HMIPS
HM INSPECTORATE OF
PRISONS FOR SCOTLAND
INSPECTING AND MONITORING

RETURN VISIT TO HMP LOW MOSS

24-26 JANUARY 2018

Contents

Overview by HM Chief Inspector of Prisons for Scotland

Introduction

I stated in my introduction to my report on the full inspection of HMP Low Moss, undertaken between 29 May and 6 June 2017, that:

> *"In relation to the provision of healthcare, we will revisit the prison with colleagues from Healthcare Improvement Scotland early in 2018."*

This report is based on our findings during that return visit which was undertaken from 24 to 26 January 2018.

I would like to thank the Inspectors from Healthcare Improvement Scotland (HIS), who undertook the vast majority of the inspection activity on this occasion. It was pleasing to note that most of those involved also took part in the full inspection. This provided as true a reflection as possible of the changes made and the distance travelled in the intervening seven months.

Inspection Findings

What was immediately evident during the preparation for the inspection was the scale of the effort that had been made, and the volume of work undertaken since the full inspection.

It was also evident, even prior to the return visit, that NHS Greater Glasgow and Clyde (GGC), Glasgow City Health and Social Care Partnership (GCHSCP) and the local management within HMP Low Moss had responded in a positive manner to the observations, comments and criticisms contained within the full inspection report. It was pleasing to note that during the intervening seven months, work had been undertaken across a number of areas, with clear plans in place to address identified shortcomings.

Whilst not everything is yet as it should be, all parties should be commended for the work they have initiated and the improvements they have made. Special recognition should be given to the staff that work within the Health Centre. They have continued to provide a caring, humane and professional service, despite the challenges posed by the significant changes that have been implemented, and the preparations for those still to be made.

In this introduction I intend to focus on structural issues that still require to be addressed. The following section goes into detail on the progress made in specific clinical and health-related areas. However, I feel it is important to be clear and unambiguous about what has still to be done.

During the full inspection we spoke at length with NHS and Scottish Prison Service (SPS) staff, and two clear priorities emerged which both groups of staff raised with equal levels of concern:

- the failings of and frustrations derived from the paper-based 'Kardex' prescribing process; and
- the need for continuity of healthcare staff within the residential settings.

It would appear that the lack of an electronic prescribing process creates a number of issues for both staff and prisoners, and impacts on the smooth delivery of medications to patients. If a patient is to receive a medication or have that medication altered, the healthcare staff, the GP and potentially the Pharmacist need to alter the Kardex. This requires the Kardex to be physically present in each of these locations. This process necessitates the maintenance, filing and transportation of them on a regular basis; alongside all the incumbent challenges and shortcomings such a process creates.

I find it surprising that an electronic system has not been developed to remove paper from this process, with all its associated risks. I am aware that this is not just an issue within HMP Low Moss, and would challenge NHS Scotland to deliver electronic prescribing within prisons as a matter of urgency.

I am aware that considerable effort has been expended to get the complemented healthcare staff group up to strength. The importance of this must not be underestimated, and effort must continue to ensure that healthcare vacancies are minimised. NHS GGC must undertake an in-depth review to establish why staff turnover is higher than normal within HMP Low Moss, and put in place actions to mitigate this. High staff turnover potentially undermines operational stability and consistency, and can negatively impact on staff morale.

Healthcare staff were clear that if they could be consistently allocated to the same areas they would get to know their patients. This would allow them to deal with their issues more readily, and most importantly, undertake the dispensing of daily medications much more efficiently. This position was fully supported by the SPS staff working in the residential areas, who noted that when staffing was consistent, processes ran more smoothly, were completed in less time, and allowed the healthcare staff to engage in other beneficial and valued healthcare activities.

The impact of the regular mass movement of prisoners, known as the route, on the delivery of services including healthcare, is something that local SPS management should look to review. This would enable them to fully understand the impact that it has on the delivery of core activities. The route moves six times per day, during which non-operational staff, which included healthcare staff, are not permitted to move along the main interconnecting corridors. This has a significant impact on the productive time of those delivering services. Whilst the maintenance of a safe and ordered environment must be paramount, it is also vital that there is a broad understanding why such restrictions exist, and what impact they have on the delivery of a valuable and valued service. It is estimated that up to 10 productive hours can be lost during the core 8am to 4pm working week due to this restriction. It is not clear to the NHS or inspectors why such restrictions are necessary when this

situation does not occur in all other establishments. Local SPS management should review this situation, in partnership with NHS GGC and other partners, in order to find a solution to significantly reduce this considerable restriction on core and critical services.

