HMP Lowdham Grange

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

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 Nottinghamshire Healthcare NHS Foundation Trust at HMP Lowdham Grange on 25 & 26 October 2023.

Following our last joint inspection with His Majesty's Inspectorate of Prisons (HMIP) in April 2023, we found that the quality of healthcare provided by Nottinghamshire Healthcare NHS Foundation Trust at this location required improvement. We issued a S29A Warning notice as a result of breaches under 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 S29A Warning notice that we issued in June 2023 and to find out if patients were receiving safe care and treatment.

At this inspection we found that despite some improvements, there had not been sufficient progress and we found new concerns. As a result, we issued a Notice of Proposal to impose conditions for the provider at this location.

We do not currently rate services provided in prisons.

At this inspection we found:

- Systems to manage patient applications were unsafe.
- The management of medicines had improved since our last inspection.
- Incidents were not always investigated in a timely manner and learning from incidents was not identified and shared with staff.
- There was no oversight of patient complaints and staff followed different processes.
- Patients did not receive timely responses to complaints.
- Staff supervision and training rates had improved, and staff felt more supported than at our last inspection.
- Patients with identified need for psychological interventions did not have their needs met.

Our inspection team

This inspection was carried out by two CQC health and justice inspectors, one CQC inspector and one CQC inspection manager.

Before this inspection we reviewed a range of information provided by Nottinghamshire Healthcare NHS Foundation Trust including training and supervision data, meeting minutes, policies and procedures and governance information.

Background to HMP Lowdham Grange

HMP Lowdham Grange is a Category B private prison situated in the village of Lowdham in Nottinghamshire. The prison accommodates approximately 1000 male prisoners and is operated by Sodexo Ltd.

NHS England commission Nottinghamshire Healthcare NHS Foundation Trust (NHFT) to deliver healthcare services at HMP Lowdham Grange. NHFT are 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 His Majesty's Inspectorate of Prisons (HMIP) in May 2023 and was published on HMIP's website on 16 August 2023 and can be found at:

Report on an unannounced inspection of HMP Lowdham Grange by HM Chief Inspector of Prisons 15-26 May 2023 (justiceinspectorates.gov.uk)

Inspected but not rated

Are services safe?

Safety systems and processes

During our inspection we reviewed the patient application system to follow up a patient complaint. We found that there was no safe system to manage patient applications and ensure patients received the care they needed in a timely manner. We found that:

- Only one administrator had access to the electronic system to view the applications patients had made and only one hour per week was allocated to view the applications and action them which was insufficient.
- There was no process to review patient applications in the absence of the one staff member with access to the system.
- Healthcare staff told inspectors that they did not have enough administrators to process patient applications in a timely manner.
- At the time of our inspection, there were 268 outstanding applications from patients dating back to 7 September 2023.
- On review of a sample of patient applications submitted since 7 September, inspectors found one example of a patient who had tooth ache and what he believed to be an infection. The patient's application had not been reviewed by a clinician and the concerns were not acted upon appropriately.
- When inspectors concerns were raised with the provider a new system was implemented however this did not provide sufficient time for clinicians to address the number of applications received.
- Following the inspection, the provider gave assurance that all outstanding applications had been reviewed by a clinician, a response sent to the patient and an appointment made where appropriate.

This meant that patient applications had not been reviewed daily for the 6 weeks prior to our inspection, and we were not assured that patient applications were clinically triaged to manage patient risk effectively. Following the inspection, the provider gave assurance that access for all staff to the electronic patient application system had been requested and contingency plans were in place to manage the applications until access was granted.

Incident investigations & lessons learned

At our last inspection we found that incidents, including serious untoward incidents, were not always investigated in a timely manner, and there was no evidence of learning from local incidents, complaints and death in custody findings shared with the team. At this inspection we found that 330 incidents had been reported since our last inspection, and there was no evidence available to show that the provider had reviewed and investigated these incidents to identify and mitigate risk or share learning to prevent recurrence. We found that:

- There was a backlog since April 2023 of 330 incident reports which had not been reviewed.
- There had been no quality assurance or oversight of incident investigations and managers had not identified that incidents were not being reviewed until 2 weeks prior to our inspection.
- The head of healthcare and area manager were unable to access the incident tracker which prevented them identifying themes and learning and meant they did not have oversight of incidents for their service.
- Not all staff had access to the provider's incident reporting system 'Ulysees' to report or investigate incidents. 3 senior nurses were due to receive training in the month following our inspection.
- A thematic review of incidents was carried out by managers in response to our inspection feedback. This review identified themes from incidents since January 2023.

This meant that systems and processes to investigate and learn from incidents were ineffective.

Medicines Management

Inspected but not rated

Are services safe?

At our last inspection we found that medicines management was weak and there was no pharmacist oversight of the service. There had been no medicines management meetings, and we found some unsafe practices such as the opening of gabapentin capsules to disperse in water before administration. Pharmacy technicians felt unsupported, and medicines were dispensed off site with no local screening by a pharmacist. Systems for monitoring stock medicines were not robust, and medicines requiring destruction were not disposed of in tamper proof bins.

At this inspection, we found that significant improvements had been made to medicines management. We found that:

- A regional pharmacist had been recruited since the last inspection and visited the prison 2 days per week.
- Pharmacy staff felt supported, and a senior pharmacy technician was also now in post.
- Drugs and therapeutics meetings were now held regularly and included a review of learning from medicines incidents by the pharmacy team.
- Monthly team meetings were held to monitor and address any issues in relation to medicines management.
- The practice of opening gabapentin capsules to disperse in water prior to administration had stopped and a notice to staff had been sent to advise of the change in practice.
- Medicines were now stored under a patient named medicines system in locked cupboards. Stock medicines were stored securely with an audit process to monitor medicines removed from stock.
- The appropriate medicines destruction bins were now in place and an additional larger bin was also on order.

