# HMP Stafford

## Inspection 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.

## Ratings

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|---|---|
| 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 caring? | 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 comprehensive inspection of healthcare services provided by Practice Plus Group Health & Rehabilitation Services Limited (PPG) at HMP Stafford. We also followed up on Requirement Notices issued after our last inspection in March 2021. At the last inspection in March 2021, we found the quality of healthcare provided by PPG at this location required improvement. We issued Requirement Notices in relation to Regulation 12, Safe care and treatment, Regulation 17, Good governance and Regulation 18, Staffing.

The purpose of this comprehensive inspection was to determine if the healthcare services provided by PPG were meeting the legal requirements of the Requirement Notices that we issued in April 2021, and 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 required improvements had been made and the provider was meeting the regulations. We took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering how we carried out this inspection. We therefore undertook some of the inspection processes remotely. The provider consented to our remote activity to reduce inspection activity carried out on site and minimise infection risks 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:

- Staff identified any urgent clinical need and acted appropriately to safeguard patients.
- Medicines management had improved, and most patients received their medicines in a timely way.
- The quality of care plans for patients with long-term conditions was varied. Some were very detailed, however other care plans required review and updating. Patients with diabetes did not always have clear care plans in place.
- The staffing of healthcare teams was more stable and there were generally sufficient numbers of staff to meet patients' needs.
- Staff received regular supervision and felt supported.
- We observed staff to be kind, caring and compassionate in their interactions with patients.
- The service was responsive to patients' needs and anything urgent was prioritised. However, there were extended waits for routine appointments with the GP and Advanced Nurse Practitioner.
- Governance systems had improved, and regular audits were carried out, identifying where improvements could be made. Staff and patients were able to provide feedback about the service and felt listened to.
- Staff told us there was a more open culture and they felt able to confidently report incidents. However, there was a backlog of incidents requiring review.

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

- The provider should review diabetes care plans and ensure patients are supplied medicines in line with those plans.
- Ensure that staff are aware of and follow the required procedures for the administration of medicines.
- Ensure that mechanisms are used and embedded for monitoring and following up on omitted doses.
- Managers should have enough time allocated to review and investigate incident reports.

## Our inspection team

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

**How we carried out this inspection**

We conducted a range of interviews with staff and accessed patient clinical records on 26, 27 & 28 April 2022. We conducted searches of the electronic records of patients who had been identified as having missed doses of medicines and long-term conditions such as diabetes.

Before this inspection we reviewed a range of information that we held about the service including notifications and action plan updates. Following the announcement of the inspection we requested additional information from PPG which we reviewed.

During the inspection we spoke with:

- Three nurses
- One advanced nurse practitioner
- One GP
- One physiotherapist
- One senior pharmacy team leader and the regional lead pharmacist
- Pharmacy technicians and health care assistants
- The interim Head of Healthcare and Deputy Head of Healthcare
- Deputy Regional Manager
- Regional Quality and Governance Manager.

We also spoke with NHS England & Improvement (NHSE/I) commissioners and requested their feedback prior to the inspection. We spoke with numerous patients across the prison and observed morning and afternoon medicines administration.

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

- Audits relating to medicines
- Medicines missed dose reports
- Concerns and complaints log
- Policies and procedures relating to medicines
- Communications sent to patients
- Feedback received from patients
- Quality assurance and governance meetings records
- Incident reporting data
- Information relating to the staffing model, vacancies and recruitment
- Staff rotas
- Minutes of staff meetings
- Staff training and supervision records.

## Background to HMP Stafford

HMP Stafford is a Category C training prison for men convicted of a sexual offence. The prison is in the town of Stafford and accommodates up to 751 prisoners. The prison is operated by Her Majesty's Prison and Probation Service. At the time of the last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) nearly half of the prisoners were over 50 years old and many had significant healthcare needs.

Health services at HMP Stafford are commissioned by NHSE/I. The contract for the provision of healthcare services is held by PPG. PPG is registered with CQC to provide the regulated activities of diagnostic and screening procedures, personal care, and treatment of disease, disorder or injury.

