HMP The Verne

Inspection report

The Verne
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Date of inspection visit: 26 May 2022
Date of publication: 26/08/2022

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 well-led?	**Inspected but not rated**

Overall summary

We carried out an announced focused inspection of healthcare services provided by Practice Plus Group Health & Rehabilitation Services Limited (PPG) at HMP The Verne to follow up on the requirement notice issued after our last inspection in February 2020. At the last inspection in February 2020, we found the quality of healthcare provided by PPG at this location required improvement. We issued a requirement notice in relation to Regulation 17, Good governance.

The purpose of this focused inspection was to determine if the healthcare services provided by PPG were meeting the legal requirements of the requirement notice that we issued in February 2020, and 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 patients were receiving safe care and treatment.

At this inspection we found the required improvements had been made and the provider was meeting the regulations. We took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering how we carried out this inspection. We therefore undertook some of the inspection processes remotely.

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:

- New systems and processes had been implemented to strengthen governance of the mental health service.
- Caseloads were well managed, and all patients had a named worker.
- Patients had personalised care plans.

Our inspection team

The inspection was carried out by one CQC health and justice inspector.

How we carried out this inspection

We conducted a range of interviews with staff and accessed six patient clinical records on 26 May 2022.

Before this inspection we reviewed some information that we held about the service including notifications and action plan updates.

During the inspection we spoke with:

- Head of healthcare who is also the CQC registered manager
- Regional quality and governance manager
- Mental health clinical lead

We also spoke with NHS England & Improvement (NHSE/I) commissioners and requested their feedback prior to the inspection and spoke with the prison governor and deputy governor for their feedback on the mental health provision available in the prison.

We asked the provider to share a range of evidence with us. Documents we reviewed included:

- Standard operating procedure for integrated mental health services HMP The Verne
- Local operating policy for referral and allocation into the integrated mental health team
- Local operating policy for care programme approach
- Mental health and justice indicators of performance data March 2020-April 2022
- Mental health monthly patient care audits October 2021-April 2022
- Local quality delivery board meeting presentation April 2022
- Internal quality visit mental health report February 2022
- Weekly multi-disciplinary meeting minutes May 2022
- Psychology referral process

Background to HMP The Verne

HMP The Verne is a Category C training prison for men convicted of a sexual offence. The prison is in the town of Portland in Dorset and accommodates approximately 600 prisoners. The prison is operated by Her Majesty's Prison and Probation Service.

Health services at HMP The Verne are commissioned by NHS England & Improvement. The contract for the provision of healthcare services is held by Practice Plus Group Health & Rehabilitation Services Limited (PPG). PPG is registered with CQC to provide the regulated activities of diagnostic and screening procedures, personal care, and treatment of disease, disorder or injury.

Our previous comprehensive inspection was conducted jointly with Her Majesty's Inspectorate of Prisons (HMIP) in February 2020 and published on the HMIP website on 3 June 2020. We found a breach of Regulation 17, Good governance in relation to mental health services.

The-Verne-web-2020.pdf (justiceinspectorates.gov.uk)

Inspected but not rated

Are services well-led?

Governance arrangements

At our last inspection we found that the oversight and systems to monitor treatment for patients with mental health problems were inadequate. We found multiple waiting lists for the mental health team and one caseload list meaning patients did not have an allocated key worker. There was no process to monitor or review patients on the caseload, and care plans were not completed consistently. Two of the three staffing posts within the mental health team were covered by agency staff which further compounded the risk.

At this inspection, we found that a number of improvements had been made to the mental health service and there was much improved caseload management. In particular we found that:

- Governance of the mental health service had improved with a daily mental health morning meeting in place, and a weekly multi-disciplinary team meeting to review patients.
- The team consisted of permanent staff who were overseen by the mental health clinical lead and this provided consistency for patients receiving support.
- A standard operating procedure for the mental health service had been implemented which evidenced a clear referral and allocation process.
- A referral process had been implemented for patients to access psychological therapies.
- Waiting lists on the electronic patient record system (SystmOne) had been refined with two clear waiting lists for urgent and routine referrals.
- There were no outstanding referrals at the time of the inspection.
- All patients on the mental health caseload were allocated a key worker.
- A care plan template had been introduced and was utilised by staff to record patient care plans.
- Care plans we reviewed during the inspection were in date and personalised.
- Care plan audits took place monthly and evidenced compliance.
- An internal quality visit was carried out by the provider in February 2022 to review the mental health service and found the issues highlighted at the last CQC inspection had been addressed.
- Health and Justice Indicators of Performance data indicated that patients received timely access to assessment and treatment from the mental health service.