During a period of change, it is vital that staff affected are aware of how those changes will affect them and their working environment. Both SPS and NHS staff stated that whilst they were aware that changes were being discussed, they were not always made aware, in sufficient time, of the impact those changes may have on the way they organise their activities and services. Local management must ensure that they provide sufficient time within their plans to facilitate timely and detailed communications with the staff, and where appropriate the patients that will be affected by the change. Local staff understood that change was necessary and were supportive of it, but would have appreciated more time to adjust, and to be provided with a more detailed explanation of the changes being made.

Finally and not directly related to the full inspection, is the issue of the increased number of prisoners being assessed as being under the influence. During this return visit, and in line with findings in a number of recent inspections, staff raised their concerns regarding the increasing number of prisoners being assessed as being under the influence, which staff generally attribute to Novel Psychoactive Substances or Spice. During one recent weekend, 22 individuals were assessed by medical and prison staff as displaying behaviour that was uncharacteristic or concerning. On assessment they were judged to have been under the influence of an unknown substance. During another weekend, healthcare staff had attended three prisoners who were assessed by healthcare staff as being in respiratory arrest. Staff reported that the majority of these incidents occurred at the weekend, when a far smaller number of prison and healthcare staff are on duty. This places a significant additional pressure on SPS and NHS staff alike. SPS management, at a national level, must undertake to assess and evaluate the impact that the apparent significant increase in those within their care being assessed as being under the influence is having on those working, residing and visiting prisons.

Next Steps

This report identifies a number of areas where significant progress has been made, and other areas where improvements are still outstanding. However, it is clear that the local staff and management are working to a plan, and that they have the support needed to ensure that the changes already made are sustained, and that any that are still outstanding will be sustainable once initiated. All parties involved should take credit for the manner in which they have approached the challenges they faced.

Her Majesty's Inspectorate of Prisons for Scotland (HMIPS) will continue to monitor the progress in HMP Low Moss, through regular monitoring visits undertaken by Independent Prison Monitors and Inspectors.

David Strang
HM Chief Inspector of Prisons for Scotland
23rd May 2018

Return Visit Findings – Standard 4 Health and Wellbeing

About This Report

1. This report sets out the findings from HMIPS and Healthcare Improvement Scotland's return visit to HMP Low Moss. The report focusses on the healthcare provision, specifically looking at primary care, addictions and mental healthcare.

How We Carried Out the Return Visit

2. The inspection team was made up of the Deputy Chief Inspector of Prisons, and a Senior Inspector, two Inspectors and a Clinical Partner from HIS.

3. Prior to the return visit, the team analysed the previous inspection report and the improvement action plan, along with supporting evidence provided by GCHSCP.

4. We carried out the return visit to HMP Low Moss from 24 to 26 January 2018. During this visit, the team spoke with members of staff and patients; and reviewed care plans and other documentation such as daily records and incident reports. A focus group meeting was also held to allow staff to speak with members of the inspection team.

Summary

5. Following the full inspection, GCHSCP completed an improvement action plan. The plan highlighted how they planned to improve and develop health services within the prison to meet prisoners' healthcare needs. This included the development of new processes and pathways of care, improved training and support for staff as well as recruitment, and linking this in with existing services across the partnership. During the return visit we were able to see the impact of the improvement plan and the positive progress made since the full inspection.

Staffing

6. During the full inspection the Healthcare Team faced many challenges in sustaining a consistent workforce to deliver services. Staff sickness, challenges in recruiting to key posts and retaining staff had all impacted on the range of interventions and treatments offered to patients.

7. During the return visit senior managers told us that recruitment and retention remained a challenge. Addiction nurses, primary care nurses, and a dental hygienist had all been successfully recruited. However, we were told that staff turnover was higher within HMP Low Moss compared to the other prisons within the partnership. A seconded senior nurse was also appointed to support the team to improve service delivery. An agreement was in place to "over recruit" in order to quickly fill posts and compensate for the shortfall.

