HMP Peterborough

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

The five questions we ask and what we found

Are services safe?

We did not inspect the safe domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notice issued on 9 February 2018.

At this focused inspection we found that whilst some improvements had been made in some areas of medicines management, we identified new concerns and found evidence that medicines were still not managed properly and safely.

At this focused inspection we found that systems were in place to identify patients with long term conditions, however care plans were not in place for these patients.

Are services effective?

We did not inspect the effective domain at this inspection.

Are services caring?

We did not inspect the caring domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notice issued on 9 February 2018.

At this focused inspection we found that Sodexo Limited had taken adequate action to address the concerns identified during our last inspection, and the standard of record keeping had improved to better demonstrate that patients were involved in decision making about their care.

Are services responsive to people's needs?

We did not inspect the responsive domain at this inspection.

Are services well-led?

We did not inspect the well-led domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notice issued on 9 February 2018.

At this focused inspection we found that Sodexo Limited had taken adequate action to address the concerns identified during our last inspection in respect of complaints management. Patients could complain to healthcare confidentially, and the governance of complaints was much improved.

However, we found evidence that some governance systems and processes still did not effectively assess, monitor and improve the quality of services provided. A number of risks which we identified during our inspection, for example in relation to medicines management, had not been identified or acted upon by Sodexo Limited.

During this inspection we found that whilst some improvements had been made, in other areas the provider had not taken sufficient action to address the areas we previously identified as requiring improvement. As a result of this, we took enforcement action and issued the provider with a Warning Notice under Section 29 of the Health & Social Care Act 2008.

Action the provider MUST take to improve

- The provider must ensure that medicines are managed safely and consistently at all times across the prison.
- The provider must ensure that care plans are in place to evidence the ongoing care and treatment for patients with long term conditions.
- The provider must ensure that governance systems and processes effectively assess, monitor and improve the quality of services provided.

Our inspection team

Our inspection was carried out by one CQC health and justice inspector supported by a Her Majesty's Inspectorate of Prisons (HMIP) healthcare inspector.

At the same time a comprehensive inspection of health and social care services delivered within the male prison was carried out in partnership with HMIP.

Background to HMP Peterborough

HMP Peterborough is a local Category B prison. It is England's only dual purpose-built prison for men and women, who are kept separate at all times. The prison is located in the city of Peterborough, Cambridgeshire, and accommodates up to 360 female adult prisoners and young offenders, and 868 adult male prisoners. The prison is operated by Sodexo Justice Services.

Sodexo Limited provide primary health care and clinical substance misuse services at the prison. Sodexo Limited is registered with CQC to provide the regulated activity of Treatment of disease, disorder or injury at the location HMP Peterborough.

Our last joint inspection with Her Majesty's Inspectorate of Prisons (HMIP) was of the female side of the prison in September 2017, when we found breaches of Regulation 12, Safe care and treatment, and Regulation 17, Good governance. The joint inspection report can be found at:

A comprehensive inspection of Sodexo Limited was carried out in partnership with Her Majesty's Inspectorate of Prisons (HMIP) at HMP Peterborough between 16 and 19 July 2018. This inspection was of the male side of the prison. At the same time, we carried out a focused inspection of the female side of the prison to follow up on the breaches of Regulation 12, Safe care and treatment, identified during our September 2017 joint inspection with HMIP.

Before this focused inspection we reviewed a range of information that we held about the service, including action plans we had received from the provider in response to the Requirement Notices issued on 9 February 2018.

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

Our key findings from this focused inspection were as follows:

- Whilst some improvements had been made, medicines were not managed safely and consistently.
- Care plans were not yet in place for patients with long term conditions.
- Action had been taken to address poor standards of record keeping.
- Patients could make a confidential complaint about healthcare and the governance of the complaints system was much improved.
- Some governance systems remained ineffective and we found similar issues during this inspection to those raised during our last inspection.

We do not currently rate services provided in prisons

Are services safe?

Appropriate and safe use of medicines

At our previous inspection in September 2017 we found that medicines were not managed consistently and safely. This included:

- Medicines were not available in the necessary quantities at all times.
- The risks associated with medicines not administered as prescribed were not safely managed.
- Patients experienced delays in receiving repeat prescriptions which resulted in unacceptable gaps in treatment.

During this focused inspection we found evidence that some improvements had been made to the management of medicines;

- Medicines were available in the necessary quantities, and patients no longer experienced a delay in accessing their repeat medication.
- A new system had been introduced to allow patients to order their repeat medication in advance, which meant that patients no longer experienced unnecessary gaps in treatment.

However, we also found that medicines were not managed consistently and safely. New concerns identified during this inspection were:

- In possession risk assessments were not readily available to prescribers at the point of prescribing, and these risk assessments were not routinely reviewed.
- Pharmacy technicians did not routinely check that in possession medicines delivered to house blocks reflected the current prescription for the patient.
- Stock supplied through patient group directions (PGDs) was not labelled in line with legal requirements.
- Access to the pharmacy room was open to any staff who carried healthcare keys.
- Access to the controlled drugs (CD) cabinet was not robust. One nurse signed for the key but was seen to pass this on to another nurse with no recorded audit trail.