Our previous comprehensive inspection was conducted jointly with Her Majesty's Inspectorate of Prisons (HMIP) in January 2020 and published on the HMIP website on 12 May 2020. We found a breach of Regulation 12, safe care and treatment in relation to medicines management.

https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-stafford-2/

We carried out a follow up inspection in March 2021 and the report was published in April 2021. We found breaches of Regulation 12, safe care and treatment, Regulation 17, Good Governance and Regulation 18, Staffing.

https://www.cqc.org.uk/location/1-4056946898/reports

Inspected but not rated

# Are services safe?

**Safety systems and processes**

Upon arrival at the prison, patients received a healthcare screening from a registered nurse who identified any immediate needs and signposted patients to the various healthcare services available. Urgent, same day appointments were available with the GP and Advanced Nurse Practitioner (ANP) should a patient need to be seen quickly. Applications that were made by patients to see a healthcare professional were triaged by the clinical lead in order to identify potentially urgent matters.

On each shift a member of staff was allocated to provide the emergency response and would respond to any radio calls from prison officers to attend emergency situations. This could include attending to a patient who had self-harmed or medical emergency. Any patients who had tested positive for COVID-19 and were experiencing symptoms would also be checked on.

Staff had access to emergency bags and defibrillators in various areas of the prison and these were checked on a regular basis.

Staff were provided with safeguarding training to an appropriate level and understood the safeguarding processes within HMP Stafford. A small number of staff required updated safeguarding training, and plans were in place to support them to complete this. We saw evidence of staff working with prison colleagues to report safeguarding concerns and advocating for their patients.

Prison staff were responsible for the maintenance and refurbishment of the buildings, fixtures and fittings. However, systems were in place for staff to report faults and areas that required upgrading. For example, funding had been agreed to replace some sinks and counter tops in medication administration rooms.

The clinical areas within the healthcare building were kept clean and there were suitable infection control procedures in place. There were allocated daily and weekly cleaning tasks and staff had access to the required personal protective equipment. Clinical waste was disposed of appropriately.

**How are risks to people assessed, and their safety monitored and managed so they are supported to stay safe?**

Since the previous inspection the provider had continued to advertise and recruit into vacant positions, such as for nursing, healthcare assistant and pharmacy technician roles. Due to the ongoing level of vacancies, the provider remained reliant on bank and agency staff to fill shifts on the rota, as well as offering overtime. Whilst staffing levels were generally at or above the minimum requirement, there were occasions where staffing levels dropped due to being unable to cover for sickness. When this happened, managers ensured that core and essential services, such as medicines administration, were maintained. The provider had developed a regional bank staff resource which had helped to provide greater flexibility in covering shifts.

Tasks such as medicines administration, running patient clinics and managing the 'Hotel One' ledger of daily tasks were assigned to staff so that everybody was clear as to what was expected of them during their shift. Staff told us that the staffing situation had improved since the previous inspection and felt that they generally had the time to complete the work expected of them. It was felt that this was largely because of better systems to identify and manage risk as well as an improved team working ethic.

Inspected but not rated

# Are services safe?

The planned staffing level for the late and night shifts was one nurse and one healthcare assistant and rotas confirmed that this was mostly adhered to. There had been some occasions where this staffing level had dropped to one member of staff per night due to sickness or being unable to cover a shift. Where this happened, on-call clinical advice was available if required. Medicines were no longer routinely administered during the evening which meant that staff working on the late and night shifts could focus on other work.

**Information to deliver safe care and treatment**

We reviewed the care plans of patients with various long-term conditions, such as diabetes, hypertension and chronic obstructive pulmonary disease (COPD). Some patients had very detailed and evidence based care plans which informed staff of the care and treatment they required. In other cases, the care plans were less detailed or had not been reviewed recently.

Staff maintained records using SystmOne (the electronic patient record system) for each patient when they came into the prison and recorded interactions such as when a patient attended an appointment or received medicines. The records we saw were generally completed with an appropriate level of detail which clearly identified what care or treatment the patient had received.