8. Securing bank nurse shifts continued to be a challenge. We were told that, due to security restrictions in HMP Low Moss, bank nurses were not permitted to undertake “shadow” shifts without undertaking the full three day SPS training. This meant that bank nurses who had not yet completed the training could not visit the prison to see if the working environment was suitable for them. This was a significant obstacle to attracting potential bank nurses who were unsure of whether they wanted to work in the prison setting. We were also told of planned awareness sessions to raise the profile of healthcare roles within the prison, for nurses currently on the staff bank.

9. We were informed, and observed, that staff now had access to mandatory training and had development plans in place. There were also clear pathways and evidence to assess the clinical competencies of nursing staff to undertake their role.

10. During this visit some of the new staff were attending induction training, and due to sick absence within SPS they had not been able to complete the SPS mandatory training. This resulted in the staff only being able to carry out a restricted number of duties.

11. We were also informed that once the current primary care nurses had completed their induction training, plans were in place to move to a nurse hall based model of care. This will promote continuity of care for prisoners, with the same team of nurses providing regular care and interventions where possible. Hall nursing will also provide a rapid triage and screening system to look at all self-referrals by prisoners, for all specialities.

12. During the staff focus group meetings, staff highlighted some concerns, including the strain on all prison staff over the weekend due to an increase in the numbers of prisoners being under the influence of substances. We were told that it was not uncommon at the weekend for multiple prisoners to be suspected by healthcare and prison staff of being under the influence of unknown substances.

13. Staff told us that the time taken to respond to prisoner complaints continued to impact on the daily clinical time available. GCHSCP had developed a business case for recruiting two whole time equivalent business support posts, working across the three prisons, to manage healthcare complaints. However no decision had been reached regarding the funding of these posts.

14. GCHSCP had also developed a business case to recruit four advanced nurse practitioners to undertake some aspects of primary care, therefore reducing the demand on GP time. These posts would be shared across the three prisons within the NHS GGC boundary.

15. An improvement as a result of the GCHSCP Action Plan was the introduction of a new staff rostering system for primary care and addiction nurses. We saw that the benefit of this new roster system increased clinical activity time, and allowed more flexibility to enable staff to attend training, and receive staff supervision. We were also told that senior staff were no longer taken away from their role to support the Nursing Team to cover core duties.

16. A new system for administering medications had been introduced for addictions staff administering methadone and buprenorphine. Primary care staff administered all other supervised medications. Inspectors were told that this new system had reduced the overall time taken when administering medications to prisoners.

17. Currently, there is no electronic prescribing system available in Scottish prisons. We were told about the continued impact on time and resources as a result of having a paper system. Staff advised us that not having access to patient medication information, in a specific location, was challenging. If a prescription Kardex was not found in a specific location this could delay prisoners getting their medication. Therefore, one of the many benefits from electronic prescribing would be the reduced time spent by staff locating Kardexes. There should be no delay in medicine administration. The Healthcare Team had introduced a tracer system which could locate each Kardex. However, this system had only recently been introduced and would take time to embed into practice.

Primary Care

18. There had been a significant reduction in waiting times for prisoners to see a GP from four weeks to one week, as a result of the reorganisation of the administration process for the GP clinics as well as additional GP resource to manage the initial backlog.

19. During the return visit we were told that extra dental surgeries had been arranged to reduce the number of prisoners waiting to see the Dentist. As a result waiting times had reduced from 19 to six weeks. In addition, a Dental Hygienist had been recruited and took up post in February 2018.

20. Plans were in place for the management of prisoners with long-term conditions, including facilitating nurse-led clinics within HMP Low Moss. Diabetic clinics were already in place, and liaison with NHS GGC's managed clinical networks, meant clinical specialists were now able to support staff with their training, to enable them to run long-term condition clinics within the prisons.

Infection Prevention and Control

21. During the full inspection we described infection prevention and control audit sheets not being reliably completed. In their action plan NHS GGC provided evidence of the latest audit carried out by the Infection Prevention and Control Team. It scored 94% and was compliant with policies, procedures, environmental cleanliness and the state of the fabric of the environment.

