MENTAL HEALTH CAPACITY LEGISLATION COMMITTEE
3pm - 5pm – 29th NOVEMBER 2017
CORPORATE MEETING ROOM, HEADQUARTERS
UNIVERSITY HOSPITAL OF WALES

CARING FOR PEOPLE
KEEPING PEOPLE WELL

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
Wednesday 29th November 2017 at 3-5pm
Corporate Meeting Room, Headquarters, UHW

AGENDA

PATIENT STORY – Mental Health Act		
PART 1: ITEMS FOR ACTION		
1	Welcome and Introductions	Oral *Chair*
2	Apologies for Absence	Oral *Chair*
3	Declarations of Interest	Oral *Chair*
4	Minutes of the Mental Health and Capacity Legislation meeting held on 29 November 2016 & 9th May 2017	*Chair*
5	Action Log Review	*Chair*
6	Any Other Urgent Business Agreed with the Chair	*Chair*
MENTAL CAPACITY ACT		
7	Deprivation of Liberty Safeguard Monitoring Report	*A Cole*
8	Mental Capacity Act Monitoring Report – SBAR a) Report b) ASC Report – Highlighted by IMCA	*Medical Director*
9	Do Not Attempt Cardio Pulmonary Resuscitation	*Mental Capacity Act Manager*
10	Ratification of IMCA and LPA/CAD procedures a) LPA/CAD – approval paper b) LPA CAD Procedure c) IMCA – SBAR d) IMCA Procedure	*Mental Capacity Act Manager*

MENTAL HEALTH ACT		
11	Mental Health Act Exception Report	*I Wile*
12	Update National Core Data	*I Wile (Oral)*
HEALTHCARE INSPECTORATE WALES		
13	• Update on HIW Inspection of Links CMHT • CCSIW	*I Wile (Oral)*
MENTAL HEALTH MEASURE		
14	Mental Health Measure Monitoring Report- SBAR a) Report	*Medical Director*
15	a) Part 1 – Compliance update b) Part 2 – Quality of Care and Treatment Plans	*Medical Director*
16	Update on Sustainability a) CAMHS / Presentation b) Adult / Presentation	*Dr J Hunt* *Ian Wile* *(presentation)*
17	Provisions of Mental Health Support to Prisoners a) Report	*Chief Operating Officer*
COMMITTEE GOVERNANCE		
18	Committee Work Plan	*Board Secretary*
PART 2:	**ITEMS TO BE RECORDED AS RECEIVED AND NOTED FOR INFORMATION BY THE COMMITTEE** **Papers are available on the Health Board website**	
19	Hospital Managers Power of Discharge sub-Committee Minutes	*Chair, PoD sub-Committee*
20	Review of the Meeting	*Oral* *Chair*
	To note the date, time and venue of the next meeting:- Tuesday 6th February 2017.	

UNCONFIRMED MINUTES OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
(MHCLC)
HELD AT 10.00 AM ON TUESDAY 29 NOVEMBER 2016
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

Present:

Prof Marcus Longley	**MHCLC Chair and Vice Chair, Cardiff and Vale UHB**
Martyn Waygood	Independent Member and MHCLC Vice Chair
Margaret McLaughlin	Independent Member – Third Sector
Eileen Brandreth	Independent Member – Information, Communication and Technology

In attendance:

Dr Catrin Simpson	MCA Champion, Community Child Health
Dr Grace Kelly	MCA Champion, Dentistry Board
Dr Graham Shortland	Medical Director
Ian Wile	Director of Operations, Mental Health
Sunni Webb	Mental Health Act Manager
Jane Hancock (part)	Service User Representative
Dr Jenny Hunt	Clinical Psychologist
Julia Barrell	Mental Capacity Act Manager
Kay Jeynes	Director of Nursing, PCIC
Steve Curry	Acting Chief Operating Officer
Lucy Phelps	Service User Representative
Amanda Morgan	Service User Representative

Apologies

Alice Casey	Chief Operating Officer (Lead Executive)
Dr Annie Proctor	Clinical Board Director, Mental Health
Jayne Tottle	Clinical Board Nurse
Peter Welsh	Director of Corporate Governance
Dr Richard Evans	Clinical Board Director, Medicine
Andy Cole	Operational Manager, Mental Health, Vale of Glamorgan Social Services
Steve Lewis	Director, Advocacy Support Cymru
John Owen	Chair, Hospital Managers Power of Discharge Sub-Committee

Secretariat: Helen Bricknell

MHCLC 16/061 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

MHCLC 16/062 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

MHCLC 16/063 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

MHCLC 16/064 MINUTES OF THE PREVIOUS MEETING OF THE MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE HELD ON 10 MAY 2016

The minutes were **RECEIVED** and **CONFIRMED** as a true and accurate record following the comment from Ian Wile to be agreed - **COMPLETE**

MHCLC 16/065 ACTION LOG REVIEW

The Committee **RECEIVED** and **NOTED** the Action Log. The following points were highlighted:

1. **MHCLC 15/065 Issues Related to Learning Disabilities** – The Chair commented that this action is COMPLETE
2. **MHCLC 16/046 MCA Clinical Board Reports** – Has been picked up in Performance Reviews – COMPLETE
3. **MHCLC 16/052 Transfer to Hafan y Coed** – The logistical problems surrounding tobacco on Hafan Y Coed -to bring back at later date
4. **MHCLC 16/026 &16/043 Internal Audit Report (DoLS)** – To bring back
5. **MHCLC 16/027 DoLS Monitoring Report –** Brought to November meeting – COMPLETE
6. **MHCLC 16/050 MHA Exception Report** – To bring back when all data gathered around

MHCLC 16/066 ANY OTHER URGENT BUSINESS

There was no other urgent business.

MHCLC 16/067 PATIENT STORY – MENTAL HEALTH MEASURE

There was no Patient Story.

MHCLC 16/068 MENTAL CAPACITY ACT CLINICAL BOARD PRESENTATIONS

1. **Community Child Health**

Dr Catrin Simpson presented the position in Community Child Health as the Mental Capacity Act (MCA) Champion. She advised that ongoing training was provided to staff and the target is to reach 80% of Community Child Health staff trained by January 2018. The E Leaning module will be rolled out to staff who are unavailable to attend MCA training.

The monthly Quality and Safety meetings report on all usage of the MCA, no audit has been undertaken from the Community Child Health Directorate. An audit will be undertaken during 2017 with the Audit Clinical Lead, however no clinical incidents in Child Health had been reported.

Issues have been raised around the use of the Independent Mental Capacity Act Advisory Services (IMCA) and 16-17 year olds and the input needed when there is no identified carer to support in the Best Interest decision making, training will address the awareness of this.

The Committee **NOTED** the reports and the action that would be taken in support and **AGREED** to review the effectiveness of these presentations when all Clinical Boards had been heard.

Action – Professor Marcus Longley

ACTION: To monitor the training of the MCA module and the implementation within the Board – Dr Sian Moynihan/Dr C Simpson

2. **Dentistry**

Dr Grace Kelly, Mental Capacity Act Champion presented a challenging infrastructure for the Clinical Board and how the Mental Capacity Act and Best Interest Decisions are used. The majority of Best Interest decisions are carried out in Oral surgery and special care dentistry in relation to sedation and General Anesthesia. No Mental Capacity Act Audits undertaken will be planned.

Dental Clinical Directors have the responsibility for staff training and identifying the level of training. Not all staff will apply their training knowledge

of the MCA in undertaking Mental Capacity Assessments. There have been no clinical incidents or issues reported for the Dental Clinical Board.

In summary:

- To increase the Mental Capacity Act training within the Clinical Board and to monitor by profession who is being trained and who is using the MCA within the workplace.
- How frequently training is required
- Identify the working knowledge of MCA within staff
- Audit the knowledge and implications of the MCA
- Incident reporting around MCA and MCA reporting issues to report to monthly Quality and Safety meetings.

A case study of a patient with Learning Disabilities and ASD with limited cooperation for an exam was discussed and explained. The patient initially in a foster care setting but currently in an adult placement (paid)
The Multidisciplinary Teams, Professional Bodies (Consultant, SpR Dentistry, Social Worker, Foster family, IMCA
Referral to IMCA services required as foster family is paid carer, treatment needed is deemed “serious medical treatment”
Capacity Assessment/ Best Interest Decision carried out

The chair opened up to questions and comments

All doctors can revalidate through MARS, whilst Dentists have to revalidate through the appraisal system. Training and development needs to be strengthened through the Clinical Boards and Organisation on maturing the learning systems for the MCA and moving forward.
Discussions around Mental Capacity Act are carried out with patients but recorded on personal folders only as discussions not assessments.
Within the Dentistry Clinical Board many know of the MCA but it is the implementation that needs to strengthen.

The Committee **NOTED** the reports and the action that would be taken in support and **AGREED** to review the effectiveness of these presentations when all Clinical Boards had been heard.

Action – Professor Marcus Longley

MHCLC 16/069 MENTAL CAPACITY ACT (MCA) UPDATED CAMHS REPORT

Dr Jenny Hunt presented the updated report with the limited assurance on reporting the legislative measures for children and young people. As Deprivation of Liberty differs in those age groups of under 16’s, 16-17 year

olds and those children “looked after”. Children under 16 can be deemed competent for consenting but if they choose not to and it is against their best interests then a court order can be obtained to decide what is within their best interest.

Due to the complexities of Mental Capacity Act and Deprivation of Liberty it was agreed that Dr Hunt, Ian Wile and Sunni Webb will collate figures to assure on how the Mental Health Act assessments within Cardiff and Vale University Health Board are undertaken on under 18 year olds are carried out and reported.

The Committee **NOTED** the report.

Action: Ian Wile/ Sunni Webb/ Dr J Hunt to collate more figures around the use of MCA

MHCLC 16/070 ISSUES RELATED TO LEARNING DISABILITIES

The Director of Nursing for PCIC presented the report outlining what constitutes a deprivation of liberty within a community learning disability setting and Article 5 of the European Convention on Human Rights.

The Chair opened up to comments:

- It was noted that there is a delay with the DoLS applications being completed in hospital setting within Cardiff and Vale and the Vale Council, the risks involved and the lack of funding for section 12 payments.
- Additional Best Interest resources have been depleted and awaiting for further funding on DoLS assessments.
- Primary care for patients in Care Homes and death under a DoLS, the implications surrounding this
- The funds needed to clear 1200-1300 DoLS assessments and decisions needed at high level meeting.

In summary the financial costs to clear the backlog need to be addressed and alternative ways for section 12 monies to be used in line with Best Interest Assessors, this deems to be problematic and must be re addressed. The risk registers should reflect these governance issues.

The Committee **NOTED** the written report

Action: Ensure Risk Registers are completed to reflect the risks – Kay Jeynes

MHCLC 16/071 UPDATED DoLS REPORT

The Committee received and noted the report from the Operations Manager the Chair opened up to questions and discussions.

The Best Interest Assessments are currently a year behind due to lack of funding and not meeting the timescales, however for urgent referrals these are being adhered to.

- Dr Jenny Hunt has pointed out whether that “police cells” are being used as a place of safety.
- There will be All Wales benchmarking in May 2017
- Positive comments regarding the use of Advocacy Support Cymru

MHCLC 16/072 MENTAL HEALTH ACT ACTIVITY REPORT

The Director of Operations, Mental Health, Mr Ian Wile presented the report and advised there were no exceptions to the report.

Mr Wile was also discussing data collection at an all Wales level where 5 of the 7 Health Boards were represented. The definition for invalid detentions and details for a core data set were agreed in order to benchmark performance. It was also possible that the data set could include the use of advocacy support. Directors of Primary Care were supporting this work.

It was agreed that Cardiff and Vale Health Board would collect data and compare with other Health Boards across Wales around the numbers on invalid detentions and use of Section 5. The information can be put forward and discussed at the Vice Chairs meeting with these comparisons from the Health Boards in Wales.

The Committee **NOTED** the report

MHCLC 16/073 MENTAL HEALTH MEASURE (all ages)

The Director of Operations, Mental Health, Mr Ian Wile gave an oral update on the quantity of referrals, twice as many within the Adult Mental Health services and not being able to reach the Tier 1 targets for 28 days. The Health Board are meeting the set targets and have commenced the re-modeling around GP Surgeries. Compliance has reached over 90% in November, with Parts 2, 3 and 4 of the Measure reaching 100% within the last quarter. The Director of Operations has stated that there have been mild to moderate problems surrounding Mental Health problems.

The Chair opened up to questions and discussion:

- Dr Jenny Hunt spoke about the referrals being somewhat 9 weeks on the waiting lists and they have significantly reduced to 6 weeks wait. There have been no clinical incidents or high risks to report. Low numbers of 16-17 year olds have been assessed by the Adults team, safeguarding measures have been adhered to under this legislation.
- Independent member, Mrs Eileen Brandreth remarked how impressed she is presently, with the Health Board and secondary Mental Health services, the third sector for out of hours are encouraging direct referrals and the promotion of "Well Being Clinics" thus allowing the steering of these groups to run effectively.

The Committee **NOTED** the report.

MHCLC 16/074 SERVICE CHANGES – IMPACT ON LEGISLATION

The Director of Operations had nothing further to add to the report. The Mental Health Act Services Manager explained that there will be Benchmarking workshops in January. The Code of Practice has 6 new chapters and updates for staff and Hospital Managers will be available if required to contact the Mental Health Act Manager.

Mental Capacity Act will be rolled out as part of Mandatory Training, starting in March 2017.

The Committee **NOTED** the update.

MHCLC 16/075 MENTAL HEALTH ACT 1983: CODE OF PRACTICE FOR WALES

The Mental Health Act Manager, Ms Sunni Webb advised that there are six new chapters to the Code of Practice and updates on the Guiding Principles. If anyone would like training or further guidance on the Code of Practice then please contact the Mental Health Act Manager. There are slides on the Intranet for internal staff.

The Committee **NOTED** the oral update

MHCLC 16/076 GOVERNANCE REMIT AND FREQUENCY

The Committee had no further questions or comments and the report was **NOTED.**

PART 2 REPORTS FOR INFORMATION

MHCLC 16/077 HOSPITAL MANAGERS POWER OF DISCHARGE SUBCOMMITTEE MINUTES

The Director of Operations, Mental Health, Mr Ian Wile reported that there were no incidents to report.

The Committee had no further questions or comments and the report was **NOTED.**

MHCLC 16/078 REVIEW OF THE MEETING

The Chair mentioned that "All Wales Benchmarking" will be brought back in 2017 for further discussion

MHCLC 16/079 DATE OF NEXT MEETING

The next meeting would be held at 10am on Tuesday 9 May 2017 in the Corporate Meeting Room, Headquarters, University Hospital of Wales (UHW).

UNCONFIRMED MINUTES OF THE
MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE
(MHCLC)
HELD AT 09.00 AM ON TUESDAY 9th MAY 2017
CORPORATE MEETING ROOM, HEADQUARTERS, UHW

4.1

Present:

Prof Marcus Longley	**MHCLC Chair and Vice Chair, Cardiff and Vale UHB**
Martyn Waygood	Independent Member and MHCLC Vice Chair
Margaret McLaughlin	Independent Member – Third Sector

In attendance:

Sue Bailey	Clinical Director for Quality, Safety and Patient Experience
Maria Jones	Nurse Representative
Dr Graham Shortland	Medical Director
Ian Wile	Director of Operations, Mental Health
Sunni Webb	Mental Health Act Manager
Dr Jenny Hunt	Clinical Psychologist
Julia Barrell	Mental Capacity Act Manager
Kay Jeynes	Director of Nursing, PCIC
Steve Curry	Acting Chief Operating Officer
Lucy Phelps	Service User Representative
Amanda Morgan	Service User Representative
Jeff Champney-Smith	Vice-Chair, Hospital Managers Power of Discharge Sub-Committee

Apologies

Alice Casey	Chief Operating Officer (Lead Executive)
Dr Annie Proctor(DNA)	Clinical Board Director, Mental Health
Jayne Tottle	Clinical Board Nurse
Peter Welsh	Director of Corporate Governance
Dr Richard Evans(DNA)	Clinical Board Director, Medicine
Andy Cole	Operational Manager, Mental Health, Vale of Glamorgan Social Services
Eileen Brandreth	Independent Member – Information, Communication and Technology
Steve Lewis (DNA)	Director, Advocacy Support Cymru
Jane Hancock (DNA)	Service User Representative

Secretariat: Helen Bricknell

MHCLC 16/080 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting.

MHCLC 16/081 APOLOGIES FOR ABSENCE

Apologies for absence were noted.

MHCLC 16/082 DECLARATIONS OF INTEREST

The Chair invited Members to declare any interests in the proceedings on the agenda. None were declared.

MHCLC 16/083 MINUTES OF THE PREVIOUS MEETING OF THE MENTAL HEALTH AND CAPACITY LEGISLATION COMMITTEE HELD ON 29TH NOVEMBER 2016

The minutes were RECEIVED and CONFIRMED as a true and accurate record following the amendment to minute MHCLC 16/068:

The monthly Quality and Safety meetings report on all usage of the MCA, no audit has been undertaken from the Community Child Health Directorate. An audit will be undertaken during 2017 with the Audit Clinical Lead, however no clinical incidents in Child Health had been reported.

MHCLC 16/084 ACTION LOG REVIEW

The Committee **RECEIVED** and **NOTED** the Action Log

MHCLC 16/085 ANY OTHER URGENT BUSINESS

There was no other urgent business.

MHCLC 16/086 PATIENT STORY – MENTAL CAPACITY ACT

There was no Patient Story.

MHCLC 16/087 MENTAL CAPACITY ACT CLINICAL BOARD PRESENTATIONS

1. **Clinical Diagnostics and Therapeutics**

The Clinical Director for CD&T, Sue Bailey presented the position in Clinical Diagnostics and Therapy. It was advised that ongoing Mental Capacity Act

training was provided to all staff as it is now an element of Mandatory training from April 2017 and Personal Appraisal Development Reviews (PADR). Compliance figures were unavailable from LED at the current time.

The Clinical Board dementia action plan and Dementia Champions across the patch all provide a helpful service within the clinical board. A baseline audit was undertaken and the following was highlighted:

- No clinical incidents relating to capacity
- From April 2016 to March 2017, 49 incidents of violence and aggression behavior were reported, 5 of these lacked capacity, 19 deemed to have capacity and the remainder not known. Phlebotomy and Occupational Therapy were the main areas.
- There is a mis-understanding of “capacity”, and what constitutes capacity within these areas. Mainly verbal consent is gained within the Clinical Boards. At point of referral it has been assumed that capacity has been recorded and this is not always the case.
- The Medical Director has agreed with the report presented and with the Mental Capacity Act being part of the Mandatory Training element, it has improved the compliance recording and the impact it has received within the services.
- The Interim Chief Operating Officer has clarified the importance of the different types of consent given and how it is recorded, given the vast multiplex of procedures that are undertaken by the Clinical Boards.
- Vice Chair asks how well the PADR works with the staff and the training levels, it has been agreed that it is a good mechanism for staff to complete and is taken seriously and it is important in identifying training needs and setting objectives.

The Committee **NOTED** the reports and the action that would be taken in support and **AGREED** to review the effectiveness of these presentations when all Clinical Boards had been heard.

2. Mental Health

The Director of Operations, Mental Health, Ian Wile gave a presentation on the 3 directorates within Mental Health, Working Adults, Older People Services and Psychology/Therapies. The report/audit compiled is an amalgamation of the 3 directorates.

Clinical Directors are responsible for their areas but felt that all staff have a responsibility to have an understanding of the Mental Capacity Act. The Mental Health Clinical Board have a quality and safety meeting and the Mental Capacity Act and Deprivation of Liberty Safeguards are standing agenda items with no outstanding items to report within.

Mental Health is a high reporting topic that is dealt with promptly throughout the Clinical Boards. Governance issues that have been reported in Psychology/ Counselling. Concerns have been raised with senior clinicians relating to informal admissions and consent to admission. But no capacity to such admission has been obtained and documentation completed on patients files to reflect this.

Healthcare Inspectorate Wales have visited older people services recently and compliance with DoLS and MCA has been questioned relating to staff training and awareness.

Training data feedback has not been made readily available, but mandatory training can be recorded and monitored.

- No evidence of audit through the Mental Health Clinical Board. Professor Robert Kidd has outlined an audit which is due to be rolled out this summer.
- Clinical incidents and assaults on staff by patients have been identified through the Sentinels' group. Assessments are to be undertaken prior to staff prosecuting.
- Comment from the older people's directorate that training is needed.
- Older People's Service not aware of any incidents regarding the Mental Capacity Act.
- Issues raised by IMCA services have been disseminated to Clinical Boards.
- Lack of awareness around the Adult services and DoLS regulations.

Comment was made on the compliance figure of 80% around Mental Capacity Act awareness/compliance and how it has been achieved throughout the Clinical Board, more training and awareness over the next 18-24 months to improve the outcome on Mental Capacity Act awareness.

- The feedback from the IMCA services is a valuable tool, raising awareness across the Health Board.
- The issue for the Mental Health Clinical Board is the difference between the MHA Act to the MCA, it has been highlighted that the DoLS training could be more beneficial**.**
- Within patient files especially in older people services written documentation surrounding the MCA can be improved upon.
- Being able to demonstrate that using the least restrictive measures have been considered and documented are more apparent than being threaded through patients' notes.
- Code of practice states that if someone needs to be detained then it is appropriate to do so, but there is a need to ensure that it is

documented thoroughly within the notes/care and treatment plan and which avenues are explored.
- Community areas have more practical avenues and ways of gaining consent but more detail needed around area of capacity.

- Moving forward the data of Mental Capacity Act training can be captured on ESR training.
- Centrality of training is highlighted throughout the Clinical Boards

Maria Jones and Sue Bailey leave the Committee meeting.

The Committee **NOTED** the reports and the action that would be taken in support and **AGREED** to review the effectiveness of these presentations.

MHCLC 16/088 UPDATED DoLS MONITORING REPORT

The Committee received and noted the report from the Operations Manager. The Chair opened up to questions and discussion. There are currently urgent assessments outstanding for Cardiff and Vale due to the nature of hospital referrals.

- The statistic table does not meet100% on the last page of the report due to a typo.
- Debate has been around the costings of the assessments and budgets being met.
- Apologies around lateness of dissemination of the report.
- Discussion is needed on how to take forward the regular reporting of the Clinical Boards.
- Having all clinical boards attend and present at the committee has focused more on the awareness of MCA.
- Auditing can identify the key issues needing more training.
- Issues raised in IMCA's reports need to be raised, a strategy plan is in place to ensure all components can be discussed and carried forward with best governance practices and Data Protection Act being adhered to.
- Do Not Attempt Cardio Pulmonary Resussitication (DNA CPR), issues raised around this and the root cause analysis.
- Training and how to report into performance reviews
- Audits can be carried out in sections and feedback reviewed over the next 12 months.

Committee to receive reports 3 times a year without clinical board presentations.

Chair summarizes and a report to be brought forward to next committee.
ACTION – Medical Director

MHCLC 16/089 MENTAL HEALTH ACT ACTIVITY REPORT

The Director of Operations, Mental Health, Mr. Ian Wile presented the report and advised there were no exceptions to the report. Explanations of the breaches to the Mental Health Act were reported, why and what steps were followed to rectify the breaches. The Mental Health Clinical Board was reporting a high standard of non-compliance due to mis-communication and incorrect paperwork breaches occurred. The 4 occasions of unlawful detentions have not been taken further.

The number of 136 assessments in custody have remained low.

The Chair of the Committee leaves the meeting 10.32am, Mr. Martyn Waygood continued to Chair as Vice Chair of the Committee.

The Committee **NOTED** the report.

MHCLC 16/090 SECTION 117 COMPLIANCE

The Director of Operations, Mental Health, Mr Ian Wile gave an oral update on Section 117, stating it would no longer come to Committee as a standing item. A serious incident had been reported where a service user fell out of contact from the services and 117 aftercare was not maintained.
A centralized list of 117 aftercare and monitoring of compliance has been compiled and is best practice throughout Wales. Cardiff and Vale University Health Board have gone through in excess of 21,000 files to ensure the sector is covered with patients that move out of area or who are no longer under the care of Section 117. Up to date lists are audited every 2/3 months.

The Vice Chair **NOTED** the report, the committee **AGREED** that it will no longer be a standing item on the Agenda.

The Committee **NOTED** the report.

MHCLC 16/091 a) SECTION 136 PARTNERSHIP ARRANGEMENTS

The Director of Operations, Mr Ian Wile gave an oral report, this piece of work was in conjunction with the police. The amount of mental health well-being and social care issues have increased across all of the services, and are aiming to be targeted more effectively.

Partnership working is taking place to provide better services with a "sanctuary" for those not in need of the acute/crisis setting.

b) CONCORDANT DELIVERY PLAN

The Director of Operations had nothing further to add to the report, but outlined the following:

- Training front line officers
- Place of refuge for those in need of well-being support, short stay
- Mental Health Learning Disability being taken forward by Caswell Clinic
- Representation by all health boards and Cardiff and Vale are coming forward with nominations.
- Call centre triage, mental health practitioners – 24/7 support.
- Not to implement another layer and for it to be addressed initially within the current infrastructure.

Medical director leaves the committee 10.47hrs

The Committee **NOTED** the report

MHCLC 16/092 HEALTH INSPECTORATE WALES - MENTAL HEALTH ACT ANNUAL REPORT

The Chair **NOTED** that there is no current report available.

MHCLC 16/093 HEALTH INSPECTORATE WALES – INSPECTION REPORTS

The Chair **NOTED** that there is no current report available.

MHCLC 16/094 REVIEW OF SMOKING EXEMPTION

The Committee **NOTED** there is no written report and Ian Wile gave an oral update

Project group put together in Mental Health service, including the caring staff, patients and Ethics Committee on the general overview that a proposal of no smoking within Mental Health services. A draft plan to be taken back to the project group and for it to be piloted in the summer with a period of 3 months initially.

The Chair opened up to discussion, NO COMMENTS made.

MHCLC 16/095 HOSPITAL MANAGERS POWER OF DISCHARGE SUBCOMMITTEE MINUTES

The Vice Chair of the Power of Discharge group had nothing further to add to the report.

The Vice Chair opened up to comments:

- It was noted how well the appraisal system for the Power of Discharge members has been working effectively in their development process.

The Committee had no further questions or comments and the report was **NOTED.**

MHCLC 16/096 MENTAL HEALTH ACT BENCHMARKING REPORT

The Director of Operations, Mental Health, Ian Wile gave an overview of the report produced. It was documented that the definitions around invalid detentions are to be investigated .

Due to the sensitivity of information shared anonimised data was given from 4 other health boards which was included in the report. It was discussed that the noting of rectifiable errors is of importance for training standards within the directorate and work is taking place on reducing them. The report will be refined and completed bi-annually for submitting at committee. Mr Ian Wile to attend the Mental Health Act Managers' meeting and encourage the other Health Boards in Wales to share information and complete their reports.
The work completed from Cardiff and Vale Health Board surrounding the current status of invalid detentions and the measures in reducing these will enable the All Wales group to reduce these figures dramatically.

The Vice Chair opened up to comments :
The Interim Chief Operating Officer commented that it was only when seeing the data in front of you it impacts on how it has been functioning within the Clinical Board to date.

The committee **NOTED** the report

The Vice Chair mentioned that "All Wales Benchmarking" will be brought back in 2017 for further discussion.

MHCLC 16/097 MENTAL HEALTH MEASURE MONITORING REPORT

The Director of Operations, Mental Health, Mr. Ian Wile delivered an oral update. The Manager of the service, Mr. Julian Willett has given some predictions over the yearly quarters of 2017/18; currently there has been high profile from the media with regard to the royal family, (Prince Harry) and the discussions around Mental Health services. Over 1200 referrals were received over the last 12 months putting high pressures within the team. The recruitment process is nearly complete for the assessing roles to enable the vast quantity to flow more productively and meet the 28 day target.

- Good progress on the CAMHS service**.**
- Single point of referrals for GP's into part 1 services.
- No long term sickness has been reported

Report tabled from CAMHS, the target was achieved for under 16's, breach was made for not reaching target of 56 days for assessment within the services due to a member of staff leaving the post.

The Committee **NOTED** the report

MHCLC 16/098 COMMITTEE WORK PLAN

The Committee **RECEIVED** and **NOTED** the work plan

MHCLC 16/099 HOSPITAL MANAGERS' POWER OF DISCHARGE SUB COMMITTEE MINUTES

The Committee **RECEIVED** and **NOTED** the report

MHCLC 16/100 REVIEW OF THE MEETING

The Chair reviewed the meeting and no comments were brought forward.

MHCLC 16/101 DETAILS OF NEXT MEETING

The next meeting will be held on Tuesday 3rd October 2017, Boardroom, Headquarters, UHW

ACTION LOG FOLLOWING MHCLC MAY 2017

Minute	Date of Meeting	Subject	Agreed Action	Action To	Status
ITEMS TO BE BROUGHT TO A FUTURE MEETING					
MHCLC 16.028	10.05.16	Section 136 Partnership Arrangements	Check figures for the under 18s, CAMHS absconders and children cared for on an adult ward	I Wile	Data was hard to obtain. It was believed that no children had been affected – this will be double checked. Update to be received at **May 2017** meeting
MHCLC 16/052	9.8.16	Transfer to Hafan y Coed	Seek ideas from volunteers and the Third Sector to enable patients to purchase cigarettes.	I Wile	Update to be received at **May 2017** meeting
MHCLC 16/052	9.8.16	Transfer to Hafan y Coed	Bring the benefits realization report for Welsh Government to Committee after the first year.	I Wile	**October 2017**
MHCLC 16/050	9.8.16	MHA Exception Report	Ask the Police to provide details of BME within the Section 136 figures.	I Wile	**October 2017**
COMPLETED ACTIONS (TO BE REMOVED ONCE REPORTED TO MEETING AS COMPLETE)					
MHCLC 16/046	9.8.16	MCA Clinical Board Reports	Include Clinical Board compliance with the Mental Capacity Act and training within the performance management framework.	S Curry	**COMPLETE** to stay on log for monitoring purposes.

Cardiff and Vale DoLS Partnership Board Report
22nd September 2017

Cardiff and Vale of Glamorgan Deprivation of Liberty Safeguards and Mental Capacity Act Team

The Cardiff and the Vale DOLS / MCA Team operate the Supervisory Body responsibilities of the Deprivation of Liberty Safeguards on behalf of Cardiff and Vale UHB, City of Cardiff Council and Vale of Glamorgan Council, through a partnership management board consisting of senior representatives of each Supervisory Body.

The team acts on behalf of the three Supervisory Bodies in the:

- **Coordination of DoLS assessments as requested by Managing Authorities by undertaking the following assessments:**
  - Age - 18 and over
  - Mental Illness- Is medically diagnosed with a mental disorder
  - Mental Capacity - Lacks capacity for the decision to be accommodated in the hospital or care home
  - No refusals - there is no Advanced Decision previously made to refuse treatment or care, or conflict relating to this such as LPA or Deputy
  - Eligibility - This determines whether the person meets the requirements for detention under the Mental Health Act 1983;
  - Best Interests - The person needs to be deprived of liberty for reasons of health, safety and best interests.
- **Supervision and workload management of over 20 Best Interest Assessors;**
- **Advice and support to health and social care teams across the sector in relation to MCA/DoLS issues;**
- **Training for care homes and all inpatient sites across the hospitals of Cardiff and the Vale of Glamorgan areas.**

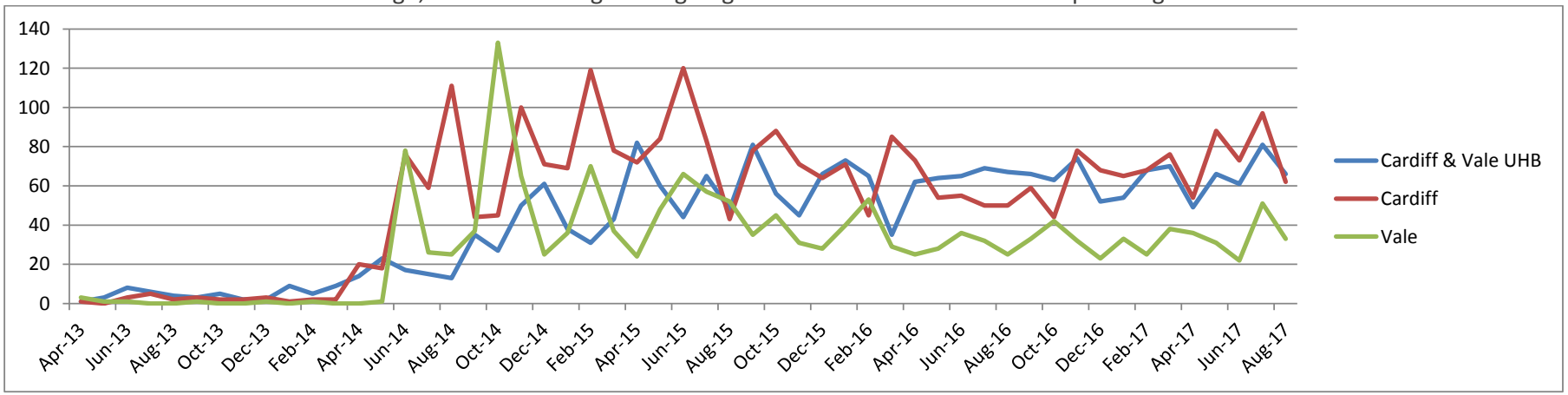
The DoLS team is based in the Vale of Glamorgan and consists of:

- 1 full time administrator
- 1 full time DOLS/MCA Coordinator (Band 7)
- 2.5 full time Best Interest Assessors

- 1.0 full time Best Interest Assessors (Cardiff Council funded)
  - Cardiff Council withdrew 1.0 FTE BIA from the team in July 2017
- 1.0 full time Best Interest Assessor (Vale of Glamorgan funded)
- 11 rota'd Best Interest Assessors

Referral rate…

The effects of the revised definition of Deprivation of Liberty following the Cheshire West Ruling continue to impact on the number of requests for Standard and Urgent Authorisations as described in the graph below. It is noticeable that in the three and a half years post Cheshire West, the number of referrals has remained high, but is stabilising leading to greater confidence in workforce planning.



The table below shows the number of DoLS referrals per Supervisory Body over the last 4 years.

REFERRALS	2013/14	% of referrals	2014/15	% of referrals	2015/16	% of Referrals	2016/17	% of Referrals
Cardiff Council	32	34.4%	866	49.1%	778	39.4%	882	41%
Vale Council	6	6.4%	489	27.7%	534	27%	424	20%
C&V UHB	55	59.1%	406	23%	661	33.5%	837	39%
Total	93	100%	1761	100%	1973	100%	2143	100%

It is interesting to compare the relationship between the total number of care home beds with the total number of DoLS Authorisation requests with the total number of relevant care home beds in the area. During 2016/17 the Vale of Glamorgan received 424 DoLS Requests from 903 care home beds; 882 Requests for 2091 beds in Cardiff while we received 837 for 1711 adult hospital beds across the UHB. It is interesting to note a ratio of 1 request to 2.1 in the Vale, 1 request to 2.3 Cardiff Care Home beds is comparable to 1 to 2.0 hospital beds.

Best Interest Assessments

The Welsh Government Expert Group have estimated by talking to each Supervisory Body that each DoLS Assessment takes on average one whole working day when taking into account the coordination, interview, consultation and administration for each assessment. The Cardiff and Vale DoLS Team averages 1.5 assessments per BIA, per working day.

ASSESSMENTS t	Completed Assessments 2014/15	% completed Assessments 2014/15	Completed Assessments 2015/16	% Completed Assessments (2015/16)	Completed Assessments (2016/17))	% completed assessments (2016/17)	Outstanding Assessments
Cardiff Council	298	34.4%	305	32.4%	409	36%	1154
Vale Council	169	19.5%	216	22.9%%	191	17%	558
C&V UHB	397	45.9%	419	44.5%%	522	47%	52

It should be noted that the DoLS Team is not able to meet the statutory timescales (21 day) for Standard Authorisation Requests. We are currently one year behind timescale, but this is slowly reducing. The team is able to meet statutory timescales for Urgent Authorisation Requests which primarily are made from hospital wards. The Partnership Board has accepted that Urgent Requests need to be prioritised but as part of the analysis for this report, it is noted that the DoLS Team completed 119 Standard Requests for the UHB Supervisory Body which were prioritised above much older requests form the two local authorities. To this end, the Operational Manager has reviewed the Prioritisation Matrix and reminded the DoLS Coordinator to take length of delay into consideration when prioritising.

DoLS Authorisations

The Authorisation of completed DoLS assessments is an essential and important part of safeguarding vulnerable people. The Code is clear that the Authorisation must be undertaken by a senior manager independent of the provision of the care. The Partnership Board is asked to note that:

- Cardiff Council are in the process of recruiting a MHA/MCA Lead to act as main Authoriser which will reduce delay for Cardiff Council;
- C&V UHB are reviewing their Authoriser protocol;
- Vale of Glamorgan will continue with OM and HoS Authorisation.

AUTHORISATIONS	Outstanding Authorisations on 21st Sept 2017
Cardiff Council	63
Vale Council	4
C&V UHB	47

Law Commission Review into DoLS

The Law Commission published its review into the Deprivation of Liberty Safeguards and a draft Bill recommending a repeal of DoLS and the implementation of a new scheme. The proposed new scheme, called **Liberty Protection Safeguards (LPS)**, focuses on placing human rights protections (Art 5 & 8) at the beginning of the care planning process and includes people in their own home, supported living or shared lives schemes, and 16 and 17 year olds. In this way, people will not have to wait for an 'authorisation' of their care after the event, but will have their human rights protected before a deprivation occurs.

The proposal introduces the role of **'independent reviewer'**, who must not be involved in the person's care but must consider if the new care plan is 'proportionate and necessary' based on a mental capacity and medical assessment.

In cases where a person is objecting or the care plan is for the protection of others, the case will need to be referred to an **Approved Mental Capacity Professional** to further scrutinise the care plan for approval. There is no requirement for secondary Authorisation from the Responsible Body.

The Cardiff and Vale DoLS Partnership Board will need to consider the local implementation of the new scheme as the Bill is passed as an Act within the next few years, but in the meantime the existing DoLS remains in place.

Cardiff and Vale DoLS Team will continue to work on WG working groups on this issue as required.

Section 12 Doctors

Currently each and every DoLS Assessment requires a mental health and eligibility assessment by a Section 12 (MHA83) medical examiner at a cost of £182. The cost per Supervisory Body is indicated in the table.

The LPS scheme, although requires a medical assessment, the independent reviewer is able to make use of existing medical assessments rather than commissioning a stand-alone assessment. This represents a significant saving over the resource heavy DoLS process.

Use of Section 12 Doctors	Total number of occasions Sec 12 doctor used (2016/17)	Total Cost (£)
Cardiff Council	409	£74,454.36
Vale Council	191	£34,769.64
C&V UHB	522	£100,486.08

Cardiff and Vale DoLS Partnership Board Report
22nd September 2017

RPR/IMCA Reviews

The role of the IMCA/Relevant Persons Representative in protecting the rights of people deprived
of their liberty cannot be overstated. AJ vs A Local Authority [2015] reminded supervisory Bodies of the duty to nominate a paid RPR (IMCA) where the SB is not satisfied that the relevant person has a representative to appropriately maintain contact, represent and support him or her. The table shows the number of referrals for a paid RPRs per authority and the number of reviews requested by RPRs.

Relevant Persons Representative in 2016/17	Total Number of IMCA referrals	Total Number of Reviews requested
Cardiff Council	312	5
Vale Council	139	5
C&V UHB	?	6

Partnership Agreement

Further to a recent Vale of Glamorgan internal Audit, a formal partnership agreement has been proposed, utilising Vale of Glamorgan template setting out the following:

- Function of Partnership Board
- Confirmation of Vale of Glamorgan as lead provider
- Confirmation of Funding agreement
- Resolution of complaints
- Quality Assurance
- Information Sharing Protocol

Cardiff and Vale Partnership Funding

FUNDING	Current Funding Equation	Funding Outturn 2015/16	Actual Funding %	% of Referrals	Funding based on Referrals	% Completed Assessments 2016/17	Funding Based on Comp Ass
Cardiff Council	40.74% (+1BIA)	£155,000*	52.9%	41%	£119,940	36%	£105,313
Vale Council	14.65% (+1BIA)	£60,829	20.7%	20%	£58,507	17%	£49,731
C&V UHB	44.61%	£76,708	26.2.0%	39%	£114,089	47%	£137,492
	100%	**£292,537**	**100%**	**100%**	**£292,537**	**100%**	**£292,537**

*including additional BIA at £45k

Assuming, that the Cardiff and Vale DolS Team undertook assessments according to the actual funding percentages paid into the Team: Cardiff Council had 184 fewer completed assessments than paid for, Vale had 41 fewer than paid for while the UHB had 228 more than paid for.

Assuming the DoLS Team completes 800 to 1000 assessments during 2017/18, and the actual funding proportion as at 16/17 (17/18 figures not available at time of writing): the number of completed assessments funded per Authority is shown in the table opposite.

	Actual Funding % 2016/17	No. of assessments according to funding %	Difference between allocation and actual
Cardiff Council	52.9%	593	-184
Vale Council	20.7%	232	-41
C&V UHB	26.2%	294	+228

	Actual Funding % 2016/17	Number of funded assessments at 800 per year	Number of Assessments at 1000 per year
Cardiff Council	52.9%	424	529
Vale Council	20.7%	166	207
C&V UHB	26.2%	210	262

2017/2018 so far…

This table shows the number of completed assessments undertaken in the first 5 months of 2017/18. At the end of August 2017, the Team has already completed the number of funded assessments for the UHB. Any further DoLS assessments completed by the Cardiff and Vale DoLS Team for the UHB Supervisory Body will be entirely funded by Cardiff and Vale of Glamorgan Councils.
This is an untenable position. Possible solutions include:

2017/18	Apr	May	Jun	Jul	Aug	Total
Cardiff Council	22	19	24	10	16	**91**
Vale Council	8	12	3	15	5	**43**
C&V UHB	40	57	54	55	55	**261**

- The Cardiff and Vale DoLS Team do not undertake further assessments for the UHB Supervisory Body
- The Cardiff and Vale DoLS Team charge the UHB £300 per assessment for every assessment above the funded quota.
- The UHB provides additional funds to the Team to cover the additional workload.

Issues to consider

The Cardiff and Vale DoLS Partnership Board is asked to note and consider:

Best Interest Assessors capacity/resource

- Ongoing risk associated with the number of outstanding DoLS Authorisation requests.

DoLS Team Funding

- The UHB might wish to consider increasing funding to the DoLs Team to ensure continued compliance with the safeguards
- Renegotiating the DoLS funding equation or revising funding arrangements

Law Commission Review

- Local implementation of the proposed Liberty Protection Safeguards in due course.

Partnership Agreement

- Letter of Understanding confirming Vale of Glamorgan as Lead Provider
- Information Sharing Protocol

Andrew Cole,
Operational Manager
Vale of Glamorgan Council
September 2017

MENTAL CAPACITY ACT (MCA) 2005 UPDATE REPORT

Executive Lead : Medical Director
Author : Mental Capacity Act Manager – tel. 029 2074 3652
Caring for People, Keeping People Well : This report underpins the Health Board's "Culture" element of the Health Board's Strategy – "Working better together…"
Financial impact : No direct impact of this report, but the failure to comply with MCA could lead to costly complaints and litigation
Quality, Safety, Patient Experience impact : Adherence to MCA will mean that vulnerable patients will receive the treatment and care they need, in line with their best interests.
Health and Care Standard Number 4.2 **CRAF Reference Number** 8.1.3
Equality Impact Assessment Completed: ~~Yes / No /~~ Not Applicable

8

RECOMMENDATION

The Board is asked to:

- **NOTE this report**

SITUATION

The Mental Health and Capacity Legislation Committee has agreed that regular reports, providing information about the UHB's use of the Mental Capacity Act 2005 (MCA), should be tabled.

It is important to note that this information does not provide direct assurance about compliance with MCA: rather, it provides an indication of awareness of and use of MCA throughout the UHB.

Demonstrating compliance with MCA can only be done by scutinising patients' notes. It is clear that MCA is still not embedded in clinical practice throughout the UHB.

BACKGROUND

The Mental Capacity Act 2005 (MCA) came into force mainly in October 2007 – a decade ago. It was amended to include the Deprivation of Liberty Safeguards (DoLS), which came into force in April 2009.

The MCA covers three main issues –

- The process to be followed where there is doubt about a person's decision-making abilities and decisions may need to be made for them (e.g. about treatment and care)

- How people can make plans and/or appoint other people to make decisions for them at a time in the future when they can't take their own decisions
- The legal framework for authorizing deprivation of liberty when adult, mentally disordered, incapacitated people are deprived of their liberty in hospitals or care homes (DoLS)

People, aged 16 years and over, who have impaired decision-making abilities may present in any of the services that the UHB provides.

It is not possible to state how many people with impaired decision-making abilities are patients of the UHB, but the likelihood is that it is a significant minority. Nor is it possible to know how many decisions UHB staff are making on behalf of people who cannot take those decisions for themselves.

Failure to comply with MCA could lead to the following –

- Patients refusing treatment that they need and their refusal being taken at face value, with no assessment of their capacity to make the decision being made. This could (and does) result in serious harm to vulnerable patients
- Patients not receiving care and treatment tailored to their individual circumstances
- Patients being kept unnecessarily in hospital, because staff are either ignorant of the MCA decision-making process or are not confident in using it
- Healthcare professionals and the UHB being sued, prosecuted, complained about and being reported to professional bodies
- Adverse inspection reports and publicity for the UHB

In order to assist UHB staff with understanding and using MCA, the following are in place -

Training (mandatory)

- A module of the EIDO consent e-learning course (not linked with the electronic staff record (ESR))
- Face-to-face teaching from the MCA Manager including Monthly UHB wide sessions at various locations, "Mandatory May and November" training and Senior Medical Induction
- Bespoke training on request
- The All-Wales MCA e-learning course is available for use on ESR

Information and advice

The MCA Manager provides information and advice to UHB staff on all aspects of MCA. There is also a "Mental Capacity" page on the intranet.

Policies and procedures

A number of policies and procedures are in place to support UHB staff in implementing MCA. The MCA Manager also tries to ensure that other policies adequately and accurately reflect MCA where appropriate.

Additional information

Use of MCA within the UHB

Appendix 1 sets out information that indicates the use of MCA within the UHB.

Independent Mental Capacity Advocacy

See also the report (Appendix 2) provided by Advocacy Support Cymru (ASC) – the statutory advocacy provider.

Clinical Board MCA Leads

The following updates have been provided by the MCA Leads –

PCIC CB

- Developing Covert Medication guidelines for the UHB, primary care and care homes. MCA central to this issue, so the guidelines will help to embed MCA within practice
- An audit of mental capacity assessments is being undertaken in District Nursing

Surgery CB

- An audit has been carried out in Trauma & Orthopaedics. 25 sets of patient notes were reviewed. Mental capacity assessments were completed for 9 patients, for two decisions only – surgery and discharge planning. The vast majority of the assessments were deficient in some way – either because there was no evidence that support had been given to the patient to help them make their own decision, or because it wasn't clear why the assessor thought that the patient failed in some aspect of the functional test. Assessments also need to be carried out for other decisions, if necessary.
- Mental capacity assessments will be included in a LocSSIP (Local Safety Standards for Invasive Procedures) that is being developed for trauma procedures carried out in either in-patient wards or in outpatients

Specialist Services CB

- The High Dependency Unit mental capacity assessment audit concluded that
  - Documentation of decision making around capacity issues generally extremely poor across all professionals

  - Evidence of poor understanding of the MCA and the responsibilities of healthcare professionals
  - Documentation of capacity most likely when considering invasive or risky procedures
- The CB's Directorates are now undertaking mental capacity assessment audits

Dental CB

- An audit of mental capacity assessments is being carried out for special care dentistry patients requiring dental general anaesthesia in SSSU, UHW
- Hope to replicate in Community Dental Service, with CD assistance
- MCA Manager to be invited to provide MCA training to a staff audit meeting before end of year
- Line managers to identify MCA training level as certain staff use regularly, while other divisions never apply MCA

CD&T CB

- MCA is an agenda item at CB and Directorate QS+E meetings where issues are regularly discussed
- MCA Manager has been asked to provide MCA training for Phlebotomists
- Second mental capacity audit (of staff who have undertaken MCA training) to be undertaken in October
- Considering how to undertake audit of mental capacity assessments within the CB
- As part of the work on NatSSIPs (National Safety Standards for Invasive Procedures) the requirement for consent (and capacity) is being addressed

Women and Children CB

No information received

Medicine CB

No information received.

Mental Health CB

No information received.

ASSESSMENT

It is clear that further continuing work is required to fully embed the MCA. There is on-going development of the provision of training and support.

APPENDIX 1

Mental Health & Capacity Legislation Committee

MENTAL CAPACITY ACT ISSUES AND INFORMATION
October 2017

Information on the use of MCA is as follows –

1) Queries to Mental Capacity Act Manager

Period	No of queries
1/7/15 – 30/9/15	23
1/10/15 – 31/12/15	19
1/1/16 – 31/3/16	24
1/4/16 – 30/6/16	18
1/7/16 – 30/9/16	23
1/10/16 – 31/12/16	26
1/1/17 – 31/3/17	30
1/4/17 – 30/6/17	28

8.1

There are no obvious themes or trends to the queries. Some are straightforward, whilst others are complex.

This is an example of a simple query – Can a patient's relative sign a consent form to share information with Social Services when the patient cannot consent themselves?

This is an example of something more complex – A pregnant woman needs to be transferred to the maternity unit to give birth. However, there is reason to doubt her mental capacity to make decisions about her birth related care and treatment. What needs to be done?

2) Monitoring reports from the Independent Mental Capacity Advocacy (IMCA) service

Referrals from the UHB to IMCA are as follows:

Decision/Issue	July-Sept 16	Oct–Dec 16	Jan-Mar 17	Apr – Jun 17
Accommodation	14	10	16	18
POVA Safeguarding	1	0	2	2
Care Review	2	2	6	1
Serious Med T/ment	8	6	4	5

DoLS s.39A	0	0	1	4
DoLS s.39C	0	1	0	0
DoLS s. 39D	6	4	7	5
DoLS RPR	62	74	76	82
TOTAL	**93**	**97**	**112**	**117**

For further information, please see the advocacy service report (Appendix 2)

The very high use of IMCA as the patient's Relevant Person's Representative under DoLS continues to cause workload pressures for the IMCA service.

3) Healthcare Inspectorate Wales (HIW) reports

2 inspection reports, published between April 2017 and end of June 2017, were found on HIW's website –

a) UHL – Mental Health Services for Older People (MHSOP) & Medicine

MHSOP - We noted improvements in the monitoring of Deprivation of Liberty Safeguards (DoLS) legislation on the Older People's Mental Health wards.

The health board must ensure that responsible clinicians record capacity assessments within the designated area on the health board's electronic patient record system.

b) UHW - Emergency Unit

The health board must ensure that if there are any reasons to doubt a patient's capacity to make a particular decision, a mental capacity assessment will be required and the outcome of the assessment documented accordingly.

5**) Complaints from patients/carers**

2 complaints concerning or related to MCA issues during the period Jan – June 2017 have been brought to the attention of the MCA Manager. However, it is very likely that there are other complaints in this period which include MCA issues.

One case concerned a dispute over a Do Not Attempt Resuscitation Order (DNACPR). The other concerned the care given to a patient and what information could be given to his family.

6) Public Services Ombudsman for Wales reports - http://www.ombudsman-wales.org.uk/en/publications/The-Ombudsmans-Casebook.aspx

The Ombudsman's Case Book for the periods January to March 2017 and April to June 2017 includes 7 cases that were upheld against Cardiff and Vale UHB or GPs/Dentists in the UHB area. MCA issues were not explicitly mentioned in any of the cases and there is no evidence to suggest that mental capacity was an issue in any of the cases either.

7) Other – e.g. serious incidents

Common issues are falls and the development of pressure sores. Between April and June 2017, there were at least 4 cases of either falls or pressure damage where it was clear or very likely that the patient had a cognitive impairment.

8) Staff training

The Learning, Education and Development Department was not able to provide training figures for this report as it is still overseeing the migration of data to ESR.

Appendix Two

Mental Capacity Act issues highlighted by the IMCA Team, Advocacy Support Cymru

Date: August 2017
In their role as statutory advocacy providers within Cardiff and Vale UHB, Advocacy Support Cymru (ASC) has highlighted a number of issues, as follows –

Capacity and consent/Best Interest process/IMCA role

- General lack of understanding and acknowledgement from professionals across the health board in relation to IMCA role.
- General lack of understanding and acknowledgement from professionals as to when the Mental Health Act/Mental Capacity Act should be used.
- The IMCAs have encountered a general lack of understanding from Professionals of what capacity means in terms of the Mental Capacity Act 2005 and how it applies in practice. Professionals appear to be of the understanding that if a person who is deemed to lack capacity and "consents" to the move or to treatment, this consent is valid. We also have experience of Professionals believing that because a patient is not objecting but is compliant with a decision that the patient has capacity. In reverse, we encounter people who have their capacity status questioned and assessed because they are disagreeing with the proposed treatment or course of action. We are often told that as if a patient disagrees they "must lack insight and lack capacity".
- IMCAs are repeatedly explaining to the professionals the purpose of the Best Interest process, explaining in detail about the "least restrictive" principle and why the patient should be central to the process. IMCAs also question staff about the legal authority (or lack of it) they are using in order to impose a decision on a client who is objecting and protesting to the BI outcome.
- The IMCA team have recently received a number of referrals that are very short notice, or where a decision has already been made, Serious Medical Treatment has already taken place, or a Best Interest Meeting is due to take place the following day.
- The IMCA was instructed in relation to a Long Term Move of Accommodation. P had been fully CHC funded by Cardiff and Vale UHB since at least February 2017. The IMCA has raised the following concerns:
    - A capacity assessment in relation to a Long Term Move of Accommodation had not been completed.
    - A DNAR has been in place since October 2016, but an IMCA was not consulted.
    - There is no DoLS in place, although it has been applied for an assessor has not yet met with the gentleman as he wasn't deemed as high priority.
    - This gentleman has been left in a darkened room with no mental or physical stimulation since he arrived at the Nursing Home. He is not encouraged to take part in activities.
    - There is nothing in the Care Plan to suggest that meetings have taken place to discuss P's care, other than notes in the Care Plan to 'respect his privacy'.
    - P weighs only 37 kilos and is not regularly weighed.
- IMCA was instructed in relation to a move of accommodation decision. P had a wife; however, the IMCA was informed that his wife did not wish to be formally consulted with on

this process. The IMCA visited P to ascertain his wishes and views regarding discharge and also attended meetings on his behalf. However, the IMCA received a phone call from P's wife requesting information on the IMCA role and stated that she would like to be consulted with on decisions regarding her husband. The IMCA raised concerns with professionals that more clarification should have been sought by the decision maker as to the position of P's wife and how involved she wished to be in the best interest process.

Capacity assessments

- The IMCAs have encountered some professionals who have displayed confusion around capacity assessments and the fact that they should be issue specific. Some professionals/health staff appear to be of the understanding that capacity is general, and not issue specific. There have also been cases where IMCAs have been informed that someone lacks capacity, but there is no formal capacity assessment on file/been completed.

Serious Medical Treatment decisions/Lack of communication/Referrals

- IMCAs are often involved with patients (either as a direct result of a referral for a long term move of accommodation or because we are the appointed Relevant Person's Representative under the Deprivation of Liberty Safeguards) who are in hospital having undergone surgery or serious medical intervention but where there are no family and friends involved and yet there are no IMCA referrals for these patients. As a result of the referral we are discovering that a non-emergency surgical or serious medical treatment decision has taken place without the safeguards of an IMCA. Do not resuscitate orders (DNAR) are in place without consultation with the patient, any family or an IMCA having been appointed.
- Lack of referrals from decision makers in SMT decisions, instead a number of professionals are relying on RPR involvement instead of making a specific IMCA referral. IMCA's have explained to professionals and decision makers that each IMCA decision requires a separate referral.
- In the last 3 months, the IMCA team have only received 5 SMT referrals.

DoLS

- IMCA was instructed as a 39a IMCA. P had explicitly expressed his desire to travel independently outside of his local area, however owing to staff concerns regarding his ability to return to the home he was prevented from leaving the home despite the fact there was no legislation in place to restrict P's movements in this way.
- IMCA was appointed as the RPR for P. Upon meeting P for the first time and speaking to staff that support him, the IMCA was made aware that P is being covertly medicated. The IMCA informed the staff that an IMCA should have been instructed for this best interest decision and requested that a review of the covert medication decision be held. The MDT have made best interest decisions without the correct safeguards in place.
- IMCA was appointed as RPR. Although P was not objecting or protesting to being in hospital she was very clear in her wish to be discharged back to her own home. P had a son who was very supportive of his mother's wishes and also wanted his mother to return home. The MDT did not feel that a discharge home was appropriate and this is being challenged. However, the IMCA has not been able to establish why P's son had not been appointed as the RPR for his mother, as he is representing her wishes and views. The IMCA has not been

able to establish why this is the case, however has been informed by the DoLS team that the son had not been offered the RPR role at all.

Lack of POVA referrals

- In the last three months, the IMCA team have only received 2 PoVA referrals.

