# HMP Frankland

## 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.

# Overall summary

We carried out an announced focused inspection of healthcare services provided by G4S Health Services (UK) Limited at HMP Frankland on the 4 January 2019.

We last inspected the service in May 2018 when we judged that the quality of healthcare provided by G4S Health Services (UK) Limited was in breach of CQC regulations. We issued a Warning Notice in relation to Regulation 17 Good governance and a Requirement Notice in relation to Regulation 9 Person centred care. The full focused report on the May 2018 inspection can be found on our website at https://www.cqc.org.uk/location/1-1988036653

The purpose of this inspection was to determine if the healthcare services provided by G4S Health Services (UK) Limited were now meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008.

We do not currently rate services provided in prisons.

At this inspection we found:

- Patient risk was identified, managed and monitored more effectively than at the time of our previous inspection. The provider had improved systems and processes with respect to the completion of medicines in-possession risk assessments (MIPRA).
- Some aspects of medicines management required ongoing monitoring.
- Shared learning from incidents took place and was appropriately shared with staff.
- Nursing staff had completed specific training in respect of managing long term conditions.
- Measures were in place to review patients' care plans, but involving patients in care planning required further development.
- Effective managerial oversight of staff supervision arrangements was in place and needed further development to ensure it was fully embedded across the service.
- Overall systems to support good governance at local level were not fully embedded across the service.

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

- Staff should be sufficiently trained to support and enable them to carry out their duties.

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

- Ensure that effective governance arrangements, assess, monitor and mitigate any risks relating to the health, safety and welfare of people using the service.

## Our inspection team

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

Before the inspection we reviewed a range of information that the provider had sent to us, for example, an action plan, minutes of clinical governance and medicines management meetings, a care plan tracker, fridge temperatures audits, a local manager check list, a supervision tracker and a training matrix.

During the inspection we asked the provider to share with us further information. We also spoke with healthcare staff, other healthcare partners, prison staff and commissioners.

## Background to HMP Frankland

HM Prison Frankland is a high security prison holding category A high risk, category A and category B adult males. The prison is located in the village of Brasside in County Durham, England and accommodates up to 842 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/hmiprisons/inspections/hmp-frankland/

# Are services safe?

**Risks to patients**

At our last inspection, we found that the risks to patients were not adequately managed, for example, not all patients had an up to date medicines in possession risk assessment. Ordering equipment and stock management was not sufficiently audited.

- During this focused inspection, we found that patient risk was identified, managed and monitored more effectively than at the time of our previous inspection. The provider had improved systems and processes with respect to the completion of medicines in-possession risk assessments (MIPRA). Records showed 19 patients did not have a current MIPRA assessment. The head of healthcare assured us that arrangements were in place to complete the outstanding IMPRA assessments before the end of January 2019.
- The service had some vacancies across the team; including, one Band 7 clinical lead and eight Band 5 nurse posts across primary healthcare and substance misuse services. Two applicants were going through the vetting process. Vacancies were appropriately managed through the use of a core group of regular agency staff.
- Systems for stock ordering were in place and audited by healthcare support workers. Equipment required was appropriately sourced and supplied to patients.

**Appropriate and safe use of medicines**

At our last inspection, we found that arrangements for managing medicines did not always keep people safe.

- During this focused inspection we found that progress had been made in some aspects of medicines management, however there continued to be some areas that were in development.
- Patient Group Directions (PGDs) and protocols used by staff to administer medicines were now in date and had been signed and authorised by staff and the head of healthcare. This ensured that staff were appropriately authorised to administer patients' medicines safely.
- Previously we found that monitoring of fridge temperatures was a significant concern. At this focused inspection we found that new fridges had been purchased across the prison, temperature recording forms had been developed and a centralised recording spreadsheet was in use. A revised refrigerator and medicines storage room temperature monitoring standard operating procedure had been developed to monitor and escalate incidents of temperatures being out of range. The escalation process had been in use since September 2018 with issues identified and rectified promptly.
- Healthcare support workers had been given responsibility for monitoring fridge temperatures. A daily record was completed which the head of healthcare and clinical primary care lead reviewed as part of the weekly completion of the local manager's quality assurance checklist. Oversight of the system had improved and this ensured medicines were fit for purpose and stored correctly within the recommended temperature ranges.
- A new medicines trolley had been purchased for one wing and this negated the need to remove medicines from containers prior to dispensing. The new system ensured medicines administration was safe and in line with the provider's medicines policy. We had some concerns about the removal and storage of medicines in a treatment room on another wing. We brought this to the attention of the head of healthcare during the inspection who took immediate action to resolve the issue.
- A training and competency spreadsheet had been developed, which provided information on staff training and competency assessments for the safe handling of medicines. However, we found that the competency assessments, which were completed as part of the annual appraisal, were not always completed accurately. For example it was not always clear what dates assessments took place and for one person the assessment had been signed as completed but the document was blank. Further work was needed to ensure that all staff were trained and competent in the safe handling of medicines.
- At the last inspection we found that compact agreements (documents signed by the patient detailing the rules regarding holding medicines in possession) and medicines risk assessments were not always available in patients' records. At this focused inspection we saw that medicines risk assessments were completed as part of the reception screening process. We also saw that work was underway to ensure that all

required patients had compact agreements in their records. Staff had identified those patients who did not have a signed compact agreement, and engagement had begun to ensure they were contacted.

