

**NINA MURPHY ASSOCIATES**



**Independent Governance  
and  
Prescribing Review  
HMP Brixton**

**October 2017**

**Review Team**

Ruth Cudjoe  
Pamela Strange  
Sanjay Mistry  
Rob Jayne

**Quality Assurance**

Dr Sadru Kheraj  
Sheeylar Macey

## Table of Contents

Introduction	4
Background	4
Aims and Outputs	5
The Prison and its Population.	5
Healthcare Services	6
Task 1 - To review healthcare providers' clinical governance arrangements and assurance of quality across Primary Care, Mental Health, Substance Misuse and other services.	10
Task 2 - To review the effectiveness, quality and safety of medicines management with reference to receiving assurance to meet the requirements of Article 2	18
Task 3 - Gain assurance that there are adequate standards and safeguards in place to ensure that medications are administered safely and drug trading is considered and systems applied to reduce this.	26
Key Findings and Conclusions	32
Appendix A - Terms of Reference	35
Appendix B - Methodology	38
Appendix C - Themed Analysis of Incidents where Medication is Involved	40
Appendix D - Brixton Prison Service Improvement Plan	42
Nina Murphy Associates LLP	57



## Introduction

NHS England commissioned a review of the clinical governance of the providers of healthcare at HMP Brixton. The purpose of the review was:

- To review healthcare providers' clinical governance arrangements and assurance of quality across Primary Care, Mental Health, Substance Misuse and other services.
- To review the effectiveness, quality and safety of medicines management in particular the protocol for the prescribing of anti-psychotic and other mental health medication and its implementation in practice.
- To gain assurance that there are adequate standards and safeguards in place to ensure that medications are administered safely and drug trading is considered and systems applied to minimise this.

The full terms of reference are attached to this report as Appendix A.

## Background

The review was commissioned as a result of a report of an Independent Investigation into the Case of AC. This report had been commissioned by the Secretary of State for Justice in accordance with Article 2 of the European Convention on Human Rights.<sup>1</sup>

The Article 2 investigation related to an incident that occurred in June 2010 and identified that AC had not been prescribed antipsychotic medication that should have been provided to him.

Recommendation G of the Article 2 investigation states:

***The partners involved in providing health care to prisoners with mental health problems must be absolutely clear about which service or services have***

---

<sup>1</sup> Article 2 of the European Convention on Human Rights protects the right to life. The article contains a limited exception for the cases of lawful executions and sets out strictly controlled circumstances in which the deprivation of life may be justified.

The obligations on a State under Article 2 consist of three principal aspects: the duty to refrain from unlawful deprivation of life; the duty to investigate suspicious deaths; and in certain circumstances, a positive obligation to take steps to prevent avoidable losses of life.

***responsibility for prescribing anti-psychotic medication and develop systems to ensure it is prescribed in a timely fashion***

The full methodology used to carry out this review is set out at Appendix B.

**Aims and Outputs**

NHS England wish to gain independent assurance to understand if the systems and processes which, were introduced after the events leading up to the incident described in the Article 2 investigation, have reduced the likelihood of recurrence.

To do this we have been tasked with examining systems used in the prison and looking at the components of the current system of Clinical Governance.

Clinical governance is the system through which NHS organisations (and NHS contract holders) are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.<sup>2</sup>

We have taken an approach to look for evidence to show how specific aspects of clinical governance operate in this custodial environment.

Effective systems of governance, properly operated should provide assurance of safe practice to Care UK as providers and employers and to NHS England as a commissioner.

We represent the information provided by the prison team and where we have compared this to other information sources we have footnoted the source.

**The Prison and its Population.**

In July 2012, HMP Brixton became a resettlement prison, housing sentenced category C/D prisoners.<sup>3</sup>

The Head of Healthcare at the prison, Amanda Darville told us that in July 2017 all Category D were moved out of the prison and it now only holds Category C prisoners.

---

<sup>2</sup> Scally and Donaldson: Clinical governance and the drive for quality improvement in the new NHS in England BMJ 1998;317:61

<sup>3</sup> <http://www.justice.gov.uk/contacts/prison-finder/brixton> - updated September 2017 Checked 12<sup>th</sup> October 2017

“It has an operational capacity to hold 798 prisoners and as of 24<sup>th</sup> August 2008. It no longer serves any courts.”<sup>4</sup>

The operational capacity was noted as 810 prisoners by HM Inspectorate of Prisons in their January 2017 inspection.<sup>5</sup>

The figures supplied to the HM Inspector of Prisons inspectorate in January 2017 showed that 9% of the population was aged over 50 with a breakdown as follows:

Age range	Number	Percentage
50-59	61	8.5%
60-69	5	0.7%
70+	1	0.1%

We were told by the Head of Healthcare that there had been a recent substantial change to the prison population. She reported that in July 2017, 250 prisoners arrived at HMP Brixton over a two-week period. She estimated that 90 prisoners over the age of 65 are in G wing alone. In the prison, G wing is now used as a vulnerable prisoner’s wing with capacity for 250 prisoners.<sup>6</sup> We were told that this has resulted in an older age profile for the prisoners.

We believe that this information is accurate and that this has made a significant change in the age profile of the prison and an increased occurrence of long term health conditions within the prison population.

### **Healthcare Services**

Health care services are provided via an NHS Contract between NHS England and Care UK. On its website, Care UK describes itself as the largest independent provider of health and social care in the UK.<sup>7</sup>

The secondary mental health service is sub-contracted by Care UK to Barnet, Enfield & Haringey (BEHMHT) Mental Health Trust. BEHMT is principally a large provider of integrated mental health service to the three boroughs included in its

---

<sup>4</sup> <http://www.justice.gov.uk/contacts/prison-finder/brixton> - updated September 2017 Checked 12<sup>th</sup> October 2017

<sup>5</sup> <https://www.justiceinspectors.gov.uk/hmiprisoners/wp-content/uploads/sites/4/2017/06/Brixton-Web-2017.pdf>

<sup>6</sup> We were advised by healthcare staff that the majority are prisoners convicted of sexual offences

<sup>7</sup> <http://www.careuk.com/>

name. It also provides community services in Enfield and also a range of specialist mental health services in other areas, including HMP Brixton.<sup>8</sup>

South London and Maudsley NHS Foundation Trust also provide a small IAPT (increasing Access to Psychological Therapies) service.

This secondary mental health service has 1.2 whole time equivalent (WTE) psychiatrists, 3 Registered Mental health nurses, 1 WTE Occupational therapist, 1 WTE Assistant psychologist and 0.4 WTE Psychologist.

Care UK is the prime provider with overall clinical responsibility for the healthcare service (aside from the substance misuse psycho-social service provided by the Forward Trust) and operates an on site management structure led by a Head of Healthcare who came into post in January 2017. The Head of Healthcare is a registered mental health nurse (RMN). There was a gap of some months between the departure of the previous post holder and the arrival of the present one.

The head of healthcare is supported by a deputy, a registered general nurse, (RGN) who has recently been promoted from within the prison healthcare service.

A daily healthcare handover procedure has been instigated across the prison, this is held at lunchtime. This replaced a system of separate meetings amongst each team.

Primary care provision includes an on-site GP, Monday to Friday between 09.00 and 18.00.

The Lead GP works on Monday, Tuesday and Thursday with regular locums on Wednesday and Friday. This represents a GP establishment of 1.1 whole time equivalents. There is at present no overlap time for the lead GP and the locums to meet.

A morning surgery runs daily for two hours from 09:00 to 11:00. This provides twelve ten minute pre-bookable slots with provision for two emergency appointments.

An afternoon clinic runs for one hour and offers six appointments though additional emergency appointments may be added.

---

<sup>8</sup> <http://www.beh-mht.nhs.uk/>

This offers a total of seventy bookable appointments per week with a GP.

The Friday morning surgery is for G wing prisoners only. In addition to these appointments, the GP is also required to attend the segregation wing, which can house up to seven individuals, on a daily basis.

GP Medical input out of hours is provided by a telephone consultation service operated by Care UK. This does not include any provision for a GP to attend the prison.

Registered nurses are on site seven days per week including bank holidays from 07:30 to 18.00. There is no nursing cover available out of hours and there is no inpatient unit.

Mental Health and Substance Misuse Services are available from Monday to Friday.

There is an in-house pharmacy service available from Monday to Friday. The service is provided by two registered pharmacists.<sup>9</sup>

There are also two pharmacy technicians. Additional services provided by the pharmacists include a minor ailments clinics and smoking cessation advice. The pharmacy is staffed Monday to Friday from 08.30 to 17.00.

#### **Details of who can Prescribe in the Prison and Details of the Agreed Formulary.**

The GP, GP Locums and the Psychiatrist are all able to prescribe any medication.

The independent nurse prescriber specialising in substance misuse is able to prescribe within her scope of practice and competence.

There are also two independent prescribing pharmacists whose prescribing competencies include minor ailments and asthma. There is no specific formulary for the pharmacists to follow for these clinics. They only prescribe within their scope of practice.

---

<sup>9</sup> Pharmacist independent prescribers, can prescribe any medicine for any medical condition within their competence, including some controlled medicines (except diamorphine, cocaine and dipipanone for the treatment of addiction)  
<http://www.nhs.uk/chq/Pages/1629.aspx?CategoryID=68>

The pharmacists rely on seeing appropriately referred patients and prescribing within their competence.

We have seen no detailed clinical prescribing audits relating to conditions and individual prescribers. Such audit would provide a rich source of learning and assurance.

