HMIPS
HM Inspectorate of Prisons for Scotland
INSPECTING AND MONITORING

Report on Return Visit to HMP Perth
26 - 28 November 2018

Contents

Introduction and background

This report is part of the programme of inspections of prisons carried out by HM Inspectorate of Prisons for Scotland (HMIPS). These inspections contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies; known as the National Preventive Mechanism (NPM); which monitor the treatment of and conditions for detention. HMIPS is one of several bodies making up the NPM in the UK.

HM Chief Inspector of Prisons for Scotland (HMCIPS) assesses the treatment and conditions of prisoners across the Scottish Prison Service estate against a pre-defined set of standards. These Standards are set out in the document 'Standards for Inspecting and Monitoring Prisons in Scotland', published in May 2018 which can be found at https://www.prisonsinspectoratescotland.gov.uk/standards

The Standards reflect the independence of the inspection of prisons in Scotland and are designed to provide information to prisoners, prison staff and the wider community on the main areas that are examined during the course of an inspection. They also provide assurance to Ministers and the public that inspections are conducted in line with a framework that is consistent and that assessments are made against appropriate criteria. While the basis for these Standards is rooted in International Human Rights treaties, conventions and in Prison Rules, they are the Standards of HMIPS.

HMIPS assimilates information resulting in evidence-based findings utilising a number of different techniques. These include:

1. obtaining information and documents from the Scottish Prison Service (SPS) and the prison inspected;
2. shadowing and observing SPS and other specialist staff as they perform their duties within the prison;
3. interviewing prisoners and staff on a one-to-one basis;
4. conducting focus groups with prisoners and staff;
5. observing the range of services delivered within the prison at the point of delivery;
6. inspecting a wide range of facilities impacting on both prisoners and staff;
7. attending and observing relevant meetings impacting on both the management of the prison and the future of the prisoners such as Case Conferences; and
8. reviewing policies, procedures and performance reports produced both locally and by SPS headquarters specialists.

The information gathered facilitates the compilation of a complete analysis of the prison against the standards used. This ensures that assessments are fair, balanced and accurate.

This report provides a summary of the inspection findings during a return visit that took place following a full inspection that identified a number of concerns in the provision of healthcare in HMP Perth.

Overview by HM Chief Inspector of Prisons for Scotland

Introduction

When HM Inspectorate of Prisons for Scotland (HMIPS) undertook a full inspection of HMP Perth between 14 and 25 May 2018, a number of serious concerns were raised in relation to the provision of healthcare within the establishment. These concerns were such that Standard 9, Health & Wellbeing was graded as 'poor performance'.

At the time of the inspection, HMIPS deemed it necessary and appropriate to escalate these concerns to local SPS management and the external management structures of Perth and Kinross Integrated Joint Board Health and Social Care Partnership (the Partnership). These actions were undertaken to seek assurance that immediate steps would be taken to address these concerns. The details of these concerns are highlighted in the introduction to Standard 9 in the full inspection report. However, for clarity, I highlight the specific actions that were taken:

- The Partnership were asked to provide assurance that patients with physical healthcare needs in HMP Perth were being identified and appropriate care had been put in place.
- The Partnership and the SPS were asked to ensure that those prisoners who had returned from court with a change of circumstance were being reviewed by a member of the clinical team, as per the requirements of the Talk to Me Strategy.
- HIS inspectors returned to HMP Perth on 31 May 2018 for two days to assess progress made following the concerns raised during the inspection.
- The Partnership was then asked to provide an improvement action plan to address the issues highlighted one week following the return visit. Inspectors requested an update of this document one month following the return visit.
- Inspectors informed the Partnership that they would be returning to the prison in six and 18 months to assess progress.

As a result of the return visit on 31 May and 1 June, and further discussions with senior managers that took place in the establishment on 8 June, HMIPS were reassured that the SPS and the Partnership were taking appropriate actions in response to the concerns raised.

HMIPS supported by colleagues from HIS, subsequently returned to HMP Perth between the 26 and 28 November 2018 to undertake a further inspection of the healthcare provision, and will return again in late 2019 to undertake a further inspection of the healthcare provision.

