HMP Onley

Inspection report

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

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services responsive to people's needs?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

We carried out a focussed announced inspection of healthcare services provided by Practice Plus Group Health and Rehabilitation Services (PPG) at HMP Onley. PPG took over the contract from the previous provider following a joint His Majesty's Inspectorate of Prisons inspection (HMIP) of the service in June 2022. At the last inspection, we found the quality of healthcare provided by the previous provider at this location required improvement. We issued Requirement Notices in relation to Regulation 12, Safe care and treatment and Regulation 17, Good governance to the previous provider.

The purpose of this inspection was to determine if the provider was meeting the legal requirements and regulations under Section 60 of the Health and Social Care Act 2008 and that prisoners were receiving safe care and treatment.

At this inspection we found that some improvements had been made, however we found that improvements were required in other areas.

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

At this inspection we found:

- Staffing levels within the mental health team were not sufficient to meet the demand in a timely manner.
- There was a backlog of applications requiring triage by the mental health team, although action had been planned to address this.
- Patients on the mental health team caseload did not always receive timely support, some patients received regular reviews and had a comprehensive care plan. Other patients had not been seen since their initial triage appointment and had no care plan in place.
- Oversight of subcontracted providers was good, with regular meetings and monitoring of waiting times.
- Improvements had been made in many areas of medicines management.
- Medicines fridge temperatures were not always recorded each day. Action had not been taken to safeguard medicines where temperatures were out of the recommended range.

The provider must:

- Ensure that staffing levels in the mental health team are increased so they can meet patient needs in a timely way.
- Ensure that medicines are stored according to manufacturer's guidance and action is taken to safeguard medicines supplies in line with the provider's medicines policy.
- Ensure that blood glucose monitoring equipment is managed appropriately.

Our inspection team

Our inspection team was comprised of two CQC health and justice inspectors and one CQC medicines optimisation inspector.

How we carried out this inspection

We conducted interviews with staff and the head of healthcare and accessed patient clinical records on 31 October 2023. We also looked at waiting lists for mental health services.

Before this inspection we reviewed a range of information that we held about the service including notifications and action plan updates. Following the announcement of the inspection we requested additional information from PPG which we reviewed. Documents we reviewed included:

- Meeting minutes
- Medicines policies and incident reports
- Information relating to recruitment and a staffing profile
- Staff rotas
- The provider's action plan submitted after the previous inspection.

Background to HMP Onley

HMP Onley is a Category C training and resettlement prison which accommodates up to 742 men with varying sentences. The prison is located in a rural area near Rugby and is operated by His Majesty's Prison and Probation Service.

Health services at HMP Onley are commissioned by NHS England. The contract for the provision of healthcare services is held by PPG, who took over service provision after the last inspection. PPG is registered with CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

Our previous comprehensive inspection was conducted jointly with HMIP in June 2022 and published on the HMIP website in September 2022. We found a breach of Regulation 12, Safe care and treatment and Regulation 17, Good governance and issued requirement notices to the previous healthcare provider.

https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2022/09/Onley-web-2022.pdf

Inspected but not rated

Are services safe?

Safe and effective staffing

Staffing in the mental health team was not sufficient to meet the needs of the population. Between 11 September and 22 October 2023 there were 18 days where there was only one mental health nurse on duty, and 6 days where there were no mental health nurses available. There were 2 substantive and 1 agency mental health nurse which meant there was little resilience to cover for sickness and annual leave. There was a clinical lead for the mental health team, as well as an art therapist and 2 learning disability nurses who each worked two days per week at HMP Onley.

Referrals to the mental health team could be made by any member of staff in the prison or by patients. These were triaged by the mental health team to check for any urgent need. Staff could not always assess routine referrals within the 5 day target and there were 86 patients on the waiting list awaiting triage, although it wasn't apparent how long they had been waiting for. A 'triage week' was planned for after the inspection to reduce the backlog.

