HMP Stafford

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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 well-led?	**Inspected but not rated**

Overall summary

We carried out an announced focused inspection of healthcare services provided by Practice Plus Group Health & Rehabilitation Services Limited (PPG) at HMP Stafford in response to information of concern we received about medicines management and staffing levels. Following our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) in January 2020, we found the quality of healthcare provided by PPG at this location required improvement. We issued a Requirement Notice in relation to Regulation 12, Safe care and treatment relating to medicines management.

The purpose of this focused inspection was to determine if the healthcare services provided by PPG were meeting the legal requirements of the Requirement Notice that we issued in May 2020, and to determine if the provider was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that prisoners were receiving safe care and treatment.

At this inspection we found not all required improvements had been made and the provider was not meeting the regulations in relation to medicines management. We also found additional concerns in relation to staffing and governance.

We took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering how we carried out this inspection. We therefore undertook some of the inspection processes remotely and spent less time on site. The provider consented to our remote activity to reduce inspection activity carried out on site and minimise infection risks due to the coronavirus pandemic.

We do not currently rate services provided in prisons. We highlight good practice and issues that service providers need to improve and take regulatory action as necessary.

At this inspection we found:

- Patients did not always receive their medicines in a timely way which, in some cases, had a clinical impact on their health.
- There were not always sufficient staff to safely administer medicines which caused delays and meant there were occasions when patients could not have pain relief.
- Improvements had been made to the storage and security of medicines.
- Pharmacy technicians had been allocated to designated wings which resulted in some initial improvements to medicines management, although this had not been sustained.
- The provider had experienced staffing challenges due to the coronavirus pandemic which meant they could not always allocate all shifts on the rota.
- Staff did not always receive supervision, and some felt unsupported.
- Governance systems were not always effective in assessing, monitoring and improving the quality and safety of patient care.
- Records relating to patient care and treatment were not always completed as required.

During our feedback at the end of this inspection the provider agreed to produce an action plan to address the issues covered in this report. We were assured by the evidence received that the provider had identified and begun to address the issues sufficiently and further improvements would be made in a timely manner.

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

- Patients must receive their medicines as prescribed without delays or gaps in treatment.
- Governance systems must be re-established and used to detect and act upon risks to patient care.
- Supervision and support for staff must be provided on a regular basis.

Overall summary

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

- The provider should complete their planned recruitment to vacant positions and seek to further expand the staff team so that there is sufficient cover available to provide a service that meets patients' needs.
- Local and standard operating procedures should be reviewed at appropriate intervals and staff should be aware of how these apply to their roles.

Our inspection team

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

How we carried out this inspection

We conducted a range of interviews with staff and accessed patient clinical records remotely on 2 and 3 March 2021. We carried out a shortened site visit on 4 March 2021. We conducted searches of the electronic records of patients who had been identified as having missed doses of medicines and sampled 15 patient records.

Before this inspection we reviewed a range of information that we held about the service including information we had requested from the provider when we received concerns about staffing levels and medicines. Following the announcement of the inspection we requested additional information from PPG which we reviewed.

During the inspection we spoke with:

- Three nurses
- One advanced nurse practitioner
- One GP
- One senior pharmacy team leader
- Two pharmacy technicians
- Head of Healthcare
- Deputy Regional Manager
- Regional Quality and Governance Manager

We also spoke with NHS England commissioners and requested their feedback prior to the inspection.

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

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

Background to HMP Stafford

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

Health services at HMP Stafford are commissioned by NHS England. The contract for the provision of healthcare services is held by Practice Plus Group Health & Rehabilitation Services Limited (PPG). PPG is registered with CQC to provide the regulated activities of diagnostic and screening procedures, personal care, and treatment of disease, disorder or injury.

Our previous comprehensive inspection was conducted jointly with HMIP in January 2020 and published on the HMIP website on 12 May 2020. We found a breach of Regulation 12, safe care and treatment in relation to medicines management. The report can be found at the following address:

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/05/Stafford-web-2020.pdf

Inspected but not rated

Are services safe?

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

Prior to the inspection we received information of concern relating to staffing levels and asked the provider to supply staff rotas and information relating to vacancies and staff recruitment. There were occasions where patients did not receive care and support, or it was delayed, because of insufficient staff being available.