This report is based on our findings during the return visit, which was undertaken between 26 and 28 November 2018. The report focusses solely on the healthcare services provided by the Partnership within the establishment.

I would like to thank the inspectors from HIS, who undertook the vast majority of the inspection activity on this occasion.

My Conclusion

It is clear that HMP Perth and Perth and Kinross Integrated Joint Board Health and Social Care Partnership, have invested and committed considerable time and resource to improve healthcare provision in the period between the full inspection in May 2018 and the return visit in November 2018. Commendable progress has been made in many of the areas highlighted in the full inspection report, and it is testament to the Partnership that the service remains committed to addressing the serious concerns raised, and improving the holistic approach to healthcare provision. I am pleased to note areas of developing good practice.

Next Steps

HMIPS and HIS recognise that it will take time to embed the improved practices, recruit the new staffing model and determine the impact on patient care of the revised working practices. The Inspectorate will return in late 2019 to allow the partnership to continue to work towards achieving their own action plan and confirm continued progress.

Wendy Sinclair-Gieben
HM Chief Inspector of Prisons for Scotland

Return visit findings

Inspectors focused on the following areas for this return visit:

- Workforce planning
- Staff competency and supervision
- Reliable identification of patients with long-term physical health conditions and their subsequent care plans
- Local management and the relationship of the Partnership
- Substance misuse
- Mental health

How we carried out the return visit

Prior to the return visit, the inspection team analysed the previous report and the improvement action plan together with the Partnership.

The inspection team spoke with staff and patients throughout the return visit and reviewed a range of documentation, care plans and other documentation such as daily records and incident reports. A focus group was held with staff so they could speak with members of the inspection team.

Summary

HMP Perth had invested and committed considerable time and resource to improve healthcare provision following the original inspection in May 2018. In the six months following the inspection, progress has been made in many of the areas highlighted in the original report and is testament to the Partnership that the service is committed to introducing change and is heading in the right direction.

However, the service still has much to do and inspectors were made aware of an ongoing critical incident that had highlighted the many challenges faced by the service in being able to deliver a comprehensive healthcare service.

Overall, inspectors recognised that although progress had been made; the impact on patient care would not be fully visible for some time as new processes and developments bedded in. The inspection team will follow up on these on the return visit in late 2019.

Governance/leadership

The Partnership has overall governance of the health services in HMP Perth as part of their hosting arrangements. The Integrated Joint Board (IJB) governance group is chaired by the chief officer and receives reports directly from the healthcare senior managers at HMP Perth. Prisoner healthcare is discussed at several groups including the HSCP Care, and Professional Governance Forum and NHS Tayside's Clinical Quality Forum. This has resulted in greater visibility of prisoner healthcare in both the Partnership and NHS Tayside, and support for improving prisoner healthcare delivery. Senior healthcare managers in HMP Perth reported having a supportive relationship with both the Partnership and NHS Tayside.

Senior managers told inspectors that developing a person-centred culture within prisoner healthcare was a key driver for change. This one-year programme of work is a joint initiative with the SPS and funding had been secured from the health and social care prisons improvement fund. This one-year programme is designed to develop practitioners as effective facilitators of sustainable practice and culture change. This was a positive development and inspectors will follow up its progress and impact on the service.

On the first day of the return visit, senior managers informed inspectors that because of a sudden increase in the number of prisoners in the prison, the Partnership had declared a critical incident. The Partnership were concerned that the increasing population of the prison had affected the healthcare team, principally the nursing teams ability to deliver safe and timeous care to those requiring healthcare services within HMPs Perth and Castle Huntly. Inspectors were told that an executive oversight group and an operational contingency group had been formed to address the potential risks associated with the increase in the prisoner population on the safety of staff and patients, and in delivering safe effective person-centred healthcare.

