HMP Whatton

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 this announced inspection on 11 June 2019 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We planned the inspection to check whether the registered provider was meeting the legal requirements in the Health and Social Care Act 2008 and associated regulations.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

•Is it safe?

•Is it effective?

•Is it caring?

•Is it responsive to people's needs?

•Is it well-led?

These questions form the framework for the areas we look at during the inspection.

We do not currently rate services provided in prisons.

At this inspection we found:

- Healthcare managers had identified staffing levels needed to meet the needs of patients, and recruitment had taken place in the last year to address this.
- The monitoring system to ensure that emergency equipment was suitable for use, was not effective as it did not identify out of date items. We raised concerns about this at the start of the inspection, however no immediate action was taken to replace out of date items.
- Records of personal care were not completed contemporaneously and care plans were recorded inconsistently.
- The provider had safe systems in place to manage and respond to safeguarding concerns.
- The provider carried out regular infection prevention control audits, identifying areas of non-compliance and were taking action to address them.
- Medicines were appropriately stored, transported, administered, and disposed of safely.
- Staff understood their responsibilities to raise concerns and record and report safety incidents internally and externally.
- Staff reviewed patients' long-term conditions. However, care plans were not always recorded in the same place, which compromised staff's access to up to date information.
- Nurses ran regular clinics for patients with long-term conditions, such as, epilepsy, diabetes and Hepatitis and patients care plans were updated in accordance with national guidance.
- Waiting times were reasonable, Patients could see the nursing staff and were triaged on the same day.
- Staff said that they worked in a supportive environment, they enjoyed working as a team and worked well together.
- The provider's audit schedule was being developed to ensure it covered all aspects of the service.
- There was an effective process in place to evaluate patient feedback to develop the service. Patients were mainly positive about the healthcare they received.
- The recording and oversight of some data relating to medicines was ineffective
- The provider was not analysing their non-attendance rates, which would help develop the service.

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

- Ensure the monitoring of emergency equipment is effective.
- Ensure that care records are completed consistently and contemporaneously so that staff have access to up to date information.

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

- Ensure that the supply of medications to prisoners on arrival is timely.
- Ensure that monitoring of prescribed medicines is effective including, medicines supplied to patients prior to transfer, medicine reviews and in-possession risk assessments.
- Ensure managers monitor clinic attendance rates to develop the service.

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) health and justice inspector with an inspection manager and two other health and justice inspectors.

Before this inspection we reviewed a range of information that we held about the service, including commissioners' quality visit reports. Following the announcement of the inspection we requested additional information from the provider, which we reviewed.

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

Background to HMP Whatton

HMP Whatton is a Category C training prison in Nottinghamshire with an operational capacity to hold 841 convicted male prisoners. It fulfils a national function to provide services that seek to address the offending behaviour of men mainly convicted of sexual offences. More than 90 per cent of Whatton's population are serving sentences in excess of four years, with just under three-quarters of these serving indeterminate or life sentences. Prisoners held at HMP Whatton come from across the country, and about two-thirds are aged over 40. The prison is operated by Her Majesty's Prison and Probation Service.

Care & Custody (Health) Limited is commissioned by NHS England to provide primary health care, mental health and substance misuse services at the prison. The provider is registered with the CQC to provide the following regulated activities at the location: Treatment of disease, disorder or injury and Diagnostic and screening procedures.

CQC has not previously inspected this location. It was last inspected by Her Majesty's Inspectorate of Prisons between 15 to 26 August 2016.

The HMIP inspection report can be found at:

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/12/HMP-Whatton-Web-2016.pdf

We announced our intention to undertake a comprehensive inspection of healthcare services provided by Care & Custody (Health) Limited, on 29 May 2018. The inspection took place from the 11 to 13 June 2019.

Are services safe?

Safety systems and processes

There were clear defined systems and processes to keep patients safe. The provider ensured all staff followed their own and the prison's safeguarding policy, which included reference to reporting on modern slavery, neglect, physical and sexual abuse, violence and discrimination. Healthcare staff and managers had good links with the prison's safeguarding team and made referrals to the prison safer custody team if they had concerns. We saw meeting minutes where actions to protect patients were discussed.

Safeguarding meetings that took place in the prison were attended by a multidisciplinary team, that included prison chaplaincy, offender management, the mental health team, prisoner offender supervisors and governors. Healthcare staff shared information relating to patients they were aware of who required personal assistance or may be vulnerable.

