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 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**

Overall summary

We carried out an announced focused inspection of healthcare services provided by Oxleas NHS Foundation Trust, remotely on 20 December 2022 and on-site 29 December 2022.

Following our last joint inspection with HM Inspectorate of Prisons (HMIP) in November 2021 we found that the quality of healthcare provided by Oxleas NHS Foundation Trust at location HMP Thameside required improvement. We issued *a Requirement Notice in relation to Regulation 12, Safe Care and Treatment and Regulation 16, Complaints, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014*.

The purpose of this focused inspection was to determine if the healthcare services provided were meeting the legal requirements of the Requirement Notices that we issued in November 2021and to find out if patients were receiving safe care and treatment. At this inspection we found that some improvements had been made, however the provider continued to be in breach of the regulations and more work was needed.

We do not currently rate services provided in prisons.

At this inspection we found:

- Systems and processes to administer medicines for patients were not always safe. Some patients had missed doses of medicines, some of which were critical and systems for managing medicines reconciliation were not effective.
- Complaints were not responded to consistently. Staff had not always responded to the complaint in full or ensured that concerns raised were investigated and acted on. Staff did not always inform the patient how to escalate concerns if they remained dissatisfied with the response.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- The provider must ensure that patients receive their medicines as prescribed.
- The provider must ensure complaints are fully investigated and responded to and that proportionate action is taken in all cases. The provider must ensure that complainants are informed of how to escalate the complaint in accordance with local guidelines.

The areas where the provider **should** make improvements are:

- The provider should review the storage of emergency equipment bags and ensure that medical devices are suitable for use.
- The provider should ensure that local and regional complaint guidelines are consistent.

Our inspection team

Our inspection team was led by a CQC inspector with support from two members of the CQC medicines optimisation team.

Before this inspection we reviewed a range of information provided by the service including the requirement notice action plan, meeting minutes, medicines policies, management information, as well as medicines records for some patients.

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

Background to HMP Belmarsh and HMP Thameside (healthcare)

HMP Thameside is a local/reception 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.

Oxleas NHS Foundation Trust 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?

Appropriate and safe use of medicines

Systems and processes to administer medicines for patients were not always safe. At the last inspection, systems for managing repeat prescriptions and for undertaking medicines reconciliation (the process of accurately listing a prisoner's medicines they were taking at home and comparing it to what is currently prescribed) were not effective. At this inspection, we saw that this was still the case and as a result, some patients had missed doses of medicines, some of which were critical. For example, one patient missed 6 days of a critical medicine for their heart condition. Staff had not documented why this patient missed their medicines. Other patient medicines were delayed due to prescriptions not being restarted appropriately, or delays in responding to information received following a new reception.

The provider was aware that they were not meeting their key performance indicator for medicines reconciliation. We were told that there was an action plan to drive improvement in this area to ensure that prisoners received the correct medicines. This included recruiting more pharmacy technicians who would be dedicated to completing medicines reconciliation.

At the previous inspection, the storage of some medicines in the treatment rooms was poorly organised. At this inspection, we saw that medicines storage was organised. Fridge and room temperatures of medicines storage areas were monitored appropriately, and staff knew how to escalate any issues.

At our last inspection we found that some patients were issued medicines meant for other patients. During this inspection we did not identify any new concerns of this nature.

At the previous inspection, the system for dealing with pharmacy queries had resulted in delays. We were also told that prisoner representatives could raise concerns with pharmacy and healthcare staff on behalf of the other prisoners.

At this inspection, we identified that whilst some emergency equipment bags were safely stored in the healthcare dispensing offices, one bag was stored in a communal area and therefore easily accessible to officers and prisoners. This meant they could access medicines and sharp implements. Following the inspection, the provider has now taken action to minimise the risks associated with this.

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 responsive to people's needs?

Complaints

The system in place to receive and respond to complaints was not effective. At the last inspection we found that complaints were not always investigated or responded to appropriately and that patients who made a complaint were not always informed of how to escalate their concerns if they were dissatisfied with the response.

During this inspection we found there was a total of 59 complaints had been logged in November and December 2022 up to the day of inspection. Some of the issues logged as complaints were in fact requests for appointments and the provider was developing a new process to separate the two. We reviewed a sample of complaints from both months and found that little improvement had been made in responding to complaints.

The provider had drafted new procedures locally and for the prison healthcare group as a whole. These were expected to be rolled out in January 2023. Local guidance for healthcare staff at HMP Thameside was to ensure complaints were responded to within seven days. The prison wide guidance was for complaints to be responded to within 30 days. Most complaints we reviewed had been responded to promptly, however, complaints were not always investigated fully, and each point raised by the complainant had not been responded to. Staff had not always demonstrated an understanding of how the patient may be impacted by their concern or informed complainants of how to escalate their concerns should they be dissatisfied with their response.

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 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints Staff did not fully investigate or respond to complaints, and staff did not always demonstrate concern or understanding for what the patient may be experiencing. There was no information contained within the responses to advise patients what action they could take should they be dissatisfied with the response.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose There were delays in administering some medicines to prisoners. Five prisoners missed one or more doses of medicines to treat either a physical or mental health condition.