As HMP Perth is a local prison it is required to accept all those sent by the court. Inspectors were informed that from April to November 2018 the average prison population was 661 each day. Since the beginning of November 2018, the population had steadily increased and had risen from 654 to 703 in custody on 23 November 2018. This reflects the situation nationally, which had seen a rise in remand, short and long-term convicted prisoners. Inspectors were also informed that the reduction in those released on Home Detention Curfew, following the recent review by HMIPS and Her Majesty's Inspectorate of Constabulary in Scotland, was having an impact on the prisoner population.

The prison had an agreed operating level of 631 prisoners. This has now been adjusted to 700 prisoners due to the increase in the overall prisoner population in Scotland. The expectation by the SPS is that healthcare staffing levels are sufficient for whatever level of population is accommodated in the establishment. The Partnership had requested that HMP Perth divert prisoners away from the establishment, in order to maintain patient and staff safety. At the time of this return visit, there was no diversion of prisoners in place.

Inspectors saw evidence that the Partnership had begun to put in place systems and processes to manage the risks relating to an increase in prisoner numbers, including greater collaborative working with the SPS to provide personal protection and key training to bank/agency staff regularly working in the prison. A standard operating procedure for monitoring omissions and delays in care had also been introduced.

When inspectors asked how information about the critical incident and the Partnerships response was disseminated across staff, they were told that the NHS Tayside Associate Nurse Director and the Lead Nurse for Perth and Kinross Health and Social Care Partnership, had spoken with the staff who were on duty when they visited the prison once the critical incident had been declared. However, inspectors found that this information had not been cascaded to staff not present when the Associate Nurse Director and the Lead Nurse briefed staff. This was evident during the focus group, as some of these staff were unaware of the critical incident or what

the Partnership was doing in response. When this was raised with senior managers, they agreed that the information should have been shared.

Recommendation 1: The Partnership must ensure that all staff are kept informed about any critical incidents and their impact on the services the staff provided in the prison. This includes how decisions are made to omit or delay care, and how they should be escalated locally.

Senior managers described plans to improve the service as per the improvement plan submitted. These included:

- Strengthening links with physiotherapy, occupational therapy and the joint equipment store, to improve the availability of equipment provision to patients
- Shadowing a long-term condition clinic in primary and secondary care in the community
- Ongoing use of a pharmacy technician-led asthma clinic to help patients with their self-management
- Up-skilling of a GP by working with a neurologist regarding epilepsy management
- Ongoing improvements to documentation and record keeping

A recent reorganisation of the nurse office accommodation had meant all healthcare support workers and band 5 and band 6 nurses were working out of the one office, while all senior charge nurses worked out of another. Inspectors were told that cross-team working and communication channels had significantly improved as a result. Whereas previously band 5 nursing staff raised issues directly with the head of nursing or senior charge nurse, they were now able to approach the band 6 charge nurse in the first instance. Furthermore, senior managers told inspectors that staff were having regular one-to-one meetings with their line managers, and described the ongoing support available from within the service and Staff Wellbeing Centre.

Staffing

At the time of the return visit, 15 bank/agency shifts per week had been approved to mitigate for the three vacant posts in the primary care team. A further 20 bank/agency shifts per week had been approved for the following two weeks to address the risk associated with the increase in prisoner numbers, and also the reconfiguration of the mental health team's working hours. Inspectors were told that existing staff covered some of these shifts. Personal protection training and key training was being provided for the regular bank/agency nursing staff. Senior managers advised inspectors that they had been unable to fill all of the extra 20 shifts during the first week, following the critical incident being declared.

Senior managers advised inspectors that each morning the nurse in charge decided where best to place staff according to the staffing complement and anticipated needs of the service that day. Due to the high number of bank/agency staff working at the prison, inspectors identified that there was a potential risk of diluting the skill-mix of the permanent workforce. This was also voiced by some permanent staff who expressed concerns about being able to use bank/agency staff in a safe way to deliver health care independently, as there were not always enough permanent staff to work directly alongside them.

Recommendation 2: The Partnership must assess and manage the risks associated with the use of a significant number of bank/agency staff whilst maintaining staff and patient safety.