There is an overall Care UK preferred prescribing list.

*The Care UK Health in Justice Preferred Prescribing List and Monitoring requirements version 2.5 issue date September 2016 review date September 2018* is used to guide all prescribing.

There is monitoring of compliance with the prescribing of the preferred drugs of choice in the prescribing quality indicators data. The most recent data shows that the percentage of Care UK formulary drugs prescribed was 83.77 %. (3926 items with 3289 prescribed on the Care UK formulary)

### **External review**

HMP Brixton as with all prisons in England, is subject to periodic inspection. The most recent inspection carried out by HM Inspector of Prisons (HMIP) at an unannounced visit on the January 3<sup>rd</sup> and 4<sup>th</sup> and 9<sup>th</sup> and 13<sup>th</sup> 2017.

The inspection was carried out jointly with the Care Quality Commission (CQC), Ofsted the inspectorate for educational establishments and the General Pharmaceutical Council (GPhC).

The inspection came on the first day in post of the appointment of the new head of healthcare, this must have been immensely challenging for her and the team.

The lead organisation in this inspection is HMIP. The CQC was represented by two inspectors, unlike the inspection undertaken in the NHS there were no specialist advisers involved.

Specialist advisers are usually clinicians with understanding of the service under inspection and therefore the level of scrutiny of health care services is less clinically focussed than in the inspection of say a general practice or NHS Trust service.

Following the inspection areas identified as requiring action were added to the Brixton Prison Service improvement plan. The June 2017 update is attached at Appendix D. We refer to the action plan during this report.

**Task 1 - To review healthcare providers' clinical governance arrangements and assurance of quality across Primary Care, Mental Health, Substance Misuse and other services.**

The Healthcare Team are required to implement the systems and processes described in the Care UK Clinical Governance Policy. This policy provides clear guidance on the management of all aspects of clinical governance.

To ensure that safety, learning and prioritised action occurs all aspects of the Clinical Governance Policy guidance require implementation, supported by appropriate evidence and audit.

All Care UK services are required to hold monthly quality governance and assurance meetings that include the following items:

Safeguarding, Complaints, Incidents/SIRIs, KPIs, Patient Experience and Involvement, Mortality and Morbidity, IPC, Health and Safety, Learning and Development, Retention and Recruitment.

The reviewers had access to the notes made following the HMP Brixton Integrated Quality Assurance and Improvement meetings between June 2016 and June 2017. The following observations are made from the available information:

8 of the 12 (66%) meetings held in this period had representation from the prison service.

The quality of information contained within the notes has deteriorated over the period reviewed with minimal detail or evidence contained within each section.

The written notes make it difficult to understand the issues discussed or what action has been taken. If there are supporting reports that are discussed these have not been provided to the reviewers.

The deterioration appears to have occurred at the time the meeting template was changed in November 2016.

There is a template for the minutes which covers the topics of safeguarding, complaints, incidents (including medicines management incidents and issues),

performance (KPI's) patient experience and clinical audit for each agenda. We have not been supplied with the reports/ data submitted to these meetings.

Topics of Infection Prevention and Control, Health and Safety, Learning and Development and Recruitment and Retention issues are also meant to be discussed. There is no documentation in the meeting notes provided that any of this has occurred during 2017.

It is noted that a successful BSI ISO 9001<sup>10</sup> audit was completed in June 2016.

Clinical audits are mentioned and some outcomes briefly noted, we presume but cannot be certain that this is the main forum for their discussion.

The minutes as presented do not provide assurance of the effective delivery of the system of governance.

### **Incident Reporting and Investigation**

Incident reporting and investigation is a key component of a system of governance, assurance and learning. The review team was provided with a spread sheet detailing the incident data recorded between 1<sup>st</sup> August 2016 to 19<sup>th</sup> July 2017. An analysis of this data has been undertaken.

From the data supplied to us, we note that no incidents at all were recorded on Datix between 9<sup>th</sup> November 2016 and 7<sup>th</sup> May 2017.

We were told that one reason for the non-recording of incidents during this period was that staff were not trained to use or did not have access to the Datix system<sup>11</sup> and that this has now been resolved.

We do not know if the absence of any reported incidents over this period raised an alert on the overall Care UK performance or governance monitoring of the prison.

---

<sup>10</sup> ISO 9001 is the internationally recognized Quality Management System (QMS) standard that can benefit any size organization. Designed to be a powerful business improvement tool, ISO 9001 Quality Management certification can help you to: Continually improve, streamline operations and reduce costs. <https://www.iso.org/iso-9001-quality-management.html>

<sup>11</sup> Datix Limited is a patient safety organization that produces web-based incident reporting and risk management software for healthcare and social care organizations.

There is no discussion on the lack of incident reporting seen in the minutes of either the quality or medicines management meetings of this period.

The HMP Brixton Service improvement plan identifies a risk of low numbers of Datix incidents being reported and actions to address this included audit of the number recorded with an aim of reporting 10 a week. This approach is not congruent with the incident reporting policy.

We were told that incident reporting is now much improved and that all staff are reporting incidents. However, setting a numeric target for reporting is inappropriate as it could skew the numbers if staff were to report to increase the numbers rather than because it is an actual clinical incident.

This occurred in May 2017 when there are three recordings of prisoners declining medication. Whilst it is obviously important to record medication refusal in a medical record and to take appropriate clinical action it does not meet the criteria for a reportable incident.

In addition, there is already an agreed policy and procedure for this.

A total of 98 incidents were recorded, 19 of which were deemed to be high risk, including a death following release.

A significant number of incidents relate to missed external appointments due to unavailability of prison officer escorts, these do meet the criteria for incident reporting.

### **Medication Related Datix Reports**

There were 27 incidents relating to medication issues (excluding the reports of prisoners declining medication) between 14<sup>th</sup> September 2016 and 4<sup>th</sup> August 2017. This is based on the information supplied to us by the Head of Healthcare.

There were no incidents relating to the prescribing of anti-psychotic medication.

### **Datix incident Investigation**

All health care incidents which meet the criteria set out in the Care UK policy should be reported via Datix. Some are also reported via the prison based paper system.

We were told that currently all investigations are undertaken by the Head of Healthcare and her deputy. Both have received on line Datix training but neither have completed training in root cause analysis or any other form of incident investigation although the Head of Healthcare told us that she has many years of experience in investigation and therefore understands the principles.

This means that the same two people who have responsibility for the service enter the data, decide on the level of investigation, carry out the investigation and receive and approve the report at local level.

Others should be included in the discussion of the investigation reports such as at the quality or medicines management committees but as already noted that no assurance can be gained from the minutes of the meetings that this is taking place.

The eventual organisational sign off of the investigation should be provided by wider Care UK systems.

We were unable to scrutinise the full sign off as this requires access to the Datix system.

We were given printed copies of six completed and approved incident report forms. Five were last updated by the Deputy Head of Healthcare and one by the Regional Manager.

The majority of investigations look at the response to incidents to seek to explain these rather than actually looking for learning to prevent recurrence.

Although individual Incidents may be investigated there is currently no thematic analysis by the Brixton Healthcare Team. We note that the categorisation and sub categorisation of incidents is inconsistent making it difficult to do rapid effective analysis. Our analysis is found at Appendix C.

### **Discussion of Incident reporting**

We would observe incidents should be discussed at both the quality meeting and the medicines management meeting. There is considerable cross over of attendance at these two meetings.

We compared the numbers reported with the numbers discussed at meeting for the period where we had data from incident reporting and the minutes of the meetings, this information is presented in the table below:

Date	Datix date reported	Number noted in QA Minutes	Number noted in medicines management meeting
September 2016	2	7 noted	No minutes
October 2016	2	No Minutes	0
November 2016	0	1	2
December 2016	0	No meeting	No meeting
January 2017	0	0	No meeting
February 2017	0	0	1
March 2017	0	0	No meeting
April 2017	0	No meeting	1
May 2017	15	0	3 possibly 4 unclear note
June 2017	5	1	No meeting
July 2017	2	No notes supplied	No notes supplied
August 2017	1	No notes supplied	No notes supplied
Total	27	9	7 or 8

There is no clear link between events recorded on Datix and discussion at meetings. Our analysis of the Datix incident log shows 27 incidents in this period related directly to medication and less than a third have been noted at the appropriate meeting and an unknown number actually discussed.

In addition there is no detailed discussion of incidents recorded in the quality meeting minutes throughout 2017.

There are plans for the pharmacy team to become involved in the process of Datix reporting, particularly in incidents related to medication. The Lead Pharmacist had yet to do the relevant training; his deputy is in the process of completing the Datix training modules.

The training has provided a lot of information but does not provide practical hands on experience of how to investigate an incident.

The pharmacy has no reported dispensing incidents to discuss. The pharmacy keep a near miss record up to date which was seen to be active and in use, these are errors that are picked up during the dispensing process. These near misses are not added to Datix.

We were told that there are discussions about lessons learned at team meetings but these are not minuted.

There are plans to add an agenda item to the minutes and document discussions.

### **Effectiveness of action taken**

Lack of officer observation of medication queues was observed at the HIMP review and is noted on the risk register

During this review, we directly observed that officers were not supervising medication administration queues.

The risks of non-supervision of the administration of medication include medication being passed to another prisoner, not being taken and hoarded and of mistakes being made in administration due to chaos or distraction that can occur at the hatch when there is no one outside observing and overseeing the queue.

There are four incidents reported on Datix for the last year relating to missing medication.