**Lessons learned and improvements made**

At our last inspection, we found arrangements did not effectively support shared learning from incidents with all healthcare staff.

- During this inspection we found that learning from incidents was discussed in team meetings. Learning from incidents was also shared at daily handover meetings and during one to one supervision sessions, which provided opportunities for staff to develop professionally and improve outcomes for patients.
- Staff also discussed incidents that had occurred, at the monthly patient safety and quality medicines management meeting, attended by healthcare partners and pharmacy services.
- Shared learning took place across the North East prisons at the integrated clinical governance board, at death in custody reviews and was subsequently shared with staff at team meetings and in one to one sessions.
- A governance team within G4S Healthcare Limited circulated a monthly audit of outstanding incidents to the heads of healthcare, which ensured that reported incidents were investigated in a timely manner.

# Are services effective?

**Effective needs assessment, care and treatment**

At our last inspection, we found that not all nursing staff with responsibility for the care and treatment of patients with long term conditions had completed appropriate training specific to this role. Arrangements for reviewing care plans and ensuring patient involvement in their care plans required further development.

- During this focused inspection, we found that patients' immediate and ongoing needs continued to be fully assessed. Effective management of long term conditions was in place. One Band 6 nurse and one Band 5 nurse had lead responsibility for the care and treatment of patients with long term conditions had completed specialist training to support them in this role. Twice weekly long term conditions clinics were held and patients with multiple care needs, including long term conditions were discussed at a weekly complex care meeting.

- Care plans were in place for patients identified as having complex medical conditions, including long-term conditions such as diabetes. Care plans were clear and showed which member of staff had delivered treatment to a patient. Care plans were individually personalised to meet the needs of the patient. We reviewed the care records of 11 patients and found that five did not have a care plan. We brought this to the attention of the clinical lead for primary care; they took action on the day of the inspection and put arrangements in place to review these patients. Despite an absence of care plans for these patients we saw clear evidence in care records of regular healthcare input from nursing staff including regular reviews of care provided.
- The provider had developed a weekly care plan tracker, which detailed those patients with a care plan, the type of care plan, for example, wound care and a review date. A weekly audit of care plans that required review was produced. Where possible healthcare managers aligned care plan review dates with patients' next planned clinical appointment. Work remained ongoing, and some care plans still required a review. However the head of healthcare and the clinical lead were aware of these and plans were in place to complete a review.
- We saw evidence of some improvement in the involvement of patients in the development and ongoing review of their care plans. The provider had completed a care plan audit in November 2018 that showed 50% of patients had consented to their treatment. Healthcare managers had discussed with staff how to engage patient involvement in care planning and how to record consent. All staff had read the provider's policy on recording consent. The provider was aware that further work was needed to evidence that patients had been consulted as part of the process and a draft care plan competency framework was being developed. To support this, training in the completion of care plans had been rolled out and feedback on training provided was positive.

**Monitoring care and treatment**

At our last inspection, we found nurses did not have access to specialist nurse advice on adjusting dosages of insulin for patients who were insulin dependent.

- During this focused inspection, we found that patients with long-term conditions continued to be monitored through nurse led clinics and complex care meetings. A range of healthcare staff including GPs, advanced nurse practitioners, healthcare support workers and podiatrists worked effectively together to deliver coordinated care. Diabetic patients had access to diabetic specialists from a local NHS trust through a telemedicine system. (Telemedicine is the remote diagnosis and treatment of patients by means of telecommunications technology).
- The clinical lead for primary care had developed a wound care pathway, alongside a local competency framework that was implemented in July 2018. This ensured that that nurses delivering wound care were competent to do so.

**Effective staffing**

At our last inspection, it was unclear what training staff had completed, which made it difficult to fully understand the competencies and skills mix of the staff group. Clinical and managerial supervision did not take place regularly across all levels of the team.

- During this focused inspection, we found that a training matrix and a separate mandatory training matrix were now in place. The head of healthcare monitored staff training and completed a monthly local manager's quality assurance check of compliance against

mandatory training, which was reviewed at the regional patient safety and quality group. However, a review of training completed by staff showed that mandatory training rates were low at 65% compliance. Healthcare managers accepted that there was further work that needed to be done to improve the overall compliance with training and there were plans in place to address this.

