HMP Wakefield

Inspection report

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Date of inspection visit: 17 October to 18 October 2023
Date of publication: 20/11/2023

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 Practice Plus Group Health and Rehabilitation Services (PPG) at HMP Wakefield between 17-18 October 2023.

Following our last joint inspection with HM Inspectorate of Prisons (HMIP) in October 2022, we found that the quality of healthcare provided by PPG at this location required improvement. We issued three Requirement Notices in relation to Regulation 12, Safe Care and Treatment, Regulation 17, Good Governance and Regulation 18, Staffing, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The purpose of this focused inspection was to determine if the healthcare services provided were meeting the legal requirements of the Requirement Notices that we issued in February 2023 and to find out if patients were receiving safe care and treatment.

At this inspection we found the required improvements had been made in relation to Regulation 12, Safe Care and Treatment. However, the provider remained in breach of Regulation 17, Good Governance and Regulation 18, Staffing.

We do not currently rate services provided in prisons.

At this inspection we found:

- Systems and processes were not effective in monitoring and managing risk to patients. Audits relating to long term conditions, in-possession medicines and fridge temperatures did not identify concerns relating to quality and safety.
- The provider did not provide guidance to staff about when to report medicine related incidents and the mental health team did not report incidents related to availability of staff.
- The mental health team did not provide any therapies in relation to the wellbeing of patients due to the availability of staffing.

However;

- Staffing levels for the primary care team, pharmacy and in-patient services had improved.
- Effective processes and systems had been established relating to in-possession medicines, the safe and secure transportation of medicines to the segregation unit and the use of the out of hours medicines cupboard and emergency medicines cupboard.
- The service now had a critical medicines policy, and this was embedded into practice.
- Staff clinically triaged all healthcare applications in a timely way.
- Quality assurance meetings had taken place regularly. The quality of recording for these meetings had improved and minutes were easily accessible for all staff on the shared drive.
- Healthcare staff meetings took place regularly, meeting minutes evidenced a wide range of information sharing with the staff team, however learning from local quality assurance meetings was not included.
- The central database used to record information for all staff to access was well organised with clear files to identify the categories of information available to staff.
- Managers used data to identify and understand patient safety concerns, gaps in service provision and opportunities for service improvement, especially in relation to medicines and repeated complaints.
- The number of complaints had reduced, particularly in relation to medicines.
- All patients with end of life needs or social care needs had a good quality care plan in place, specific to their needs and preferences.
- Staff received monthly clinical supervision and recording of this had improved.

Our inspection team

This inspection was carried out by two CQC health and justice inspectors and one pharmacist specialist inspector.

Before this inspection we reviewed a range of information provided by the service including the requirement notice action plan, meeting minutes, policies and procedures and management information.

Background to HMP Wakefield

HMP Wakefield is a high-security prison for category A and B male prisoners, almost exclusively holding those with a determinate sentence of over 10 years, prisoners serving a life sentence and prisoners with an indeterminate sentence for public protection. The prison is operated by His Majesty's Prison and Probation Service.

PPG is the health provider at HMP Wakefield. The provider is registered with the CQC to provide the following regulated activities at the location: Treatment of disease, disorder or injury, Personal care and Diagnostic and screening procedures.

Our last comprehensive inspection of HMP Wakefield was in November 2022. The inspection report can be found at: Report on an unannounced inspection of HMP Wakefield by HM Chief Inspector of Prisons 31 October - 11 November 2022 (justiceinspectorates.gov.uk)

Inspected but not rated

Are services safe?

Safe staffing

The primary care and pharmacy teams had enough staff, who knew the patients and to keep people safe from avoidable harm. The mental health team did not always have enough staff available to deliver the required interventions.

Nursing staff

At the previous inspection we found that the service did not have adequate numbers of staff available across the health service, including pharmacy, primary care, mental health and the in-patient unit.

At this inspection we found staffing levels for primary care and in-patient services had improved. We reviewed rotas for the last 3 months prior to the inspection which showed the number of staff on duty was consistently higher than at the last inspection.

From October 2023, staffing rotas for primary care and inpatient services had been separated to create two separate details for staff. This provided clarity for staff and managers to ensure that adequate staff were on duty daily to deliver safe patient care.

However, the mental health team had continued to experience staffing issues. Although recruitment was mostly successful, absences (for a variety of reasons), impacted on the performance of the team and delivery of care. Managers told us a minimum of 4 staff were needed on a daily basis to deliver the mental health service.

Between 01 February 2023 and 18 October 2023 there were 155 days where the service was delivered by 3 or less staff; of these, there were 115 days when the service was delivered by 2 staff members. From November 2023, staffing rotas showed an improving picture.

