

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 focused inspection of healthcare services provided by Central and North West London NHS Foundation Trust (CNWL) at HMP High Down from 1 to 3 June 2021. This was in response to information of concern we received about medicines management, staffing issues, wait times for health appointments, health screenings, and systems to ensure equipment was maintained safely.

The purpose of this focused inspection was to determine if the provider was 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.

At this inspection we found the provider was not meeting the regulations in relation to governance. Systems and processes did not always ensure the maintenance and quality of care.

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 inspection processes remotely, such as the review of electronic patient records. The provider consented to our remote activity to reduce inspection activity carried out on site with the aim of minimising infection risk 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:

- Governance systems were not always effective in assessing, monitoring and improving the quality and safety of patient care.
- Systems for monitoring storage temperatures of medicines were not fully effective.
- Systems for checking items stored in emergency bags were not fully effective.
- Oversight of medicines administration systems and processes required strengthening, including use of the electronic patient record system.
- All eligible staff had received medicines management training.
- The pandemic had significantly impacted staffing levels during 2020 and early 2021 which had compromised patient care at times. Steady progress with recruitment had been achieved since January 2021 however; ongoing monitoring was required due to a high number of vacancies in the physical health care team.
- Most, but not all staff, felt supported by managers and received regular supervision; newly appointed staff had received an induction.
- Oversight and management of patients with long-term conditions required improvement, including improved care planning.
- Oversight and management of unactioned tasks on the electronic clinical recording system required improvement.
- Access to GP services was sufficient however; a review of patient waiting lists remained 'work-in-progress'.
- The completion of secondary health screenings within seven days of a person entering prison had significantly improved since March 2021. However, not all patients who missed their secondary health screening were offered a further appointment.
- Treatment rooms were generally clean and tidy although flooring in some areas did not meet current infection prevention control standards. This was the responsibility of the prison and out of CQC scope however, this had been raised with the prison governor for their review.
- There was good engagement between healthcare staff and patients.
- The provider had a current action plan in place to drive up service improvements.

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

Overall summary

- 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).

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 medicines optimisation inspector.

How we carried out this inspection

We accessed patient clinical records remotely on 1 June 2021 and carried out a site visit on 2 and 3 June 2021. We conducted searches of patients who had been identified as having missed doses of medicines and 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 when we received concerns that included staffing levels and medicines. Following the announcement of the inspection we requested additional information from the provider which we reviewed.

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

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

- Medicines missed dose reports
- Clinical incidents relating to medicines
- Policies and procedures relating to medicines
- Staff rotas
- Information relating to the staffing model, vacancies and recruitment
- Staff supervision and induction compliance data
- Mandatory training compliance data
- Initial and secondary health screening compliance data
- Minutes of governance and quality assurance meetings
- Minutes of medicines governance meetings

Background to HMP High Down

HMP High Down is a large category B prison near Banstead in Surrey which 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 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 did not always ensure that equipment was safe and maintained.

Before the inspection we received concerns that the systems for checking items stored in emergency bags were not fully effective. Staff did not complete, or record emergency bag checks consistently, and essential equipment was found to be missing on three occasions from the emergency resuscitation bags between October 2020 and March 2021. There was no effective system in place to monitor whether emergency bag checks were being completed.

During this focused inspection, we found that the systems for recording and monitoring the contents of emergency bags had improved. A new checklist had been placed in each area to ensure equipment was checked consistently, and staff told us of the process followed to check the bags and of the action taken to drive up performance following a review of clinical incidents. However, whilst most daily checks had been completed during April and May 2021 there remained some gaps; one for a period of six days. An emergency response bag we opened however, contained all documented equipment and emergency medicines were in date. We saw a new audit tool had been devised to improve management oversight through the use of spot checks on a weekly basis and monthly audit to hold individuals to account if required. Whilst this oversight had formed part of the provider's current action plan, the target date for its introduction had passed.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety however, they had not been consistently applied during 2020 and 2021.