In the last 3 months the number of qualifying patients under Cardiff and Vale Health Board supported by the IMCA team is: 117

RPR: 82
IMCA 39A: 4
IMCA 39C: 0
IMCA 39D: 5
Long Term Move of Accommodation: 18
Serious Medical Treatment: 5
Care Review: 1
POVA: 2

MENTAL CAPACITY ACT (MCA) - DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR)

Executive Lead : Medical Director
Author : Mental Capacity Act Manager – tel. 029 2074 3652
Caring for People, Keeping People Well: This report underpins the Health Board's "Culture" element of the Health Board's Strategy – "Working better together…"
Financial impact : No direct impact of this report, but the failure to comply with MCA could lead to costly complaints and litigation
Quality, Safety, Patient Experience impact: Adherence to MCA will mean that vulnerable patients will receive the treatment and care they need, in line with the law.
Health and Care Standard Number 4.2 **CRAF Reference Number** 8.1.3
Equality Impact Assessment Completed: ~~Yes / No /~~ Not Applicable

RECOMMENDATION

The Board is asked to:

- **NOTE this report and support the actions being taken;**
- The Senior Nurse, Resuscitation Service and MCA Manager will co-ordinate a Senior Medical Staff Grand Round session to cover DNACPR and the law. Guidance will be published in the Medical Directors Bulletin.
- The Medical Director, Mental Capacity Act Manager and the Resuscitation Service will recommend, in a paper to the Quality, Safety and Patient Experience Committee, that this issue is considered as part of the routine reports to that Committee by the Clinical Boards. The support of the Chair of the MHCLC in raising this issue with the Chair of the Quality, Safety and Patient Experience Committee is requested as an action.

9

SITUATION

The Independent Mental Capacity Advocacy (IMCA) service has expressed concern about the frequency with which they come across patients for whom a DNACPR order is in place, but where there has been no consultation with the patient, family/friends or an IMCA.

The Mental Health and Capacity Legislation Committee has asked for a report on this issue.

It is important to note that this report does not provide direct assurance about compliance with the law: rather, it provides an indication of the position within the UHB.

BACKGROUND

The requirement for patients, their family or friends, or an IMCA to be consulted about DNACPR decisions arises from both the Mental Capacity Act 2005 (MCA) and the Human Rights Act 1998 .

The MCA sets out that where a person lacks capacity for a serious medical treatment decision (which includes DNACPR) and there is no-one to consult with about their best interests, the IMCA must be instructed (MCA, s.37)

There are two pieces of recent case law on DNACPR –

Tracey, R (On the Application Of) v Cambridge University Hospitals NHS Foundation Trust & Ors [2014] EWCA Civ 822 (17 June 2014)

In 2014, the Court of Appeal ruled that there had been an unlawful failure to involve Mrs Tracey in the decision to impose a DNACPR notice on her. This failure was in breach of Article 8 (right to respect for private and family life) of the European Convention on Human Rights. The Court said that there should be a presumption in favour of involving the patient and there would have to be convincing reasons not to do so. Merely causing the patient distress would not be a convincing reason. Where the clinician assesses that to attempt CPR would be futile, they must tell the patient that this is their view.

Winspear v City Hospitals Sunderland NHS Foundation Trust [2015] EWHC 3250 (QB) (13 November 2015)

In this case, the High Court ruled that there had been an unlawful failure to involve Mr Winspear's mother in the decision to make a DNACPR order. Mr Winspear lacked capacity to be involved in the decision himself, but a DNACPR order was put in place without a discussion with any family/friends. This was in breach of Article 8 (right to respect for private and family life) of the European Convention on Human Rights.

As a result of these two cases, the British Medical Association, the Resuscitation Council (UK), and the Royal College of Nursing published Decisions Relating to CPR, 2016.

ASSESSMENT

There is some information available about the use of DNACPR within the UHB –

1) An audit conducted in January 2016, of 50 DNACPR decisions in hospital, found that
   - in 20.7% of cases, there was no record of whether the patient had capacity to be involved in the decision
   - in 24.2% of cases no discussion had been had with patients (or if it had, it wasn't documented) about DNACPR
   - in 38% it was clear that no discussion had taken place with patient's family/ friends

   Unfortunately, the All-Wales standardised audit (agreed by Welsh Government) does not directly address the question of where patients lack mental capacity to be involved in DNACPR discussions, whether family or friends were consulted.

2) An audit conducted in early 2016, of 56 DNACPR decisions in hospital, found that in 25% of cases, the DNACPR decision had not been discussed with either the patient or their family/friends. Once again, this audit did not directly address the question of where patients lacked mental capacity to be involved in DNACPR discussions, whether family or friends were consulted.

3) An analysis of 4 DNACPR incidents in Medicine Clinical Board during 2017 found that in one case a DNACPR decision had been made without discussion with the patient or their family/friends.

4) There is also significant other anecdotal evidence from clinicians and the IMCA service of DNACPR decisions being made without discussion with the patient or their family/friends, or an IMCA, in both hospitals and the community.

Thus, there is some, but limited, evidence to show that DNACPR decisions are not always being made lawfully.

The IMCA service and the 3 UHBs for whom they provide a service are working to produce a list of "red flag" events/situations, where the IMCA service will formally notify the UHB where they have come across one of these events/situations. DNACPR decisions where no-one has been consulted about the decision are likely to be one such event. Any DNACPR issues raised will be recorded on DATIX and will be passed on to the Relevant Directorate Management Team.

As actions:

- The Senior Nurse, Resuscitation Service and MCA Manager will co-ordinate a Senior Medical Staff Grand Round session to cover DNACPR and the law. Guidance will be published in the Medical Directors Bulletin.

- The Medical Director, Mental Capacity Act Manager and the Resuscitation Service will recommend, in a paper to the Quality, Safety and Patient Experience Committee, that this issue is considered as part of the routine reports to that Committee by the Clinical Boards. The support of the Chair of the MHCLC in raising this issue with the Chair of the Quality, Safety and Patient Experience Committee is requested as an action.

APPROVAL OF LASTING POWER OF ATTORNEY (LPA) AND COURT APPOINTED DEPUTY (CAD) PROCEDURE
Name of Meeting: Mental Health and Capacity Legislation Committee **Date of Meeting:** 3rd October 2017

Executive Lead: Medical Director
Author: Mental Capacity Act Manager, Julia.Barrell@wales.nhs.uk, Tel. 029 2074 3652
Caring for People, Keeping People Well: This procedure underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy. The UHB is committed to ensuring that patients receive treatment and care in accordance with the law.
Financial impact: not applicable
Quality, Safety, Patient Experience impact: Patients must be treated only in compliance with the legal framework. Where there is doubt about an adult patient's mental capacity to give consent, the Mental Capacity Act 2005 (MCA) must be followed. This includes understanding the roles and working appropriately with attorneys and deputies, when required to do so by law.
Health and Care Standard Number 4.2 Patient information
CRAF Reference Number 8.1.3
Equality and Health Impact Assessment Completed: ~~Yes /~~ ~~No /~~ Not Applicable An Equality Impact Assessment on the UHB Consent Policy (from which this procedure derives) was undertaken and feedback was received on the way it operates. The EqIA found there to be no negative impact on the equalities groups and positive impact on some of the groups - age; disability; race; religion and Welsh language.

10.1

ASSURANCE AND RECOMMENDATION

ASSURANCE provided by:

- The review of this procedure that has been undertaken to ensure that it reflects the law and assists staff to comply with it

The Mental Health and Capacity Legislation Committee is asked to:

- **APPROVE** the Lasting Power of Attorney (LPA) and Court Appointed Deputy (CAD) procedure
- **APPROVE** the full publication of the Lasting Power of Attorney (LPA) and Court Appointed Deputy (CAD) procedure in accordance with the UHB Publication Scheme

SITUATION

This procedure has been in force within Cardiff and Vale University Health Board (the UHB) since 2013 and was due for review.

The procedure sets out what LPAs and CADs are and how clinicians should work with them.

BACKGROUND

The Mental Capacity Act 2005 (MCA) makes provision for a person's decision-making authority with regard to property and affairs, and health and welfare to be vested in another person, either by way of a Lasting Power of Attorney (LPA) or by the appointment of a Court appointed deputy (CAD).

The procedure provides further information and detail in support of section 12 (Patients who lack capacity to give or withhold consent) of the UHB's Consent to Examination or Treatment Policy.

The aim of this procedure is to provide information and direction to Cardiff and Vale UHB staff regarding Lasting Powers of Attorney (LPA), Enduring Powers Of Attorney (EPA) and Court Appointed Deputies (CADs), so that UHB staff know how to respond appropriately and lawfully when a patient who has an attorney or deputy presents for treatment and care.

ASSESSMENT

The substance of the procedure has not changed and only minor amendments have been made.

Consultation on the draft procedure was undertaken with the following –

- UHB Intranet Consultation pages – 16th June to 14th July 2017

No comments were received.

The primary source for dissemination of this procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: 113 **Version Number: 2**	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

LASTING POWER OF ATTORNEY AND COURT APPOINTED DEPUTY PROCEDURE (MENTAL CAPACITY ACT 2005)

Introduction and Aim

The aim of this procedure is to provide information and direction to Cardiff and Vale UHB staff regarding Lasting Powers of Attorney (LPA), Enduring Powers of Attorney (EPA) and Court Appointed Deputies (CADs), so that UHB staff know how to respond appropriately and lawfully when a patient who has an attorney or deputy presents for treatment and care.

The procedure provides further information and detail in support of section 12 (Patients who lack capacity to give or withhold consent) of the UHB's Consent to Examination or Treatment Policy.

The Mental Capacity Act 2005 (MCA) makes provision for a person's decision-making authority with regard to property and affairs, and health and welfare to be vested in another person, either by way of a Lasting Power of Attorney (LPA) or by the appointment of a Court appointed deputy (CAD).

10.2

Objectives

- Adherence to this procedure means that health professionals will be acting lawfully.

Scope

This procedure applies to all of our staff in all locations, including those with honorary contracts.

Equality Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has not been completed, as this procedure has been developed in support of the Consent to Examination or Treatment Policy.
Documents to read alongside this Procedure	Department for Constitutional Affairs (2007) Mental Capacity Act Code of Practice, TSO, London HMSO (2005) Mental Capacity Act 2005, TSO, London Cardiff and Vale UHB Consent to Examination or Treatment Policy
Approved by	Mental Health and Capacity Legislation Committee

Document Title: *Insert document title*	2 of 12	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

Accountable Executive or Clinical Board Director	Medical Director
Author(s)	Mental Capacity Act Manager

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
2	*Date of Committee or Group Approval*	*TBA*	Revised document. Minor amendments including • Use of current UHB template • Links to examples of registered LPA and CAD documents added • Link to search the register of LPAs and CADs added • Weblinks checked References to other documents checked and amended where necessary

10.2

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Approved By:		

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APPENDIX A Useful contact details

10.2

1. DEFINITIONS

Enduring Power of Attorney (EPA):- An EPA is a legal document that deals with property and affairs – they do not cover health and welfare (see section 10).

Lasting Power of Attorney (LPA):- A LPA is a legal document that allows a person to appoint another person/persons (the attorney or donee) to make decisions that are as valid as one made by the person (the donor) (see section 11). LPAs cover either property and affairs or health and welfare.

Court Appointed Deputy (CAD):- The Court of Protection can appoint a person (a deputy) to take decisions about property, affairs, health and social care on behalf of a person who lacks mental capacity to take these decisions (see section 12).

2. RESPONSIBILITIES

Executive responsibility for this procedure lies with the Medical Director.

Clinical Board Directors are responsible for ensuring that staff are aware of this procedure, how to access it and what to do if they have queries about it.

All staff who have contact with patients in the course of providing them with all aspects of treatment and care (including research) have a responsibility to familiarise themselves with, and follow the content of this procedure and to ensure that they remain up to date with regard to relevant legislation, case law and guidance regarding LPAs, EPAs and CADs.

The most senior health professional involved with the patient's care has specific responsibilities for working with attorneys and deputies – see section 13.

The Mental Capacity Act Manager is responsible for ensuring that this procedure is updated as necessary; that relevant training is available; and to provide information, support and training to UHB staff as required.

NOTE: Where staff are unsure about the legal aspects of LPAs, EPAs and CADs in a particular case, they must seek advice from the Mental Capacity Act Manager/Patient Safety Team in the first instance. If this does not resolve the matter and legal advice is needed, staff must contact the Director of Governance/Board Secretary in order to arrange this. Please see Appendix A for contact details.

3. RESOURCES

No extra resources are required to implement this procedure.

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Approved By:		

4. TRAINING

Specific training is not required for this procedure. However, the Mental Capacity Act Manager can provide training on this procedure, or as part of more general Mental Capacity Act training, if required.

5. IMPLEMENTATION

Clinical Board Directors are responsible for ensuring that staff who work within their Clinical Boards implement this procedure. The Mental Capacity Act Manager will provide support as required.

6. ENDURING POWER OF ATTORNEY (EPA)

An EPA is a document appointing a person (an 'attorney') to manage the property and financial affairs of another person (the 'donor').

If the donor becomes unable to make financial decisions, the EPA must be registered before it can be used.

New EPAs can no longer be created. However if a person made a EPA before October 2007, it can still continue to be used.

EPAs deal with property and affairs – they do not cover health and welfare.

Attorneys of EPAs must consider the Mental Capacity Act and its Code of Practice when acting on behalf of the donor.

Examples of registered EPAs can be found here - https://www.gov.uk/government/publications/enduring-power-of-attorney-valid-example

7. LASTING POWER OF ATTORNEY (LPA)

A person who is aged 18 years and over and who has mental capacity to do so may make a LPA.

A LPA is a legal document that allows a person to appoint another person/persons (the attorney or donee) to make decisions that are as valid as those made by the person (the donor).

There are two types of lasting power of attorney –

- Property and affairs (money and property)
- Health and welfare (healthcare, including consent to examination or treatment, and social care)

The donor can appoint more than one attorney. The attorneys can be appointed to act

- jointly (must always act together), or
- jointly and severally (attorneys may either act together or independently), or
- jointly in respect of some specified decisions, but severally otherwise

An attorney for a property and affairs LPA does not have authority to make health and welfare decisions (unless they are also an attorney for a health and welfare LPA). A health and welfare attorney does not have authority for property and affairs, unless they have also been appointed as a property and affairs attorney.

An LPA does not come into effect until it has been registered and stamped on each page by the Office of Public Guardian.

Attorneys of LPAs must have regard to the MCA Code of Practice and act in the person's best interests.

If it is suspected that an LPA exists but evidence cannot be gained to substantiate this, an enquiry can be made to the Office of the Public Guardian for a search of the register of attorneys - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/286541/OPG100_Apply_to_search_PG_registers.pdf

This is a free service.

7.1 Property and affairs LPA

Unless the donor states otherwise, once the LPA is registered, the attorney has authority to make all decisions about the donor's property and affairs even if the donor still has capacity to make the decisions for him/herself.

The attorney should allow and encourage the donor to do as much as possible for him/herself, and should only act when the donor asks them to, or when the donor loses capacity to make the decisions. If UHB staff have concerns that an attorney is acting inappropriately, they should discuss the matter with the Mental Capacity Act Manager. It may be necessary to contact the Office of the Public Guardian for advice and also notify the UHB's Safeguarding Adults Team.

The donor may, however, wish to hand over responsibility for all decisions to the attorney, even those he/she still has capacity to make.

7.2 Health and welfare LPA

LPAs can be used to appoint attorneys to make decisions about health and welfare, which can include healthcare, including medical treatment decisions and social care. Donors can add restrictions or conditions to areas where they do not give attorneys the power to act. For example, a donor might only want an attorney to make decisions about their social care and not their healthcare.

There are particular rules for LPAs authorising an attorney to make decisions about life-sustaining treatment (see section 7.4).

A health and welfare LPA can only be used at a time when the donor lacks capacity to make a specific decision.

When health professionals are proposing medical treatment and care or are preparing a care plan for a patient who has appointed a health and welfare attorney, they must first assess whether the donor has capacity to agree to the treatment or care plan or to parts of it. If the donor lacks mental capacity to give or withhold consent, health professionals must then consult the attorney and obtain their consent.

If a decision is needed about a health and welfare matter for which the attorney does not have authority to decide and a best interests decision needs to be made, the attorney must still be consulted, if practical and appropriate, about what they consider to be in the patient's best interests.

7.3 Restrictions on the powers of health and welfare attorneys

Attorneys do not have the right to consent to or refuse treatment in situations where:

10.2

- **the donor has capacity to make the particular healthcare decision**
  An attorney has no decision-making power if the donor can make their own treatment decisions.

- **the donor has made an advance decision to refuse the proposed treatment**
  An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment. But if the donor made an LPA after they had made an advance decision, and gave the attorney the right to consent to or refuse the treatment specified in the advance decision, the advance decision will no longer be valid and applicable. For more information about advance decisions, please refer to section 11.8 of the UHB's Consent to Examination or Treatment Policy.

- **a decision relates to life-sustaining treatment**
  An attorney has no power to consent to or refuse life-sustaining treatment, unless the LPA document explicitly authorises this

- **the donor is detained under the Mental Health Act**
  An attorney cannot consent to or refuse treatment for a mental disorder for a patient detained under the Mental Health Act (MHA) 1983, except in the case of Electro-convulsive therapy (ECT), where the attorney may refuse consent. However, if the ECT is to be given to

the patient under MHA, Section 62 (urgent treatment) the attorney has no authority to refuse.

LPAs cannot give attorneys the power to demand specific forms of medical treatment that healthcare professionals do not believe are necessary or appropriate for the donor's particular condition.

Attorneys must always follow the MCA and make decisions in the donor's best interests. If health professionals disagree with the attorney's assessment of best interests, they should discuss the case with other health professionals and/or get a formal second opinion. They should then discuss the matter further with the attorney. If they cannot settle the disagreement, they must seek legal advice. This will be arranged via the appropriate advisor within the UHB (See Appendix A). An application to the Court of Protection may be necessary.

7.4 Health and welfare LPA that authorises an attorney to make decisions about life-sustaining treatment

An attorney can only consent to or refuse life-sustaining treatment on behalf of the donor if the LPA explicitly grants this authority to the attorney.

The attorney must not be motivated by the desire to bring about the donor's death.

10.2

If there is doubt that the attorney is acting in the donor's best interests, an application can be made to the Court of Protection for a decision. While the court is coming to a decision, healthcare professionals can give life-sustaining treatment to prolong the donor's life or stop their condition getting worse.

8. COURT APPOINTED DEPUTY

The Court of Protection can appoint a person (a deputy) to take decisions about property, affairs, health and social care on behalf of a person who lacks mental capacity to take these decisions.

Deputies, like attorneys, must have regard to the MCA Code of Practice and act in the person's best interests.

Deputies cannot refuse consent for life-sustaining treatment.

If a decision is needed about a health and welfare matter for which the deputy does not have authority to decide and a best interests decision needs to be made, the deputy must still be consulted, where practical and appropriate, about what he/she considers to be the patient's best interests.

If health professionals feel that a deputy is not acting the best interests of the patient, and they have not been able to resolve the matter with the deputy, they should contact the Office of the Public Guardian (see section 11. below).

If it is suspected that a deputyship order exists but evidence cannot be gained to substantiate this, an enquiry can be made to the Office of the Public Guardian for a search of the register –

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/286541/OPG100_Apply_to_search_PG_registers.pdf

8.1 Restrictions on the powers of Court Appointed Deputies

Restrictions on a Court Appointed Deputy (CAD) include –

- The CAD believes, or has reasonable grounds for believing, that the person has capacity to take the decision in question
- The CAD cannot prohibit a named person from having contact with the person with impaired capacity, nor can the CAD direct the person's responsible healthcare professional to allow a different responsible healthcare professional to take over that responsibility
- The CAD cannot overturn a decision made by an attorney acting under an LPA granted by the person before they lost capacity
- The CAD cannot refuse the provision or continuation of life-sustaining treatment for a person who lacks capacity to consent to it (only the Court can take this decision)

9. WORKING WITH AN ATTORNEY OR DEPUTY

If staff are made aware that a patient has an attorney or deputy, particularly regarding health and welfare, this information must be reported to the most senior health professional involved in the patient's care.

The senior health professional must

- attempt to make contact with the attorney or deputy and ask to see the lasting power of attorney/court order
- satisfy themselves that the LPA is registered by inspecting the document and ensuring that it has been stamped on every page by the Office of the Public Guardian
- with the consent of the attorney, take a copy of the LPA or court order and file it in the patient's notes
- understand the powers that have been conferred on the attorney/deputy
- make arrangements to inform other health professionals involved in the patient's care that the patient has an attorney or deputy together with details of the authority the attorney/deputy has

Examples of registered LPAs can be found here - https://www.gov.uk/government/publications/lasting-power-of-attorney-valid-examples

Examples of court orders appointing a deputy can be found here - https://www.gov.uk/government/publications/deputy-court-order-valid-example

If health professionals decide to provide treatment and care to the patient, they must

- in the case of a health and welfare LPA, assess whether or not the patient has mental capacity to give or refuse consent to the treatment. If the patient has capacity, then the patient will make the decision
- consider whether this treatment and care falls under the authority of the attorney/deputy
- seek consent for the treatment and care from the attorney/deputy, if the attorney/deputy has the authority to take the decision. Refusal must be respected. Where appropriate (i.e. if written consent would normally be obtained from the patient if they had mental capacity to do so), complete (Consent) Form 4. If the decision does not need to be formally documented on (Consent) Form 4, ensure that the attorney/deputy's consent is recorded in the patient's notes.
- if the attorney/deputy does not have the authority to take the decision, then the health professional will need to make a best interests determination. The attorney or deputy must be consulted as part of this determination, where practical and appropriate.

10. LPAS/CADS AND ADVANCE DECISIONS TO REFUSE TREATMENT

An attorney cannot consent to treatment if the donor has made a valid and applicable advance decision to refuse a specific treatment. But if the donor made an LPA after they had made an advance decision, and gave the attorney the right to consent to or refuse the treatment in question, the advance decision will no longer be valid and applicable. For more information about advance decisions, please refer to section 11.8 of the Consent to Examination or Treatment Policy.

Note that neither a CAD nor the Court can overturn a valid and applicable advance decision. A CAD, therefore, has no authority to consent to treatment that is the subject of a valid and applicable advance decision.

11. DISAGREEMENT/DISPUTE WITH THE ATTORNEY/CAD

In the event that health professionals believe that an attorney or a CAD is not acting in a person's best interests, the Mental Capacity Act Manager must be informed and a decision will be made about whether advice should be sought from the Office of the Public Guardian (OPG).

In the event that an attorney of a health and welfare LPA with the authority to refuse life-sustaining treatment does refuse such treatment and health professionals do not feel that this is in the best interests of the patient, legal advice must be sought immediately (via the on-call senior manager if out-of-hours).

Information about the OPG can be found here -

http://www.justice.gov.uk/about/opg.htm

Contact details are

Office of the Public Guardian
PO Box 16185
BIRMINGHAM
B2 2WH

Tel. 0300 456 0300

Mon, Tues, Thurs, Fri – 9.00am – 5.00pm
Wed – 10.00am – 5.00pm

Fax. 0870 739 5780

12. AUDIT

Adherence to this procedure will be monitored by a variety of processes, including structured and ad-hoc case note review and as part of the UHB and Clinical Board/Directorate clinical audit plan.

Related clinical audit activity which may include monitoring compliance with this procedure, will be reported to Clinical Board Quality, Safety and Experience Groups and the UHB Mental Health and Capacity Legislation Committee.

13. DISTRIBUTION

This procedure will be made available on the UHB intranet, Clinical Portal and internet sites.

14. REVIEW

This procedure will be reviewed every 3 years or sooner if appropriate.

Document Title: *Insert document title*	12 of 12	Approval Date: dd mmm yyyy
Reference Number:		Next Review Date: dd mmm yyyy
Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

APPENDIX A

Useful contact details

Julia Barrell, MCA Manager, Tel. 029 2074 3652 (for both consent and mental capacity issues)

Maria Roberts, Patient Safety Team Manager, Tel. 029 2074 6387

Graham Shortland, Medical Director, Tel. 029 2074 2130 (Executive Lead)

Peter Welsh, Director of Governance / Board Secretary, Tel. 029 2074 5544 (in relation to obtaining Legal Advice)

Out of hours legal advice/guidance in emergency situations, via the On Call Senior Manager rota

APPROVAL OF INDEPENDENT MENTAL CAPACITY ADVOCACY (IMCA) PROCEDURE
Name of Meeting: Mental Health and Capacity Legislation Committee **Date of Meeting:** 3rd October 2017

Executive Lead: Medical Director
Author: Mental Capacity Act Manager, Julia.Barrell@wales.nhs.uk, Tel. 029 2074 3652
Caring for People, Keeping People Well: This procedure underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy. The UHB is committed to ensuring that patients receive treatment and care in accordance with the law.
Financial impact: not applicable
Quality, Safety, Patient Experience impact: Patients must be treated only in compliance with the legal framework. Where there is doubt about an adult patient's mental capacity to give consent, the Mental Capacity Act 2005 (MCA) must be followed. This includes instructing IMCA when required to do so by law.
Health and Care Standard Number 4.2 Patient information
CRAF Reference Number 8.1.3
Equality and Health Impact Assessment Completed: ~~Yes /~~ ~~No /~~ Not Applicable An Equality Impact Assessment on the UHB Consent Policy (from which this procedure derives) was undertaken and feedback was received on the way it operates. The EqIA found there to be no negative impact on the equalities groups and positive impact on some of the groups - age; disability; race; religion and Welsh language.

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- The review of this procedure that has been undertaken to ensure that it reflects the law and assists staff to comply with it

The Mental Health and Capacity Legislation Committee is asked to:

- **APPROVE** the Independent Mental Capacity Advocacy procedure
- **APPROVE** the full publication of the Independent Mental Capacity Advocacy procedure in accordance with the UHB Publication Scheme

10.3

SITUATION

This procedure has been in force within Cardiff and Vale University Health Board (the UHB) since 2013 and was due for review.

The procedure sets out the circumstances, under MCA, in which clinicians have a legal duty to instruct IMCA and the circumstances in which they have discretion to instruct IMCA.

BACKGROUND

The MCA makes provision for the IMCA service and the **legal duty** to instruct the IMCA service about certain decisions where patients

- aged 16 years and over lack mental capacity to make those decisions
- have no-one (apart from paid carers) whom it would be appropriate to consult with about their best interests

The decisions are: serious medical treatment and a move to, or a change in, long term accommodation. The UHB may also wish to instruct an IMCA in safeguarding adults (adult protection) cases and care reviews.

Under the Deprivation of Liberty Safeguards (DoLS) provisions, there is also a requirement for the Supervisory Body (UHB) to appoint IMCA in certain circumstances. IMCA may also be appointed as the Relevant Person's Representative.

ASSESSMENT

The substance of the procedure has not changed and only minor amendments have been made.

Consultation on the draft procedure was undertaken with the following –

- Safeguarding Adults Manager
- UHB Intranet Consultation pages – 16th June to 14th July 2017

No comments were received.

The primary source for dissemination of this procedure within the UHB will be via the intranet and clinical portal. It will also be made available to the wider community and our partners via the UHB internet site.

Reference Number: UHB 186 **Version Number: 2**	**Date of Next Review:** *To be included when document approved* **Previous Trust/LHB Reference Number:** *Any reference number this document has been previously known as*

INDEPENDENT MENTAL CAPACITY ADVOCATE PROCEDURE
(Mental Capacity Act 2005)

Introduction and Aim

This procedure explains what Independent Mental Capacity Advocates (IMCA) are and the legal duties of Cardiff and Vale University Health Board (UHB) in relation to IMCA.

The Mental Capacity Act 2005 (MCA) makes provision for the IMCA service and the **legal duty** to instruct the IMCA service about certain decisions where patients

- aged 16 years and over lack mental capacity to make those decisions
- have no-one (apart from paid carers) whom it would be appropriate to consult with about their best interests

The decisions are: serious medical treatment and a move to, or a change in, long term accommodation. The UHB may also wish to instruct an IMCA in safeguarding adults (adult protection) cases and care reviews.

Under the Deprivation of Liberty Safeguards (DoLS) provisions, there is also a requirement for the Supervisory Body (UHB) to appoint IMCA in certain circumstances.

This procedure provides further information and detail in support of section 12.10 (Independent Mental Capacity Advocates) of the UHB Consent to Examination or Treatment Policy.

The MCA Code of Practice states (para 10.14) that organisations should have procedures for staff regarding IMCA.

Objectives

- Adherence to this procedure means that health professionals will be acting lawfully when providing patients with impaired mental capacity with treatment and care
- The UHB will be acting lawfully with respect to the DoLS provisions

Scope

This procedure applies to all health professionals employed by the UHB, including those on honorary contracts, who make decisions about

- Providing serious medical treatment

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Approved By:		

- Admissions to and discharges from hospital
- Safeguarding adults (adult protection)
- Care reviews of patients in NHS funded accommodation

It also applies to UHB staff who undertake the duties of the Supervisory Body in accordance with the DoLS provisions.

Equality Health Impact Assessment	An Equality and Health Impact Assessment (EHIA) has not been completed, as this procedure has been developed in support of the Consent to Examination or Treatment Policy.
Documents to read alongside this Procedure	Consent to Examination or Treatment Policy (UHB 100), 2016 Mental Capacity Act 2005 Code of Practice Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice
Approved by	Mental Health and Capacity Legislation Committee

Accountable Executive or Clinical Board Director	Medical Director
Author(s)	Mental Capacity Act Manager

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

10.4

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
2	*Date of Committee or Group Approval*	*TBA*	• Minor amendments – e.g. changes of word order, updating references to other documents, etc • Inclusion of para 7.3 – DoLS Relevant Person's Representative

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Approved By:		

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10.4

1. RESPONSIBILITIES

Executive responsibility for this procedure lies with the Medical Director.

Clinical Board Directors are responsible for ensuring that staff are aware of this procedure, how to access it and what to do if they have queries about it.

All staff who make decisions (i.e. the decision-makers) about

- Providing serious medical treatment
- Admissions to and discharges from hospital
- Safeguarding adults (adult protection))
- Care reviews of patients in NHS funded accommodation

have a responsibility to familiarise themselves with, and follow the content of, this procedure and to ensure that they remain up to date with regard to relevant legislation, case law and guidance regarding IMCA.

Staff who undertake Supervisory Body duties under DoLS are also required to comply with this procedure.

The Mental Capacity Act Manager is responsible for ensuring that this procedure is updated as necessary; that relevant training is available; and to provide information, support and training to UHB staff as required.

NOTE: Where staff are unsure about the legal aspects of IMCA in a particular case, they must seek advice from the Mental Capacity Act Manager/Patient Safety Team in the first instance. If this does not resolve the matter and legal advice is needed, staff must contact the Director of Governance/Board Secretary in order to arrange this. Please see Appendix A for contact details.

2. RESOURCES

No extra resources are required to implement this procedure.

3. TRAINING

Specific training is not required for this procedure. However, the Mental Capacity Act Manager can provide training on this procedure, or as part of more general Mental Capacity Act training, if required.

4. IMPLEMENTATION

Clinical Board Directors are responsible for ensuring that staff who work within their Clinical Boards are familiar with and follow this procedure, where necessary. The Mental Capacity Act Manager will provide support as required.

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Approved By:		

5. THE ROLE OF IMCA

The IMCA's role is to represent and support the person in question.

IMCAs should (this list is not exhaustive)

- Confirm that the person instructing them from the UHB has the authority to do so (i.e. is the decision-maker – the person who needs the decision made, or someone the decision maker has asked to instruct the IMCA on their behalf)
- Where possible, meet and talk to the person in question
- Discuss the person and their situation with the healthcare team and other paid staff who look after the person
- Obtain the views of anyone else who can provide information about the wishes, feelings, values and beliefs of the person in question
- Find out what, if any, alternative options there are for the person
- Where appropriate, seek a second medical opinion
- Support the patient to access the safeguards enshrined in the MCA

The IMCA must provide a report on their findings to the decision maker.

6. CIRCUMSTANCES IN WHICH AN IMCA MUST BE INSTRUCTED

6.1 Serious Medical Treatment

The UHB (in practice, the healthcare professional who needs to make the decision) has a duty to instruct an IMCA where decisions are being made about "serious medical treatment" where the person (aged 16 years and over)

- Lacks mental capacity to make the decision, and
- Has no-one, other than paid care staff, with whom it is appropriate to consult about whether the decision is in the person's best interests,

Serious medical treatment is that which involves giving new treatment, stopping treatment that has already started or withholding treatment that could be offered where

- There is a fine balance between the likely benefits and the burdens and risks of a single treatment
- A decision between a choice of treatments is finely balanced,
- What is proposed is likely to involve serious consequences for the patient

Serious consequences are those which could have a serious impact on the person. It could include treatments which

- Cause serious and prolonged pain, distress or side-effects
- Have potentially major consequences for the patient e.g. major surgery or stopping life-sustaining treatment
- Have a serious impact on the patient's future life choices (e.g. interventions for ovarian cancer)

Whether the treatment is "serious" will depend on the individual patient's situation and circumstances, but may include

- Cancer surgery and chemotherapy
- Electro-convulsive therapy
- Therapeutic sterilisation
- Major surgery (e.g. heart, brain surgery)
- Amputation
- Treatment that involves permanent loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration
- Termination of pregnancy

Where an urgent decision is needed – e.g. to save the person's life - an IMCA does not need to be instructed. This reason for non-referral must be recorded. However, if serious medical treatment is required after the emergency treatment, an IMCA must be instructed.

There is no duty to instruct an IMCA if the proposed treatment is for a mental disorder and that treatment is authorized under the Mental Health Act 1983. However, if a person is subject to the Mental Health Act and the proposed treatment is for physical illness e.g. cancer, an IMCA must be instructed.

6.2 Change of Accommodation

An IMCA must be instructed where a decision is needed about a move to or a change in accommodation, arranged or provided by the NHS (including residential care that is provided under s.117 of Mental Health Act 1983)

- Where the person lacks capacity to make the decision, and
- There are no family or friends who it is appropriate to consult about the person's best interests, and
- The move is likely to be for a period of 28 days or more in hospital, or 8 weeks or more in a care home

If the person's stay is longer than was expected and so exceeds the time periods above, an IMCA must be instructed.

If the placement or move is urgent, an IMCA need not be instructed, but the decision-maker (i.e. the person who needs the decision made) must involve

an IMCA as soon as possible if the person is likely to stay in hospital longer than 28 days, or longer than 8 weeks in a care home.

6.3 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) provide a legal framework for depriving a person who, because of mental disorder, is unable to consent to their accommodation in a hospital (other than under the Mental Health Act 1983) or care home in order to receive treatment and care. In certain circumstances, a person who is subject to DoLS must have an IMCA instructed for them.

An IMCA must be appointed in the following circumstances -

a) Section 39A of MCA

This applies where

- An urgent authorisation is given, or
- A standard authorisation is requested and there is not an existing authorisation in force, or
- An assessment is being undertaken to decide whether there is an unauthorised deprivation of liberty

The Managing Authority (the part of the UHB that is providing the care – i.e. the ward) must ascertain whether there is anybody, other than people engaged in providing care or treatment in a professional capacity or for remuneration, whom it would be appropriate to consult in determining what would be in the best interests of the person to whom the request for the authorisation relates.

If there is not, the Managing Authority must notify the Supervisory Body, and the Supervisory Body must instruct an IMCA to represent the person.

b) Section 39C of MCA

This provides for the appointment of an IMCA if the relevant person's representative's (RPR) appointment ends and the Managing Authority is satisfied that there is nobody, other than people engaged in providing care or treatment in a professional capacity or for remuneration, whom it is appropriate to consult in determining what would be in the person's best interests. Again, the Managing Authority must notify the Supervisory Body that this is the case, and the Supervisory Body must then instruct an IMCA to represent the person.

The IMCA's role in this case comes to an end upon the appointment of a new RPR for the person.

c) Section 39D of MCA

This provides for the instruction of an IMCA by the Supervisory Body where

- The relevant person does not have a paid RPR, and
- The person themselves or their representative requests that an IMCA is instructed to help them, or
- The Supervisory Body believes that instructing an IMCA will help to ensure that the person's rights are protected.

7. CIRCUMSTANCES IN WHICH AN IMCA MAY BE INSTRUCTED

7.1 Safeguarding Adults (Adult protection)

The NHS has powers to instruct an IMCA for a person who lacks capacity where it is alleged that

- The person is being or has been abused or neglected by another person, or
- The person is abusing or has abused another person

In such cases, an IMCA can be instructed even if the person in question has family and friends who are available to be consulted about the person's best interests. The decision-maker must be satisfied that the involvement of IMCA will benefit the person.

An IMCA can only be instructed if the health care professional proposes to take, or has already taken, protective measures.

Responsibility for deciding whether an IMCA should be instructed sits with the professional leading the safeguarding investigation. They must consider whether an IMCA should be instructed for all people at risk. They must also make a decision about instructing an IMCA at both the strategy discussion/meeting and the case conference/safeguarding planning stages. Their reasons for not instructing IMCA must be recorded.

If, as a result of the safeguarding process, it is proposed that the person in question be moved to alternative accommodation and there are no family or friends who it would be appropriate to consult, an IMCA must be instructed.

7.2 Care Reviews

A healthcare professional can instruct an IMCA when

- They have arranged accommodation for the incapacitated person
- They aim to review the arrangements (as part of a care plan or otherwise)

- There are no family or friends whom it would be appropriate to consult

Reviews should relate to decisions about accommodation

- For someone who lacks capacity to make a decision about accommodation that will be provided for a continuous period of more than 12 weeks and has been arranged by the UHB
- That are not the result of an obligation under the Mental Health Act 1983

Involvement of an IMCA should be considered at each initial care review following a change of accommodation and subsequently if there is still uncertainly about the placement. An IMCA must be involved if an IMCA was involved in the initial placement.

The decision maker's reasons for not instructing IMCA must be recorded in the patient's notes.

7.3 DoLS Relevant Person's Representative (RPR)

If no-one can be found who is suitable and eligible to act as a patient's RPR under DoLS, then IMCA may be appointed.

The role of the RPR is to

- Maintain contact with the patient
- Represent and support the patient with regards to DoLS – such as, where appropriate, asking for a review of the authorisation, making a complaint, or appealing to court against the authorisation

8. WORKING WITH IMCA

The decision-maker (except where IMCA is appointed as RPR)

- Must identify those occasions where they have a duty to instruct IMCA and those situations where they have discretion to instruct an IMCA (If the decision maker is unsure about whether an IMCA should be instructed in any particular case, they should contact the IMCA office for advice (Tel: 029 2054 0444)
- Must instruct IMCA by completing the IMCA referral form - http://www.ascymru.org.uk/english/contact-us (scroll down the page to find the IMCA referral form link) and emailing or faxing the form to the IMCA office (details on the form)
- Must let all relevant people know when an IMCA is involved in a case
- Must record the IMCA's involvement in the case
- Must give the IMCA access to relevant medical records

- Must, on receipt of the IMCA's report, consider it in determining the best interests of the person in question
- Must record how they have taken the IMCA's report into consideration, including any reason for disagreeing with the IMCA's findings
- Must inform the IMCA of the final decision taken and the reason for it.

In the event of disagreement about the person's best interests, the decision maker and IMCA should try to settle the disagreement through discussion as soon as possible. If they cannot achieve resolution, then the matter must be dealt with through the Concerns system.

If there is no other way of resolving the dispute, an application may need to be made to the Court of Protection.

9. AUDIT

Adherence to this procedure will be monitored by a variety of processes, which may include structured and ad-hoc case note review and as part of the UHB and Clinical Board/Directorate clinical audit plan.

Related clinical audit activity which may include monitoring compliance with this procedure, will be reported to Clinical Board Quality, Safety and Experience Groups and the UHB's Mental Health and Capacity Legislation Committee.

10. DISTRIBUTION

This procedure will be made available on the UHB intranet, Clinical Portal and internet site.

11. REVIEW

This procedure will be reviewed every 3 years or sooner if appropriate.

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Version Number:		Date of Publication: dd mmm yyyy
Approved By:		

APPENDIX A

Useful contact details

Julia Barrell, MCA Manager, Tel. 029 2074 3652

Maria Roberts, Patient Safety Team Manager, Tel. 029 2074 6387

Graham Shortland, Medical Director, Tel. 029 2074 2130 (Executive Lead)

Peter Welsh, Director of Governance / Board Secretary, Tel. 029 2074 5544 (in relation to obtaining Legal Advice)

Exceptional Report – Invalid Mental Health Act Detentions
Name of Meeting : Mental Health & Capacity Legislation Committee **Date of Meeting :** 03 October 2017

Executive Lead : Chief Operating Officer
Author : Mental Health Clinical Board Director of Operations
Caring for People, Keeping People Well: This report underpins the Health Board's "Sustainability" and "Values" elements of the Health Board's Strategy.
Financial impact : None
Quality, Safety, Patient Experience impact : To ensure the appropriate use of the mental health act and it being used in the least restrictive way.
Health and Care Standard Number: 1 (governance & assurance); 2 (Equality and Diversity); 5 (Patient Experience); 9 (Information and consent); 10 (Dignity and Respect); 11 (Vulnerable adults); 18 (Communicating effectively); 19 (Information); 20 (Records Management); 22 (Managing risk), 23 (Dealing with concerns and managing incidents), 26 (Workforce training organisational development)
CRAF Reference Number – 8.1.2
Equality and Health Impact Assessment Completed: Not Applicable

ASSURANCE AND RECOMMENDATION

ASSURANCE is provided by:

- Mental Health Clinical Board Director of Operations

The Board is asked to:

- **AGREE**

11

SITUATION

Any exceptions highlighted in the Mental Health Act Monitoring report are intended to raise the Committee's awareness of matters relating to the functions of hospital managers and give assurance that the care and treatment of patients detained by Cardiff and Vale University Health Board and those subject to supervised community treatment is only as the Act allows.

There are no exceptions for this period from the main Mental Health Act Monitoring Report.

BACKGROUND

For the information of the Committee - The number of patients detained without authority continues to decrease:

Period	Number of incidents
October – December 2015	6
January – March 2016	5
April – June 2016	2
July – September 2016	0
October – December 2016	4
Jan – March 2017	0
April – June 2017	0
July – September	0

ASSESSMENT AND ASSURANCE

The number of patients detained without authority has been eradicated during this quarter. All actions taken have clearly had a positive impact to improve the situation.

The Mental Health Act Manager has visited all wards across all sites with a poster containing information on the Mental Health Act which has been well received.

The Head of Operations and Delivery, Mental Health Clinical Board and the Mental Health Act Manager continue to work with Mental Health Act Leads from other Health Boards to agree and collate core data so that reliable and valid information can be routinely compared from each Health Board. This will then be submitted to the Committee yearly.

Mental Health Measure Monitoring Report **April 2017**

Executive Lead: Chief Operating Officer
Author: Head of Operations and Delivery – Mental Health
Financial impact - NA
Quality, Safety, Patient Experience impact -
Healthcare Standard Number 1 and 6 CRAF Reference Number – 8.1.2
Equality Impact Assessment Completed: Not Applicable

RECOMMENDATION

The Board/Committee is asked to:

- **Agree the approach taken by the Mental Health Clinical Board**

SITUATION

The UHB Mental Health Measure performance is reported to and monitored by the Welsh Government on a monthly basis, with reports back to the UHB Performance Monitoring Committee.

BACKGROUND

The Mental Health (Wales) Measure 2010 (the Measure), is a National Assembly for Wales law that has similar legal status to an Act of Parliament. The Measure introduces a number of important changes to the assessment and treatment of people with mental health problems in Wales. Parts 1 to 4 of the Measure set the main legislative requirements relating to Mental Health service provision and are supported by subordinate legislation and guidance.

ASSESSMENT

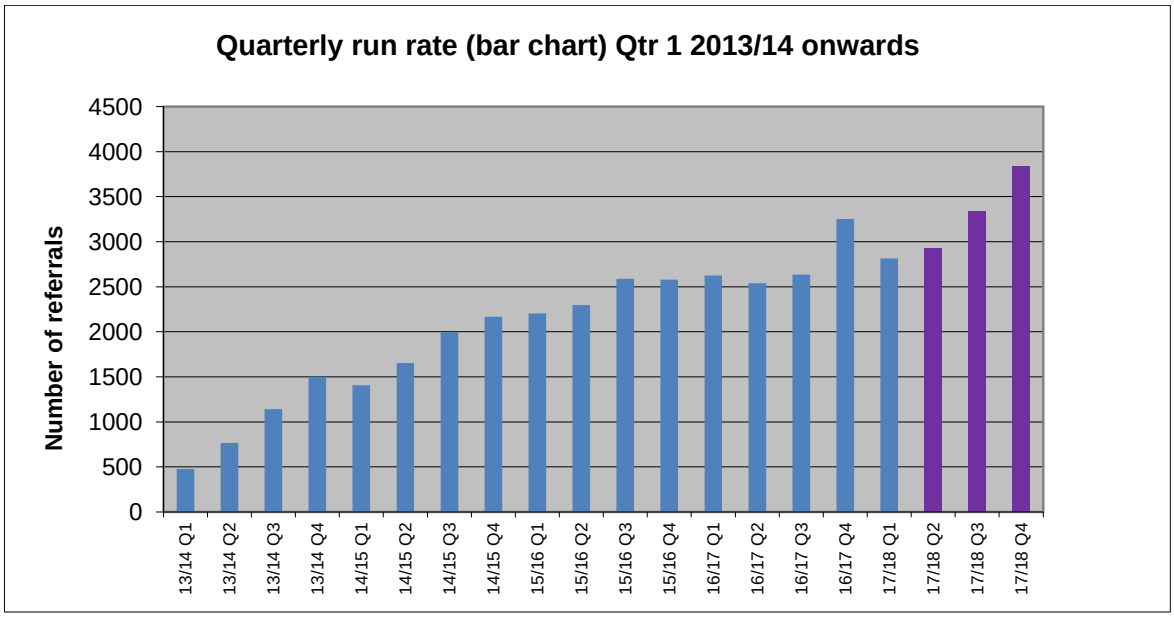
For Parts 1, 2 & 3 of the Measure, local activity and compliance information is collated and submitted to WG via standard reporting templates.

Part 1 : PMHSS

For Quarters 1 and 2 of 2017/18, PMHSS has received less referrals per month compared with Quarter 4 of 2016/17 with referrals only topping 1,000 on one occasion (May (1070)) and are projected to top 1,000 in September. However, the average referrals for the first half of the financial year are still over 950 with an estimated average for the second half (historically always our busiest period) of over 1100 per month.

Figure 1 below shows the Quarterly referral run rate for PMHSS with confirmed data in blue and estimated data in purple. Estimated data is based on previous average month-on-month changes in referral rates for the previous three years.

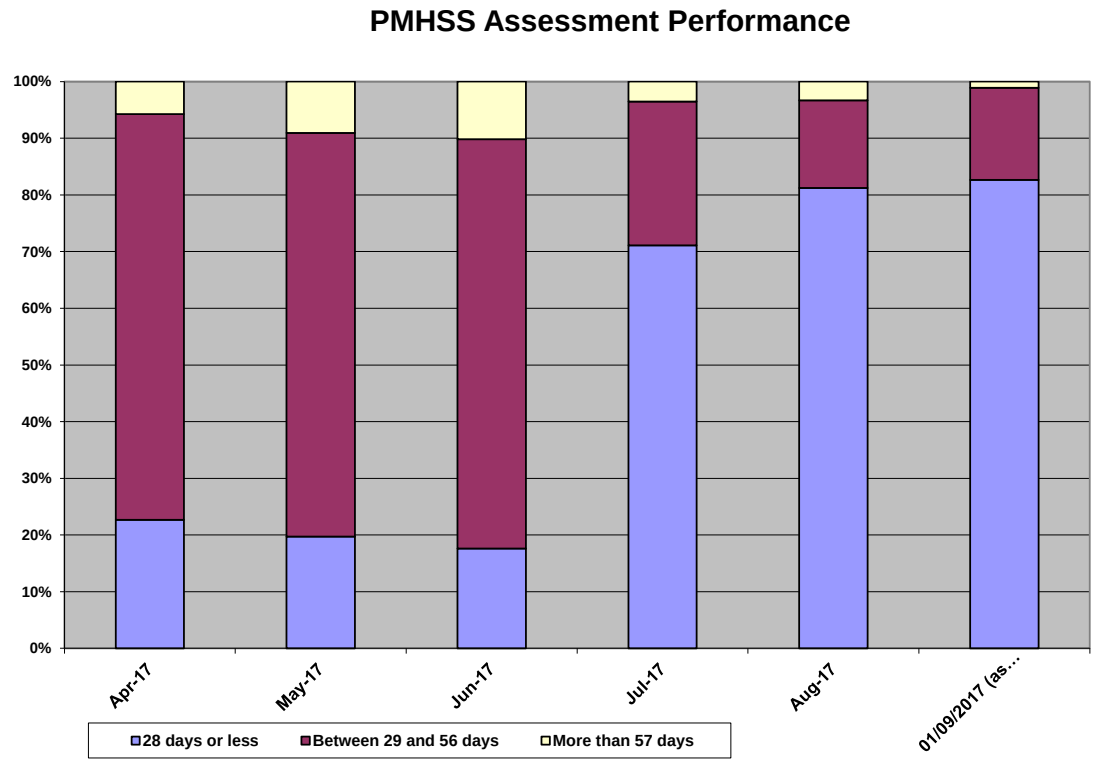
Figure 1:



As stated in the previous Monitoring Report, additional funding has afforded the service the ability to increase its capacity for Band 4 Clinical Psychology Assistant Practitioners and Band 6 PMHSS Practitioners. At time of writing there are 3.5wte vacancies for Band 4's as all four of the previous post-holders have left to embark on their respective Clinical Psychology Doctorates. Interviews for these posts are in October. Only one Band 6 post remains vacant. We had appointed to the vacancy but the candidate decided to take up an offer elsewhere. This post has yet to go back out to advert.

See Figure 2 for details but pressure on meeting Tier 1 performance targets remains high due to a culmination in the aforementioned sharply increased referral numbers in the last Quarter of the last financial year – which was compounded by the service losing three members of qualified staff (2.4wte) to unplanned medium to long term sickness in the early part of the financial year - but also an increase in the number and variety of group and one-to-one interventions being offered by the service. This latter point is likely to become a more important factor following the recent publication of the Matrics Cymru. The breaches in compliance in the early part of 2017/18 were due in the main to the aforementioned higher than expected volume of referrals in Quarter 4 of 2016/17 coupled with the loss of 2.4wte qualified staff to sickness.

Figure 2



Current under-18 assessment activity, i.e., that activity which is provided solely by Children & Young Persons (CYP) Primary Care Team, is below the Welsh Government target. In effect this shortfall in compliance can detrimentally affect the overall UHB summary by as much as 10%. However, recent work done with this service, particularly around IT systems and methods of reporting, appears to show a marked improvement in this area; although still not meeting full compliance, performance for Quarter 2 for under-18s has averaged around 70%.

The team is currently at 90% plus for the 28 day target of providing an intervention following completion of a Part 1 assessment.

Mitigation of risk

- PMHSS went live with a Bank staff arrangement in August ’15 and have a small pool of staff to draw from. Shifts are currently on Monday and Tuesdays between 5pm and 8pm and every other Saturday between 9am and 5pm. A mini audit of this arrangement revealed that at least 15% of all Part 1 assessments are carried out by the Bank staff. PMHSS has also offered secondment opportunities when slippage money has been identified. This arrangement too has had a positive impact on assessment performance.
- The Clinical Board is currently reviewing all community vacancies for scrutiny as to whether the resource can be redirected to the PMHSS team to assist with demand, even on a temporary basis.

CYP Issues

The clinical board is currently in regular contact with CYP services regarding:

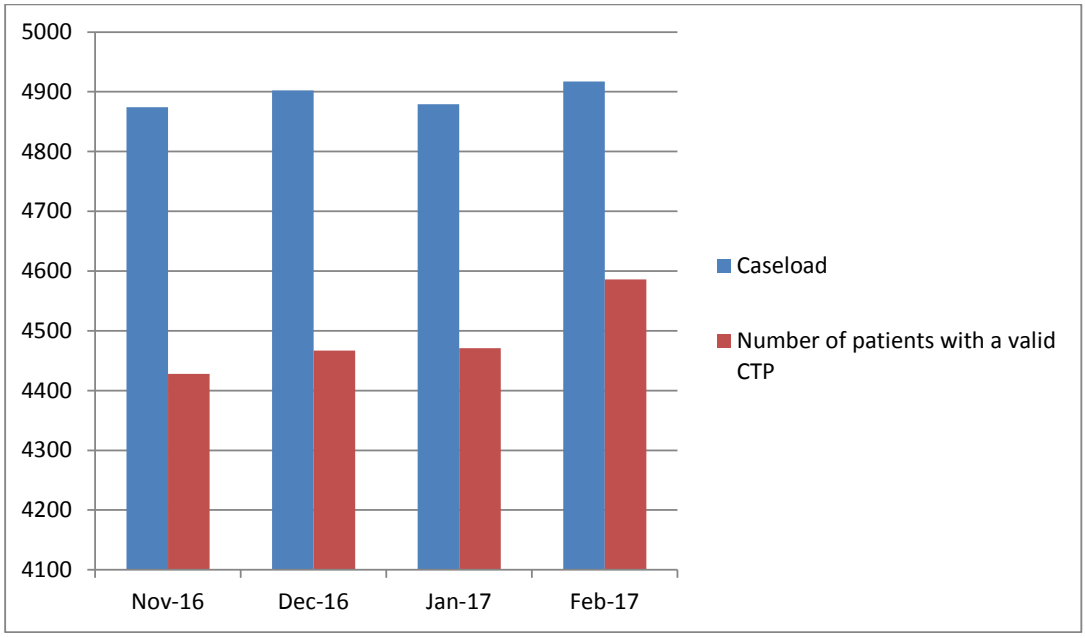
- The average referral rate for financial year 2017/18 is 107. The previously documented discrepancy between CAMHS and C&V MHCB activity numbers has improved since CYP went on to Paris in October ‘16 but still has a little way to go before being entirely reliable. Regarding the aforementioned increased funding, a proportion of that funding has gone to CYP to increase capacity.

Part 2 & 3 : Care and Treatment Planning

Care and Treatment Planning within Secondary Mental Health Services

The performance target set by Welsh Government for Part 2 is 90%. Monthly caseload variance is due to rates of referrals and discharges. The data includes Adult, Older Adult, Forensic, Learning disabilities and CAMHS services:

Metric	Nov-16	Dec-16	Jan-17	Feb-17
Total number of patients in receipt of secondary MH services in C&V	4,874	4,902	4,879	4,917
90% of Service users have a valid CTP	4,428 90.8%	4,467 91.1%	4,471 91.6%	4,586 93.3%



Performance Issues

Adult, Older Adult and Leraning Disabilty are all reprorting performance of 90% and above. CAMHS are reporting improved figures over the last 4 months but their performance is below 75%. Despite the steady improvement, the Mental Health Clnical Board lead for part 2 and 3 will attended the local CAMHS service to discuss performance related issues.

14

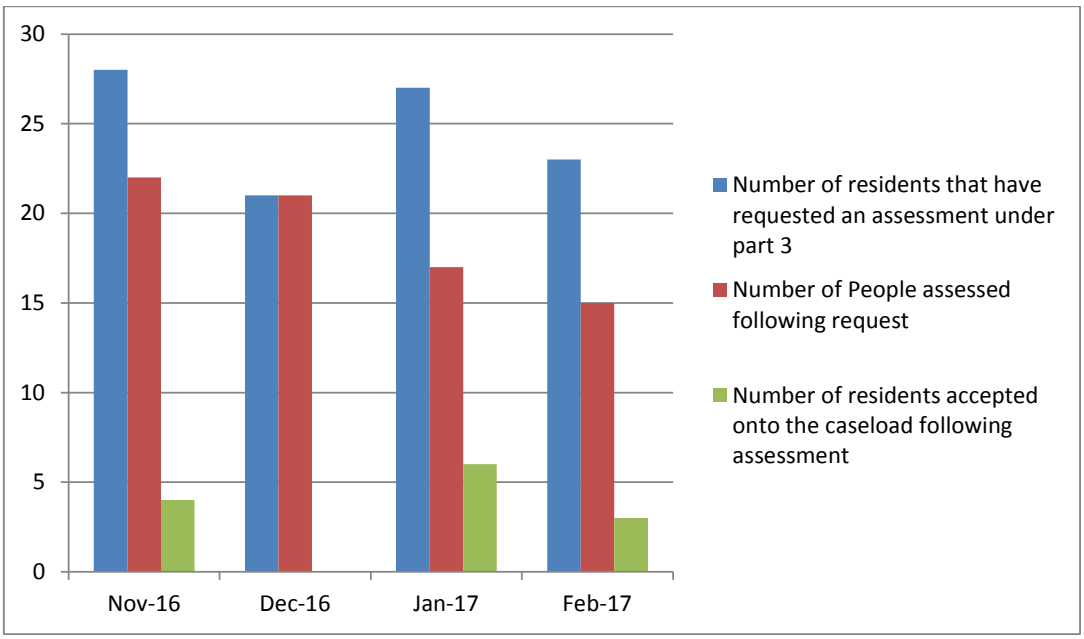
CTP Audit
The National Together for Mental Health Delivery Plan – 2016-2019 has highlighted the Mental Health Clinical Board will need to consider the following additions to the CTP audit in the coming months:

- The number/percentage of CTP's where housing, finance and employment needs are addressed with treatment plans to enable to the identification of recovery focused objectives.
- An increased percentage of service users and carers throughout the UHB who positively rated (either strongly agreed or partly agreed) that they were satisfied/felt involved with their CTP on an annual review.

Part 3
Right to request an assessment by self –referral

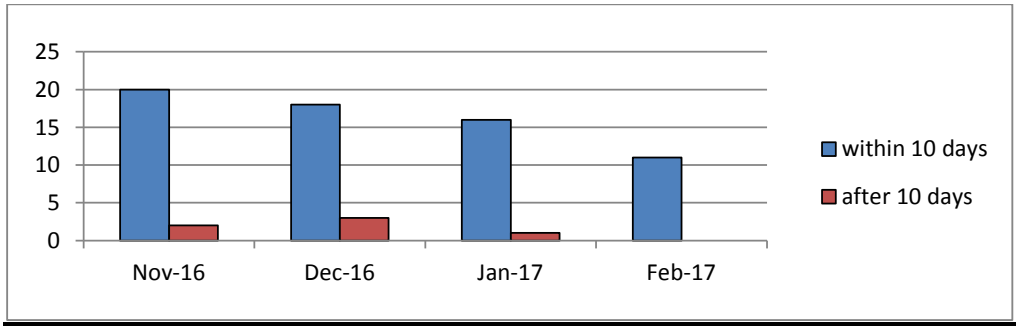
Service user's who have previously received secondary mental health services and have been discharged have a right to self refer for an assessment of their mental health for up to three years following discharge.