The review team, directly witnessed an open trolley full of medication, including controlled drugs, being pushed through prisoner areas, by one female member of the pharmacy staff with no officer escort.

No standard operating policy (SOP) was referred to with regard to the movement of controlled drugs around the prison.

We were not able to gain assurance that the system as set out in the Care UK policy is operating effectively so that incidents are robustly investigated and issues identified and action taken in order to mitigate, as far as possible, the same situation arising again.

### **Risk Register**

There is a recently established healthcare risk register and the risks identified are detailed and appropriately documented.

There is one closed risk dated September 2016 relating to limited patient access to the GP and other clinics. The review team saw evidence that this has been satisfactorily resolved.

There are four open risks, relating to nurse recruitment and retention, lack of supervision of medicine administration queues, communication of medical results to patients and non-compliance with clinical audit. These have appropriate actions and review dates.

### **Oversight and Review of the Risk Register**

The regular review and management of the risk register is essential to good risk management and therefore patient and staff safety. The Terms of Reference for the monthly HMP Brixton Integrated Quality Assurance and Improvement meeting include:

*To review and update the risk register.*

Our scrutiny of the minutes show that there was either no access to the risk register or that it was being updated. It is therefore concluded that there had been no discussions or recognition of all the risks faced by the service at these meetings.

The Service Improvement Plan, that was last updated on 27<sup>th</sup> June 2017, identifies that the Risk Register is out of date and only the Head of Healthcare has access to it.

Where risks are noted and tracked (such as officer supervision) it is not clear what has been done to reduce the risk. Other risks were not recorded and therefore not mitigated.

### **Clinical Supervision for the Primary Care Nursing Team**

In order to test the systems and processes in place to maintain high quality and safe practice of the nurses we asked about any systems in place for direct supervision of practice to assess competency and opportunities for reflection and learning.

We were provided with the Care UK local operating plan (LOP) for supervision dated July 2017, review due June 2018. There is no ratification date. The author is the deputy head of healthcare.

There is a reference in the policy to a Care UK Clinical Supervision policy with a link to it on the Care UK intranet. We were not provided with a copy of this policy.

The LOP notes the processes that should be followed to ensure effective, regular management and reflective supervision and that it should be completed in a timely and appropriate way.

If the LOP is adhered to it would offer assurance of regular review of nursing practice including competency in the safe administration of medication and the opportunity to identify and address of any areas of poor or unsafe practice.

At the moment compliance with this LOP is work in progress. We were told that that has been much resistance within the nursing team to set up regular supervision and that as yet this is not happening. The Head of Healthcare assured us that she is monitoring the situation and expects all staff to participate in the process.

The ongoing lack of a systematic approach and compliance with supervision of clinical practice raises a concern that there is no assurance of competency among the nursing team. The systems and process in place for the mental health team, as described in the next section in contrast do offer assurance.

### **Governance of the Mental Health Service**

There is director level representation from BEHMHT at the prison Partnership Board meetings, and the team leader sits in on the daily Senior Management Team meetings with the prison.

The team leader also attends the monthly Care UK Clinical Governance meetings, as well as the regular MDT meetings and Medicines Management meetings as a matter of course.

The team, which often is additionally represented by one of the psychiatrists, attends the complex case reviews discussed in the MDT fortnightly meeting.

The minutes of the medicines management meetings show that a psychiatrist attended five of the seven meetings between June 2016 and May 2017.

The service is also subject to the governance processes of BEHMHT. We did not view any minutes of their governance meetings.

We were informed that the manager attends the relevant forums and that the relevant senior managerial roles of BEHMHT are filled by individuals who all have clinical and managerial experience of prison health care service.

This includes the medical director of the Trust, who previously provided inputs to YOI Feltham.

### **Supervision Arrangements for the Mental Health Team**

The nursing and Occupational Therapy team members have regular monthly clinical supervision sessions to a model template that BEHMHT is currently in the process of changing across all services.

They are also provided with a monthly reflective practice session, provided by an external facilitator from the Tavistock and Portman NHS Foundation Trust.

The psychologists have their own clinical supervision structure through the relevant Trust professional disciplines, as do the psychiatrists.

Ongoing professional development for each member is individualised through their annual Performance Development Review mechanism, and access to external training occurs accordingly, such as the Team Leader currently undertaking an MSc in relevant subjects.

The consultant psychiatrist currently chairs a forum of London psychiatrists, drawn from various organisations, who are working in prison environments. The team, in turn, provide mental health training within the prison, to the relevant bodies on request, such as the RAPT service, prison officers and some primary health care staff.

**Task 2 - To review the effectiveness, quality and safety of medicines management with reference to receiving assurance to meet the requirements of Article 2**

**In particular the review will examine the protocol for the prescribing of anti-psychotic and other mental health medication and its implementation in practice.**

The consultant psychiatrist established a written protocol entitled: '*Prescribing Protocol for Antipsychotic Medication*' in October 2015.

It effectively describes the process for managing the interface between the GPs, the primary care service, the substance misuse team and the secondary care mental health team.

This protocol was described to us as ‘working well’, and it identifies the structure of prescribing responsibilities across the patient journey and the mental health team processes for managing and reviewing the medication regime of anyone accepted onto their caseload.

Other services that have primary responsibility for a case can readily re-refer them to the mental health team where there were emerging difficulties with medication or mental health needs.

No actual incidents have been reported relating to prescribing issues and anti-psychotic medication, however as already described the incident management and investigation system has not been working as effectively as required.

### **Existing Diagnoses and Prescribing**

Any prisoner who is already being prescribed antipsychotic medication and medication for other mental health issues when they arrive at HMP Brixton will, through the initial reception screening process, be referred to the mental health team for a review. The aim of this review is to ensure that the administration of the medication that has already been prescribed will continue.

We were told that prisoners’ referrals to the mental health team are usual seen within 48 hours. Prisoners should arrive with 5 to 7 days’ supply of their regularly prescribed medication and there are systems in place for the review and reissue of medication by the mental health team.

The Mental Health Team have responsibility for the regular review, management and prescribing of medication and ensure regular blood testing and ECGs for those on high dose antipsychotic and depot medication

### **No existing current mental health diagnosis or prescribed mental health medication**

For prisoners without an existing mental health diagnosis the health screening template questions are asked by a nurse who may or may not have mental health training.

It was observed at a reception screening session that there is little opportunity for anything other than asking the questions and recording the answers and if the response suggests there is no problem it is accepted.

If a concern is identified this would be flagged up with the GP and consideration of opening an ACCT<sup>12</sup> would be made if appropriate.

## **Health screening for transfers into the Prison**

### **Reception Health Screening**

For those with an existing diagnosis the reception screening should establish the known health problems and ensure that appropriate referrals to the relevant health care services are made as well as making sure there is continuity in the prescribing as set up by healthcare services in the transferring prison.

Although HMP Brixton receives prisoners who are predominantly near the end of their sentences, the reception screen remains a vital portal for identification of existing or emerging mental health difficulties that warrant further inputs by experienced mental health clinicians at the earliest opportunity.

The potential exists for an individual, who might benefit from medication or other intervention, being missed at this stage of the prisoner journey.

### **The process for transfers in to access healthcare and ensuring continuity of medication**

Transfers in are scheduled to take place on Tuesdays, Wednesdays and Thursdays and are usually from 2pm onwards. Occasionally they happen on Monday and Friday but we were told this is a rare occurrence. There are on average 25 transfers every week.

All new transfers in are seen and screened by a nurse in reception before they are taken to the wing. These are all Registered General Nurses (RGNs) and at least one has a dual qualification RGN/RMN. Some are Band 5 nurses some Band 6. There is

---

<sup>12</sup> The ACCT document is a series of forms held together in a bright orange folder opened in response to concern that an individual in prison is at risk of self-harm or suicide.

a timeline for the processing of new prisoners and the aim is to get them to their wing as soon as possible.

A GP is usually on site from Monday to Friday but we noted that there are some days when there may not be, for example on the day of a review team site visit on 14<sup>th</sup> September<sup>13</sup> no GP was on site.

The GP is not based in reception at the time of the screening so communication is done by the nurse sending an electronic task message within the clinical software, usually to alert the GP of a prisoner's diagnosis e.g. a long-term condition such as diabetes or epilepsy and the need to review their medication.

Usually this is picked up and actioned by the GP who makes the relevant appointments for the patient to be reviewed and ensures that medication prescribing is continued as appropriate.

There is a recently introduced prescribing software module in the SystmOne clinical software<sup>14</sup> that has been introduced across the board as a way of reducing the risk of medication transcribing errors.

The GP is required to re-prescribe on transfer using this system to ensure accurate, ongoing authorisation of medication. This includes all medications that the prisoner was prescribed in the transferring prison.

Therefore prisoners on antipsychotic medication will have their prescription reauthorized by the GP. Referral to the mental health team is made, and they then take over.

As already described, pharmacy services are always available, Monday to Friday and would be able to dispense any prescribed medication if for some reason the prisoner has not been transferred with it and it was in stock.

Once the GP has reviewed and prescribed the medication it will be screened by the Pharmacy team and coded as having been done so.

---

<sup>13</sup> We do not know if the GP absence was investigated as an Incident. When no GP was present on 25<sup>th</sup> May 2017, an incident report was prepared on the 31<sup>st</sup> May 2017.

<sup>14</sup> SystmOne is a commercial clinical software product used throughout the prison service to provide clinical records. It has a centralised server and patient records can be made available at different sites if needed.

We saw evidence in the patient records that Pharmacy screening had been completed by the Brixton prison pharmacy.