- Despite their best efforts, the provider was not always able to ensure the actual staffing levels were as planned on the rota. The provider relied on bank and agency staff to fill shifts on a routine basis because of vacancies in the staff team. The impact of COVID meant some staff cancelled shifts due to illness or having to self-isolate. Rotas confirmed the provider was not always able to fill all shifts which impacted on the delivery of healthcare services. Recruitment was ongoing at the time of the inspection and the provider planned to review their recruitment strategy.
- When actual staffing levels had dropped below the planned level, local managers had ensured that core and essential services, such as medicines administration and the screening of patients who had just arrived at the prison, were maintained. Managers told us that urgent and essential services would always be prioritised, and that staff had pulled together as a team to cover these. For example, staff had carried out a significant number of COVID vaccinations in addition to their normal workload. When the prison experienced a large COVID outbreak staff also had to ensure they carried out observations of numerous unwell patients.
- The rotas showed that staff sometimes had to administer medicines on more than one wing of the prison, due to there being insufficient staff to cover all areas. This was confirmed by staff which meant that medicines administration was delayed for some patients.
- The member of staff assigned as 'Hotel One' (healthcare emergency responder) was sometimes also designated to administer medicines. Should they be called to attend an emergency this would disrupt the administration of medicines.
- The daytime staffing levels at the weekend were lower than during the week because there was no planned delivery of healthcare services other than medicines administration. However, staff told us that the lower staffing levels meant they could spend the majority of their time administering medicines during weekend shifts and not have the time to carry out other tasks such as completing checklists or providing social care.
- The planned staffing level for the late and night shifts was one nurse and one healthcare assistant. There had been occasions over the previous three months where there had only been one, or sometimes no staff working on these shifts due to late notice sickness. When it had not been possible to recruit a bank or agency staff member, social care delivery was impacted, because this always required two staff to be present. It also meant that night-time medicines administration (usually carried out at 8pm) had to be brought forward to 4pm so these medicines were administered too early and not in accordance with the prescriber's instructions.
- Staff we spoke with told us they felt that the planned staffing levels were not sufficient and, when there were less staff than planned, this impacted upon the delivery of services to patients. Staff felt that they were working under constant pressure and sometimes did not feel comfortable leaving work at the end of their shift.

Appropriate and safe use of medicines

At our last inspection we found that patients sometimes experienced gaps in treatment because their medicines were not ordered in a timely manner. Also, medicines were not always stored and transported around the site securely.

During this focused inspection, we found the necessary improvements had been made to the storage and security of medicines. However, patients still did not always receive their medicines in a timely way, and we saw that some patients still experienced gaps in treatment which, in some cases, impacted their health.

- Deliveries of medicines were stored in an area that could only be accessed by healthcare staff. The provider had obtained wheeled, lockable cases which staff used to transport medicines to the wing treatment rooms.

Inspected but not rated

Are services safe?

- Following our previous inspection, the provider recruited additional pharmacy staff and made pharmacy technicians responsible for medicines management on their designated wing. This had resulted in some improvements to the ordering and administration of medicines. However, the impact of a COVID outbreak at the prison and staff turnover meant that progress had stalled.
- During our inspection we identified 12 patients from our sample who had experienced gaps in treatment. There were different reasons for these delays, such as: delays in repeat prescriptions being processed, delays in placing orders with the supplying pharmacy, the time taken for the supplying pharmacy to process orders and not following up patients who did not attend to collect their medicines. Some of these patients missed doses of critical medicines such as those prescribed for heart conditions, epilepsy and diabetes. We saw that, for some patients, the missed medicines had a clinical impact on their health such as increased blood sugar levels or increased seizures.
- The administration of medicines was taking longer due to the prison being in lockdown, meaning patients were only able to collect medicines in much smaller groups. This was compounded by staff sometimes having to administer on two wings. Some patients did not receive pain relief at lunch time because sufficient time had not elapsed since the morning administration.
- Patients did not always receive medicines at the correct time because there were not always staff available to administer in the evening. Some patients were prescribed medicines to be given at 8pm, however should there be issues with night-time staffing, this was brought forward to 4pm. Those patients would receive night-time sedation and modified release medicines too early (modified release medicines are released into the body over an extended time period to provide a longer lasting therapeutic effect). The provider told us they were looking at ways to safely reduce the amount of times medicines were administered each day.
- Some action had been taken to try and reduce the burden of medicines administration on staff's time. The collection of in-possession medicines had been moved from the weekend to weekdays as managers had recognised this was placing additional pressure on staff working at weekends. A decision had been taken for staff to order all patients' prescribed medicines, whether or not patients had requested them, during the COVID outbreak at the prison. These changes had been communicated to patients.
- Feedback from staff indicated that medicines management remained an issue and they often found that patients' medicines were not available. Staff also told us that medicines administration took up a lot of their time to the detriment of other tasks that they were required to carry out.
- Prison related issues were impacting on the management of medicines. When patients first arrived at the prison, any medicines they had brought with them were placed into the property store to quarantine as a COVID precaution. The issues described above meant that some new patients had not received their medicines for several days because of the time taken to process prescriptions and place orders with the pharmacy. This meant those patients experienced a delay in receiving their medicines The Head of Healthcare was aware of and dealing with this issue.

Lessons learned and improvements made

PPG had a quality and governance team who worked closely with local managers. We reviewed minutes of various meetings relating to medicines management and local Quality Assurance and Improvement meetings and saw that issues were discussed with a view to making improvements. However, due to the COVID outbreak at the prison these meetings had been paused in September 2020 and not reconvened. This meant that trends and themes within incident reports were not discussed, and lessons and improvements were not always identified or shared with staff.

Incidents relating to medicines were not always reported in line with the provider's policy. The issues we identified about gaps in treatment for individual patients had not been reported which meant that action may not have been taken to prevent recurrence of such issues. Staff told us that they did not always have time to log incident reports due to working under pressure.

Inspected but not rated

Are services effective?