Metric	Nov-16	Dec-16	Jan-17	Feb-17
Number of residents that have requested an assessment under part 3	28	21	27	23
Number of People assessed following request	22	21	17	15
Number of residents accepted onto the caseload following assessment	4	0	6	3



All part three requests and outcomes are scrutinised prior to reporting. There continues to be a high number of DNA/CNA rate following requests being made to teams.

Following part 3 requests there is a requirement to issue an outcome of assessment report within ten working days. The target set out by Welsh Government for this is 100%.



Part 4 : Advocacy Services

Part 4 Inpatient Advocacy

The UHB is 100% compliant with part 4 of the measure to provide in-patient advocacy service across the University Health Board. The last return to Welsh Government as at June 2017 demonstrated a total of 55 new patients (47 compulsory patients and 8 informal patients) and a continuing caseload of 104 patients over a three month period in line with reporting requirements under the “Duty to Review” for Post-Legislative Assessment of the Mental Health (Wales) Measure 2010.

Community Advocacy

The Community Advocacy Service is provided by ASC which is commissioned separately by the Mental Health Clinical Board and continues to see growth across the Community setting.

1st April - 30th June 2017

Number of qualifying compulsory patients assisted:	1
Number of qualifying informal patients assisted:	30

14

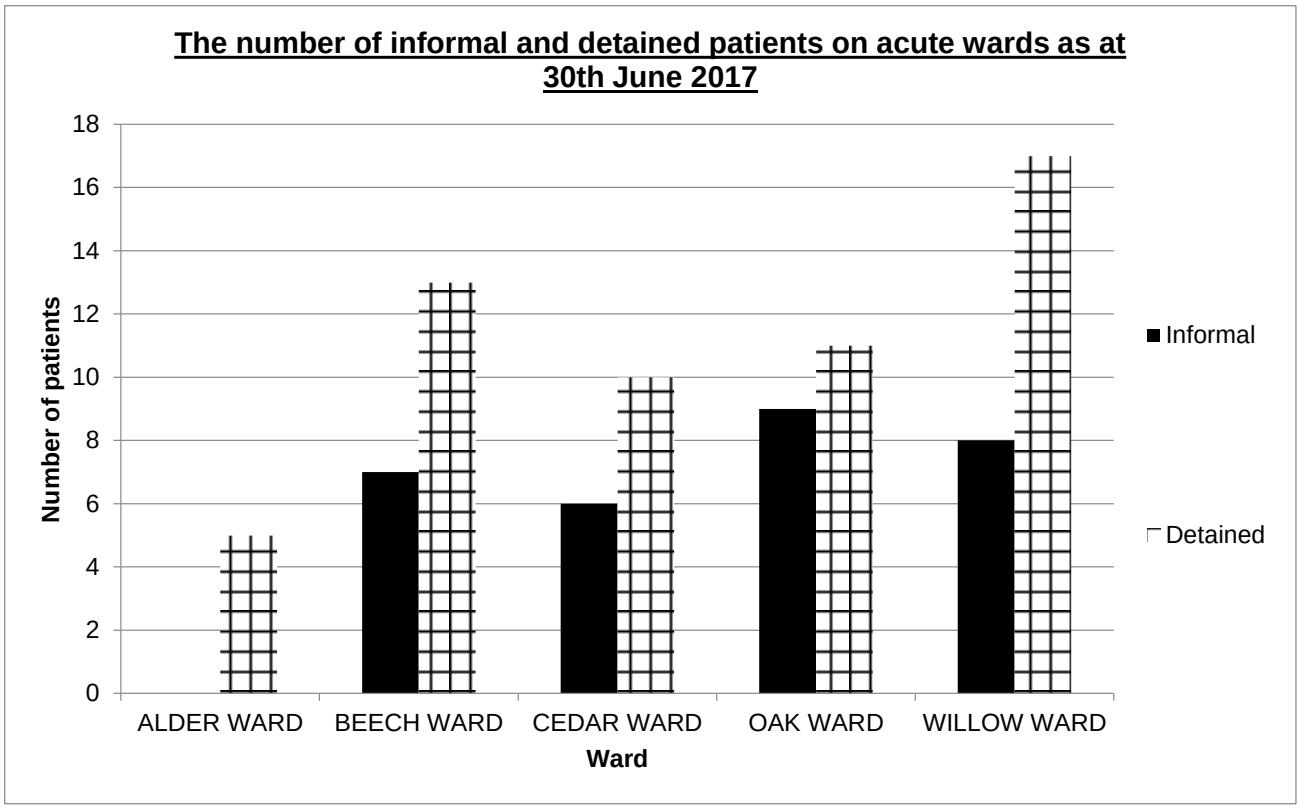
Report to the

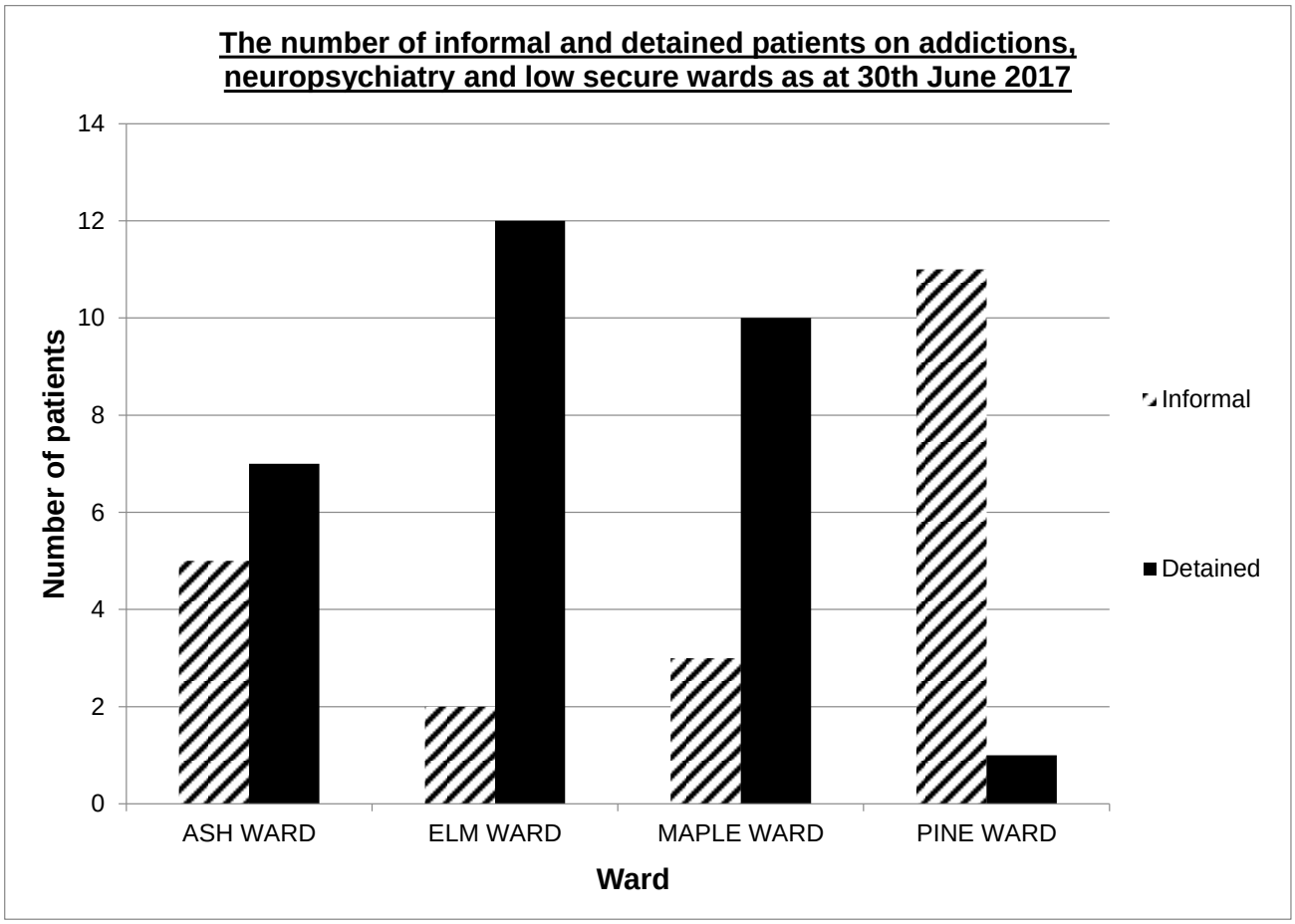
Mental Health and Capacity Legislation Committee

on the use of The Mental Health Act, 1983

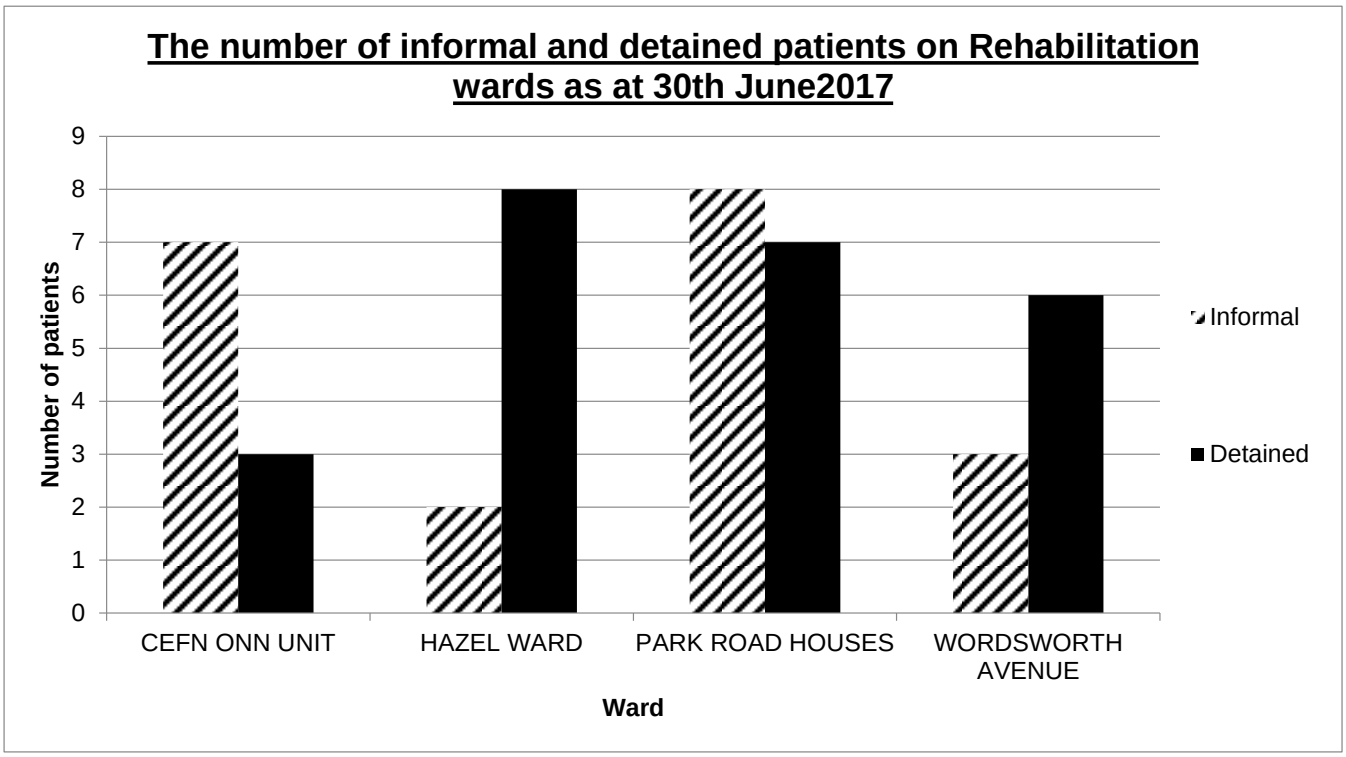
April- June 2017

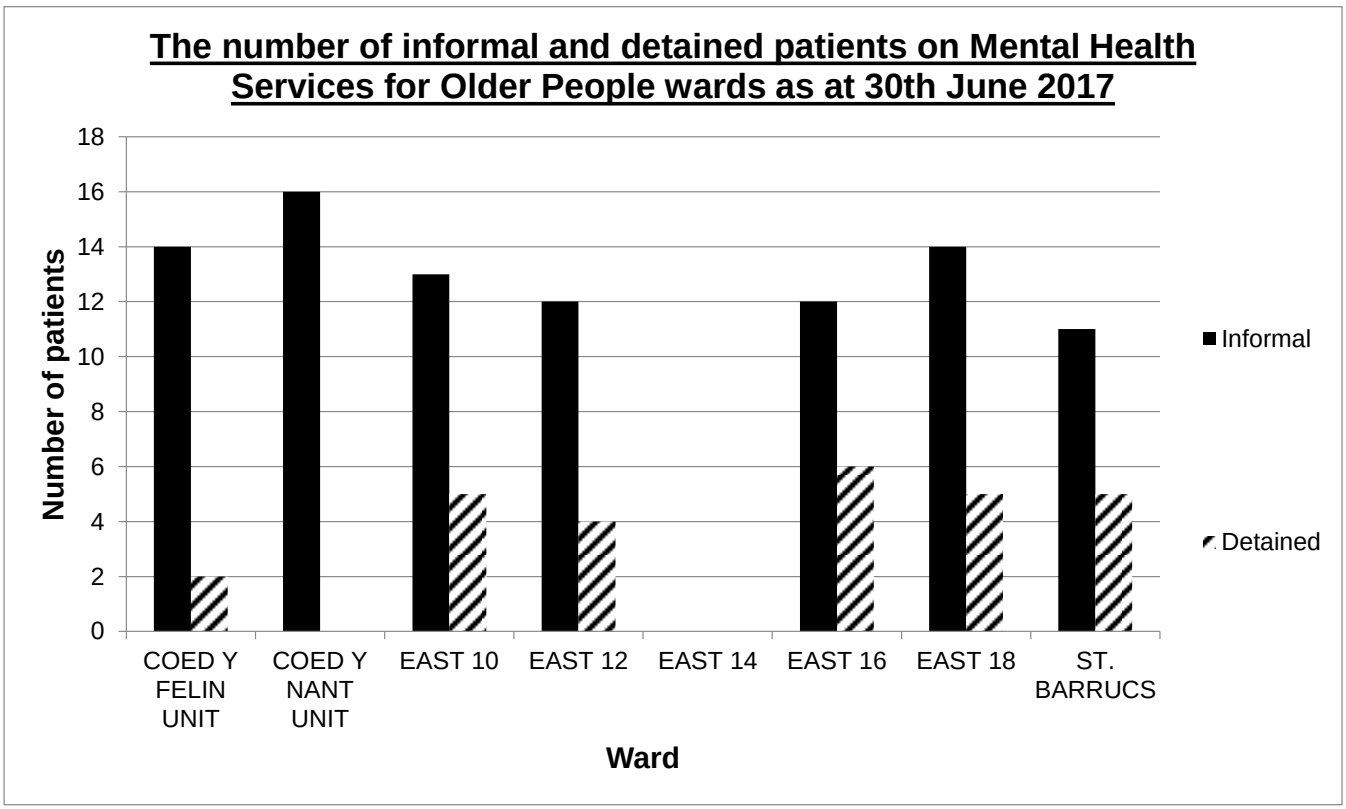
14.1


The number of informal and detained patients on acute wards as at 30th June 2017
Number of patients
0
2
4
6
8
10
12
14
16
18
ALDER WARD
BEECH WARD
CEDAR WARD
OAK WARD
WILLOW WARD
Ward
Informal
Detained


The number of informal and detained patients on addictions, neuropsychiatry and low secure wards as at 30th June 2017
Number of patients
0
2
4
6
8
10
12
14
ASH WARD
ELM WARD
MAPLE WARD
PINE WARD
Ward
Informal
Detained

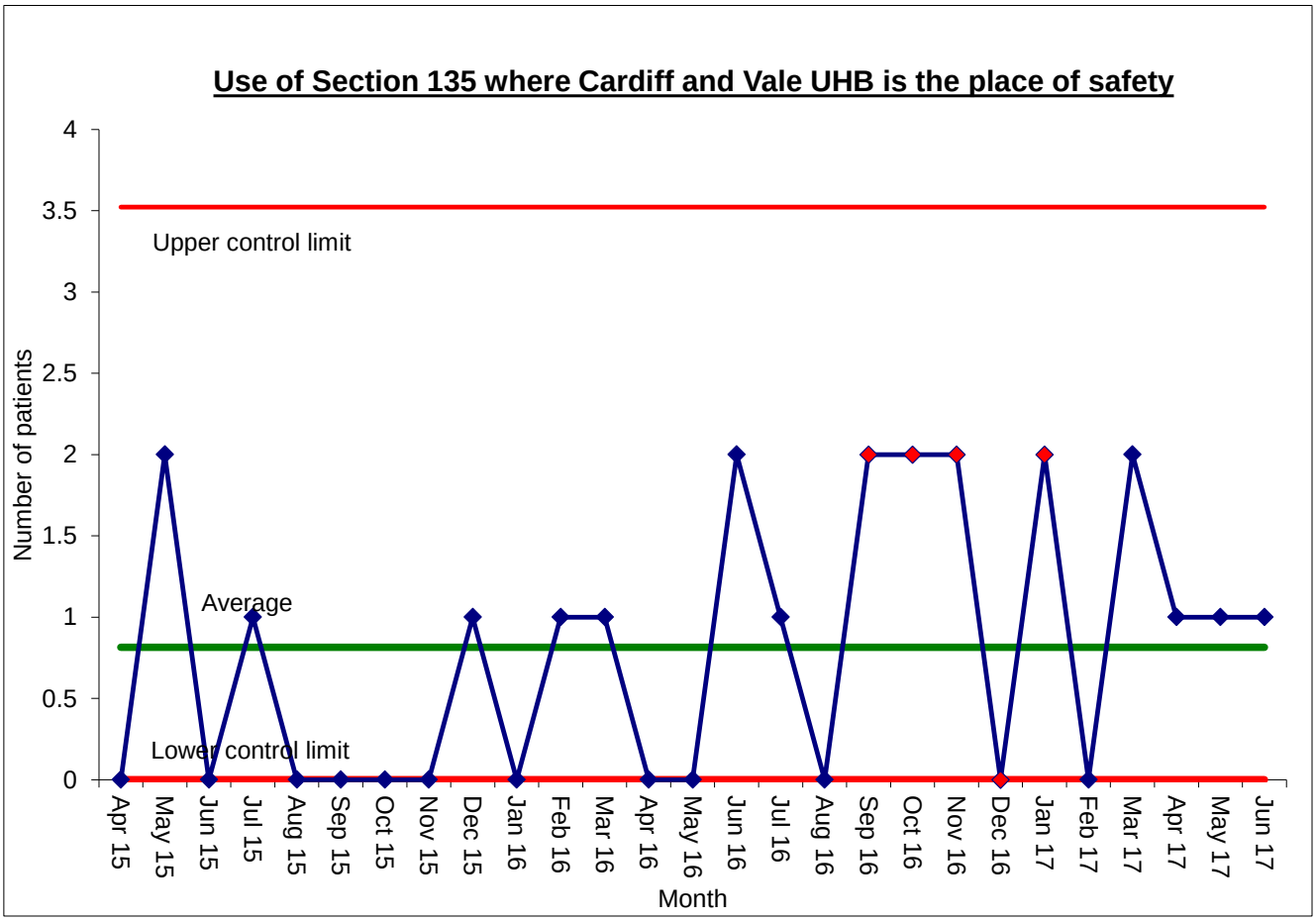
14.1


The number of informal and detained patients on Rehabilitation wards as at 30th June2017
Number of patients
0
1
2
3
4
5
6
7
8
9
CEFN ONN UNIT
HAZEL WARD
PARK ROAD HOUSES
WORDSWORTH AVENUE
Ward
Informal
Detained


The number of informal and detained patients on Mental Health Services for Older People wards as at 30th June 2017
Number of patients
0
2
4
6
8
10
12
14
16
18
COED Y FELIN UNIT
COED Y NANT UNIT
EAST 10
EAST 12
EAST 14
EAST 16
EAST 18
ST. BARRUCS
Ward
Informal
Detained

14.1

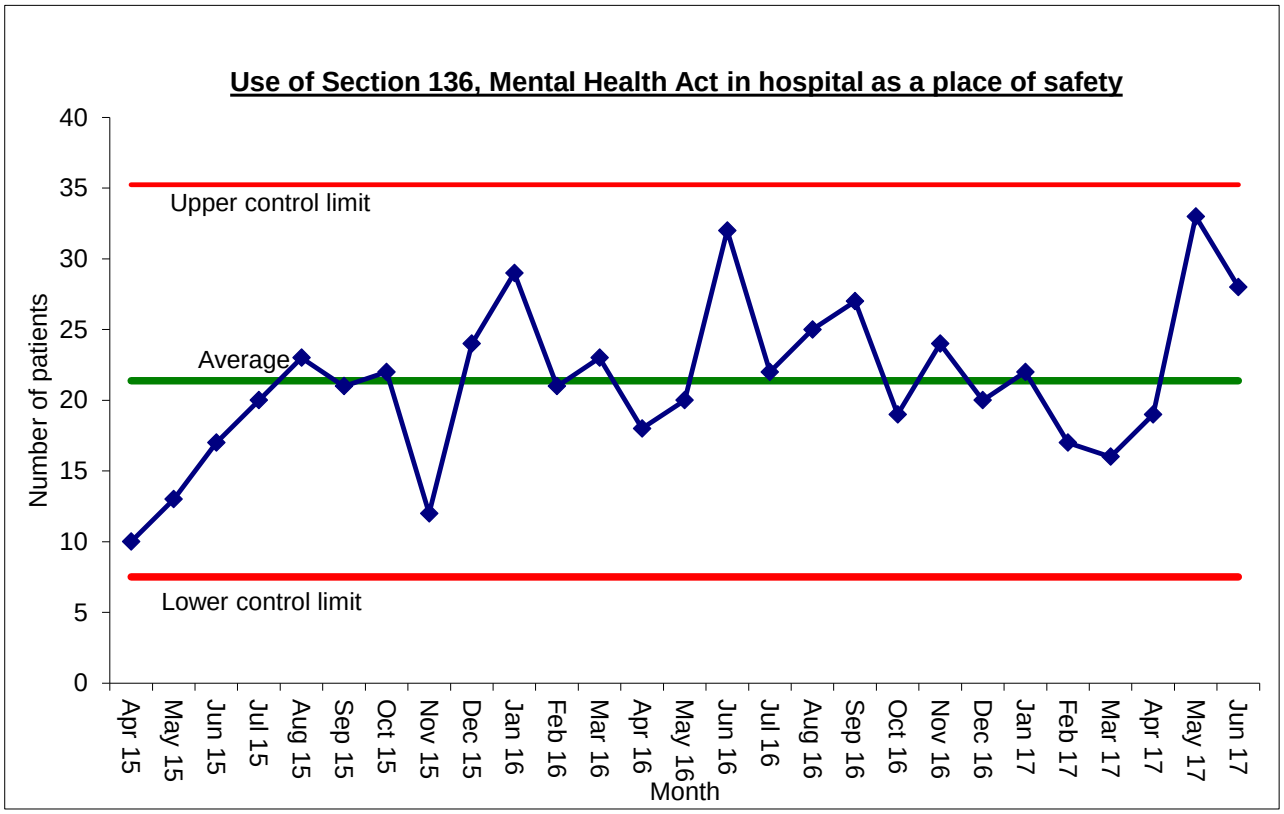
Section 135 – Warrant to search for and remove a mentally disordered person/patient from private premises to a place of safety



During the period April- June 2017 Section 135 (1) powers were used on three occasions. All three patients were subsequently detained under Section 2.

14.1

Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within Cardiff and Vale UHB



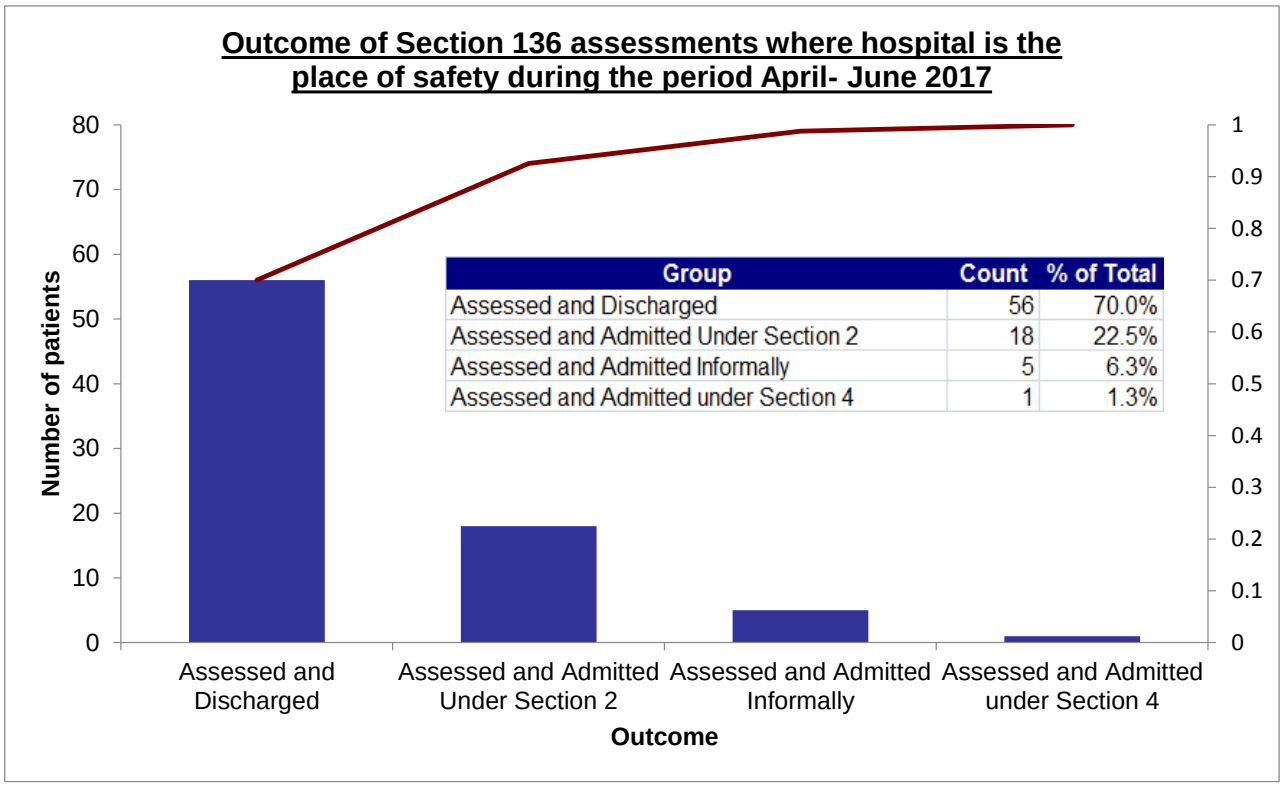
In the period April- June 2017 a total of 80 assessments were initiated by Section 136 powers where the MHA assessment took place in a hospital as the place of safety.

CAMHS

Six of these assessments were carried out on patients under the age of 18. The outcomes were as follows:

- Two discharged with no mental disorder
- Three discharged to community services
- One detained under section 2 to a different Health Board

14.1



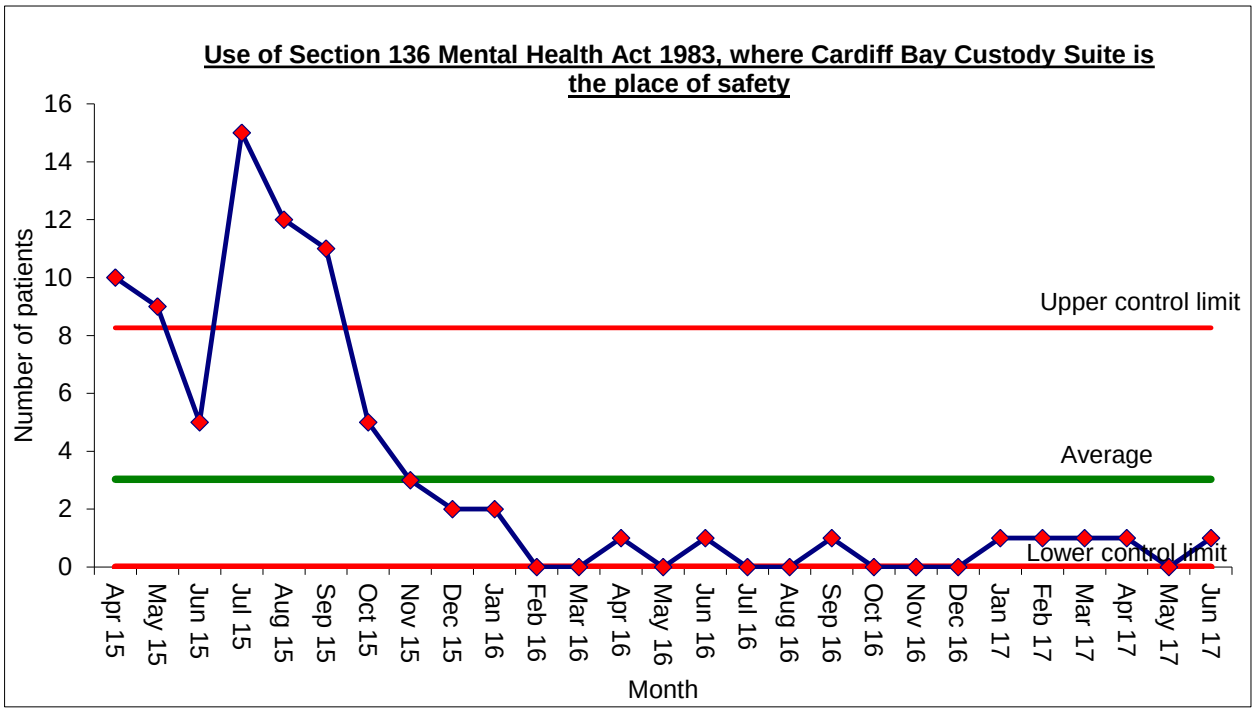
Group	Count	% of Total
Assessed and Discharged	56	70.0%
Assessed and Admitted Under Section 2	18	22.5%
Assessed and Admitted Informally	5	6.3%
Assessed and Admitted under Section 4	1	1.3%

The pareto chart highlights that 70% of individuals assessed under 136 were not admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self referral.

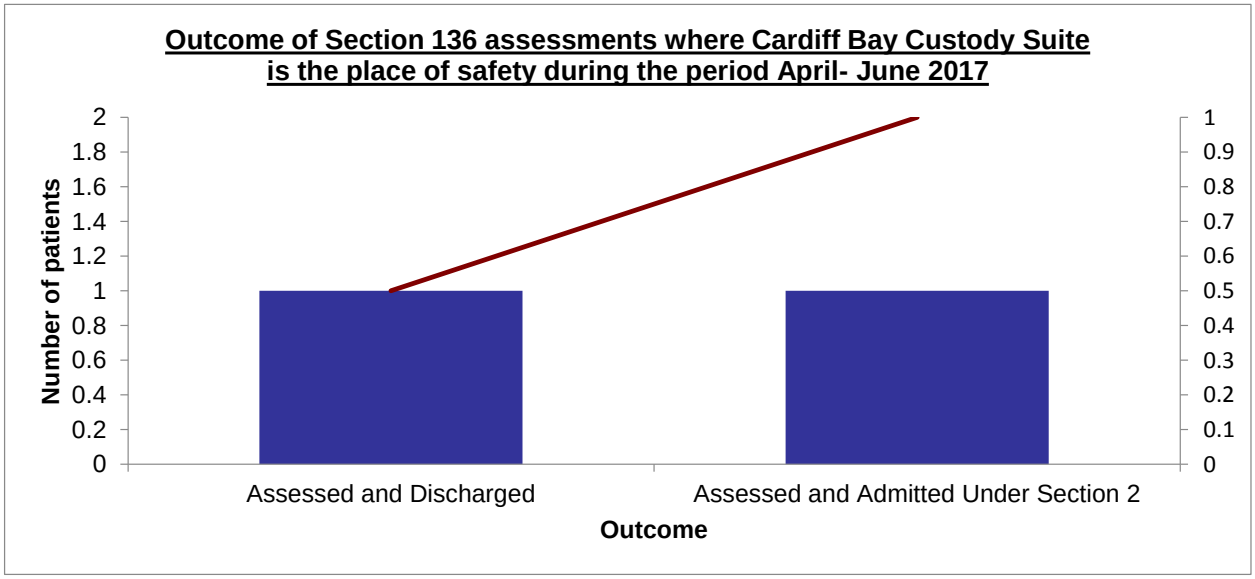
- Three of the patients detained under Section 2 were detained to other Health Boards.

14.1

Section 136- Mentally disordered persons found in public places Mental Health Act assessments undertaken within the police station



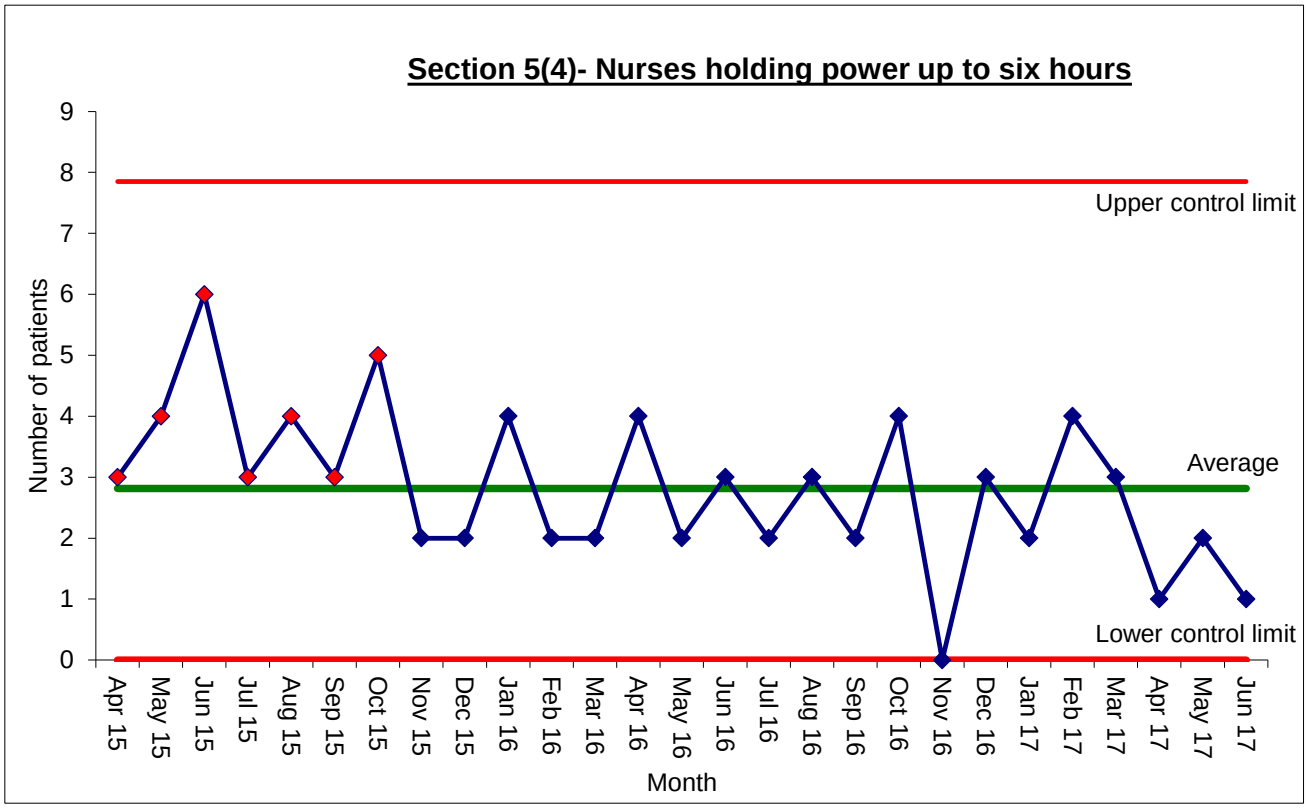
During the period April- June 2017 a total of two assessments were initiated by Section 136 powers where MHA assessments took place in Cardiff Bay Custody Suite due to the unmanageable risk of violence.

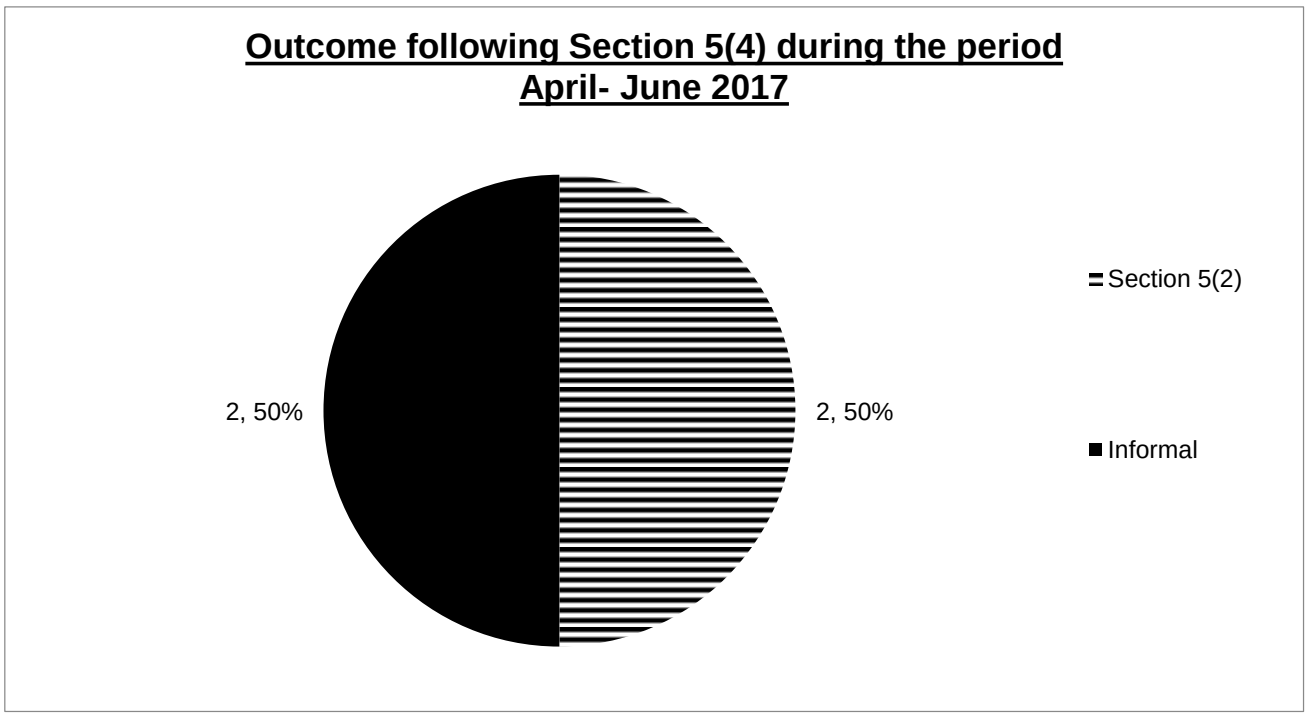


The pareto chart highlights that one individual was assessed under 136 and admitted to hospital. Those individuals who are not admitted or discharged to another service are provided with information on Mental Health support services for possible self referral.

14.1

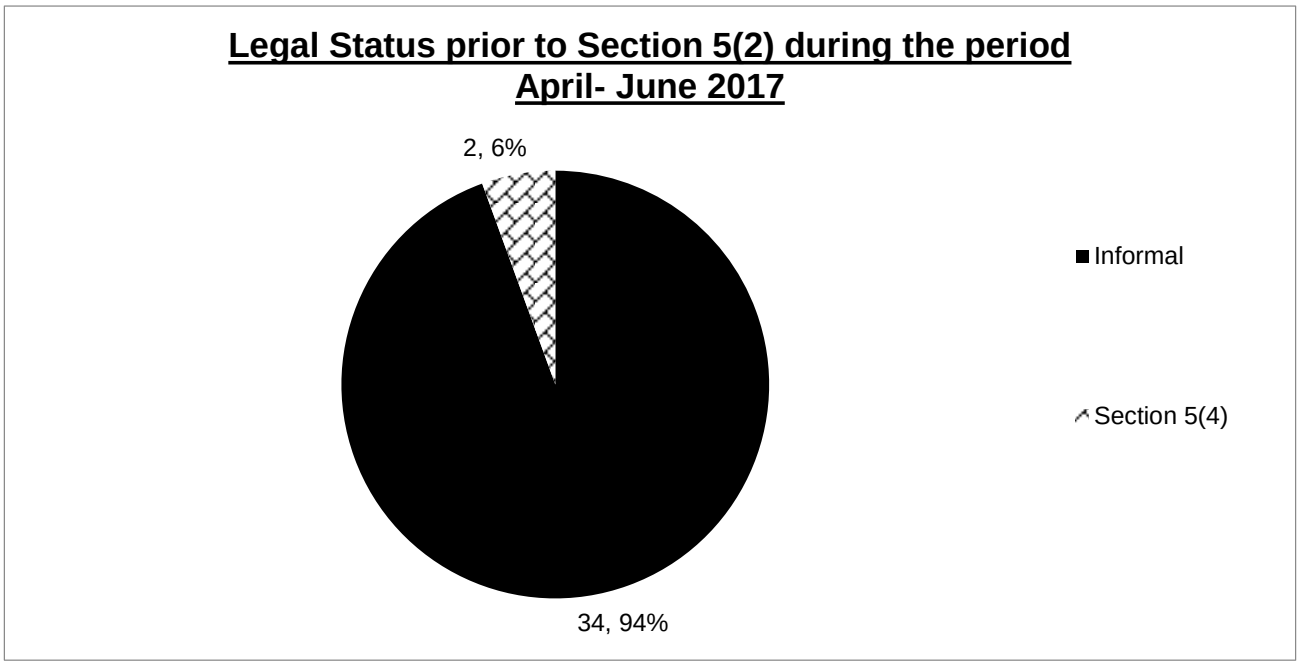
Section 5(4) Nurses Holding Power

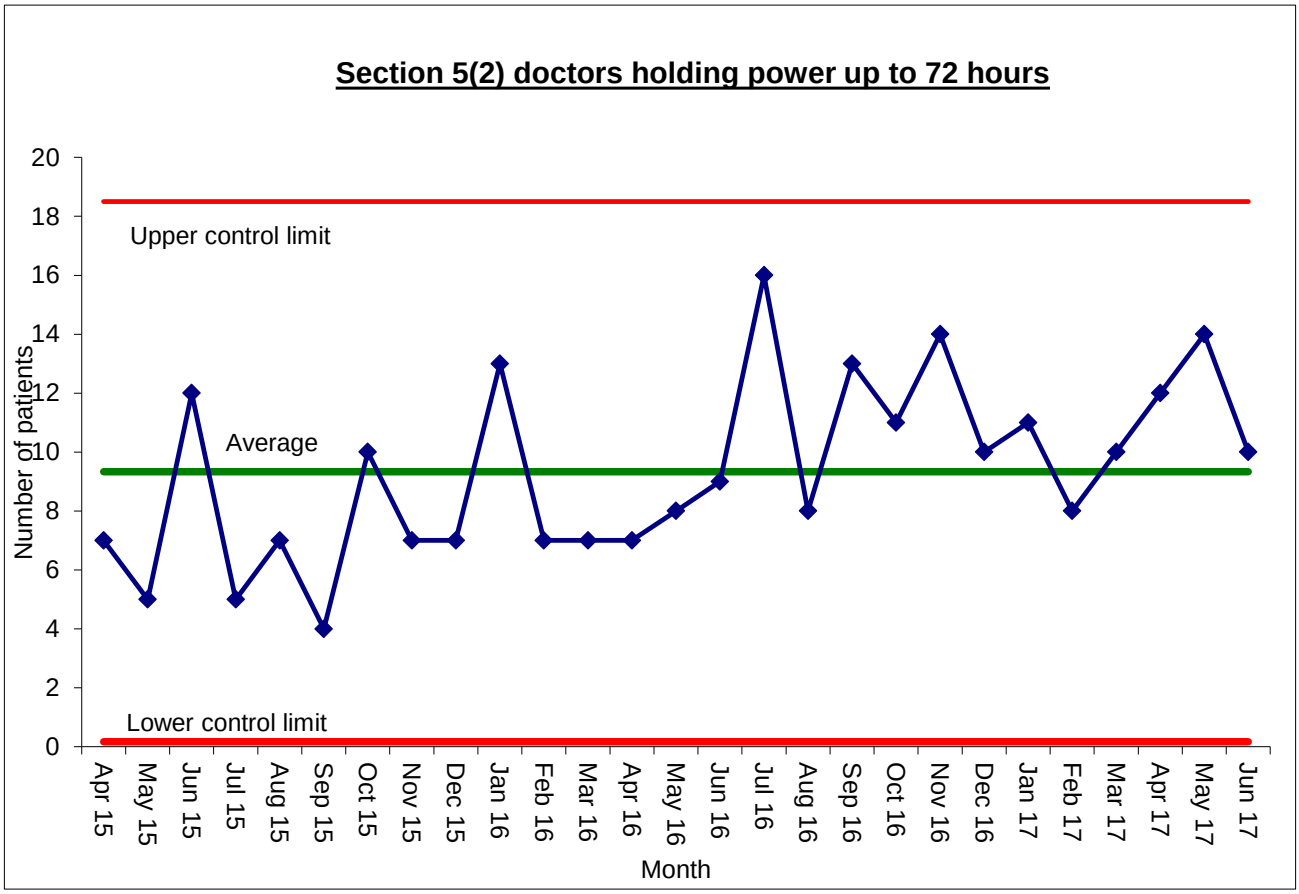




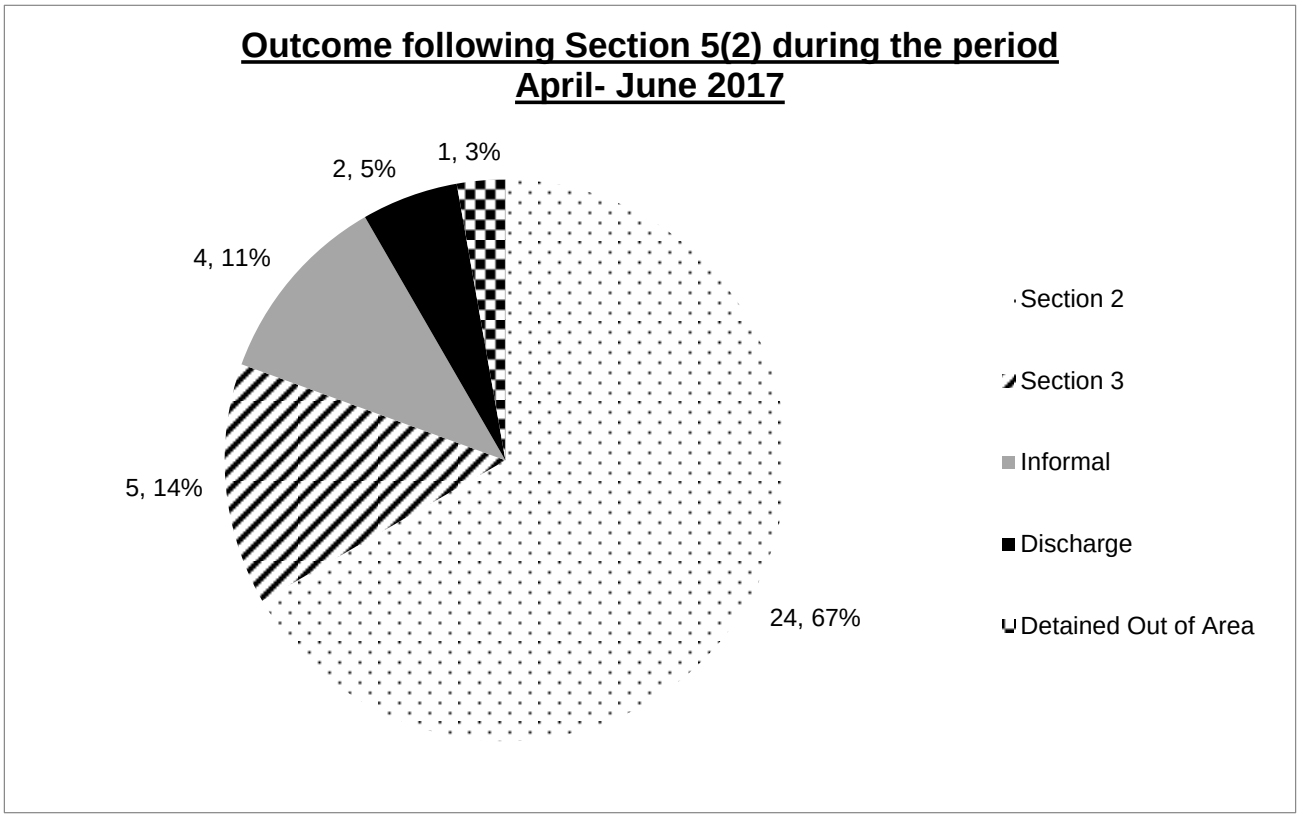
14.1

Section 5(2) Doctors Holding Power



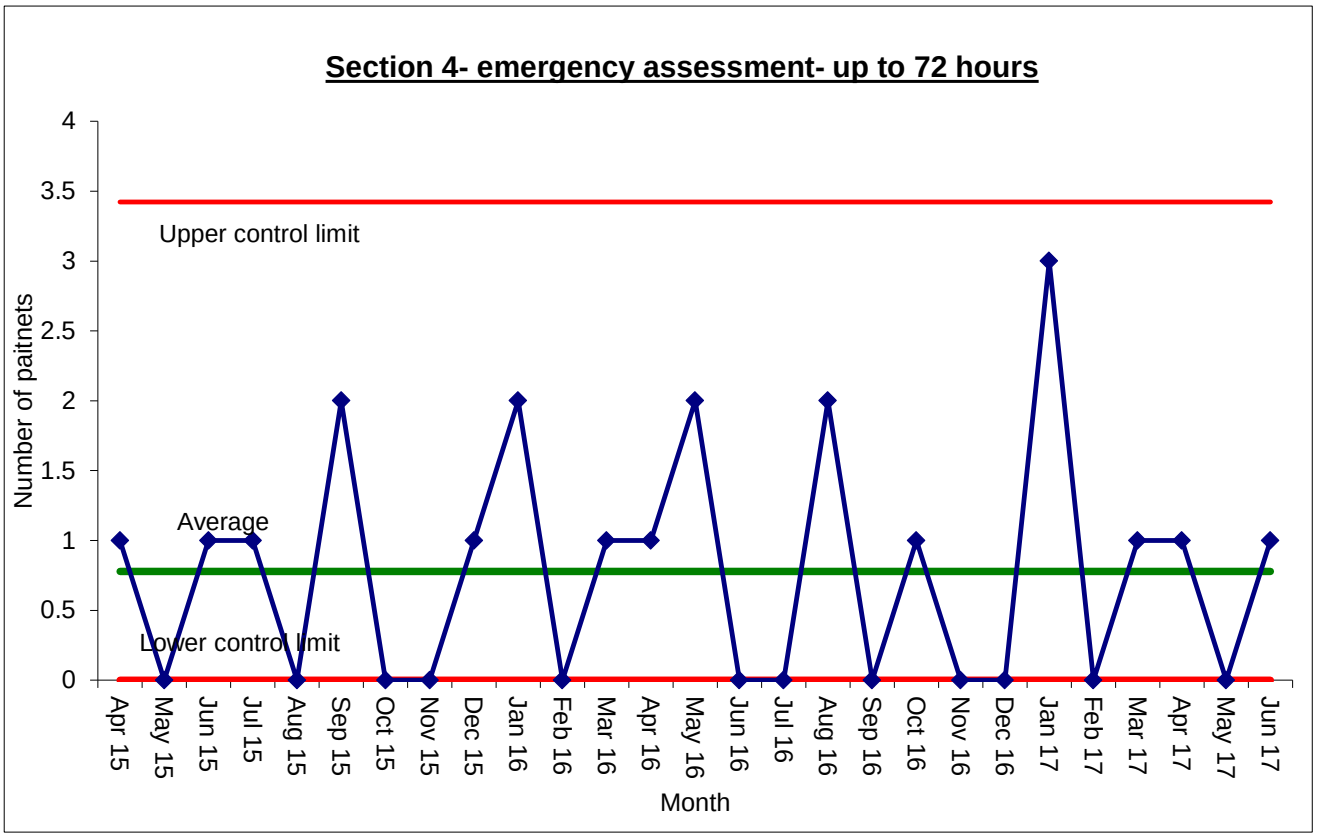


14.1


Outcome following Section 5(2) during the period April- June 2017
1, 3%
2, 5%
4, 11%
5, 14%
24, 67%
Section 2
Section 3
Informal
Discharge
Detained Out of Area

14.1

Section 4- Admission for Assessment in Cases of Emergency

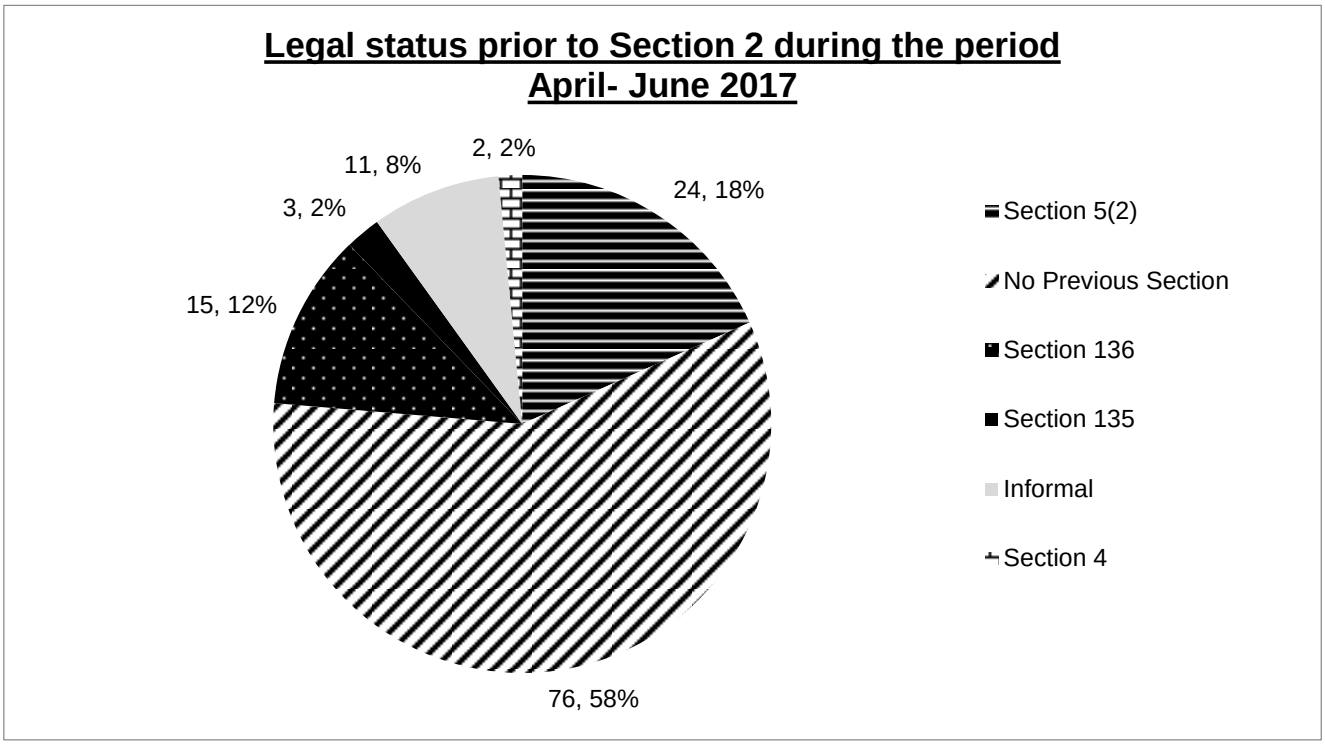


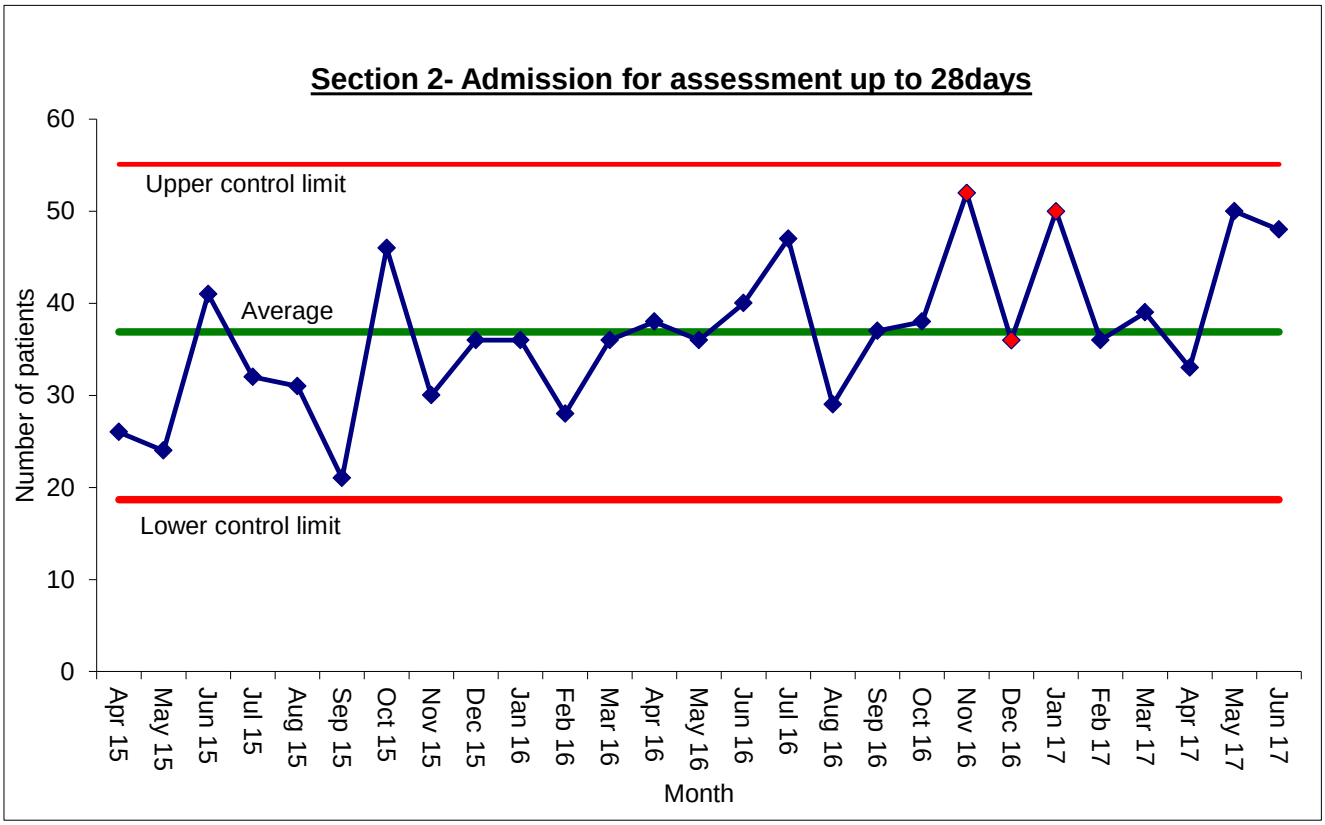
Section 4 was used on two occasions and subsequently converted to Section 2 during the period April- June for the following reasons:

- Potential immediate risk to themselves and others. No section 12 Doctor available.