We were told that prisoners usually arrive with their medication so there is not normally a need to arrange for any dispensing on the day of arrival although there are some occasions when this does not happen. There were two such incidents recorded on Datix for the last year although neither related to anti psychotic medication.

### **Ensuring ongoing Access to Medication on Transfer to HMP Brixton**

Most medication is brought in possession (IP) and kept by the men. Medication that is not in possession is transferred with the prisoner and handed to the nurse who then arranges for it to be taken to the wing where the prisoner will be staying.

It is then placed in the medicine cupboard in the appropriate wing treatment room.

Of the five prisoners transferred in from the Isle of Wight three were on medication two were not. The observations by the reviewer noted compliance with the above procedures.

### **Observation of the process of screening**

The team observed five prisoners being screened.

None of the five men were being prescribed any anti psychotic medication. Only one reported a history of mental health problems. He reported that he had previously been taking an antidepressant medication (citalopram) but stated that he no longer required it and had asked the GP at his previous prison to stop prescribing it. This prisoner volunteered information about his past medical history and treatment.

Questions were asked, using the template, about any previous contacts with mental health services. These seem to be focused on contacts outside the prison service before the men were seen within the prison healthcare system so the direct relevance of these at this point is unclear.

There was specific questioning about how they were feeling now to establish if there was a likelihood of self-harm.

## Healthcare Records

Transfers in are all from another prison so they will have an existing healthcare record on the SystemOne clinical software which includes medication currently prescribed, information about medical history as well as contacts with healthcare services.

The screening tool used to structure and record the initial healthcare assessment is called the *transfer screening template*. This provides a structure to questions that have to be asked and a way of recording and coding the responses.

The questions asked appear to be very similar to those that are used for first night screening for new prisoners rather than adapted for those who are already in the system and have been through a first night health assessment.

As a result, many of the questions are a repetition of what has already been asked at a previous screening, the answers to which can be found by viewing the medical record. For example, medication history and previous diagnoses such as diabetes.

We were told that the healthcare staff do not have any information about the prisoners that are due to be transferred in so no medical information about the patient is unavailable until they arrive in the prison.

The nurse is asking the prisoner to provide a medical history and an account of their medication which can be found by checking the medical record but this is not done until the template has been completed.

It is possible to move from the template to check the record and the icons such as those for medication can be clicked on and viewed. However, it does not appear to be standard practice amongst staff completing the screening to do so.

### **Observations about the process for ensuring effective information for transfers into the prison.**

We recognise that there is always a time pressure at reception and a balance to get prisoners settled in to a new environment and to carry out a review of their immediate healthcare needs.

However, the pressure due to the need to process patients within a certain timeframe allied to a data driven template entry approach to screening means that it is possible the quieter, more withdrawn prisoner who could be experiencing

a psychotic illness could be missed. The mental health professionals we talked to in this prison identified this as one of their key concerns. We would agree that the data driven template entry approach lacks clinical curiosity and could be seen as a missed opportunity for “fresh eyes” to review a prisoner.

The nurses do not seem confident enough in the use of the SystemOne software to be able to move across the record to establish medication history and the answers to other questions asked such as immunisation history and relevant medical history and diagnoses.

If they were able to do this it would make the process less tedious for both the nurse and the prisoner and make better use of the time available.

A further opportunity for review could be seen at second screening.

The screening nurse told us that the prisoners are not necessarily told about the second screening at the initial screening and that there is a high non-attendance (DNA) rate in response to an appointment being sent to them for this purpose.

The rationale given for this was that prisoners do not wish to see nurses they wish to see a GP. We did not see any data that monitors DNA rates for second reception screening.

### **How the Rationale for Prescribing is Gained and Reviewed.**

The SystemOne record is the basis for prescribing and dispensing of medication and it is evident that there is an implicit assumption that these records have been appropriately maintained at the previous prison.

There are systems in place for the review and follow up of patients on medication when they are transferred to HMP Brixton as already described.

The HMP Brixton pharmacist screens monthly prescription requests before the prescriptions are printed in the dispensary. There is clear evidence and coding associated with ‘pharmacist screened’, as part of this process the pharmacist will review the patient notes for any changes and will also ascertain whether there are any compliance issues.

The pharmacist’s prescriptions are internal prescriptions and these (unlike the FP10 prescription form widely used in the NHS) are not printed with the details of the individual prescriber.

We were told that the prescription form has been authorised for use and is legally acceptable in the prison. Prescriptions are all signed in ink by an authorised prescriber.

Initially it appeared that the only way to identify the prescriber was via recognition of the signature as the prescriptions do not contain the printed name of the prescriber.

However, the example provided to the pharmacist on the review team suggests that prescriptions are generated and printed in the pharmacy, and under the issuer heading is the name of the prescriber who can therefore be identified.<sup>15</sup> It is not entirely clear if this does precisely comply with the requirements of all prescribing legislation.

### **Medication Reviews**

Medication reviews are part of the weekly ward round caseload discussions of the mental health team.

The Care UK audit tool dealing with responsibilities and prescribing (dated 14<sup>th</sup> November 2016, completed by the pharmacists alone) does cover questions relating to Offender Health but the areas have been marked N/A on the audit. We would observe that the audit would be more effective if completed for all prescribers.

### **The process for Risk Assessing Prescribing or Ceasing Prescribing.**

There is a joint procedure to identify whether or not there is a clinical need for prescribing for those being managed by the primary care team. Concerns are raised to the doctor as tasks and can arise from the pharmacy team or nurses on ward.

The doctor would then be responsible for reviewing and assessing the need for a continued prescription. It is not clear the length in time that this process can take;

---

<sup>15</sup> Guidance (“NHS England area team HM prisons Medicines standards, health and justice commissioning, version 2, January 2014” under section 3.1 Prescription forms) states that prescription will include contact details which allow the prescriber to be contacted by the dispensing pharmacy if necessary.

however current wait periods to see a GP at HMP Brixton was reported as two to three weeks.

**Task 3 - Gain assurance that there are adequate standards and safeguards in place to ensure that medications are administered safely and drug trading is considered and systems applied to reduce this.**

**System of medication delivery including in possession systems, consider what drugs are IP, how compliance is established**

#### **Management of in possession (IP) Medication**

There is a clear system for risk assessment in place for in possession and not in possession medication and there is a points system to determine this.

For prisoners arriving who already have in possession medication this is honoured on their arrival. We were told that the IP risk assessment is done at second health screening by the nurse.

The integrated quality assurance minutes of 18<sup>th</sup> May 2017 note that IP assessment is now part of the initial screening template. As previously noted we did not have any evidence this was carried out in the cases we observed.

The Care UK Prescribing Quality Indicators Framework Data for August 2017 shows that completed IP risk assessment for those on active medication is:

Number on active medication 491.

Number of those that had an IP risk assessment 489.

Therefore 99.59 % had had an IP risk assessment.

In comparison HMP Pentonville achieved 78.4% and HMP Wormwood Scrubs 87.9%

The HMP Brixton medicines management meeting notes for April and May 2017 note IP risk assessment as 70%. We were not provided with any more recent minutes but the above data suggests that there has been a marked improvement.

We did not establish if all the IP risk assessments were reviewed at HMP Brixton or whether previous risk assessments that have been coded in the record are included.

IP risk is reviewed as the need arises, for example if a patient is found to be non-compliant with medication and the prescriber identifies that the nurses should administer the medication to ensure that it is being taken.

The GP gave an example of when a patient was thought not to be taking their medicine to control their epilepsy it was changed to not in possession in order to monitor compliance.

IP risk should also be reviewed if there is a change in circumstances such as a significant life event or there have been problems with trading / losing prescribed medication or bullying.

Nurses and pharmacists may request that the doctor reviews the IP status if they think it may be appropriate or necessary to do so.

The IP risk template is very detailed and there is an accompanying algorithm.

What is less clear is the consideration of the environmental risks. Not all cells contain a lockable cabinet, this was confirmed by the January 2017 HMIP inspection. When we asked the nurses how the prisoners secured their medication in their cells they had no clear response.

This offers a clear risk of diversion and bullying as many drugs which can be held IP may be perceived to have a tradeable value or render those who hold them vulnerable.

### **Abusable medication**

Some medications deemed a high risk are not allowed in possession in any circumstances such as controlled drugs and those that have a tradeable value. No definitive list of such drugs has been supplied to the team.

The April and May 2017 medicines management meetings minutes report on the following “abusable meds” for both months these are noted as “Mirtazapine 12%, Methadone 6% and Codeine 3%”.

We presume that the percentages represent the percentage of prisoners in receipt of these drugs. We do not know why these three drugs in particular are the focus of the report as the minutes do not make this clear.

If the figures are representative of a percentage of the prison population then based on an estimate of 800 prisoners: 96 are prescribed Mirtazapine, 48

Methadone and 24 Codeine. The report does not include other abusable drugs such as Tramadol or Pregabalin both of which are prescribed.

#### **How Requests for Drugs of Potential Abuse are Handled.**

The Care UK prescribing quality indicators latest data show that 7.34% of items prescribed were abusable medications (288 items of a total of 3926 prescribed)

The lead GP runs a pain clinic and takes responsibility for reviewing patients on abusable medication such as Pregabalin, Gabapentin and Tramadol. The aim is not to continue prescribing such medication without a clear indication for it.

The GP refers to and follows the NICE guidance on the management of neuropathic pain.<sup>16</sup>

The approach is supported by a patient information notice (PIN) which clearly sets out the approach to managing patients on such medication. This includes the information which prisoners are expected to provide.

