HMP Frankland

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.

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 domain in full at this inspection. We only inspected those aspects that related to the concerns raised by whistle blowers.

- The risks to patient safety were not adequately assessed and monitored by healthcare staff.
- Arrangements for managing medicines did not always keep people safe.
- The service did not share learning from incidents in order to make improvements when things went wrong.
- The service had safeguarding systems in place. Staff knew how to identify and report concerns.

Are services effective?

We did not inspect the effective domain in full at this inspection. We only inspected those aspects that related to the concerns raised by whistle blowers

- Patients with long-term conditions were monitored through nurse led clinics and complex care meetings that were held monthly.
- Supervision arrangements of the staff team were poor.

Are services caring?

We did not inspect the caring domain in full at this inspection. We only inspected those aspects that related to the concerns raised by whistle blowers

- Staff treated patients with kindness, respect and compassion.
- Patients spoke positively about the contacts they had with health care staff.

Are services responsive to people's needs?

We did not inspect the responsive domain at this inspection

Are services well-led?

We did not inspect the well-led domain in full at this inspection. We only inspected those aspects that related to the concerns raised by whistle blowers

Summary of findings

- Managers did not demonstrate they had the experience, capability and skills to deliver a high-quality and sustainable healthcare service. They did not always work effectively with frontline staff to provide consistent leadership.
- The service gathered appropriate information through their quality, performance and contract reporting arrangements.
- Despite regional and local risk registers, risks to patients were not always well managed.
- The provider's systems and processes to support good governance and management were not implemented effectively at local level.
- There was limited evidence of systems and processes for learning, continuous improvement and innovation.

Key findings

Areas for improvement

Action the service MUST take to improve

- Provide opportunities to involve people in making decisions about their care and treatment, and support them to do this.Assessments must be reviewed regularly and whenever needed throughout the person's care and treatment.

HMP Frankland

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC health and justice inspector, accompanied by two CQC health and justice inspectors and a CQC pharmacist specialist.

We do not currently rate services provided in prisons.

Background to HMP Frankland

HM Prison Frankland is a high security prison holding category A, category A high risk and category B adult males. The prison is located in the village of Brasside in County Durham, England and accommodates up to 844 adult male prisoners. The prison is operated by Her Majesty's Prison and Probation Service.

G4S Health Services (UK) Limited (G4S) is commissioned by NHS England to provide primary health care and clinical substance misuse services at the prison. G4S is registered with CQC to provide the regulated activities of Diagnostic and screening procedures and Treatment of disease, disorder or injury at the location HMP Frankland.

Our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) was in March 2016. We did not find any regulatory breaches at this inspection. The joint inspection report can be found at:

https://www.justiceinspectorates.gov.uk

Why we carried out this inspection

We undertook this announced focused inspection on the 15, 16 and 17 May 2018. This inspection was carried out in response to a number of whistle blower allegations that CQC received between 1 December 2017 and the 17 March 2018, concerning the quality of care delivered to prisoners at HMP Frankland. The purpose of the inspection was to determine if the registered provider, G4S Health Services (UK) Limited, 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.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents.
- Shared learning from incidents was limited, with frequent missed opportunities for staff to learn from events that potentially impacted upon the service and patient care.
- Prisoners who held their medicines in possession were not subject to a risk assessment as required by local policy
- Prisoners were positive about their interactions with staff and said they received good care and treatment.
- Patients with long-term conditions were monitored effectively
- Staff including managers did not receive regular clinical and or managerial supervision
- The healthcare team lacked effective leadership and there were limited formal governance arrangements, which did not provide sufficient oversight of the management, quality and safety of services provided.

Detailed findings

- The service gathered appropriate information through their quality, performance and contract reporting arrangements.
- Governance systems and processes did not support the management of risks to patients, despite regional and local risk registers being in place.

How we carried out this inspection

Before this focused inspection we reviewed a range of information that we held about the service, including information we had received through a series of anonymous whistle blowing alerts. We were not assured from our contact with G4S prior to the inspection that patients in receipt of healthcare services provided by G4S were safe, and we took the decision to undertake a focused inspection.

During the inspection we asked the provider to share with us a range of information which we reviewed. We spoke with healthcare staff, prison staff and people who use the service, and sampled a range of records.

Are services safe?

Our findings

Safety systems and processes

- The service had safeguarding systems in place. All staff received up-to-date safeguarding and safety training appropriate to their role. Staff knew how to identify and report concerns. All staff we spoke with demonstrated a good understanding of their responsibilities regarding safeguarding, and had received training relevant to their role.
- G4S had a whistleblowing policy dated August 2015, which had passed its review date of August 2016. Staff could raise concerns through their internal processes, known as 'Speak Out', which is a 'G4S global whistleblowing system', hosted by an independent specialist hotline and case management provider.
- A member of the healthcare team was employed full time in the capacity of a chaperone. Staff who acted as chaperones were trained for the role. The role was to assist GP consultations, advanced nurse practitioner consultations and other nurse led clinics, during which they worked closely with operational staff. We received positive patient feedback on the role of the chaperone.