All healthcare staff had completed safeguarding level 2 training, and there were plans for all staff to be trained to level 3.

The prison informed the healthcare team when there were plans to physically restrain a prisoner. Nursing staff were trained to observe and identify appropriate restraint techniques. Following restraint, nursing staff carried out a physical assessment and checked all patients for injury or distress. They completed records following the use of restraint to document whether any injuries occurred, and any treatment given.

Healthcare staff took a proactive approach to protect vulnerable groups and worked effectively with prison teams to prevent abuse. For example, the mental health team would check with the security and the offender management teams when involving a patient's family in any planning of care and community treatment.

The provider carried out regular infection prevention control audits and identified any high-risk areas that were non-compliant with IPC standards Responsibility for the condition and maintenance of the healthcare department lay with the prison. Care & Custody (Health) Limited managers had escalated all concerns to the prison and to the contractors who provided some deep cleaning. They had also reported such issues via the provider's incident reporting system. Staff were carrying out effective hand hygiene audits that promoted safer practice.

The provider had policies and operating procedures in place for staff to follow should there be an outbreak of communicable diseases. Staff informed patients upon arrival of available vaccinations and how to report illness. There was good uptake of immunisation and vaccinations which helped with the prevention of illness within the establishment.

Electrical equipment was safe and appropriate. Managers kept a log of all equipment and checks of the maintenance and use of equipment was carried out weekly. Portable appliance testing (PAT) was done by the prison annually. All equipment maintenance checks were due during the month of the inspection.

Equipment was available for staff to use when a medical emergency occurred. Staff were required to check the sealed emergency bags weekly, or after use, record their findings and any action taken. A standard operating procedure set out this process, including notifying pharmacy staff if items were within 28 days of their expiry date. Whilst records of checks were complete, on the first day of the inspection we found items that had passed their expiry date in both bags. We immediately brought this to the attention of senior staff. We were particularly concerned because one bag did not contain two items necessary to check a patient's blood sugar level in an emergency. We checked again on the third inspection day and found that the previous concern had not been addressed. We again raised this with senior staff who took immediate action to address it. However, our findings showed that the monitoring system to ensure that emergency equipment was suitable for use, was not effective.

Risks to patients

Care & Custody (Health) Limited initially reduced the number of staff when they began to provide services in 2017. Managers had since identified the staffing levels needed to meet the needs of patients, so wider recruitment had taken place in the last year. However, there was only one member of staff responsible for overseeing substance misuse patients, which was insufficient to provide a full range of psychosocial interventions.

Substance misuse clinical staff were aware of individual patient needs and risks and GPs followed national prescribing guidance. Although the nursing team were qualified to meet the clinical needs of these patients, one

member of staff was responsible for the psychosocial care and treatment. This meant that responsibilities such as, assessments, care planning, planning treatment reviews and interventions, were being completed by one member of staff. This posed a risk to patients receiving substance misuse treatment if this member of staff was absent. Managers had identified this and recorded it on their risk plan. Managers were working with a community substance misuse provider to start to deliver psychosocial interventions weekly.

Due to pharmacy staff absence, the efficient and safe running of the pharmacy was reliant on one pharmacy technician and the support of healthcare support workers. This posed a risk to maintaining the service, as did the absence of regular supervision or annual appraisal for pharmacy staff, in line with the provider's policy. However, this had been identified on the risk register and managers were ensuring that pharmacy staffing levels met the needs of patients.

Managers also reviewed and planned rotas to ensure there were appropriate levels of nursing staff. Where there were some shortages, regular agency staff were used. These agency staff accessed the systems and worked regularly in the prison environment, understanding the patient population.

Staff completed detailed risk assessments when patients arrived at HMP Whatton. Staff also completed person-centred risk assessments with patients who were at risk of self-harm or suicide. Staff worked with the prison and attended prison-led Assessment Care in Custody and Teamwork (ACCT) reviews, as part of developing a bespoke support plan for prisoners who were in crisis. Staff knew how to report any patient risks within the wider prison.

Nursing staff used appropriate health screening tools to identify deterioration in patient health. For example, they used recognised tools to carry out regular checks and assessments when patients were reducing their opiate substitute medications. Staff supported patients who were on the end of life pathway, recording and monitoring their health. Changes in a patient's condition were identified and acted upon.

All health staff attended daily handovers between teams. Patient risks were discussed and recorded appropriately

Managers assigned a nurse to respond to any medical emergencies daily. Staff knew where the emergency bags, oxygen and defibrillators were located.