During the May 2018 inspection, inspectors saw evidence that staff with management responsibilities, for example senior charge nurses, were not working to their band on a regular basis. They were expected to perform tasks such as medicine administration and clinics, which were normally carried out by band 5 and band 6 nursing staff.

During the return visit, inspectors observed this had changed and that the senior charge nurses now had protected managerial time. However, inspectors were not assured that the senior charge nurses' time was being utilised to its best advantage, given the current critical incident and the resulting increased use of bank/agency staff. Permanent staff told inspectors that the increase in bank/agency staff was having a negative impact on the delivery of healthcare, and meant staff were not receiving the appropriate level of support and supervision during a time of high stress. Senior managers explained that throughout the duration of the critical incident, they assured themselves of the competencies of prisoner healthcare permanent staff, but acknowledged greater governance of bank/agency staff was required.

An increased visibility of the charge nurses across the full seven-day week will provide assurance to all clinical staff that they are being both supported in fulfilling their duties, and in identifying which tasks may be delayed or omitted. This in turn will assure the Partnership that the risks associated with this critical incident have been appropriately identified, and are being assessed and managed on a daily basis.

Recommendation 3: The partnership must ensure that during this critical incident:

- **Robust and direct supervision of all staff, including bank/agency staff is in place in clinical areas across the full seven-day week**
- **Staff are supported by a senior manager in the identification of delays and omissions in care delivery**
- **That appropriate support is provided to all staff in all aspects of their work, including the increased stress associated with working through a critical incident**
- **That the risks associated with the use of so many bank/agency staff are identified, mitigated and managed**

A number of initiatives had been introduced to better understand/manage the increasing demand for supervised medications in the prison. These included:

- A joint time and motion study of the time taken to complete medicines administration, including delays caused by patients not being presented promptly by SPS staff
- The addition of extra nursing staff to administer medicines
- The introduction of a new formulation of buprenorphine that takes considerably less time to dissolve in patients' mouths, reducing the time taken to observe this process

Senior managers stated that any bank/agency staff who are not familiar with working in the prison, would not be expected to undertake medicine administration on their 'first few' shifts. Thereafter, they would be supported by another staff member who may be a competent witness rather than a registered nurse. Due to the wide variety of medicines administered in the prison setting, it was identified that bank/agency staff may not be fully familiar with all of them. Inspectors were concerned that staff had no access to medicine information, such as the British National Formulary, at the point of medicine administration.

Recommendation 4: The Partnership must ensure that registered nurses comply with all aspects of the Nursing and Midwifery Council standard for medicines management, including having knowledge of:

- **Therapeutic uses of the medicine to be administered**
- **Normal doses of the medicine to be administered**
- **Side-effects of the medicine to be administered**
- **Precautions and contra-indications of the medicine to be administered**

Recommendation 5: The Partnership must ensure that information about medicines is available to all registered nurses at the point of administration

Inspectors observed medication administration throughout most of the prison. SPS staff were seen to stand away from the patients while they received their medicines to maintain confidentiality. Appropriate checks of the prescriptions and patients' identities were observed by inspectors.

Inspectors reviewed three controlled drug registers (CDRs) and found a number of alterations and overwriting of amounts and patient names not being written out in full. This was not in line with the Misuse of Drug Regulations 2001. There was no process in place to formally check or audit the completeness of CDRs, and inspectors were informed that ad hoc checks were carried out on occasion when topping up the supply of controlled drugs.

Inspectors reviewed the Datix reports (incident reports) for medication adverse events occurring between June and November 2018. These reports were appropriately risk-graded. However, there was no evidence of alterations or overwriting of stock balances in CDRs being identified in the Datix reports provided.

Recommendation 6: The Partnership must ensure that:

- **Controlled drug registers are completed in accordance with the requirements of the Misuse of Drug Regulations 2001**
- **That the completion of controlled drug registers is audited and all required improvements are actioned**
- **Datix reporting is carried out for all medication incidents, including alterations and overwriting in the controlled drug registers where corrections had not been appropriately documented and annotated**

Primary Care

A new electronic core dataset record had been introduced to assess all patients referred to primary care, which was aligned to a district nursing model. The record had an initial RAG-rated (red/amber/green) general nursing assessment section, which would be completed for all patients. Any patients scoring red or amber would prompt further assessments to be completed.