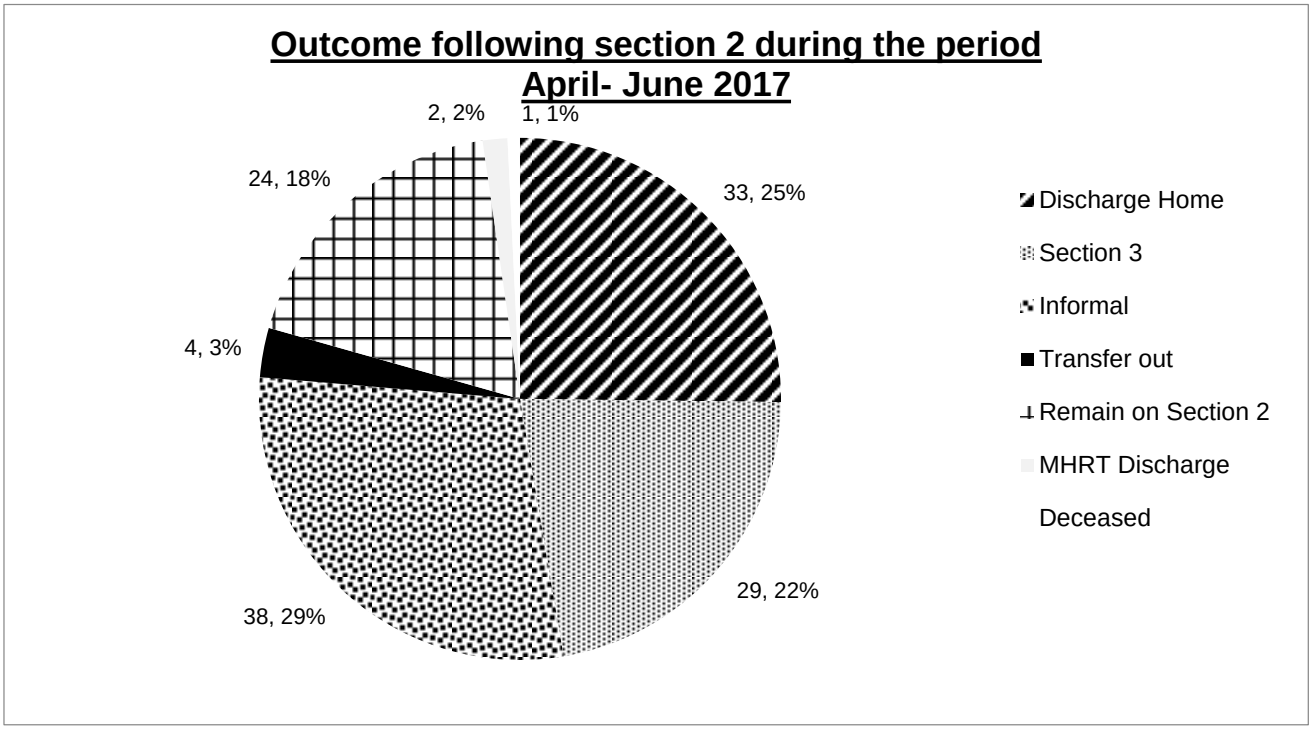
14.1

Section 2- Admission for Assessment





14.1

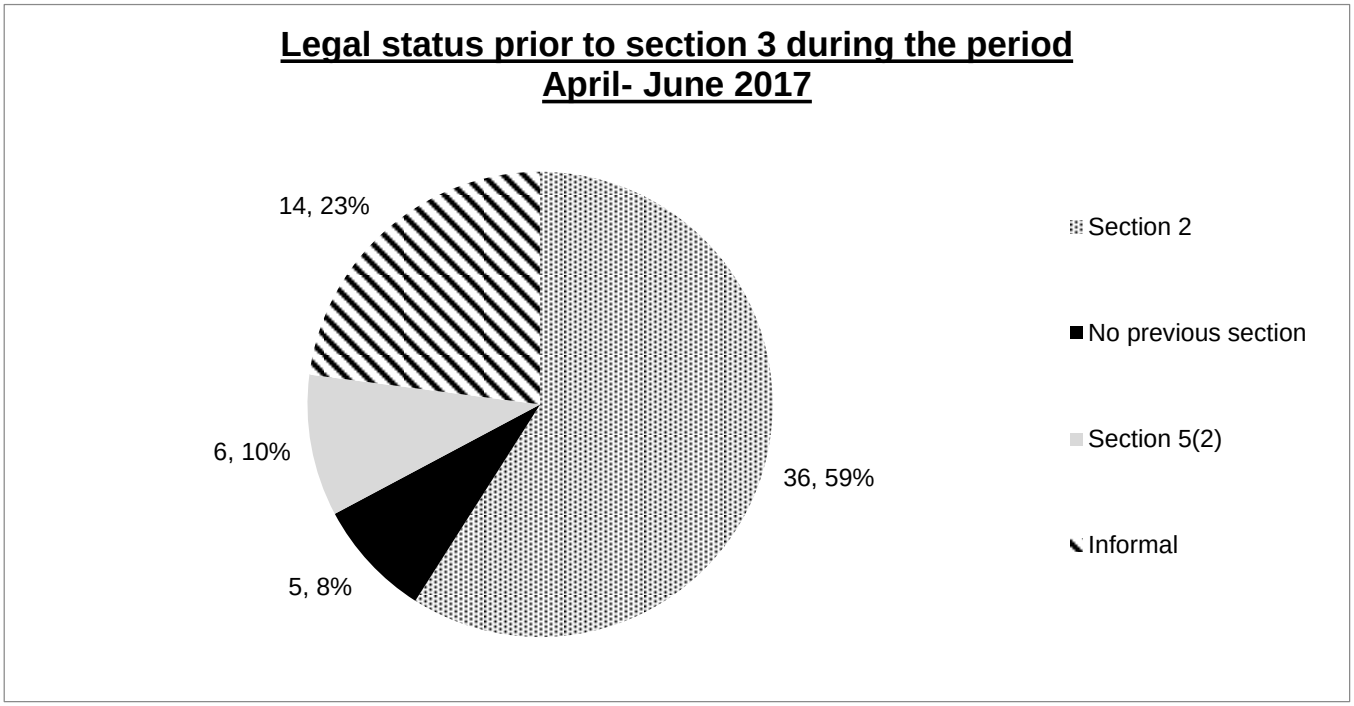


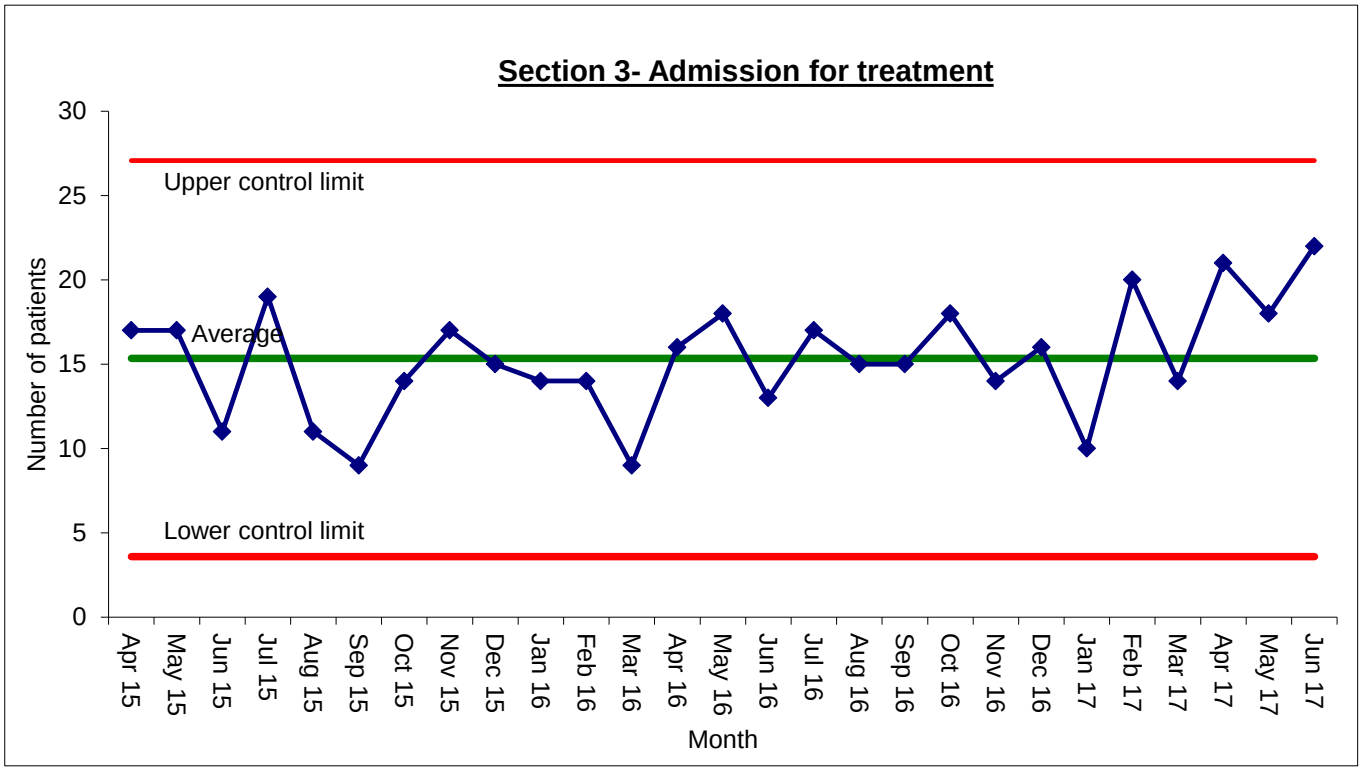
CAMHS

One of these assessments was carried out on a patient under the age of 18 years old. The patient was subsequently discharged from section 2.

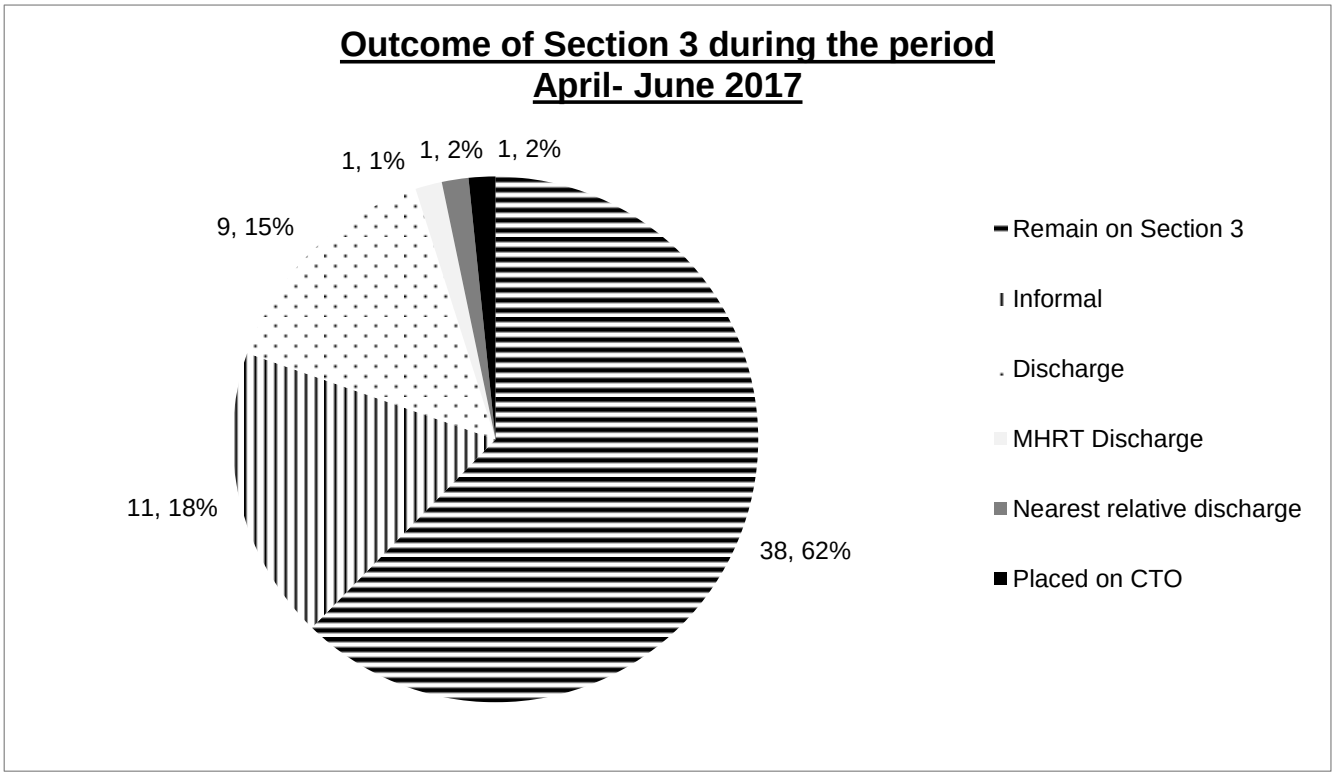
14.1

Section 3- Admission for Treatment





14.1

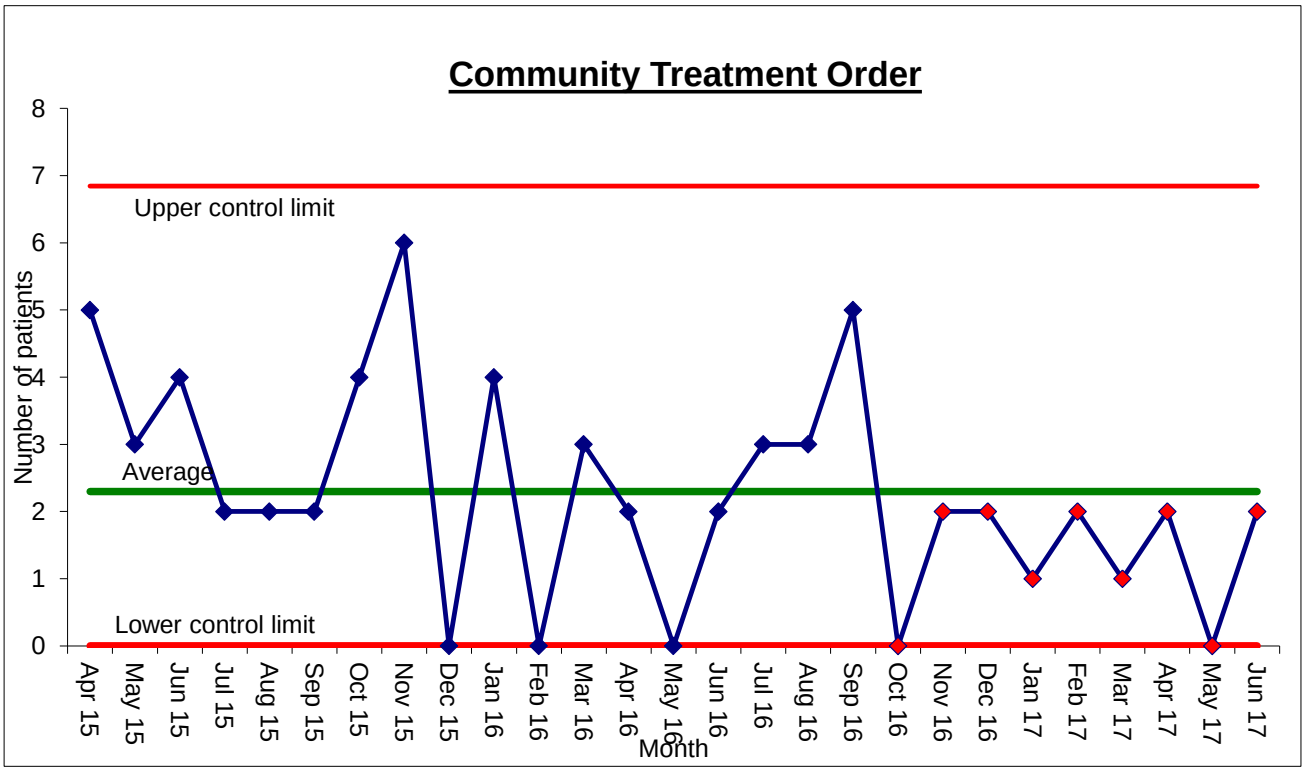

Outcome of Section 3 during the period April- June 2017
1, 1%
1, 2%
1, 2%
9, 15%
11, 18%
38, 62%
Remain on Section 3
Informal
Discharge
MHRT Discharge
Nearest relative discharge
Placed on CTO

14.1

Community Treatment Order

During the period April- June 2017 four patients were discharged to Community Treatment Orders.

As at 30th June 2017, 36 patients were subject to a Community Treatment Order (CTO).



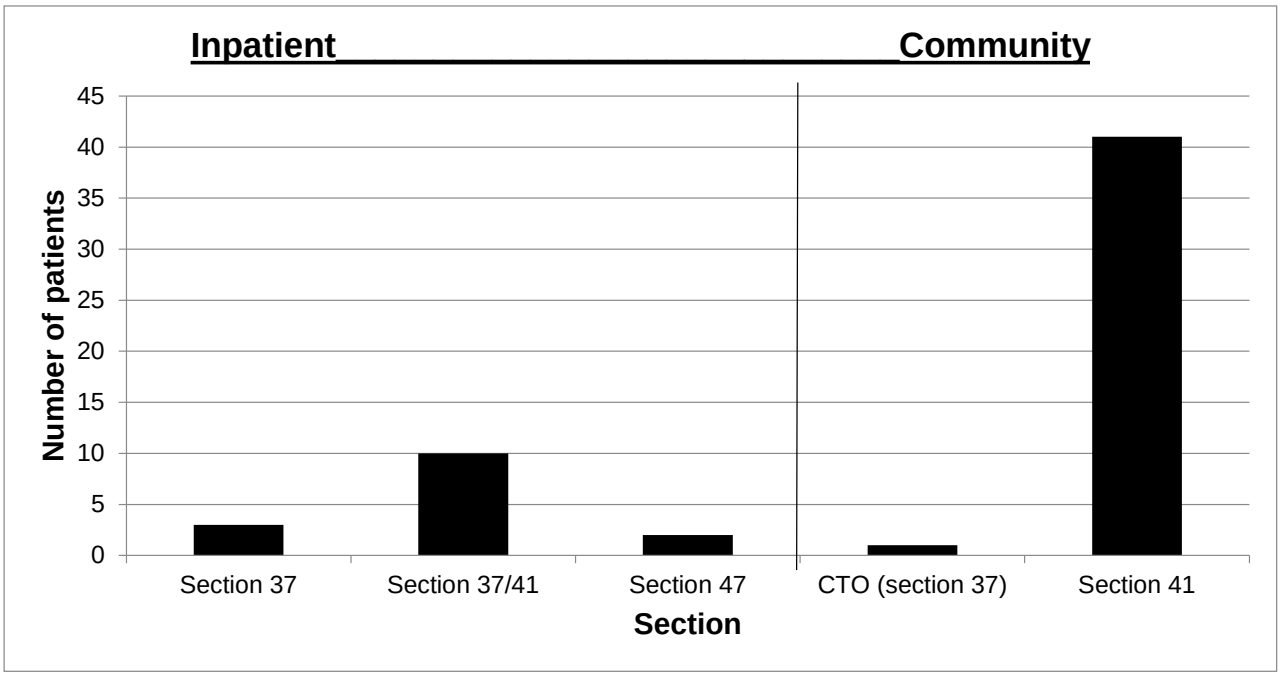
Recall of a community patient under Section 17E

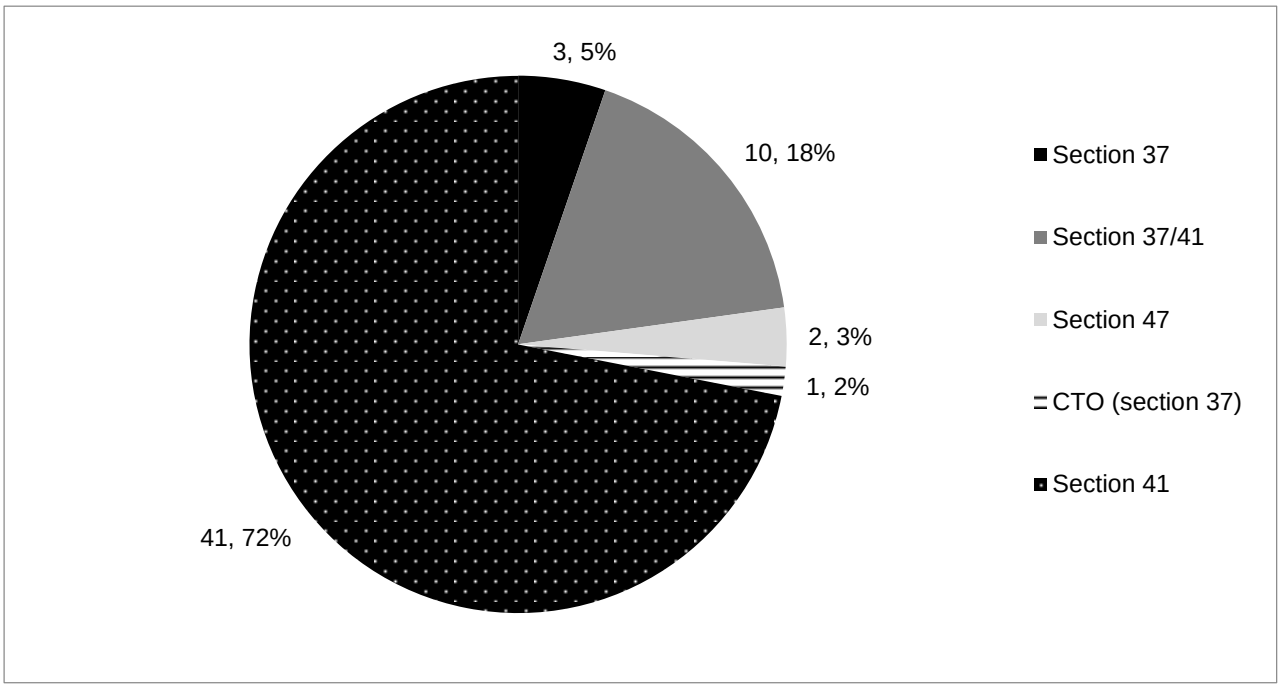
During the period April- June 2017, the power of recall was used on one occasion. The patient was subsequently revoked from the CTO and detained in hospital.

14.1

Part 3 of the Mental Health Act 1983

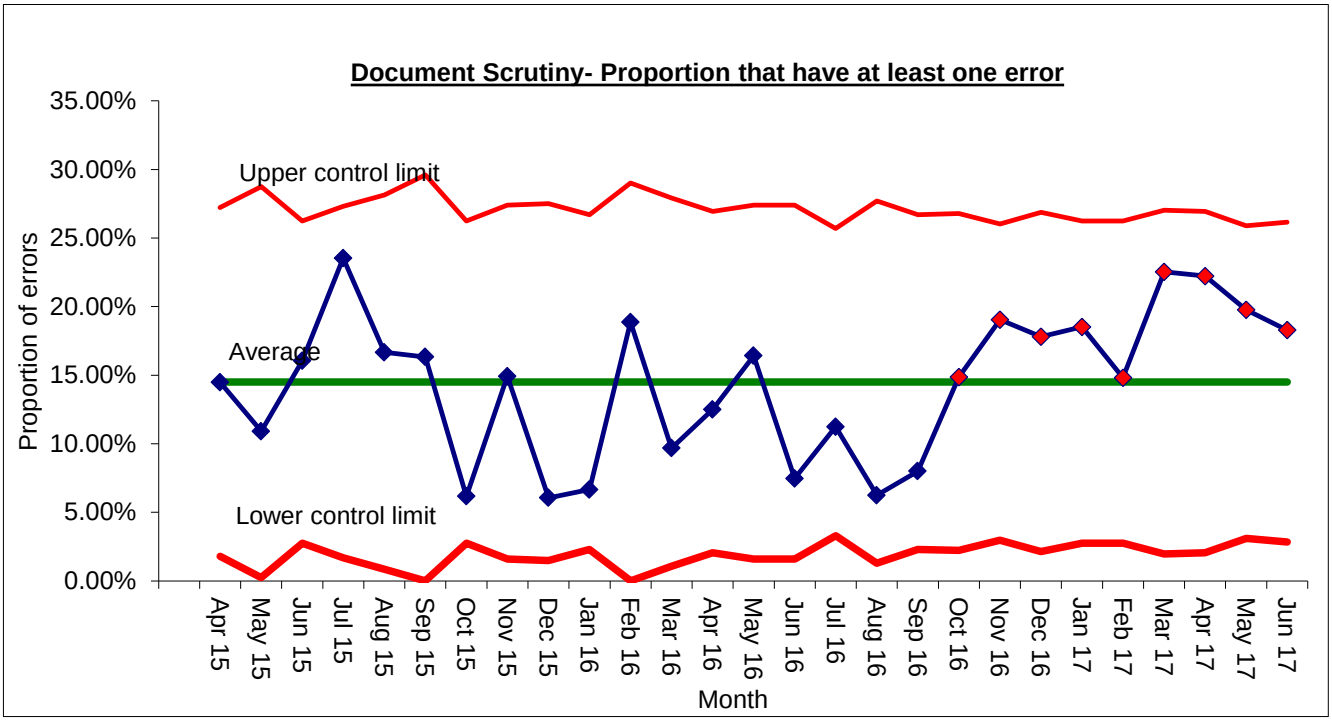
The number of Part 3 patients detained in Cardiff and Vale University Health Board Hospitals or subject to Community Treatment/ Conditional Discharge in the community as at 30th June 2017.



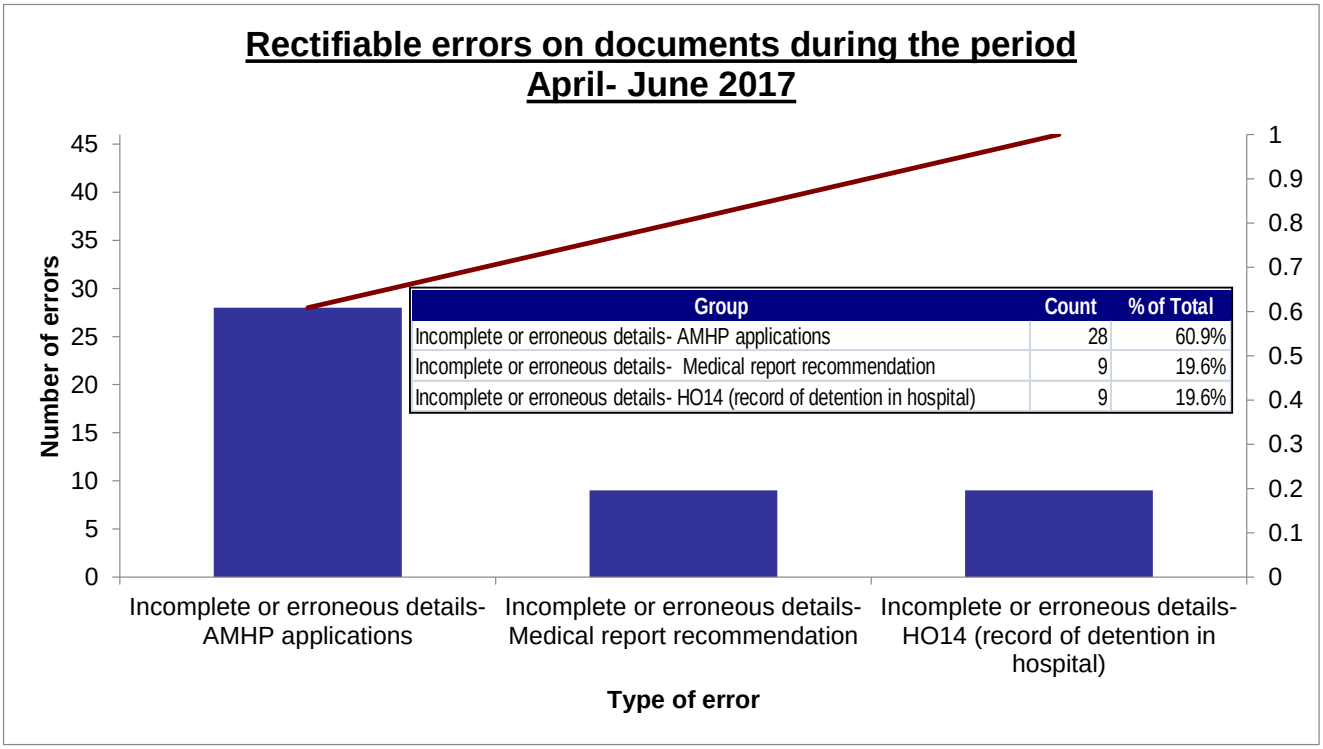


14.1

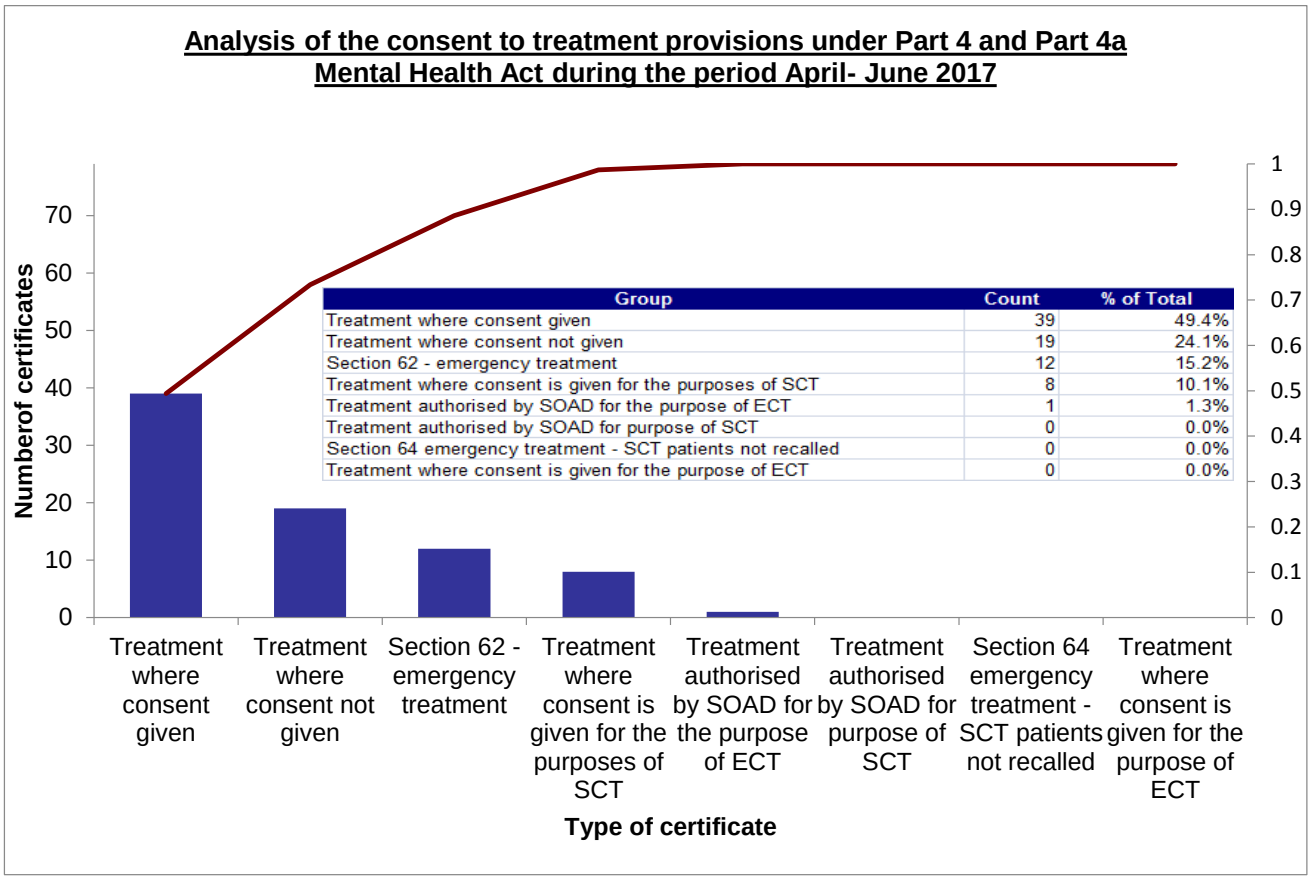
Scrutiny of documents during the period



The chart above is a different type of control chart (P Chart) which looks at the proportions. The width of the control limits is dictated by the size of the denominator, so a larger denominator will have narrower limit.



Consent to Treatment



Urgent treatment

There are some circumstances in which the approved clinician may authorise a detained patient's urgent treatment under section 62 however this applies only to patients whose treatment is covered by Part 4 of the Act which is concerned with the treatment of detained patients and Part 4A supervised community treatment patients recalled to hospital.

Urgent treatment is defined as treatment that is:

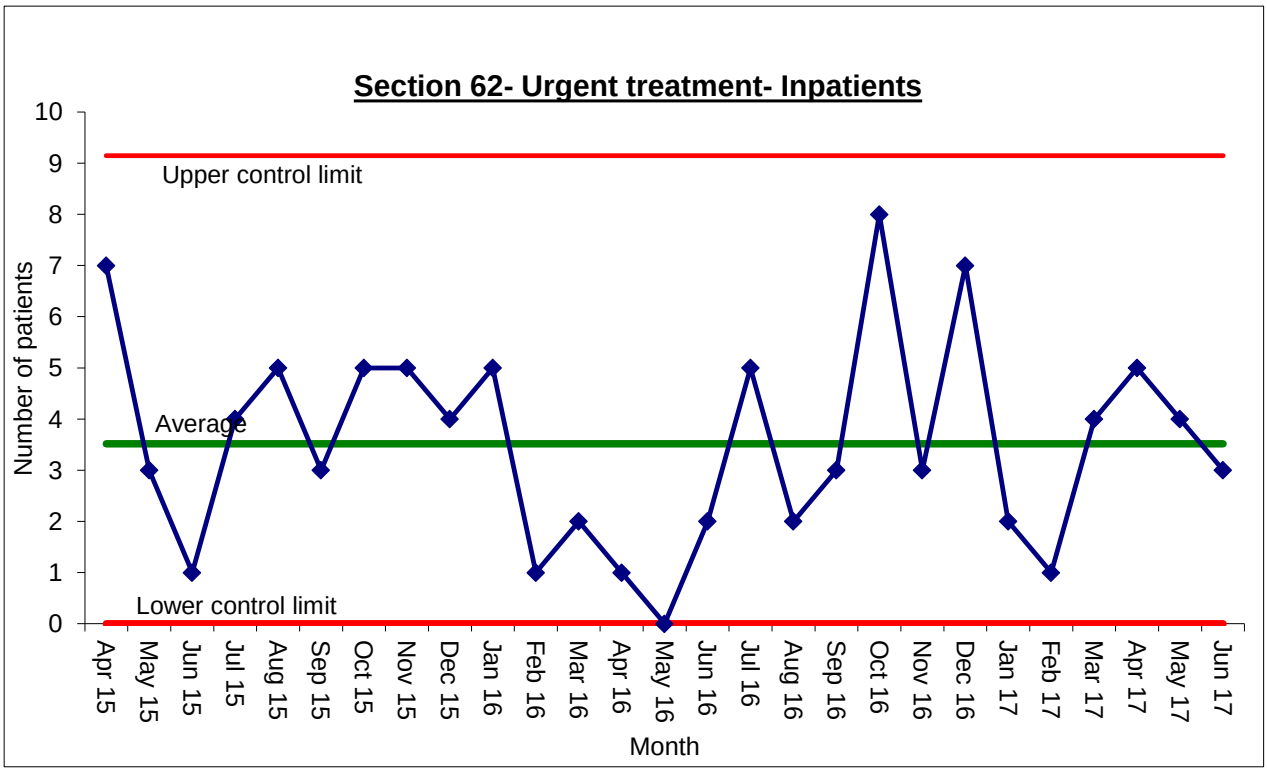
- Immediately necessary to save the patient's life; or
- That is not irreversible but is immediately necessary to prevent a serious deterioration of the patient's condition; or
- That is not irreversible or hazardous but is immediately necessary to alleviate serious suffering by the patient; or
- That is not irreversible or hazardous but is immediately necessary and represents the minimum interference to prevent the patient from behaving violently or being a danger to himself or others.

14.1

A patient's treatment may be continued pending compliance with s.58, if discontinuation would cause serious suffering to the patient.

Urgent treatment can be used in any of the following instances:

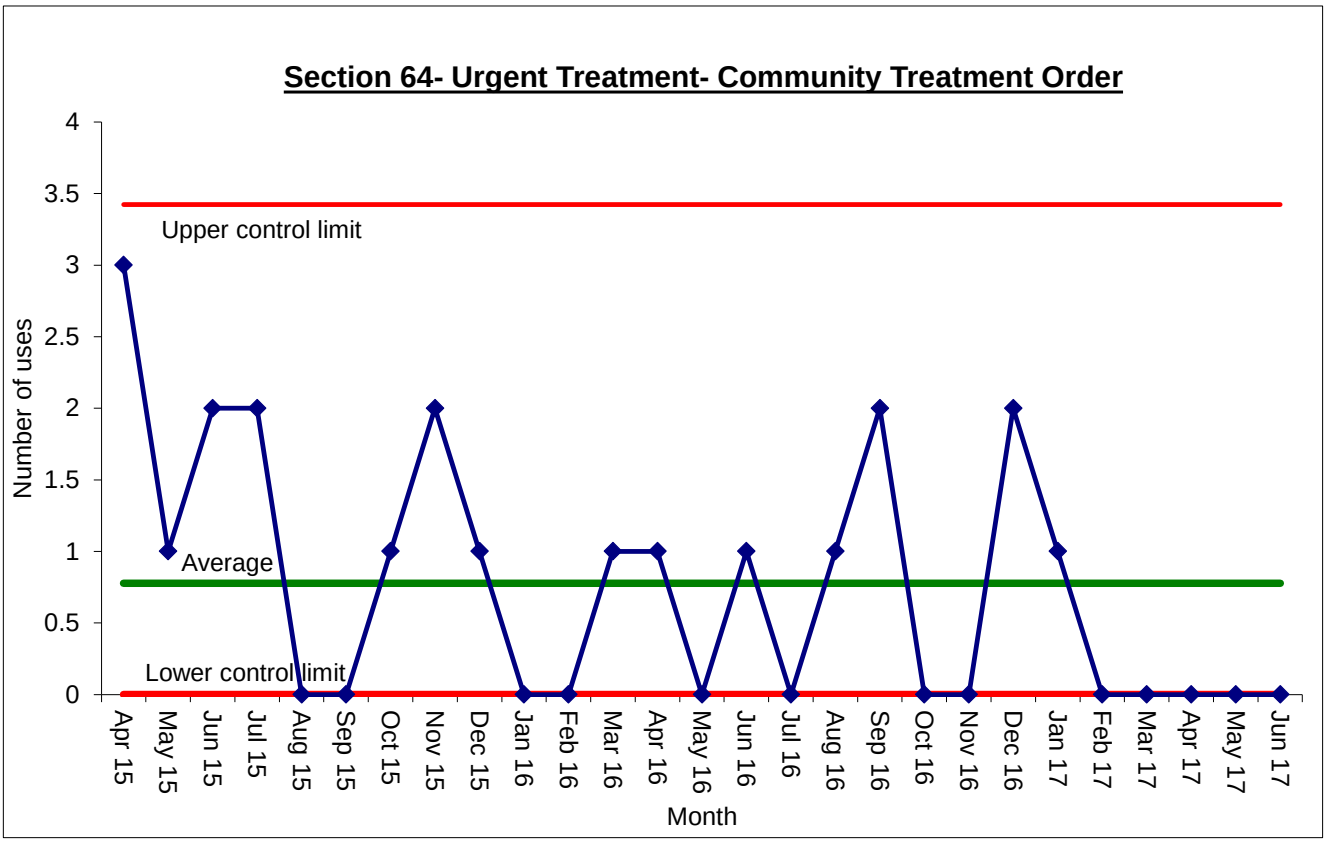
- Where the SOAD has not yet attended to certify treatment within the statutory timeframe.
- Where the SOAD has not yet certified treatment for ECT which needs to be administered as a matter of urgency.
- Where medication is prescribed outside of an existing SOAD certificate.
- Where consent has been withdrawn by the patient and the SOAD has not yet attended to certify treatment.
- Where the patient has lost capacity to consent to treatment and the SOAD has not yet attended for certification purposes.



14.1

The above chart highlights that Section 62 was used on twelve occasions for the following reasons:

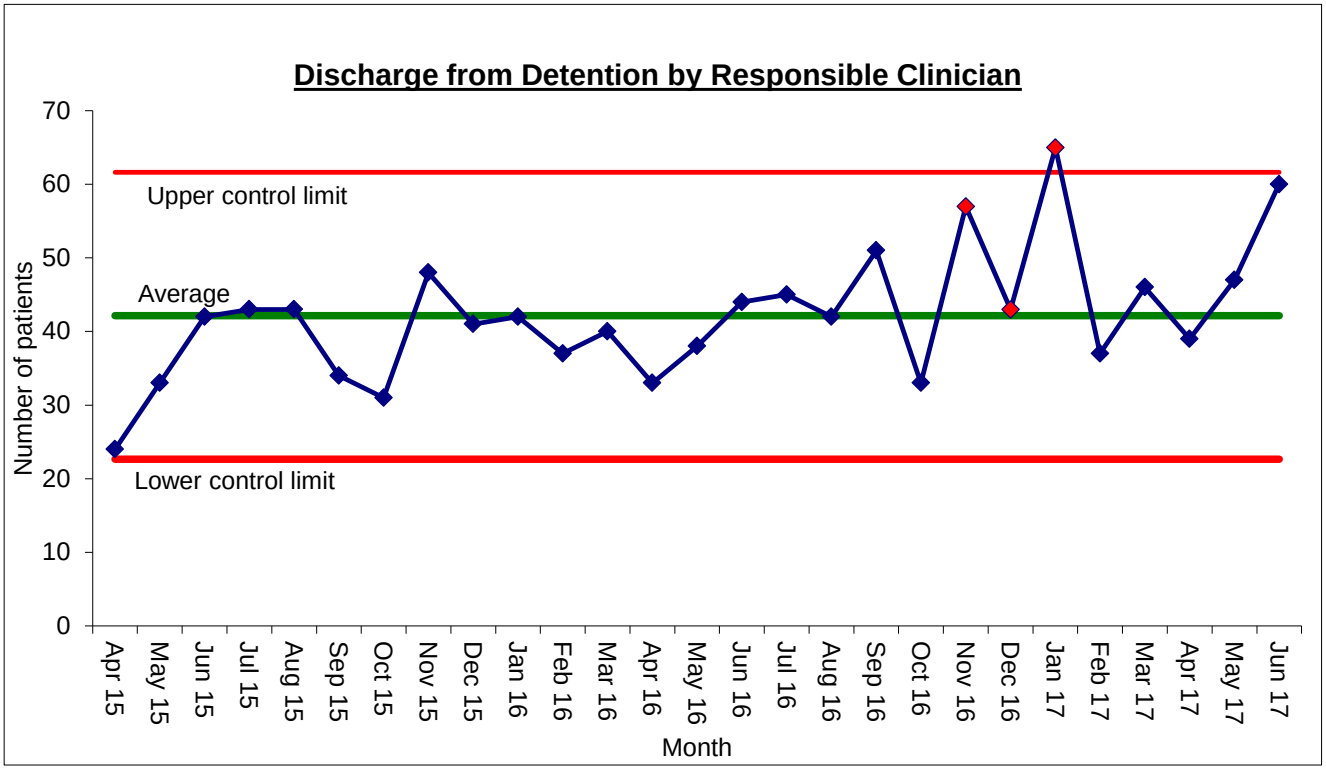
- 3 month rule x4
- Time limited certificate expired- Awaiting SOAD
- Awaiting SOAD for certification of ECT x 3
- Patient consent withdrawn x3
- Change in medication

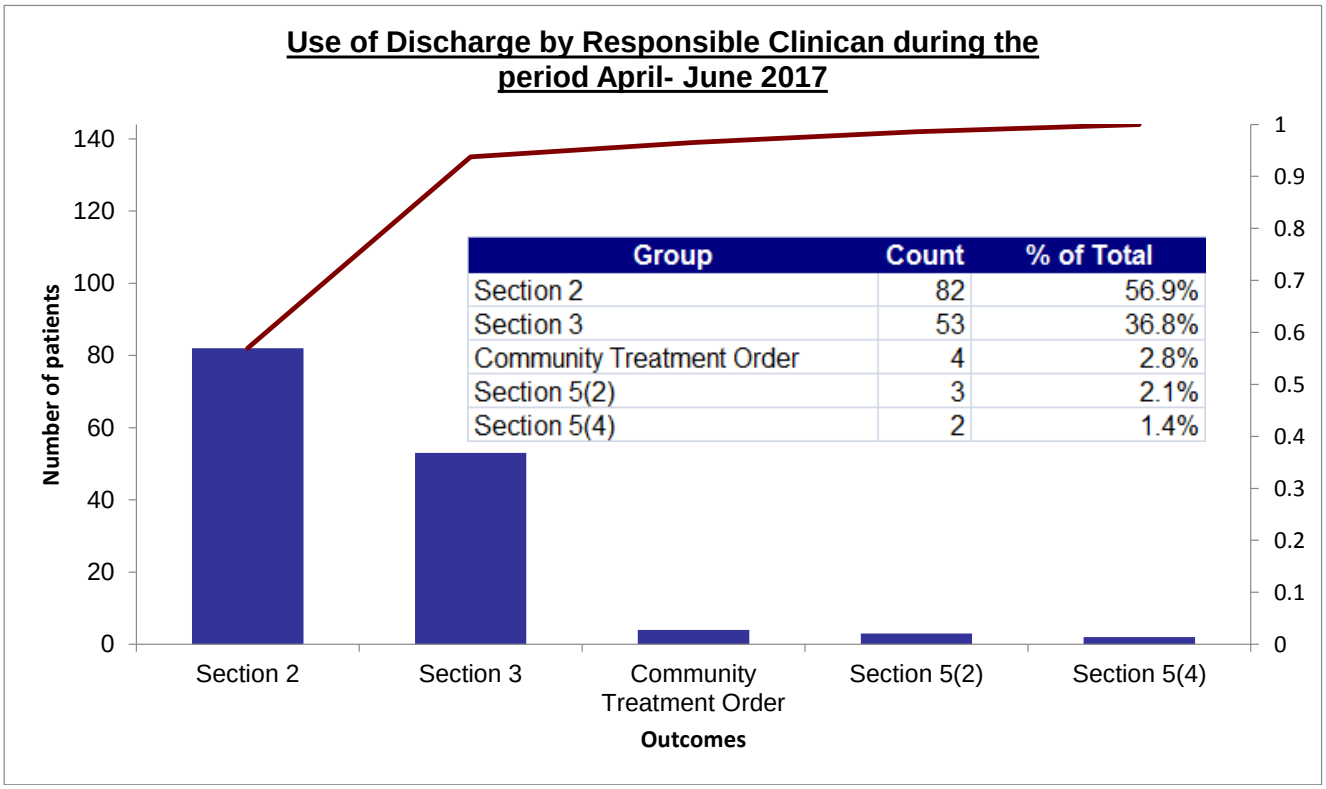


The above chart highlights that Section 64 was not used at all during the period.

