HMP Belmarsh and HMP Thameside (healthcare)

Inspection report

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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 summary

The five key questions we ask and what we found

Are services safe?

We did not inspect the safe domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in September 2017.

At this focused inspection, we found that the systems for monitoring storage temperatures of medicines were not always effective in ensuring their suitability for use, and systems for checking emergency bags were not fully effective.

Are services effective?

We did not inspect the effective domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in September 2017.

At this focused inspection, we found that most patients with long-term conditions and those requiring wound care did not have personalised care plans in place. This meant that information needed to help staff plan and deliver care and treatment was not readily available. There was no clear system to monitor patients with long-term conditions to ensure the care and treatment they received met their needs.

Are services caring?

We did not inspect the caring domain at this inspection.

Are services responsive?

We did not inspect the responsive domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in September 2017.

At this focused inspection, we found that access to GP services was sufficient, and healthcare staff dealt with applications for treatment promptly. While outstanding tasks (prompts for staff to take action regarding a patient) for the GP had reduced, the overall number of unactioned tasks had increased significantly and there was no effective process in place to manage this.

Are services well-led?

We did not inspect the well-led domain in full at this inspection. We inspected only those aspects mentioned in the Requirement Notices issued in September 2017.

At this focused inspection we found that some systems did not effectively assess, monitor and improve the quality and safety of the service. We saw evidence of the provider using audits feedback to improve service delivery.

Key findings

Our key findings were as follows:

- Systems for monitoring storage temperatures of medicines were not fully effective.
- Systems for checking items stored in emergency bags were not fully effective.
- Oversight and management of patients with long-term conditions required improvement, including improved care planning.
- Oversight and management of unactioned tasks on the SystmOne electronic clinical recording system required improvement.
- Access to GP services was sufficient.
- Oversight and management of healthcare applications had improved.
- The provider had started to use audits to improve service delivery.

Action the service MUST take to improve:

Oxleas NHS Foundation Trust must ensure that governance systems and processes assess, monitor and improve the quality and safety of services.

Our inspection team

Our inspection was completed by two CQC health and justice inspectors.

We do not currently rate services provided in prisons.

Background to HMP Thameside

HMP Thameside is a local category B prison in South East London that can hold up to 1,232 convicted and remanded men. The prison is operated by Serco, and is situated next to HMP Belmarsh and HMP Isis.

Oxleas NHS Foundation Trust is the health provider at HMP Thameside. The trust is registered to provide the following regulated activities at the location: Treatment of disease, disorder or injury, Diagnostic and screening procedures, and Personal care.

CQC inspected HMP Thameside with Her Majesty's Inspectorate of Prisons (HMIP) in May 2017. During this inspection, we found evidence that fundamental standards were not being met and issued Requirement Notices in September 2017 in relation to Regulation 12, Safe care and treatment, and Regulation 17, Good governance, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The joint inspection report published following the May 2017 inspection can be found here: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/09/HMP-Thameside-Web-2017.pdf

We subsequently asked Oxleas NHS Foundation Trust to make improvements to address these breaches.

Why we carried out this inspection

We undertook an announced focused inspection on 16 and 17 August 2018. This inspection was carried out in order to follow up on the regulatory breaches found during our last inspection.

The purpose of the inspection was to determine if the registered provider, Oxleas NHS Foundation Trust, 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.

How we carried out this inspection

Before this focused inspection we reviewed a range of information that we held about the service, including action plans we had received from the provider in response to the Requirement Notices issued in September 2017.

During the inspection we asked the provider to share with us a range of information which we reviewed. We spoke with healthcare staff, prison staff and people who use the service, and sampled a range of records.

Are services safe?

Medicines management

At our last inspection, we found that the systems for monitoring storage temperatures of medicines were not effective in ensuring their suitability for use. We noted excessive room temperatures, and found a lack of recording of fridge and room temperatures.

During this focused inspection, we found that the systems for monitoring storage temperatures of medicines were still not entirely effective:

- Staff did not consistently record fridge and room temperatures in treatment rooms across the prison.
- Staff did not always contact the pharmacy for advice, or submit an incident report, when fridge or room temperatures were found to be out of range.
- In the A3 treatment room, staff stored medicines in a broken fridge for approximately 10 days, despite the pharmacy team instructing staff not to use it. The medicines in this fridge were subsequently destroyed and reordered for the patients.
- The pharmacy team had been proactive during recent hot weather in completing regular audits of medicines storage and recording. They also investigated the effectiveness of medicines in areas where they had identified storage concerns.

Overview of safety systems and processes

At our last inspection, we found that the systems for checking items stored in emergency bags were not fully effective. Daily checks did not identify expired items that required replacing.

During this focused inspection, we found that the systems for monitoring the contents of emergency bags were still not fully effective:

- Staff did not complete and/or record emergency bag checks consistently.
- We found different forms being used by staff to record emergency bag checks. This resulted in a lack of consistency around the frequency of checks, and the checking of expiry dates of emergency medicines.
- In the A3 and Reception treatment rooms, we found emergency medicine (Glucagon) that had expired. This had not been identified by staff checks.

There was no effective system in place to monitor if emergency bag checks were being completed. The provider had recently undertaken a review of the emergency bag check process which had identified similar concerns to those we found. They had appointed a nurse to lead on improving the process, who was producing an updated checklist for staff to use. However, we found limited improvements at the time of our inspection.

Are services effective?

Coordinating patient care and information sharing

At our last inspection, we found that care plans for patients with identified long-term health conditions and/or wound care were not person-centred. The plans did not provide information that detailed how a patient's care and treatment that should be delivered.