Before the inspection we received concerns that the provider had experienced significant staffing challenges throughout pandemic with high levels of staff sickness and several staff having to shield or isolate at home. At the time of an HMIP scrutiny visit in March and April 2021, it was found that they had been unable to cover shifts adequately when agencies were unable to provide suitably qualified nurses. This had put pressure on the team and had affected the delivery of the service.

During this focused inspection, we asked the provider to supply staff rotas and information relating to vacancies and staff recruitment. The provider confirmed they had continued a recruitment campaign throughout the pandemic, and steady progress had been made since January 2021. At the time of this inspection there was one remaining vacancy in the mental health team and a vacancy rate of 36% in the primary care team.

Staff rotas during April and May 2021 confirmed the majority of shifts unfulfilled by substantive staff had been filled by bank and agency staff, most of whom worked regularly in the prison health care service. To mitigate risks that may arise at short notice due to staff sickness, for example, two lead nurses were able to 'step down' into clinical roles to ensure core and essential services, such as medicines administration and the screening of patients who had just arrived at the prison, were maintained.

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 change. At the time of this inspection, the current head of healthcare (HoHc) had been in post for approximately three

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months. This was an interim position whilst the substantive post remained under recruitment; however, the HoHc was an experienced manager who had made progress with identifying and addressing a number of areas where service improvements were required. The provider confirmed the interim HoHc would remain in post for a period of time following recruitment to the new lead position to support with their induction and to provide consistency to the team.

Two deputy lead nurses had been allocated from the provider's Health and Justice Services Directorate to provide two days a week of support at the prison; one to support with the clinical care provided and the second to support with managing the roster. A Band 7 primary care lead had also been appointed to cover maternity leave and commenced on site during the first week of June 2021.

During the inspection staff told us they had been particularly challenged during periods of the pandemic when they had been required to combine different roles. Many reported, however, there had been a recent improvement in staffing levels that meant they had more time to deliver care and treatment. Most, but not all staff, told us they were supported by their managers and other team members. Some staff felt less supported and told us they would benefit from increased mentoring or support to help them with becoming more confident in undertaking the full range of tasks required.

Following the HMIP scrutiny visit in March and April 2021, the provider had implemented an action plan to drive forward service improvements. The ongoing review and monitoring of the staffing situation was included in the plan and was shared regularly with the governor and NHS England and NHS Improvement (NHSEI) commissioners. Whilst mitigation and oversight of staffing had been put in place, the provider continued to experience challenges with recruitment to the primary care team and regular, longer term monitoring was required.

Before the inspection we received concerns that not all newly recruited staff received an induction or regular supervision. During this focused inspection newly recruited staff told us they had received an induction and spoke of a range of support provided from managers and peers within their teams. Data also confirmed all staff recruited to the mental health team from January to April 2021, and five out of six bank staff recruited to the primary care team from January to May 2021 had completed their induction. One bank staff member's induction programme remained in progress.

Staff reported a mixed response when asked if they received regular supervision during this inspection. Data confirmed 21% of staff had received supervision in December 2020, a time when the prison was experiencing many challenges associated with the pandemic. As at March and April 2021, 67% of staff had received supervision that demonstrated improvement. Staff told us they received additional support through team and daily staff handover meetings.

Before the inspection we received concerns that comprehensive secondary health screenings were not completed by health care staff. During this inspection, we found that paper reception screenings had been introduced during the pandemic to mitigate risks arising from reduced access to the prison. Paper-based screenings enabled patients to be screened by health care staff with the use of in-cell telephony which reduced the risk of a patient's screening being missed. The easing of restrictions meant the paper screening version had been removed from circulation and face-to-face screening assessments had been reintroduced.

Compliance with secondary screenings completed within seven days of arrival had increased from 3% in March 2021 to 78% in May 2021. (The provider told us this figure did not include new arrivals in late May which meant compliance was likely to be higher). Furthermore, two members of staff had been allocated to oversee the completion of secondary screenings to ensure risks were appropriately identified and onward referrals made as required.