14.1

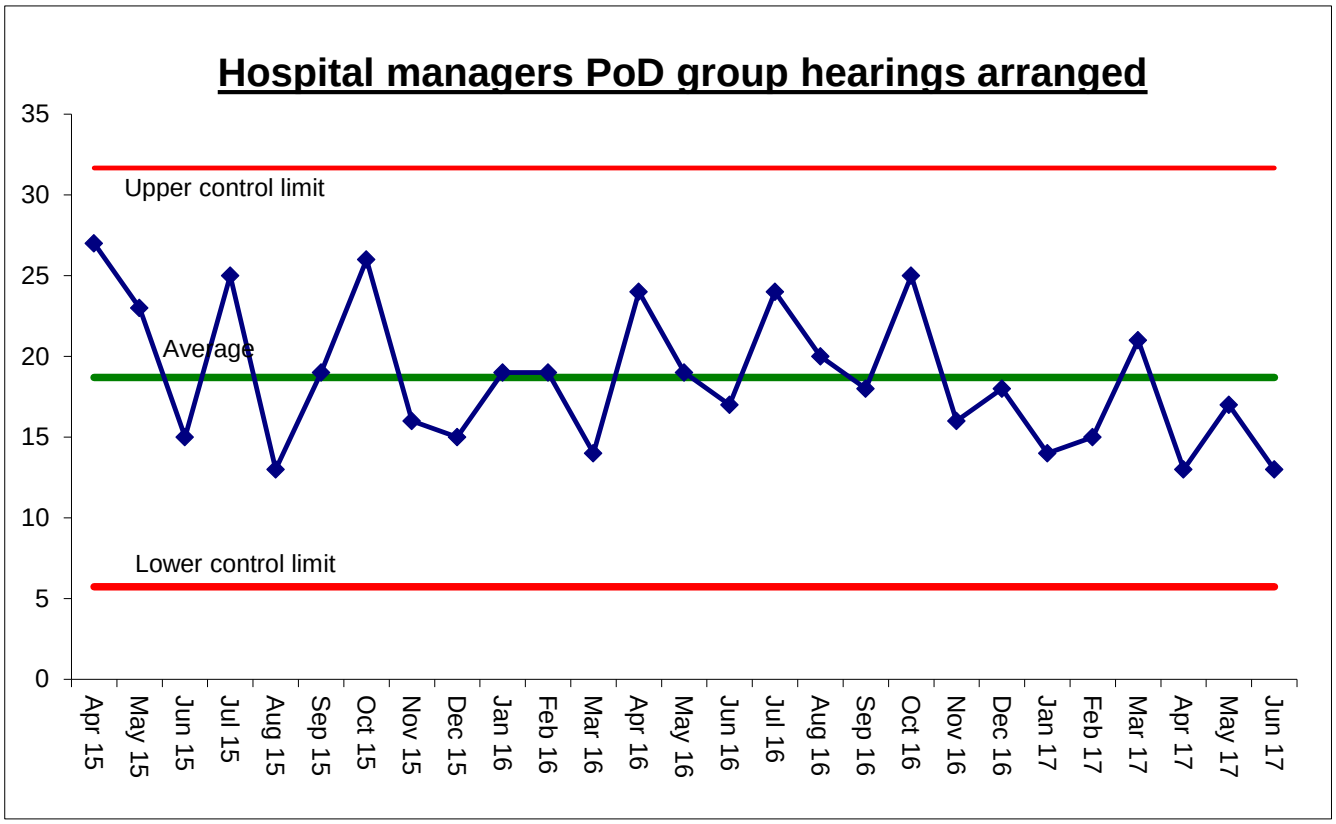
Section 23- Discharge

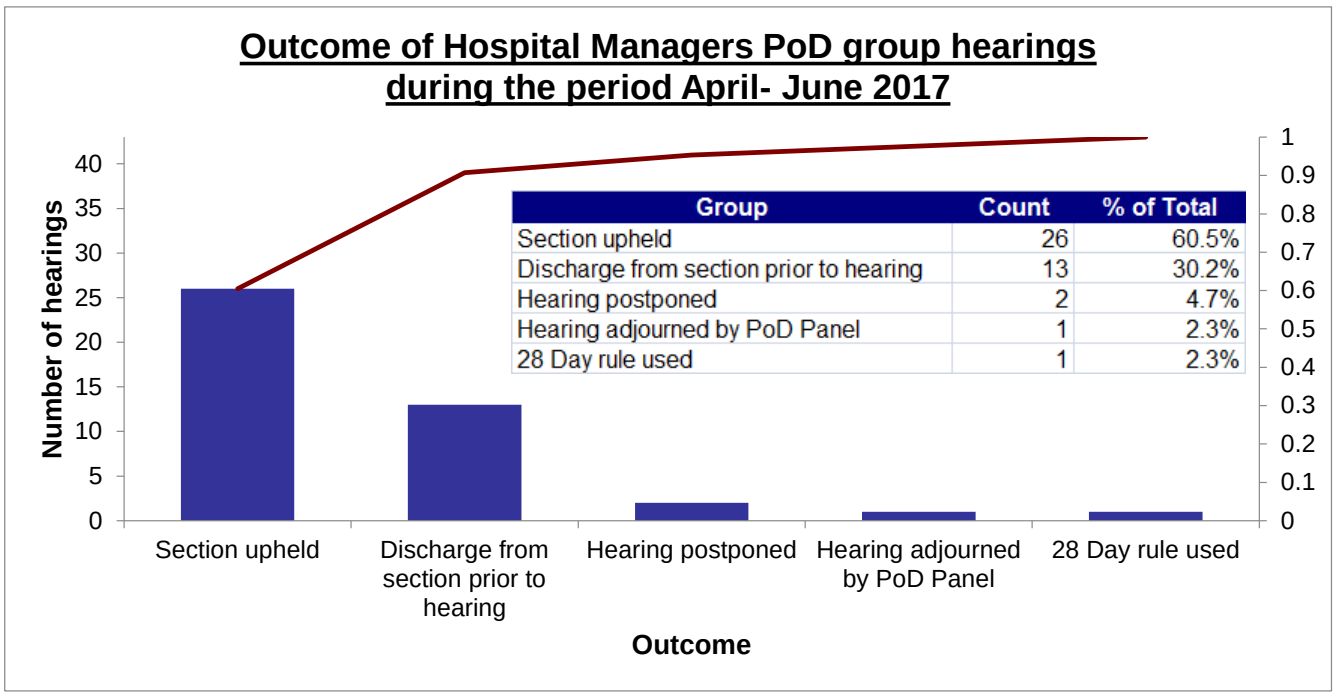




14.1

Hospital Managers- Power of Discharge





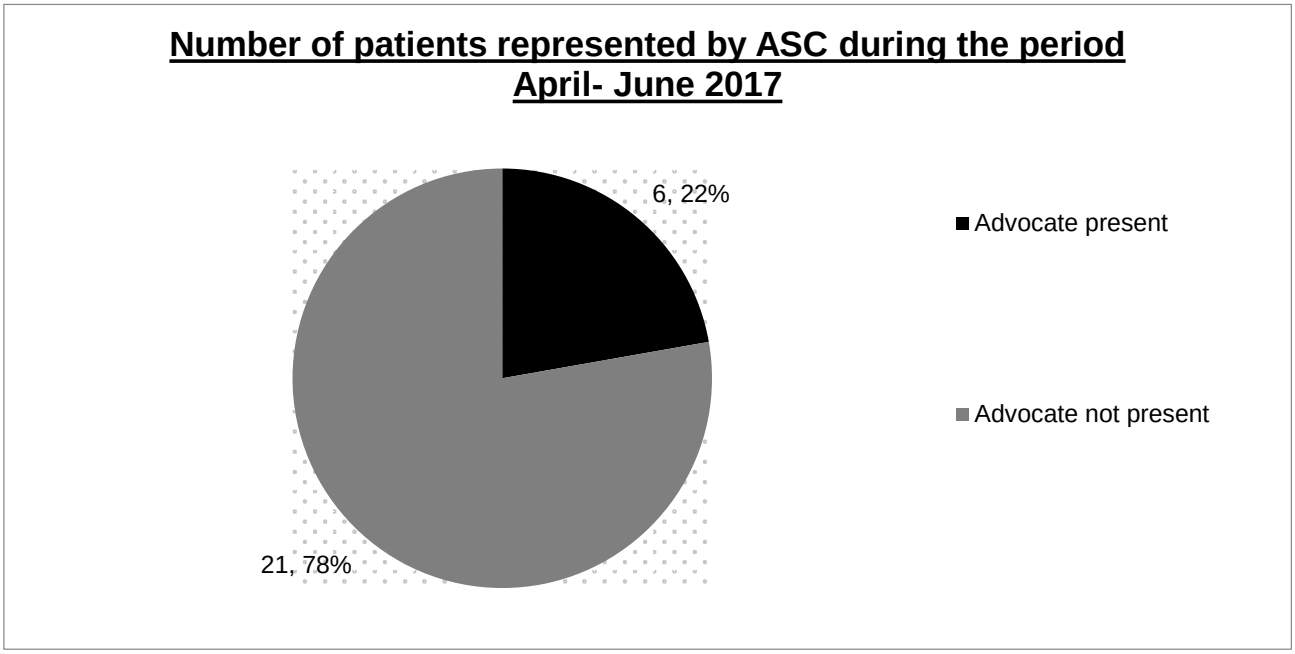
14.1

One hearing was adjourned for the following reason:

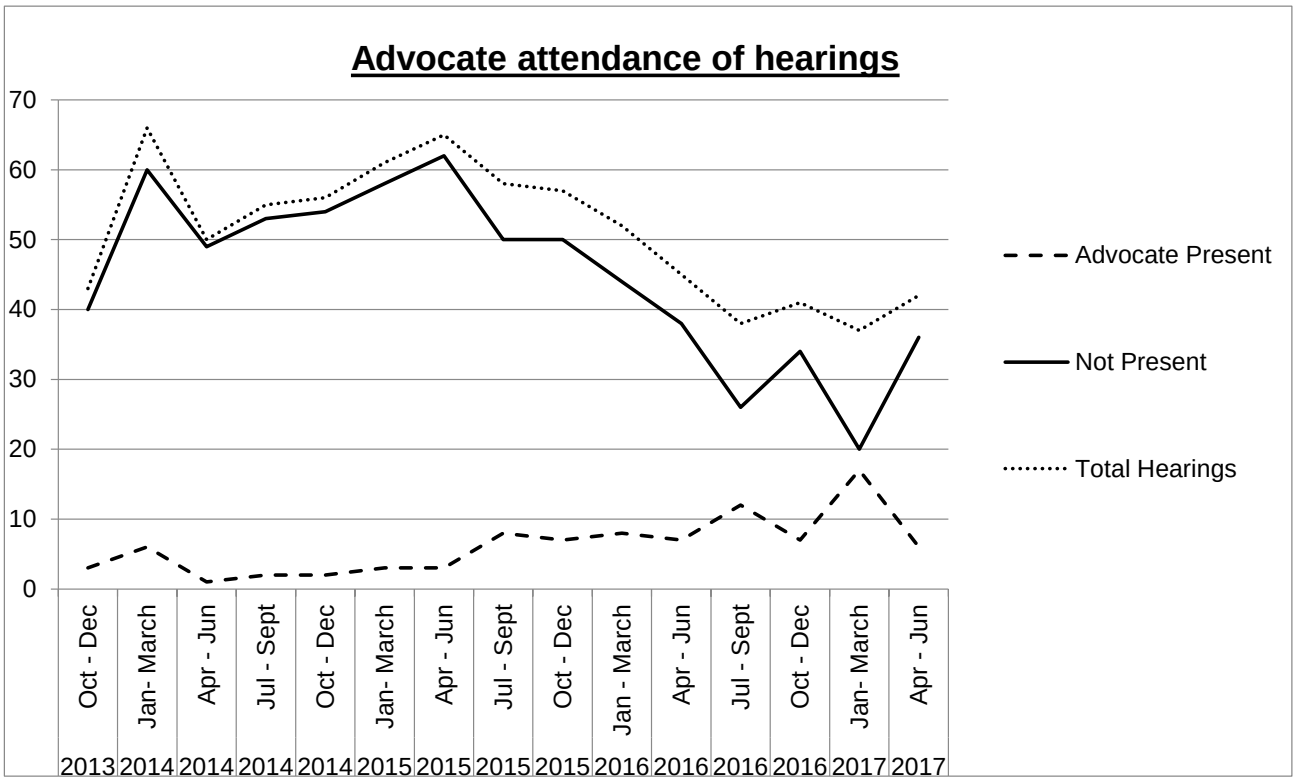
- Renewal document not completed

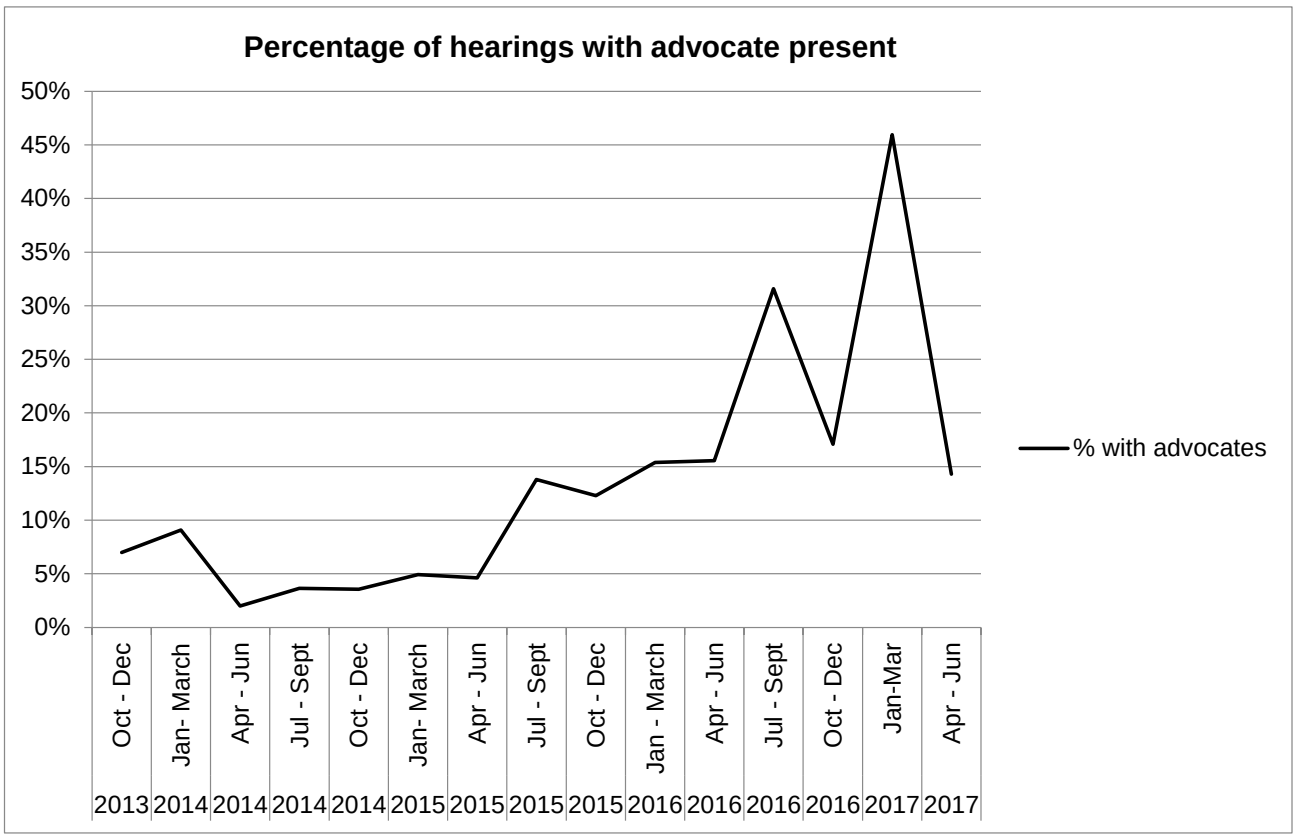
Two hearings were postponed for the following reasons:

- Ward and advocate could not attend
- Social work report not received



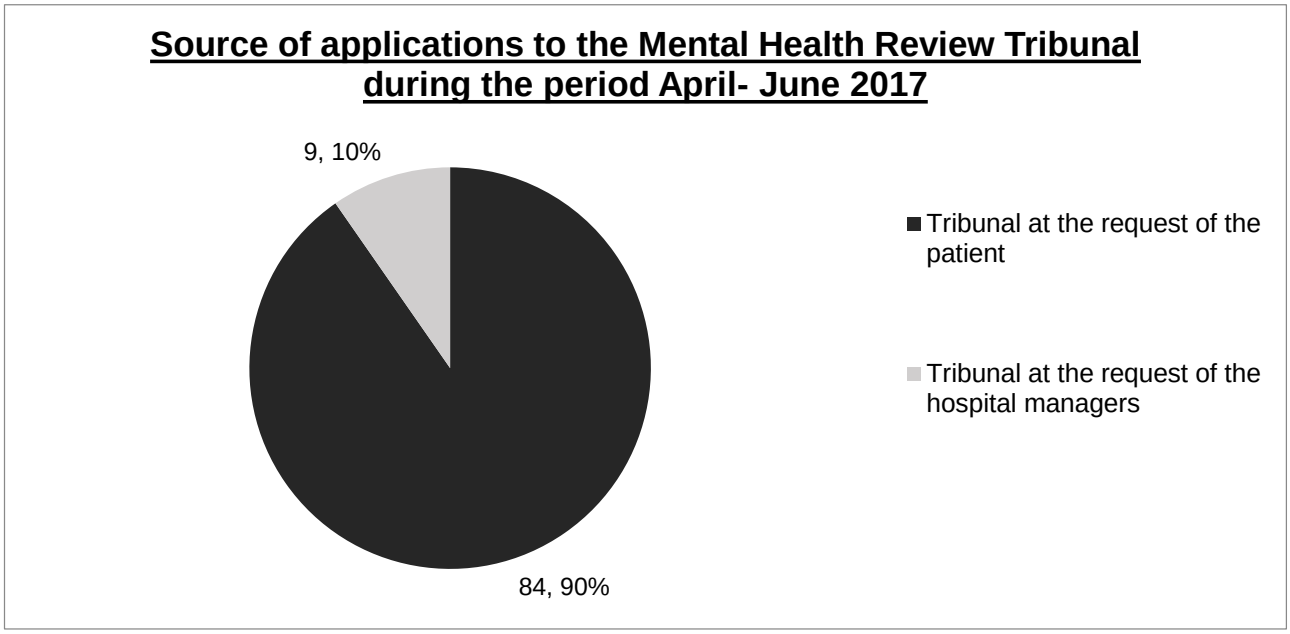
14.1

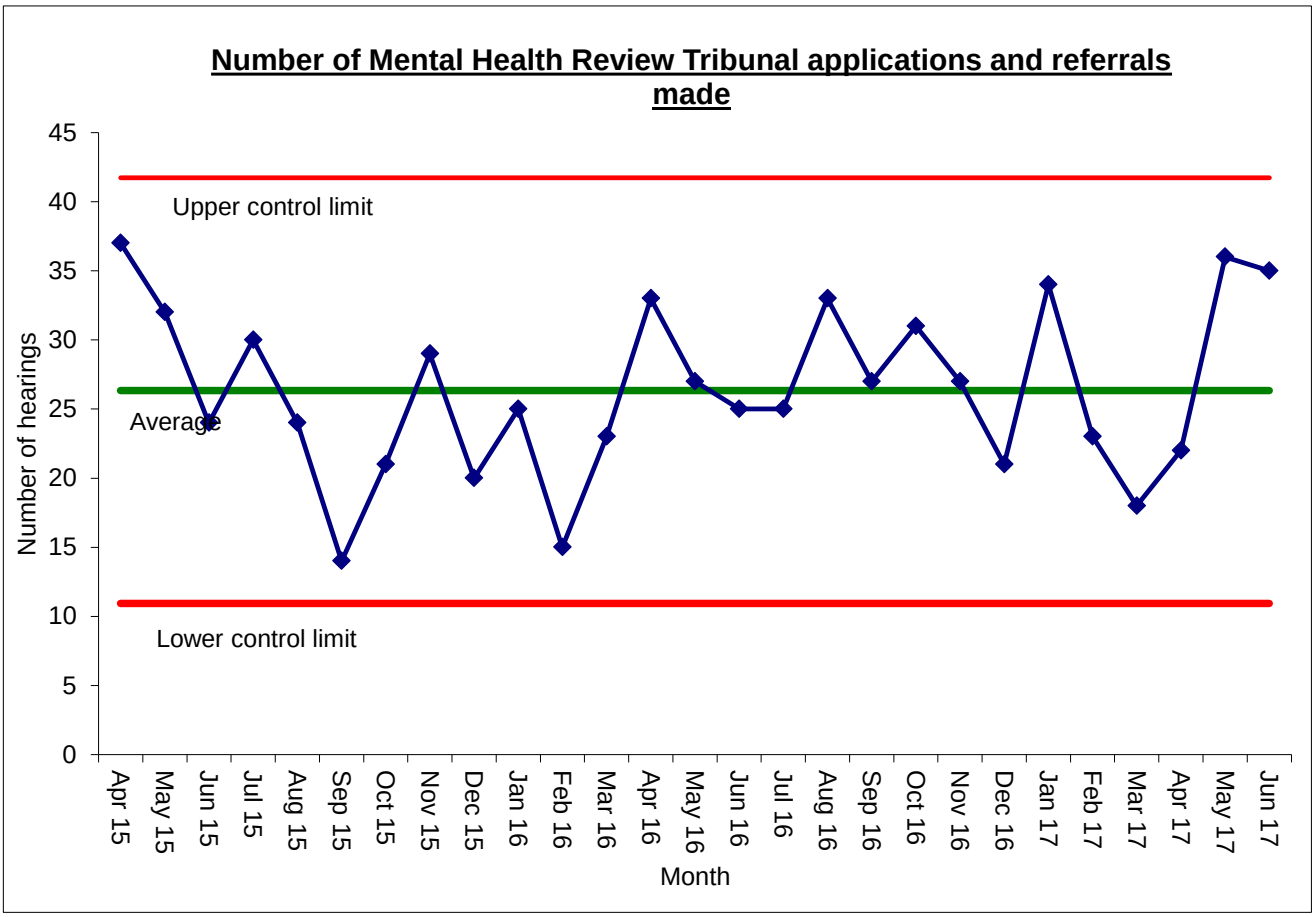

Advocate attendance of hearings
70
60
50
40
30
20
10
0
Oct - Dec 2013
Jan- March 2014
Apr - Jun 2014
Jul - Sept 2014
Oct - Dec 2014
Jan- March 2015
Apr - Jun 2015
Jul - Sept 2015
Oct - Dec 2015
Jan - March 2016
Apr - Jun 2016
Jul - Sept 2016
Oct - Dec 2016
Jan- March 2017
Apr - Jun 2017
Advocate Present
Not Present
Total Hearings


Percentage of hearings with advocate present
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
Oct - Dec 2013
Jan- March 2014
Apr - Jun 2014
Jul - Sept 2014
Oct - Dec 2014
Jan- March 2015
Apr - Jun 2015
Jul - Sept 2015
Oct - Dec 2015
Jan - March 2016
Apr - Jun 2016
Jul - Sept 2016
Oct - Dec 2016
Jan-Mar 2017
Apr - Jun 2017
% with advocates

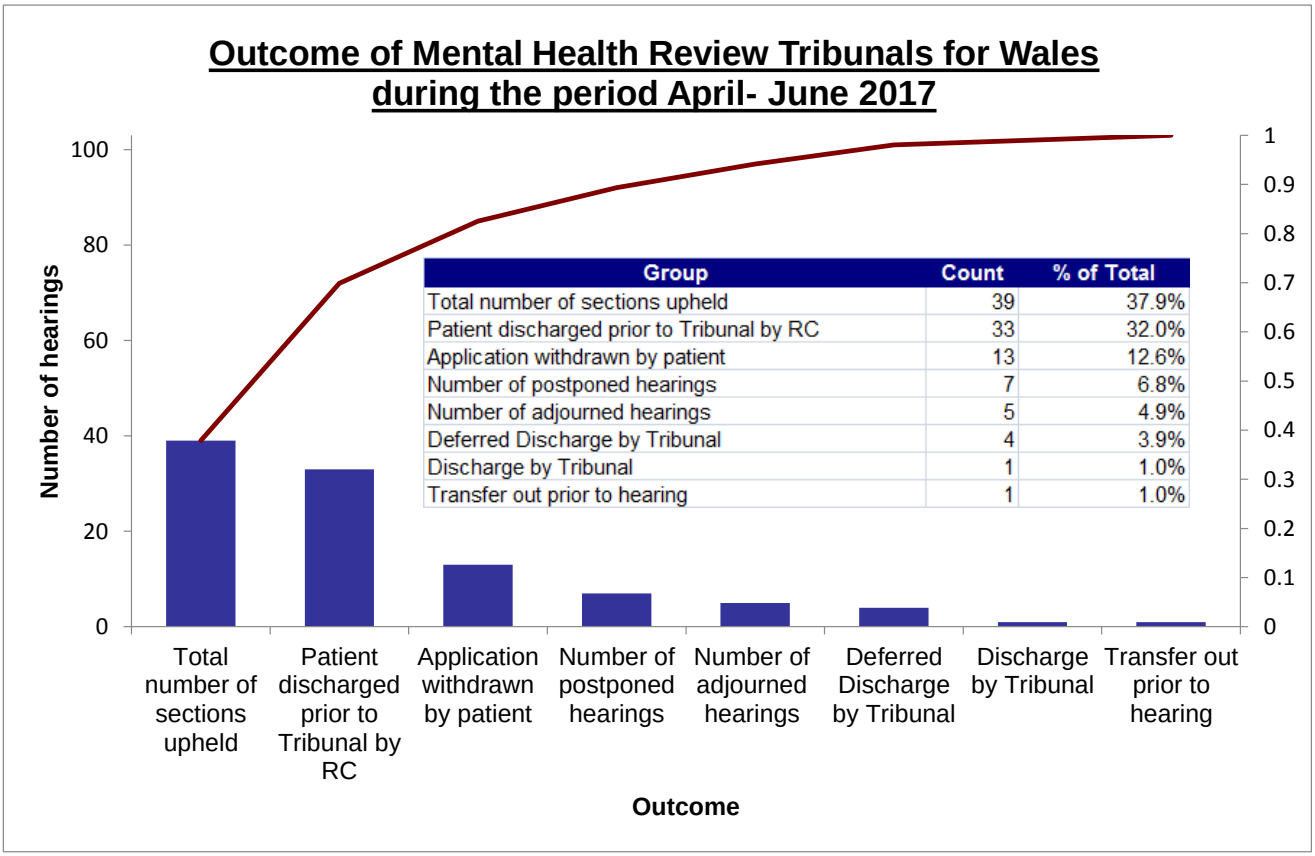
14.1

Mental Health Review Tribunal (MHRT) for Wales





14.1



Group	Count	% of Total
Total number of sections upheld	39	37.9%
Patient discharged prior to Tribunal by RC	33	32.0%
Application withdrawn by patient	13	12.6%
Number of postponed hearings	7	6.8%
Number of adjourned hearings	5	4.9%
Deferred Discharge by Tribunal	4	3.9%
Discharge by Tribunal	1	1.0%
Transfer out prior to hearing	1	1.0%

Seven hearings were postponed for the following reasons:

- At the request of the legal representative to obtain an independent social circumstances report
- Legal representative unable to attend due to personal circumstances
- Patient was on a medical ward and was too unwell to attend
- At the request of the Responsible Clinician to attend an urgent meeting
- No information available in relation to funding
- Tribunal panel needed at short notice for a section 2 MHRT
- Legal member of Tribunal did not attend on the day of the hearing

14.1

Five hearings were adjourned during the period for the following reasons:

- Further evidence required x 2
- Medical member had previous involvement of patient
- Patient terminated legal representative at hearing
- Due to change in circumstance of patient

Summary of other Mental Health Act Activity which took place during the period April- June 2017

Exclusion of visitors

During the period the Exclusion of Visitors Procedure was not implemented.

Section 19 transfers to and from Cardiff and Vale UHB

Five detained under Part 2 of the Mental Health Act were transferred back to their locality health board from Cardiff and Vale UHB to a hospital under a different set of Managers.

One patient was transferred to a medium secure facility.

Three patients detained under Part 2 of the Mental Health Act was transferred back to Cardiff and Vale UHB as their locality health board from a hospital under a different set of Managers.

One patient was transferred to Cardiff and Vale UHB for a specialist placement (Neuropsychiatry).

Death of detained patients

During the period there has been one death of a detained patient.

Section 117

Section 117 continues to be monitored by the MHA Department. As at 30th June 2017 Cardiff and Vale UHB maintain responsibility for 1564 patients eligible to section 117 after care.

During this period Cardiff and Vale UHB updated the 117 register to include a further 34 and discharged 44.

Glossary of Terms

Definition	Meaning
Informal patient	Someone who is being treated for mental disorder in hospital and who is not detained under the Act.
Detained patient	A patient who is detained in hospital under the Act or who is liable to be detained in hospital but who is currently out of hospital e.g. on section 17 leave.
Section 135	Allows for a magistrate to issue a warrant authorising a policeman to enter premises, using force if necessary, for the purpose of removing a mentally disordered person to a place of safety for a period not exceeding 72 hours, providing a means by which an entry which would otherwise be a trespass, becomes a lawful act.
Section 135(1)	Used where there is concern about the well being a person who is not liable to be detained under the Act so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care.
Section 135(2)	Used where the person is liable to be detained, or is required to reside at a certain place under the terms of guardianship, or is subject to a community treatment order or Scottish legislation. In both instances, the person can be transferred to another place of safety during the 72 hour period.
Section 136	Empowers a policeman to remove a person from a public place to a place of safety if he considers that the person is suffering from mental disorder and is in immediate need of care and control. The power is available whether or not the person has, or is suspected of having

	committed a criminal offence. The person can be detained in a place of safety for up to 72 hours so that he /she can be examined by a doctor and interviewed by an Approved mental Health Professional in order that arrangements can be made for his/her treatment or care. The detained person can be transferred to another place of safety as long as the 72 hour period has not expired.
Part 2 of the Mental Health Act 1983	This part of the Act deals with detention, guardianship and supervised community treatment for civil patients. Some aspects of Part 2 also apply to some patients who have been detained or made subject to guardianship by the courts or who have been transferred from prison to detention in hospital by the Secretary of State for Justice under Part 3 of the Act. A part 2 patient is a civil patient who became subject to compulsory measures under the Act as a result of an application for detention by a nearest relative or an approved mental health professional founded on medical recommendations.
Section 5(4)	Provides for registered nurses whose field of practice is mental health or learning disabilities to invoke a holding power for a period of not more than 6 hours by completing the statutory document required. During this period, the medical practitioner or approved clinician in charge, or his or her nominated deputy should examine the patient with a view to making a report under section 5(2). Alternatively a patient can be detained under section 2 or 3 if a full Mental Health Act assessment is achieved during the 6 hour period.
Section 5(2)	Enables an informal inpatient to be detained for up to 72 hours if the doctor or approved clinician in charge of the patient's treatment reports that an application under

	section 2 or 3 ought to be made. The purpose of this holding power is to prevent a patient from discharging him/herself from hospital before there is time to arrange for an application under section 2 or section 3 to be made. As soon as the power is invoked, arrangements should be made for the patient to be assessed by a potential applicant and recommending doctors.
Section 4	In cases of urgent necessity, this section provides for the compulsory admission of a person to hospital for assessment for a period of up to 72 hours. An application under this section should only be made when the criteria for admission for assessment are met, the matter is urgent and it would be unsafe to wait for a second medical recommendation i.e. where the patient's urgent need for assessment outweighs the alternative of waiting for a medical recommendation by a second doctor. A psychiatric emergency arises when the mental state or behaviour of a patient cannot be immediately managed. To be satisfied that an emergency has arisen, there must be evidence of: • An immediate and significant risk of mental or physical harm to the patient or to others • And/or the immediate and significant danger of serious harm to property • And/or the need for physical restraint of the patient. Section 4 cannot be renewed at the end of the 72 hour period. If compulsory detention is to be continued, the application must either be converted into a section 2 (admission for assessment) with the addition of a second medical recommendation, in which case the patient can be detained for a maximum of 28 days under that section beginning with the date of admission under section 4 or an application for treatment under section 3 should be

	made. The Act does not provide for a section 4 to be converted into a section 3 because the criteria for admission under each of these sections are different.
Section 2	Authorises the compulsory admission of a patient to hospital for assessment or for assessment followed by medical treatment for mental disorder for up to 28 days. Provisions within this section allow for an application to be made for discharge to the Hospital Managers or Mental Health Review Tribunal for Wales. If after the 28 days have elapsed, the patient is to remain in hospital, he or she must do so, either as an informal patient or as a detained patient under section 3 if the grounds and criteria for that section have been met. The purpose of the section is limited to the assessment of a patient's condition to ascertain whether the patient would respond to treatment and whether an application under section 3 would be appropriate. Section 2 cannot be renewed and there is nothing in the Act that justifies successive applications for section 2 being made. The role of the nearest relative is an important safeguard but there are circumstances in which the county court has the power to appoint another person to carry out the functions of the nearest relative: • The patient has no nearest relative within the meaning of the Act • It is not reasonably practicable to find out if they have such a relative or who that relative is • The nearest relative is unable to act due to mental disorder or illness • The nearest relative of the person unreasonably objects to an application for section 3 or guardianship.

	• The nearest relative has exercised their power to discharge the person from hospital or guardianship without due regard to the persons welfare or the public interest This procedure may have the effect of extending the authority to detain under section 2 until the application to the county court to appoint another person is finally disposed of. Patients admitted under section 2 are subject to the consent to treatment provisions in Part 4 of the Act.
Section 3	Provides for the compulsory admission of a patient to a hospital named in the application for treatment for mental disorder. Section 3 provides clear grounds and criteria for admission, safeguards for patients and there are strict provisions for review and appeal. Patients detained under this section are subject to the consent to treatment provisions contained in Part 4 of the Act below.
Supervised Community Treatment (SCT)	Provides a framework to treat and safely manage suitable patients who have already been detained in hospital in the community. SCT provides clear criteria for eligibility and safeguards for patients as well as strict provisions for review and appeal, in the same way as for detained patients.
Community Treatment Order (CTO)	Written authorisation on a prescribed form for the discharge of a patient from detention in a hospital onto SCT.
Section 17E (recall of a community patient to hospital)	Provides that a Responsible Clinician may recall a patient to hospital in the following circumstances: • Where the RC decides that the person needs to

14.1

	receive treatment for his or her mental disorder in hospital and without such treatment there would be a risk of harm to the health or safety of the patient or to other people. • Where the patient fails to comply with the mandatory conditions set out in section 17B (3).
Revocation	Is the rescinding of a CTO when a SCT patient needs further treatment in hospital under the Act. If a patients' CTO is revoked the patient is detained under the powers of the Act in the same way as before the CTO was made.
Part 3 of the Act	Deals with the circumstances in which mentally disordered offenders and defendants in criminal proceedings may be admitted to and detained in hospital or received into guardianship on the order of the court. It also allows the Secretary of State for Justice to transfer people from prison to detention in hospital for treatment for mental disorder. Part 3 patients can either be "restricted", which means that they are subject to special restrictions on when they can be discharged, given leave of absence and various other matters, or they can be unrestricted, in which case they are treated for the most part like a part 2 patient.
Section 35	Empowers a Crown Court or Magistrates Court to remand an accused person to hospital for the preparation of a report on his mental condition if there is reason to suspect that the accused person is suffering from a mental disorder.
Section 36	Empowers a Crown Court to remand an accused person who is in custody either awaiting trial or during the course of a trial and who is suffering from mental disorder, to hospital for treatment.
Section 37	Empowers a Crown Court or magistrates' court to make a hospital or guardianship order as an alternative to a penal

	disposal for offenders who are found to be suffering from mental disorder at the time of sentencing.
Section 38	Empowers a Crown Court or Magistrates Court to send a convicted offender to hospital to enable an assessment to be made on the appropriateness of making a hospital order or direction.
Section 41	Empowers the Crown Court, having made a hospital order under s.37, to make a further order restricting the patients discharge, transfer or leave of absence from hospital without the consent of the Secretary of State for Justice. Section 41 can also operate as a community section for people who were originally on section 37/41. When a section 37/41 is conditionally discharged it leaves the power of Section 41 in place. This means that the person can leave hospital and live in the community but with a number of conditions placed upon them.
Section 45A	This is a court sentence to hospital for someone with a mental disorder at any time after admission, if the Responsible Clinician considers that treatment is no longer required or beneficial, the person can be transferred back to prison to serve the remainder of their sentence.
Section 47	Enables the Secretary of State to direct that a person serving a sentence of imprisonment or other detention be removed to and detained in a hospital to receive medical treatment for mental disorder.
Section 48	Empowers the Secretary of State for Justice to direct the removal from prison to hospital of certain categories of unsentenced mentally disordered prisoners to receive medical treatment.

Section 49	Enables the Secretary of State for Justice to add an order restricting the patients discharge from hospital to a s.47 or s.48.
CPI Act	Criminal Procedure (Insanity) Act 1964. This Act as amended by the Criminal Procedures (Insanity and Unfitness to Plead) Act 1991 and the Domestic Violence, Crime and Victims Act 2004 provides for persons who are found unfit to be tried or not guilty by reason of insanity in respect of criminal charges. The court has three disposal options: • To make a hospital order under section 37 of the MHA 1983 which can be accompanied by a restriction order under section 41. • To make a supervision order so that the offenders responsible officer will supervise him only to the extent necessary for revoking or amending the order. • Order the absolute discharge of the accused.
CTO (section 37)	Once an offender is admitted to hospital on a hospital order without restriction on discharge, his or her position is the same as if a civil patient, effectively moving from the penal into the hospital system. He or she may therefore be suitable for supervised Community Treatment (SCT).
Administrative scrutiny	The University Health Board has formally delegated its duty to administratively scrutinise admission documents to officers identified in the scheme of delegation. Medical scrutiny is undertaken by Consultant Psychiatrists.
	Compliance with the Consent to Treatment provisions under Part 4 & 4A of the Act is related to treatments requiring the patient's consent or a second opinion. If a patient has capacity but refuses treatment a Second Opinion Appointed Doctor (SOAD), i.e. a Registered Medical Practitioner appointed for the purposes of Part 4 of the Act can authorise treatment having consulted two Statutory Consultee's who have been professionally

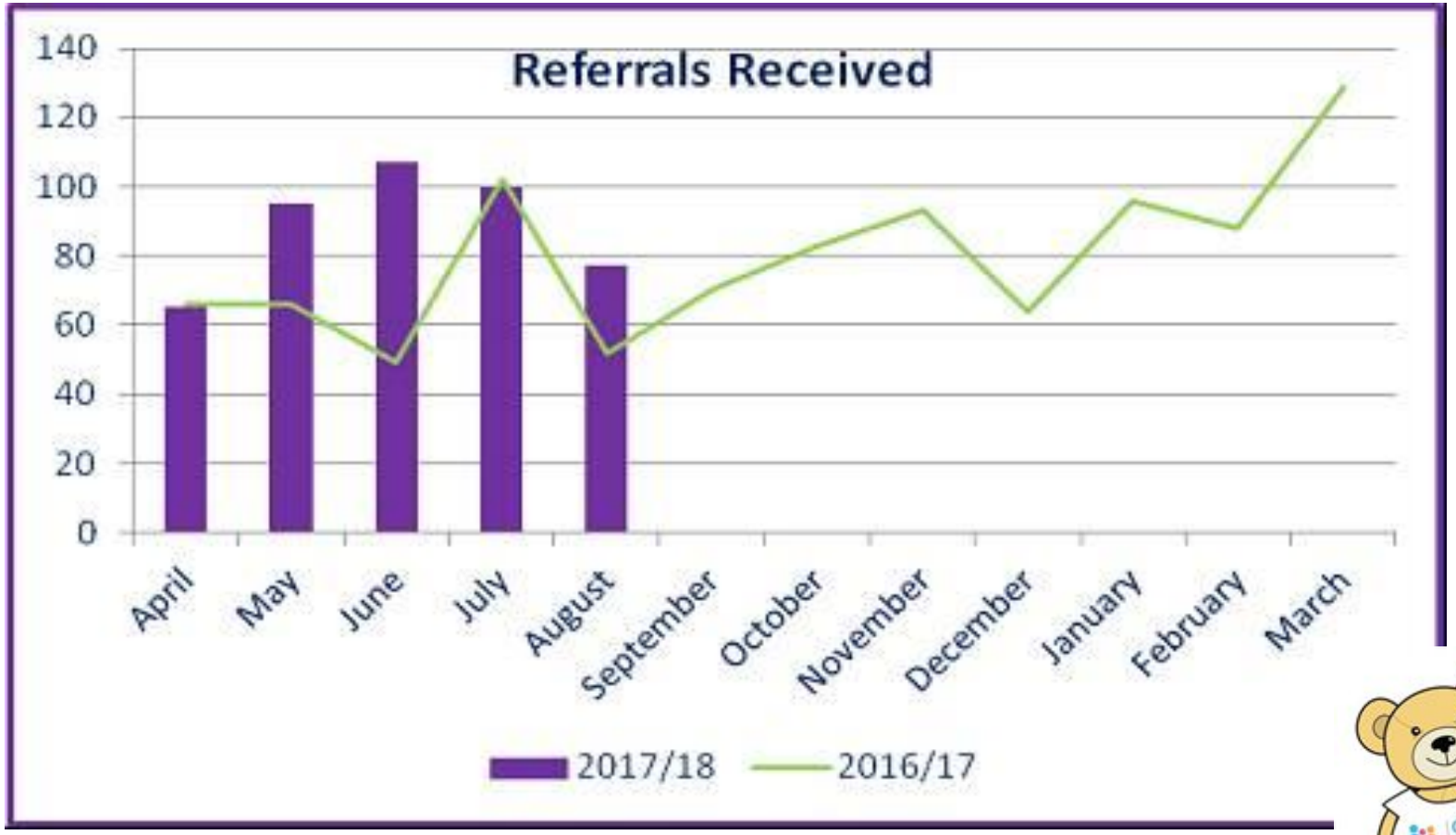
14.1

	concerned with the medical treatment of the patient for mental disorder. If the patient lacks capacity to consent SOAD authorisation is required.
Section 58(3)(a)	Certificate of consent to treatment (RC)
Section 58(3)(b)	Certificate of second opinion (SOAD authorisation)
Section 58A(3)(c)	Certificate of consent to treatment, patients at least 18 years of age (RC)
Section 58A(4)(c)	Certificate of consent to treatment and second opinion, patients under 18 years of age (SOAD)
Section 58A(5)	Certificate of second opinion (patients not capable of understanding the nature, purpose and likely effects of the treatment). (SOAD)
Part 4A	Certificate of appropriateness of treatment to be given to a community patient (SOAD)
Section 62 – Urgent treatment	Where treatment is immediately necessary, a statutory certificate is not required if the treatment in question is: • To save the patient's life • Or to prevent a serious deterioration of the patients condition, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed • Or to alleviate serious suffering by the patient, and the treatment does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard • Or to prevent the patient behaving violently or being a danger to themselves or others, and the treatment represents the minimum interference

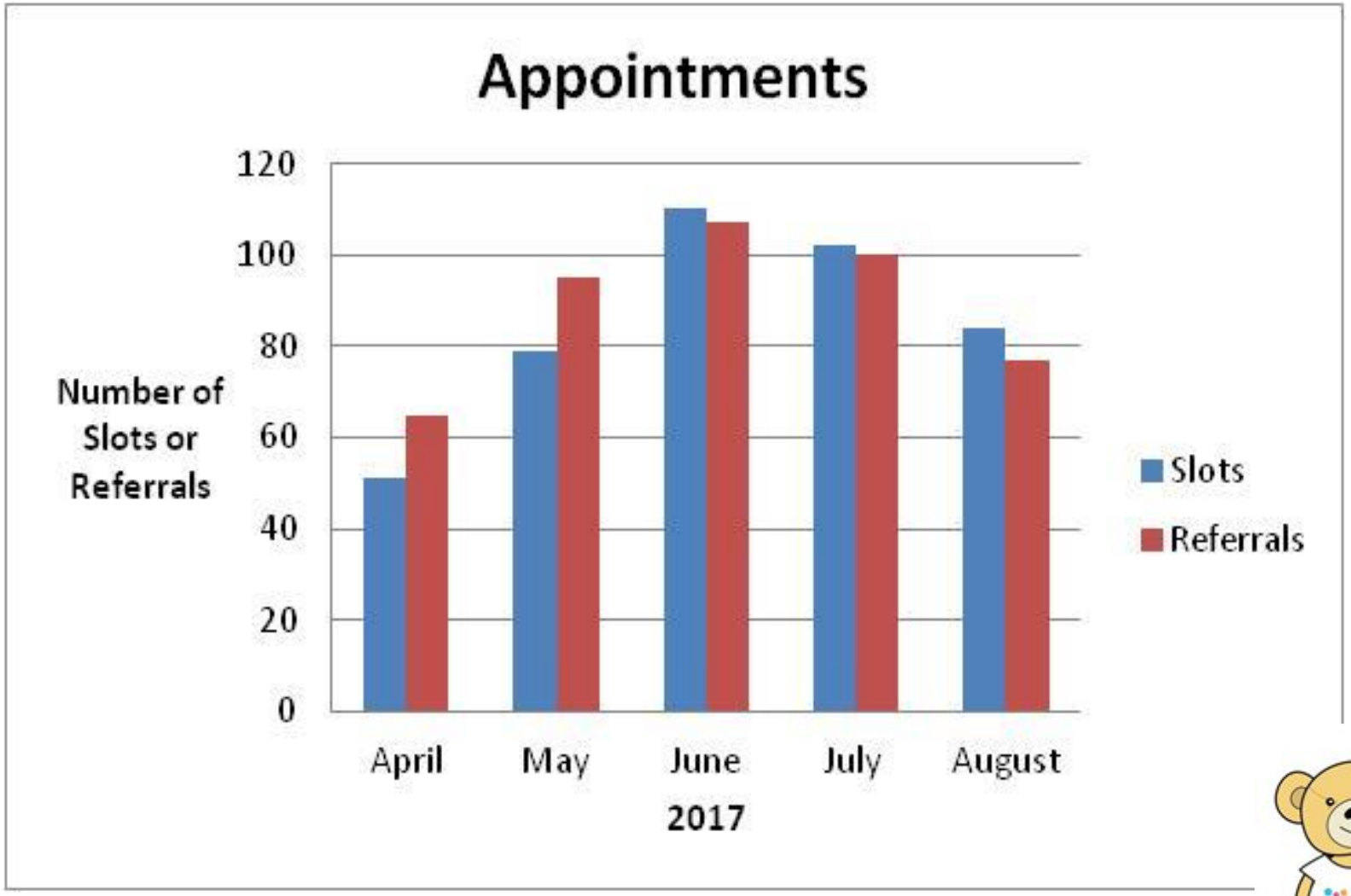
14.1

	necessary for that purpose, does not have unfavourable physical or psychological consequences which cannot be reversed and does not entail significant physical hazard.
Section 23	Provides for the absolute discharge from detention, guardianship or from a community treatment order of certain patients, by the Responsible Clinician, the Hospital Managers (or Local Social Services Authority for guardianship patients) or the patients nearest relative. The discharge must be ordered; it cannot be affected by implication. Section 23 does not apply to patients who have been remanded to hospital by the courts or to patients subject to interim hospital orders. The Secretary of State for Justice has powers to discharge restricted patients under section 42(2). If at any time Responsible Clinicians conclude that the criteria justifying the continued detention or community treatment order are not met, they should exercise their power of discharge and not wait until such time that the detention order or SCT is due to expire.
Section 117	Services provided following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act following the discharge of a patient from detention for treatment under the Act. The duty applies to SCT patients and conditionally discharged patients as well as those who have been absolutely discharged.

Primary Mental Health for Children and Young People Referral Profile

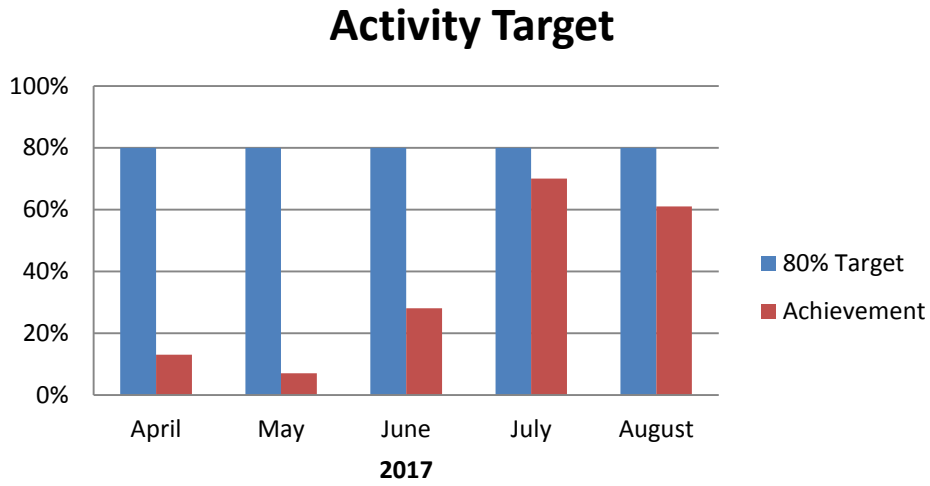


Slots offered/ number of referrals



Performance against Part 1

- The performance for Part 1 of the measure for the CYP service has not achieved 80% since transfer from Cwm Taf Health Board.
- Waiting list for assessment at transfer - 36 weeks, service working on the backlog.
- March referrals increased significantly due to referrals being passed from Cwm Taf SCAMHS in month.
- Significant improvement seen in July and August.



- In August the CYP service took back 24 ,16 year olds from Adult PMHSS who were already over 28 days which impacted on performance in August along with parental cancellations in month due to holidays.

Actions taken to improve performance

- Improved data capture and accurate use of PARIS.
- Electronic referral process introduced reducing delays.
- Referrals being appointed to in month available slots.
- Scoping Bank options to assist with referral peaks which are common for CYP services.
- Vacancies filled and more appointments to be made with new staff now operational and delivering Part 1 assessments
- Staff have job plans with allocated assessment /clinic slots.
- Telephone assessment piloted and used in suitable circumstances.

Developing a sustainable model

- New guidance produced by Together 4 Children and YP National Programme to be issued with focus across 5 elements – Part 1 is one element. The new guidance has been developed because nationally and locally the focus on the Part 1 assessment measure has led to reduced delivery of other preventative elements - with the unintended consequence of increasing Part 1 demand.
- CAMHS Planning Network to introduce peer review of CYP PMH services.
- Working with partners to develop a sustainable GP/School cluster model with a single point of access.
- Scoping the development of a consultation/advice line.
- Working with CSI team on more in depth Demand and Capacity modelling, allocating time for interventions on a 1+2 basis.
- Working with adult services, graduate support workers and 3rd sector on a menu of group interventions.

NHS WALES GIG CYMRU | Bwrdd Iechyd Prifysgol Caerdydd a'r Fro | Cardiff and Vale University Health Board

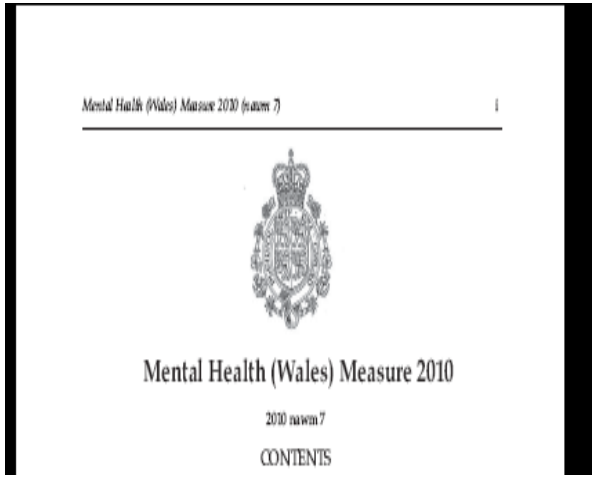
Mental Health (Wales) Measure 2010

Ian Wile

Mental Health Clinical Board

- The Mental Health (Wales) Measure is ‘Primary Legislation’ in Wales and has been given Royal Approval.

- The MH(W)M is applicable to all age groups.

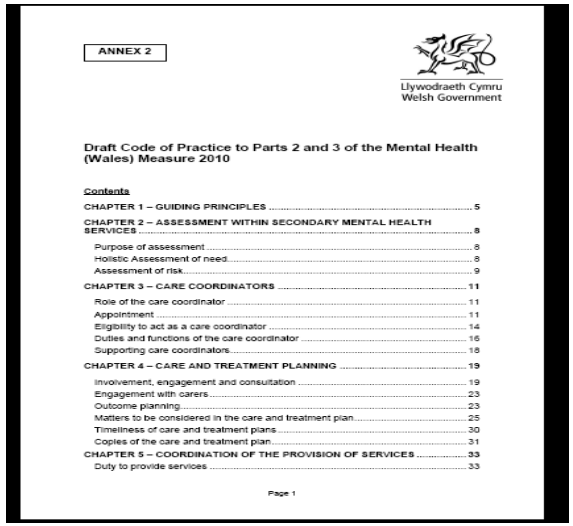


Mental Health (Wales) Measure 2010 (nawm 7) 1

Mental Health (Wales) Measure 2010

2010 nawm 7

CONTENTS



ANNEX 2

Llywodraeth Cymru
Welsh Government

Draft Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010

Contents

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16.1

Part 1 - Local Primary Mental Health Support Services

Statutory obligations on mental health partners to implement LPMHSS that meets ***five functions***

1. The carrying out of **assessments** in accordance with part 1

2. Provision for individuals of local primary mental health **treatment (interventions)** where required following assessment

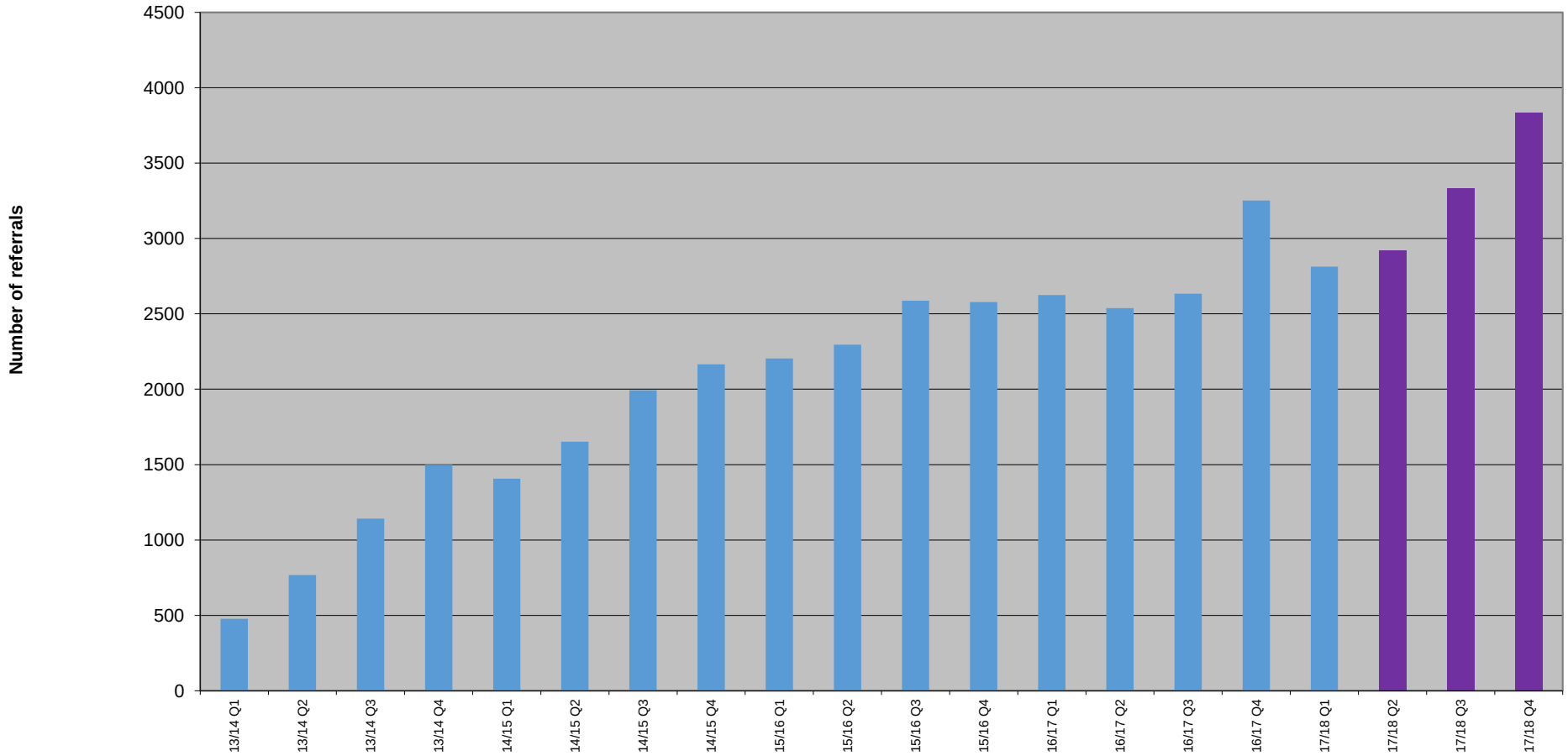
3. The making of **referrals** to other services which might improve or prevent a deterioration in the individuals mental health

4. The provision of **information and advice** for individuals and their carers about other services that are available to them

5. **Information and advice and other assistance** for primary care providers (GP's and practice staff) so as to improve the services related to mental health which they provide or arrange

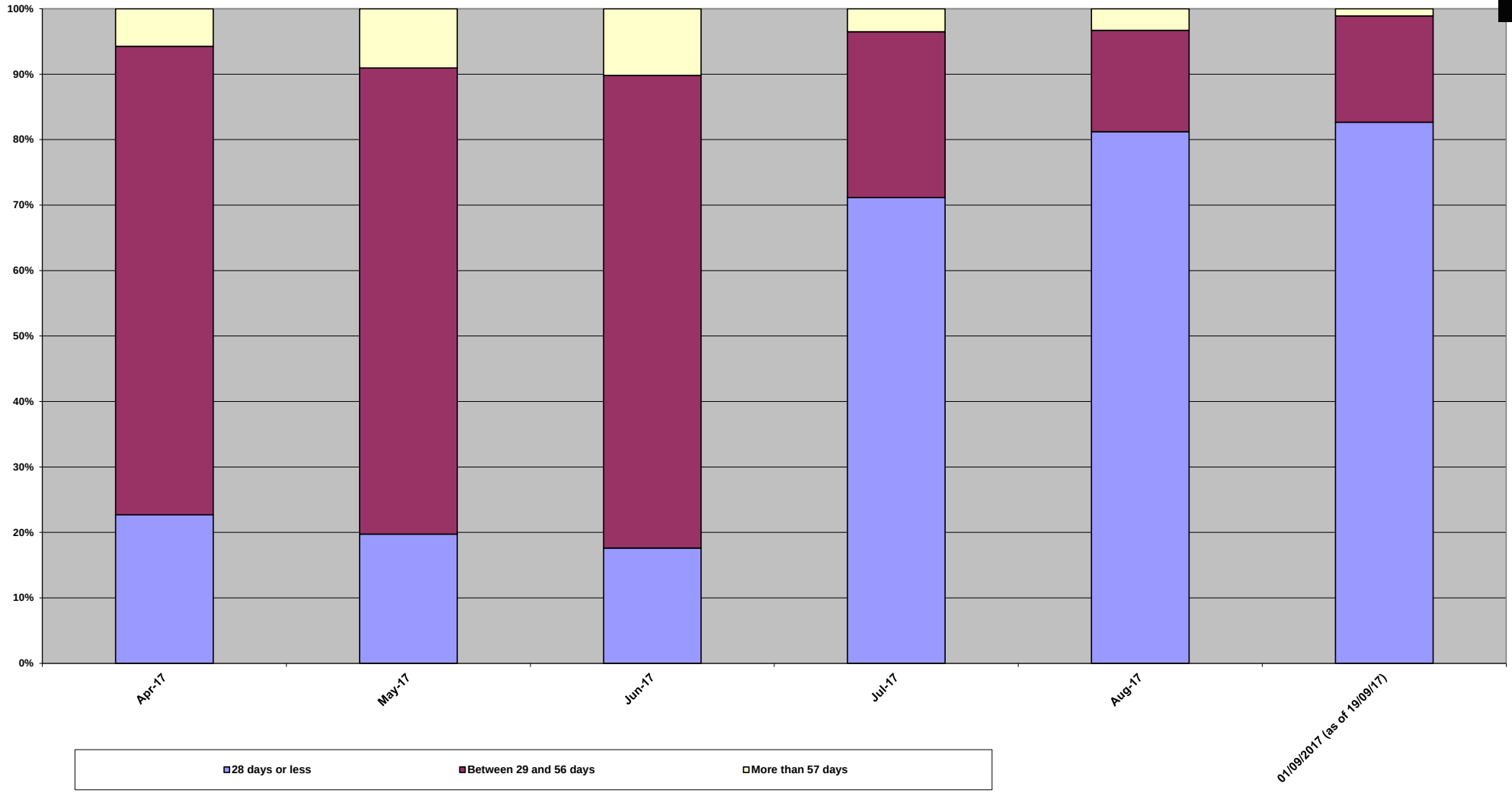
16.1

Quarterly run rate (bar chart) Qtr 1 2013/14 onwards



16.1

PMHSS Assessment Performance



16.1

Mitigation of Risk

- Camhs Repatriation
- Pause SPOE
- Weekly Reporting with alert parameters
- Flexible Establishment to meet demand
- Direct Booking
- Temporary Cover to meet demand fluctuations- PMHSS went live with a Bank staff arrangement in August ’15 and have a small pool of staff to draw from. Shifts are currently on Monday and Tuesdays between 5pm and 8pm and every other Saturday between 9am and 5pm. A mini audit of this arrangement revealed that at least 15% of all Part 1 assessments are carried out by the Bank staff. PMHSS has also offered secondment opportunities when slippage money has been identified. This arrangement too has had a positive impact on assessment performance.
- The Clinical Board is currently reviewing all community vacancies for scrutiny as to whether the resource can be redirected to the PMHSS team to assist with demand, even on a temporary basis.

Health Needs Assessment of HMP Cardiff

Extended summary and recommendations

Author: Kimberley Cann, Speciality Registrar in Public Health

Date: February 2016 **Version**: 1.0

Publication/ Distribution:

For distribution to identified project Stakeholders, those working within HMP Cardiff, Public Health Wales, or Cardiff and Vale University Health Board, and affiliated organisations. Available for distribution to the general public.

Purpose and Summary of Document:

This extended summary details the health needs assessment of current health needs and service provision in HMP Cardiff and the recommendations made.

Introduction

In 2013, Her Majesty's Inspectorate of Prisons (HMIP) published the latest inspection report of Her Majesty's Prison (HMP) Cardiff. The recommendations from this included that an up-to-date health needs assessment (HNA) should be commissioned (recommendation 2.56).[1] The last HNA for HMP Cardiff was published in 2009. This HNA seeks to address the highlighted need for an up-to-date HNA on behalf of Cardiff and Vale University Health Board (UHB) and HMP Cardiff.

HMP Cardiff is a category B prison serving the courts in the eastern half of South Wales. As of 30th June 2015 HMP Cardiff held 816 men and had an operational capacity of 820, similar to the population size at the previous HNA in September 2009 when the prison held 808 men.[2,3] The prison currently has a high turnover of prisoners: 'churn' rate. It has an average of 384 receptions per

month and an estimated 4,602 annually, giving a churn rate of 5.6 (based on June-October 2015 data).[4] The age distribution of the prison population is slightly older than in 2009, with fewer offenders aged 21-29 years (38% versus 51%).

HMP Cardiff has a high proportion of prisoners who are on remand (unconvicted or convicted unsentenced prisoners) or who have short sentences. As of 30th September 2015, 36% of the prison population were on remand.[5] This compares to around 13% of the prison population in England overall.[6] The proportion of prisoners with shorter sentences has also greatly increased since the last HNA in 2009. Of those that had been sentenced, 34% and 8% of prisoners had sentences of less than 6 months, and 13% had sentences between 6 and less than 12 months, in 2015 and 2009 respectively.

Prisoners are well documented as having poorer health than the general population. There are a wide range of determinants that impact on the health of prisoners before, during and after incarceration. This HNA is focused predominantly on clinical healthcare provision. However, the HNA follows the WHO definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.[7]

Methods

This HNA followed the approach by Marshall et al. (2000) involving three components: epidemiological, comparative and corporate.[8] The Health Needs Assessment Template for Adult Prisons published by Public Health England was used as a guide to inform this HNA where relevant.[9] A number of recently conducted HNAs were available to inform this HNA. Thematic HNAs for prisons in Wales were conducted in 2012 for mental health and 2013 for dental health.[10,11] These were utilised and updated for HMP Cardiff where possible.

The epidemiological aspect involved a description of health status, existing service provision, and the effectiveness of current services where this information was available. This was obtained from five separate sources; (i) previous HNAs, (ii) Read code extraction and analysis from the prison SystmOne information system by the NHS Wales Informatics Service (NWIS), (iii) summary reports provided by prison healthcare and UHB staff, (iv) the Sexual Health in Wales Surveillance System (SWS), and (iv) a literature review. Wherever possible, triangulation of sources was used to help identify the variation in estimates and reliability of different data sources.

The corporate aspect involved three approaches: (i) interviews with prison and UHB staff and with relevant Welsh Government representatives; (ii) a survey of prisoners; and (iii) a Stakeholder workshop. A number of other prisons were identified as suitable comparators and approached to complete a survey and their most recent HNA requested as part of the comparative aspect. Topics covered were those previously identified as relevant by meetings with Stakeholders at HMP Cardiff during the corporate aspect of this HNA in November 2015.