Risks to patients

- The risks to patients were not adequately identified, managed or monitored, for example, the use and application of in possession risk assessments.
- There was a rota system to ensure enough staff were on duty to meet the needs of patients. The service had seven vacancies across the team, including, Band 6 and Band 5 nurses. At the time of the inspection we were told that three nurses had been recruited and were going through security vetting checks prior to being appointed.
- Regular agency nurses and bank staff were used to fill vacancies. Whistle blower contacts we received alleged that some agency nurses were not clinically skilled to perform nursing tasks and this put patients at risk. We found evidence that historically some agency nurses had not been clinically competent and these nurses were no longer contracted to work at the prison.
- Whilst there were arrangements in place to minimise risks to patient safety, not all were effective, for example, stock ordering of bandages was done through a central point at a local prison. We were told that there could be delays in getting stock into the prison due to security checks, and nursing staff did not always report in a timely manner when equipment had run out or when stock levels were low. We found that stock and equipment ordering arrangements were not clear and stock levels were not audited.

Information to deliver safe care and treatment

- Staff had the information they needed to deliver safe care and treatment to patients. The care records we saw showed that information needed to deliver safe care and treatment was available to staff. There were effective systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

Appropriate and safe use of medicines

- We looked at the systems in place for medicines management, including storage, handling, and administration. We found that the arrangements for managing medicines did not always keep people safe.
- Nursing staff administered medicines which could not be held safely in possession by prisoners. We observed the process for the administration of medicines, which was not in line with professional guidance. Medicines had routinely been removed from the original dispensed containers in advance of the time of administration in one area of the prison which increased the risk of errors occurring. This practice had been placed on the risk register, however not all options for the safe administration of these medicines had been explored.
- Medicines were administered in a timely manner in accordance with the prisoners' daily regime. However, we saw one example where the time between administrations was not as clinically indicated, which meant that the person received their medicines too close together increasing the risk of side effects. In addition, the administration of some pain relief was recorded in a way that made it difficult for staff administering subsequent doses to identify and thus increased the risk of prisoners receiving inappropriate treatment.
- Healthcare staff used a range of clinical protocols and patient group directions (PGDs) for the administration of some medicines. PGDs are written instructions to assist healthcare staff in the supply or administration of medicines to patients, usually in planned

circumstances. These documents were past their review-by date and not signed by all relevant staff. We brought this to the attention of senior staff during the inspection.

- The process for recording and administration of controlled medicines kept people safe. Records were reviewed frequently and stock balance checks were recorded. There was a system in place to ensure medicines transported to wings could be audited and this transport occurred mostly at a safe time. There was a system in place for the prisoners who held and managed their prescribed medicines and for staff to maintain adequate supplies of other medicines.
- Storage within the wings was secure. However on several wings we found loose strips of 'homely' medicines that could not be identified. Homely medicines are We brought this to the attention of senior staff during the inspection.
- We could not be assured that the storage of medicines requiring refrigeration were appropriately monitored and that staff understood what to do when fridge temperatures exceeded the required range (2 to 8 Celsius). For example, staff had identified that certain fridges were out of range and had moved medicines to another fridge; however this fridge had been inconsistently monitored. In February 2018 monitoring had taken place on only four days during the month. In other months maximum and minimum temperatures had been consistently recorded as 0.1 and 41.5 Celsius, but no action had been taken. We brought this to the attention of senior staff during the inspection, who then checked that the quality of the medicines had not been compromised.
- Arrangements for prisoners holding their medicines in possession were poor. Nursing staff were not following G4S policies to ensure prisoners were safe to hold medicines in possession. Nursing staff who carried out reception health assessments told us that compact agreements (documents signed by the prisoner detailing the rules regarding holding medicines in possession) were signed by prisoners as part of the reception process. However we could not find evidence of the signed documents, and we could not be assured that this process had been completed. G4S policy stated that in possession risk assessments should be completed as part of the reception screening of all prisoners who arrived with in possession medicines. Of the records we looked at, we could not find evidence that these risk assessments had been completed and that decisions to issue medicines to prisoners in possession were safe.
- Staff understood their duty to raise concerns and report incidents and near misses and managers and lead clinicians supported them when they did so.
- Data made available to us during the inspection showed that there had been an increase in the number of serious incidents reported by nursing and healthcare staff in recent months, which was positive.
- The service did not share learning from incidents with healthcare staff in order to make improvements when things went wrong. We reviewed incident reports and minutes of meetings where significant events were discussed. Minutes showed that an analysis of the significant event was undertaken and actions identified to improve patient safety. However there was no evidence to show that such learning and actions were subsequently shared with healthcare staff.
- Staff told us that they did not receive feedback from incident reports they submitted which meant there were missed opportunities to learn from events and improve outcomes for prisoners.