Some of the core dataset records had further documentation, for example a Situation, Background, Assessment, Recommendation document, completed for those with diabetes. However, individualised, person-centred, outcome-focused care plans were not in place for patients. The core dataset records and accompanying documentation were used to identify patients with long-term health conditions. They were audited weekly and compliance with completion of them had improved over the past four weeks.

A small number of patients with long-term physical healthcare needs and mobility issues were receiving enhanced care from the primary care team. Some were willing to discuss their experiences with inspectors. Despite the many challenges described by the prisoners, such as accessing appropriate bathing facilities, most reported that the healthcare they received was 'good'. However, inspectors were also told about instances when the personal care needs of an individual were discussed by staff within earshot of other prisoners, staff not introducing themselves at a multi-disciplinary meeting, and a patient not receiving appropriate chronic pain management for an underlying condition. These issues were discussed with senior managers and resulted in follow up action by the lead GP. These patients did not have a care plan in place at the time of the return visit, but the senior charge nurse for primary care confirmed that plans to introduce anticipatory care planning (a process whereby treatment and care changes as the patient's condition changes and develops) were underway. This would have been helpful in these cases.

Recommendation 7: The Partnership must ensure that person-centred, outcome-focused care plans are in place for all patients requiring enhanced care, or who are identified as benefiting from such a document. These must be written with, and agreed by, the patient.

The structure and format of twice-daily staff huddles had been reviewed in order to improve the quality, and address concerns regarding confidentiality.

Mental Health

It was evident during the return visit that the mental health team had spent time focusing and considering the barriers and challenges faced in providing a comprehensive mental health service in the prison. On reviewing the improvement plan, it was evident that the team had begun to explore ways to improve the team's effectiveness. These included:

- Reviewing and implementing clinical documentation
- Reviewing the structure and working hours of the team
- Implementing structured clinics to increase the number of patients being seen for assessment.

As many of these initiatives had only been in place for a few months, inspectors acknowledged that the full impact on patient care and on service delivery would not be evident for some time. This is an area that inspectors would be keen to return to during the return visit in 2019.

The mental health team's composition was being reviewed, with consideration being given to the structure and model of delivering a psychology service within the prison. Historically there had been long running challenges in establishing a psychological therapy service within the prison. During the return visit, inspectors were told that there was a drive by senior managers to strengthen the links with the wider NHS Tayside psychological therapy service. At the time of the visit, the clinical psychologist post was vacant and under review. Inspectors were told that there had been a successful bid for Mental Health Strategy Action 15 Funding, for two whole-time equivalent (WTE) band 7 nurse therapists. Once an agreed model of psychological therapy services had been agreed the posts would be advertised and people would be recruited.

Although the mental health nurses had secured places on a low intensity psychological therapies course during December 2018 and January 2019, given the current demands on the service and the current team composition it would be difficult for them to put into practice the skills learnt.

Recommendation 8: The Partnership must ensure that they prioritise the development and implementation of a psychological therapy service within HMP Perth

Furthermore, inspectors were advised that funding had been secured to employ 1.5 WTE mental health occupational therapists. These posts would be integral in supporting the assessment, planning and provision of the health and care needs of individual prisoners. This approach to multi-disciplinary working is good practice and inspectors look forward to seeing how these new posts develop within the prison during the next return visit.

A restructure of working hours for the mental health team had recently been introduced to improve the clinical time mental health nurses had to see patients, access supervision and training, and develop the service. Inspectors recognised that it would take time for the full impact of this change to become evident. That said, it was noted that the actual waiting times for an assessment by the mental health team had remained the same at four weeks.

Good practice: **Inspectors were encouraged to see that the mental health team had developed a suite of assessment and care planning tools that also covered psychological and social factors. This enabled staff to carry out a comprehensive assessment of patients care needs and assess their risk of harm to themselves or other people.**

Those prisoners who had returned from court with a change of circumstance were now being reviewed by a member of the clinical team, as per the requirements of the Talk to Me Strategy.