An out of hours GP service was available but limited to telephone advice and remote prescribing.

Staff regularly reviewed patient decisions about their critical care and kept a clear record. We reviewed the records of two out of five Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. Staff recorded patient choice and ensured these were up to date and available to relevant staff.

Track record on safety

Staff understood their responsibilities to raise concerns and record and report safety incidents, internally and externally. Managers also attended the prison safer custody meetings and informed healthcare staff about any risks to patients.

Managers updated staff on safety issues from a range of sources within the prison establishment. They attended the morning senior management team where they would be informed of any significant issues and passed these over to the healthcare team during handover.

Managers used governance information from across the provider's services to inform safe clinical practice and service improvements

Appropriate and safe use of medicines

Medicines management was overseen by two sub-contracted pharmacists, with different responsibilities for aspects of auditing and monitoring the service. Both visited fortnightly and reviewed how medicines were managed, reporting any concerns to the head of healthcare. We saw evidence of improvements that had been made in response to pharmacists' observations. For example, the development of a clear process for transporting controlled drugs to ensure safe practice. However, patients did not have access to the visiting pharmacists for advice about their medicines as they would in the community.

Medicines were supplied by a pharmacy some distance from the prison and we saw examples of delays in the supply of prescribed medicines which led to interruptions in patients' treatment. Whilst staff could expedite the supply of critical medicines, some patients experienced anxiety because they could not receive their medicines

immediately on arrival at the prison. Ongoing concerns about medicines supply were identified in the provider's risk register and formal meetings had been arranged to ensure the associated risks were monitored. Pharmacy staff appropriately stored, transported, administered and disposed of medicines.

Medicines were prescribed by GPs or the visiting psychiatrist. A nurse prescriber could also administer some medicines to patients under suitable protocols. A range of local standard operating procedures were, in date, signed by staff and available for reference. All staff with responsibility for administering medicines had received training.

Most medicines were supplied and administered to patients confidentially from a dedicated pharmacy with support from prison staff. We observed staff checking patients' identity and respectful conversations between staff and patients during these sessions. Patients were encouraged to take responsibility for re-ordering and collecting their prescribed medicines, in line with community prescribing services. Where ordered items were not available staff offered advice about when they would arrive to reduce any anxiety. Those unable to remember to take their medicines regularly were supported by the use of dosette boxes.

Patients who failed to attend to collect their medicines were automatically re-booked for the next appropriate session. However, if the timeliness of their medicines was critical to their health and wellbeing, pharmacy staff alerted the appropriate healthcare professional through the electronic patient record system, to ensure the patient was followed up.

Medicines were stored and transported securely, although pharmacy storage space was approaching capacity. Staff followed secure transportation protocols; for example, when delivering medicines to patients accommodated in the care and separation unit. The temperature of the pharmacy and medicine fridge was routinely monitored, and a protocol set out the action staff should take if these temperatures were out of range. Staff demonstrated that they were aware of these procedures. Lockable storage was available on some accommodation wings so that patients could keep their medicines securely.

The recent change in classification of some strong painkillers had impacted significantly on how nurses administered them to patients. The team had developed an interim arrangement, which was time consuming and also required them to carry dispensed medicines to patients in their cells on three days a week. This had been risk assessed and prison officers were assigned to support this arrangement. Improved arrangements were being implemented to enable dispensing of these medicines in single dose packages and address unsafe practice.

Medicines management was discussed at the quarterly Drugs and Therapeutics/GP meeting and minutes we reviewed showed that national guidance was considered, any concerns were addressed, and improvements made. Routine pharmacist audits enabled the group to review staff's compliance with standard operating procedures. Further prescribing audits were planned. The number of complaints relating to medicines were low, which indicated a good level of patient satisfaction.

Lessons learned and improvements made

Managers had an open, transparent, candid approach toward patients. Although there had been no recent significant incidents, managers informed patients if something went wrong. We reviewed a response that was sent to several patients when staffing levels were low and some appointments needed to be rebooked. Managers had shared this with commissioners which helped them to obtain funding for additional staff. Staff we spoke with said they would be honest toward patients about untoward events.

Healthcare staff used an online reporting system to record incidents. We saw a range of comprehensive incidents reports that were acted upon appropriately. Managers were appropriately assigned to review, investigate and handle all incidents. We saw actions were put in place as a result of learning from incidents. For example, the stock drugs list was amended in response to an incident involving a diabetic patient.