Are services safe?

Whilst significant improvement was noted in compliance with secondary screenings, a review of electronic patient records found that not all patients were offered a further screening appointment should they miss the initial time. Systems for ensuring patients were routinely offered a further opportunity to attend a secondary screening appointment were not effective.

Before the inspection, we received concerns following an HMIP scrutiny visit that routine appointments to see a GP took too long and GP waiting lists for medication reviews were much longer. However, during this focused inspection we found that waiting times for routine appointments to see a GP were between two and four weeks which we assessed as being in line with community provision. Progress was being made to reduce waiting lists for a medication review and, as at 1 June 2021, there were 33 patients awaiting a review.

A new GP provider had started on 1 April 2021 and a GP lead within the provider's offender care directorate had been allocated to provide additional oversight within the service. Improvement plans in the management of waiting lists were in place and were incorporated in the provider's current action plan. Work was ongoing to review and cleanse waiting lists and actions included the provision of additional GP hours to support a review of outstanding medicine reviews, and a review of the triage process including the delivery of staff refresher training. The action plan had a completion target date of 31 July 2021.

Information to deliver safe care and treatment

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

Before the inspection, we received concerns following an HMIP scrutiny visit that systems were not always followed to ensure patients consistently received their medicines.

Some patient recording systems required review to support with the analysis of patient information to inform service improvements. For example, a missed dose report dated February to May 2021 confirmed 923 patients had missed at least one dose of a medicine. These included a range of medicines, including critical medicines, that should be followed up to encourage patient compliance.

Of 923 patients included in the missed dose report, 725 patients (78%) had at least one dose of one medicine recorded as missed, but the reason for the missed dose was not provided. Some patients on the list had already left the prison. The provider did not have systems in place to appropriately analyse the data or ensure that patients who missed doses were followed up.

Two patient care records associated with the missed dose report had a gap in the prescribing of one of their medicines. As they were not prescribed, they would not appear in an administration missed dose report. Therefore, we were not assured that the continuity of prescribing for all long-term conditions was maintained.

Appropriate and safe use of medicines

Before the inspection, we received concerns that policies and procedures were not always followed regarding medicines management processes. During this focused inspection we found some concerns within medicines management processes that indicated that the provider's policies and procedures were not always adhered to. It was identified that:

- Medicines were dispensed from an on-site pharmacy. There were systems and processes to ensure where medicines were not available, the prescriber was contacted, and an alternative medicine was considered.

Are services safe?

- Controlled drugs (CDs) were administered on one occasion to a patient within a treatment room whilst the medicines cabinets were open. This was not in line with policies and procedures and presented a safety risk.
- Medical gases were stored in the on-site pharmacy and a medical gas store. These areas had incomplete signage and lacked racking for the cylinders. During our inspection, the provider confirmed the gases had been delivered without the appropriate racks and that this had been escalated to the supplier.
- Systems for monitoring storage temperatures of medicines were not always effective in ensuring their suitability for use. Three out of four fridge records indicated temperatures had been outside of their recommended range. Staff told us one fridge was faulty but not resolved, and the other two fridges had not been investigated. The HoHc was not aware there was a faulty fridge and was investigating this following the inspection. The provider told us they were looking to invest in a new electronic system that would escalate out of range fridge temperatures to a central hub for investigation.
- CD records were generally complete however, in one CD record two medicines had been returned to pharmacy for destruction which was not reflected in the CD log.
- Whilst records of the use of FP10 (a prescription form) records were kept, and records included a serial number completed on issue, the serial number was not pre-populated on the issuing sheet. This presented a risk that, if a prescription was missing, this would not be identified.
- A review of medicines incidents confirmed that two patients had been given another patient's medicine in error during April 2021. Appropriate remedial action was taken immediately following the incidents. Whilst the investigation found it was likely patients' identifiers (IDs) were not always checked during medicines administration in line with the provider's policies and procedures, during our inspection, we observed all patients being asked for ID prior to any medicine being administered.