Patients deemed as requiring ongoing mental health support did not always receive this due to staffing pressures. Patients were added to the caseload of a member of the team at allocations meetings. We reviewed a sample of 6 patient records and saw that 3 of those patients received regular reviews and had detailed care plans in place. However, 3 patients had not been seen since their initial triage review, and 2 did not have a care plan in place. Therefore, it wasn't clear how often they should be seen.

Medicines optimisation

Pharmacy staff had been unable to carry out compliance checks of patients who kept their medicines in possession in their cell due to their staffing levels. A pharmacist and pharmacy technician had been recruited and were undergoing employment checks prior to commencing their role.

Medicines were prescribed by prison clinicians. Pharmacy staff arranged for the prescriptions to be dispensed off site and delivered to the prison by a pharmacy contractor via a service level agreement. Medicines reconciliation was undertaken by pharmacy technicians following initial reception screening and prescribing was tasked to one of the GPs.

Due to staffing shortages patients were unable to arrange appointments with a member of the pharmacy team. The head of healthcare had developed a plan to implement an appointment system once the new pharmacist was in post.

Staff had implemented an omitted doses clinic system to prompt patients when doses had been missed to encourage them to collect their in-possession medicines.

Clinical staff had failed to act on fridge temperatures which were outside of the required range which meant that there was a risk medicines could be affected and impact on a patients' well-being.

Staff had implemented stock control systems and prescriptions, orders and delivery notes were stored appropriately. We found that arrangements in place to track the prescribing and administration of controlled drugs and to ensure a log was maintained of all controlled drug stationary.

Prior to COVID, a system had been in place for cell checks however this had not been restarted due to staff shortages. Which increased the risk patients were not taking their medicines as prescribed.

At this inspection, we found that equipment to monitor blood sugar levels was not being managed appropriately. This meant that the provider could not be assured that blood glucose readings were accurate.

Inspected but not rated

Are services safe?

Medicines management policies were under review as they were not always service specific. We were informed that policies were due to be reviewed and updated as required.

Inspected but not rated

Are services responsive to people's needs?

Equity in access

Patients requiring routine mental health support did not always receive this in a timely way. Triage assessments were taking longer than the 5 day target which meant there was a risk that their mental health could deteriorate in the meantime.

Patients that were on the caseload of a mental health nurse were not always seen in line with their care plan. Two patients had not been seen in the 6 to 8 week period since their triage assessment and had no care plan in place.

Inspected but not rated

Are services well-led?

Governance, management and sustainability

Patients on the mental health team's caseload were assigned to a member of the team who assumed responsibility for their ongoing care and reviews. However, oversight of the caseloads wasn't sufficient as we saw that not all patients were seen in line with the frequency stated in their care plan. Some patients did not have a plan of care in place at all which meant it was unclear what support they required. Actions that stemmed from a review with a patient, such as referral to the psychiatrist, were not always carried out.

There was good oversight of subcontracted providers which involved contract review meetings and more informal support. PPG had worked with the dental provider to bring in an additional dental session each week to clear a backlog on the waiting list.

There had been many improvements to pharmacy services, driven by a detailed action plan and audits of pharmacy provision. However, systems to monitor the medicines fridge temperatures were not being operated effectively. Staff were logging maximum temperatures above the recommended range, no action had been taken to rectify this. The fridges contained vaccinations, and some had been given to patients. The provider took advice from the manufacturer regarding the use of vaccinations that had been exposed to temperatures above the recommended range and ordered replacement stock after our inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was not a sufficient number of staff in the mental health team to ensure patients received timely assessment and ongoing care and treatment.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems and processes designed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk were not used effectively. In particular: Actions were not taken to safeguard medicines where fridge temperatures were out of range. Oversight of the mental health team caseload was not effective meaning that not all patients received timely care. Blood glucose monitoring equipment was not regularly checked to ensure it was working correctly.