioritisation of dental appointments. Evidence provided included data showing that average numbers of appointments provided had been 130 per month and the non attendance rate had been reduced to around 13%.

Plans had also been approved to refurbish the dental suite to improve patient care. As this would mean the dental suite would be out of use for between four and six weeks, arrangements were in place to ensure that patients with urgent dental care needs were appropriately triaged by the dental team and where necessary, arrangements would be made to escort them to community dental services.

Are services well-led?

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

We did not inspect this key question during this desk top inspection.