22. During the return visit we found that the daily cleaning schedules were signed off and were complete, and the environment was clean. However, we noted that a number of staff were not adhering to the national uniform policy by wearing wrist jewellery, stoned rings and some were wearing nail polish. All of these would inhibit effective hand hygiene.

Emergency Equipment

23. During the full inspection we found that the process for checking emergency bags was not robust. A number of items in the emergency bags, including drugs, were out-of-date, yet the weekly checks of the equipment were signed as being complete. GCHSCP's Action Plan provided the prison with a new Standard Operating Procedure outlining the weekly checking procedures of all equipment and drugs kept within the emergency bags. As such, all bags should remain sealed unless used for an emergency or where the seal was already broken to check and audit the contents of the bag. During the return visit we saw that new emergency bags were now in use. Also, to minimise any confusion in an emergency, the bags around the prison were all the same with the same contents.

24. Following the full inspection we reported that not all staff were trained in the management of medical emergencies. In their Action Plan, GCHSCP stated that a programme was underway to ensure that appropriate staff completed medical emergency training or basic life support training. During the return visit we were told, and saw evidence that, all available staff had completed basic life-support training. We were also told that this training would be on-going from hereon in. This was a positive response to our full inspection findings.

25. Nationally agreed 'code red' or 'code blue' terms were used in the prison to respond to emergencies. 'Code red' relates to an emergency where the patient is bleeding and 'code blue' where the patient has breathing difficulties or is not breathing. All 'codes' are dealt with as emergencies, with nursing staff responding as quickly as possible. Healthcare staff highlighted some issues with the reporting of emergencies. We were told that sometimes a code red or blue was reported, and when staff attended there was no emergency. On other occasions, a request for a nurse to attend rather than a 'code' was made, and on arrival the patient was seen to have needed an emergency response. There is a need for clarification for SPS staff to know when a 'code' needs to be put out on the radio, and when this is not appropriate.

Health Improvement

26. During the full inspection we reported that information promoting public health-based prevention, such as the distribution of condoms, were not available to prisoners. On the return visit we were told that condoms were readily available to prisoners through clinics within the Health Centre, and by asking healthcare staff directly. We were also shown the sets of posters which had been provided to SPS staff in Kelvin and Clyde Halls for display in each flat. These posters described how to obtain condoms, information on common illicit drugs and information about Naloxone training. On visiting Kelvin and Clyde Halls we found that the posters were displayed in most floors within Clyde Hall, but in fewer floors within Kelvin Hall.

27. As all Scottish prisons move to a smoke free environment, we were encouraged to see that there was a clear strategy and plan in place to support the move to a smoke free prison. As nicotine replacement products no longer need to be prescribed, this had resulted in a positive step towards smoking cessation within prisons. Smoking cessation advisors can now check for any drug interactions

between the nicotine replacement therapy, and any medications the patient is taking. If there are no contra-indications, the smoking cessation advisor can provide smoking cessation products. We were also told that there are plans to train SPS Prison Officers as well nursing staff as smoking cessation advisors.

28. We were concerned to hear that despite there being an increase in the numbers of prisoners receiving Naloxone training and being given Naloxone kits on liberation, SPS Officers had returned a significant number of Naloxone kits as they had not been taken away by prisoners on liberation. We were advised that this was because the kit had not been included in the prisoners' belongings. To resolve this issue a review and re-introduction of an existing protocol had been agreed between SPS and healthcare to place the kits in a separate valuable bag alongside the prisoners' valuables. This system was being trialled to assess its effectiveness as a method of getting the kits home with prisoners. We were told that this process would be audited over the coming months.

Mental Health

29. Since the full inspection we were able to see that there had been many positive developments to support delivery of a mental health service in the prison.

30. The introduction of a data base for patients allocated to the Mental Health Caseload Team supported collaborative care planning for prisoners. Review dates were set following assessment and updated as clinical need required. This included evidence of psychotherapeutic treatment plans through the Structured Psychosocial Interventions in Teams.

31. The data base also clearly identified those prisoners seeking help from both the Mental Health Team and the Addiction Team, thereby demonstrating a collaborative approach to care.

32. During our meeting with the Mental Health Team we were told that there had been a clarification of their role and duties, and they now had protected time allocated for clinical supervision.