During this focused inspection, we found that care planning remained an area of concern. Information needed to help staff plan and deliver care and treatment was not readily available for many patients we reviewed:

- Many patients with long-term conditions still did not have a care plan. Of 19 patient records for people with diabetes or epilepsy that we reviewed, only five patients had a care plan in place.
- Some the care plans that we saw were not individualised, and it was not evident from the clinical record that staff had discussed the care plan with the patient. Some of the care plans were created at previous prisons, and had not been reviewed since the patients had arrived at Thameside.
- Patients requiring wound care did not have care plans in place, although we did see evidence of effective treatment in the medical notes.
- Inpatients had care plans in place that informed their on-going care and support, which was positive.

During this focused inspection, we found that the management of patients with long-term conditions required improvement. Patients with long-term conditions were not sufficiently monitored to ensure the care and treatment they received met their needs:

- At the time of our inspection, the provider had identified 79 patients with long-term conditions, who were added to a waiting list for a nurse-led review.
- The provider did not maintain accurate information to identify all prisoners with a diagnosed long-term condition. Some patients with identified long-term conditions had not been added to the long-term condition waiting list. Conversely, some patients with a recorded diagnosis had no clinical indication in their record that they suffered from the health condition. Although regular long-term condition clinics were noted on the clinic list, many available slots in July and August 2018 had not been used to undertake reviews. This demonstrated lost opportunities to provide effective care and treatment.

The provider had appointed a named nurse in July 2018 to oversee and develop the management of long-term conditions. However, there had been limited progress at the time of our inspection.

Are services caring?

We did not inspect the caring domain at this inspection.

Are services responsive to people's needs?

Access to the service

At our last inspection, only one GP was available on site daily for an average population of 1200, and they had limited capacity and limited access to patients at times.

During this focused inspection, we found that access to GP services was sufficient:

- GP provision had improved with additional support from a second GP scheduled at least twice weekly to help cover tasks such as the inpatient unit review.
- Waiting times for the GP were short, with patients waiting approximately two days for routine care.
- Urgent appointment slots were available each day, although there was no clear process in place for prioritising patients.
- The provider had employed an advanced nurse practitioner (ANP) to support the GP, who was due to start in October 2018. The GP had developed good links with nursing staff, and was working with them to develop their skills to help meet patient demand.

At our last inspection, we found avoidable delays in people accessing healthcare for advice and treatment due to a significant backlog of healthcare applications. Staff had no capacity to deal with the amount of applications received, which was approximately 60-80 each day.

During this focused inspection, we found improvements in the management of healthcare applications:

- Staff still received a significant number of applications (483 were received in the seven days before our inspection).
- Of 153 applications that were awaiting review, only four were overdue in relation to the provider's stated review target of four days. This meant that staff were reviewing applications quicker than during our last inspection and improving patients' access to care. Time for healthcare application reviews was scheduled into the weekly staffing rota. Two computer terminals had been installed in the healthcare centre to help staff process applications, and further terminals were being installed across the prison during our inspection.

At our last inspection, 150 tasks (prompts for staff to take action regarding a patient) on the SystmOne electronic clinical recording system were overdue, of which over 50 were for the GP. Some tasks contained urgent requests which were not dealt with promptly. The GP also had a backlog of 169 blood test results awaiting review.

During this focused inspection, we found that while outstanding tasks for the GP had reduced, the overall number of unactioned tasks had increased significantly. This increased the risk that patients' immediate health needs may not be being met:

- The number of outstanding tasks for the GP and urgent blood results to review had decreased significantly. The GP now had allocated time each day to review tasks and complete any urgent actions.
- The total number of overdue tasks on SystmOne had risen to 855. Many of these tasks appeared to be historic, with some dating back to 2016. These tasks required review and cleansing to ensure that patients with any outstanding health needs were seen promptly. At the time of our inspection, there was no clear process in place to monitor and address outstanding tasks.

Are services well-led?

Governance arrangements

At our last inspection, we found that there was a lack of positive action being taken to address the issues identified with the healthcare application system and the number of tasks and blood test results building up on SystmOne.

During this focused inspection, we found that governance systems remained insufficient to assess, monitor and improve the quality and safety of the service. The provider's action plan gave assurances about improvements, some of which was not supported by our findings:

- Service managers did not have sufficient oversight of the significant number of overdue tasks on SystmOne, and had not acted to address this concern. It was not clear that overdue tasks were being periodically reviewed.
- The provider previously gave assurances that improvements to the processes for monitoring storage temperatures of medicines and emergency bags were in place. However, we did not find evidence of sufficient progress with this this during our inspection.
- The provider previously told us that improvements to the management and oversight of long-term conditions had been achieved through the appointment of a lead nurse in November 2017. However, the management and oversight of long-term conditions remained a concern.

At our last inspection, we found that audits of the service were not always effective in identifying issues and bringing about improvement, specifically around care planning.

During this focused inspection, we saw evidence that the provider had started to use audits to improve service delivery:

- The provider completed audits of care plans, although few of these related to patients with physical health needs. Audit results were shared with the trust's Clinical Effectiveness Group for monitoring, and discussed at monthly team meetings.
- We saw evidence of the inpatient unit manager assessing the quality of care plans, identifying areas of concerns, and communicating this to staff in order to share learning and drive improvements. Audit results indicated some improvements were required around risk assessments and involving patients in care planning.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems and processes to support good governance and management of the service were limited and under developed at local level and this impacted upon their overall effectiveness of the service. Those that existed needed further development. Overall, governance systems remained insufficient to assess, monitor and improve the quality and safety of the service: Systems for monitoring and recording storage temperatures of medicines were not fully effective in ensuring their safety and suitability for use; Systems for monitoring and recording the contents of emergency bags were not fully effective; Oversight and management of patients with long-term conditions required improvement, including improved care planning; There was no clear process in place to monitor or address unactioned tasks on the SystmOne electronic clinical recording system.