Confirmation will be sought from patient records of hospital discharge summaries or clinic letters and without confirmation from the appropriate consultant the drug will not be prescribed.

If these drugs were prescribed in primary care the GPs will speak to the patient's own GP to gather the background information and discuss the withdrawal of the prescribing and the offering alternatives.

Complex cases are discussed at the weekly multidisciplinary team meetings and if necessary patients will be referred to appropriate specialist clinics.

The lead GP was clear that she works with the patient to establish justification of prescribing and creates a plan for the management of this such as a reducing regime with the aim to use alternative pain relief management such as physiotherapy and substitute drug therapy.

This system seems to work well but it is reliant on the rest of the GPs who provide cover when the lead GP is not there continuing with agreed plans.

---

<sup>16</sup> NICE Clinical Guideline CG96. March 2010

Before she went on her recent six weeks leave the lead GP met with the locum GP who was covering for her to bring him up to speed with all the cases asking him to consolidate the plans of reduction and prescribing decisions in her absence.

She reported that there had been some incidents while she was on leave where there was pressure not to reduce dosage and that this had not been done in her absence. For example, one patient had not continued to have his dose of Tramadol reduced as had been planned.

Discussions about cases take place at the weekly multidisciplinary team meetings which are attended by the Lead GP. They are not attended by the regular locum GPs. There is little opportunity for the Lead GP and the locums who provide regular cover to discuss cases as there is no overlap in working hours.

There is currently a discussion about the possibility of a locum GP working on a Wednesday afternoon every 2 weeks so there is some overlap and opportunity for discussion of cases.

The lead GP finds the daily lunch time multidisciplinary handover meetings with all staff a useful opportunity to have '*eyes on the ground*' from nurses and other staff who come into contact with patients who wish to be prescribed drugs of potential abuse. For example, a patient who says he has a debilitating back problem but is seen easily running upstairs.

## **Compliance**

Where medication is held not IP, nurses will be able to consider compliance. There are systems in place for the monitoring and reporting of missed medication.

The lead GP also checks compliance opportunistically whenever she sees the patient for whatever reason.

## **What Drugs are Administered and Who Administers Them**

Drugs that are not suitable for in possession and drugs for prisoners who have been risk assessed as not suitable to have IP drugs will be administered by the nursing staff.

Prisoners who are prescribed methadone have it administered daily by the substance misuse nurse in a specially designated area on the wing.

All wings have a treatment room and there is a nurse specifically allocated to work in each one every day. It is their responsibility to administer medication from the drug cupboard in the treatment room through a hatch.

Administration is done in the morning, lunch time and evening. There has been a recent change to the nurses working hours so they now start at 07:30 with the aim to have completed the medication administration by 08:45 so that the prisoners can go to their activities on time.

Prescribing is electronic and there is a computer in each treatment room for the identification of medicines to be administered and the recording of those given.

### **Safety of Medicine Administration**

Concerns about oversight of medication queues have been noted earlier in this review.

The pharmacist on the review team was concerned about the chaotic way in which medication was stored in the drug cupboard on G wing which could lead to potential drug errors if the incorrect medication was dispensed. This was raised with the head pharmacist who said he would look into it.

There have been reported incidents where staff were unable to administer medication and the issue related to either medication being returned to the wrong packet and instances where staff could not find items in the drug cupboard.

### **Identify the skill requirements for medication administration. How competency is established and recorded.**

When we asked how assurance of competency was established we were told that there is an expectation that qualified nurses are trained and competent to administer medication.

Whilst this is a skill that is learnt during nurse training, this would not normally be gained within a custodial health care setting and staff require new skills in how to safely administer medication in such an environment.

There is no formal system in place for the supervision of nurses in medication administration either observational or reflective.

The Head of Healthcare and her deputy told us they have a hands-on approach spending time on the wings with the nurses so there is opportunistic observation. As far as we are aware no records are made of any observations.

The Head of Healthcare told us that she had observed nurses counting controlled drugs without the aid of a drug tablet counter. She identified this as risky practice advised the nurses of this and has ordered tablet counters for all of the treatment rooms where controlled drugs are stored.

We were told by the deputy pharmacist that she had arranged and delivered a teaching session by for nurses in storage, recording and managing controlled drugs in response to concerns that had been identified about the processes the nurses were using.

This was a proactive response by the pharmacist who had noted the issue and responded to it rather than as a request from the Head of Healthcare after scrutiny of the systems.

### **Map the Way in which Medication is Recorded including Omissions and Refusals.**

The prisons patient medication record on SystemOne is where the dispensing of medication is recorded, this includes omissions and refusals.

Nurses should state the reason for refusal on SystemOne. It seems that it is possible to edit the system and go back and mark a missed dose as administered if a patient does not attend at the designated time.

It was observed during a visit a medication was given at a later time than was prescribed. The dose had already been marked as missed but when patient came it was changed to administered but no notes were added to explain what had happened.

There is inconsistency of practice. If medication is refused and the refusal noted on the drug chart this should remain. Whilst analysis of the audit trail on the system would identify any change, it should be apparent to all users.

If a prisoner changes their mind and then a record of the medication must be made. It is not possible to extrapolate from this small survey if staff are

consistently recording this in the same way and this should become part of regular audit.

There is a local operating protocol (LOP) about the management of repeated omission of medication. It is entitled:

*‘Managing omitted doses of medication at HMP Brixton Local operating protocol’*

Ratified 26<sup>th</sup> April 2017, review date September 2018, and authored by the pharmacy team.

This LOP is clear about what should happen. It states that when a patient misses 3 doses of not in possession (NIP) medicine in a 7 day period the nurse should in the first instance speak to the patient and find out why they are not compliant and document the response. The nurse should then send a task message to the GP about the patient’s compliance.

Adherence to the LOP should be considered at the integrated quality assurance meeting rather than ad hoc scrutiny.

The pharmacy team offers some safety netting when reviewing monthly repeat prescriptions and will flag any non-compliance to the doctor if it has not been done so already.

## **Key Findings and Conclusions**

**Task 1- To review healthcare providers’ clinical governance arrangements and assurance of quality across Primary Care, Mental Health, Substance Misuse and other services.**

Some of the elements of the process good clinical governance practice are clearly in place; such as integrated quality assurance and improvement meetings and integrated medicines management meetings with clear terms of reference.

It has not been possible to establish a system within the Care UK nursing team of regular clinical supervision for the review and monitoring of practice and to offer opportunity for reflection in order to improve practice.

The BEHMHT nursing team does appear to have a system of clinical supervision which does offer greater assurance and opportunities to challenge.

Analysis of the governance system in operation demonstrates that these processes are not fulfilling the purpose for which they exist. Key components of clinical governance including basic oversight of systems reflected in the agreed minutes of meetings, clinical audit, incident reporting and investigation, fostering an open and reflective challenge and effective risk management do not offer assurance.

A consequence of this is that the organisational culture of healthcare in the prison is inward looking and reactive. This in turn makes it difficult to drive forward effective change.

**Task 2 - review the effectiveness, quality and safety of medicines management with reference to receiving assurance to meet the requirements of Article 2**

**In particular the review will examine the protocol for the prescribing of anti-psychotic and other mental health medication and its implementation in practice.**

The joint protocol offers a clear system and allocation of responsibility for prescribing anti-psychotic medication. The system of referral and assessment appears to work smoothly.

There are systems to ensure continuation of prescribing and for the review and reauthorisation of medication as appropriate.

There is a clear system for ensuring that those with existing mental health problems continue with the administration of their prescribed medication and that they have a timely review by the in house mental health services.

For those that do not have an existing diagnosis it is vital that staff read the previous medical notes and address their assessment accordingly. Care UK should work on amendments to the initial assessment/secondary assessments to allow exploration of presenting issues to improve efficiency and effectiveness.

Whilst we have seen no numerical quantification of the take up of secondary screening, we established from a variety of sources that improvements are required. This review should alert the commissioning organisation to audit their contractual compliance against secondary assessments given the prison is not as busy as a local prison.

**Task 3 Gain assurance that there are adequate standards and safeguards in place to ensure that medications are administered safely and drug trading is considered and systems applied to reduce this.**

**System of medication delivery including in possession systems, consider what drugs are IP, how compliance is established**

#### **Management of In possession (IP) Medication**

There is a clear approach to the management of requests for drugs of potential abuse by the lead GP. We established that the approach is less consistent when GP locums are prescribing. Having a more detailed audit of prescribing followed by case based discussion would promote more consistent care.

The audits which were supplied to us appear to be uniprofessional in their approach, they reflect pharmacy practice but do not necessarily extend to the work of all prescribers. The audits we saw were mainly focussed on process and therefore should cover everyone.

The long-standing issues of lack of officer support to monitor medication queues remains a significant risk to safe drug administration. We were unable to see what action was planned to ensure that this occurred consistently.

The absence of escorts to pharmacy staff collecting controlled drugs is a significant risk to the staff and could lead to diversion. This is an issue which was acknowledged by the pharmacists and yet had not led to any incident reporting.

## **Appendix A - Terms of Reference**

### **Terms of Reference Governance and Prescribing review HMP Brixton**

#### **Introduction**

NHS England wishes to commission a review of the clinical governance of the various providers of healthcare at HMP Brixton.

