HMP Thameside

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 rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services caring?	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 focused announced inspection of healthcare services provided by Practice Plus Group Health and Rehabilitation Services (PPG) at HMP Thameside. PPG took over the contract from the previous provider on 01 June 2023. The provider shared concerns with us regarding the challenges they faced at the service.

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 patients were receiving safe care and treatment.

At this inspection we found that the provider had worked hard to progress towards a safe service for patients. A significant amount of work had already been undertaken by the provider and regional management support had been brought in to develop the service. More recently an interim head of healthcare had been appointed to continue to advance the service. However we found that the provider was in breach of Regulation 17, Good Governance, Regulation 12 Safe care and treatment and Regulation 18 Staffing.

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 across healthcare were not sufficient to meet patient need in a timely manner.
- Staff across healthcare were not up to date with their mandatory training. Completion of all mandatory training sessions was 37% at the time of inspection.
- Staff understood how to protect patients from abuse, although they were not familiar with internal reporting arrangements.
- There was a backlog in the review and investigation of incidents reported internally.
- Staff kept records of patients' care and treatment, although these were of mixed quality. Some lacked pertinent information. There was no discharge planning for patients admitted to the inpatient unit (IPU).
- The triage process did not work effectively, and patients were not always given an appointment when needed and where appointments were booked this was not always promptly in accordance with clinical need.
- The service did not have access to the full range of healthcare specialists, including an occupational therapist, dietician and speech and language therapist.
- Complaints made by patients were categorised as concerns rather than complaints. There was no monitoring of response times, themes or trends as well as whether the complaint was upheld or not.
- Managers had not provided staff with regular 1:1 supervision.
- There were a number of leadership vacancies in the service, but support had been drafted in from nearby regions for some of the vacancies as an interim measure. Management had not yet provided newly recruited leads with leadership training.
- Leaders did not operate effective governance processes. Meetings lacked structure and the purpose of an agenda item and proposed action, or outcome was not consistently recorded.
- Management information was not complete and could not be relied upon to inform service delivery. Staff could not always access the data required to understand performance, make decisions and improvements.

However, we also found that:

- Management were aware of the risks faced by the service. A risk register had been developed which recorded each identified risk along with mitigating action.
- Staff were kind and caring and had a positive approach towards providing care and treatment for patients. Staff worked hard and pulled together to deliver the service.

Overall summary

- The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The provider must:

- The provider must ensure that staffing vacancies are recruited to, so they can meet patients' needs in a timely way.
- The provider must ensure that all staff complete their mandatory training.
- The provider must ensure the backlog of incidents are reviewed and/or investigated.
- The provider must ensure that patient records are clearly written with all necessary information.
- The provider must ensure there are effective patient triage arrangements in place.
- The provider must ensure patient complaints are correctly recorded as such and that timescales for responses are monitored, an outcome provided, and that this information is reported on.
- The provider must ensure that leaders have the necessary skills to provide good leadership and support for staff.
- The provider must ensure that suitable governance arrangements are in place and that meetings operate effectively.
- The provider must ensure that management information is available and accurate.

The provider should:

- The provider should ensure that staff are familiar with internal safeguarding reporting procedures.
- The provider should ensure staff received regular 1:1 clinical and managerial supervision.
- The provider should review how blood glucose monitoring equipment is managed.
- The provider should review systems for managing medicines to ensure patients have the medicines that they need.
- The provider should continue to work on embedding systems to provide oversight of medicines related risks.

Our inspection team

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

How we carried out this inspection

We conducted interviews with staff and the head of healthcare and accessed patient clinical records.

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 whilst on site. Documents we reviewed included:

- Meeting minutes
- Policies
- Information relating to recruitment and a staffing profile
- Staff rotas
- Complaints
- Risk Register
- Training records
- Incidents
- Management information
- The provider's action plan

Background to HMP Thameside

HMP Thameside is a reception and resettlement category B establishment. The prison is located within Thamesmead, Greenwich, England and accommodates up to 1232 male adult prisoners. The prison is privately run by Serco.

Practice Plus Group is the healthcare provider at HMP Thameside. The provider is registered with the CQC to provide the following regulated activities at the location: Treatment of disease, disorder or injury, and Diagnostic and screening procedures.

Our last joint inspection with HMIP was in November 2021. The joint inspection report can be found at: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-thameside-3/

Inspected but not rated

Are services safe?

Safe and clean environment

Maintenance, cleanliness and infection control

The environment was visibly clean and clutter-free, and clinical areas we viewed met infection control standards. Nurses completed set cleaning tasks each day and were supported by prisoner orderlies who helped clean communal areas and mop floors. Staff and patients told us that the level of cleanliness was good.