This meant staff prioritised the daily duty mental health role and attending meetings, such as ACCT (Assessment, Care in Custody and Teamwork) reviews and complex care meetings. Consequently, the waiting time for clinical triage peaked at 8 weeks, although this had recently reduced to 8 days. Groupwork had not been delivered. Managers have developed an action plan to maintain oversight of this and have prioritised the delivery of triage, care programme approach requirements and case load review and management.

The mental health team had received additional funding to expand the team and recruitment remained ongoing.

Staff did not routinely report staffing shortages as an incident; only 4 incidents were reported between 01 February 2023 and 18 October 2023.

Medicines management

The service used systems and processes to safely prescribe and store medicines however administration and recording was not always accurate, and it was not possible to ascertain whether prisoners had always received their in-possession (IP) medicines.

Inspected but not rated

Are services safe?

Medicines were supplied by the prison's on-site pharmacy. Supervised medicines administration took place at 8am and 5pm from a hatch at the treatment centre linked to all four wings. There was adequate staffing of pharmacy technicians and nurses to undertake medicines administration. Prisoners were routinely asked for proof of identity before their medicines were administered. Controlled drugs were administered from the same area. Prison officers supported healthcare staff during administration of medicines.

At our last inspection we found in possession medicines were not regularly available for patients to collect, including critical medicines.

At this inspection we found approximately 75% of prisoners had all or some of their medication as in-possession and these were readily available. IP medicines were supplied from Monday to Friday from a separate hatch at a different time of the day. Medicines records were not always completed accurately when prisoners did not receive their IP medicines.

At our last inspection we found the transportation of medicines to the segregation unit/CSC was not safe. This process had improved, and staff now used robust lockable boxes to safely and securely transport medicines.

At our last inspection we found records of the use of the out of hours medicines cupboard and emergency medicines cupboard were not maintained by staff. At this inspection we found that this had improved. There was out-of-hours provision for critical medicines, such as antibiotics. Medicines were labelled correctly, and their use was checked regularly.

Staff followed national guidance in conducting a medicines reconciliation to ensure prisoners received the correct medicines.

Management of risk, issues, and performance

At the previous inspection we found issues in relation to recording of fridge temperatures. At this inspection we found fridge and room temperature records showed readings outside the accepted range and there was no evidence that actions had been taken to address this. There was a longer-term plan to move locations and to embed LogTag (Automatic monitoring) for all refrigerator monitoring.

We previously identified the service did not have a process in place relating to the administration of critical medicines. The service now had a critical medicines policy, and this was embedded into practice.

At the previous inspection we found that incidents were not regularly reported in relation to the lack of availability of some medicines and missed doses, including critical medicines. At this inspection this remained a concern. Audits did not reflect the number of IP medicines that had not been collected and records that were not completed. Processes did not identify where prisoners had missed their medication due to routine medicines not being re-prescribed in a timely manner. Incidents had not been recorded on the Datix incident reporting system.

There was no guidance for staff with regards to what constitutes a medicine incident and when to report it. This was not covered in any PPG or local policies including the critical medicine policy.

There was inadequate monitoring of prisoners with chronic disease such as asthma or COPD. We found 1 prisoner's records showed that he did not have the necessary inhalers to manage his condition and there had been no annual review.

Inspected but not rated

Are services effective?

Staff accurately assessed the physical and mental health needs of all patients. They developed care plans which were reviewed regularly and updated as needed. Care plans for end of life and social care reflected patients' assessed needs and were personalised. However, care plans for long term conditions were poor. The mental health team did not provide interventions for wellbeing.

Assessment of needs and planning of care

At our last inspection we found applications for healthcare were not clinically triaged in a timely way, this meant patients experienced delays in having their needs accurately assessed and managed.

At this inspection we found significant improvements in how staff managed applications. The administration team had introduced a new system to effectively manage the application process, including timely clinical triage. We reviewed the process, associated data, and monitoring activity. This was well managed and was clearly having a positive impact on managing patient requests. There was an effective audit trail in place, which included the scanning of all applications to maintain oversight.

At our last inspection we found issues in relation to care planning; including the absence of care plans for those with social care and end of life (EOL) needs and the quality of care plans for those with long term conditions (LTC).

At this inspection we found that staff had made good progress with care plans relating to EOL care and social care. EOL care plans were comprehensive and reflected the national Gold Standard Framework. Patients' needs and preferences were clearly documented. Care plans also included a monthly multi-disciplinary meeting with specialist community services; minutes from these meetings included reviews of current care and anticipatory medicines for the deteriorating patient.

Care plans for social care patients had improved, these were more detailed and individualised. The local authority had appointed a dedicated social worker to assess and oversee the social care needs of patients. This meant oversight of social care provision within the prison was maintained and relationships between PPG, the prison and local authority had been strengthened. All care plans were reviewed regularly by staff and updated when patients' needs changed.