Lessons learned and improvements made

- Staff understood their duty to raise concerns and report incidents and near misses and managers and lead clinicians supported them when they did so.
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Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing at reception.
- We were not assured that all nursing staff with responsibility for the care and treatment of patients with long term conditions had received specific training and were competent to do so. We observed that health care staff did not always record on patient records which team member had carried out specific treatments for a patient, such as compression bandaging for leg ulcers, so we could not be confident that these treatments were being delivered by staff members who had the training or competence to do so. This was an area of concern reported to us by an anonymous whistle blower. It was alleged that staff without appropriate clinical training and competence were undertaking clinical tasks, such as changing dressing and bandages. The investigation report completed by G4s Health Services (UK) Limited into such allegations upheld this allegation.
- Arrangements were in place which ensured that end of life care would be delivered in a coordinated way that took into account the needs of individual patients.A dedicated end of life care room was located in the inpatient area of healthcare. There was no one requiring end of life care at the time of our inspection.
- Care plans were in place for patients identified as having complex medical conditions, social care needs, frailty concerns, including dementia, or receiving end of life care. Those care plans we viewed were appropriate to the patients' needs and conditions. The quality of care plans was good and individually personalised to meet the needs of the patient.
- We observed a number of care plans were due for reviewSome of the care plans had been set as requiring a four monthly review, and had passed their suggested review period, although patients had been discussed at complex care meetings as recently as April. It was not clear if patients had been involved in care plan reviews.

Monitoring care and treatment

- Patients with long-term conditions were monitored through nurse led clinics and the complex care meetings that were held monthly. For patients with the most complex needs, clinical leads and Band 6 nurses worked with GPs, advanced nurse practitioners and when relevant any other health and care professional to deliver a coordinated package of care. However nurses did not have access to specialist nursing services for advice on titration of insulin for patients who were insulin dependent.

Effective staffing

- A comprehensive training matrix was in place, which demonstrated that the uptake of mandatory training by staff was good. Staff had completed training in safeguarding adults and children, fire safety awareness, infection control, basic and intermediate life support and information governance. However we found training certificates in staff files and in a group clinical supervision folder did not correlate with the information held on the training matrix, which made it difficult to fully understand the competencies and skills mix of the staff group.
- We found that not all training courses attended by staff had been logged on the training matrix; for example, some staff had attended a wound care training course in January 2018, and this course was not shown on the training matrix. We also found that some staff members were delivering care in specialist areas, such as wound care, and there was no evidence available to demonstrate that they had received the necessary training. It was therefore unclear how the provider assured themselves that staff members were adequately skilled to carry out their roles.
- The training matrix demonstrated a number of nursing staff responsible for providing a range of nurse led clinics needed to complete training in asthma care, diabetes care and epilepsy. We were not assured that all of the staff team was competent to deliver their roles safely and effectively.
- We were not assured that agency staff had received appropriate training and were competent to undertake clinical duties. Agency staff training was not routinely recorded on the training matrix. Some training records in staff files evidenced that agency staff had attended training courses.
- Processes were being developed by senior members of the healthcare team to support assurance of clinical staff members' skills and knowledge, such as an advanced practice competency framework intended to monitor team members' specific abilities to deliver

treatments. A new induction pack was also being developed to provide all permanent and agency staff joining the team with a base level of knowledge about the service and the wider prison. However, it was too soon to assess the impact of these processes at this inspection.

- Supervision arrangements for the staff team were insufficient. Clinical and managerial supervision did not take place regularly across all levels of the team. A schedule had recently been developed for clinical group supervision; however the first session planned for May 2018 had been cancelled. We saw a clinical group supervision file that included a number of training sessions and observed practice documents; however there was no evidence that group supervision was taking place for staff on a regular basis.
- Staff confirmed that they did not receive regular formal supervision, that there were good informal supervision arrangements and they felt supported and could approach any of the Band 6 nurses for advice and support. We observed that informal supervision arrangements were good. However some staff we spoke with told us they did not know who their line manager was, or what supervision arrangements were in place.
- Supervision schedules had recently been developed for nursing staff to receive regular individual supervision sessions with their line manager; however we did not find evidence that these were taking place regularly as planned. Effective oversight of staff supervision and arrangements for supervision was absent throughout the service.
- All staff told us that they had received an appraisal, but these documents were not available for all staff at the time of the inspection.