Where patients required referral to another service within the prison, such as the mental health team, this was recorded in SystmOne. Any referrals made to external hospitals for outpatient appointments were also clearly recorded along with the reason for the referral. Pathology results, such as blood tests, were also available to staff to review and informed ongoing patient care.

**Appropriate and safe use of medicines**

At our last inspection we found that patients often experienced gaps in treatment because their medicines were not ordered in a timely manner. Storage of medicines was disorderly in some medication rooms and staff told us they felt under pressure when administering medicines due to staffing challenges. Before this inspection we received further information of concern regarding the supply of medicines to the prison from the pharmacy provider. During this inspection we found that improvements had been made and the provider had identified areas for further improvement.

Since our last inspection improvements had been made to the safe and secure storage of medicines. Structural improvements had been made on D wing and there were plans to upgrade all other wings with similar facilities to enable safe and efficient medicines administration. Pharmacy staff had reorganised the storage of medicines and removed any items that were no longer needed, this meant that medicines were much easier to locate and kept in alphabetical order.

We observed the administration of medicines by staff on various wings during the morning and afternoon. Patients were treated with dignity and respect and staff ensured that they checked patients' identification before giving their medicines to them. Administration procedures such as hand washing and no touch technique were not always being followed in line with policy. We fed this back to the provider who dealt with the matter swiftly.

Medicines were mostly available although we did witness a few occasions when medicines were not available. We brought these to the attention of staff, and they were followed up by the provider immediately. Staff and patients we spoke with told us that the ordering and administration of medicines had improved in recent months. Some staff

mentioned that they, 'no longer dreaded medicines administration' as they had done previously. The regional pharmacist was supporting onsite four days a week and there were plans to increase the pharmacy staffing levels further. Our review of patient records identified that patients with diabetes did not always have the required medicines in place. The provider acknowledged this as being an area requiring improvement.

Various mechanisms had been put in place since our last inspection to monitor omitted doses of medicines. These included running reports from SystmOne, checking administration records and staff filling out monitoring forms during medicines administration. We saw on two occasions where these forms were not being used or were unavailable and the provider reminded staff about the importance of completing these forms. Staff followed up patients who had not been to collect critical medicines.

Processes had been changed to allow the continuing use of suitable medicines brought in by patients. The medicines reconciliation rate was 100% within 72 hours during March 2022 which meant that patients' medicines were continued appropriately on admission to the prison.

There had been improvements to the processing of repeat prescriptions since working with a new offsite pharmacy and staff were actively ensuring that medicines were ordered ahead of time so that any supply issues could be identified. Administration times on the wings had been reduced to twice a day, and there was provision for in-cell administration for medicines requiring administration at night-time. Patients were also informed when they could collect any medicines which they kept in their cell. Over 75% of patients had their medicines in-possession and all patients had in-possession risk assessments in place during March 2022.

At the previous inspection we saw that there had been a large number of complaints about medicines, many of which related to medicines not being available. At this inspection the number of complaints relating to medicines had dropped significantly.

Patients had access to pharmacy technicians to deal with non-clinical medicines issues but there was no pharmacist clinic in place to give clinical advice. The provider had plans to restart pharmacist clinics following suspension during COVID restrictions. There was remote assistance to help with medicine reviews, prescription issues, care plans and blood test scheduling.

Medicines for end of life symptoms were prescribed safely and appropriately both within the electronic system and on paper copies. Palliative care advice from specialists was available when needed. However, the records did not indicate whether one patient had been provided with mouth care medicines and an inhaler. This was addressed by the provider when we raised it.

**Lessons learned and improvements made**

PPG had a quality and governance team who worked with local managers in reviewing complaints, incidents and other opportunities for learning. We reviewed minutes of various meetings such as medicines management, incident review forums and staff meetings. We saw that there was a focus on learning lessons and sharing learning with staff.

The provider acknowledged that there was still improvement to be made in the way that incidents were reported and investigated. However, we saw that there had been an improvement since the previous inspection and staff told us they felt more confident in making incident reports. Staff felt that the focus was on learning lessons rather than apportioning blame.