- Information regarding staff training showed a number of nursing staff responsible for providing a range of nurse led clinics had completed training in asthma care, diabetes care and epilepsy. We were assured that the staff team was competent to deliver their roles safely and effectively. Healthcare managers assured themselves that only regular agency nurses, with knowledge of the patient group, appropriately skilled and trained were contracted.
- A supervision policy and procedure was in place and supported staff to access supervision and professional development. Staff confirmed that they received regular formal supervision, that there were good informal supervision arrangements and they felt supported by band 6 nurses, the clinical lead for primary care and the head of healthcare. Effective managerial oversight of staff supervision arrangements was in place and the provider had developed a supervision tracker to monitor the uptake of supervision and identify gaps. Staff appraisals were scheduled to take place in January 2019.

# Are services caring?

We did not inspect the caring domain at this inspection.

# Are services responsive to people's needs?

We did not inspect the responsive domain at this inspection.

# Are services well-led?

### Leadership capacity and capability

At our last inspection, we had concerns about the leadership and capability of some managers and their ability to deliver high quality sustainable healthcare services at the prison.

- During this focused inspection, we found that a new and experienced head of healthcare had been in post since September 2018. The head of healthcare along with the clinical lead for primary care collectively demonstrated they had the skills, knowledge, appropriate experience and capability to deliver a high-quality and sustainable healthcare service at the prison.
- The head of healthcare was visible within the service and was actively involved in the day to day delivery of the service. We observed staff regularly engage with the head of healthcare sharing patient information, and seeking support and guidance when necessary. We observed effective joint working between the head of healthcare and the clinical lead for primary care throughout the inspection who both demonstrated a commitment to improving the service and improving outcomes for patients.

### Culture

- During this focused inspection staff told us staff morale across the team had improved and managers listened to and worked with staff. They said that the healthcare partners worked together in a clear multidisciplinary manner.
- Staff said they were kept informed of outcomes from reported incidents and opportunities to discuss and share learning from incidents occurred in staff handovers and at supervision sessions. Other staff told us that communication across the team had improved, leadership was stronger as was clinical leadership.

### Governance arrangements

At our last inspection, we found that systems and processes to support good governance and management of the service were limited at local level and this impacted upon their overall effectiveness. Systems used to audit the service were not effective.

- During this focused inspection, we found that a range of systems had been introduced to support the ongoing development of the service, for example, weekly manager checklist which reviewed monitoring arrangements in respect of fridge temperatures, staff training, care plan audits and staff supervision. Although early indications appeared to suggest that new systems and processes were effective, we were unable to fully assess the impact they were having on the service.
- There were effective links between local and wider governance systems including oversight at the regional patient safety and quality group to monitor compliance.

### Managing risks, issues and performance

At our last inspection, we found that risks to patient care and treatment were not always well managed, in particular for patients holding medicines in-possession.

- During this focused inspection, we found that a weekly MIPRA audit report measuring compliance was produced and this was reviewed by the head of healthcare as part of the local manager checklist.
- A senior partnership oversight meeting jointly held with healthcare partners was set up in August 2018 to strengthen partnership working and ensure oversight of patient safety in respect to medicines in-possession risk assessments (MIPRA) and treatment compact completion. Issues pertinent to HMP Frankland were discussed at the local medicines management group. Additionally, compliance was monitored through the local management checklist.

### Appropriate and accurate information

At our last inspection, we found that although the service gathered appropriate information through their quality, performance and contract reporting arrangements, it was not clear how this was used to improve service delivery.

- During this focused inspection, we found that the service gathered appropriate information through their quality, performance and contract reporting arrangements and this was used to improve service delivery. The head of healthcare completed local management checklists and attended the Regional Patient Safety, Quality Assurance Group which monitored compliance with a range of processes. This information was used to review to improve service delivery and outcomes for patients.
- The service continued to submit data and/or notifications to external organisations as required.

# Are services well-led?

**Continuous improvement and innovation**

At our last inspection, we found that systems to support continuous improvement were not regularly and consistently applied.

- During this focused inspection, we found monitoring and auditing checks were undertaken on a regular basis, and we could see evidence that improvements were starting to take place, but we were not able to fully assess the impact of these measures.
- Shared learning from reported incidents was now effective and was used to improve the service and improve outcomes for prisoners. For example, an incident when a fridge temperature was found to be out of range was discussed at the November 2018 staff meeting.
- A service development programme unit that all healthcare partners attended to discuss service development and issues that affected all providers (for example, MIPRA) had been set up and provided an opportunity to review service provision and make improvements.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>**Staff should be sufficiently trained to support and enable them to carry out their duties.** |