- To review healthcare providers' clinical governance arrangements and assurance of quality across Primary Care, Mental Health, Substance Misuse and other services
- To review the effectiveness, quality and safety of medicines management in particular the protocol for the prescribing of anti-psychotic and other mental health medication and its implementation in practice.
- To gain assurance that there are adequate standards and safeguards in place to ensure that medications are administered safely and drug trading is considered and systems applied to reduce this.

This follows on from an independent report into the case of AC.

#### **Scope and Aim**

The review will consider the audits, systems, process, policies, protocols and procedures used by the current health and social care providers at HMP Brixton. It will have a focus on understanding how the systems operate across all providers within the prison and at an individual level for prisoners.

The aim is to understand how robust the systems are and how they provide assurance. Specifically, the review must consider the detail of the prescribing protocols and how these are applied in practice.

#### **Methodology**

A team of appropriately experienced clinicians who have experience of prison healthcare and systems of clinical governance will gather, review and assess the written policies, procedures and protocols. Members of the team including a currently external registered pharmacist will undertake a site visit to walk through the system and gather information from patient records to establish how the systems operate in practice. The team will consider the audit data from the providers and any information that shows how systems operate.

The review team will consider the complex case meeting system and review any minutes from the meeting.

The review team will also consider a sample of individual prisoner healthcare records to gain a full understanding of the granular operation of the prescribing protocols.

The review team will catalogue the prescribing leads for each organisation and details of who can prescribe in the prison and gather the details of any agreed formulary, including how requests for drugs of potential abuse are handled.

Specifically, they will examine the procedures to understand how prescribing is continued from either the outside world or other prisons, how the rationale for that prescribing is gained and reviewed. Consider the process for risk assessing prescribing or ceasing prescribing.

Review the system of medication delivery including in possession (IP) systems, consider what drugs are IP, how compliance is established in such cases.

Establish what drugs are administered and who administers medication. Identify the skill requirements for medication administration. Identify how competency is established and recorded for medication administration. Map the way in which medication is recorded, including omissions and refusals.

Targeted interviews will take place with staff within the various providers of care in the prison.

### **Outcomes**

Introduction of systemic operating procedures for the delivery of medicines optimisation and management of controlled/tradeable drugs

Clarity of skills required for the staff undertaking medicines administration

Compliance with audits set up by NHS England Health in the Justice System team in line with medicines management standards.

### **Output**

At the completion of the data collection and analysis of systems a written overview report will be provided. This should be available within 12 working days of the receipt of the final information.

The report will offer reflection on the systems and processes and will make key findings and draw conclusions.

### **Reviewers Responsibilities and Assurance**

All reviewers will consider any real or perceived conflicts of interest in this case. A declaration of no conflicts should be attached to the report.

Details of the reviewers will be appended to the report.

Reviewers provide their own administration and are liable for the costs of this.

Reviewers are liable for the associated costs of this work such as travel and subsistence. These are not chargeable to the commissioner.

Any matters which require disclosure such as safeguarding, concerns about an individual's probity, competence or behaviour will be shared with the commissioner in line with the requirements of the reviewers' registration body

## **Appendix B - Methodology**

The review was undertaken by a team of four appropriately experienced clinicians which included an external currently registered pharmacist.

The methodology applied by the team to the review was that as set out in the terms of reference.

### **Site Visits**

The full review team undertook a site visit to HMP Brixton on 14<sup>th</sup> September 2017.

The date that had been originally mutually agreed for the visit was 18<sup>th</sup> August. This was cancelled by the Head of Healthcare due to the last-minute unavailability of key managers and staff.

On 14<sup>th</sup> September, the team met with the head of health care and her manager, the senior pharmacist and the deputy of healthcare and the consultant psychiatrist. We had expected to meet with a locum GP, the lead pharmacist and the mental health team lead but they had all become unavailable and were not on site on the day of the visit.

We also met with individual nurses and pharmacy staff and attended the lunch time multidisciplinary handover meeting.

We had a walk through the healthcare centre and visited the treatment rooms on the wings and observed the administration of some lunchtime medications. We also viewed some patient records on SystemOne.

A reviewer visited the reception area where new patients attend for their initial health screening and spoke to a nurse to understand about the content of the assessment and how the screening process works in practice.

The lead reviewer carried out follow up visits on 21<sup>st</sup> and 28<sup>th</sup> September in order to meet with key staff, who had not been available at the first visit, and to ascertain further detail and explanation of some of the systems and processes in place. There was also a structured telephone interview with the lead GP on 5<sup>th</sup> October 2017 with the lead GP in the week that she returned from leave.

On 28<sup>th</sup> September the pharmacist reviewer joined the lead reviewer in a meeting onsite with the Head of Healthcare.

The mental health expert reviewer had a telephone discussion with the mental health team leader the week after the initial site visit.

In advance of the first site visit the lead reviewer requested from the head of healthcare information relating to the systems and processes in place for the team to review before the visit. Further information which had not yet been received or identified as required at the visit and not seen was also requested during and after the visit. Most of the requested information was provided some was not.

The lead reviewer channelled requests from the team for information and clarification of what we had seen and read in the information provided to us in emails to the head of healthcare, and in her absence to her deputy, throughout the process. There was some direct email communication for clarification between the pharmacist reviewer and the Lead Pharmacist.

Each reviewer wrote a report of the findings on their area of focus for the review and these were reflected in an overall report of the findings of the whole team.

Information reviewed included local operating procedures, local and national policies, protocols, procedures and standards relating to medicines management and clinical governance, minutes of meetings for clinical governance and medicines management, Datix incident reporting, medicines management audit data, risk register, service improvement plan.

## Appendix C - Themed Analysis of Incidents where Medication is Involved

### HMP Brixton Datix drug incidents 1 August 2016 - 10 August 2017

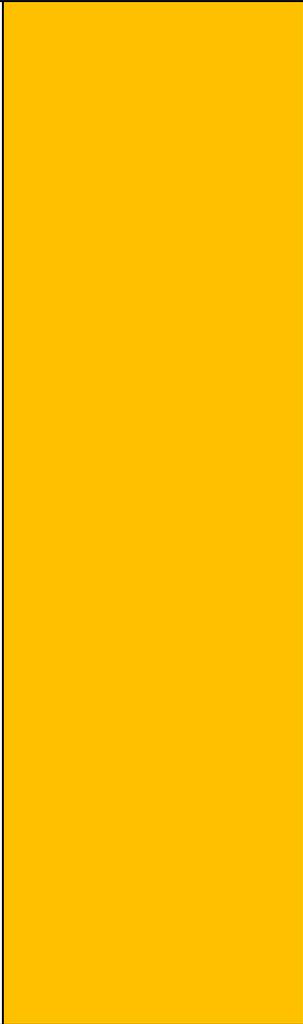
(No incident reporting from Nov 2016 - May 2017)

Type of Incident	How many	Datix ID and detail
Drug error	5	<p>W45321 - mix up with tablets patient received wrong antibiotics</p> <p>W44720 - methadone given to the wrong patient</p> <p>W46432 - Zopiclone 7.5mg x4 tablets given at hatch in error</p> <p>W48007 - given methadone when had been stopped on SystmOne but still on script</p> <p>W45178 - patient prescribed antibiotics but not administered until the next day and was admitted to hospital (KCH)</p>
Unavailability of prescribed medication on transfer	2	<p>W37582 - antiretroviral medication not sent with transferred prisoner and had to be sourced from a local hospital</p> <p>W37584 prisoner did not have prescribed medication, Propranolol and Meloxicam on transfer from HMP Pentonville. Arrived too late for prescription and dispensing to be arranged so missed evening doses.</p>
Concealed meds	2	<p>W45043</p> <p>W45142- Controlled drug</p>
Drug OD	4	<p>W45411 - antihypertensives due to lack of unlock</p> <p>W462641-Nefopam</p> <p>W47248 - 21 tablets - not identified what they were. Still being investigated</p> <p>W46077 - Aspirin and Clopidogrel</p>

Type of Incident	How many	Datix ID and detail
Missing meds	4	W38070 - Methadone 135mls stolen  W38795 - 5x2mg Buprenorphine stolen  W44559 - 6 doses of unknown meds missing  W48007 - missing Concerta tablet - still being investigated
Not checking patient ID	1	W4504 - patients getting meds with no ID and request for support denied
Meds not arrived on Wing	1	W45180 - G wing? still in DIP
Prescription expired	2	W45182 - so non-administration for 3 days  W45183 - as above different patient
Declined Meds	4	W45332  W45404 - fluoxetine  W45405  W45486
Hoarding	1	W46238 - Theophylline - toxic blood levels
Abuse to nurse while giving meds lack of support from officer	1	W45048
<b>Total</b>	<b>27</b>	

**Appendix D - Brixton Prison Service Improvement Plan**

Issue	Actions	whom	when	Update 27/06/2017	Rag
Low number of Datix being reported	<ul style="list-style-type: none"> <li>• To audit the number of datix submitted weekly for 1 month aiming for 10 a week</li> <li>• register of staff showing access</li> <li>• To discuss and review datix and any actions in the Quality Meetings.</li> </ul>	<p>Jubril</p> <p>Mandy</p> <p>Mandy</p>	July	<p>This has greatly improved with numbers reported over 40 incidents in the last 6 weeks</p> <p>completed</p>	