Inspected but not rated

# Are services effective?

**Effective needs assessment, care and treatment**

When patients first arrived at the prison their needs were assessed in an initial healthcare screen and referrals made to the relevant service. Patients could request an appointment by completing a healthcare application form on their wing. Prisoner Health Champions were available to support patients to complete these forms. These were then assessed by the clinical lead or advanced nurse practitioner (ANP) to determine the urgency of the request and so the patient was directed to the most appropriate service.

The majority of patients were seen by the most appropriate health professional, although there were occasions when patients were put onto the GP waiting list that could have been seen by another clinician. Patients with long-term conditions (such as diabetes or hypertension) were seen by the practice nurse. We saw examples of detailed and person-centred care plans which were evidence-based and demonstrated patient involvement. However, there were still improvements to be made with diabetes care. There was not always a clear diabetes care plan and the relevant monitoring of diabetes was not always in place. Some patients did not receive all required medicines for diabetes as it was unclear from records whether the correct amount of insulin, needles and lancets were being given. One person who had required emergency treatment with a gel used for the treatment of hypoglycaemia did not have their treatment reviewed or glucose prescribed.

The recently opened Specialist Care Unit (SCU) provided bed-based reablement support for up to six patients at HMP Stafford. This was a regional unit and patients could be transferred from other prisons. The SCU team provided outreach support to patients at HMP Stafford and other locations. In addition, two end of life care suites were located in the SCU. Prior to the SCU opening staff had undergone a tailored training programme and received specialist support and advice from the local hospice.

We looked at records of patients residing on the SCU and saw that staff assessed risks to their health and safety, such as using a falls risk assessment and monitoring their risk of developing pressure ulcers. Outcome based care plans were then written with the input of patients with the aim of supporting patients to progress to the point where they could return to their normal location. A physiotherapist and their assistant were located on the SCU and provided support to patients, for example with any exercises that were part of their reablement plan. A patient we spoke with provided very positive feedback about their experience of the SCU.

**Effective staffing**

At our last inspection we found that staff were rarely receiving supervision and many staff told us they did not feel supported. At this inspection we saw that there had been significant improvement and the staff we spoke with were very positive about the support they received from managers. Staff received regular clinical and managerial supervision and there was a system in place to ensure supervision meetings were regularly planned and took place. We sampled some supervision records which showed that discussions took place about any support required, training and performance. Staff told us they could request additional supervision sessions if required and they could also raise concerns at any time.

Staff told us they had access to the training required to fulfil their duties effectively. This included training such as safeguarding, infection control and access to specialist courses such as long-term conditions management. Records confirmed that most staff were up to date with required training and support was in place for any staff who were not fully up to date.

New staff received an induction into PPG and also working at HMP Stafford, we spoke with a newer member of staff during our inspection who confirmed they had been made to feel very welcome and provided with the support they needed.

Inspected but not rated

# Are services effective?

**Co-ordinating care and treatment**

Primary care staff working for PPG co-ordinated care and treatment with partners such as the mental health team, external hospitals and the local authority (where a patient was receiving social care). We saw that referrals were made to other professionals when required and PPG worked with the prison to facilitate escorts for external hospital appointments. Whilst most hospital escorts went ahead as planned, some prison officer staffing issues had led to cancellations in the days before our inspection.

**Consent to care and treatment**

Records confirmed that patients were asked to provide consent to care and treatment and this was routinely recorded in SystmOne. Any patients declining treatment such as medicines or hospital referral were asked to sign a disclaimer and staff ensured that they understood the risks of such a decision.

Inspected but not rated

# Are services caring?

**Kindness, respect and compassion**

During our inspection we observed how staff interacted with patients around the prison, including during medicines administration and also in the healthcare building. Staff were polite, courteous and treated patients with respect. It was also evident that staff knew their patients well and showed an interest in how they were feeling, whilst remaining professional.

Feedback from patients about staff was positive and we were told that staff were friendly and respectful. Staff told us that the team now enjoyed working at HMP Stafford and that this transferred into their interactions with patients resulting in a positive atmosphere.