The clinical governance team used incident reporting to review the number and types of incidents each month. This ensured lessons could be learned and improvements made. For example, around 35% of the incidents during 2018 to 2019 were related to medicines, including controlled drugs. In response, the provider ensured that a full pharmacy audit was carried out. A reminder about reporting medicines incidents was circulated to staff through the provider's, News Bulletin.

Are services safe?

Managers were accountable to the wider management team within the organisation. This meant that overall risks to safety from service developments and changes in demand could be assessed, planned for and managed effectively.

Are services effective?

Effective needs assessment, care and treatment

During our inspection we observed an initial health screening assessment undertaken by a nurse of two patients who had arrived from another prison. These patients' needs were assessed using a current evidenced based tool. Where patients' needs were identified staff made appropriate referrals to other services such as, GP, mental health, dentistry, substance misuse and social care. Staff also identified patients at risk of self-harm and suicide and reported this to prison staff so that immediate care could be provided within the wider prison.

Staff assessed patients who were referred to the mental health team within five days. Urgent referrals were seen on the same day. Nursing staff prioritised attending the Assessment Care in Custody and Teamwork (ACCT) reviews if the prisoner was not known to the mental health team so that they could be a part of developing a bespoke support plan for prisoners who were in crisis. There was an on-call duty rota for staff to cover any other ACCT weekday reviews.

Care & Custody (Health) Limited had supported nursing staff to complete qualified triage training, this meant that staff were on a daily rota to assess patients who had concerns about their physical and mental health and respond in a timely compassionate way.

Healthcare staff were aware of patients' individual and diverse needs. Staff responded equitably to needs related to ethnicity, religion, nationalities, sexual orientation and gender. They also supported patients who were engaged with the transgender pathway. Healthcare managers helped facilitate patients to attend appointments at out of area gender identity clinics and supported patients within the prison estate to live as their preferred gender.

Healthcare staff had completed training in the Mental Health Act (MHA). Where patients were referred for assessment under the Act, staff understood the patients' rights and referred to the MHA Code of Practice.

Monitoring care and treatment

Healthcare managers collected and monitored patients' care and treatment outcomes and submitted Health and Justice Indicators of Performance (HJIPS) data quarterly to commissioners. There were clear clinical governance arrangements in place which facilitated service improvements by using and analysing this data. Where outcomes were not being achieved, the provider put additional resources in place. For example, the waiting list for physiotherapy was high, so additional sessions were planned.

There was a comprehensive physical health strategy, contributed to by all staff that was intended to support and improve the physical health and wellbeing of patients.

A nurse practitioner and a health care assistant carried out annual physical assessments for patients on the mental health pathway. The psychiatrist reviewed mental health medications which ensured that accurate up to date information about care and treatment was used. However, managers needed to ensure that routine medication reviews were completed to monitor the effectiveness of treatment.

Effective staffing

Care & Custody (Health) Limited employed a range of staff with experience relevant to their roles. There were now sufficient staffing levels to meet the needs of patients. The team was made up of an administration team, a GP, two pharmacy staff, six band 5 nurses, two health care assistants, an occupational therapist, clinical matron, three mental health nurses, one intellectual & development disabilities (IDD) nurse, one consultant forensic psychiatrist and one part-time psychiatrist. There were vacancies for a clinical psychologist for two days a week and two nursing posts. These posts would further increase patient access to psychological support and clinical care.

Care & Custody (Health) Limited had developed a new corporate training package and were aware that staff needed to complete further training in order to be compliant with the provider's policy. Managers kept a log of the training completed and recorded compliance rates separately. The training matrix showed, 80% of staff had completed infection prevention training; 70% had completed Mental Capacity Act (MCA). However, only 40% of staff had completed information governance (IG), to date. There were plans to deliver further MCA training this year and ensure staff had access to the online IG training.

Managers ensured their staff completed a range of prison specific training such as, self-harm and suicide, Assessment Care in Custody and Teamwork, health and safety, PREVENT and personal protection. All staff completed substance misuse and mental health awareness training during their induction. Although staff had access to

ongoing training, we were informed that's some staff felt the provider had not sourced appropriate training for immunisation and vaccination. Staff felt this could put them at risk of becoming deskilled, and of losing confidence. Managers had escalated this to the clinical governance team, who were looking at resources for the next year.

Healthcare staff were supported to maintain and further develop their professional skills. All healthcare staff had an annual appraisal. The provider had recently launched an online system which helped keep records up to date.