Staff adhered to infection control principles, including handwashing and wearing appropriate personal protective equipment, such as disposable gloves.

Medicines optimisation and pharmacy services

Medicines were supplied by the in-house pharmacy and were stored securely.

Staff monitored medicines storage temperatures; however, we saw some gaps in the monitoring records. We also saw temperature readings outside of the recommended ranges. Staff had highlighted their findings and took action to safeguard the medicines.

Medicines were prescribed by GPs and nurses and pharmacy professionals were on site daily. Whilst there were no pharmacy-led clinics, patients could access support with medicines issues by speaking to staff at medicines administration points.

Medicines were administered by nurses and pharmacy technicians; records of this were made on the electronic system. Medicines were administered at 7am, 11.30am, 4pm and 6.30pm. Patients on three or four times a day regimen had the medicines administration times adjusted to allow appropriate dosing intervals.

Medicines administration points were clean with handwashing facilities available.

When medicines doses needed to be transported within the prison, staff used lockable boxes to minimise the risks.

Emergency medicines and equipment were checked daily. However, 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.

Staff could access medicines out of hours via an emergency drug cupboard or via FP10 prescriptions dispensed at a local community pharmacy. Staff supplied patients with medicines for minor ailments via a local protocol.

In-possession risk assessments were in place for those self-administering their medicines and were reviewed as needed. Patients on high-risk medicines requiring blood tests were being monitored appropriately.

During this inspection, we identified medicines issues related to prison officer support. We observed overcrowding at one of the medicines queues. (Staff told us this happened frequently). We saw evidence of patients having missed doses due to not being unlocked. We saw records of 4 incident reports when medicines were not requested in time for patients being released or being transferred. This had resulted in patients leaving the establishment without their medicines.

Inspected but not rated

Are services safe?

The provider had raised their concerns with prison officer support and how this had impacted medicines optimisation. We were told that high turnover of prison staff had contributed to poor management of medicines concerns. The interim head of healthcare spoke with the lead director regarding this concern whilst we were on site.

When doses of medicines were missed, staff usually documented the reason for this, for example, refusal, or if a dose was clinically inappropriate. During this inspection, we identified an incident where a disease-modifying anti-rheumatic drug was not prescribed on reception and therefore missed for 8 days. In addition, a prescription for an antihypertensive medicine ran out and was not re-prescribed for 23 days. We highlighted these findings to staff who took immediate action to safeguard the patients.

Systems were being embedded to ensure oversight of medicines-related risks, for example, medicines incident reporting and medicines audits. Whilst staff had completed medicines management audits, they identified areas where staff required upskilling and improvements were needed. For example, staff needed more training on the use of the electronic medicines administration record system.

The provider had also identified issues with the management of drugs liable to misuse (diazepam, codeine etc) and had decided to treat them like schedule 2 controlled drugs to increase oversight.

The provider held regular medicines management group meetings. We saw evidence that learning from medicines incidents, audits, and any medicines alerts was shared in meetings.

The provider was aware that they were not meeting their key performance indicator for medicines reconciliation (the process of accurately listing a patient's medicines they were taking prior to reception and comparing it to what is currently prescribed). The provider was working towards improvements in this area.

Safe staffing

Nursing staff (Mental health, Primary Care and inpatient unit)

There were a number of vacancies being filled by agency staff with some gaps in the rotas. Managers had calculated the number and grade of nurses and health care assistants required on each shift.

The service had several vacancies which spanned across all healthcare services. There was a vacancy for an advanced nurse practitioner, clinical lead, 4 band 6 nurses and 3 Health care assistants (HCA) for primary care, 2 mental health nurse vacancies for the in-reach team. The inpatient unit (IPU) had 7 nurse vacancies and two health care assistant vacancies. The provider was working hard to recruit to the identified vacancies as well as bring in staff from other regions. However, continued shortages had meant there had been no staff to provide regular long-term condition management and vaccination clinics or provide therapeutic and constructive activities on the IPU to maintain patient well-being and encourage recovery.

The number of nurses and health care assistants on most shifts did not match the core staffing level the provider had assessed to be required. Most roles were covered by agency nurses, however, cover for some roles was not consistently provided. For primary care temporary cover had not been sourced for the vacant clinical lead post or advanced nurse practitioner; and health care assistants for primary care were not consistently fully staffed each day. Mental health services frequently operated with registered and unregistered nursing staff consistently below the optimum number. The IPU generally had the required number of staff.