Effective staffing

The service had staffing vacancies across various primary care and pharmacy roles and was reliant on bank and agency staff to fill shifts on the rota. The staff team had been impacted by the COVID outbreak as well as the resignation of several members of staff. Staff we spoke with during the inspection described significant challenges around staffing during the coronavirus pandemic, with numerous staff unwell or isolating due to the virus from October 2020 onwards.

Recruitment was ongoing and the provider told us that they would review their recruitment strategy and consider innovative means of attracting suitable applicants. The provider was also in the process of reviewing the induction period provided to new members of staff to take into account the challenges posed by COVID and also to ensure that new starters received a suitable introduction to HMP Stafford. Some staff told us that they felt they could not always offer support to new starters because they did not have the time.

Some staff we spoke with raised concerns about a lack of support and supervision. The provider confirmed that, due to the COVID outbreak at the prison, regular clinical supervision sessions had not been happening for about six months. The Head of Healthcare also confirmed that management supervision had only been taking place sporadically and was not always recorded.

Some senior staff had accessed clinical supervision with colleagues that worked at other locations through a forum that the provider had established across the country. There had been staff wellbeing days at various points during the pandemic. Managers told us these had been initially well received but their positive impact had reduced more recently. The provider acknowledged that more could be done to integrate bank and agency members of staff into the healthcare team, such as by including them in team meetings and offering support and supervision if required.

Inspected but not rated

Are services well-led?

Leadership capacity and capability

A newly appointed Head of Healthcare had started in post shortly before our inspection and they had already identified areas where improvements were required, such as: changes to medicines administration practice and more structured staff supervision. The leadership capacity had been affected by the COVID outbreak at the prison which had reduced the visibility of managers at HMP Stafford. The provider acknowledged that more could have been done to support local managers and the staff team to navigate the challenges posed by the pandemic.

The leaders we spoke with had clear knowledge of the concerns and the capability to see through changes. The provider planned to speak with the service commissioners to seek support to expand and develop the staff team and to support the changes and improvements that were required.

Immediately following our inspection, the provider produced a comprehensive action plan which set out the steps they planned to take to address the issues identified in the report. This gave us assurance that areas for improvement had been identified and a range of short and long-term actions had been put into place.

Governance arrangements

The provider had an established governance structure including a programme of audits and reporting arrangements to the regional management and governance team. However, risks were not always identified or acted upon, meaning that risks to patient care were not always mitigated.

Incidents relating to medicines management were not always reported meaning that the provider did not have accurate information about the number or type of incidents that were occurring. The local Quality Assurance and Improvement meetings which met to review incidents and ensure lessons were learned and shared with staff had not met since September 2020 due to the COVID outbreak. This meant that any lessons learned were not identified or shared with staff to reduce the risk of similar incidents happening again.

Checklists relating to wing treatment rooms and emergency equipment checks were not completed on a regular basis. We saw that one emergency bag had not been checked on numerous occasions during the month before our site visit.

Local and standard operating procedures were not always reviewed in a timely manner and staff were not fully aware of how these applied to their role. Work had been carried out prior to our inspection to review a number of procedures that had passed their review date. Some of these were awaiting management sign-off but others had not yet been reviewed. The staff we spoke with were not always aware of these procedures or how they applied to their work.

Records relating to medicines administration were not always completed. We checked fifteen electronic patient records and saw that there were gaps where no record had been made to confirm if the medicines had been administered or not. Staff were not always able to follow up on patients who had not attended to collect medicines that they kept in-possession, including critical medicines. Should a patient not attend to collect these medicines on the designated day, records did not always show whether the patient had subsequently received these medicines.

The electronic patient record system had a task function which enabled staff to send a message to colleagues to complete a task, such as: ordering medicines or placing a patient on a waiting list. On the day of our inspection a member of staff told us there were 97 tasks open or ongoing relating to primary healthcare. It was not clear who had oversight of tasks and ensuring that they were completed and closed promptly which created the risk that a patient may not receive medication or appropriate care if the task was not actioned in a timely way.

Inspected but not rated

Are services well-led?

Managing risks, issues and performance

The provider had identified medicines management and staffing as risks for the service. PPG was sighted on the need to recruit additional staff and ensure sufficient staffing levels, however recruitment challenges for PPG in the West Midlands region, alongside the significant coronavirus outbreak within the prison impacted upon the provider's ability to address risks in a timely way.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided to service users in a safe way. In particular: Patients did not always receive their medicines in a timely way and sometimes experienced gaps in treatment because medicines were not available.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems and processes designed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk were not used effectively. In particular: Risks relating to the service provision had not always been identified or acted upon in a timely way. Medicines-related incidents were not always reported and learning from incidents was not effectively identified and shared with staff. Systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided were not effective. In particular: Systems designed to ensure equipment was present and in working order were not being utilised effectively. The provider did not maintain securely an accurate, complete and contemporaneous record in respect of

This section is primarily information for the provider

Requirement notices

each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. In particular:

Medication administration records were not always completed.

The provider did not maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity. In particular:

Management supervision meetings were not always recorded.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staff did not receive appropriate support and supervision to enable them to carry out the duties they are employed to perform.