<p>HMP Brixton training is currently red</p>	<ul style="list-style-type: none"> <li>• Each prison shut down day staff to be given protected time to complete e –training</li> <li>• Monitor monthly and report to HOHC and performance meetings</li> <li>• Each supervisee to discuss and review in staff supervision</li> <li>• Training to be shown as green</li> </ul>	<p>Mandy/Natalie</p> <p>Jubril</p> <p>Mandy/Natalie</p> <p>Mandy</p>	<p>Monthly</p> <p>Monthly</p> <p>Monthly</p>	<p>completed</p> <p>Currently 94.1% showing green</p> <p>Update August currently 88.43%</p>	
<p>Patient satisfaction surveys are red</p>	<ul style="list-style-type: none"> <li>• Patient surveys to be green</li> <li>• Identify which clinicians are not issuing patient surveys</li> </ul>	<p>Mandy</p> <p>Mandy/Barbar</p>	<p>July</p>	<p>Currently showing green with over 135 completed for</p>	

rating	<ul style="list-style-type: none"> <li>Address any non-compliance within supervision with individual</li> <li>address with Band 6's</li> <li>Weekly target report to be delivered to HOHC and staff team</li> </ul>	<p>a</p> <p>Mandy</p> <p>Mandy</p> <p>Jubril</p>	<p>June</p> <p>June</p> <p>weekly</p>	<p>June</p> <p>To continue to monitor</p> <p>Update August Vast improvement meeting targets</p>	
Vacancy factor high at Brixton	<ul style="list-style-type: none"> <li>Recruitment call to be arranged fortnightly</li> <li>Improve vacancy factor by improving job advert</li> </ul>	<p>Mandy</p> <p>Alex/Mandy</p>	<p>May</p> <p>fortnightly</p>	<p>Completed</p> <p>Done, this is scheduled 1030 Thursday's first one is 18<sup>th</sup> May This are now scheduled in with Alex</p> <p>August Update 1-1 phonecalls now scheduled with Christie</p> <p>Advert reviewed</p>	

	<ul style="list-style-type: none"> <li>Review recruitment fortnightly</li> <li></li> </ul>	Alex/Mandy/Natalie		Completed	
<p>DQ Cquin has been identified for 2017-18</p> <p>Failure notice given for dq3, this will be repeated on the 17<sup>th</sup> July</p>	<ul style="list-style-type: none"> <li>DQ to be improved within cquin framework and failings reported to HOH weekly</li> <li>Admin to meet with Jason Randles to understand and be trained in merging documents, Duplicates and reducing the NHS numbers.</li> <li>A weekly report to be run on all areas of dq3 and immediate action taken on areas not passing</li> <li>Staff to be made aware again of the importance of their role in relation to this failure notice. To be an agenda item at the monthly staff meeting and constant reminders to be given in handovers.</li> </ul>	<p>Jubril</p> <p>Carlene</p> <p>Natalie/Jubril/Davidson</p> <p>Mandy/Natalie</p>	<p>Weekly</p> <p>Weekly</p>	<p>Meeting scheduled for 3<sup>rd</sup> July</p> <p>Update August DQ Cquin on target</p>	
Dental waiting list above national target	<ul style="list-style-type: none"> <li>Inform Time for teeth for extra sessions for 12 weeks</li> <li>Monitor wait times weekly and report to HOHC</li> <li>Report to LDP and Partnership current stats</li> </ul>	<p>Mandy</p> <p>Jubril</p> <p>Mandy</p>	Monthly	<p>Additional sessions are ongoing, next available appointment date is 28<sup>th</sup> July</p> <p>August Update Current wait time is 7 weeks. There is a backlog of the additional sessions</p>	

				due to the two shut down days per month. Dentist is aware and has scheduled them in for the next quarter.	
Healthcare regime not meeting HMP regime, administering of medicines going beyond time allocated with no supervision from prison staff	<ul style="list-style-type: none"> <li>Initial conversations to be made with residential governor</li> <li>Bring to the attention of the LDB</li> <li>Consult staff to change start and finish times if agreed by LDB</li> <li>Review how controlled substance Treatment is administered possibly using bank hca staff to work with qualified staff to administer medication</li> </ul>	Mandy	May	Completed	
		Mandy	May	Completed	
		Mandy	September	4 HCA's are going through recruitment process currently. Nursing agency also sourcing appropriate staff.	
		Mandy/Adrian	September	August Update New regime due to commence September where regime will meet both Healthcare and prison expectations.	

High volume of escorts going to secondary care	<ul style="list-style-type: none"> <li>• audit and report to HOHC types of clinics, wait times release</li> <li>• identified staff to attend relevant telemedicine training</li> <li>• discuss audit results with partnership/LDB to investigate purchasing services into prison</li> <li>• meet with Lead GP and monitor within supervision to discuss strategies for reducing escorts</li> </ul>	<p>Carlene/Nandana Mandy</p> <p>Mandy/Claire</p> <p>Mandy</p>	<p>Continue monthly</p> <p>26<sup>th</sup> June</p> <p>Monthly</p>	<p>Review September</p> <p>Completed</p> <p>September</p> <p>September</p>	
Comms not calling codes red or blue and just requesting nurse to attend	<ul style="list-style-type: none"> <li>• Raise in next safer custody meeting</li> </ul>	Mandy		Discussed with K M-C and this has improved. Review September	
Increase Nurse	<ul style="list-style-type: none"> <li>• Training audit to be completed</li> </ul>	Natalie	August	completed	

led clinics	<ul style="list-style-type: none"> <li>Investigate training available with university, address sponsored places</li> <li>Investigate bringing in clinical training in house such as suturing</li> <li>Identify the first 3 nurse led clinics required</li> </ul>	Natalie	September	Ongoing	
		Natalie	September	Ongoing	
		Natalie	September	Ongoing	
No retinopathy clinics within HMP Brixton	<ul style="list-style-type: none"> <li>Make contact with services</li> <li>Establish IT support</li> <li>Identify quantity of patients</li> <li>Establish nurse Lead</li> <li>Obtain security consent for camera</li> </ul>	Mandy/Claire	Complete	Complete	
		Mandy/Davids on	July	Email sent on 27 <sup>th</sup> June to chase up service. They were waiting for equipment to arrive end of June Email received 29/06/2016 to say	
		Mandy/Jubril/Natalie	July		
			July		

		Mandy/ Natalie  Mandy	July	delay in equipment, hope to commence September	
Nurse led clinics are limited and not meeting population needs	<ul style="list-style-type: none"> <li>• Seek HNA recommendations</li> <li>• Identify clinics that can be put into place in a timely manner</li> <li>• Those clinics that have been identified such as Secondary screen and BBV to have protected regular scheduled times.</li> </ul>	Mandy  Mandy/Natalie /Nandana  Natalie/Debbie /Maggie	July  July/August  June	Awaiting report  Awaiting report  Completed These are now scheduled on the rota	
<b>From hmip action plan</b> Designated leads should be introduced for older people and long-term conditions to support a systematic and evidence-based approach to care.	We currently run both asthma and diabetes specific clinics and have a community provider come into Brixton to provide diabetic eye screening. We will build on this by identifying two designated leads, 1 for LTC and 1 for Older Prisoners and training will be provided in both these areas. Weekly Nurse led clinics will commence for both LTC and Older prisoners. LTC register and Older Prisoner registers will be reviewed and maintained by each lead. These areas will also be overseen by the Lead G.P and will be reported to the monthly quality meetings.	Mandy/Natalie	September		

Prison staff should be trained in resuscitation skills to ensure they can respond appropriately to medical emergencies	All healthcare staff are trained in ILS including Automated external defibrillator. Healthcare attend safer custody meetings where HMPPS staff training is an agenda item. Healthcare will support Safer Custody in this area, identifying appropriate training for HMPPS staff. Reporting of the number of staff trained will take place at the Local Delivery Board.	Mandy/Kevin	Dec 2017		
Wing treatment rooms should be cleaned regularly and fulfil national infection control requirements.	We currently have an B6 Charge Nurse identified as the IPC lead for the service. Annual schedule of audits have been undertaken and outcomes are discussed at the monthly Quality Assurance meetings. Daily Cleaning schedules have been implemented and are management checked weekly. Deep cleans will be organised and undertaken every 6 months. Area's that have been identified not meeting infection control standards will be agenda items for the local delivery board for action.	IPC lead (Debbie)	September	Daily cleaning schedules are management checked regularly.  Daily schedules are management checked, Infection control audits carried out regularly with pass rates	
Reception	We will identify an assessment tool to be used at		October		

<p>screening should include identification of key issues such as social care needs and learning disabilities. Nursing staff should be proactive in their communication with reception staff in relation to key health indicators.</p>	<p>the point of reception to meet Social Care and Learning Disabilities. All nursing staff will be trained on how to use this assessment tool effectively. Joint training with prison reception staff will be undertaken to ensure staff across both disciplines have the skills to meet the needs of these individuals. Specific read codes will be allocated for all LD and social care so that these patients automatically appear on a register in order for quick identification. A LD and Social care lead will be identified and they will provide specialist interventions and care for these patients.</p>				
<p>Prisoner access to primary care, dental and hospital appointments should reflect community waiting times.</p>	<p>We have recently recruited a Data Performance Officer who will monitor and report via the monthly performance meeting the current wait times for 2 weeks and 18 weeks appointments. These targets will be monitored and reported to the Quality meetings. They will also be taken to the Local Delivery board if cancellations and delays have been unavoidable due to escorting shortages. Dentistry wait times have recently been discussed with NHSE and additional monies have been given to address the excessive wait times and to reduce to the community equivalent.</p>	<p>Jubril</p>	<p>September</p>	<p>A much improved service with the additional dental clinics, wait times are 7 weeks just out of line with community services. Monitoring continues</p>	