Staff had access to supervision. There was an organisation structure setting out supervisor roles. We saw evidence staff received supervision in line with the provider's policy and where objectives and training opportunities were discussed during managerial supervision.

Staff within the mental health team had occasional group clinical supervision, facilitated by the psychiatrist. However, clinical group supervision was not routinely planned. There were plans for this going forward.

Coordinating care and treatment

When patients were referred to healthcare services, healthcare staff, including nurses and healthcare assistants carried out assessments, care planning and delivered care. This meant that care was delivered in a coordinated way.

Patients with long-term conditions had care plans; nursing staff reviewed care plan objectives and updated them. In most of the cases we viewed, care plans were completed for any chronic disease, for example, diabetes. However, there was a lack of consistency around where staff were completing the details for the care plans on the patient record system, which compromised other staff's timely access to up to date information.

Lead nurses ran regular clinics for patients with long-term conditions, such as epilepsy, diabetes, blood-borne viruses (BBV) and men's health . There were annual clinics for screening patients with chronic lung diseases and heart problems. Patients were monitored in line with national guidance. The lead nurse understood the main issues some diabetic patients have, such as having poor control with sugary food and not being compliant with their treatment. Nursing staff developed patient care plan objectives using this information, to inform patients about the importance of their care and how to get support.

Healthcare staff worked effectively with different teams within the prison, such as psychology, safer custody and offender management. There were regular management meetings of the multi-agency substance misuse committee, with appropriate attendance. Issues discussed included, intervention activity, incidents, drug testing and use of illicit substances. This group reported into the prison's safer custody meeting, which demonstrated positive partnership working.

Patient records and care plans were held electronically. However, the system to manage social care was not always coordinated. We found examples of prisoners receiving social care on A8 wing, whose records were not held electronically and were not updated until the end of the day. Therefore, health staff did not have access to up to date information about the prisoner throughout the day. Social care agency staff recorded a summary of the care they delivered on paper records, which were held by the patient. However, these records were not comprehensive, which meant that health staff did not always have access to complete information.

Healthcare staff worked together to plan the ongoing care and treatment for patients who were due to be transferred or released into the community. Records showed that those patients engaging in opiate substitution therapy to manage their addiction were well supported, including during reduction and transition to abstinence. Patient records demonstrated that substance misuse workers engaged well with their patients and established a mutually agreed approach to reduction that took account of the patient's individual circumstances. For example, when a patient on a reduction programme became anxious, the GP temporarily halted reduction, and supported the patient at their preferred pace.

There were clear pathways within the mental health team for assessments of learning disability, dual diagnosis and psychiatrist support.

The mental health team attended fortnightly allocation meetings, where those patients on waiting lists were allocated onto caseloads. Patients were triaged on referral and seen immediately or booked to see a psychiatrist.

Healthcare staff saw patients prior to their release, they provided each patient with harm-minimisation, advice and

arranged community health appointments if needed. The social worker and occupational therapist worked together to ensure any prisoner needing a social care package upon release had appointments in place.

Helping patients to live healthier lives

Healthcare staff had developed a range of health promotion information to inform patients about healthy living. We saw information displayed on the walls in healthcare and on the wings. Staff had worked with the gym to promote exercise and healthy eating. Staff also worked with individual patients to improve healthy living such as weight loss, living with diabetes, and mobility.

The provider's health promotion lead worked with the prison's catering team to assist those patients who needed calorie rich diets to gain weight and maintain energy levels.

Dental staff worked with the nursing staff to promote better oral health. There were dental therapy sessions which nursing staff could refer patients to for oral health promotion.

Nursing staff took the opportunity to highlight other health screening opportunities, such as blood borne virus screening, or booking an appointment for the older person's clinic for a full health review. Where additional health needs were identified, referrals to the appropriate health professional were made promptly.

Consent to care and treatment

Staff understood the consent and decision-making requirements of relevant legislation and guidance. Staff had received training and understood the Mental Capacity Act (2005). We saw some examples where patients' consent to clinical decisions was recorded and appropriately reviewed. For example, where patients did not wish to go to the end of life unit, their decisions were discussed and recorded so that they could continue to receive care on the wing and maintain contact with their peers.

Patients were routinely asked to record their consent to holding their prescribed medicines safely.

Are services caring?

Kindness, respect and compassion

Staff treated patients with kindness, dignity and respect. We observed staff being patient and taking time to listen to any concerns and requests. Staff were aware of the diverse needs of this prison population. Interactions were positive, and staff understood individual needs such as communication and how they liked to be treated.