**Involving people in decisions about care and treatment**

Information about the healthcare service was available to patients and staff involved them in decisions about their care and treatment. Should a patient require an interpreter this would be arranged over the telephone.

Patients with long-term conditions were offered a copy of their care plan by the practice nurse and we saw one patient bringing their care plan to a review appointment. Records evidenced that patients were involved in discussions about treatment choices.

**Privacy and dignity**

Healthcare appointments were carried out in private with consultation room doors closed, unless a risk assessment suggested that this would not be safe. Any patients receiving social care assistance received this in their cell.

Staff were reminded to lock their computers when leaving their desk so that any confidential medical information about patients was not left on display.

Inspected but not rated

# Are services responsive to people's needs?

**Responding to and meeting people's needs**

Patients were able to request an appointment with various healthcare services such as the GP, nurse or dentist by completing a paper application form. These were triaged by a clinician who would ensure that any urgent needs were responded to quickly. Routine requests were then allocated to a waiting list and appointments booked. During our observations we saw that staff responded to ad-hoc queries raised by patients, for example at medicines hatches. This ensured that, where possible, queries were resolved without the need for patients to request and wait for an appointment.

There was information displayed about the healthcare services available on the wings of the prison as well as in the healthcare waiting area. Health Champions were available on each wing and easily identifiable with a uniform. They provided support and advice to other patients on their wing and could help them to complete forms. Health Champions also took blood pressure readings which were passed on to healthcare staff who could take any action necessary. Health Champions represented their wing at meetings with PPG where they could raise any issues and provide feedback. We spoke with some Health Champions during our visit who were positive about the changes that had been made by PPG in the months before the inspection. They felt that PPG listened to their feedback and dealt with issues they raised.

**Timely access to services**

At the time of our inspection there were extended waiting times for routine appointments with the GP and Advanced Nurse Practitioner. The provider acknowledged that this was an issue and was working to increase the capacity of each of these clinics. Urgent need was dealt with quickly and all requests for an appointment were triaged so patients were allocated to the correct waiting list. PPG continued to use the services of an off-site GP who carried out 'back-office' duties such as any prescribing work which didn't require face to face contact with patients.

Waiting times for other primary care services were reasonable and monitored regularly by the clinical lead.

**Listening and learning from concerns and complaints**

The healthcare complaints policy was displayed on the wings around the prison along with complaints forms. There was a separate, confidential post box for healthcare related complaints to be posted into and these were collected by a member of the PPG administrative team. The complaints were reviewed and allocated to the appropriate person for investigation and response.

We sampled some responses to recent complaints and saw that they were timely, polite and provided responses to the issues raised. The administrative team maintained a central log of all complaints which included monitoring of any trends and themes, which was discussed in governance meetings.

At our previous inspection, complaints relating to medicines accounted for the majority of all complaints. We saw that the number of complaints about medicines had reduced significantly, which reflected the improvements that have been made. Any learning and improvements resulting from complaints were shared with staff during the daily Buzz meetings, wider staff meetings or by email communications.

Inspected but not rated

# Are services well-led?

**Leadership capacity and capability**

Since our last inspection there had been further changes of managers at HMP Stafford. A head of healthcare and deputy head of healthcare had been appointed on a temporary basis to drive the improvements that were required in medicines managements, governance and the culture of HMP Stafford. All of the staff we spoke with were positive about the leadership shown and felt that the improvements had been driven by strong leadership and an improved, open culture. Leaders were clearly visible to staff around the site and it was apparent that they knew staff well.

The provider had identified that further support was required due to the nature and complexity of the issues that existed at HMP Stafford. They had allocated additional regional staff to support the staff team, such as the regional lead pharmacist. A senior manager from another region had held a 'listening event' with staff, whereby all staff were invited to speak confidentially with them and raise any concerns they had. The provider had acknowledged where errors may have been made in the past and was committed to learning from these.

There were plans in place to make permanent appointments to the senior positions at HMP Stafford to provide longer-term stability. The provider was aware that this transition period was critical and committed to providing ongoing support at HMP Stafford during this period.

The leadership team had worked to bring about improved working relationships between different groups of staff. For example, we saw there was a good working relationship between the pharmacy team and other healthcare staff, and they worked together to resolve medicines related issues.