This meant that systems were now in place to safely manage medicines.

Inspected but not rated

Are services effective?

Effective staffing

At our last inspection we found that staff did not receive the training, appraisal and supervision required to fulfil their roles, and did not always have the required competencies to carry out their duties. We found that:

- A healthcare assistant carried out the initial health reception screening for all new arrivals to the prison contrary to NICE guidelines which meant that patient safety could be compromised.
- Staff did not receive regular supervision in line with the trust policy. Staff told inspectors they felt unsupported, did not receive regular supervision, and felt 'tired' and 'burnt out'.
- There was no support or formal supervision in place for the pharmacy technicians working at the prison.
- There had been no competency checks for pharmacy technicians completed in last 12 months in line with the trust policy.
- 11 staff members out of 28 eligible had not received an appraisal in the last 12 months in line with the trust's policy.
- Training data provided by the trust showed that mandatory training compliance was 72% which was too low.
- 2 staff members had not received hospital life support training since 2020 and the overall compliance for primary care staff completing hospital life support training was only 41%.
- Only 75% of the mental health and primary care teams had completed Mental Capacity Act training.
- An audit of infection prevention and control (IPC) in January 2023 identified an action for all staff to complete IPC training, however only 64% of staff had completed this training.

At this inspection we found that some improvements had been made:

- A qualified nurse now carried out all reception screenings in line with best practice.
- Staff told us they felt supported and now had a manager or someone they could go to. Supervision data indicated that all staff had been offered regular supervision in line with the trust policy since the last inspection.
- In September 2023 95% of staff eligible received clinical supervision, 92% managerial supervision and 100% safeguarding supervision. This was an increase from 40%, 78% and 88% in June 2023.
- Competency checks had been completed for 2 of the 3 pharmacy technicians. The third technician was currently on long term sick leave so the provider intended to complete the checks with them on their return.
- In September 2023 the completed appraisals for staff were 60% which was an increase from 46% in June 2023.
- 86% of staff had now received the appropriate level of life support training.
- 80% of appropriate staff had received Mental Capacity Act training.
- 85% of staff had now received infection prevention and control training.

However, we found that overall mandatory training data was inaccurate and compliance data provided to inspectors included staff members who had left the service, therefore this was not reliable. Up to date mandatory training compliance data was requested but not provided and managers did not have a clear oversight of mandatory training.

Inspected but not rated

Are services responsive to people's needs?

Responding to and meeting people's needs

At our last inspection we found that there were over 100 patients waiting for psychological interventions, and only 2 days of psychology provision per week within the staffing model, which was not enough to meet the demand. At this inspection we found that psychology provision still did not meet the needs of the population, 72 patients were waiting for psychological interventions at the time of this inspection. We found that:

- A psychology assistant had been re-deployed in the 8 weeks prior to our inspection.
- Although the mental health team was unable to provide routine services due to safety concerns in the 3 months prior to this inspection, no efforts had been made to support patients in alternative ways such as using in-cell telephony or bringing patients to the healthcare centre.
- A psychologist had not yet been recruited and the vacancy remained out to advert.
- 2 assistant counsellors had been recruited and were awaiting vetting before taking up their posts.

This meant that patients with identified need for psychological therapy did not have their needs met.

Learning from concerns and complaints

At our last inspection we found that there was no quality assurance process or oversight of patient complaints. Complaints were reviewed and responded to by clinical matrons who were not always able to respond in a timely manner due to staffing pressures. Themes and learning from complaints were not identified and shared with staff.

At this inspection we found that there was still no oversight or quality assurance of complaints in place, and the system for reporting, logging and investigating a complaint was unclear with staff managing complaints in different ways. We found that:

- Managers were not all clear about where complaints were logged and who would respond to them.
- Although an administrator sent a holding acknowledgement to some patients following a complaint, not all complaints were passed to the administrator so not all patients received this acknowledgement.
- Complaints which managers responded to without giving to administration to log were missed from the complaints data tracker.
- Complaints logged by administration did not always have evidence of a response to the patient.
- Inspectors were told that complaints were all managed by the Patient Advice and Liaison Service (PALS) however staff told us that not all complaints were sent to PALS.
- Managers told us they had only realised recently that staff were not following the same process for managing complaints and acknowledged that staff required training in managing complaints and a standard operating procedure was required to clarify the process.

This meant that the management of patient complaints was poor, patients did not always receive a timely response to their complaint, and there was no local oversight of complaints about the service to identify themes and learning.

Inspected but not rated

Are services well-led?

Governance (including processes for managing risks, issues and performance)

At our last inspection we found that the provider did not have sufficient oversight of the risks posed to the service and control measures to reduce the risk. At this inspection we found that the risk register included details of risks, risk owners, control measures and review dates. However, we found that the ongoing issues with the complaints system was not included on the risk register. Furthermore, we found that the concerns regarding the patient application system had not been identified by staff or added to the risk register prior to the inspection visit. Managers were not aware of how to escalate risks for the service to senior managers or to the trust board.

Engagement with patients

At our last inspection we found that there had been no patient engagement since the start of the Covid-19 pandemic and there were no health champions to support the communication between patients and the healthcare service. This meant that patient feedback did not inform service delivery.

At this inspection we found that there were no health champions in place or face to face consultation due to the restrictions in the prison which were outside of the provider's control, however the provider had utilised patient safety questionnaires to gain patient feedback as an interim measure.