33. Improved access to psychological therapies was evident within the care plans of the Mental Health Team, together with the introduction of posts resourced through the Mental Health Innovation Fund.

34. We were also told that the triage of mental health referrals had been improved by providing a separate mental health referral. This had increased the information gathered about the reasons for a mental health referral, to allow appropriate triage. The move to a nurse hall based model of care will also provide a rapid triage and screening system for mental health referrals. This will mean that patients will have the opportunity to discuss face to face their reasons for referral with a member of the Healthcare Team.

35. A system had also been introduced to record 'self-injurious behaviour'. The attending primary care nurse would attend incidents of self-harm and complete a form which would be passed to the Mental Health Team. The Mental Health Team would then follow this up with a mental health assessment within 24 hours.

Substance Misuse Service

36. During the full inspection the Addictions Team was unable to offer its normal range of interventions and treatments due to on-going staffing shortages. Harm reduction groups had ceased and Naloxone training and kits were not being handed out to prisoners. There were also challenges in recruiting to posts. We also saw little evidence to indicate that the Mental Health Team and Addiction Team took a collaborative approach to the management of patients identified as having addictions as well as mental health issues.

37. Since the full inspection there had been a successful recruitment process and five addiction nurse posts had been filled, including an alcohol liaison post. Furthermore, an NHS GGC practice development nurse for addictions had been providing input, which meant that there was an increased focus on training and development for the Addiction Team. Training sessions with Glasgow Addiction Services and Naloxone Awareness sessions delivered by Scottish Drugs Forum had also been provided. For Naloxone, 'Training for Trainers' had been completed for 12 NHS staff, increasing the overall number of trainers.

38. It was encouraging to see that the addiction nurses received clinical supervision from a member of the Prison Healthcare Team. However, as the Team was newly established and had newly qualified nursing staff, supervision provided by an experienced addiction worker would better support the development of their skills leading to an improved service.

39. Due to the increase in staff numbers and improvements in training being provided to the team, we were told, and saw evidence that, the Healthcare Team were now able to start the implementation of the Partnerships Prison Healthcare Drug, Alcohol & Tobacco Strategy. This strategy provided a clear tiered model of service delivery and clear pathways of care, within prison healthcare for prisoners with substance misuse issues. We were also told that random spot-checks of prisoners in-possession of medication were now carried out routinely and audited.

Regime and Environment

40. We were informed that the healthcare managers and SPS colleagues met regularly to discuss operational issues. We were also told that NHS managers had requested additional staff lockers at the front gate, as only 10% of NHS staff had access to a locker. We were also concerned to hear that some NHS staff described situations where they had been verbally abused by prisoners, particularly when administering medications and the SPS Officers had not responded to this. We were told of occasions when the nurse had to ask the SPS Officer to intervene or put the prisoner 'on report'. Some staff involved in the focus group reported that they felt vulnerable at times in the prison, whilst others reported that they felt safe and that SPS staff were supportive and did intervene where necessary.

41. Some healthcare staff reported occasions when they were stopped from bringing items into the prison which had been brought in on other days. We were also given examples where bags containing confidential patient records were not allowed into the prison. On these occasions, we were told that SPS Officers requested that the patient records be placed into clear plastic bags. This would breach patient confidentiality.

42. We found that the operational needs of the establishment adversely impacted the delivery of healthcare. In particular, healthcare staff not being given advance notice of lockups, and staff not being allowed to move around the prison during the daily 'routes'. This resulted in the provision of care being stopped during this time. This stoppage equated to potentially two hours of lost clinical time every day.

43. As a matter of urgency, SPS and NHS management should review how they communicate and discuss concerns received from staff. Any concerns should be brought to the attention of management and dealt with in a timely manner, so that staff feel they are being supported.

44. As part of our inspection programme of prisoner healthcare in Scotland, Healthcare Improvement Scotland will continue to monitor the progress made to address the concerns highlighted within this report.

Annex A

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Annex B

GCHSCP	Glasgow City Health and Social Care Partnership
GGC	Greater Glasgow and Clyde
GP	General Practitioner
HIS	Healthcare Improvement Scotland
HMIPS	Her Majesty's Inspectorate of Prisons for Scotland
HMP	Her Majesty's Prison
NHS	National Health Service
SPS	Scottish Prison Service

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