**Culture**

Staff reported that the culture of HMP Stafford had improved since our previous inspection and that they felt valued, listened to and supported. The provider had acknowledged there had been difficulties with staff feeling unable to report matters of concern and had taken action to try and change this. The leadership style supported a more open and inclusive staff culture and managers were visible and communicated well with staff.

There were daily 'Buzz' meetings where staff reported any issues, tasks they had completed and work that remained to be completed. We observed a meeting and saw that all staff were encouraged to contribute, and records confirmed that the discussion followed an agenda, but also encouraged staff to raise any other issues.

At our previous inspection we found that not all incidents relating to medicines management were being reported as expected. The provider had done some work with staff to raise awareness of what to report and provide more staff with access to the Datix incident reporting system. Staff told us that they were encouraged to report incidents and we saw that any lessons learned, and improvements were shared with staff.

Staff received support through regular supervision and staff meetings and could also speak to managers at any time. During our inspection we observed staff speaking with the head of healthcare regularly and it was apparent that there was an 'open door' approach to engaging with and supporting staff.

**Governance arrangements**

At our last inspection we found that the systems to assess, monitor and improve the quality and safety of the services being provided were not effective, or had not restarted following the pandemic restrictions. At this inspection we saw the

provider had an established governance structure including a programme of audits and regular checks were carried out in areas such as infection control and medicines management. Audits identified where there were issues and ensured that actions were put into place to make improvements. For example, a member of the pharmacy team regularly audited medicines stock to ensure that stock management and record keeping were in line with requirements.

Senior leaders had appropriately delegated tasks to various staff, such as auditing and the triage of patient applications for an appointment. There was also oversight of the waiting lists for various services to ensure that patients were on the correct waiting list and to identify where further resources may need to be targeted.

Local and standard operating procedures relating to medicines management had been reviewed and updated since our last inspection. These were available to staff and informed how they carried out various duties such as the ordering and storage of medicines.

**Processes for managing risks, issues and performance**.

At our last inspection we found that risks relating to the service provision had not always been identified or acted upon in a timely way. Medicines-related incidents were not always reported and learning from incidents was not effectively identified and shared with staff. At this inspection we found that improvements had been made, although further work was needed to address a backlog of incident reports and investigations.

During this inspection we reviewed the Datix incident reporting system and saw examples of incidents being appropriately reported and investigated. Medicines related incidents were reviewed at the medicines management meeting and learning took place across the organisation. Where any learning had been identified this was shared with staff during meetings, individual supervision and through other communications.

There was a significant number of outstanding incident reports, the head of healthcare told us they had prioritised which needed to addressed first. However, there were still numerous incident reports outstanding which had not been fully investigated. The provider was aware of this issue and working on reducing this number to a more manageable level.

**Appropriate and accurate information**

We sampled patient records and care plans and saw that, generally, the records were completed with sufficient detail to understand the care and support being offered. Care plans were reviewed with patient involvement and updated to ensure they remained accurate.

At our last inspection we saw that medicines administration records were not always completed to confirm if a patient had received or declined their medicines. At this inspection we noted that record keeping had improved and the majority of medicines administration records were completed as required. The head of healthcare told us that they would remind staff of the importance of keeping accurate records.

**Engagement with patients, the public, staff and external partners**

Patients were able to provide feedback about the service and we saw that several compliments had been received about individual staff. There was also a complaints process which was advertised and available to patients. Health Champions regularly met with managers and provided feedback about the service on behalf of others on their wing.

Inspected but not rated

# Are services well-led?

Staff were able to provide feedback through various means, such as staff meetings, supervision sessions and could also speak with managers informally if needed. The provider had held a 'listening event' where staff could speak confidentially with a manager from another region to discuss any concerns or worries. Staff members' views were listened to and acted upon and this was confirmed by feedback we received from the staff we spoke with.

There were good working relationships between the prison senior team and healthcare managers. We spoke with the deputy governor who told us that PPG had made improvements to medicines management processes and worked collaboratively with them.