However, care plans for patients with a LTC required further work. We reviewed 7 clinical records for patients with different LTCs. Only 1 record included a care plan that adequately addressed the patients' needs. The remaining 6 care records included care plans that were incomplete and mostly populated with the patients' name and prescribed medicines. Not all had physical observations recorded or actions/goals agreed for patients; some boxes were left blank. Overall, the quality was poor.

Best practice in treatment and care

At the previous inspection we identified that there were no therapies available for wellbeing for patients with mental health problems and we found that limited progress had been made at this inspection. One staff member had completed the required training to deliver groupwork. The first group of participants had been identified, with a view to starting sessions by the end of November 2023. All staff had access to e-learning as an introduction to group work, but managers told us additional training was required over 8 weeks to ensure staff were competent to deliver group-work, but staff had not had the opportunity to complete this.

From October 2023 the nursing team had started to offer some brief interventions on a 1:1 basis, however this had been minimal, with approximately 3 patients.

Inspected but not rated

Are services effective?

Managers regularly competed a range of audits across all services and outcomes were discussed with staff in team meetings to improve the safety and quality of the service.

At the previous inspection we identified that care plans for LTC were of poor quality. At this inspection we found that audits of LTC care plans did not identify issues relating to quality, despite oversight from local and regional managers.

Skilled staff to deliver care

Since the last inspection, the recording of clinical supervision had improved. Data indicated that staff received monthly clinical supervision opportunities in various forms including group, one to one, peer review and complex care discussions.

Clinical supervision records suggested that sessions were well-attended and provided staff with regular opportunities to share learning and discuss concerns.

Healthcare staff meetings were scheduled regularly, and these had taken place in March, June and October 2023. The meeting minutes evidenced a wide range of information sharing with the staff team, including updates regarding recruitment and staffing, medicines management, and service updates for each pathway.

Although learning was identified during quality assurance meetings, this was not shared with staff during full staff meetings which meant they did not have the opportunity to implement learning from feedback.

Inspected but not rated

Are services well-led?

At the previous inspection we found several areas for improvement in relation to good governance. For example, staff did not report medicine related incidents and records for medicines fridges showed recordings of out of range temperatures and no action was taken. In addition, managers did not analyse data sufficiently to identify and understand patient safety concerns, gaps in service provision and opportunities for service improvement, especially in relation to medicines and repeated complaints.

At this inspection we found that managers and staff had made some improvements. Concerns remained regarding incident reporting, acting on out of range fridge temperatures, systems used to monitor IP medication and some audits. Following this inspection PPG told us concerns relating to the audits of LTC were to be escalated regionally and to the national team to look at quality.

Managers acknowledged the challenges the mental health service had experienced in relation to staffing and the delivery of interventions, a plan was in place to try and introduce groupwork soon.

Since the last inspection quality assurance meetings had taken place regularly, including medicines management meetings. The quality of recording for these meetings had improved and minutes were easily accessible for all staff on the shared drive. Meeting minutes included details of attendees, apologies, discussions, and actions to take forward.

Quality assurance meeting records evidenced the discussion of concerns and complaints regarding the service and the themes identified from these. Clinical audit findings were also discussed and the learning from these identified to help improve the service.

We reviewed records for individual complaints including some for patients that had repeatedly complained. Records evidenced appropriate investigation and responses to complaints, and identified themes were addressed during quality assurance meetings. The number of complaints in relation to medicines had decreased.

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 **How the regulation was not being met:** The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: • The refrigerator and room temperature records showed readings outside the accepted range and there was no evidence that actions had been taken to address this. • Medicines audits did not reflect the number of in possession medicines that had not been collected and records that were not completed. Processes did not identify where prisoners had missed their medication due to routine medicines not being re-prescribed in a timely manner. • There was no guidance for staff with regards to what constitutes a medicine incident and when to report it. • Incidents had not been recorded on the Datix incident reporting system in relation to medicines and the mental health staffing shortfalls. • Care plans for long term conditions were of poor quality. Audits did not identify issues relating to quality, despite oversight from local and regional managers. This was in breach of regulation 17(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had failed to ensure that sufficient numbers of suitably qualified, competent, skilled and

This section is primarily information for the provider

Requirement notices

experienced persons were deployed in order to meet the requirements of fundamental standards in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In particular:

- Adequate numbers of staff were not always available within the mental health team. Between 01 February 2023 and 18 October 2023 there were 155 days when the service did not have the appropriate number of staff on duty. This meant mental health interventions for wellbeing were not available.

This was in breach of regulation 18(1)(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.