Feedback from patients was overwhelmingly positive about the way staff treated them. Patients referred to staff by name and felt they worked hard to assist them when they could.

Staff ensured patients' privacy and dignity was always respected, including during physical or intimate care. There were privacy curtains within clinic rooms and doors were kept closed during consultations. Where assistance with personal care was required, staff encouraged patients to be as independent as possible and any assistance was always given in private.

Involvement in decisions about care and treatment

Staff explained treatment options to patients and involved them when developing their care pans, we saw examples where care and treatment options were reviewed, and patients' decisions were recorded.

Staff had access to Language Line and interpreters when needed. Staff were aware that the population group at HMP Whatton was aging and delivered care and support accordingly. For example, regular hearing checks and appointments for hearing aid devices were facilitated.

Staff helped patients to get the information they needed about their care. There was a range of leaflets and information regarding healthcare services and health conditions displayed in healthcare and each wing. This included details about mental health, low moods, sleep problems, stress and anxiety. There was also range of substance misuse information available.

The mental health team developed specific care plans for patients with learning disabilities and personality disorder that were based on individual diagnosis. Nursing staff worked with patients diagnosed with dementia and referred these patients to the mental health team if they had a specific need for emotional support.

At the time of inspection, there were 17 patients on a Care Programme Approach pathway (CPA). Patients on a CPA have been diagnosed with enduring mental health issues and are eligible for more in-depth support. CPA care plans were regularly reviewed. Such patients were managed through a multidisciplinary approach, including psychiatry. The team worked well with community mental health teams. For example, managers ensured all patients were allocated a community mental health worker in time for their release.

Patients engaging with the substance misuse team had care plans in place to support their recovery. Records showed that these were reviewed opportunistically and recorded in the running record, alongside any individual or group interventions. However, care plans were brief and not always reviewed as indicated. Those patients who failed to attend their appointments were followed up to encourage their continuing engagement with the service.

Are services responsive to people's needs?

Responding to and meeting people's needs

Care & Custody (Health) Limited provided a range of health services. There was a comprehensive health promotion strategy and plan for the year. This included the running of regular clinics such as, opticians, physiotherapy and podiatry. There were planned awareness days, including, sexual health, healthy hearts, national non-smoking day, bowel cancer awareness, oral health, men's health and healthy eating.

The provider met with commissioners regularly. We saw records of meetings that discussed planning services at HMP Whatton to meet the needs of the population, many of whom had enduring mental health needs, social vulnerabilities and long-term health conditions with multiple co-morbidities.

There was a separate purpose-built end of life care unit, not in use at the time of our inspection. When required, managers planned staffing cover and communicated with the prison effectively, in order to assist family visits if the patient wished. However, this unit was remote from accommodation wings, which meant that patients were separated from their peers.

Patients attended the healthcare unit to see mental health practitioners. These rooms were not suitable for use. For example, the dedicated therapy suite was prone to water leaks from above. Managers had reported this issue to the prison.

Nursing staff attended the Care and Separation Unit daily and carried out an immediate assessment of risk to ensure prisoners were safe to be held in the unit. Prisoners could ask to see healthcare staff at any time. Medications were administered daily, and doctors completed three visits to the unit a week. The mental health team attended reviews and saw patients on their caseload who were located on the unit

The prison supported prisoners with higher needs for personal care in the older person's and social care units. Prisoners on these units were able to receive care that met these needs in a safe, fit for purpose facility. Healthcare staff met with prison staff regularly, to discuss how social care services could be planned and developed. Healthcare staff provided immobile patients with a personal wrist alarm, so that patients could summon assistance from their bedside.

Patients requiring psychosocial substance misuse treatment were seen by staff on a one to one basis. Due to low staffing levels there were limited group work interventions available. The provider had identified on their risk register that there were no structured psychosocial intervention programmes, due to unsuccessful attempts to recruit suitable staff. This risk was assessed as amber as a new provider had been identified and was due to start providing services by July 2019.

An intellectual and development disabilities pathway was implemented for those patients assessed with an IQ lower than 70, a specific neurodevelopmental disorder, or were not able to progress with an adapted offending behaviour programme. The IDD nurse provided support to patients with learning disabilities. They also supported patients who had issues with day to day functioning in the prison. The mental health team provided additional interventions to these patients, which helped patients to progress with rehabilitation within the prison.