Inspected but not rated

Are services safe?

Medical staff

There was a 1.4 GP vacancy from a 2.1 whole time equivalent, although a GP from another location had recently stepped in to provide support with a view to making the position permanent. There were 3 part-time consultant psychiatrists, with a whole time equivalent of 1.6 and a 0.6 vacancy.

Mandatory training

Staff were not up to date with most of their mandatory training.

Overall, staff in this service had undertaken 37% of the various elements of training that the service had set as mandatory. Staff attendance was low due to staffing shortages and limited time to undertake training, this included core training such as; patient safety 10%, NEWS2 14% primary care and ILS 22%. Management regularly spoke with staff at handover and team meetings regarding training attendance and completion and some staff had been booked on face to face training.

Safeguarding

Not all staff had completed training in safeguarding adults or children. Staff were knowledgeable about which signs to look out for, however, they were less familiar with the internal reporting procedure.

Not all staff had completed training in safeguarding adults or children, training figures were as follows; safeguarding children level 2, 33%, children level 3, 0%, adult level 3, 6%, adult level 2, 18%.

The head psychologist took the lead on safeguarding for the service and provided support to staff in relation to safeguarding concerns. However, this was a new role and not all staff knew who the safeguarding lead was. The lead had not undertaken the required level 4 safeguarding training, although this had been booked

Data and information governance

We found that data collection around the service's key performance indicators was limited. Staff told us that some of the information had been recorded or coded incorrectly, and we found that explanations for low performance in relation to areas such as health screening, waiting times and reviews had not always been analysed or explained. This meant the provider did not have clear oversight of the service to monitor it effectively. The provider told us they had recently employed a business manager who was in the process of cleansing the data to ensure it provided a more accurate overview of the service.

Track record on safety

The service had reported one serious incident during the 6 months prior to inspection. This had not been reported promptly by staff, however, as soon as it was brought to the attention of management the correct procedure was followed. Management provided staff with additional support and ad-hoc training as well as regular discussion at daily handover meetings.

Reporting incidents and learning from when things go wrong

Inspected but not rated

Are services safe?

Staff knew which incidents to report and how to report them. Staff reported all incidents they should report in accordance with the requirements of the provider. We were informed by management that following mobilisation; staff had failed to report incidents including one serious incident. This meant that management were not aware promptly and learning could not take place. Following identification of the serious incident by management, measures were put in place to ensure staff were aware of their responsibilities and incident reporting has increased.

Incidents were not reviewed and/or investigated promptly by management. Following mobilisation there were few staff trained in investigating incidents. This had resulted in a backlog. Regional management took on this role, until sufficient numbers of staff could be recruited and trained. During the period November and December 2023, a total of 71 incidents had been reported, of which 33 had been reviewed and/or investigated, 38 were awaiting review or approval some of which dated back to early November 2023. Whilst this was an improving picture, regional management continued to monitor and review incidents and were working hard to review them promptly. Measures had been put in place to clear the backlog.

Inspected but not rated

Are services effective?

Assessment of needs and planning of care

We reviewed patient records including some care plans for 7 patients with mental health needs, 13 primary care records, 4 long-term conditions, 8 triage records, plus 4 IPU during our inspection. Records were of mixed quality. Good practice in terms of assessment, treatment and risk management was evident in some records across mental health and primary care, however, some records were poorly completed, lacked relevant detail and had not always been saved correctly on the system. We shared our concerns with the provider who confirmed they were working with staff improve care records.

Triage

Patients requesting an appointment were not consistently triaged promptly or accurately.

An untrained member of staff assessed potential new patients when they were referred to the service or requested an appointment using the electronic prison application system. Management recognised this was a risk, qualified nurses did not have access to the system and management had been working with the prison to arrange this. We observed the process and identified a number of errors were made which meant some patients were either not allocated an appointment or an appointment was not allocated promptly according to the patient's needs.

Management had liaised with the prison to add more users to the system (including nurses), this was a lengthy process. We raised concerns with management during the inspection and temporary measures were put in place to provide patient care safely until additional access to the relevant software had been approved.

Mental health

Mental health care plans were inconsistent and did not always include details of an accurate diagnosis, goals and objectives. Patients were not always seen in accordance with agreed timescales. Some care plans were written well and included a clear diagnosis with treatment goals and outcomes defined, others lacked detail including a clear diagnosis, what the presenting problem was with a clear treatment plan. Management were aware and working with staff to improve the standard of care records.