Overall, inspectors recognised that progress had been made to improve the areas highlighted in the original report, but realised that it would take time for the changes to become embedded into practice and determine the impact on service delivery and patient care.

Substance misuse service

Following the inspection in May 2018, the substance misuse team acknowledged that a review of the whole opiate replacement pathway, and more timely access to Opiate Replacement Therapy (ORT) were required. At the time, inspectors were told that this could only be achieved with additional access to non-medical prescribers (NMPs).

A review of non-medical prescribing workforce requirements within the prison setting had been completed, in line with community substance misuse services across Tayside. A bid had been submitted to Alcohol and Drug Partnerships across Tayside for government funding to secure 5.5 WTE NMPs, and to up-skill the current band 5 substance misuse registered nurses as NMPs to give the team the capacity to prescribe in addition to case management. If successful, this will improve accessibility to the service and support quicker access for patient's requiring ORT therapy.

Inspectors were encouraged that steps had been taken to reduce the length of time that patients who request to commence onto ORT therapy had to wait. Following referral, patients are now directly allocated a registered nurse for assessment.

Inspectors were told that accessing appropriate training for the substance misuse team continued to be a challenge, but the team were exploring shadowing opportunities for staff in the community.

Inspectors were encouraged to see that the service had secured a community harm reduction worker (four sessions per week) to support implementation of peer development, and 2.5 WTE health improvement advisors within the prison to support delivery of public health initiatives. Inspectors look forward to seeing the impact of these additional staff and service developments at the next return visit.

There continues to be no Patient Group Directions (PGD) for the prescription of detoxification therapy offered by appropriately trained nursing staff in the prison. This was discussed with the Specialist Clinical Pharmacist who advised inspectors that multi-disciplinary work was ongoing around this issue. A review of detoxification therapy is to be undertaken to ensure it is clinically appropriate, and the PGD for this will be introduced mid-2019. PGD for commonly used medication, for example antibiotics and common clinical condition medicines are to be introduced in February 2019.

There continues to be a lack of opportunity for multi-disciplinary discussions to review and discuss patient care. During the return visit, inspectors observed the weekly team allocation meeting. It was promising to see that all referrals were discussed, and that there was opportunity to review and discuss patients. However, the meeting was attended by substance misuse nurses and caseworkers only.

Recommendation 9: The Partnership should ensure that there are robust processes in place to enable multi-disciplinary reviews of patients referred to the substance misuse service

Inspectors were also told that a member of the substance misuse team now attends the mental health team weekly meeting to discuss those patients with co-morbidities.

Annex A

Summary of recommendations

Recommendation 1: The Partnership must ensure that all staff are kept informed about any critical incidents and their impact on the services the staff provided in the prison. This includes how decisions are made to omit or delay care, and how they should be escalated locally

Recommendation 2: The Partnership must assess and manage the risks associated with the use of a significant number of bank/agency staff whilst maintaining staff and patient safety

Recommendation 3: The partnership must ensure that during this critical incident:

- robust and direct supervision of all staff, including bank/agency staff is in place in clinical areas across the full seven-day week
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Recommendation 9: The Partnership should ensure that there are robust processes in place to enable multi-disciplinary reviews of patients referred to the substance misuse service

Annex B

Inspection team

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Annex C

Acronyms

CDRs	Controlled Drug Registers
GP	General Practitioner
HIS	Health Improvement Scotland
HMCIPS	Her Majesty's Chief Inspectorate of Prisons for Scotland
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HMP	Her Majesty's Prison
IJB	Integrated Joint Board
MHN	Mental Health Nurse
NHS	National Health Service
NMP	Non-medical prescribers
NPM	National Preventative Mechanism
OPCAT	Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment
PGD	Patient Group Directions
RAG rating	Red, Amber Green rating
SPS	Scottish Prison Service
WTE	Whole-time equivalent

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http://www.nationalpreventivemechanism.org.uk/

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