Findings and gap analysis

The interviews with Stakeholders identified six areas of particular importance to HMP Cardiff in the current context and the key findings are summarised by topic below. The topics reflect the change in population at HMP Cardiff since the last HNA, to more remand prisoners and those with shorter sentences. The full findings of the HNA are available in the Technical Document which can be requested.

SystmOne

1. The recommendations made by the mental HNA regarding SystmOne are currently still ongoing. However, limited progress has been made to date.
2. Use of SystmOne by dental staff has increased substantially since the oral HNA.
3. SystmOne data extracted by NWIS does not correlate with staff reports generated from SystmOne or other information systems used.
4. Use of SystmOne by staff does not appear consistent.
5. It is not currently possible to reliably ascertain waiting times for mental or oral healthcare using SystmOne.
6. The Read codes available in SystmOne are often not found to be helpful to staff. Changes to the main display screen and which codes are available would improve consistency of use and usefulness.
7. SystmOne is not used consistently to record drug addiction therapy and does not match that recorded in the Pharmacy system

Substance Misuse

8. A high proportion of the prisoners will have drug or alcohol need, or both.
9. There is good communication between substance misuse services within the prison.
10. The new 41-bed substance misuse unit is fully utilised and may not offer sufficient capacity in future should any further increases in need be experienced.
11. The provision of CARAT services may be impacted by a change of provider in 2016. This has the potential to affect a large proportion of the prison population.
12. The CARAT team provide important harm reduction counselling services which impacts on issues such as NPS, BBV, stress management, and sleep.
13. The CARAT team work proactively to ensure outside prescribing agencies have access to the court list in case prisoners do not return to HMP Cardiff before the prison team are aware.
14. Use of NPS may be increasing within the prison and their use has been linked to deaths, psychosis and aggressive behaviour. However, staff training and prisoner education on NPS is underway.
15. There is currently no way to monitor the trend in NPS use within the prison. However, there are plans to introduce mandatory NPS testing.

16. There is often limited time for substance misuse services to engage with prisoners at HMP Cardiff following their detox, due to the high churn rate and limited staff resources.
17. There are concerns among staff over the lack of availability of substance misuse services at weekends, particularly for any prisoners who may arrive in crisis on Fridays.
18. HMP Cardiff does not match comparator prisons in having a 7-day service for substance misuse.
19. Rapid and accurate surveillance of substance misuse within the prison would aid in following the changing profile of drugs used, particularly following the prison becoming smoke-free.

Mental health

20. HMP Cardiff may be experiencing particularly high prevalence of anxiety and depressive disorders compared to comparator prisons.
21. Co-morbidity of mental health conditions is likely to be very common in the prison population.
22. Staff report large increases in psychiatric morbidity in recent years, particularly psychotic disorders and ADHD. However, a spot audit found prevalence of ADHD to be similar to that expected in the community.
23. Mental healthcare staff may benefit from having their time protected to ensure they are available when needed.
24. It was not possible to directly compare staffing levels for mental healthcare with other prisons due to differences in the terminology and roles of staff.
25. Only a small proportion of those referred to the primary care mental health team are recorded as being seen or having been released before being seen. It is not know whether this is due to issue with the data capture system or whether these patients are not being seen.
26. Comparator data suggest that HMP Cardiff primary mental healthcare team experience higher than expected numbers of referrals and case load but that a smaller proportion are being seen each month.
27. Prescribing of mirtazapine is still high and has not changed since it was identified as an issue in the mental HNA (2013).
28. NICE guidance on the mental health of adults in contact with the criminal justice system is due to be published in November 2016.
29. The Royal College of Psychiatrists has recently published Standards for prison Mental Health Services.
30. There is uncertainty over who the most appropriate member of staff is to conduct reception screening for mental health issues.
31. Delays in secondary care appointments post-release are a risk factor for mental ill-health of released prisoners.
32. Mental healthcare resources are felt to be unable to meet the needs of all clients, particularly in secondary care.
33. The high churn and numbers of new receptions received at HMP Cardiff is likely to result in an increased need for counselling services. The availability and level of skill of counselling delivered at HMP Cardiff is variable due to a reliance on recruiting students to provide this.

34. There are delays in transfers to tertiary care due to high demand and insufficient resources. This has the potential to prevent prisoners receiving care prior to release.
35. Mental healthcare at HMP Cardiff does not match practice in the community by the lack of a register of patients with chronic or long-term conditions. SystmOne has the potential to provide this.

Oral health

36. Staff satisfaction is good among the dental staff at HMP Cardiff.
37. The number of dental appointments available for the population size is greater than comparator prisons.
38. There are large differences between SystmOne (staff reports) and service activity as recorded by CDS. The cause of this is not clear.
39. The proportion of the prison population seen by the dentist is within the wide range seen in comparator prisons.
40. 70% of prison mentors report responding to the survey question found it difficult or very difficult to see the dentist. However this was a very small sample and may not be generalisable to the prison population.
41. Reported waiting times for dental healthcare are similar or shorter than for comparator prisons.
42. There is good partnership working between the dental and prison staff.
43. The DNA rate for the dentist was 47% which was significantly higher than in comparator prisons; the main reason given by prisoners for a DNA was that their problem had gone away.
44. Dental service provision changes have been made to reflect the changing prisoner profile.
45. A number of improvements have been made to service provision since the previous oral health needs assessment in 2013.
46. An automated external defibrillator is not currently available in the dental surgery and core quality standards are not being met.
47. A substantial amount of work has been undertaken recently to promote oral health among prisoners which is reported to have been well-received.
48. The price of toothpaste in the prison shop remains high and may be preventing prisoners from purchasing it.
49. Good progress has been made with many of the recommendations of the oral HNA (2014). Those outstanding may benefit from being checked for ongoing relevance.

Infectious disease

50. Incidence rates of some STIs are much higher at HMP Cardiff than for men in the community in Cardiff and Vale LAs.
51. Most attendances at the GUM clinic are by patients who have not been before.
52. Data suggest that a lower proportion of the prison population attends GUM than at comparator prisons. However, this cannot be assumed to reflect greater need.

53. GUM service provision does not currently match that available in the community where there are walk-in and next day clinics. Treatment is also limited by what equipment can be taken into the prison.
54. Vaccination rates for hepatitis B appear higher than in comparator prisons and are increasing steadily. However, direct comparisons are difficult due to differences in reporting.
55. The DNA rates for the GUM and BBV clinics were 37% and 43%; this results in wasted appointments and staff resource. However, the introduction of appointment cards is reported to have reduced DNAs at the BBV clinic.
56. There is a lack of clarity over the provision of condoms to prisoners.
57. Encouraging prisoners not to urinate for 2 hours prior to their appointment is an issue.
58. There may be a lack of peer support for prisoners on treatment for BBV.
59. Lack of access to patient's notes in other prisons through SystmOne can delay treatment of transferring prisoners.
60. Lack of communication between SystmOne and information systems in the community increases the risk of losing patients to follow-up.
61. There is potential for further health promotion work for BBV in the prison population, particularly in preventing re-infections.
62. Guidance on the physical health and well-being prisoners is due to be published by NICE in November 2016.
63. The evidence base suggests that peer education may be effective in reducing risky sexual health behaviour in prisoners following release.

Smoking

64. There are currently no smoking cessation clinics held at HMP Cardiff, as would be available in the community and are available in comparator prisons.
65. SystmOne is not currently used to record smoking cessation services and aid provision.
66. Successful implementation of smoking bans in prison is dependent on a number of factors and some research is available on these.
67. Smoking bans may not help to prepare prisoners for release but a number of interventions have been shown to be effective in supporting continuing abstinence after release.
68. The implementation of a smoking ban at HMP Cardiff may impact the prison population, staff and families of prisoners in a variety of ways, some of which may be unpredicted.

After release

69. Around half of offenders at HMP Cardiff are likely to remain in the Cardiff area after release.
70. Mental health post-release care in the community may be delayed and not available during a critical period for prisoners when released.
71. Prisoners may be discouraged from utilising oral healthcare after release due to difficulties in finding an NHS dentist.

72. There is much variation in the provision of substance misuse services in the community for prisoners following release, but work is currently underway to harmonise this.
73. There is limited available substance misuse support for prisoners in the weeks immediately following release, due to difficulties in getting appointments.
74. The short sentences and remand status of a large proportion of the population of HMP Cardiff is likely to result in greater social care need following release than many other prisons.

Other services

75. Waiting times for GP appointments are not readily available for monitoring.
76. DNA rates for the GP were 27%, this is not unfavourable compared to comparator prisons but still reflects a large wasted resource.
77. The main reason given by prisoners for a DNA was 'other' (not any of the options anticipated by staff).
78. Prisoners may benefit from the availability of more triage, particularly if delivered in a way that enables privacy.
79. There is felt to be a lack of understanding in general practice in the community and in hospitals regarding processes within the prison.
80. Future increases in mental ill-health and personality problems may impact on the service delivered by GPs in the prison.
81. The high churn rate often makes it difficult to identify appropriate prescriptions for prisoners following reception before they leave the prison.
82. Prevalence estimates of epilepsy in HMP Cardiff are slightly lower (0.7%) than those in the community and comparator prisons. However, data recording may not be accurate and there may be a greater prevalence of factors which could trigger a seizure in prison than in the community.
83. It was not possible to fully evaluate the extent of health promotional activities undertaken in HMP Cardiff in this HNA. Such work would be beneficial in identifying gaps and when preparing a health promotion strategy for the prison.
84. There is currently no trained diabetes Nurse available as there would be in the community, and in some comparator prisons.
85. Many prisoners report eating fruit and vegetables regularly, but there are concerns by staff over the prisoner's diet and available support and advice.
86. Many of the prisoners surveyed reported that they would like to see more healthy food on the menu. Poor selection and poor quality were reported as the main reasons stopping prisoners from eating healthily.
87. Many prisoners report undertaking regular exercise and that they would like to do more. The main reason preventing them is reported to be lack of access to the gym.
88. There is a high prevalence (59%) of sleep problems reported by prisoners surveyed. Prisoners may benefit from the establishment of a sleep clinic.

Recommendations

Specific areas of work	
SystmOne	
1	A review of SystmOne should be undertaken. This should include any outstanding issues highlighted by the mental HNA, differences between data when using different extraction methods, ways to improve consistency and ease of use by staff, and ways to reliably ascertain waiting times for healthcare.
2	It should be agreed whether SystmOne should continue to be used to record drug addiction therapy in addition to the Pharmacy system, if so an agreed set of Read codes should be used by all staff.
3	Once a set of Read codes has been agreed for different areas of healthcare, training of staff should be undertaken.
4	SystmOne should be assessed for the ability to highlight which prisoners have chronic or long-term conditions on a regular basis.
General	
5	A plan should be put into place to ensure recommendations following this HNA are actioned and followed-up at a later date.
6	The Action Plan developed by staff to reduce DNAs should be put into place and audited at regular intervals.
Substance misuse	
7	Implementation of mandatory NPS testing should go ahead within the next 6 months, ideally prior to the prison going smoke-free.
8	An action plan should be developed to tackle how best to ensure engagement with substance misuse services before prisoners leave the prison.
Mental health	
9	It should be ensured that there are sufficient services in place to meet need relating to anxiety and depressive disorders.
10	An in-depth analysis of resources and the availability of mental healthcare staff to match need should be undertaken. Including an analysis of the differences between figures for referrals and numbers seen.
11	Prescribing levels of mirtazapine should be reduced within in the prison.
12	It should be determined whether prisoners with short sentences or on remand can remain an open case with community services to prevent them being discharged and whether this would reduce delays in obtaining an appointment following release.
13	It should be ensured that there are sufficient services in place to meet the need for counselling.
14	A full analysis of delays in transfer to tertiary mental healthcare should be undertaken. This should include data comparisons with the mental health team in the UHB.
15	An action plan should be agreed to ensure prisoners receive the care needed prior to release despite short incarceration periods.
Oral health	
16	The feasibility of subsidising the cost of toothpaste in the prison shop should be looked into.
17	Outstanding recommendations from the oral HNA (2014) should be reviewed for applicability and implemented where appropriate.
Infectious diseases	
18	An action plan should be developed for targeted health promotion work, including prevention of BBV re-infection in prisoners.
Smoking cessation	
19	Read codes should be agreed and used to record smoking cessation services and aid provision.

After release	
20	The feasibility of sign-posting prisoners to dental surgeries accepting new patients prior to release should be assessed.
21	The current work to harmonise the provision of substance misuse services in the community for prisoners should be supported wherever possible.
22	There should be adequate provision of substance misuse support for prisoners in the weeks immediately following release.
23	It should be ensured that support is available for those with mental ill-health in the first few weeks following release where needed.
Other	
24	Work should be undertaken to improve communication and awareness of prison-specific issues amongst primary and secondary care in the community.
25	An action plan to speed up the process of identifying appropriate prescriptions for prisoners following reception should be developed.
26	The full extent of health promotional activities in the prison should be evaluated to identify gaps as part of the scoping process when developing a health promotion strategy for the prison.
27	The feasibility of increasing access to the prison gym for those who wish to use it should be assessed.

Procedural issues	
Substance misuse	
28	It should be ensured that the practice of proactively informing prescribing agencies outside the prison of any prisoners that may not return to HMP Cardiff following a court appearance is continued following any change in provider of substance misuse services.
Mental health	
29	Staff time for mental healthcare should be protected.
30	Current service provision should be checked against the new standards for prison mental health services issued by the Royal College of Psychiatrists.
31	It should be ensured that an RMN is involved in the primary screen process. If acting in a supervisory role, it should be ensured that any staff undertaking the screen have received a minimum standard of training.
Oral health	
32	Sharing of good practice between prisons should be encouraged.
33	An automated external defibrillator should be available in the dental surgery to meet core quality standards.
Infectious diseases	
34	All opportunities for sexual health promotion activities should be utilised in this population.
35	Where possible, service provision of GUM services should match that seen in the community.
36	The appropriate provision of condoms should be agreed amongst staff.
37	Awareness of the need not to urinate for 2 hours prior to appointments amongst prisoners should be improved through coordinated action.
Smoking	
38	Access to smoking cessation clinics should be provided following introduction of the smoking ban, to match service provision in the community.
39	The implementation plan of any smoking ban should be evidence-based.

40	Arrangements should be made for the signposting of prisoners on release to supportive smoking cessation services in the community.
After release	
41	The potential for increased social care need among prisoners at HMP Cardiff should be taken into account by LA when preparing for implementation of the Social Services and Well-being Act.
Other	
42	There should be a trained diabetes Nurse available to patients, as would be available in the community.

Monitoring of potential issues	
General	
43	Implications of the NICE guidance for prison services should be assessed following publication (due November 2016).
Substance misuse	
44	Utilisation of the substance misuse unit should be monitored to enable an action plan to be developed if need outstrips capacity.
45	The ability of CARAT services to meet prisoner needs should be monitored following the change of provider.
46	The new contract for substance misuse services should ensure that current harm reduction counselling services are continued.
47	Staff training and prisoner education of NPS should continue; this should be ensured following any change of provider for CARAT services.
48	Following the introduction of mandatory NPS testing, the findings should be collected and monitored in a standardised way on a quarterly or more frequent basis.
49	Submission of non-forensic finds to the Wedinos programme should continue on a regular basis.
Mental health	
50	There should be regular monitoring of mental health needs in the prison population, particularly co-morbidity, psychotic disorders and ADHD. Sufficient support should be made available to meet any increase in need.
After release	
51	The differing needs of this group should be taken into consideration in any cluster or neighbourhood work in the local community.
Other	
52	Waiting times for GP appointments should be regularly monitored.
53	There should be ongoing surveillance of the prevalence of epilepsy and incidence of seizures within the prison population.

Further research	
General	
54	Research should be undertaken into the feasibility of accessing SystmOne in other prisons, as reported to be done by some prisons in England.
55	Research should be undertaken into the feasibility of sharing information between SystmOne and information systems used in the community.
Substance misuse	
56	Further research should be conducted into whether prisoner needs are being met over the weekend and if not a plan to ensure those in crisis are seen should be put in place.
Oral health	
57	Differences between staff reports generated from SystmOne and service activity recorded by CDS should be investigated. This may be due to differences in recording and coding practices.
58	Further research, with a large sample size, into how accessible the prisoners find the dental service to be would be beneficial.
Infectious diseases	
59	The feasibility of arranging a peer support network for those on treatment for BBV should be investigated.
Smoking cessation	
60	Research should be conducted into the feasibility of providing interventions to encourage continuation of abstinence after release.
61	A study should be conducted into the impacts of the smoking ban on prisoners, staff and families, utilising both quantitative and qualitative methods. This should begin prior to implementation of the ban to enable before and after comparison.
Other	
62	Research should be conducted into the feasibility and benefits of providing more triage to patients.
63	Further research should be conducted into whether prisoners are achieving recommended intakes of fruit and vegetables. If needed, potential barriers within the prison environment should be investigated.
64	Further research should be conducted into how many of the prisoners are currently achieving the recommended levels of physical activity.
65	Further research should be conducted into the feasibility and benefits of providing a sleep clinic.

References

1. HM Chief Inspector of Prisons (2013). Report on an announced inspection of HMP Cardiff. Her Majesty's Inspectorate of Prisons, London.

2. Ministry of Justice (2015). Prison population figures: 2015. Available online at: https://www.gov.uk/government/statistics/prison-population-figures-2015 [accessed 23/11/15]

3. Public Health Wales (2009). HMP Cardiff health needs assessment 2009. Cardiff and Vale of Glamorgan Local Public Health Team.

4. Data provided by prison staff directly from prison management system, August – November 2015.

5. National Offender Management Service (2015). Freedom of Information request. Received 21st December 2015.

6. Public Health England (2014). Health and justice health needs assessment template: adult prisons. London.

7. World Health Organisation (1948). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946 and entered into force on 7 April 1948.

8. Marshall T, Simpson S, Stevens A (2000). Toolkit for Health Care Needs Assessment in Prisons. Department of Public Health and Epidemiology, University of Brimingham.

9. Public Health England (2014). *Health and justice health needs assessment template: Adult prisons*. London. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/331628/Health_Needs_Assessment_Toolkit_for_Prescribed_Places_of_Detention_Part_2.pdf [accessed 01/12/15]

10. Public Health Wales (2013). Prison health needs assessment: technical report. Thematic review 2013: mental health needs and provision across the Welsh prison estate.

11. Public Health Wales (2014). Oral health needs assessment of the prison population in Wales: technical document.

Report on an unannounced inspection of

HMP & YOI Cardiff

by HM Chief Inspector of Prisons

25–26 July, 1–5 August 2016

This inspection was carried out with assistance from colleagues at the General Pharmaceutical Council and in partnership with the following bodies:

Estyn
Arolygiaeth Ei Mawrhydi dros Addysg a Hyfforddiant yng Nghymru
Her Majesty's Inspectorate for Education and Training in Wales

HM Inspectorate of Probation
Arolygiaeth Prawf EM

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Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Introduction

HMP & YOI Cardiff is a category B local training prison holding male adult prisoners sentenced by the courts in south east Wales. In recent times a significant number of prisoners have also transferred in from English prisons. At the time of this inspection the prison held some 770 men. We found that outcomes in the areas of safety and respect had declined since our last inspection in 2013 from being reasonably good to not sufficiently good, which was disappointing. However, outcomes in the area of resettlement had improved and were now reasonably good. Overall, this inspection found a mixed picture of progress in a local prison that had faced the same challenges as many other local prisons.

Those challenges included staff shortages following the benchmarking process and an increased availability and use of new psychoactive substances (NPS), leading to an inevitable increase in unpredictable and violent behaviour. The prison had also implemented a smoking ban that was unpopular with some. In addition, Cardiff had an unusually high level of reported mental health problems. It is to the prison's credit that, despite these challenges, it did not feel unstable, and staff-prisoner relationships had been maintained. It is clear that those relationships were a key feature of the prison, and helped it in facing the challenges.

However, as far as outcomes for prisoners were concerned, there were significant issues affecting the safety of the establishment. There were rising levels of violence and weak management of key areas such as the use of force. The segregation unit provided a poor environment, and more needed to be done to address the supply of illegal drugs into the prison.

In common with many other older prisons, the physical environment left much to be desired. Some cells were in a poor state, and there was a lack of basic facilities such as clean clothes and bedding. On a positive note, health care was generally good, and there was good provision for those suffering from severe mental health issues. However, there were a large number of prisoners with lower level mental health problems whose needs were not being adequately met.

The entirely appropriate efforts to bring stability and predictability to the regime had inevitably meant that time out of cell was more restricted than it otherwise would have been; it was hoped that a full regime would quickly be restored. At the time of the inspection the very good range and quality of activities on offer was not being fully utilised. Resettlement work was done well to meet the needs of the short-stay prisoners who formed the large majority of the population, and this had counterbalanced some shortcomings in delivering effective offender management. There was some particularly good work evident in the area of family contact.

In summary, HMP & YOI Cardiff relied very heavily on a decent, hard-working staff group who had maintained good relationships with the men in their care, and had done well to keep the prison stable through some challenging times. However, for the future, the prison needs to reduce its reliance on key individuals and embed sound working practices and processes into the operation of the establishment, thereby ensuring long-term safety and stability.

Peter Clarke CVO OBE QPM October 2016
HM Chief Inspector of Prisons

Introduction

Fact page

Task of the establishment
HMP & YOI Cardiff is a category B local training prison holding male adult prisoners serving the courts in south east Wales.

Prison status (public or private, with name of contractor if private)
Public

Region/Department
Wales

Number held
770

Certified normal accommodation
539

Operational capacity
820

Date of last full inspection
18-22 March 2013

Brief history
HMP & YOI Cardiff dates back to 1827. Its main role was previously to hold unconvicted and short to medium-term sentenced prisoners. The accommodation was predominantly Victorian, with high levels of overcrowding.

Today the prison continues to hold unconvicted and trial prisoners from local courts and short-term prisoners serving up to two years. A new wing was built in 1996 to accommodate 218 additional men, including 96 lifers. Major refurbishment and modification of cellular accommodation has seen the capacity rise.

A new health care centre was opened in May 2008. The facility provides 21 beds, mostly commissioned by the local health board.

Short description of residential units

A wing	mainly convicted prisoners
A1	mainly kitchen workers
Care and separation unit	separated men including R45
B wing	mainly convicted prisoners
B1	vulnerable prisoners
C wing	induction prisoners
D wing	enhanced prisoners
E wing	mainly convicted prisoners
F wing	mainly remand prisoners
F1	prisoners undergoing detoxification
H	health care unit

Fact page

Governor: Darren Hughes

Escort contractor: GeoAmey

Health service commissioner and providers: Cardiff and Vale NHS trust

Learning and skills providers: NOMS in Wales

Independent Monitoring Board chair: Steve Cocks

Community rehabilitation company: Working Links

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About this inspection and report

A1 Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

A2 All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

A3 All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. The tests are:

Safety	prisoners, particularly the most vulnerable, are held safely
Respect	prisoners are treated with respect for their human dignity
Purposeful activity	prisoners are able, and expected, to engage in activity that is likely to benefit them
Resettlement	prisoners are prepared for their release into the community and effectively helped to reduce the likelihood of reoffending.

A4 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the National Offender Management Service.

- **outcomes for prisoners are good.**
  There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

- **outcomes for prisoners are reasonably good.**
  There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

- **outcomes for prisoners are not sufficiently good.**
  There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

- **outcomes for prisoners are poor.**
  There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

A5 Our assessments might result in one of the following:

- **recommendations**: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections

- **examples of good practice**: impressive practice that not only meets or exceeds our expectations, but could be followed by other similar establishments to achieve positive outcomes for prisoners.

A6 Five key sources of evidence are used by inspectors: observation; prisoner surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

A7 Since April 2013, all our inspections have been unannounced, other than in exceptional circumstances. This replaces the previous system of announced and unannounced full main inspections with full or short follow-ups to review progress. All our inspections now follow up recommendations from the last full inspection.

A8 All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the General Pharmaceutical Council (GPhC) and HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

A9 This explanation of our approach is followed by a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of prisoners and conditions in prisons.* The reference numbers at the end of some recommendations indicate that they are repeated, and provide the paragraph location of the previous recommendation in the last report. Section 5 collates all recommendations, housekeeping points and examples of good practice arising from the inspection. Appendix II lists the recommendations from the previous inspection, and our assessment of whether they have been achieved.

A10 Details of the inspection team and the prison population profile can be found in Appendices I and IV respectively.

A11 Findings from the survey of prisoners and a detailed description of the survey methodology can be found in Appendix IV of this report. Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant.[1]

[1] The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Summary

Safety

S1 Prisoners often arrived at Cardiff late in the evening after spending excessive periods in court cells. Reception staff were polite but the reception process sometimes took too long. First night arrangements and induction were reasonably effective. About a quarter of prisoners felt unsafe in the prison and recorded levels of assaults were high. Some aspects of violence reduction work were underdeveloped. Prisoners at risk of self-harm were well supported. Safeguarding arrangements were underdeveloped. Security arrangements were generally proportionate but there were some significant shortcomings. Work to reduce the high availability of drugs was particularly weak. Most cells in the segregation unit were in very poor condition and there was a lack of structured support for segregated prisoners. Adjudications were managed reasonably well. Use of force was high and governance was poor. Important documentation was often not completed or missing. The incentives and earned privileges (IEP) scheme was generally managed appropriately. Substance misuse services were satisfactory, but monitoring of prisoners undergoing detoxification was inadequate. Outcomes for prisoners were not sufficiently good against this healthy prison test.

S2 At the last inspection in 2013, we found that outcomes for prisoners in HMP & YOI Cardiff were reasonably good against this healthy prison test. We made 18 recommendations in the area of safety. At this follow-up inspection we found that six of the recommendations had been achieved, four had been partially achieved, seven had not been achieved and one was no longer relevant.

S3 Most prisoners said that escort staff treated them well. Although journeys to the prison were usually short, prisoners often spent much of the day waiting for escort staff to collect them from court cells. Vehicles usually arrived late in the day and reception processes could be lengthy, which meant that many prisoners did not reach their cells until late in the evening. Reception holding rooms were stark and displayed little information about the prison. Initial safety interviews were good for most prisoners. First night arrangements were adequate. The induction programme provided a brief overview of prison life and this was supplemented by good access to helpful induction staff and wing peer workers.

S4 In our survey, just under a quarter of prisoners said they felt unsafe, which was similar to comparator prisons. However, recorded levels of assaults and fights were higher than in similar prisons. Although most incidents were relatively low level, there had been some serious incidents, including a murder. Measures to investigate and analyse violence were good but the interventions available to challenge bullies and support victims were little used. A dedicated landing was effective in helping to keep vulnerable people safe and gave them some reasonable, though limited, activity.

S5 There had been seven deaths in custody since the previous inspection, three of which were self inflicted. Most, but not all, Prisons and Probation Ombudsman recommendations had been achieved. Although incidents of self-harm had increased since the last inspection, prisoners in crisis were usually given good support and this was reflected in generally good assessment, care in custody and teamwork (ACCT)[2] documentation. However, not enough reviews were multidisciplinary and self-harm triggers were not always identified. An

[2] Case management of prisoners at risk of suicide or self-harm.

Summary

enthusiastic group of Listeners[3] was well supported by the prison and the local Samaritans, but the restricted regime reduced prisoners' access to Listeners.

S6 The oversight and promotion of adult safeguarding was inadequate, although PACT (Prison Advice and Care Trust) and the National Probation Service provided support and advice for the safeguarding of children and visitors. There was limited staff awareness of safeguarding processes on most residential units.

S7 Security arrangements were generally proportionate but there were some unnecessary practices, such as routine strip-searching of all prisoners entering the segregation unit. Analysis and management of intelligence were effective but necessary subsequent actions were often not completed. Very little suspicion testing took place, there were few targeted searches and very few finds. Security-led meetings were well attended, but links with the drug strategy team were weak. In our survey, almost half the prisoners said it was easy to get illegal drugs and supply reduction work lacked rigour and coordination. The recent transition to a no smoking prison had been managed reasonably well, although it had led to a temporary rise in violent behaviour and misuse of other substances.

S8 Most cells in the segregation unit were in very poor condition. Some communal areas were superficially clean, but there were signs of damp on crumbling walls. The number of prisoners segregated over the previous six months was comparatively low and governance was reasonably good. Day-to-day relationships between staff and prisoners were reasonably good but the regime, particularly for longer-stay prisoners, was poor. Too many prisoners with complex needs did not have individual management plans and too little activity or distraction was in place to help prevent psychological deterioration. Adjudications were managed well, but had increased significantly since the last inspection and some minor charges could have been dealt with less formally.

S9 Use of force had increased and was comparatively high. Governance was ineffective. Important documentation was often not fully completed or missing, giving little assurance of proportionality. Use of special accommodation was high but authorisation paperwork was completed thoroughly and indicated that its use was justified and for short periods.

S10 Prisoners on the basic level of the IEP scheme could attend scheduled activities and most did not remain on basic for very long. A small number of prisoners remained on basic for long periods without sufficient support to change their behaviour. The enhanced unit on D wing was seen as a reasonable incentive by most prisoners.

S11 Psychosocial support for substance-using prisoners was satisfactory and appropriately focused on harm reduction. However, most prisoners could not access group work and there was not enough monitoring and observation during alcohol and opiate detoxification.

[3] Prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners.

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Respect

S12 The maintenance and cleanliness of residential units varied from adequate to poor. Too many prisoners were not receiving necessities such as clean clothes and cells often lacked basic facilities. Staff-prisoner relationships were good and a strength of the establishment. Peer supporters also provided effective support. The management of equality and diversity was weak and not enough was being done to identify and meet the needs of diverse groups. Faith provision was good. Complaints were well managed. Health services were reasonably good overall, but mental health services did not meet the high level of need. The quality of food was reasonable. Outcomes for prisoners were not sufficiently good against this healthy prison test.

S13 At the last inspection in 2013, we found that outcomes for prisoners in HMP & YOI Cardiff were reasonably good against this healthy prison test. We made 18 recommendations in the area of respect. At this follow-up inspection we found that six of the recommendations had been achieved, one had been partially achieved and 11 had not been achieved.

S14 Although clean, outside areas, particularly exercise yards, were austere. Communal areas in residential units were generally clean, but some areas suffered from damp. Showers were poorly ventilated and many had little or no screening. Cells lacked basic facilities, such as curtains, lockable cupboards and, in many cases, kettles. Most toilets were inadequately screened. There was poor availability of clean clothes and bedding and many prisoners had only one set of clothes, which was unacceptable. The application system was not working effectively.

S15 Staff-prisoner relationships were a strength of the prison. Together with some very good peer advisers, staff did much to mitigate some deficiencies in provision. Relationships had been maintained despite low staff morale. Consultation arrangements with prisoners were poor.

S16 The strategic management of equality and diversity was weak. There was an up-to-date policy and action plan but equality monitoring data were not used to identify and address discrimination. The data showed disparities in treatment in most areas but no investigations had taken place. The needs of prisoners with disabilities were poorly met. Some helpful work had begun to meet the needs of older prisoners. There had been no recent consultation with, or formal support for, other protected groups. Equality representatives were enthusiastic about their role but lacked training and support. Investigations into discrimination incidents were reasonably good.

S17 Although prisoners in our survey were negative about respect for their beliefs and access to services, in our individual and group meetings they were positive about the support they received from the chaplaincy. The chaplaincy worked well together and inductions for newly arrived prisoners were good. The chapel was a welcoming environment but the multi-faith room was austere, cramped and sometimes too hot.

S18 Replies to complaints were generally good and many resolved prisoners' problems, although the tone of some was abrupt. Quality assurance arrangements were reasonably good.

S19 The library had sufficient legal text books and prison service instructions, but there was no identified person to assist prisoners with their legal problems or to apply for bail. No prisoners were using 'access to justice' laptops, although in principle they were available.

S20 Primary care health services were reasonably good and, in our survey, prisoners reported improved access to nurses and doctors. However, non-attendance rates were too high at

around one in four. In the health centre, patients waited too long to be seen in bleak waiting rooms with no information in them. There was a serious problem with damp in the centre and urgent remedial action was required to meet infection control standards in the wing treatment rooms. Health care complaints were not dealt with confidentially. It was concerning that health services staff were not examining reports from death in custody clinical reviews, which meant that learning opportunities were being missed. Inpatient beds were being used inappropriately for non-clinical reasons. Pharmacy services were generally good but some patients were inappropriately required to take night sedation in the afternoon. There was good access to an appropriate range of dental services. There was a very high demand for mental health services. Provision for those with serious illnesses was good, but there were gaps in service provision for men with emotional issues and mild to moderate mental health problems. No staff had recent training in mental health awareness. The Care Quality Commission (CQC) found there were no breaches of the relevant regulations.[4]

S21 The quality of the food was reasonable. Some prisoners waited too long before they received their first canteen orders, which could have led unnecessarily to problems with debt.

Purposeful activity

S22 Recent temporary arrangements had been effective in increasing regime predictability, but time out of cell was too limited. Strategic management of activities provision was good. The range and extent of provision was very good and met the needs of most prisoners. Nearly all prisoners were engaged in some kind of activity for some of the time. Teaching, learning and achievements were generally good. Library provision was reasonable but access was limited. PE provision met the needs of most prisoners. Outcomes for prisoners were reasonably good against this healthy prison test.

S23 At the last inspection in 2013, we found that outcomes for prisoners in HMP & YOI Cardiff were reasonably good against this healthy prison test. We made 10 recommendations in the area of purposeful activity. At this follow-up inspection we found that one of the recommendations had been achieved, four had been partially achieved, four had not been achieved and one was no longer relevant.

S24 Time out of cell under a temporary restricted regime was poor. The new arrangements had been implemented in late July 2016 as a result of shortfalls in staffing and were due to end in September. Although unlocking and attendance at activities had become much more predictable as a result, some prisoners could be locked up for over 27 hours, only being let out briefly to collect their meals. Our roll checks during the working day showed that 46% of prisoners were locked behind their doors. About 15% of unlocked prisoners were in association rather than in purposeful activities. Up to 90 minutes of association time was provided to most prisoners every weekday.

S25 Strategic management of learning and skills was good and its profile and relevance in the management of the prison had improved. There were good systems to quality assure data about learning and skills, although the range of data collected was too limited. A comprehensive needs analysis made effective use of labour market information, and had been used to inform the planning of the range of activities offered. Self-assessment took good

[4] CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk.

account of available data. Staff were well qualified and most had good opportunities to develop their skills further. Most classrooms and workshops were of good quality, had good access to learning equipment and to modern technology. There was still work to be done to evaluate prisoners' post-release outcomes.

S26 In 2015 to 2016 nearly all prisoners who completed a course achieved a certificate for units of credit or a qualification. The range of qualifications and attainment was appropriate for the transient nature of the population. Many prisoners developed vocational and study skills that prepared them well for future study or training for employment.

S27 The breadth of provision was good, having improved further since the previous inspection. The number of overall activity places had increased and there were enough to engage all prisoners in full-time activity if unlocked. Only 26 prisoners were unemployed, although most prisoners were under occupied. Most activities were purposeful and provided good work-related skills. Attendance and punctuality were not good enough.

S28 A broad range of learning and vocational activities had been developed to meet the needs of short-term prisoners. Peer mentors worked well in classes to motivate and support learners and played an important supervisory and training role in workshops. Peer mentors could not obtain accreditation for their skills. Teaching and learning were generally good and prisoners' work was of a good standard. There were many impressive examples of tutors embedding literacy, numeracy and digital literacy into class sessions. Classrooms and workshops were calm environments where prisoners felt safe and behaved well.

S29 The library was well stocked and met a very wide range of prisoner needs well. Opportunities to visit the library were too limited, although more equitable access was being planned.

S30 Nearly all prisoners had good access to physical activity, including a wide range of sporting activities. Access to PE activities varied too much between wings and redeployment of PE staff had resulted in valuable and popular courses for prisoners being put on hold. Many prisoners understood the importance of healthy lifestyles, including the need for healthy diets, the impact of substance use and the benefits of taking regular exercise. Health and fitness screening of prisoners on admission was thorough and prisoners received a useful induction to the gym.

Resettlement

S31 The strategic oversight of resettlement work was reasonable. Offender management was variable and cross deployment of offender supervisors limited what could be achieved. Community rehabilitation company (CRC) provision to meet the resettlement needs of the high number of short-stay prisoners was good. Public protection work was sound. Too many categorisation and home detention curfew assessments were delayed as a result of staff shortages. Accommodation services were good. With some exceptions, visits arrangements were adequate and excellent work was done to promote family ties. Outcomes for prisoners were reasonably good against this healthy prison test.

S32 At the last inspection in 2013, we found that outcomes for prisoners in HMP & YOI Cardiff were not sufficiently good against this healthy prison test. We made 13 recommendations in the area of resettlement. At this follow-up inspection we found that seven of the recommendations had been achieved, two had been partially achieved, three had not been achieved and one was no longer relevant.

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Summary

S33 There was a reducing reoffending strategy and its implementation was overseen by a live action plan and regular meetings. It related to the resettlement pathways and was separate from offender management work, which was also managed separately. This created some risk of lack of coordination, although this was largely mitigated by reasonable joint working. Over 70% of prisoners spent less than three months at Cardiff, limiting the ability of the prison to undertake useful interventions, although some short programmes were offered. The CRC provision had greatly improved resettlement support, especially for the large number of remand and short-term prisoners. There was good involvement of community partners.

S34 Offender management work was severely hindered by cross-deployment of uniformed offender supervisors. The level of planned contact with prisoners was limited and often dependent on prisoners taking the initiative. Many prisoners were unaware of the contents of their plans. The quality of OASys (offender assessment system) assessments was mixed and staff did not draw sufficiently on available sources of information. Quality assurance of assessments and plans was limited and many plans did not reflect the prisoner's current circumstances.

S35 Public protection procedures were sound. Identification of MAPPA (multi-agency public protection arrangements) eligible offenders was good and MAPPA processes were effective, with good engagement with risk management in the community. The risk management meeting focused well on the highest-risk men, but did not provide overall governance of public protection measures.

S36 Adequate systems were in place for categorisation and home detention curfew. It was positive that prisoners were invited to make written representations on a newly designed form. However, staff shortages led to delays in completing these procedures.

S37 The number of life sentence prisoners had reduced greatly since the last inspection. A probation officer supported the few who remained, but Cardiff remained an unsuitable location for most lifers. The small number of IPP (indeterminate sentence for public protection) prisoners could not undertake appropriate risk reduction work at Cardiff.

S38 Basic custody screens and resettlement plans were normally completed effectively. CRC caseworkers were seeing every prisoner. They worked hard to identify and follow up practical resettlement needs early, and to support preparation for release. Some very good resettlement work was done with veterans and a regular veterans group meeting was well attended.

S39 Accommodation services were generally good and included help with maintaining and surrendering tenancies, dealing with housing benefit and applications for accommodation before release. Job Centre Plus and peer supporters provided a reasonable service to prisoners before discharge. Debt and finance management support was available to all prisoners, but they were not able to open a bank account.

S40 The prison had good links with community and employer groups. However, many prisoners' awareness of outside progression opportunities was too limited, and the CRC did not help prisoners enough to access opportunities on their release. Prisoners under the age of 25 had good access to independent careers advice from Careers Wales.

S41 Arrangements to ensure continuity of health care on transfer and release were sound. Strong partnership working between prison and community service providers had improved continuity of treatment and care for substance using prisoners.

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S42 The visits hall was a bright environment with some reasonable facilities. Consultation with visitors was good. Visits started on time and visitors reported a decent experience. However, holding rooms were in poor condition and there were too few closed visits booths. There were delays with booking visits by telephone and remand prisoners could not have a daily visit. Good, innovative work was done to encourage prisoners to maintain family ties. The range of interventions was wide and sessions were well attended. Family days took place regularly and security restrictions were appropriate.

S43 There were no accredited offending behaviour programmes or victim awareness work, but some useful courses were available through the education department and were well used. For those prisoners whose sentences were neither too short for meaningful offending behaviour work nor long enough for transfer to a training prison, there was very little to help them achieve personal change.

Main concerns and recommendations

S44 Concern: About half the prisoners in our survey said it was easy to get illegal drugs. Supply reduction work lacked rigour and coordination and there was no supply reduction action plan. There were few finds and suspicion testing was not usually completed.

Recommendation: Managers should ensure rigorous and coordinated work to tackle the availability of drugs in the prison. A detailed supply reduction action plan should be implemented and integrated with the drug strategy.

S45 Concern: Most cells lacked basic facilities, such as curtains, toilet screening, lockable cupboards and, in many cases, kettles. Cells and showers were poorly ventilated. There was poor availability of clean clothes and bedding and many prisoners had only one set of clothes.

Recommendation: Cells should be properly equipped with curtains, toilet screens, lockable cabinets and mattresses. Cells and showers should be properly ventilated. Prisoners should be able to obtain a regular supply of clean clothes and bedding.

S46 Concern: Equality and diversity processes were weak. There was little systematic support for prisoners with protected characteristics and there was evidence of poor outcomes for many groups. In our survey, black and minority ethnic and disabled prisoners were particularly negative about their treatment. The prison did not regularly consult or monitor outcomes for all protected groups. Evidence of potential discrimination emerging from equality monitoring was not addressed.

Recommendation: Governance and management oversight of diversity should ensure that the needs of all prisoners with protected characteristics are identified, assessed and met, and that evidence of potential discrimination is addressed promptly.

S47 Concern: Prisoners spent too much time locked in their cells and some were in their cells for up to 27 hours. When out of their cells, not enough prisoners were engaged in purposeful activities.

Recommendation: Prisoners should spend the working day out of their cells, with good access to purposeful activity and association. They should also have time to attend to their domestic needs and at least one hour's outdoor exercise each day.

Summary

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Section 1. Safety

Courts, escorts and transfers

Expected outcomes:
Prisoners transferring to and from the prison are treated safely, decently and efficiently.

1.1 In our survey, prisoners were more positive than the comparator about escorts and transfers, and those we spoke to said they were treated well by escort staff. Vans were clean and in good order.

1.2 Journeys to the prison were usually short, but prisoners often spent much of the day waiting for escort staff to collect them from court cells. Prisoners were usually taken off vans promptly, but they could be held on the vehicle for over an hour when a number arrived at the same time.

1.3 In our survey, 75% of prisoners said they were told in advance that they were coming to Cardiff against the comparator of 63%. Information leaflets about Cardiff were provided for court cells, but none of the newly arrived prisoners whom we spoke to had seen them.

Recommendation

1.4 **Prisoners should be held in court cells for the minimum period possible**. (Repeated recommendation 1.6)

Early days in custody

Expected outcomes:
Prisoners are treated with respect and feel safe on their arrival into prison and for the first few days in custody. Prisoners' individual needs are identified and addressed, and they feel supported on their first night. During a prisoner's induction he/she is made aware of the prison routines, how to access available services and how to cope with imprisonment.

1.5 Reception facilities were clean but in need of decoration. Holding rooms were stark with iron benches and very little information about the prison was displayed. There was graffiti on the walls.

1.6 The reception process became protracted at busy periods and vans frequently arrived late. Prisoners could spend well over two hours in reception, often until late in the evening. Conditions were mitigated by relaxed, reassuring and helpful staff. Prisoners told us they were well supported by staff.

1.7 In our survey, 32% of prisoners said they felt depressed or suicidal on arrival compared with 24% in similar prisons. Safety procedures had improved since the last inspection. Listeners[5] and peer workers were available in reception and provided useful support. All prisoners were interviewed in private using a first night suicide and self-harm screening tool, which covered key indicators of risk. However, professional telephone interpretation was not used

[5] Prisoners who have been trained by the Samaritans to provide confidential emotional support to fellow prisoners.

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when needed, and one officer told us that he had used 'Google Translate' to ask about suicide and self-harm, which was inappropriate.

1.8 First night arrangements were adequate. All first-night prisoners were identified on the wing roll board and on cell doors. First-night prisoners received enhanced monitoring, but there was no special oversight of prisoners who might be withdrawing from alcohol or drugs (see paragraph 1.55). First night cells were similarly deficient to those on other wings (see paragraph 2.2).

1.9 The first night centre was very busy in the morning, when staff from various departments visited new arrivals. All prisoners had a one-to-one interview with an induction peer worker, who helped them to understand and complete procedures to meet their immediate needs. Prisoners told us that they felt reassured by them.

1.10 Prisoners were given a basic information booklet, which was only available in English and did not provide all the information they might need. We saw other information booklets, including an easy-to-read format, which were no longer used.

1.11 Induction consisted of a slide presentation of about 45 minutes which gave a brief overview of prison life. In our survey, only 40% of prisoners attending induction said it told them what they needed to know against the comparator of 49% and 62% at the previous inspection. However, prisoners told us that the helpful wing staff and peer workers mitigated the deficiencies of the formal induction. Prisoners who had previously been at Cardiff were able to opt out, which was not appropriate in all cases; for example, one man had not been in the prison for six years and was still allowed to drop out.

Recommendation

1.12 All prisoners who need one should have an effective induction that prepares them for life in the prison.

Bullying and violence reduction

Expected outcomes:
Everyone feels and is safe from bullying and victimisation (which includes verbal and racial abuse, theft, threats of violence and assault). Prisoners at risk/subject to victimisation are protected through active and fair systems known to staff, prisoners and visitors, and which inform all aspects of the regime.

1.13 Prisoners' perceptions of safety had deteriorated since the previous inspection but were similar to the comparator. In our survey, 23% of prisoners said they felt unsafe and more prisoners (26%) than at our last inspection (15%) said that they had been victimised by other prisoners. The prison had not completed a safety survey since 2011.

1.14 The number of assaults and fights had increased. Much of the violence was low level but there had been some serious incidents, including a murder. During the previous six months, there had been 76 assaults on prisoners and 30 fights between prisoners, both more than at other local prisons. A smoking ban had been introduced in April 2016 and there had been a temporary increase in violent incidents in May. Prisoners reported a number of ongoing frustrations, including the smoking ban and the long periods they spent locked in their cells.

1.15 Systems to investigate and analyse violence were good. Reports were submitted to the monthly safer custody meeting, which monitored and reviewed trends using the violence

diagnostic tool. Investigations into violent incidents were adequate. The prison had referred 52 cases to the police in the previous six months. The number of recorded bullying incidents was low but we were not confident that all incidents were identified. The system to monitor bullies and support victims had only been used twice in the last six months. No prisoner representatives were trained in violence reduction.

1.16 A dedicated landing could accommodate 31 prisoners who were at risk of harm from other prisoners and required additional support or protection. Prisoners on the unit valued the opportunity to live separately from the main population and felt safe. Some of these prisoners worked in the health care gardens, but too many spent most of the day on the unit and had poor access to the gym and library.

Recommendations

1.17 Prisoners' negative perceptions of their safety should be investigated and the findings acted on.

1.18 Effective systems should be in place to monitor bullies and support victims.

Self-harm and suicide prevention

Expected outcomes:
The prison provides a safe and secure environment which reduces the risk of self-harm and suicide. Prisoners are identified at an early stage and given the necessary support. All staff are aware of and alert to vulnerability issues, are appropriately trained and have access to proper equipment and support.

1.19 There had been seven deaths since the previous inspection, three of which were self-inflicted. One was a murder. The Prisons and Probation Ombudsman (PPO) had highlighted recurring weaknesses in early days procedures. Action plans were in place and most, but not all, of the PPO's recommendations had now been achieved. It was concerning that the head of health care had not received the clinical reviews into these deaths.

1.20 There had been 123 self-harm incidents in the previous six months compared with 55 at the last inspection, and far more assessment, care in custody and teamwork (ACCT) case management documents were being opened. Staff supported prisoners in crisis well, engaging with them meaningfully and encouraging participation in activities. The quality of ACCT documents was generally good. Initial assessment interviews were detailed and observational entries showed positive interactions. However, members of the health care and chaplaincy teams did not attend enough case reviews and triggers that could cause a prisoner to self-harm were not consistently identified.

1.21 The 13 Listeners were well supported by the Samaritans and prison staff. A Listener and a Samaritan attended the safer custody meetings. Listeners provided a reasonable service to prisoners, but regime restrictions had reduced their movement around the prison and limited the time they could spend with prisoners in crisis. In our survey, fewer prisoners (44%) than the comparator (53%) and at the last inspection (52%) said they were able to speak to a Listener at any time if they wanted to.

Recommendations

1.22 The health care and safer custody leads should implement promptly all recommendations from Prisons and Probation Ombudsman death in custody investigations.

1.23 A multidisciplinary team of staff should attend assessment, care in custody and teamwork (ACCT) case reviews.

1.24 Prisoners in crisis should be able to speak to a Listener at any time.

Safeguarding (protection of adults at risk)

Expected outcomes:
The prison promotes the welfare of prisoners, particularly adults at risk, and protects them from all kinds of harm and neglect.[6]

1.25 The safeguarding policy was out of date and there was no dedicated lead to safeguard and promote the welfare of adults at risk of harm. The prison was not represented on the local safeguarding adult board. PACT (Prison Advice and Care Trust, a national charity that provided prisoners with family engagement support) and the National Probation Service had developed robust safeguarding protocols for children and vulnerable adults who visited the prison.

1.26 A separate landing was set aside for prisoners who could not cope in the main population (see paragraph 1.16). There was low staff awareness of safeguarding protocols on other wings.

Recommendation

1.27 The prison and the local safeguarding adult board should develop effective safeguarding policies and procedures.

Security

Expected outcomes:
Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence as well as positive staff-prisoner relationships. Prisoners are safe from exposure to substance misuse while in prison.

1.28 Security procedures were generally appropriate for a local prison and did not unnecessarily restrict access to a full regime. However, some practices were disproportionate and not justified by a balanced assessment of threat; for example, all prisoners were unnecessarily strip-searched in reception and on admission to the segregation unit. Closed visits were used frequently (37 at the time of the inspection) and often for reasons not directly related to

[6] We define an adult at risk as a vulnerable person aged 18 years or over, 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation'. 'No secrets' definition (Department of Health 2000).

visits. Reviews took place every month, but many were cursory and prisoners usually stayed on restrictions for at least three months with no further supporting information. Security was supported by very good relationships between staff and prisoners and many interactions that we observed showed that officers knew the circumstances of the prisoners. Supervision was effective in key areas such as residential wings, education and prison workshops.

1.29 Risk management systems were well integrated and effective. The prison was not risk averse in allocating activity places. Security meetings were usually well attended. The standing agenda was appropriate and included a thorough analysis of information reports. Security objectives were agreed and reviewed through consideration of intelligence. Reports from other areas of the prison were also discussed.

1.30 Links between the security committee and the drug strategy team were not adequately developed and minutes of meetings did not give assurance that the prison-wide security strategy was effective.

1.31 The security department received an average of nearly 400 information reports each month. They were processed and categorised quickly by full-time security collators and analysts. Intelligence was communicated to other areas of the prison, but staff shortages affected the speed of reaction to security issues. Too few target searches had been carried out and there had been very few finds.

1.32 The security department managed other intelligence systems to identify and manage sophisticated and covert forms of organised crime and staff corruption. However, the sharing of information by the police was limited. The prison had an appropriate focus on extremism and the risks of radicalisation.

1.33 In our survey, 49% of prisoners said it was easy to get illegal drugs against the comparator of 39% and 34% at our last inspection. The random mandatory drug test (MDT) positive rate averaged 10.3% during the previous six months. Most positive tests were for subutex and cannabis. New psychoactive substances (NPS)[7] had become prevalent since our last inspection but were not tested for. The MDT suite was dirty and the small holding rooms lacked ventilation.

1.34 Suspicion testing was minimal, with only three tests completed in the last six months against 126 requests. There was no supply reduction action plan and not enough coordination and integration of supply reduction and drug strategy (see main recommendation S44).

1.35 Managers had taken appropriate measures to implement the smoking ban in April 2016. Peer supporters had been trained to provide smoking cessation support. Prisoners could access nicotine replacement therapy and buy e-cigarettes. A temporary increase in violence was recorded following the ban (see paragraph 1.14). Some prisoners made improvised cigarettes from tea bags and nicotine patches, lighting them on dismantled kettles and television power cables.

Recommendations

1.36 Strip-searching should be proportionate to the risks presented and intelligence-led searches should be prompt and subject to management checks.

1.37 Closed visits should be used only for incidents that relate to visits.

[7] New psychoactive substances are new drugs that are developed or chosen to mimic the effects of illegal drugs such as cannabis, heroin or amphetamines. They may have unpredictable and life threatening effects.

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Good practice

1.38 *Managers had taken appropriate measures to implement the smoking ban in April 2016, including training peer supporters to provide smoking cessation support and ensuring access to nicotine replacement therapy and e-cigarettes. Despite a short-term rise in violence, these measures had been reasonably effective.*

Incentives and earned privileges[8]

Expected outcomes:
Prisoners understand the purpose of the incentives and earned privileges (IEP) scheme and how to progress through it. The IEP scheme provides prisoners with incentives and rewards for effort and behaviour. The scheme is applied fairly, transparently and consistently.

1.39 The incentives and earned privileges policy had recently been reviewed and published. All men had signed compacts. The scheme offered the usual differentials in access to private cash, visits and time out of cell, and prisoners saw the enhanced unit on D wing as a meaningful incentive. Fewer prisoners than we usually see at local prisons were on the basic or enhanced levels of the scheme. About two-thirds of prisoners were on the standard level, 21% on entry level, 11% on enhanced and 2% on basic.

1.40 Those on basic could attend work activities and had at least one domestic period when they could shower, make a telephone call and attend exercise. The time spent on basic was relatively short and prisoners were usually promoted to standard within a week or two. However, we found examples of a few with more complex needs struggling to achieve promotion and remaining on basic for months. Planning was poor to help this small group return to the standard regime and deal with the underlying causes of their poor behaviour. Reviews were often cursory, poorly attended and rarely focused on relevant issues.

Recommendation

1.41 Prisoners on the basic level of the incentives and earned privileges scheme should be helped to improve their behaviour, so they can move to the standard level.

Discipline

Expected outcomes:
Disciplinary procedures are applied fairly and for good reason. Prisoners understand why they are being disciplined and can appeal against any sanctions imposed on them.

Disciplinary procedures

1.42 There had been 866 adjudications in the previous six months, compared with 706 at the last inspection. Written records and hearings that we attended indicated that adjudications were conducted fairly and prisoners were given the opportunity to explain their version of events.

[8] In the previous report, incentives and earned privileges were covered under the healthy prison area of respect. In our updated Expectations (Version 4, 2012) they now appear under the healthy prison area of safety.

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There were examples of adjudicating governors dismissing cases for lack of evidence or anomalies in the procedures. Punishments were fair and the recently reviewed tariff was useful to adjudicating governors. However, some charges were minor and could have been dealt with less formally. Monthly statistics on the number and nature of adjudications were presented to the segregation management meetings, but there was little evidence that they were used to identify trends.

The use of force

1.43 The level of use of force was high, with 201 cases in the previous six months (25 per 100 of the population), which was higher than we see at other local prisons. Management and monitoring of the use of force were weak in important areas. Links to violence reduction, the security committee and the senior management team were underdeveloped and there was no dedicated use of force committee. Information on the nature of the incident, its location, the ethnicity and age of the prisoner was collated each month and evaluated at monthly segregation management meetings, but we saw little evidence of data being used to inform a strategy to reduce numbers or manage patterns or trends.

1.44 When completed, documentation showed that spontaneous incidents were managed appropriately and that minimum force was used for short periods with evidence of de-escalation techniques. The video recordings of planned incidents also reflected well managed interventions which were conducted correctly. However, too much paperwork was incomplete, frequently lacking written accounts by officers and accident reports from health care staff. Use of the special cell had increased but records showed that it was for short periods and justifiable reasons.

Recommendations

1.45 Use of force paperwork should be completed thoroughly and subject to rigorous governance.

1.46 Information about trends and patterns should be used strategically to help reduce the use of force.

Segregation

1.47 Use of segregation was comparatively low. There had been 120 cases during the previous six months, about 15 cases per 100 of the population which was lower than we find at other local prisons. At the time of the inspection, eight prisoners were in segregation, four of whom were held under prison rule 45 for good order and half as punishment following adjudication. The average stay was 10 days, although there had been some notable exceptions of longer stays.

1.48 Living conditions in the small segregation unit were poor. Some communal areas were superficially clean, but there was damp on the crumbling walls and the showers and holding room were dirty. Most cells were in a very poor state. Many were filthy, with graffiti scratched into plastic windows and on the inside of cell doors. There were signs of damp on many cell walls, most of the toilets were heavily stained and some did not flush properly.

1.49 Governance of segregation was reasonable. A staff selection policy was in place and a segregation monitoring and review group, led by a senior manager, met each month to monitor the number held in segregation and the reasons. Relationships between segregation

unit staff and prisoners were good. Formal planning was being developed to address segregated prisoners' needs and individual management plans had been raised for a few. However, many prisoners with complex needs did not have individual management plans and too little was done to prevent psychological deterioration caused by segregation. Although the basic daily routine included showers, an hour of exercise and access to a telephone, prisoners spent nearly all day locked in cells with nothing meaningful to do. This was particularly concerning for longer-stay prisoners. This isolation was exacerbated by many prisoners not having radios.

Recommendations

1.50 Cells and communal areas in the segregation unit should be clean and in good repair.

1.51 All longer-stay prisoners should have management plans to ensure that their needs are met and to prevent psychological deterioration.

1.52 All prisoners in segregation should have a radio, unless an individual risk assessment indicates otherwise.

Substance misuse

Expected outcomes:
Prisoners with drug and/or alcohol problems are identified at reception and receive effective treatment and support throughout their stay in custody.

1.53 The substance misuse policy lacked detailed action plans and development targets. The demand and supply reduction strands of the strategy were not integrated (see paragraph 1.34).