Risks to patients

At our previous inspection in September 2017 we found that there were no systems to ensure that people with identified needs were safely followed up in a timely manner by the appropriate healthcare professional. These included:

- The systems to identify and manage patients with long term conditions and control measures were not adequate to ensure that the risk to these patients was as low as possible.
- No care plans in place for patients with long term conditions.

At this focused inspection we found that systems had been implemented to identify patients with long term conditions, however care plans were not yet in place for these patients. Patients with a long term condition were now identified on reception in to the prison or during routine appointments with healthcare professionals. Patients were then added to newly established registers for each long term condition, which meant that nurses could monitor patients using the registers to ensure patients received appropriate ongoing care.

We found that care planning had not sufficiently improved to ensure that patients received care and treatment appropriate to their needs. Care plans were not yet in place for patients with long term conditions. A template had been added to the electronic patient record system for staff to complete; however, care plans had not yet been added which meant that it was not possible to evidence the care required for patients with long term conditions.

Are services effective?

We did not inspect the effective domain at this inspection.

Are services caring?

Involvement in decisions about care and treatment

At our previous inspection in September 2017 we found that patient records were not fit for purpose and did not always evidence that patients were involved in the decision making in relation to their care and treatment. During this inspection we found evidence that the provider had acted to address poor standards of record keeping. The standard of record keeping had improved and now provided evidence that patients were involved in decisions about their care and treatment.

Actions taken included:

- An independent audit was commissioned to identify areas of strength and weakness in relation to record keeping.
- An action plan was developed in response to the independent record keeping audit which was monitored by managers.
- Record keeping training was delivered to all staff by senior managers.

Are services responsive to people's needs?

We did not inspect the responsive domain at this inspection.

Are services well-led?

Governance arrangements

At our last inspection in September 2017 we found that monitoring and governance systems were absent or ineffective:

- Regular audits were not undertaken, and where audits had taken place the information had not been assessed and used to improve the quality and safety of services.
- Sodexo Limited had not identified where patients' safety had been compromised and had therefore not responded appropriately.

During this focused inspection we found that some action had been taken to improve audit and governance systems, however some governance systems and processes remained ineffective.

Actions taken included:

- An audit cycle had been agreed which included scheduled clinical audits over the next year.
- Some audits had been carried out in relation to record keeping and prescribed medicines, which were contributing to improvements.
- Incident investigations were carried out for all incident reports submitted and lessons learned were shared during team meetings.
- Work had been undertaken to analyse the reason for missed appointments.
- A service action plan was in progress which incorporated areas for improvement identified from our last inspection in 2017; however, this did not include any recommendations from the recent health needs analysis.

During our last inspection in September 2017 we found that the complaints system was not fit for purpose and this had not been identified by local monitoring systems. This included:

- The complaints system was not confidential,
- Responses to patient complaints were not always respectful in tone,
- Complaints were not always investigated,
- Lessons were not learned from complaints, and
- There was no quality assurance of complaints.

At this focused inspection we found evidence that planned improvements had been made and an effective complaints system was in place.

Actions taken included:

- Patients made a complaint using the prison complaints system, however confidential healthcare complaint envelopes were available for patients to use to ensure that their complaint could be kept confidential.
- Responses we sampled during this inspection were polite and respectful in tone.
- Complaints were investigated by clinical nurse managers and overseen by the head of healthcare.
- Lessons learned from complaints were analysed by the head of healthcare and shared with staff during team meetings.
- The head of healthcare quality assured all complaints to ensure they were handled appropriately.

However, we found evidence during this inspection that some governance systems and processes did not effectively assess, monitor and improve the quality of services provided. Sodexo Limited had not identified where safety had been compromised, and this was also our finding during our last inspection in September 2017.

At this inspection we found that senior clinical nurse managers did not systematically oversee nursing duties and as a result a number of risks which we identified during this inspection had not been identified or acted upon. These included:

- The nurses' cleaning and clinical room checks were not consistently completed.
- Emergency equipment was not consistently checked and we found some out of date equipment and medicines in the emergency bags.
- The Controlled Drug licence information displayed in the pharmacy showed that the licence expired in December 2016. Although senior managers assured us that a licence application was in progress, timely action had not been taken to prevent this lapse.
- There was a significant backlog of patients awaiting a secondary health screen. On 31 May 2018, the secondary screening of 250 patients were outstanding. On 11 June 2018 this had been reduced to leave 86 outstanding. A triage nurse was tasked with addressing the backlog however this process was not based on individual patient risk and was being done on a wing by wing basis. The longest waiting time for secondary health assessment was since December 2016.
- Some action had been taken in response to our September 2017 inspection of the female side of the

Are services well-led?

prison, with an action plan in place and some corresponding improvements made. However, learning from this was limited as we found similar concerns during this inspection in relation to the male side of the prison.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that 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. We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Warning Notice under Section 29 of the Health & Social Care Act 2008**

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Warning Notice under Section 29 of the Health & Social Care Act 2008**