Following our inspection, the provider submitted an interim action plan in response to areas of concern raised within medicines management. This included:

- Medicine administration competency check to be undertaken by all staff including agency and bank staff.
- Additional medicines optimisation training delivered by the pharmacy team for all eligible staff.
- A review of the local induction checklist to ensure that medicines competencies are included in the programme.
- Posters to be displayed in all clinical areas reminding staff to keep cupboards locked when patients are in the clinical area.
- Senior managers to observe at least one medicines administration round per week.
- New medicine cupboards to be ordered to reduce the risk of medicines being mislaid.
- Staff to be reminded to check prisoner ID before administering medicines.
- A review of prison officer support to assist with supervising medicine queues with the prison and NHSEI.

Before our inspection we received concerns that not all staff were competent with medicines administration. During this inspection we found all eligible staff had received medicines competency and medicines calculation training as required. Qualified staff from the mental health team had assisted with administration during the pandemic and periods of staff sickness; however, no staff member worked outside of their scope of practice. As staffing levels had increased, staff from the mental health team were not currently required to assist with administration.

Are services effective?

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

Effective needs assessment, care and treatment

Before this inspection we received concerns that the delivery of services had been affected by the significant staff challenges that had occurred during the pandemic. During this 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 on-going 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.

We found that oversight and management of patients with long-term health conditions was improving, including the development of care planning. A primary care lead had recently been identified to provide support at the prison and was responsible for oversight of the management of long-term health conditions, which included the upskilling and development of staff. Progress was limited at the time of our inspection and this needed further development to enable all staff to support the delivery of safe and effective care.

Whilst the provider had a clinical audit cycle process in place, some audits, such as those related to care planning had yet to resume following the pandemic when they were delayed due to the need to prioritise the direct provision of patient care and treatment.

Following a review of patients with a long-term health conditions, we found that patient registers were not up to date and did not always reflect the current patient population. For example, one patient was identified as suffering from epilepsy when a more in-depth review of the record confirmed the information was not accurate. This meant patient records were not always clear which could present a risk in the delivery of safe and effective care.

Are services responsive to people's needs?

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

Before this inspection, we received concerns that there were many outstanding tasks (prompts for staff to take action regarding a patient or a non-clinical request) on the electronic patient record system, including some urgent requests which were not dealt with promptly. This increased the risk that patients' immediate health needs may not be met. During this focused inspection, we found that management of tasks on the electronic clinical recording system remained a concern. The total number of open tasks on electronic patient record system was 3,441: of which 1,143 were 'not started', and 30 were categorised as 'urgent' tasks. The provider confirmed requests for urgent care were addressed in handover/ multidisciplinary meetings, through direct email, telephone, or face-to-face contact with the professional concerned. However, given the number of open tasks this increased the likelihood that a request for clinical action would not be responded to in a timely way.

Several staff told us they had experienced delays in a response to tasks they had raised in relation to patient care. We found some tasks had been allocated to a specifically named GP as opposed to a generic GP option. This meant there was a risk a task would not be actioned if the named individual was away from work. Some staff told us tasks were inappropriately labelled as urgent, which highlighted there was an outstanding training need. Current systems did not therefore support the consistent management and oversight of the use of tasks within the electronic patient record.

Are services well-led?

Leadership capacity and capability

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

Before the inspection, we received concerns that there had been inconsistency within the leadership team. These concerns suggested that the inconsistency within the leadership team had meant oversight of the delivery of care and treatment had been compromised at times. A scrutiny visit undertaken by HMIP during March and April 2021 identified there had been significant challenges in maintaining adequate staffing levels with staff often undertaking several competing roles that had led to delays and had contributed to them feeling stressed.

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 change.