1.54 Psychosocial support for substance-using prisoners was satisfactory and appropriately focused on harm reduction. Prisoners were seen on the day following arrival and given harm reduction advice, including information about NPS. At the time of the inspection, 268 prisoners were using substance use services provided by Wales Council for Alcohol and Drug Advice (WCADA). Most interventions were one to one, but included group work on substance misuse awareness, harm reduction and overdose prevention. Only prisoners on the 40-bed drug support unit on F1 were able to attend group work because of restrictions on prisoner movements. There were no self-help groups such as Alcoholics Anonymous and no recovery training. Only one peer supporter was available. The drug support unit lacked a supportive regime and housed prisoners who were not receiving drug treatment.

1.55 Cardiff and Vale University Health Board provided clinical substance misuse services. A substance misuse lead nurse had been appointed and the clinical director and the GP specialised in treating substance users. Following reception screening, drug and alcohol dependent prisoners received first night medication and were located on the first night centre (see paragraph 1.8). Officers on this unit did not know which prisoners were detoxifying and cells did not have observation hatches. The inpatient health care centre could provide 24-hour medical supervision, but beds were rarely available for prisoners who were detoxifying. This was particularly concerning when prisoners withdrawing from alcohol could not be admitted.

1.56 During the previous month, 111 prisoners had been prescribed methadone or buprenorphine, mainly on a maintenance basis, which was appropriate for a short-stay

population. Treatment for heroin users not in contact with community services had become more flexible. Although Lofexidine[9] was prescribed initially, once access to community treatment had been arranged prisoners could start methadone stabilisation before release.

1.57 Joint working between psychosocial support and mental health services had improved. Weekly clinical meetings facilitated good care planning and coordination.

Recommendations

1.58 Group work interventions should be open to prisoners regardless of where they are held in the prison. The range of substance misuse support services should be developed and include mutual aid groups.

1.59 Prisoners undergoing detoxification, especially for alcohol, should be located in the health care centre with appropriate 24-hour monitoring and observation.

[9] Lofexidine is used to alleviate the symptoms of mild to moderate opiate withdrawal.

Section 1. Safety

Section 2. Respect

Residential units

Expected outcomes:
Prisoners live in a safe, clean and decent environment within which they are encouraged to take personal responsibility for themselves and their possessions. Prisoners are aware of the rules and routines of the prison which encourage responsible behaviour.

2.1 Outside areas, particularly exercise yards, were clean but austere, with little greenery. There was exercise equipment in the yards but no seats. Most internal communal areas were clean. Basement accommodation in three wings suffered from damp and stale air. Communal showers in some residential units were dilapidated. Showers were generally poorly ventilated and some were mouldy. Many were not adequately screened.

2.2 Most cells originally designed for one prisoner were shared by two and were overcrowded. Most cells had adequate furniture but often lacked lockable cabinets. Many mattresses were of poor quality and there was no functioning exchange programme. No screening was provided for toilets in shared cells and prisoners improvised with old sheets to achieve some degree of privacy. There were no curtains and many cells did not have a kettle. The level of decoration was generally poor and graffiti and offensive posters had not been removed. Some prisoners told us they did not have enough cleaning products and some cells were dirty. The poor living conditions were exacerbated because prisoners were locked up for so long (see paragraph 3.1 and main recommendation S47).

2.3 Prisoners could not access enough clean bedding and suitable clothes. Most had to wear prison-issue clothing, some of which was of poor quality, and prisoners frequently received only one set of clean clothes and bed linen each week. There were severe shortages of some items, such as socks and towels. Prisoners resorted to washing their prison-issue clothes in their sink to keep items that fitted.

2.4 Prisoners complained that cell bells were left unanswered for far too long. The cell bell log had not been monitored for some months and showed that some calls were not answered promptly.

2.5 In our survey, 39% of prisoners said applications were dealt with fairly against the comparator of 47% and 62% at the previous inspection. Managers did not quality assure responses to applications. The application process was not confidential, as applications were given to peer mentors. On one residential unit they were left in an in-tray in the association area where other prisoners could see them.

2.6 In our survey, only 13% of prisoners said they could get their property if they needed to. We were told that the poor time out of cell was a significant contributor to this.

Recommendations

2.7 **Cells designed for one should not be occupied by two prisoners.** (Repeated recommendation 2.8)

2.8 **Managers should ensure that applications are dealt with promptly and effectively.**

Staff-prisoner relationships

Expected outcomes:
Prisoners are treated with respect by staff throughout the duration of their time in custody, and are encouraged to take responsibility for their own actions and decisions.

2.9 Prisoners we spoke to generally felt well supported by staff. In our survey, 71% of prisoners said that most staff treated them with respect. Although personal officer work had deteriorated, 72% said they had a staff member to turn to if they had a problem against the comparator of 67%.

2.10 Staff-prisoner relationships were generally good and we were impressed by the level of practical support offered to prisoners, including new prisoners and those in crisis. These relationships had been sustained despite poor staff morale. Staff supervision of prisoners during association was good. These good relationships, together with some very good peer advisers, partially mitigated other deficiencies in the prison.

2.11 Consultation arrangements were poor. Scheduled monthly consultations with prisoner representatives from each wing had only taken place twice in the last six months and were poorly attended by representatives. Most monthly forums scheduled for each wing did not take place.

Recommendation

2.12 There should be regular effective consultation forums with prisoners.

Equality and diversity

Expected outcomes:
The prison demonstrates a clear and coordinated approach to eliminating discrimination, promoting equitable outcomes and fostering good relations, and ensures that no prisoner is unfairly disadvantaged. This is underpinned by effective processes to identify and resolve any inequality. The distinct needs of each protected characteristic[10] are recognised and addressed: these include race equality, nationality, religion, disability (including mental, physical and learning disabilities and difficulties), gender, transgender issues, sexual orientation and age.

Strategic management

2.13 The strategic management of equality and diversity was weak. The manager of the team was also responsible for managing residential units and an officer detailed to work part time on equality issues spent almost all their time on other duties. Equality and diversity meetings were held regularly and attended by staff from a range of departments, including the governor, but not by equality prisoner representatives. Not all staff had completed their mandatory online equality and diversity training. The equality and diversity policy and action plan were up to date but equality monitoring data were not used to identify and address discrimination. The data showed disparities in treatment in most areas, which had not been investigated.

[10] The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

2.14 The six equality representatives were enthusiastic about their role but lacked training and support. Equality representatives did not meet new arrivals to explain the support they could offer, nor did they meet regularly as a group for support and to share learning.

2.15 In theory, prisoners could report discrimination incidents but the only forms available during the inspection were in Welsh. During the previous six months, 37 incidents had been reported, compared with only 12 at the previous inspection. Investigations into discrimination incidents were reasonably good. Complainants and witnesses were interviewed, but some replies did not fully explain how the incident had been investigated and addressed. There was no external quality assurance of investigations.

2.16 Identification of prisoners' protected characteristics was good but we were not confident that the data were used to address discrimination. For example, the equality team were unaware of the existence of key data on sexual orientation and lessons learned from discrimination incidents were not discussed at the diversity and equality meetings.

2.17 With the exception of older prisoners, there had been no recent consultation with, or formal support for, protected groups. Community organisations did not attend the prison to offer support or advice to protected groups (see main recommendation S46).

Protected characteristics

2.18 At the time of the inspection, 14% of the population were black or minority ethnic prisoners. In our survey, fewer black and minority ethnic prisoners (51%) than white prisoners (75%) said that most staff treated them with respect and 49% against 24% said they had been victimised by staff. The prison monitoring data also suggested disparities in treatment. For example, black prisoners were more likely than white prisoners to have an adjudication charge brought against them, to be found guilty at an adjudication hearing, to be on the basic level of the incentives and earned privileges (IEP) scheme and to be segregated. No investigation was being carried out to understand and address these disparities (see main recommendation S46).

2.19 Eight Gypsies and Travellers were held at the time of the inspection. The weekly support meeting for this group had been discontinued, as had the support from Ihsaan Social Support Association Wales to help with resettlement needs.

2.20 Six per cent of the population were foreign nationals, many of whom were uncertain about what would happen when their sentences finished. Seven prisoners were being held under immigration powers, one for six months. One immigration detainee told us that he was only informed of his detention on the final day of his custodial sentence. Prisoners had a face-to-face meeting with an immigration enforcement officer within two weeks of arrival. They could also apply to see the officer, who visited the prison every week. An offender supervisor in the offender management unit had received additional training on foreign national issues. Foreign nationals could apply for a free five-minute telephone call to their country of origin in lieu of visits. There was still very little information displayed in languages other than English and Welsh. We were not confident that staff used telephone interpreting services when necessary.

2.21 We found no evidence of discrimination or less favourable treatment of different religious groups. Prisoners in our groups and members of the chaplaincy felt that a prisoner's religion did not affect their treatment.

2.22 The prison had identified 253 prisoners with disabilities, which reflected the numbers in our survey. Very few adjustments had been made for this group. We found several prisoners

with mobility problems living in unadapted cells. Health care staff assessed these prisoners, but there was no multidisciplinary care planning and links with wing officers and the equality team were poor. In our survey, prisoners with disabilities reported more negatively than others across a wide range of questions. The equality monitoring tool was not used to monitor the group's treatment (see main recommendation S46).

2.23 A compact had been agreed for a transgender prisoner who was released the week before our inspection. Staff told us she was able to purchase products appropriate to her acquired gender. The prison had identified seven gay or bisexual prisoners, while our survey suggested about 30. Prisoners were asked their sexual orientation by a member of the chaplaincy on the wings, which could have inhibited full disclosure. The weekly chaplaincy support meeting for gay and bisexual prisoners had been discontinued since our last inspection.

2.24 Seven prisoners were over the age of 60, with the oldest 68. Prompt action had been taken to address needs identified at a forum for older prisoners shortly before our inspection. Reading glasses were now available for prisoners to borrow while reading in the library. The gym ran two sessions a week for older prisoners.

Recommendation

2.25 Professional interpreting should be used when accuracy or confidentiality are required.

Faith and religious activity

Expected outcomes:

All prisoners are able to practise their religion fully and in safety. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and resettlement.

2.26 Forty-six per cent of prisoners had no recorded religion, 42% were Christian and 10% Muslim. The composition of the chaplaincy reflected this mix. A Humanist celebrant offered support to prisoners of no religion and the needs of minority faiths were catered for.

2.27 Although prisoners in our survey were more negative than at similar prisons about respect for their beliefs and access to services, we also heard many positive reports about the support they received from the chaplaincy.

2.28 The chaplaincy worked well together. A chaplain saw all new prisoners shortly after their arrival. The meetings were constructive but not always conducted in private and some prisoners were asked intimate questions on the landings. The chaplaincy contributed to a wide range of meetings across the prison, but not assessment, care in custody and case management (ACCT) reviews (see paragraph 1.20).

2.29 The chapel was a welcoming, serene environment. In contrast, the multi-faith room used by all non-Christian faiths was austere and hot, and struggled to accommodate all Muslims for Friday prayers. Other than a small sink, there were no ablution facilities near the multi-faith room.

Recommendations

2.30 The reasons for prisoners' poor perceptions of religious activity should be investigated and the findings acted on.

2.31 Prisoners should be able to attend religious services in facilities that are well ventilated, spacious, appropriately decorated and furnished.

Good practice

2.32 *A Humanist celebrant attended the prison to support prisoners of no faith.*

Complaints

Expected outcomes:
Effective complaints procedures are in place for prisoners, which are easy to access, easy to use and provide timely responses. Prisoners feel safe from repercussions when using these procedures and are aware of an appeal procedure.

2.33 During the previous six months, 538 written complaints had been submitted, less than at other local prisons. The most common complaints related to residential units (70), health care (47), property (48) and sentence planning (24). Complaints boxes were situated at a distance from staff offices, enabling prisoners to submit them confidentially. Not all complaint forms were available on all wings. Complaints were investigated promptly and thoroughly. The quality of replies was good. Many were polite, clearly written and resolved prisoners' problems, although the tone of a few replies was abrupt. A manager quality assured 10% of replies each month and fed back to staff when necessary. A monthly complaints report was presented to the senior management team, but it only covered the type of complaint and the location. Complaints about health care were inappropriately handled through the general complaints system (see paragraph 2.40).

Legal rights

Expected outcomes:
Prisoners are fully aware of, and understand their sentence or remand, both on arrival and release. Prisoners are supported by the prison staff to freely exercise their legal rights.

2.34 The prison held large numbers of unconvicted, unsentenced and recalled prisoners and those appealing their sentence or conviction. Despite a high demand for legal services, there was no dedicated provision. Prisoners received no help in applying for bail and bail accommodation and no support services were working in the prison. Prisoners could apply to borrow an 'access to justice' laptop to work on their case, but no prisoners were using one during our inspection. The library stocked a reasonable range of legal text books and prison service instructions. Facilities for legal visits were good.

Recommendation

2.35 Prisoners should be able to access effective legal advice easily.

Health services

Expected outcomes:
Prisoners are cared for by a health service that assesses and meets their health needs while in prison and which promotes continuity of health and social care on release. The standard of health service provided is equivalent to that which prisoners could expect to receive elsewhere in the community.

Governance arrangements

2.36 Overall health care was reasonably good. Cardiff and Vale University Health Board commissioned and provided health services. A draft comprehensive health needs assessment had been prepared to inform the prison health development plan. There were regular, well-attended partnership meetings with the governor and working relationships were positive.

2.37 There were sufficient well-led health care professional posts with the necessary competencies to provide health services, although the variety of activities was reduced because of vacancies. A registered nurse was on duty 24 hours a day. Health care professionals had excellent access to training and were up-to-date with requirements, but not all had regular, documented clinical supervision.

2.38 There were few serious incidents, and lessons learned were shared with staff. However, we were concerned that the health care manager had not received clinical review reports following deaths in custody (see paragraph 1.19).

2.39 There was no dedicated health forum but health care staff contributed to the prisoners' forum. The most recent patient survey on reasons for non-attendance had been completed in 2015.

2.40 Prisoners made few complaints about health care, 47 in the previous six months. Health complaints were made through the general complaints system which compromised medical confidentiality. The responses we sampled were timely, polite and focused.

2.41 The health centre, including inpatient unit, was clean and had excellent clinical facilities on two floors. However, the ground floor was affected by rising damp - to waist height in some places. The damp did not affect the inpatients' sleeping accommodation. A room formerly used for mental health group therapy had been dedicated to control and restraint training for prison officers, which reduced clinical flexibility. The two patient waiting rooms were bleak, with graffiti and no health promotion material. Patients waited for up to 40 minutes on wooden slatted benches before and after their appointments.

2.42 The wing treatment rooms were not used for most clinical purposes because they were not fit for purpose. The refurbishment that we previously recommended had not taken place. A recent infection control audit had been completed with a remedial action plan.

2.43 Health care emergency equipment, including automated external defibrillators (AEDs), was placed strategically across the prison and health care professionals were trained to use it. Kit was subject to regular, documented checking. No prison officers had been trained to use an AED.

2.44 Prisoners aged 50 and over received appropriate health checks and treatment. Health screening and immunisation activity was age appropriate, including blood-borne virus testing.

2.45 Health promotion literature was available in the health centre, and there were some notices on residential units. Barrier protection and harm minimisation advice were available from health care professionals. The prison had started a consultation on an integrated approach to health and well-being.

Recommendations

2.46 The health partnership board should construct a plan to address the damp in the health centre, lack of space for mental health therapy, inhospitable waiting rooms, and refurbishment requirements of the wing treatment rooms.

2.47 The health complaints system should preserve medical confidentiality.

Delivery of care (physical health)

2.48 Registered nurses screened about 380 prisoners a month on reception. Prisoners had access to a GP and substance misuse worker if required. Relevant information, such as the person escort record, was reviewed and consent was requested for access to community records. The initial health screen contained an enhanced approach to mental health assessment, which was commendable, but had limitations in identifying learning disabilities.

2.49 Secondary health screening was completed the day after arrival. An information leaflet on health services was available to prisoners, although there was none in reception when we visited. Health care did not contribute to the induction programme which was a missed opportunity to convey essential health and well-being information.

2.50 There was an appropriate range of primary care services, for which waiting times were acceptable. In our survey, about a third of prisoners said that overall quality of health care was good, and they reported better access to a nurse (60% versus 51%) and doctor (27% versus 21%) than at the last inspection. Prisoners had access to urgent GP appointments on the day, and out-of-hours GP cover was provided to the same level as in the community. During the previous three months, nearly a quarter of prisoners did not attend their GP appointments despite action to address this.

2.51 Nurses provided a community based service with initial triage of minor ailments on the residential units. Nurse-led clinics were underdeveloped but life-long conditions were well managed by the GPs. There were some visiting specialists, for example in sexual health or hepatitis C treatment, and limited access to telemedicine for skin problems. External hospital appointments were rarely cancelled, which was commendable.

2.52 The 20-bed inpatient unit was used for prisoners with physical and mental health needs, but 'lodgers' were also admitted for non-clinical reasons. Prisoners were satisfied with their care and care planning was good. The therapeutic day included communal activities, visiting education and library services. However, access to therapeutic activities was affected by a shortage of prison staff.

Recommendation

2.53 The inpatient unit should only accommodate patients with clinical needs. Its role and exclusion criteria should be clearly defined, agreed and monitored by the prison health partnership board.

Pharmacy

2.54 Patients received medication promptly from the in-house pharmacy. There were no medicines use reviews or pharmacy-led clinics. Prisoners could ask to see a pharmacist, but this service was not advertised.

2.55 Medicines management procedures were generally very good. Prescribing was evidence based and appropriate. Up-to-date reference sources, including a prison formulary (a list of medications used to inform prescribing), were available, although some old material had been inappropriately retained. Controlled drug cabinets on the wings were not secured according to legislative requirements.

2.56 Risk assessments for prisoners receiving in-possession medicines were recorded on SystmOne and reviewed when necessary. Prisoners sharing cells did not have lockable cabinets to store medication. The checking of in-possession medicines in cells was inadequate.

2.57 Medicines were administered on several wings and medicine queues were well supervised by prison officers. Medicines that caused drowsiness were often given too early, sometimes as early as 4pm. Short courses of sleeping tablets were given daily in possession wherever possible. Some prisoners had to take medication three times a day as part of a detoxification programme. The prison regime did not allow for this and nurses gave these prisoners their second dose to take away. This increased the risk of non-compliance and diversion. Nurses recorded this dose as having been administered without seeing the prisoner taking the medicine. This was poor practice.

2.58 A significant quantity of medicine was supplied as stock rather than for named patients. Stock was occasionally supplied as split packs and some had faded labels that were difficult to read. Trolleys containing stock medicines were not always secured to the fabric of the building when not in use. Prisoners could obtain medication out of hours if required.

2.59 The pharmacist and lead GP closely scrutinised the prescribing of tradable medicines and liaised systematically, using a pro forma, with community prescribers to ensure that prescribing was appropriate. Tramadol (a strong opiate-based painkiller) was not prescribed, although the pharmacy kept some stock in case of need. Mirtazapine prescribing was quite high, reflecting high prescribing in the local community. This was under review.

2.60 The prison shop and the pharmacy sold a limited number of simple remedies for common problems such as dry skin and cold sores. A limited range of patient group directions[11] (PGDs) enabled nurses to supply and administer common medicines but most basic medication had to be prescribed by a doctor. Nurses supplied some prisoners with nicotine patches under a PGD. The pharmacist said that the procedure was not always followed and prisoners were able to stockpile patches, some of which were abused.

2.61 The medicines management committee met monthly and was well attended by relevant stakeholders. The committee reviewed prescribing data and ratified policies. Appropriate up-to-date medicines protocols were available and generally followed.

Recommendations

2.62 Prisoners should have secure storage for in-possession medication and systematic checks should be conducted.

[11] Authorise appropriate health care professionals to supply and administer prescription-only medicine

2.63 All medication should be administered according to the prescriber's directions at an appropriate time for maximum therapeutic effect. Administration records should be accurate and complete.

2.64 The use of general stock should be reviewed to encourage the use of named-patient medication wherever possible.

2.65 The range of patient group directions should be expanded to avoid unnecessary consultations with the doctor. Nurses should be trained in their use to ensure that procedures are correctly followed.

Good practice

2.66 *The systematic use of a pro forma to obtain detailed information from prisoners' community GPs about their prescribed medication enabled the health care team to prescribe appropriately.*

Dentistry

2.67 Prisoners we spoke to expressed satisfaction with dental services, although in our survey only 22% were satisfied with the overall quality against the comparator of 29%. Not all treatments that prisoners wanted could be implemented because of their short stay in the prison. The dental team treated prisoners politely, respected their privacy, provided appropriate information and promoted oral hygiene.

2.68 The average waiting time for non-urgent treatment was reasonable, at four to six weeks. Prisoners requiring urgent attention were treated quickly. From April to July 2016, 27% of prisoners had failed to attend their appointments (see paragraph 2.50).

2.69 The dental suite comprised two large surgeries which were clean and suitably equipped. A separate decontamination room met best practice standards. Resuscitation equipment was shared with the health care centre, and oxygen was located in the suite.

Delivery of care (mental health)

2.70 The draft health needs assessment indicated high levels of emotional and mental health problems and serious psychiatric illnesses. This was reflected in the very high number of referrals each week, on average 45 to 50.

2.71 The mental health team responded to complex, serious and enduring mental health problems, but capacity to assist prisoners with emotional and mild to moderate problems was inadequate. Up to a third of prisoners had ongoing unmet needs. There were no longer any counsellors to help meet emotional needs, although recruitment was in progress.

2.72 The multidisciplinary in-reach team consisted of mental health care practitioners, including psychiatric nurses, occupational therapist, counselling psychotherapist, psychiatrist and sessional forensic psychiatrist. They provided a cohesive approach to complex, serious and enduring illnesses and also tried to respond to mild to moderate needs. The caseload was high, with 70 to 100 prisoners in care at any one time.

2.73 Therapeutic approaches included one-to-one support, brief interventions, cognitive therapy and trauma-informed interventions. A few therapeutic groups were limited to six prisoners for security reasons, which was clinically inefficient. Clinical rooms in the health care centre

and rooms on the wings were used for treatments, none of which was ideal. There was not enough therapy space to offer simultaneous group therapies in the health centre. There had been no recent training of prison officers in mental health awareness.

2.74 During the previous six months, 10 patients had been transferred to secure mental health units, with an average waiting time of 3.5 weeks against guidelines of 14 days. At the time of the inspection, four patients were awaiting transfer. One had been waiting for 18 weeks, which was unacceptable.

Recommendations

2.75 A mental health service model capable of meeting the emotional and mental health needs of the population should be implemented.

2.76 All staff in prisoner contact roles should be trained in mental health awareness.

2.77 Transfers to community mental health services under the Mental Health Act should take place promptly.

Social care

2.78 Arrangements for social care assessments had been put in place but no referrals had been made. There was evidence of access to occupational therapy equipment and mobility and self-care aids for prisoners who required them.

Catering

Expected outcomes:
Prisoners are offered varied meals to meet their individual requirements and food is prepared and served according to religious, cultural and prevailing food safety and hygiene regulations.

2.79 In our survey, 22% of prisoners said that the food was good compared with 29% at the previous inspection. The food we tasted during the week was hot and flavoursome and portions were of a decent size. Prisoners could choose meals from a menu published once a week and the menu changed every four weeks. A booklet explaining how to select meals was written in easy-read format and illustrated. There were four options for the evening meal, including vegan and halal options. Breakfast packs were served the night before and were unappetising and small. Prisoners could have two hot meals a day and five portions of fruit and vegetables. The kitchens provided bespoke meals for prisoners with special diets, for example, diabetics. Prisoners could not eat communally and instead ate in their cells, many on their beds feet away from their toilets.

2.80 Only 16 prisoners worked in the kitchens which had the capacity for 26, partly because of a planned move to a temporary kitchen while the main kitchen was refurbished. Prisoners completed a food hygiene qualification before working in the kitchen but could not complete any other catering qualifications.

Recommendation

2.81 Prisoners working in the kitchens should be able to study for a national vocational qualification in catering.

Purchases

Expected outcomes:
Prisoners can purchase a suitable range of goods at reasonable prices to meet their diverse needs, and can do so safely.

2.82 Prisoners could buy a wide range of products. In our survey, just under half the prisoners said that the shop sold a wide enough range to meet their needs. Prisoners could order products from three catalogues but had to pay a costly and unreasonable administration fee for each order. Some newly arrived prisoners had to wait two weeks before they received their first shop order. Delays in receiving these orders resulted in some prisoners accruing debt after borrowing essential items from other prisoners.

Recommendation

2.83 Prisoners should be able to purchase and receive items within 24 hours of arrival.

Section 2. Respect

17.1

Section 3. Purposeful activity

Time out of cell

Expected outcomes:
All prisoners are actively encouraged to engage in activities available during unlock and the prison offers a timetable of regular and varied activities.[12]

3.1 The time prisoners could spend out of their cells under the temporary restricted regime was poor. The new arrangements had been implemented in late July 2016 because of shortfalls in staffing and were due to end in September. Access to employment and education had been halved to five days each fortnight and unlocking and attendance at activities had become more predictable. However, when prisoners were unable to attend employment or education, they could typically spend as little as an hour and a half out of their cells in 24 hours. Some prisoners could be locked in their cells for up to 27 hours, only coming out briefly to collect a meal (see main recommendation S47).

3.2 When prisoners attended work and education, they could spend about eight hours out of their cells, including about 90 minutes' association. However, we observed some slippage in timetabled activities.

3.3 Our roll checks during the working day showed that 46% of prisoners were locked in their cells. There was access to outdoor exercise, but for some wings this was for only half an hour a day.

Learning and skills and work activities

Expected outcomes:
All prisoners can engage in activities that are purposeful, benefit them and increase their employability. Prisoners are encouraged and enabled to learn both during and after their sentence. The learning and skills and work provision is of a good standard and is effective in meeting the needs of all prisoners.

3.4 *Estyn[13] made the following assessments about the learning and skills and work provision:*

Overall effectiveness of learning and skills and work:	**Good**
Achievements of prisoners engaged in learning and skills and work:	*Good*
Quality of learning and skills and work provision, including the quality of teaching, training, learning and assessment:	*Good*
Leadership and management of learning and skills and work:	*Good*

[12] Time out of cell, in addition to formal 'purposeful activity', includes any time prisoners are out of their cells to associate or use communal facilities to take showers or make telephone calls.

[13] Estyn is the office of Her Majesty's Inspectorate for Education and Training in Wales. It is independent of, but funded by, the National Assembly for Wales. The purpose of Estyn is to inspect quality and standards in education and training in Wales.

17.1

Management of learning and skills and work

3.5 Overall, the management of learning and skills was good. The profile and priority of learning and skills had been raised and planning of education and work activities had improved. The head of learning and skills liaised well with the lead for learning and skills in the Wales cluster, which had enhanced planning and helped the prison to benchmark its performance against other prisons.

3.6 Procedures for quality assuring management data were good and their accuracy had improved. However, the management information system stored a narrow range of data, which impeded the demonstration of staff and prisoner successes.

3.7 A useful needs analysis had been undertaken, making good use of labour market information. The findings had informed the development of the curriculum to include vocational training in radio presentation and barista skills.

3.8 Managers used comprehensive, evaluative self-assessment well to plan and prioritise quality improvement. Staff were well qualified and most had good opportunities to develop their skills. However, a few key staff were part time and a few were approaching retirement. There was no succession plan to ensure that this staff profile would not affect prisoners adversely.

3.9 Classrooms and workshops were equipped to a good standard, with access to learning equipment and modern technology.

3.10 The impact of learning and skills on prisoners' outcomes following release had not been evaluated.

Recommendations

3.11 The learning and skills management information system should measure the performance of all prisoners and teaching staff.

3.12 The impact of learning and skills on prisoners' offending behaviour and employability on leaving prison should be evaluated.

Provision of activities

3.13 The number of activity places had increased to 750 and there were enough places for all prisoners to be usefully occupied. Only 26 prisoners were unemployed, although during the temporary regime too many prisoners spent too much time unoccupied (see main recommendation S47).

3.14 The breadth of provision was good and had improved further since the last inspection. For example, prisoners now completed a 'new roads and street works' training course. These improvements reflected the needs of the local labour market.

3.15 Nearly all activities were purposeful and provided prisoners with good work-related skills. These included valuable opportunities for prisoners to develop motivational skills and build their confidence and self-esteem.

3.16 The allocation of activities had improved since the last inspection. All prisoners completed a thorough initial assessment within the first week which identified their needs, interests and levels of literacy and numeracy. This facilitated the swift allocation of prisoners to activities.

3.17 Systems to manage attendance were not robust enough. In many workshops and classes, prisoners arrived late, which affected session planning and disrupted the progress of other prisoners' learning.

3.18 Pay rates offered a satisfactory system of incentives and bonuses.

Quality of provision

3.19 Prisoners received guidance interviews during induction which enabled them to reflect on how the opportunities offered could benefit them on their release. The broad range of learning and vocational activities were designed in small units that could be achieved quickly. This met the needs of short-term prisoners well.

3.20 Teachers knew and understood the prisoners well and planned sessions so that they developed skills, self-confidence and motivation to learn. Teaching was of a consistently good standard and sessions were delivered at a good pace to engage prisoners and encourage learning. Teachers and supervisors used good questioning skills in most sessions and listened to prisoners to improve the planning of sessions. Staff made good use of real-life scenarios in health and safety to aid prisoners' understanding.

3.21 English for speakers of other languages (ESOL) lessons were planned well and focused on pronunciation and vocabulary. Many staff embedded literacy, numeracy and digital literacy well into prisoners' learning, and music sessions were particularly effective in teaching a broad range of essential skills. In a few cases, staff relied too much on worksheets.

3.22 Classrooms and workshops were calm environments where learners felt safe and behaviour was good. Peer mentors helped motivate and support prisoners to learn in class. In workshops they played an important supervisory and training role, although there were not enough opportunities for them to gain accreditation for these skills. Most prisoners produced work of a high standard and took pride in their achievements.

Education and vocational achievements

3.23 The overall success rate for all courses in 2015 to 2016 was good. At 82%, it was 14% above the NOMS Wales key performance indicator. Nearly all learners who completed a course achieved a certificate for units of credit or a qualification.

3.24 Successful completion of vocational courses was 86%, non-vocational courses 96% and employability courses 97%. These were respectively 18%, 28% and 29% above the benchmark.

3.25 About three-quarters of learners attained units of credit on essential skills courses, a significant improvement from about half at the last inspection. However, in 2015 to 2016 outcomes in numeracy were lower than those for literacy.

3.26 The range of qualifications and certificates of credit was appropriate for the transient nature of the population. Many prisoners achieved learning goals that developed their study skills, self-esteem, confidence and attitudes to learning and prepared them effectively for the next stage of learning or training for employment purposes.

3.27 Initial assessment of prisoners was effective and many teachers followed up with a more in-depth assessment. Prisoners' learning plans contained a learning target which prisoners set and reviewed weekly, which gave them relevance to the individual. A few of these targets were not specific enough or linked well to assessment outcomes.

3.28 Where basic literacy and numeracy support was provided, prisoners gained valuable skills, but not all prisoners had equal access to this support. Prisoners in ESOL classes developed their skills well and acquired an understanding of prison terminology and regimes which helped them to settle quickly into prison life.

3.29 Opportunities for prisoners to learn about aspects of emotional wellbeing featured prominently in well-structured learning and skills courses on personal development. This had a significant impact on prisoners' self-awareness and self-esteem. For example, prisoners on the 'Tools for Change' and 'Beating the Blues' courses described how the course had helped them to develop valuable strategies to understand and manage their emotions and behaviour.

Library

3.30 The main prison library contained a good range of books and resources. There was an appropriate selection of material to appeal to prisoners, including magazines, novels and reference books.

3.31 The library stock included material for ESOL support, beginner readers and prisoners requiring accessible print. There was an appropriate selection of materials in the Welsh language and reference books related to Wales and its culture.

3.32 Prisoners had opportunities to request books from the local authority library services and these arrived promptly. Reduced library stock was available on two of the wings. Prisoners did not have equal access to the library and some prisoners were able to borrow and exchange books more frequently than others.

Recommendation

3.33 All prisoners should have equal access to the library.

Physical education and healthy living

Expected outcomes:
All prisoners understand the importance of healthy living, and are encouraged and enabled to participate in physical education in safe and decent surroundings.

3.34 The range of physical education (PE) facilities was appropriate and included two gyms, a sports hall and an all-weather pitch. A wide range of sports were offered, including football, basketball, rugby, volleyball and cricket. Exercise yards contained exercise equipment to promote physical activity. The PE team organised inter-wing competitions a few times a year. Teams of staff and prisoners had played football with a local faith organisation.

3.35 All prisoners could attend PE at least three times a week and about half the prisoners used the facilities regularly. Under the temporary regime the number of PE sessions varied too much between wings and participation in team games had been affected (see main recommendation S47).

3.36 Prisoners of all ages and fitness levels were well catered for. Valuable specialist courses had a positive impact on the health of older prisoners, those with medical conditions and those wanting to lose weight. These courses were popular with prisoners and were oversubscribed. Provision for prisoners with physical disabilities or learning difficulties was underdeveloped.

3.37 The health and fitness screening of prisoners was thorough. The PE and health care teams worked together to assess prisoners' medical condition before they undertook PE activities.

3.38 Prisoners received a useful induction to PE within the first week of arrival, including information on the benefits of a healthy diet, the safe use of equipment and safe methods of training. PE staff also provided manual handling training for all prisoners which expedited their allocation to employment and training.

3.39 Many prisoners spoke of the importance of a healthy lifestyle and were enthusiastic about the weight loss course. They were motivated to achieve challenging targets for further improvement. Many prisoners took part enthusiastically in PE sessions, including a demanding circuit training session.

Recommendation

3.40 There should be dedicated PE sessions for prisoners with disabilities.

Section 3. Purposeful activity

17.1

Section 4. Resettlement

Strategic management of resettlement

Expected outcomes:
Planning for a prisoner's release or transfer starts on their arrival at the prison. Resettlement underpins the work of the whole prison, supported by strategic partnerships in the community and informed by assessment of prisoner risk and need. Good planning ensures a seamless transition into the community.

4.1 There was a reducing reoffending strategy and action plan, based on the seven pathways and an additional veterans' pathway. Current progress in implementing the strategy was discussed at regular meetings, but actions had only recently been identified and minuted. The offender management unit (OMU) was managed separately and was not represented at these meetings. There were, therefore, limited links between offender management and the practical resettlement work delivered by St Giles Trust on behalf of the community rehabilitation company (CRC), Working Links. Staff of the two departments had started to meet, but so far not regularly.

4.2 OMU staff were not located with the CRC, and specialist teams of administrative staff, offender supervisors, categorisation and allocation staff all worked in separate rooms. Managers and staff went out of their way, with reasonable success, to improve communication but these obstacles hindered coordinated working to achieve the best outcomes for prisoners and the public.

4.3 There was an appropriate emphasis on completing a good basic custody screening tool for resettlement issues. The lack of coordination prevented the part 1 screening by offender supervisors from linking well with the part 2 screening carried out a few days later by CRC staff.

4.4 Seventy percent of prisoners were at Cardiff for three months or less, which made it difficult to deliver interventions addressing offending behaviour, although some one-to-one work was done by CRC staff. There had been no analysis of the resettlement needs of the population, but there was an appropriate focus on important areas for short-term prisoners, such as housing, employment and financial management, with effective involvement by a wide range of community organisations. The practical resettlement needs of prisoners on remand and on short sentences were appropriately met by the CRC engagement at the beginning and towards the end of the sentence. Little was done to reduce the risk of reoffending by prisoners with sentences of several months, who were not moved elsewhere, other than education and work.

Recommendation

4.5 All resettlement staff should work in close cooperation, and as far as possible in close proximity, to ensure the best outcomes in reducing the risk of prisoners re-offending.

Offender management and planning

Expected outcomes:
All prisoners have a sentence plan based on an individual assessment of risk and need, which is regularly reviewed and implemented throughout and after their time in custody. Prisoners, together with all relevant staff, are involved in drawing up and reviewing plans.

4.6 Offender management staff worked hard, but their effectiveness was undermined by the frequent redeployment of most of the uniformed offender supervisors. It was not unusual for only one of the eight supervisors to be available for offender management work on any one day. They were not able to contact prisoners on their caseload regularly, but described their work as reactive, picking up essential tasks or responding to prisoner applications. Weekly OMU surgeries on the wings had been a good innovation, but they had been discontinued because of staff shortages.

4.7 There was a very small backlog of OASys assessments to the credit of OMU staff. The quality of these assessments, both 'layer 1' risk reviews and 'layer 3' full assessments, was uneven. In the sample that we analysed, prison and probation offender supervisors had not used all the relevant information available, especially from probation sources.

4.8 There was some quality assurance of OASys assessments, sentence plans and risk management plans, but it was limited in scope. A number of the individual plans which we examined did not set objectives and targets appropriate to the stage of the prisoner's sentence and his personal circumstances.

4.9 During the previous nine months, 166 applications for home detention curfew (HDC) had been made, of which 80 had been approved, twice as high a proportion as at the previous inspection. Staff reported delays in receiving responses to requests for information relevant to HDC from community probation staff and CRCs.

Recommendation

4.10 A consistent team of offender supervisors, sufficient in number to meet the need, should deliver the core work of individual prisoner assessment and planning to a reliable standard.

Public protection

4.11 Public protection issues were consistently identified and managed on arrival at the prison and as they arose. This depended on the competence of individual staff and managers, and there was only limited governance of the structures and systems involved. The minutes of regular interdepartmental risk management meetings only recorded discussion of individual prisoners presenting management challenges, although the published policy included the appropriate governance functions.

4.12 Prisoners eligible for public protection measures on release under MAPPA (multi-agency public protection arrangements) were identified promptly and OMU staff and managers played an active role in community risk management meetings. Fulfilling MAPPA obligations was more difficult with prisoners from England, of whom there been an influx in recent weeks.

Recommendation

4.13 The interdepartmental risk management committee should provide governance of public protection systems and processes, in line with the published policy.

Categorisation

4.14 The disruptive effects of overcrowding drafts on prisoners' progress were no longer a problem, since group transfers out of Cardiff no longer took place at short notice. Categorisation and re-categorisation processes were carried out effectively, and suitable forms had been devised locally for prisoners to make their own representations to the board. OMU staff delivered these forms, and gave appropriate support to prisoners who had difficulty writing submissions. Until recently, there had been a strong record of timeliness in decisions on both re-categorisation and HDC; this had slipped over the summer because of staff shortages.

Indeterminate sentence prisoners

4.15 The number of life sentence prisoners had reduced from 60 to 16 since the previous inspection. A probation officer kept in touch with these men, and delivered short one-to-one interventions on topics such as anger management. Little else was available to support progress through their sentence. Some prisoners remained at Cardiff because offender managers had decided that was the best option for them to progress because they were close to their family or there were other factors relevant to reduction of risk.

4.16 Seventeen men were serving indeterminate sentences for public protection. OMU staff said that a new arrangement to transfer them to HMP Parc had not yet been implemented.

Recommendation

4.17 IPP prisoners should not be held at HMP & YOI Cardiff unless there are clear opportunities to work on reducing the risk of re-offending.

Reintegration planning

Expected outcomes:
Prisoners' resettlement needs are addressed prior to release. An effective multi-agency response is used to meet the specific needs of each individual prisoner in order to maximise the likelihood of successful reintegration into the community.

4.18 The CRC for Wales, Working Links, was represented in the prison by St Giles Trust. Its caseworkers were located in the centre of the residential areas and were very accessible to prisoners. In recent weeks, in spite of working hard, offender supervisors had not been able to keep pace with basic custody screenings, because they had to prioritise public protection and risk assessment work. All prisoners received initial custody screening to meet immediate practical needs and a resettlement plan from the CRC. This was a major improvement since the previous inspection.

4.19 Peer advisers worked effectively to support prisoners towards resettlement, especially in signposting to housing and other services. The advisers were given structured training towards NVQ level 3, and the level of training and supervision of their work by a CRC staff

member was very good. They were available to prisoners at each stage from reception and co-delivered resettlement modules in the last 12 weeks of the sentence. Their work remained effective despite being limited to an hour a day shortly before the inspection.

Accommodation

4.20 St Giles workers saw all new arrivals during induction. Prisoners with housing issues were dealt with quickly. Accommodation services were good and included maintaining and surrendering tenancies, housing benefit and applications for accommodation before release. Regular surgeries were held across the prison to advise prisoners and to identify changes in circumstances. All prisoners were seen again 12 weeks before discharge to identify and address any changes in circumstances. The team had links with community housing support groups across the region and offered a range of practical help, including referrals to community tenancy support services and tenant arrears advice services. A two-hour programme offered advice and guidance on tenancy issues. Communication with the OMU was good. The CRC said that 87% of prisoners were discharged into settled accommodation.

Education, training and employment

4.21 Before leaving prison, younger prisoners were offered advice from a Careers Wales adviser, who helped them to plan their next steps. However, many prisoners' awareness of opportunities in the community was too limited for them to make informed decisions.

4.22 The prison had good links with community and employer groups, and encouraged potential employers to become involved in the prison. This enabled a few prisoners to progress, for example, from railway track maintenance classes into similar employment. The skills prisoners gained in vocational workshops prepared them reasonably well for the world of work.

4.23 The CRC worked well with Job Centre Plus staff to help prisoners identify vacancies. However, the CRC did not have sufficiently well-developed links with education, training and employment providers to help prisoners on release.

Recommendation

4.24 The CRC should have effective links with employers and further education institutions to support prisoners on release.

Health care

4.25 Pre-discharge health arrangements were satisfactory. Prisoners were seen in reception before release and given medication to take home. Discharge summaries were faxed to GPs. Patients with enduring mental health problems were subject to the care programme approach[14] and there were extensive communications with community services. Arrangements for prisoners with end-of-life needs were in place.

[14] The care programme approach (CPA) was a case management system introduced in the 1990s. It was designed to ensure that patients with complex or enduring psychiatric disorders were monitored and cared for. The Welsh CPA emulated the English CPA.

Drugs and alcohol

4.26 Partnership working between the prison and community drug and alcohol service providers had been strengthened. A multi-agency case management database shared information between the police, the prison and community agencies. Prison link workers from the community were involved in clinical review meetings to ensure prisoners' treatment continued after their release. Before release, prisoners were informed about harm reduction, overdose prevention and new psychoactive substances (NPS). A detailed through-care release plan was completed and on release a 'meet at the gate' service was available.

Finance, benefit and debt

4.27 Job Centre Plus and peer supporters provided a full range of benefit and employment advice to prisoners before discharge and ensured that benefits claims were closed and arrears settled where appropriate. Prisoners due for discharge were helped to make a claim so that payments were not delayed. Job Centre Plus ran budgeting and finance courses and debt management clinics. Money Advice Services advised prisoners about debt at fortnightly clinics. Prisoners were unable to open bank accounts.

Recommendation

4.28 Prisoners should be helped to apply to open a bank account.

Children, families and contact with the outside world

4.29 The visits hall was large, bright and recently redecorated, and contained some reasonable facilities. The fixed seating in the main hall was uncomfortable and limited the number of visitors each prisoner could have. A good range of hot and cold food was available. A separate area for enhanced prisoners with more comfortable seating could accommodate seven prisoners and 21 visitors. The children's play area was well equipped and staffed. Prison staff supervised the visits hall well without affecting privacy. Consultation with visitors was good. PACT (Prison Advice and Care Trust, a charity which supports prisoners and their families) ran weekly forums for visitors to gain feedback on their visiting experience. PACT also distributed an annual visitors' questionnaire.

4.30 Visits took place every weekday afternoon and Saturday morning. Most visits started on time and visitors reported a decent experience. Staff were polite and searched visitors and children sensitively. The prisoner holding room was dirty, badly lit and poorly ventilated, and contained broken chairs and stained walls. Prisoners wore identification bibs during their visit, which was unnecessary. Visitors found it difficult to get through on the telephone booking line. Visitors could also book visits online or with staff in the visitors' waiting room after their visit. The closed visits area was too small to accommodate the high number of prisoners which restricted the number of visits they could have (see paragraph 1.28). Remand prisoners could not have visitors each day.

4.31 The PACT family engagement work was innovative and very good. A team of four family engagement workers (FEW), a therapeutic play worker and a part-time caterer had been appointed. The FEW team delivered services and programmes to help prisoners maintain and improve family relationships. Six interventions during the year to July 2016 had been attended by 21 prisoners. These interventions included a four-week relationship course which focused on communication, parenting skills, decision-making and realistic expectations of family life after release. A family literacy workshop was followed by a family day involving

storytelling to children. Each intervention had been adapted to the needs of the population. PACT had strong links with the local social services department and advocated for fathers in prison by attending children in need child protection meetings in the community.

4.32 PACT organised six family days a year during school holidays. Family days were themed and included activities for the whole family with a focus on play, education, art and communication with children. Food was provided free during family days. Security restrictions were appropriate.

Recommendation

4.33 Prisoner waiting areas should be clean and properly maintained.

Attitudes, thinking and behaviour

4.34 There were no accredited offending behaviour programmes and no victim awareness work. The 'Tools for Change' and 'Beating the Blues' education courses were delivered by the education department and were fully subscribed. Prisoners serving sentences over 12 months were likely to move to a training prison where they could complete courses. Very little work on changing attitudes and addressing offending behaviour was available for prisoners serving sentences of less than a year.

4.35 Work with veterans had continued to develop well. A range of relevant organisations, including SSAFA[15], 'Hire a hero' and Care after Combat, took part in monthly forum mornings, which were greatly appreciated by the many veterans in the prison and linked them to mentoring help in the community on release. A prison officer came in voluntarily on his day off to facilitate this.

Recommendation

4.36 The prison should have a coherent and realistic plan to deliver programmes appropriate to its population which meet identified need. (Repeated recommendation 4.67)

Good practice

4.37 *A monthly forum, involving local and national agencies which support veterans, helped veterans prepare for a constructive life after prison.*

[15] The Soldiers, Sailors, Airmen and Families Association.

Section 5. Summary of recommendations and good practice

The following is a listing of repeated and new recommendations and examples of good practice included in this report. The reference numbers at the end of each refer to the paragraph location in the main report, and in the previous report where recommendations have been repeated.

Main recommendations — To the governor

5.1 Managers should ensure rigorous and coordinated work to tackle the availability of drugs in the prison. A detailed supply reduction action plan should be implemented and integrated with the drug strategy. (S44)

5.2 Cells should be properly equipped with curtains, toilet screens, lockable cabinets and mattresses. Cells and showers should be properly ventilated. Prisoners should be able to obtain a regular supply of clean clothes and bedding. (S45)

5.3 Governance and management oversight of diversity should ensure that the needs of all prisoners with protected characteristics are identified, assessed and met, and that evidence of potential discrimination is addressed promptly. (S46)

5.4 Prisoners should spend the working day out of their cells, with good access to purposeful activity and association. They should also have time to attend to their domestic needs and at least one hour's outdoor exercise each day. (S47)

Recommendations — To the governor

Courts, escort and transfers

5.5 Prisoners should be held in court cells for the minimum period possible. (1.4, repeated recommendation 1.6)

Early days in custody

5.6 All prisoners who need one should have an effective induction that prepares them for life in the prison. (1.12)

Bullying and violence reduction

5.7 Prisoners' negative perceptions of their safety should be investigated and the findings acted on. (1.17)

5.8 Effective systems should be in place to monitor bullies and support victims. (1.18)

Self-harm and suicide

5.9 The health care and safer custody leads should implement promptly all recommendations from Prisons and Probation Ombudsman death in custody investigations. (1.22)

17.1

5.10 A multidisciplinary team of staff should attend assessment, care in custody and teamwork (ACCT) case reviews. (1.23)

5.11 Prisoners in crisis should be able to speak to a Listener at any time. (1.24)

Safeguarding

5.12 The prison and the local safeguarding adult board should develop effective safeguarding policies and procedures. (1.27)

Security

5.13 Strip-searching should be proportionate to the risks presented and intelligence-led searches should be prompt and subject to management checks. (1.36)

5.14 Closed visits should be used only for incidents that relate to visits. (1.37)

Incentives and earned privileges

5.15 Prisoners on the basic level of the incentives and earned privileges scheme should be helped to improve their behaviour, so they can move to the standard level. (1.41)

Discipline

5.16 Use of force paperwork should be completed thoroughly and subject to rigorous governance. (1.45)

5.17 Information about trends and patterns should be used strategically to help reduce the use of force. (1.46)

5.18 Cells and communal areas in the segregation unit should be clean and in good repair. (1.50)

5.19 All longer-stay prisoners should have management plans to ensure that their needs are met and to prevent psychological deterioration. (1.51)

5.20 All prisoners in segregation should have a radio, unless an individual risk assessment indicates otherwise. (1.52)

Substance misuse

5.21 Group work interventions should be open to prisoners regardless of where they are held in the prison. The range of substance misuse support services should be developed and include mutual aid groups. (1.58)

5.22 Prisoners undergoing detoxification, especially for alcohol, should be located in the health care centre with appropriate 24-hour monitoring and observation. (1.59)

Residential units

5.23 Cells designed for one should not be occupied by two prisoners. (2.7, repeated recommendation 2.8)

5.24 Managers should ensure that applications are dealt with promptly and effectively. (2.8)

Staff-prisoner relationships

5.25 There should be regular effective consultation forums with prisoners. (2.12)

Equality and diversity

5.26 Professional interpreting should be used when accuracy or confidentiality are required. (2.25)

Faith and religious activity

5.27 The reasons for prisoners' poor perceptions of religious activity should be investigated and the findings acted on. (2.30)

5.28 Prisoners should be able to attend religious services in facilities that are well ventilated, spacious, appropriately decorated and furnished. (2.31)

Legal rights

5.29 Prisoners should be able to access effective legal advice easily. (2.35)

Health services

5.30 The health partnership board should construct a plan to address the damp in the health centre, lack of space for mental health therapy, inhospitable waiting rooms, and refurbishment requirements of the wing treatment rooms. (2.46)

5.31 The health complaints system should preserve medical confidentiality. (2.47)

5.32 The inpatient unit should only accommodate patients with clinical needs. Its role and exclusion criteria should be clearly defined, agreed and monitored by the prison health partnership board. (2.53)

5.33 Prisoners should have secure storage for in-possession medication and systematic checks should be conducted. (2.62)

5.34 All medication should be administered according to the prescriber's directions at an appropriate time for maximum therapeutic effect. Administration records should be accurate and complete. (2.63)

5.35 The use of general stock should be reviewed to encourage the use of named-patient medication wherever possible. (2.64)

5.36 The range of patient group directions should be expanded to avoid unnecessary consultations with the doctor. Nurses should be trained in their use to ensure that procedures are correctly followed. (2.65)

5.37 A mental health service model capable of meeting the emotional and mental health needs of the population should be implemented. (2.75)

5.38 All staff in prisoner contact roles should be trained in mental health awareness. (2.76)

5.39 Transfers to community mental health services under the Mental Health Act should take place promptly. (2.77)

Catering

5.40 Prisoners working in the kitchens should be able to study for a national vocational qualification in catering. (2.81)

Purchases

5.41 Prisoners should be able to purchase and receive items within 24 hours of arrival. (2.83)

Learning and skills and work activities

5.42 The learning and skills management information system should measure the performance of all prisoners and teaching staff. (3.11)

5.43 The impact of learning and skills on prisoners' offending behaviour and employability on leaving prison should be evaluated. (3.12)

5.44 All prisoners should have equal access to the library. (3.33)

Physical education and healthy living

5.45 There should be dedicated PE sessions for prisoners with disabilities. (3.40)

Strategic management of resettlement

5.46 All resettlement staff should work in close cooperation, and as far as possible in close proximity, to ensure the best outcomes in reducing the risk of prisoners re-offending. (4.5)

Offender management and planning

5.47 A consistent team of offender supervisors, sufficient in number to meet the need, should deliver the core work of individual prisoner assessment and planning to a reliable standard. (4.10)

5.48 The interdepartmental risk management committee should provide governance of public protection systems and processes, in line with the published policy. (4.13)

5.49 IPP prisoners should not be held at HMP & YOI Cardiff unless there are clear opportunities to work on reducing the risk of re-offending. (4.17)

Reintegration planning

5.50 The CRC should have effective links with employers and further education institutions to support prisoners on release. (4.24)

5.51 Prisoners should be helped to apply to open a bank account. (4.28)

5.52 Prisoner waiting areas should be clean and properly maintained. (4.33)

5.53 The prison should have a coherent and realistic plan to deliver programmes appropriate to its population which meet identified need. (4.36, repeated recommendation 4.67)

Examples of good practice

5.54 Managers had taken appropriate measures to implement the smoking ban in April 2016, including training peer supporters to provide smoking cessation support and ensuring access to nicotine replacement therapy and e-cigarettes. Despite a short-term rise in violence, these measures had been reasonably effective. (1.38)

5.55 A Humanist celebrant attended the prison to support prisoners of no faith. (2.32)

5.56 The systematic use of a pro forma to obtain detailed information from prisoners' community GPs about their prescribed medication enabled the health care team to prescribe appropriately. (2.66)

5.57 A monthly forum, involving local and national agencies which support veterans, helped veterans prepare for a constructive life after prison. (4.37)

Section 5. Summary of recommendations and good practice

17.1

Section 6. Appendices

Appendix I: Inspection team

Peter Clarke	Chief inspector
Hindpal Singh Bhui	Team leader
Colin Carroll	Inspector
Fionnuala Gordon	Inspector
Martin Kettle	Inspector
Deri Hughes-Roberts	Inspector
Gordon Riach	Inspector
Natalie-Anne Hall	Researcher
Helen Ranns	Researcher
Anna Fenton	Researcher
Sigrid Engelen	Substance misuse inspector
Paul Tarbuck	Health services inspector
Helen Boniface	Pharmacy inspector
Alun Connick	Estyn inspector
Anthony Mulcahy	Estyn inspector
Gill Sims	Estyn inspector
Bob Smith	Offender management inspector
Jo Dowling	Offender management inspector
Helen Mercer	Offender management inspector

Section 6 – Appendix I: Inspection team

Appendix II: Progress on recommendations from the last report

The following is a summary of the main findings from the last report and a list of all the recommendations made, organised under the four tests of a healthy prison. The reference numbers at the end of each recommendation refer to the paragraph location in the previous report. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection in 2013, reception, first night and induction arrangements were good. Few prisoners felt unsafe and levels of violence and bullying were very low. B1 wing provided a supportive environment for prisoners less able to cope. Levels of self-harm were low but there had recently been four self-inflicted deaths in custody. Prisoners at risk of self-harm felt well supported but we were not assured that case management was effective. Illegal drugs were easily available but there was little targeted searching and there were few drug finds. The basic regime on the A1 landing was over-punitive, with insufficient safeguards. There were few adjudications and the level of use of force and segregation was low but insufficiently analysed. Substance misuse provision was reasonably good and the drug recovery wing was developing well. Outcomes for prisoners were reasonably good against this healthy prison test.

Main recommendation

The purpose and use of the A1 landing should be reviewed. Prisoners whose behaviour necessitates segregation should be formally segregated and subject to formal safeguards. (HP55)
Achieved

Recommendations

Prisoners should be held in court cells for the minimum period possible. (1.6)
Not achieved (Recommendation repeated, 1.4)

Night staff should speak to all new prisoners, provide support and check whether they have any specific needs. (1.12)
Achieved

Targets in tackling antisocial attitudes and behaviour books should be individualised, to address the specific attitudes and behaviour of prisoners. (1.19)
Not achieved

All staff should undergo up-to-date training in suicide prevention. (1.26)
Partially achieved

The quality of assessment, care in custody and teamwork (ACCT) documents, recording by case managers and the post-closure phase should be improved. (1.27)
Partially achieved

The prison should contact the Safeguarding Adults Strategic Management Board and Safeguarding Adults team to develop safeguarding policies for vulnerable adults. (1.30)
Not achieved

The prison should ensure that there are effective security measures to reduce the supply of both illicit drugs and diverted medication, including the monitoring of drug testing data. (1.36)
Not achieved

The application of the incentives and earned privileges (IEP) system should be reviewed and the generally poor prisoner perception investigated. (1.41)
Partially achieved

Prisoners on the basic level of the IEP scheme should have individualised progression targets with sufficient opportunity to demonstrate improvements. (1.42)
Not achieved

Use of force data should be collated and regularly analysed to identify trends. (1.50)
Partially achieved

All planned interventions should be video-recorded and reviewed. (1.51)
No longer relevant

Segregation unit cells should not routinely be monitored by closed-circuit television. (1.59)
Achieved

Graffiti should be removed from segregation unit cells, and toilets deep cleaned and refurbished where required. (1.60)
Not achieved

Subject to risk assessment, prisoners should be allowed to exercise together, and activities for those on long-term Rule 45 procedures should be provided wherever possible. (1.61)
Achieved

Joint-working protocols and practice should be further developed between the clinical substance misuse service and the psychosocial team to improve clinical reviews, care planning and care coordination. (1.74)
Achieved

The psychosocial team should have access to the SystmOne clinical record. (1.75)
Achieved

The psychosocial team should not be diverted to discipline duties. (1.76)
No longer relevant

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection in 2013, external areas and most wings were clean. Access to suitable bedding, clean clothes, showers and telephones was problematic. Staff–prisoner interaction was friendly and informal. Equality provision was effective, with a range of support for minority groups. Faith provision was good. The number of complaints was low and analysis was thorough. Legal services advice was comprehensive. Health services were reasonably good, although some waiting lists were too long. A wide range of mental health services was provided. The range and quality of the food provided were reasonably good. Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

Cells designed for one should not be occupied by two prisoners. (2.8)
Not achieved (Recommendation repeated, 2.7)

In-cell toilets should be adequately screened and communal showers should provide adequate privacy. (2.9)
Not achieved

The offensive display policy should be enforced and graffiti removed. (2.10)
Not achieved

Prisoners should have enough clean bedding and clothes for the week, including warm clothing for the winter. (2.11)
Not achieved

Regular, meaningful personal officer contact should be evidenced in case note entries. (2.18)
Not achieved

Governance and management oversight of diversity should be prioritised and the treatment of, and access to services by, minority groups should be monitored and action taken when required. (2.24)
Not achieved

The negative perceptions of black and minority ethnic prisoners should be further investigated and understood. (2.34)
Not achieved

Foreign national prisoners should be reliably provided with free monthly telephone calls. (2.35)
Achieved

Wing treatment rooms should be refurbished to meet infection control guidelines. (2.55)
Not achieved

An up-to-date health needs assessment should be commissioned. (2.56)
Achieved

Automated external defibrillators should be checked daily. (2.57)
Achieved

A strategy for health promotion should be developed. (2.58)
Not achieved

All prisoners should have access to primary and secondary mental health services. (2.62)
Partially achieved

The pharmacist should provide medicine use reviews. (2.69)
Not achieved

The in-possession policy should be updated and the risk assessments of each drug and patient documented, with reasons for the determination recorded. (2.70)
Achieved

Full and complete records of the administration of medicines should be made. (2.71)
Achieved

Prisoners should have timely access to dental care. (2.82)
Achieved

Prisoners should be able to receive a full shop order within 24 hours of arriving at the establishment. (2.93)
Not achieved

Purposeful activity

Prisoners are able, and expected, to engage in activity that is likely to benefit them.