There were no mental health group interventions being delivered, due to a vacancy for a clinical psychologist. However, interventions such as, anxiety, mood management, sleep hygiene and coping skills were being delivered one to one and helped patients prepare for cognitive behavioural programmes delivered by prison psychologists.

The needs of the diverse prison population were considered when planning and delivering services. Staff had diversity training and developed treatment plans, considering; age, disability, gender reassignment, race, religion and sexual orientation.

Timely access to care and treatment

All prisoners were promptly assessed by healthcare staff at reception. During the core day patients had access to a GP for any urgent needs. Staff called the out of hours GP service for advice or prescribing, if there was a late arrival into the prison.

Waiting times were reasonable; data showed that waiting times for routine appointments with the substance misuse team were five days. There was a two week wait to see the GP, which was equitable to the community. Patients had good access to nursing staff and were triaged on the same

Are services responsive to people's needs?

day. Clinics and appointments were rarely cancelled. An appropriate range of clinics were planned, and patients were booked in advance to appointments. This helped ensure access to treatment was timely.

Listening and learning from concerns and complaints

The provider had an effective concerns and complaint system. Patients could log a complaint using specific healthcare complaint forms. However, some patients submitted healthcare complaints using the prison complaint forms, used to complain about any aspect of the prison service. This meant that healthcare complaints were not always managed confidentially because these forms were sent to a prison administrator, before being passed to healthcare. Managers said they would further promote the use of healthcare complaint forms, to encourage a confidential process.

Managers kept a confidential log of all complaints. There had been 75 complaints in the six months prior to our inspection, which were varied and included complaints about all aspect of healthcare services. Healthcare managers had responded to complaints within 10 working days, in line with the provider's policy. Managers' investigations were carried out appropriately. All complaints were taken seriously, responded to clearly, and outcomes were recorded.

Are services well-led?

Vision and strategy

Care & Custody (Health) Limited had a service principles and values that were driven by quality and safety. Managers worked to provide services that were equitable with community services, with a focus on NHS Outcomes Frameworks, for example, preventing people from dying prematurely, enhancing quality of life for people with long-term conditions, assisting recovery, ensuring patients have a positive experience of care and caring for people in a safe environment.

Strategic objectives for 2019 – 2020 were developed through a structured planning process with regular engagement from internal and external stakeholders, patients and staff. Objectives were measurable, and the strategies involved the wider prison. For example, healthcare staff worked in partnership with the prison to ensure that custodial staff were available to escort patients to hospital appointments.

Staff we spoke with understood the vision and values of the organisation. Staff said they wanted to provide patients with the care they needed comparable with the care they would receive in the community.

Culture

Managers within the healthcare department were experienced, knowledgeable and maintained their professional development. Managers had regular meetings and supervision which ensured they were engaged and aware of the strategy to promote good quality care.

The head of healthcare knew what challenges were specific to their location and to the delivery of the service. Managers said they shared information with the wider organisation and felt listened to. Staff said that managers were visible and always approachable.

Staff told us that they worked in a supportive environment; they enjoyed working as a team and worked well together to ensure risks to patients were managed. They said they felt respected and valued. We also received positive comments about the healthcare staff from prison officers. Prison governors said relationships with healthcare managers were positive, due to healthcare staff being open, honest and effective.

Staff had access to Care & Custody (Health) Limited's support package. This included access to occupational health services and a counselling line. A human recourses team and policies supported the management of staff performance.

There was a whistle blowing policy should staff wish to raise any concerns about the care and treatment. This process was confidential.

Governance arrangements

There was a governance framework to support the delivery of the provider's strategy and promote the quality of care. The governance framework ensured that from the top down, managers responsibilities and accountabilities were clear. There were well attended monthly regional meetings that included contract managers, clinical governance, regional directors, human resources and business partners. We also saw records of regular training and development meetings, medicines management sub-committee meetings, national clinical governance and senior management meetings.

There were effective processes where information was shared to manage current and future performance and risks. Commissioners agreed with Care & Custody (Health) Limited a remedial action pan, highlighting issues within the service delivery, which was reviewed in February 2019. The provider was working towards managing these issues; for example, throughout 2017, a wide range of staff were recruited to provide better access to primary and mental health care.

Although there was a corporate audit schedule, some audits were not prison specific. The provider was developing their baseline clinical governance compliance audits, to ensure that key clinical audits would be in place for mental health and substance misuse. Managers at HMP Whatton were carrying out their own site audits, to quality check clinical activity and monitor specific risks. For example, a clinical record check was created for staff to review a patient's electronic record, including the quality of entries. The mental health team manager carried out prescribing audits. However, these were not carried out regularly.