Coordinating care and treatment

- Staff worked together and with other health and social care professionals to deliver effective care and treatment.
- Records showed that all relevant staff, including those in different teams and from different organisations, for example, GPs, mental health nurses were involved in assessing, planning and delivering coordinated care and treatment. Information was shared with relevant professionals when deciding care delivery for prisoners with long term conditions.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, such as when they were referred on, or after they were discharged from hospital.
- Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis to discuss the care of patients with complex needs.
- Arrangements were in place which ensured that end of life care would be delivered in a coordinated way that took into account individual the needs of different patients.

Are services caring?

Our findings

Kindness, respect and compassion

- Staff treated patients with kindness, respect and compassion.
- During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect. Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Patients spoke positively about the care and treatment they received from health care staff.

Involvement in decisions about care and treatment

- Staff helped patients to be involved in decisions about care and treatment.
- Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff.
- Patients receiving palliative care had personalised care plans, and those with Do Not Attempt Resuscitation (DNAR) orders were clearly identified.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We did not inspect the responsive domain at this inspection.

Are services well-led?

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

Our findings

Leadership capacity and capability

- Managers did not demonstrate they had the experience, capability and skills to deliver a high-quality and sustainable healthcare service.
- We observed that managers were not always visible to the nursing team. Close working between the head of healthcare and the clinical lead was not always apparent and they did not always work effectively with frontline staff to provide consistent leadership.
- Some staff were resistant to changes that the head of health care and clinical lead had tried to introduce, for example, peer reviews, observed practice and checks to treatment areas. This was not conducive to the working culture and outcomes for patients.
- Senior managers, the head of healthcare and clinical lead had responded to whistle blowing alerts, staff complaints and grievances. However G4S had not implemented and sustained improvements in response some concerns that had been upheld. For example, the provider had previously told us that in response to whistleblower concerns a system for checking fridge temperatures had been that included monitoring the recording of these checks. During this inspection we found that fridge temperatures were not recorded daily, records were not monitored and these omissions had not been identified by managers.
- CQC received seven anonymous whistleblower alerts through our 'Tell us about your experience' portal between December 2017 and March 2018. The provider told us that during this same period they had also received a number of whistleblower alerts from staff through 'Speak Out'. The provider investigated these allegations and we asked them to share the outcome with us. The provider did not provide this information to us in a timely manner and consequently we were not assured that prisoners were receiving safe care and treatment. We did not receive a report on the findings of the whistleblower alerts until the final day of our inspection, 17 May 2018. The report upheld some of the allegations.

Culture of the organisation

- Staff reported that they felt listened to and involved in the day to day management of the service.
- Other staff told us they felt supported and valued. They were confident now that equipment needed to care for patients was available and told us that patient care was personalised and focused on the needs of patients.
- We found that the head of healthcare and the clinical lead had taken appropriate action to address concerns about staff performance. When concerns about nurse's clinical abilities were reported and/or identified, action was taken to remove staff from the service pending investigations.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed, but they were not informed of outcomes of incidents.
- Incident reporting arrangements supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable. They received appropriate support, relevant information, a written apology, and were told about any actions taken to improve processes to prevent the same thing happening again.

Governance arrangements

- Systems and processes to support good governance and management of the service were limited at local level and this impacted upon their overall effectiveness. For example, we found training certificates in staff files and in a group clinical supervision folder did not correlate with the information held on the training matrix, which made it difficult to fully understand the competencies and skills mix of the staff group.
- Processes for providing all staff with the development they needed, including supervision were not fully embedded across the service. Staff meetings did not take place on a regular basis and the head of health care rarely attended.
- The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- **Managing risks, issues and performance**

Are services well-led?

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

- Risks to patient care and treatment was not always well managed, for example, equipment and stock ordering arrangement were not clear.
- The risks of individual patients holding their prescribed medicines were not routinely assessed to ensure safe patient care was provided.

Appropriate and accurate information

- The service gathered appropriate information through their quality, performance and contract reporting arrangements, although it was not clear how this was used to improve service delivery.
- The provider recorded information pertinent to the service in a Quality, Performance and Contract Report, which was shared with NHS England commissioners on a bi-monthly basis.The information was used to monitor the service and trends and provide an overview of quality performance issues.
- Information regarding serious incidents, such as medication errors, prescribing trends of tradeable medicines and safe guarding was collected. However it wasn't clear how this information was used to develop and improve the service.
- The service submitted data or notifications to external organisations as required.

Continuous improvement and innovation

- The clinical lead had put in place measures to monitor the service, these included checks of fridge temperatures and the clinical environment. However we found that the checks were not undertaken on a regular basis, and were not happening consistently, and it was difficult to assess what improvements had been made.
- Learning from reported incidents was not systemic or effective and needed to improve.

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
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients were not involved always involved in making decisions about their care and treatment. Assessment and care plans were not routinely reviewed.

This section is primarily information for the provider

Enforcement actions

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
	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes to support good governance and management of the service were limited and under developed at local level and this impacted upon their overall effectiveness of the service. Those that existed needed further development.