At the time of this inspection, an interim Head of Healthcare (HoHC) had been in post for three months and they had already identified some areas where improvements were required. Whilst the provider had always ensured a senior presence on site, on recognising the impact of a reduced leadership team, additional leadership cover was provided following the HMIP scrutiny visit in March and April 2021 to focus on clinical care and management of the staff roster. A primary care lead was also appointed in June 2021 to cover maternity leave and to provide additional resilience within the leadership team.

The provider also responded to concerns raised around staffing levels through the delivery of listening events held with the trust Speak Up Guardian and service director in February and March 2021. Systems were put in place to resolve the staffing difficulties and ensure all shifts were covered effectively.

Leaders had continued recruitment throughout the pandemic and were closely monitoring staffing levels within a current action plan; however, the primary care team continued to be dependent on a high ratio of bank and agency staff. The action plan did confirm that the interim HoHC role had been confirmed in post until such time there was successful recruitment to the role and an induction programme had been completed.

Whilst the leaders we spoke with had knowledge of where some gaps in service provision had arisen, many areas required strengthened governance processes and greater prioritisation to ensure the ongoing delivery of safe and effective care.

Governance arrangements

Before the inspection, we received information of concern relating to the effectiveness of governance systems in assessing, monitoring and improving the quality and safety of patient care. During this focused inspection, we found governance systems were not fully effective in:

- Ensuring the consistent monitoring of the storage temperatures of medicines.
- Ensuring systems for checking items stored in emergency bags were consistently followed.
- Ensuring medicines administration was consistently undertaken in line with policies and procedures.
- Ensuring the recording of missed dose incidents supported the analysis of information to drive up service improvements. (For example, in the breaking down of and reporting of reasons for a missed dose).
- Ensuring the management of patients with long-term health conditions was in line with national guidance. Furthermore, ensuring there was continuity of prescribing for all patients with a long-term health condition.

Are services well-led?

- Ensuring that systems were in place to monitor the use of, and response to 'Tasks', within the electronic patient record system were in line with agreed processes and procedures.
- Ensuring that systems enabled a further health screening appointment to be routinely offered when an initial secondary health screening appointment had been missed.
- Ensuring waiting lists were continuously reviewed to enable patients with the highest need to be prioritised for care and treatment.

Furthermore, whilst improvements had been made in governance systems in relation to staffing and recruitment, and the provision of supervision and support, systems required strengthening in:

- Ensuring supervision was always delivered in line with the provider's policy.
- Ensuring all staff received adequate support and mentoring for their role.

Engagement with patients, the public, staff and external partners

During the inspection, it was noted that the provider responded immediately to areas raised as a concern. For example, in reviewing the current action plan to include new actions to improve performance in medicines management processes. The provider also actively engaged with external partners, such as NHSEI commissioners and the prison's governor, in support of service improvement initiatives.

Staff engagement had also been positive which had helped to rebuild morale following the challenges brought about by the pandemic. Staff were kept informed of the recruitment situation and the provider demonstrated a proactive approach in helping identify and address gaps in service provision.

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 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: Systems designed to ensure the storage temperatures of medicines were not being utilised effectively. Systems designed to ensure emergency equipment was maintained were not being utilised effectively. Policies and procedures relating to medicines administration were not always followed. The electronic patient record system was not always used effectively to support analysis. (Missed dose report). Guidance was not always followed to ensure the effective management of patients with long-term health conditions. (Including continuity of prescribing). Systems were not effective in ensuring the monitoring of and oversight of the 'Task' function in the patient electronic record system. Systems were not effective in ensuring a further secondary health screening appointment was offered if the first appointment was missed. Systems did not continuously ensure appropriate triage of patients on GP waiting lists. Systems had not always been effective in ensuring supervision was provided in line with policies and procedures.

This section is primarily information for the provider

Requirement notices

Systems had not ensured all staff received appropriate levels of mentoring/support to ensure they were confident in the delivery of care and treatment.