There was a Caldicott guardian in place, so that staff could repot any concerns around patient information governance to a senior individual.

Are services well-led?

Appropriate and accurate information

Managers had identified some areas of ineffective data management oversight, but further work was required to ensure information was accurate. We found inaccuracies in some of the data managers collected for submission to NHS England. Commissioners had previously raised this, and managers had put monthly trackers in place, so all data was clinically reviewed before submitting. However, we found further discrepancies. For example, patient records showed that a risk assessment and medicines reconciliation was completed for every new prisoner to determine their suitability for managing their own (in possession) medicines. The corresponding data collection suggested that less than 80% of patients' medicines were reconciled. This meant that whilst reviews of patients' prescribed medicines were completed the monitoring system was not sufficiently reliable to provide assurance.

Every patient who left HMP Whatton to live in the community was given a week's supply of their prescribed medicines. Every patient being transferred to another establishment should also be given a supply of medications to ensure continuity of treatment. Staff told us that, of the patients transferring to another prison, only those prescribed controlled medicines left without a supply for security reasons. However, recorded data suggested that only 30 to 55% of such patients, were provided with their medicines. We raised this discrepancy with managers at the end of the inspection, who said they would review how this data was recorded.

The substance misuse lead had responsibility for reporting data to the National Drug Treatment Monitoring System; however, the data showing the amount of interventions for 2018 was inaccurate. Managers had identified an anomaly with the way this data was recorded, which had been reported and was being amended.

There was a lack of oversight of how the treatment reviews of patients with long-term illnesses were booked and managed. Staff used the relevant waiting lists inconsistently which meant that it was unclear if the presenting illness or long-term condition, had been effectively monitored. Therefore, there was no monitoring process in place to ensure patients' treatment was reviewed in a timely way.

Engagement with patients, the public, staff and external partners

Mangers collected the views of patients using a corporate patient questionnaire. There was also an easy read feedback form and patients could leave any confidential comments on healthcare application forms. This information was reviewed quarterly and feedback was used to shape the service, for example, patients could choose what posters and information was displayed in the waiting room. We saw over 80% of comments were positive about healthcare.

Managers held regular patient forums which representatives from the wider prison population attended. There were terms of reference, which clearly set out the value of receiving patient feedback and being open and honest. We saw examples of positive discussions; for example, where healthcare managers discussed the value of promoting hearing aids across the wider prison. Patients could suggest ideas for waiting times and managers informed patients of a change in some medication administration, meaning some medication could no longer be kept in-possession as it could be a risk.

Managers enabled staff to develop their roles within the team and encouraged them to give feedback on how the service was being run, which ensured improvements could be suggested by the staff that understood the service. For example, in the last year staff were supported to choose a key area they would like lead in developing, such as diabetes awareness, working with the physical education staff and recruiting some prisoner representatives.

Continuous improvement and innovation

Care & Custody (Health) Limited, had made service developments and effective changes since they began providing the service. New clinical leads within the governance teams had been recruited and understood how to implement care in a prison setting.

At the start of the contract, staffing levels were reduced to reflect the terms of the contract. However, since then, additional staff had been recruited to ensure safer levels of staffing. Financial pressures were managed, and where care was compromised, immediate risks were acted upon. For example, during 2018 they recruited one full time and one part time administration worker, after they had identified current staff were unable to meet the demands of the service. Managers said there was a strong emphasis for continuous learning within the wider organisation.

Are services well-led?

Data showed that there was an average Did Not Attend (DNA) rate, of 18% at health appointments. This included all types of clinical sessions across the service. We asked for an analysis of why this rate may be high, as prisoners were able to access their appointments more easily compared to other sites. There was no action plan in place to reduce this rate and improve the service.

We saw examples where improvements to quality were recognised. Nursing staff developed a good working relationship with the local hospital to improve access to the results of clinical tests. Patients who needed a blood test, were being offered results the same or next day, as staff were able to share systems, and the results were electronically submitted by the lab. This also helped the efficiency of nurse led clinics.

The mental health team delivered in house training to the sub-contracted dental team around personality disorders and consent to treatment. This demonstrated where staff worked well and identified areas for development and improvement across the healthcare services.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Managers' oversight of the monitoring systems to ensure that emergency equipment was suitable for use, was not effective. The records monitoring process did not ensure consistency of recording care plans and access to contemporaneous patient information.