<p>Medication administration should be consistently and adequately supervised by prison staff, to ensure privacy and compliance, and reduce the risk of bullying and diversion.</p>	<p>Healthcare will attend the new regime and core day meetings to ensure that medication supervision at each treatment hatch is detailed within the new regime and profile. Regular meeting with the Head of Residence will take place to review the compliance. The non supervision of medications has now been placed on Healthcare's risk register and will be an agenda item within the local delivery board. Currently to reduce the risk of diversion and to mitigate risk, methadone is given and 150mls water has to be drunk in front of clinical staff. suspected diversion is recorded in the patient's medical notes and also onto the prison computer system C Nomis. All medication is not dispensed unless a prisoner has an ID card, Clinical staff are advised to request an officer before commencing medication.</p>	<p>Mandy, Natalie and Band 6's</p>	<p>October</p>	<p>HOHC attends the core day review meeting to ensure officers will be detailed for meds in the new regime</p>	<p>New regime due to commence September where this issue has been addressed</p>
<p>Prisoners with significant mental health problems should be transferred to hospital without delay.</p>	<p>Head of Healthcare will monitor and review with BEH for timely transfer to either secure hospital or a 24 hr HMPSS facility. To reduce risk to patient he will be reviewed under the ACCT process and a joint decision with HMPSS, BEH and Care UK on the management and location of the patient will be agreed whilst hospital transfer is pending.</p>	<p>Mandy/John Martins</p>	<p>October 2017</p>		
<p>Prison officers should receive mental health awareness</p>	<p>We are currently participating in a Pan London development and support programme into reducing deaths in custody. A bespoke training package is being developed for Brixton and will be aimed at</p>	<p>John Martins</p>	<p>October 2017</p>	<p>Currently had no feedback from the programme</p>	

<p>training to help them to recognise when a prisoner requires assistance from mental health practitioners.</p>	<p>officers as well as healthcare staff to equip staff with the skills to reduce the number of Death in Custody and self harm occurrences. Initial meetings have taken place and waiting for the delivery of the draft training plan. BEH have also expressed an interest in delivering Mental health awareness to operational and clinical staff. Healthcare will support BEH and Safer Custody with this training initiative and will be an agenda item within safer custody.</p>			<p>organisers.</p> <p>August update Programme is due to commence November</p>	
<p>Telemedicine is not used to its full potential</p>	<ul style="list-style-type: none"> <li>• Educate locum GP's in the provision of the service from Airedale</li> <li>• Report back to NHS Commissioner with regards to Secondary Care not accepting referrals.</li> <li>• Encourage Airedale Consultants to complete referral templates on system 1</li> <li>• Airedale provide emergency consultations out of hours, to explore if this would be a better option than the current out of hours</li> <li>• Utilise the training facility on the system with other London Prisons</li> </ul>	<p>Nandana</p> <p>Mandy/Claire</p> <p>Telemedicine operators</p> <p>Mandy</p> <p>Mandy/Nandana</p>	<p>August</p> <p>July</p> <p>August</p> <p>September</p> <p>October</p>	<p>Feedback from training session on 26<sup>th</sup> June, is that Airedale have difficulty getting consultant time for some specialities and secondary care remain reluctant to take referrals</p>	

Clinical Handovers are conducted at 10am, when nursing staff could be facilitating clinics	<ul style="list-style-type: none"> <li>• Discuss with the staff to understand the reasoning of this</li> <li>• To have one clinical handover with all departments ie mental health, pharmacy, IAPT at 1330</li> <li>• Handovers to be documented</li> <li>• Sign in register to be completed</li> </ul>	Mandy Mandy Mandy Mandy	February	Completed	
Risk Register is out of date and only HOHC has access to it	<ul style="list-style-type: none"> <li>• Risk register to be updated in quality meeting</li> <li>• Risk register to be discussed in every quality meeting</li> <li>• Risk Register to be made available to all SMT</li> </ul>	Mandy Mandy Mandy	June	Completed	
Medical results not always discussed with the patient	<ul style="list-style-type: none"> <li>• GP will discuss with patient at consultation if he will be called back to discuss results.</li> </ul>	GP	September	August Update This has been achieved however call backs are not always communicated resulting in further	

				<p>delay. GP will now pre book future appointment for feedback consultation</p>	
<p>Clinical Audit non- compliance</p>	<ul style="list-style-type: none"> <li>• Data Performance Officer to regularly update those conducting audits when these are due</li> <li>• Audit schedule to be discuss at quality meetings</li> </ul>	Jubril	September	<p>August Update Audits that have been required have been achieved. Continue to monitor</p>	

## **Nina Murphy Associates LLP**

Nina Murphy Associates LLP is the leading provider of professional services to a large list of respected clients within the Healthcare Sector.

In addition to the generic advice and reviews we offer a range of services to support any Healthcare Organization in discharging their responsibilities to patients, clinicians, commissioners, the Department of Health (DH), the Home Office, the Care Quality Commission and a variety of Ombudsmen including the Prison and Probation Ombudsman (PPO) and the Parliamentary and Health Service Ombudsman (PHSO).

We provide a service that offers evidence-based reports, in line with the specific guidance and framework for the type of care being investigated. This approach has led to the development of a replicable process for the consideration of reviews, with a standardised approach to investigation and reporting.

All of the reviewers and assurance team have specific training to undertake clinical reviews.

More information is available on our website at:

[www.ninamurphyassociates.co.uk](http://www.ninamurphyassociates.co.uk)

### **The Reviewers**

#### **Ruth Cudjoe, RGN, RSCN (NMC: 78C6380E)**

Ruth worked as a general practice nurse for 8 years and in Primary Care Organisations for 13 years, until April 2011, in clinical lead and management roles.

In addition, Ruth has acted as a PCT GP practice contract manager.

Ruth has extensive experience of undertaking reviews in a variety of settings both as an NHS employee and an independent consultant and is trained in Root Cause analysis. She is a trained clinical supervisor and has set up and run systems of reflective group and 1:1 clinical supervision across a variety of disciplines within primary and community health services. She has also undertaken death in custody reviews and was part of a team that completed quality assurance reviews of Prison Healthcare across the London region for NHSE in the summer of 2016.

**Sanjay Mistry** is an experienced pharmacist who started work in the community pharmacy setting for both independent and large multiples. Here he gained a wealth of experience as a pharmacy manager, superintendent pharmacist and developed both his clinical and practical skills. He now spends a large part of his time providing clinical services and prescribing support in the general practice setting whilst still running his private consultancy business. The business carries out audits, reviews and provides recommendations in relation to pharmacy standards and pharmacy business operations.

**Rob Jayne RMN, BSc (Hons), Doctor of Nursing.** Background in forensic psychiatry and health in the criminal justice system for 20 years, as clinician and manager. Staff nurse in Medium Secure Unit, Community Psychiatric Nurse and Manager of Criminal Justice Mental Health Team (CJMHT). Clinical Manager of Psychiatric Intensive Care Unit, Prison Mental Health In-reach Team, & CJMHT. Regional Fellow for Prison Mental Health for National Institute of Mental Health, East of England. Programme Manager for Offender Health, East of England (EoE) Strategic Health Authority (SHA). Head of Offender Health, EoE SHA. Currently providing consultancy role on aspects of health in the criminal justice system.

**Pamela Strange, RN, RCNT (NMC PIN: 7013321E)** is an experienced registered nurse skilled in all areas of patient safety, clinical governance and quality improvement and having worked in both nurse and general healthcare education. For over a decade, she worked as Director of Clinical Governance in a large, complex and financially challenged organisation, leading on the embedding of patient safety and quality improvement systems and processes at all levels of the organisation.

**SheeYLar Macey, BA (Hons) MSc RGN RSCN (NMC 82C1590E)** is a Partner of Nina Murphy Associates LLP. She is a trained general nurse, a registered sick children's nurse and specialist practitioner in primary care. She holds an MSc in primary care development.

She has also been a primary care adviser to a Health Authority, a Head of Governance to a Strategic Health Authority and a Clinical Director in primary care organisations.

Sheeylar is fully trained in root cause analysis and has extensive experience of investigations across a variety of settings including custodial care.

She is experienced in helping to develop systems and processes to assure good practice in Clinical Governance and has considerable experience of planning and delivering service innovation.

Sheeylar has undertaken Health Needs Assessments (HNAs) within prison settings and been part of both procurement and commissioning teams. She has been part of the review team in over 200 reviews in a variety of settings. Sheeylar has also undertaken statutory reviews, Individual Management Reviews including Domestic Homicide Reviews (DHRs) and Safeguarding cases.

**Dr Sadru Kheraj MA MBBS FRCGP (GMC 2915630)** is a senior partner in a large London practice. For over twelve years, he was Medical Adviser to a Health Authority and then a London Strategic Health Authority.

He has worked as an adviser for the National Clinical Assessment Service. He has also been an Associate Member of the General Medical Council. Previous work has included that of Medical Director roles to several inner city PCT in London. He was a Governing Body member of a London CCG until late 2015.

He has extensive experience of investigations, clinical assessments and investigations in primary care settings. He has experience across the breadth of the health care agenda, from service development to delivery at both a strategic and an operational level. Dr Kheraj has undertaken several independent reviews into child deaths and has considerable experience of Safeguarding issues.

He has been part of the review team in over 200 reviews. He has also undertaken domestic homicide reviews. He is also a member of the Practitioner and Stakeholder Group, which supports the work of the Independent Advisory Panel on Deaths in Custody.

He has provided expert reports for the Metropolitan Police and the General Medical Council.