Primary care

The quality of records varied. We reviewed a range of patient records for patients who had attended both GP and nurse appointments. GP records were well written, concise with a clear plan. Nursing records were inconsistent, some contained appropriate information whilst others lacked detail and some follow-up appointments had not been arranged promptly in accordance with clinical need.

Most patients with a long-term condition did not all have an up to date or personalised care plan. The service did not have a long-term conditions nurse, recruitment was ongoing and the provider informed us that all nursing staff would receive training in long-term conditions with the option to specialise in specific conditions. The provider planned to train newly recruited nurses in long-term conditions and set up specific clinics.

IPU

Patient care plans lacked pertinent information, were not personalised and patients were not provided with a copy. Critical information such as end of life care, resuscitation status and care preferences had not been recorded. Patient

recorded goals were generic, lacked detail and were not personalised. Staff told us that patients were not routinely offered or given a copy of their plan and that staff did not complete discharge plans for patients returning to the general population. Management had identified that some staff required additional support to improve record keeping and were addressing this.

Best practice in treatment and care

Staff provided treatment interventions suitable for the patient group and consistent with national guidance on best practice. There was evidence of psychological intervention and input from psychologists, however, the service did not currently have an occupational therapist, dietician or speech and language specialist. The provider informed us that these positions were all being recruited to.

The service provided psychological interventions in line with National Institute for Health and Care Excellence (NICE) guidance. The clinical psychologist and therapists offered a range of interventions including cognitive behavioural therapy, dialectical behaviour therapy and cognitive remediation therapy.

Staff supported patients to attend appointments at other hospitals in relation to their physical health. The prison arranged transport for patients who required an external hospital appointment, on occasion patient appointments were cancelled due to unavailability of prison officers. The provider worked closely with the prison to ensure where sufficient prison staff were not available, patients were prioritised in accordance with clinical need.

Skilled staff to deliver care

The service did not have access to the full range of specialists required to meet the needs of patients. The team included skilled staff from a range of disciplines including qualified nursing staff on every shift, consultant psychiatrists and clinical psychologists. There were a number of vacancies across healthcare and the provider filled gaps with staff seconded from other sites as well as agency staff where possible. The team pulled together to provide care to patients and regional management had worked on site for several months in order to minimise the impact.

Managers and leads had not provided staff with regular 1:1 supervision, however we were informed that several group supervisions had been held. Some staff said they received regular 1:1 supervision and an annual appraisal, others reported that they had not received supervision. We raised this with the provider who understood the need to formalise this and ensure they facilitated staff to attend supervision sessions, management assured us this was top of their agenda.

Managers dealt with poor staff performance promptly and effectively. Managers took appropriate action and followed the provider's disciplinary policy as required.

Multidisciplinary and interagency team work

The service held regular multidisciplinary meetings to address the needs of patients with complex needs. The service held weekly multi-professional meetings that staff from all disciplines could attend. During the inspection, we attended a meeting and observed this to be well attended, well-structured and engaging. The lead GP facilitated the meeting and encouraged all attendees to provide input. However, we were informed that the meetings were not usually well attended, the GP lead was working on this and considering revising the day/time of the meeting to ensure maximum attendance going forward.

Inspected but not rated

Are services caring?

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients was positive. Patients told us that most of the team were exceptional, friendly, responsive and sensitive, but that sometimes they put in applications which were not responded to.

Staff said they always put patients first and maintained a positive and hopeful attitude when working with patients. Staff showed a deep interest in patients and were committed to delivering good clinical care.

There was a strong, visible person-centred culture amongst most of the team members. Staff were highly motivated and inspired to offer care that is kind and promotes people as individuals. Staff had an excellent understanding of what it meant for a patient to be in prison and how this may impact on their physical and mental wellbeing.

Staff maintained the confidentiality of information about patients. Handovers, multidisciplinary meetings and ward rounds all took place in a designated room to ensure discussions about patients could not be overheard.

Involvement in care

Staff involved patients in decisions about the service when appropriate. The provider had recently selected some patients to act as healthcare champions. The aim of this was so that patients could talk with their peers regarding any challenges they faced in accessing healthcare as well as to assist in educating other patients to ensure requested appointments are appropriate and necessary. A significant number of patients requested appointments which were either not needed or lacked relevant information.

Inspected but not rated

Are services responsive to people's needs?

Listening to and learning from concerns and complaints

During November and December 2023, the service received 69 complaints. The service had not recorded whether complaints had been upheld, or monitor the time taken to respond to them.

Patients knew how to complain or raise concerns. Information on how to make a complaint was available on the noticeboard and there were leaflets around the prison.

Staff knew how to handle complaints, although these were frequently categorised as a concern rather than a complaint. The service had a complaints policy and staff knew how to access this. Informal complaints were dealt with as they arose. If patients wanted to make a formal complaint they could complete a specific form. From review of a sample of complaints, we found that most had been recategorized as a concern rather than a complaint. This meant the patient's voice was not fully recognised.

When patients complained or raised concerns, they received feedback. When a formal complaint was made that required investigation, patients were contacted by the manager acknowledging their complaint. A written response was sent to the complainant. Most complaints were responded to in less than 30 days and in line with the organisation's policy. Responses were of a good standard.

Inspected but not rated

Are services well-led?

Governance, management and sustainability

Leadership

Leaders had been drafted in to support the service following mobilisation on 01 June 2023, most of the existing workforce transferred with the previous provider and did not TUPE across. This was a huge challenge for senior management and a regional manager had been deployed to the site to provide oversight and support. More recently managers from other sites had been temporarily transferred to HMP Thameside to provide additional support. Managers had taken positive steps and worked hard to implement their new systems and support staff including agency workers.

Leaders had an understanding of the services they managed. The registered manager and managing director were aware of the strengths and weaknesses within the service. They understood what the local risks were and what quality assurance measures were in place. They recognised that a coordinated approach was needed to ensure a high-quality service was provided to support patients to become well and manage their symptoms.

Leadership training opportunities were under development. There was a clear staffing structure and nurses and health care assistants had the opportunity to progress within the service. Leadership training had not taken place, recruitment was ongoing, and the provider informed us training would take place imminently.

Governance

Governance arrangements were in their infancy. Following taking over the contract in June 2023, the provider has faced numerous challenges. This had impacted on the implementation of robust governance structures. Governance structures were in early days, a series of meetings were established approximately three months after mobilisation, which included relevant staff and stakeholders.

A Local Delivery Board (LDB) oversaw the performance of the healthcare service and was attended by healthcare leads, commissioners as well as prison representatives. There was also a weekly senior management meeting, an integrated monthly staff meeting as well as a patient safety investigation review group and Quality Assurance committee who met alternate months. Few sets of minutes were available as meetings had only recently started and most had not taken place during the Christmas period.

The LDB meeting agendas provided some structure, however, whilst there was constructive discussion recorded for many items on the agenda, others were less robust. For example, whilst the number of complaints were listed, the minuted discussion failed to consider themes and trends, how long it was taking to investigate complaints and the numbers which had been upheld. Minutes for the Senior Management Team and staff meetings lacked structure, did not include standing agenda items and it was not always clear why certain matters had been discussed or what the outcome or agreed action had been. The provider recognised this as a risk and continued to develop and improve on meetings. The provider confirmed they would ensure each agenda item had a clear proposed outcome with agreed actions.

Management of risk, issues and performance

Leaders maintained a risk register. Staff had access to the risk register and could escalate concerns to the interim manager. Risks were assessed for their likelihood and impact and added to the register if they met agreed criteria. The risks identified on the risk register matched concerns discussed with staff during the inspection.

Inspected but not rated

Are services well-led?

Reviews of incidents took too long. Management had identified that mobilisation incidents were not consistently being reported or reviewed and had put measures in place to ensure they improved on the timeliness of reporting incidents.

Information management

The service used systems to collect data, however there were issues with some data input and collection which meant that management information could not always be relied upon. This meant that management lacked full oversight of how the service was performing. Management were already aware of this and beginning to take action to ensure staff input information accurately on the system and that data extracted was cleansed.

Staff made notifications to external bodies as needed. For example, one serious incident had been reported the previous year.

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 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** 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: Meetings lacked structure, they did not all have standing agenda items. The purpose of some agenda items was not always clear, outcomes and actions were not consistently recorded. Management information was not consistently accurate and some information could not be gathered and reported on in a meaningful way. Incidents were not reviewed or investigated in a timely manner. Complaints were frequently categorised as a 'concern' rather than a complaint. The outcome of the complaint as well as the timeliness of responses was not recorded or monitored.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** There was not a sufficient number of suitably qualified staff across the healthcare team to ensure patients received timely assessment of their needs and ongoing care and treatment. The service had a high number of staff vacancies across all disciplines. Temporary cover was not always provided.

This section is primarily information for the provider

Requirement notices

Managers had not ensured staff kept up to date with their mandatory training.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** Triage arrangements were not effective. Patients were not always provided with an appointment or in a timely manner. Patient care records lacked relevant detailed information.