At the last inspection in 2013, for employed prisoners time out of cell was reasonable but the many unemployed prisoners had only a few hours unlocked each day. There were too few activity places and not all of these were utilised. For those in activity, the quality and range of activities were good and provided effective work-related skills. Excellent use was made of peer mentors. Provision was suitably tailored to meet the needs of the short-term population. A wide range of qualifications was available. Success rates were mixed. Library and PE provision were good. Outcomes for prisoners were reasonably good against this healthy prison test.

Main recommendations

Opportunities for association should be increased and all prisoners should have access to association every day and during the evenings. (HP56)
Not achieved

The number of activity places should be increased and fully utilised. (HP57)
Achieved

Recommendations

Prisoners should be given the opportunity for at least one hour of exercise in the open air every day. (3.6)
Not achieved

Prisoners should have the opportunity for daily association, including in the evenings, during the week. (3.7)
Not achieved

The use of data should be improved to manage poorly performing areas of learning. (3.13)
Partially achieved

All prisoners' literacy and numeracy levels should be assessed on arrival at the prison or before starting education classes or work. (3.19)
Partially achieved

The number of essential skills classes should be increased to meet the needs of the population. (3.20)
Partially achieved

Clear strategies to promote the Welsh language and its value as a useful employment skill should be developed. (3.27)
Partially achieved

The number of qualifications above level 1 should be increased to meet the needs of more able prisoners. (3.33)
No longer relevant

Attendance and punctuality at all learning and skills activities should be improved.
Not achieved

Resettlement

Prisoners are prepared for their release back into the community and effectively helped to reduce the likelihood of reoffending.

At the last inspection in 2013, a good resettlement strategy was not supported by an action plan. Offender management did not effectively meet the needs of the high number of remand and short-term prisoners. Few prisoners had any meaningful offender supervisor contact or any form of custody plan. Categorisation, home detention curfew and public protection arrangements were sound. Too many life-sentenced prisoners were inappropriately located at the establishment. Initial assessment of resettlement needs was not sufficiently comprehensive and resettlement services were poorly coordinated. Pathway provision was mixed, although prisoners with substance misuse issues received excellent through-the-gate support, and children and family services were developing well. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Main recommendations

The needs of all prisoners, including short-term and remanded prisoners, should be identified, actioned and actively managed on a custody/sentence plan. (HP58)
Achieved

Resettlement provision should be coordinated and publicised, so that the reintegration needs of all prisoners are assessed on arrival and a reintegration plan formulated and actively managed. (HP59)
Achieved

Life-sentenced prisoners should be located at an establishment which provides a challenging regime and opportunities to progress during their sentence. (HP60)
Partially achieved

Recommendations

Implementation of the reducing reoffending strategy should be effectively managed, with the demonstrable commitment of senior managers, clear planning, the monitoring of outcomes and the involvement of all providers. (4.6)
Partially achieved

Cases posing a high or very high risk of harm to others should have effective management oversight. (4.20)
Achieved

Prisoners' views should be considered in categorisation reviews. (4.25)
Achieved

The criteria for moving prisoners on overcrowding drafts should take account of their sentence plan targets and family ties. (4.26)
No longer relevant.

The effectiveness of referrals for accommodation should be monitored and assessed to identify how the service can be improved. (4.39)
Achieved

The prison should improve its evaluation of pre-release programmes to ensure that they fully meet the education, training and employment needs of released prisoners. (4.42)
Achieved

Prisoners with financial problems should be given support to deal with outstanding debt. (4.51)
Achieved

Comfortable seating, which is not fixed to the floor, should be provided. (4.60)
Not achieved

The closed visits booths should provide adequate comfortable seating and good communication between prisoners and visitors. (4.61)
Not achieved

The prison should have a coherent and realistic plan to deliver programmes appropriate to its population which meet identified need. (4.67)
Not achieved (Recommendation repeated, 4.36)

Appendix III: Prison population profile

Please note: the following figures were supplied by the establishment and any errors are the establishment's own.

Population breakdown by:

Status	18–20 yr olds	21 and over	%
Sentenced	16	462	62.1
Recall	3	86	11.6
Convicted unsentenced	9	83	11.9
Remand	5	101	13.8
Civil prisoners	0	1	0.1
Detainees	0	3	0.4
Total	**33**	**737**	**100**

Sentence	18–20 yr olds	21 and over	%
Unsentenced	15	195	27.3
Less than six months	7	167	22.6
six months to less than 12 months	1	113	14.8
12 months to less than 2 years	7	74	10.5
2 years to less than 4 years	2	47	6.4
4 years to less than 10 years	0	68	8.8
10 years and over (not life)	0	5	0.6
ISPP (indeterminate sentence for public protection)	0	17	2.2
Life	0	16	4.3
Total	**33**	**737**	**100**

Age	Number of prisoners	%
Please state minimum age here: 18		
Under 21 years	33	4.3
21 years to 29 years	267	34.7
30 years to 39 years	280	36.4
40 years to 49 years	140	18.2
50 years to 59 years	43	5.6
60 years to 69 years	7	0.9
70 plus years	0	0
Please state maximum age here : 68		
Total	**770**	**100**

Nationality	18–20 yr olds	21 and over	%
British	30	692	93.8
Foreign nationals	3	43	6
Not stated	0	2	0.3
Total	**33**	**737**	**100**

Security category	18–20 yr olds	21 and over	%
Uncategorised unsentenced	16	209	29.2
Uncategorised sentenced	2	30	4.2
Category A	0	0	0
Category B	0	11	1.4
Category C	1	471	61.3
Category D	0	15	1.9
YOI Closed	14	1	1.9
Total	**33**	**737**	**100**

Ethnicity	18–20 yr olds	21 and over	%
White			
British	26	609	82.5
Irish	0	3	0.4
Gypsy/Irish Traveller	0	8	1
Other white	2	17	2.5
Mixed			
White and black Caribbean	1	13	1.8
White and black African	0	3	0.4
White and Asian	0	9	1.2
Other mixed	0	4	0.5
Asian or Asian British			
Indian	0	3	0.4
Pakistani	1	8	1.2
Bangladeshi	0	4	0.5
Chinese	0	0	0
Other Asian	1	7	1
Black or black British			
Caribbean	0	10	1.3
African	1	17	2.3
Other black	0	7	0.9
Other ethnic group			
Arab	0	1	0.1
Other ethnic group	0	4	0.5
Not stated	1	10	1.4
Total	**33**	**737**	**100**

Religion	18–20 yr olds	21 and over	%
Baptist	0	0	0
Church of England	0	39	5.1
Roman Catholic	1	109	14.3
Other Christian denominations	10	164	22.6
Muslim	4	71	9.7
Sikh	0	3	0.4
Hindu	0	1	0.1
Buddhist	0	3	0.4
Jewish	0	1	0.1
Other	1	9	1.1
No religion	17	337	46
Total	**33**	**737**	**100**

Other demographics	18–20 yr olds	21 and over	%
Veteran (ex-armed services)			
Total			

Sentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
Less than 1 month	9	1.2	194	25.2
1 month to 3 months	5	0.6	209	27.1
3 months to six months	4	0.5	83	10.8
six months to 1 year	0	0	37	4.8
1 year to 2 years	0	0	15	1.9
2 years to 4 years	0	0	2	0.3
4 years or more	0	0	2	0.3
Total	**18**	**2.3**	**542**	**70.4**

Sentenced prisoners only

	18–20 yr olds	21 and over	%
Foreign nationals detained post sentence expiry	0	0	0
Public protection cases (this does not refer to public protection sentence categories but cases requiring monitoring/ restrictions).	0	0	0
Total	**0**	**0**	**0**

Unsentenced prisoners only

Length of stay	18–20 yr olds		21 and over	
	Number	%	Number	%
Less than 1 month	8	3.8	78	37.1
1 month to 3 months	3	1.4	70	33.3
3 months to six months	3	1.4	38	18.1
six months to 1 year	1	0.5	9	4.3
1 year to 2 years	0	0	0	0
2 years to 4 years	0	0	0	0
4 years or more	0	0	0	0
Total	**15**	**1.9**	**195**	**25.3**

17.1

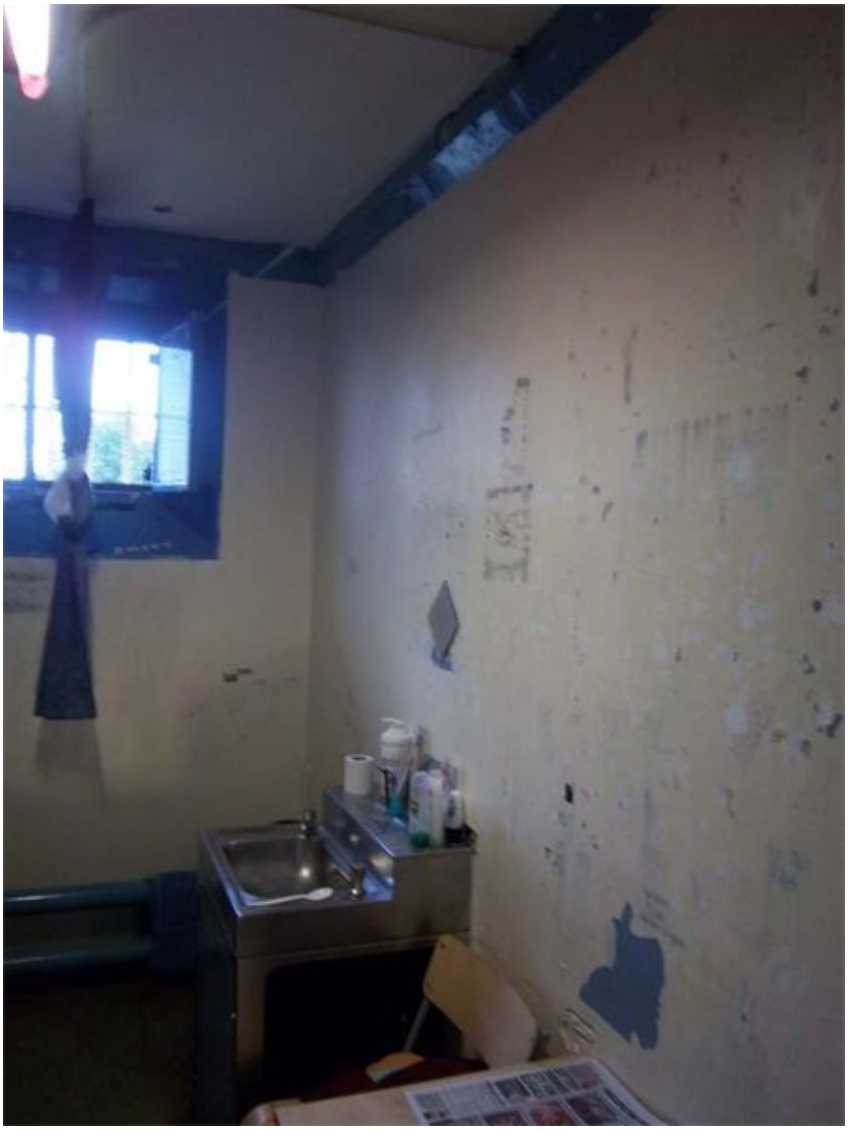
Section 6 – Appendix III: Prison population profile

Main offence	18–20 yr olds	21 and over	%
Report states: Not currently available			
Total			

17.1

Appendix IV: Photographs

Cell



Cell

Appendix V: Summary of prisoner questionnaires and interviews

Prisoner survey methodology

A voluntary, confidential and anonymous survey of a representative proportion of the prisoner population was carried out for this inspection. The results of this survey formed part of the evidence base for the inspection.

Sampling

The prisoner survey was conducted on a representative sample of the prison population. Using a robust statistical formula provided by a government department statistician we calculated the sample size required to ensure that our survey findings reflected the experiences of the entire population of the establishment[16]. Respondents were then randomly selected from a P-Nomis prisoner population printout using a stratified systematic sampling method. We also ensured that the proportion of black and minority ethnic prisoners in the sample reflected the proportion in the prison as a whole.

Distributing and collecting questionnaires

Every attempt was made to distribute the questionnaires to respondents individually. This gave researchers an opportunity to explain the purpose of the survey and to answer respondents' questions. We also stressed the voluntary nature of the survey and provided assurances about confidentiality and the independence of the Inspectorate. This information is also provided in writing on the front cover of the questionnaire.

Our questionnaire is available in a number of different languages and via a telephone translation service for respondents who do not read English. Respondents with literacy difficulties were offered the option of an interview.

Respondents were not asked to put their names on their questionnaire. In order to ensure confidentiality, respondents were asked to seal their completed questionnaire in the envelope provided and either hand it back to a member of the research team at a specified time or leave it in their room for collection.

Refusals were noted and no attempts were made to replace them.

Survey response

At the time of the survey on 25 July 2016 the prisoner population at HMP & YOI Cardiff was 770. Using the method described above, questionnaires were distributed to a sample of 218 prisoners.

We received a total of 194 completed questionnaires, a response rate of 89%. This included nine questionnaires completed via interview. Nine respondents refused to complete a questionnaire and 15 questionnaires were not returned.

[16] 95% confidence interval with a sampling error of 7%. The formula assumes an 75% response rate (65% in open establishments) and we routinely 'oversample' to ensure we achieve the minimum number of responses required.

Wing/unit	Number of completed survey returns
A	41
B	35
C	8
D	16
E	24
F	38
A1	5
B1	10
F1	10
Health care	5
Segregation unit	2

Presentation of survey results and analyses

Over the following pages we present the survey results for HMP & YOI Cardiff.

First a full breakdown of responses is provided for each question. In this full breakdown all percentages, including those for filtered questions, refer to the full sample. Percentages have been rounded and therefore may not add up to 100%.

We also present a number of comparative analyses. In all the comparative analyses that follow, statistically significant differences[17] are indicated by shading. Results that are significantly better are indicated by green shading, results that are significantly worse are indicated by blue shading. If the difference is not statistically significant there is no shading. Orange shading has been used to show a statistically significant difference in prisoners' background details.

Filtered questions are clearly indented and preceded by an explanation of how the filter has been applied. Percentages for filtered questions refer to the number of respondents filtered to that question. For all other questions, percentages refer to the entire sample. All missing responses have been excluded from analyses.

Percentages shown in the full breakdown may differ slightly from those shown in the comparative analyses. This is because the data have been weighted to enable valid statistical comparison between establishments.

The following comparative analyses are presented:

- The current survey responses from HMP & YOI Cardiff in 2016 compared with responses from prisoners surveyed in all other local prisons. This comparator is based on all responses from prisoner surveys carried out in 33 local prisons since April 2013.
- The current survey responses from HMP & YOI Cardiff in 2016 compared with the responses of prisoners surveyed at HMP & YOI Cardiff in 2013.
- A comparison within the 2016 survey between the responses of white prisoners and those from a black and minority ethnic group.
- A comparison within the 2016 survey between the responses of prisoners who consider themselves to have a disability and those who do not consider themselves to have a disability.

[17] A statistically significant difference between the two samples is one that is unlikely to have arisen by chance alone, and can therefore be assumed to represent a real difference between the two populations. Our significance level is set at 0.01 which means that there is only a 1% likelihood that the difference is due to chance.

Survey summary

Section 1: About You

Q1.2 How old are you?

Under 21	10 (5%)
21 - 29	68 (35%)
30 - 39	70 (36%)
40 - 49	33 (17%)
50 - 59	9 (5%)
60 - 69	2 (1%)
70 and over	0 (0%)

Q1.3 Are you sentenced?

Yes	120 (63%)
Yes - on recall	18 (9%)
No - awaiting trial	33 (17%)
No - awaiting sentence	20 (10%)
No - awaiting deportation	1 (1%)

Q1.4 How long is your sentence?

Not sentenced	54 (29%)
Less than 6 months	52 (28%)
6 months to less than 1 year	29 (16%)
1 year to less than 2 years	13 (7%)
2 years to less than 4 years	13 (7%)
4 years to less than 10 years	15 (8%)
10 years or more	1 (1%)
IPP (indeterminate sentence for public protection)	5 (3%)
Life	4 (2%)

Q1.5 Are you a foreign national (i.e. do not have UK citizenship)?

Yes	16 (8%)
No	173 (92%)

Q1.6 Do you understand spoken English?

Yes	188 (99%)
No	1 (1%)

Q1.7 Do you understand written English?

Yes	185 (98%)
No	4 (2%)

Q1.8 What is your ethnic origin?

White - British (English/ Welsh/ Scottish/ Northern Irish)	142 (76%)	*Asian or Asian British - Chinese*	1 (1%)
White - Irish	3 (2%)	*Asian or Asian British - other*	0 (0%)
White - other	9 (5%)	*Mixed race - white and black Caribbean*	7 (4%)
Black or black British - Caribbean	4 (2%)	*Mixed race - white and black African*	3 (2%)
Black or black British - African	5 (3%)	*Mixed race - white and Asian*	1 (1%)
Black or black British - other	0 (0%)	*Mixed race - other*	0 (0%)
Asian or Asian British - Indian	2 (1%)	*Arab*	1 (1%)
Asian or Asian British - Pakistani	4 (2%)	*Other ethnic group*	4 (2%)
Asian or Asian British - Bangladeshi	1 (1%)		

17.1

Q1.9 Do you consider yourself to be Gypsy/ Romany/ Traveller?

Yes	5 (3%)
No	179 (97%)

Q1.10 What is your religion?

None	84 (45%)	*Hindu*	0 (0%)
Church of England	24 (13%)	*Jewish*	0 (0%)
Catholic	29 (16%)	*Muslim*	18 (10%)
Protestant	3 (2%)	*Sikh*	1 (1%)
Other Christian denomination	20 (11%)	*Other*	7 (4%)
Buddhist	0 (0%)		

Q1.11 How would you describe your sexual orientation?

Heterosexual/ Straight	176 (96%)
Homosexual/Gay	4 (2%)
Bisexual	3 (2%)

Q1.12 Do you consider yourself to have a disability (i.e. do you need help with any long-term physical, mental or learning needs)?

Yes	68 (36%)
No	119 (64%)

Q1.13 Are you a veteran (ex- armed services)?

Yes	11 (6%)
No	174 (94%)

Q1.14 Is this your first time in prison?

Yes	44 (24%)
No	142 (76%)

Q1.15 Do you have children under the age of 18?

Yes	110 (59%)
No	77 (41%)

Section 2: Courts, transfers and escorts

Q2.1 On your most recent journey here, how long did you spend in the van?

Less than 2 hours	147 (78%)
2 hours or longer	31 (16%)
Don't remember	10 (5%)

Q2.2 On your most recent journey here, were you offered anything to eat or drink?

My journey was less than two hours	147 (79%)
Yes	17 (9%)
No	19 (10%)
Don't remember	3 (2%)

Q2.3 On your most recent journey here, were you offered a toilet break?

My journey was less than two hours	147 (79%)
Yes	3 (2%)
No	36 (19%)
Don't remember	1 (1%)

Q2.4 On your most recent journey here, was the van clean?

Yes	116 (62%)
No	57 (30%)
Don't remember	14 (7%)

Q2.5 On your most recent journey here, did you feel safe?

Yes	137 (74%)
No	43 (23%)
Don't remember	6 (3%)

Q2.6 On your most recent journey here, how were you treated by the escort staff?

Very well	52 (28%)
Well	85 (45%)
Neither	36 (19%)
Badly	6 (3%)
Very badly	3 (2%)
Don't remember	6 (3%)

Q2.7 Before you arrived, were you given anything or told that you were coming here? (Please tick all that apply to you.)

Yes, someone told me	142 (75%)
Yes, I received written information	6 (3%)
No, I was not told anything	35 (19%)
Don't remember	10 (5%)

Q2.8 When you first arrived here did your property arrive at the same time as you?

Yes	158 (84%)
No	20 (11%)
Don't remember	9 (5%)

Section 3: Reception, first night and induction

Q3.1 How long were you in reception?

Less than 2 hours	82 (43%)
2 hours or longer	97 (51%)
Don't remember	12 (6%)

Q3.2 When you were searched, was this carried out in a respectful way?

Yes	142 (76%)
No	34 (18%)
Don't remember	11 (6%)

Q3.3 Overall, how were you treated in reception?

Very well	39 (21%)
Well	83 (44%)
Neither	46 (24%)
Badly	15 (8%)
Very badly	3 (2%)
Don't remember	3 (2%)

Q3.4 Did you have any of the following problems when you first arrived here? (Please tick all that apply to you.)

Loss of property	20 (11%)	*Physical health*	27 (15%)
Housing problems	44 (24%)	*Mental health*	78 (42%)
Contacting employers	13 (7%)	*Needing protection from other prisoners*	12 (6%)
Contacting family	49 (26%)	*Getting phone numbers*	50 (27%)
Childcare	5 (3%)	*Other*	12 (6%)
Money worries	37 (20%)	*Did not have any problems*	42 (23%)
Feeling depressed or suicidal	59 (32%)		

Q3.5 Did you receive any help/support from staff in dealing with these problems when you first arrived here?

Yes	56 (31%)
No	83 (46%)
Did not have any problems	42 (23%)

Q3.6 When you first arrived here, were you offered any of the following? (Please tick all that apply to you.)

Tobacco	44 (23%)
A shower	82 (44%)
A free telephone call	141 (75%)
Something to eat	132 (70%)
PIN phone credit	127 (68%)
Toiletries/ basic items	107 (57%)
Did not receive anything	9 (5%)

Q3.7 When you first arrived here, did you have access to the following people or services? (Please tick all that apply to you.)

Chaplain	81 (45%)
Someone from health services	105 (58%)
A Listener/Samaritans	39 (21%)
Prison shop/ canteen	30 (16%)
Did not have access to any of these	45 (25%)

Q3.8 When you first arrived here, were you offered information on the following? (Please tick all that apply to you.)

What was going to happen to you	67 (39%)
What support was available for people feeling depressed or suicidal	52 (31%)
How to make routine requests (applications)	44 (26%)
Your entitlement to visits	43 (25%)
Health services	51 (30%)
Chaplaincy	54 (32%)
Not offered any information	64 (38%)

Q3.9 Did you feel safe on your first night here?

Yes	126 (66%)
No	55 (29%)
Don't remember	10 (5%)

Q3.10 How soon after you arrived here did you go on an induction course?

Have not been on an induction course	80 (42%)
Within the first week	49 (26%)
More than a week	48 (25%)
Don't remember	12 (6%)

Q3.11 Did the induction course cover everything you needed to know about the prison?

Have not been on an induction course	80 (42%)
Yes	44 (23%)
No	53 (28%)
Don't remember	13 (7%)

Q3.12 How soon after you arrived here did you receive an education ('skills for life') assessment?

Did not receive an assessment	68 (37%)
Within the first week	32 (17%)
More than a week	71 (39%)
Don't remember	13 (7%)

Section 4: Legal rights and respectful custody

Q4.1 How easy is it to.....

	Very easy	*Easy*	*Neither*	*Difficult*	*Very difficult*	*N/A*
Communicate with your solicitor or legal representative?	17 (9%)	53 (30%)	25 (14%)	38 (21%)	32 (18%)	14 (8%)
Attend legal visits?	18 (11%)	64 (38%)	31 (18%)	21 (12%)	14 (8%)	21 (12%)
Get bail information?	5 (3%)	22 (13%)	36 (22%)	32 (19%)	33 (20%)	37 (22%)

Q4.2 Have staff here ever opened letters from your solicitor or your legal representative when you were not with them?

Not had any letters	31 (17%)
Yes	69 (38%)
No	80 (44%)

Q4.3 Can you get legal books in the library?

Yes	49 (27%)
No	20 (11%)
Don't know	110 (61%)

Q4.4 Please answer the following questions about the wing/unit you are currently living on:

	Yes	*No*	*Don't know*
Do you normally have enough clean, suitable clothes for the week?	37 (20%)	148 (79%)	3 (2%)
Are you normally able to have a shower every day?	144 (77%)	41 (22%)	2 (1%)
Do you normally receive clean sheets every week?	106 (58%)	73 (40%)	3 (2%)
Do you normally get cell cleaning materials every week?	72 (39%)	107 (58%)	4 (2%)
Is your cell call bell normally answered within five minutes?	30 (16%)	139 (75%)	17 (9%)
Is it normally quiet enough for you to be able to relax or sleep in your cell at night time?	84 (46%)	95 (52%)	4 (2%)
If you need to, can you normally get your stored property?	23 (13%)	109 (61%)	48 (27%)

Q4.5 What is the food like here?

Very good	3 (2%)
Good	38 (20%)
Neither	50 (26%)
Bad	52 (27%)
Very bad	47 (25%)

Q4.6 Does the shop/canteen sell a wide enough range of goods to meet your needs?

Have not bought anything yet/ don't know	20 (11%)
Yes	83 (45%)
No	83 (45%)

Q4.7 Can you speak to a Listener at any time, if you want to?

Yes	80 (43%)
No	25 (14%)
Don't know	79 (43%)

Q4.8 Are your religious beliefs respected?

Yes	62 (34%)
No	24 (13%)
Don't know/ N/A	99 (54%)

Q4.9 Are you able to speak to a Chaplain of your faith in private if you want to?

Yes	83 (45%)
No	18 (10%)
Don't know/ N/A	85 (46%)

Q4.10 How easy or difficult is it for you to attend religious services?

I don't want to attend	43 (23%)
Very easy	29 (16%)
Easy	39 (21%)
Neither	9 (5%)
Difficult	13 (7%)
Very difficult	11 (6%)
Don't know	40 (22%)

Section 5: Applications and complaints

Q5.1 Is it easy to make an application?

Yes	111 (59%)
No	56 (30%)
Don't know	20 (11%)

Q5.2 Please answer the following questions about applications. (If you have not made an application please tick the 'not made one' option.)

	Not made one	*Yes*	*No*
Are *applications* dealt with fairly?	33 (19%)	56 (32%)	87 (49%)
Are *applications* dealt with quickly (within seven days)?	33 (19%)	44 (25%)	97 (56%)

Q5.3 Is it easy to make a complaint?

Yes	74 (41%)
No	45 (25%)
Don't know	61 (34%)

Q5.4 Please answer the following questions about complaints (If you have not made a complaint please tick the 'not made one' option.)

	Not made one	*Yes*	*No*
Are *complaints* dealt with fairly?	92 (50%)	25 (14%)	67 (36%)
Are complaints dealt with quickly (within seven days)?	92 (51%)	17 (9%)	70 (39%)

Q5.5 Have you ever been prevented from making a complaint when you wanted to?

Yes	36 (20%)
No	143 (80%)

17.1

Q5.6 How easy or difficult is it for you to see the Independent Monitoring Board (IMB)?

Don't know who they are	68 (38%)
Very easy	14 (8%)
Easy	20 (11%)
Neither	34 (19%)
Difficult	29 (16%)
Very difficult	12 (7%)

Section 6: Incentive and earned privileges scheme

Q6.1 Have you been treated fairly in your experience of the incentive and earned privileges (IEP) scheme? (This refers to enhanced, standard and basic levels.)

Don't know what the IEP scheme is	29 (16%)
Yes	62 (34%)
No	58 (32%)
Don't know	32 (18%)

Q6.2 Do the different levels of the IEP scheme encourage you to change your behaviour? (This refers to enhanced, standard and basic levels.)

Don't know what the IEP scheme is	29 (16%)
Yes	67 (38%)
No	60 (34%)
Don't know	22 (12%)

Q6.3 In the last six months have any members of staff physically restrained you (C&R)?

Yes	16 (9%)
No	167 (91%)

Q6.4 If you have spent a night in the segregation/care and separation unit in the last six months, how were you treated by staff?

I have not been to segregation in the last 6 months	145 (81%)
Very well	4 (2%)
Well	7 (4%)
Neither	9 (5%)
Badly	6 (3%)
Very badly	7 (4%)

Section 7: Relationships with staff

Q7.1 Do most staff treat you with respect?

Yes	130 (71%)
No	53 (29%)

Q7.2 Is there a member of staff you can turn to for help if you have a problem?

Yes	128 (72%)
No	51 (28%)

Q7.3 Has a member of staff checked on you personally in the last week to see how you are getting on?

Yes	48 (26%)
No	138 (74%)

Q7.4 How often do staff normally speak to you during association?

Do not go on association	8 (4%)
Never	47 (25%)
Rarely	41 (22%)
Some of the time	58 (31%)
Most of the time	23 (12%)
All of the time	8 (4%)

Q7.5 When did you first meet your personal (named) officer?

I have not met him/her	124 (67%)
In the first week	26 (14%)
More than a week	23 (13%)
Don't remember	11 (6%)

Q7.6 How helpful is your personal (named) officer?

Do not have a personal officer/ I have not met him/ her	124 (68%)
Very helpful	17 (9%)
Helpful	22 (12%)
Neither	11 (6%)
Not very helpful	5 (3%)
Not at all helpful	3 (2%)

Section 8: Safety

Q8.1 Have you ever felt unsafe here?

Yes	89 (47%)
No	99 (53%)

Q8.2 Do you feel unsafe now?

Yes	43 (23%)
No	141 (77%)

Q8.3 In which areas have you felt unsafe? (Please tick all that apply to you.)

Never felt unsafe	99 (54%)	*At meal times*	16 (9%)
Everywhere	32 (17%)	*At health services*	16 (9%)
Segregation unit	8 (4%)	*Visits area*	27 (15%)
Association areas	38 (21%)	*In wing showers*	32 (17%)
Reception area	14 (8%)	*In gym showers*	13 (7%)
At the gym	12 (6%)	*In corridors/stairwells*	27 (15%)
In an exercise yard	26 (14%)	*On your landing/wing*	35 (19%)
At work	20 (11%)	*In your cell*	25 (14%)
During movement	28 (15%)	*At religious services*	10 (5%)
At education	11 (6%)		

Q8.4 Have you been victimised by other prisoners here?

Yes	48 (26%)
No	137 (74%)

17.1

Q8.5 If yes, what did the incident(s) involve/ what was it about? (Please tick all that apply to you.)

Insulting remarks (about you or your family or friends)	24 (13%)
Physical abuse (being hit, kicked or assaulted)	14 (8%)
Sexual abuse	5 (3%)
Feeling threatened or intimidated	32 (17%)
Having your canteen/property taken	13 (7%)
Medication	11 (6%)
Debt	9 (5%)
Drugs	11 (6%)
Your race or ethnic origin	12 (6%)
Your religion/religious beliefs	9 (5%)
Your nationality	10 (5%)
You are from a different part of the country than others	11 (6%)
You are from a traveller community	3 (2%)
Your sexual orientation	7 (4%)
Your age	2 (1%)
You have a disability	10 (5%)
You were new here	11 (6%)
Your offence/ crime	8 (4%)
Gang related issues	8 (4%)

Q8.6 Have you been victimised by staff here?

Yes	51 (27%)
No	135 (73%)

Q8.7 If yes, what did the incident(s) involve/ what was it about? (Please tick all that apply to you.)

Insulting remarks (about you or your family or friends)	21 (11%)
Physical abuse (being hit, kicked or assaulted)	9 (5%)
Sexual abuse	4 (2%)
Feeling threatened or intimidated	30 (16%)
Medication	13 (7%)
Debt	4 (2%)
Drugs	8 (4%)
Your race or ethnic origin	10 (5%)
Your religion/religious beliefs	8 (4%)
Your nationality	8 (4%)
You are from a different part of the country than others	8 (4%)
You are from a traveller community	2 (1%)
Your sexual orientation	4 (2%)
Your age	2 (1%)
You have a disability	9 (5%)
You were new here	7 (4%)
Your offence/ crime	4 (2%)
Gang related issues	3 (2%)

Q8.8 If you have been victimised by prisoners or staff, did you report it?

Not been victimised	111 (63%)
Yes	24 (14%)
No	41 (23%)

Section 9: Health services

Q9.1 How easy or difficult is it to see the following people?:

	Don't know	*Very easy*	*Easy*	*Neither*	*Difficult*	*Very difficult*
The doctor	25 (14%)	12 (7%)	37 (20%)	24 (13%)	51 (28%)	33 (18%)
The nurse	16 (9%)	40 (23%)	65 (37%)	23 (13%)	18 (10%)	12 (7%)
The dentist	43 (25%)	4 (2%)	11 (6%)	21 (12%)	43 (25%)	48 (28%)

17.1

Q9.2 What do you think of the quality of the health service from the following people?:

	Not been	*Very good*	*Good*	*Neither*	*Bad*	*Very bad*
The doctor	39 (22%)	12 (7%)	35 (20%)	25 (14%)	35 (20%)	33 (18%)
The nurse	22 (13%)	31 (18%)	47 (27%)	31 (18%)	26 (15%)	19 (11%)
The dentist	67 (39%)	7 (4%)	16 (9%)	30 (17%)	26 (15%)	26 (15%)

Q9.3 What do you think of the overall quality of the health services here?

Not been	15 (9%)
Very good	12 (7%)
Good	35 (21%)
Neither	36 (21%)
Bad	40 (24%)
Very bad	31 (18%)

Q9.4 Are you currently taking medication?

Yes	105 (56%)
No	81 (44%)

Q9.5 If you are taking medication, are you allowed to keep some/ all of it in your own cell?

Not taking medication	81 (44%)
Yes, all my meds	14 (8%)
Yes, some of my meds	27 (15%)
No	61 (33%)

Q9.6 Do you have any emotional or mental health problems?

Yes	116 (61%)
No	73 (39%)

Q9.7 Are you being helped/ supported by anyone in this prison (e.g. a psychologist, psychiatrist, nurse, mental health worker, counsellor or any other member of staff)?

Do not have any emotional or mental health problems	73 (40%)
Yes	36 (20%)
No	73 (40%)

Section 10: Drugs and alcohol

Q10.1 Did you have a problem with drugs when you came into this prison?

Yes	88 (47%)
No	99 (53%)

Q10.2 Did you have a problem with alcohol when you came into this prison?

Yes	49 (26%)
No	137 (74%)

Q10.3 Is it easy or difficult to get illegal drugs in this prison?

Very easy	55 (30%)
Easy	34 (19%)
Neither	13 (7%)
Difficult	8 (4%)
Very difficult	10 (6%)
Don't know	61 (34%)

17.1

Q10.4 Is it easy or difficult to get alcohol in this prison?

Very easy	12 (7%)
Easy	15 (8%)
Neither	15 (8%)
Difficult	19 (10%)
Very difficult	20 (11%)
Don't know	101 (55%)

Q10.5 Have you developed a problem with illegal drugs since you have been in this prison?

Yes	23 (13%)
No	159 (87%)

Q10.6 Have you developed a problem with diverted medication since you have been in this prison?

Yes	25 (14%)
No	157 (86%)

Q10.7 Have you received any support or help (for example substance misuse teams) for your drug problem, while in this prison?

Did not/ do not have a drug problem	85 (48%)
Yes	37 (21%)
No	55 (31%)

Q10.8 Have you received any support or help (for example substance misuse teams) for your alcohol problem, whilst in this prison?

Did not/ do not have an alcohol problem	137 (75%)
Yes	17 (9%)
No	29 (16%)

Q10.9 Was the support or help you received, whilst in this prison, helpful?

Did not have a problem/ did not receive help	130 (75%)
Yes	23 (13%)
No	21 (12%)

Section 11: Activities

Q11.1 How easy or difficult is it to get into the following activities, in this prison?

	Don't know	*Very Easy*	*Easy*	*Neither*	*Difficult*	*Very difficult*
Prison job	21 (11%)	22(12%)	63 (34%)	18 (10%)	31 (17%)	30 (16%)
Vocational or skills training	39 (22%)	14 (8%)	35 (20%)	26 (15%)	39 (22%)	22 (13%)
Education (including basic skills)	32 (18%)	17(10%)	53 (30%)	22 (12%)	33 (19%)	20 (11%)
Offending behaviour programmes	50 (30%)	5 (3%)	25 (15%)	24 (14%)	34 (20%)	31 (18%)

Q11.2 Are you currently involved in the following? (Please tick all that apply to you.)

Not involved in any of these	71 (41%)
Prison job	85 (49%)
Vocational or skills training	12 (7%)
Education (including basic skills)	15 (9%)
Offending behaviour programmes	5 (3%)

17.1

Q11.3 If you have been involved in any of the following, while in this prison, do you think they will help you on release?

	Not been involved	*Yes*	*No*	*Don't know*
Prison job	49 (30%)	37 (22%)	63 (38%)	17 (10%)
Vocational or skills training	69 (49%)	31 (22%)	31 (22%)	10 (7%)
Education (including basic skills)	67 (47%)	36 (25%)	31 (22%)	9 (6%)
Offending behaviour programmes	72 (52%)	25 (18%)	30 (22%)	12 (9%)

Q11.4 How often do you usually go to the library?

Don't want to go	44 (24%)
Never	61 (33%)
Less than once a week	30 (16%)
About once a week	45 (25%)
More than once a week	3 (2%)

Q11.5 Does the library have a wide enough range of materials to meet your needs?

Don't use it	82 (47%)
Yes	46 (26%)
No	48 (27%)

Q11.6 How many times do you usually go to the gym each week?

Don't want to go	41 (23%)
0	39 (22%)
1 to 2	55 (31%)
3 to 5	42 (23%)
More than 5	3 (2%)

Q11.7 How many times do you usually go outside for exercise each week?

Don't want to go	32 (17%)
0	20 (11%)
1 to 2	40 (22%)
3 to 5	56 (30%)
More than 5	36 (20%)

Q11.8 How many times do you usually have association each week?

Don't want to go	7 (4%)
0	3 (2%)
1 to 2	22 (12%)
3 to 5	62 (34%)
More than 5	91 (49%)

Q11.9 How many hours do you usually spend out of your cell on a weekday? (Please include hours at education, at work etc.)

Less than 2 hours	71 (38%)
2 to less than 4 hours	33 (18%)
4 to less than 6 hours	29 (16%)
6 to less than 8 hours	22 (12%)
8 to less than 10 hours	8 (4%)
10 hours or more	10 (5%)
Don't know	13 (7%)

17.1

Section 12: Contact with family and friends

Q12.1 Have staff supported you and helped you to maintain contact with your family/friends while in this prison?

Yes	42 (24%)
No	136 (76%)

Q12.2 Have you had any problems with sending or receiving mail (letters or parcels)?

Yes	59 (33%)
No	120 (67%)

Q12.3 Have you had any problems getting access to the telephones?

Yes	49 (27%)
No	132 (73%)

Q12.4 How easy or difficult is it for your family and friends to get here?

I don't get visits	42 (23%)
Very easy	28 (15%)
Easy	42 (23%)
Neither	17 (9%)
Difficult	33 (18%)
Very difficult	15 (8%)
Don't know	4 (2%)

Section 13: Preparation for release

Q13.1 Do you have a named offender manager (home probation officer) in the probation service?

Not sentenced	54 (30%)
Yes	71 (39%)
No	57 (31%)

Q13.2 What type of contact have you had with your offender manager since being in prison? (Please tick all that apply to you.)

Not sentenced/ NA	111 (61%)
No contact	45 (25%)
Letter	13 (7%)
Phone	8 (4%)
Visit	15 (8%)

Q13.3 Do you have a named offender supervisor in this prison?

Yes	28 (16%)
No	151 (84%)

Q13.4 Do you have a sentence plan?

Not sentenced	54 (30%)
Yes	18 (10%)
No	110 (60%)

Q13.5 How involved were you in the development of your sentence plan?

Do not have a sentence plan/ not sentenced	164 (89%)
Very involved	3 (2%)
Involved	10 (5%)
Neither	1 (1%)
Not very involved	2 (1%)
Not at all involved	4 (2%)

17.1

Q13.6 Who is working with you to achieve your sentence plan targets? (Please tick all that apply to you.)

Do not have a sentence plan/ not sentenced	164 (89%)
Nobody	13 (7%)
Offender supervisor	4 (2%)
Offender manager	3 (2%)
Named/ personal officer	1 (1%)
Staff from other departments	5 (3%)

Q13.7 Can you achieve any of your sentence plan targets in this prison?

Do not have a sentence plan/ not sentenced	164 (90%)
Yes	7 (4%)
No	7 (4%)
Don't know	5 (3%)

Q13.8 Are there plans for you to achieve any of your sentence plan targets in another prison?

Do not have a sentence plan/ not sentenced	164 (89%)
Yes	4 (2%)
No	10 (5%)
Don't know	6 (3%)

Q13.9 Are there plans for you to achieve any of your sentence plan targets in the community?

Do not have a sentence plan/ not sentenced	164 (90%)
Yes	8 (4%)
No	6 (3%)
Don't know	5 (3%)

Q13.10 Do you have a needs based custody plan?

Yes	8 (5%)
No	77 (44%)
Don't know	91 (52%)

Q13.11 Do you feel that any member of staff has helped you to prepare for your release?

Yes	11 (6%)
No	164 (94%)

Q13.12 Do you know of anyone in this prison who can help you with the following on release? (Please tick all that apply to you.)

	Do not need help	*Yes*	*No*
Employment	39 (24%)	25 (15%)	101 (61%)
Accommodation	37 (22%)	40 (24%)	88 (53%)
Benefits	36 (22%)	42 (25%)	88 (53%)
Finances	38 (25%)	23 (15%)	94 (61%)
Education	45 (29%)	22 (14%)	88 (57%)
Drugs and alcohol	41 (25%)	42 (25%)	82 (50%)

Q13.13 Have you done anything, or has anything happened to you here, that you think will make you less likely to offend in the future?

Not sentenced	54 (30%)
Yes	50 (28%)
No	74 (42%)

Main comparator and comparator to last time

Prisoner survey responses HMP Cardiff 2016

Prisoner survey responses (missing data have been excluded for each question). Please note: where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

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	Any percentage highlighted in blue is significantly worse				
	Any percentage highlighted in orange shows a significant difference in prisoners' background details				
	Percentages which are not highlighted show there is no significant difference				
Number of completed questionnaires returned		194	6,064	194	167
SECTION 1: General information					
1.2	Are you under 21 years of age?	5%	6%	5%	7%
1.3	Are you sentenced?	72%	68%	72%	69%
1.3	Are you on recall?	9%	10%	9%	4%
1.4	Is your sentence less than 12 months?	44%	20%	44%	34%
1.4	Are you here under an indeterminate sentence for public protection (IPP prisoner)?	3%	3%	3%	1%
1.5	Are you a foreign national?	9%	13%	9%	9%
1.6	Do you understand spoken English?	100%	97%	100%	98%
1.7	Do you understand written English?	98%	96%	98%	96%
1.8	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories.)	18%	25%	18%	11%
1.9	Do you consider yourself to be Gypsy/ Romany/ Traveller?	3%	5%	3%	5%
1.1	Are you Muslim?	10%	13%	10%	9%
1.11	Are you homosexual/gay or bisexual?	4%	3%	4%	2%
1.12	Do you consider yourself to have a disability?	36%	25%	36%	21%
1.13	Are you a veteran (ex-armed services)?	6%	5%	6%	6%
1.14	Is this your first time in prison?	24%	33%	24%	30%
1.15	Do you have any children under the age of 18?	59%	54%	59%	64%
SECTION 2: Transfers and escorts					
On your most recent journey here:					
2.1	Did you spend more than 2 hours in the van?	17%	23%	17%	7%
	For those who spent two or more hours in the escort van:				
2.2	Were you offered anything to eat or drink?	44%	39%	44%	30%
2.3	Were you offered a toilet break?	8%	8%	8%	5%
2.4	Was the van clean?	62%	57%	62%	62%
2.5	Did you feel safe?	74%	74%	74%	83%
2.6	Were you treated well/very well by the escort staff?	73%	66%	73%	77%
2.7	Before you arrived here were you told that you were coming here?	75%	63%	75%	76%
2.7	Before you arrived here did you receive any written information about coming here?	3%	3%	3%	4%
2.8	When you first arrived here did your property arrive at the same time as you?	85%	78%	85%	91%

17.1

Main comparator and comparator to last time

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		HMP Cardiff 2016	Local prisons comparator	HMP Cardiff 2016	HMP Cardiff 2013
SECTION 3: Reception, first night and induction					
3.1	Were you in reception for less than 2 hours?	43%	39%	43%	59%
3.2	When you were searched in reception, was this carried out in a respectful way?	76%	78%	76%	84%
3.3	Were you treated well/very well in reception?	65%	62%	65%	75%
	When you first arrived:				
3.4	Did you have any problems?	77%	77%	77%	69%
3.4	Did you have any problems with loss of property?	11%	16%	11%	7%
3.4	Did you have any housing problems?	24%	23%	24%	21%
3.4	Did you have any problems contacting employers?	7%	5%	7%	4%
3.4	Did you have any problems contacting family?	26%	35%	26%	18%
3.4	Did you have any problems ensuring dependants were being looked after?	3%	3%	3%	2%
3.4	Did you have any money worries?	20%	24%	20%	27%
3.4	Did you have any problems with feeling depressed or suicidal?	32%	24%	32%	19%
3.4	Did you have any physical health problems?	15%	18%	15%	17%
3.4	Did you have any mental health problems?	42%	25%	42%	24%
3.4	Did you have any problems with needing protection from other prisoners?	7%	9%	7%	4%
3.4	Did you have problems accessing phone numbers?	27%	32%	27%	26%
	For those with problems:				
3.5	Did you receive any help/ support from staff in dealing with these problems?	40%	31%	40%	42%
	When you first arrived here, were you offered any of the following:				
3.6	Tobacco?	23%	79%	23%	84%
3.6	A shower?	44%	29%	44%	39%
3.6	A free telephone call?	75%	53%	75%	77%
3.6	Something to eat?	70%	70%	70%	73%
3.6	PIN phone credit?	68%	50%	68%	83%
3.6	Toiletries/ basic items?	57%	57%	57%	63%

Key to tables

Main comparator and comparator to last time

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SECTION 3: Reception, first night and induction continued					
	When you first arrived here did you have access to the following people:				
3.7	The chaplain or a religious leader?	45%	45%	45%	51%
3.7	Someone from health services?	58%	66%	58%	66%
3.7	A Listener/Samaritans?	21%	31%	21%	32%
3.7	Prison shop/ canteen?	17%	21%	17%	21%
	When you first arrived here were you offered information about any of the following:				
3.8	What was going to happen to you?	39%	40%	39%	56%
3.8	Support was available for people feeling depressed or suicidal?	31%	35%	31%	50%
3.8	How to make routine requests?	26%	34%	26%	52%
3.8	Your entitlement to visits?	25%	33%	25%	51%
3.8	Health services?	30%	43%	30%	48%
3.8	The chaplaincy?	32%	39%	32%	48%
3.9	Did you feel safe on your first night here?	66%	69%	66%	84%
3.10	Have you been on an induction course?	58%	75%	58%	66%
	For those who have been on an induction course:				
3.11	Did the course cover everything you needed to know about the prison?	40%	49%	40%	62%
3.12	Did you receive an education (skills for life) assessment?	63%	75%	63%	59%
SECTION 4: Legal rights and respectful custody					
	In terms of your legal rights, is it easy/very easy to:				
4.1	Communicate with your solicitor or legal representative?	39%	36%	39%	40%
4.1	Attend legal visits?	49%	50%	49%	63%
4.1	Get bail information?	16%	17%	16%	24%
4.2	Have staff ever opened letters from your solicitor or legal representative when you were not with them?	38%	42%	38%	44%
4.3	Can you get legal books in the library?	27%	35%	27%	27%
	For the wing/unit you are currently on:				
4.4	Are you normally offered enough clean, suitable clothes for the week?	20%	50%	20%	40%
4.4	Are you normally able to have a shower every day?	77%	74%	77%	70%
4.4	Do you normally receive clean sheets every week?	58%	66%	58%	79%
4.4	Do you normally get cell cleaning materials every week?	39%	51%	39%	52%
4.4	Is your cell call bell normally answered within five minutes?	16%	24%	16%	39%
4.4	Is it normally quiet enough for you to be able to relax or sleep in your cell at night time?	46%	56%	46%	64%
4.4	Can you normally get your stored property, if you need to?	13%	20%	13%	23%
4.5	Is the food in this prison good/very good?	22%	21%	22%	29%
4.6	Does the shop/canteen sell a wide enough range of goods to meet your needs?	45%	47%	45%	45%
4.7	Are you able to speak to a Listener at any time, if you want to?	44%	53%	44%	52%
4.8	Are your religious beliefs are respected?	34%	49%	34%	42%
4.9	Are you able to speak to a religious leader of your faith in private if you want to?	45%	50%	45%	48%
4.10	Is it easy/very easy to attend religious services?	37%	44%	37%	37%

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SECTION 5: Applications and complaints					
5.1	Is it easy to make an application?	59%	71%	59%	80%
	For those who have made an application:				
5.2	Do you feel applications are dealt with fairly?	39%	47%	39%	62%
5.2	Do you feel applications are dealt with quickly (within seven days)?	31%	32%	31%	59%
5.3	Is it easy to make a complaint?	41%	49%	41%	39%
	For those who have made a complaint:				
5.4	Do you feel complaints are dealt with fairly?	27%	27%	27%	32%
5.4	Do you feel complaints are dealt with quickly (within seven days)?	19%	23%	19%	37%
5.5	Have you ever been prevented from making a complaint when you wanted to?	20%	22%	20%	15%
5.6	Is it easy/very easy to see the Independent Monitoring Board?	19%	18%	19%	22%
SECTION 6: Incentives and earned privileges scheme					
6.1	Do you feel you have been treated fairly in your experience of the IEP scheme?	34%	40%	34%	41%
6.2	Do the different levels of the IEP scheme encourage you to change your behaviour?	38%	39%	38%	45%
6.3	In the last six months have any members of staff physically restrained you (C&R)?	9%	10%	9%	4%
6.4	In the last six months, if you have spent a night in the segregation/ care and separation unit, were you treated very well/ well by staff?	34%	35%	34%	44%
SECTION 7: Relationships with staff					
7.1	Do most staff, in this prison, treat you with respect?	71%	72%	71%	76%
7.2	Is there a member of staff, in this prison, that you can turn to for help if you have a problem?	72%	67%	72%	75%
7.3	Has a member of staff checked on you personally in the last week to see how you were getting on?	26%	27%	26%	27%
7.4	Do staff normally speak to you most of the time/all of the time during association?	17%	17%	17%	20%
7.5	Do you have a personal officer?	33%	34%	33%	46%
	For those with a personal officer:				
7.6	Do you think your personal officer is helpful/very helpful?	67%	67%	67%	65%

17.1

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SECTION 8: Safety					
8.1	Have you ever felt unsafe here?	47%	48%	47%	26%
8.2	Do you feel unsafe now?	23%	22%	23%	10%
8.4	Have you been victimised by other prisoners here?	26%	32%	26%	15%
	Since you have been here, have other prisoners:				
8.5	Made insulting remarks about you, your family or friends?	13%	13%	13%	5%
8.5	Hit, kicked or assaulted you?	8%	10%	8%	2%
8.5	Sexually abused you?	3%	2%	3%	1%
8.5	Threatened or intimidated you?	17%	17%	17%	9%
8.5	Taken your canteen/property?	7%	9%	7%	4%
8.5	Victimised you because of medication?	6%	6%	6%	2%
8.5	Victimised you because of debt?	5%	4%	5%	2%
8.5	Victimised you because of drugs?	6%	5%	6%	1%
8.5	Victimised you because of your race or ethnic origin?	7%	4%	7%	2%
8.5	Victimised you because of your religion/religious beliefs?	5%	3%	5%	2%
8.5	Victimised you because of your nationality?	5%	3%	5%	1%
8.5	Victimised you because you were from a different part of the country?	6%	4%	6%	2%
8.5	Victimised you because you are from a Traveller community?	2%	2%	2%	1%
8.5	Victimised you because of your sexual orientation?	4%	1%	4%	1%
8.5	Victimised you because of your age?	1%	3%	1%	1%
8.5	Victimised you because you have a disability?	5%	4%	5%	2%
8.5	Victimised you because you were new here?	6%	7%	6%	2%
8.5	Victimised you because of your offence/crime?	4%	6%	4%	0%
8.5	Victimised you because of gang related issues?	4%	5%	4%	1%

17.1

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	Percentages which are not highlighted show there is no significant difference				
SECTION 8: Safety continued					
8.6	Have you been victimised by staff here?	27%	33%	27%	27%
	Since you have been here, have staff:				
8.7	Made insulting remarks about you, your family or friends?	11%	12%	11%	10%
8.7	Hit, kicked or assaulted you?	5%	6%	5%	2%
8.7	Sexually abused you?	2%	1%	2%	0%
8.7	Threatened or intimidated you?	16%	13%	16%	7%
8.7	Victimised you because of medication?	7%	6%	7%	3%
8.7	Victimised you because of debt?	2%	2%	2%	1%
8.7	Victimised you because of drugs?	4%	3%	4%	1%
8.7	Victimised you because of your race or ethnic origin?	5%	4%	5%	4%
8.7	Victimised you because of your religion/religious beliefs?	4%	4%	4%	4%
8.7	Victimised you because of your nationality?	4%	3%	4%	3%
8.7	Victimised you because you were from a different part of the country?	4%	3%	4%	2%
8.7	Victimised you because you are from a Traveller community?	1%	1%	1%	2%
8.7	Victimised you because of your sexual orientation?	2%	1%	2%	1%
8.7	Victimised you because of your age?	1%	3%	1%	1%
8.7	Victimised you because you have a disability?	5%	3%	5%	2%
8.7	Victimised you because you were new here?	4%	5%	4%	3%
8.7	Victimised you because of your offence/crime?	2%	5%	2%	2%
8.7	Victimised you because of gang related issues?	2%	3%	2%	1%
	For those who have been victimised by staff or other prisoners:				
8.8	Did you report any victimisation that you have experienced?	37%	34%	37%	23%

17.1

Main comparator and comparator to last time

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SECTION 9: Health services					
9.1	Is it easy/very easy to see the doctor?	27%	21%	27%	21%
9.1	Is it easy/very easy to see the nurse?	60%	42%	60%	51%
9.1	Is it easy/very easy to see the dentist?	9%	8%	9%	9%
	For those who have been to the following services, do you think the quality of the health service from the following is good/very good:				
9.2	The doctor?	34%	40%	34%	42%
9.2	The nurse?	51%	51%	51%	56%
9.2	The dentist?	22%	29%	22%	25%
9.3	The overall quality of health services?	31%	36%	31%	30%
9.4	Are you currently taking medication?	56%	52%	56%	44%
	For those currently taking medication:				
9.5	Are you allowed to keep possession of some or all of your medication in your own cell?	40%	59%	40%	50%
9.6	Do you have any emotional well being or mental health problems?	61%	41%	61%	37%
	For those who have problems:				
9.7	Are you being helped or supported by anyone in this prison?	33%	42%	33%	44%
SECTION 10: Drugs and alcohol					
10.1	Did you have a problem with drugs when you came into this prison?	47%	32%	47%	44%
10.2	Did you have a problem with alcohol when you came into this prison?	26%	21%	26%	35%
10.3	Is it easy/very easy to get illegal drugs in this prison?	49%	39%	49%	34%
10.4	Is it easy/very easy to get alcohol in this prison?	15%	18%	15%	13%
10.5	Have you developed a problem with drugs since you have been in this prison?	13%	10%	13%	8%
10.6	Have you developed a problem with diverted medication since you have been in this prison?	14%	8%	14%	10%
	For those with drug or alcohol problems:				
10.7	Have you received any support or help with your drug problem while in this prison?	40%	56%	40%	48%
10.8	Have you received any support or help with your alcohol problem while in this prison?	37%	54%	37%	33%
	For those who have received help or support with their drug or alcohol problem:				
10.9	Was the support helpful?	52%	77%	52%	66%

17.1

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SECTION 11: Activities					
	Is it very easy/ easy to get into the following activities:				
11.1	A prison job?	46%	31%	46%	34%
11.1	Vocational or skills training?	28%	29%	28%	24%
11.1	Education (including basic skills)?	40%	44%	40%	37%
11.1	Offending behaviour programmes?	18%	17%	18%	12%
	Are you currently involved in any of the following activities:				
11.2	A prison job?	49%	44%	49%	38%
11.2	Vocational or skills training?	7%	8%	7%	7%
11.2	Education (including basic skills)?	9%	24%	9%	14%
11.2	Offending behaviour programmes?	3%	7%	3%	1%
11.3	Have you had a job while in this prison?	70%	69%	70%	57%
	For those who have had a prison job while in this prison:				
11.3	Do you feel the job will help you on release?	32%	39%	32%	48%
11.3	Have you been involved in vocational or skills training while in this prison?	51%	56%	51%	39%
	For those who have had vocational or skills training while in this prison:				
11.3	Do you feel the vocational or skills training will help you on release?	43%	44%	43%	48%
11.3	Have you been involved in education while in this prison?	53%	67%	53%	46%
	For those who have been involved in education while in this prison:				
11.3	Do you feel the education will help you on release?	47%	50%	47%	46%
11.3	Have you been involved in offending behaviour programmes while in this prison?	48%	54%	48%	34%
	For those who have been involved in offending behaviour programmes while in this prison:				
11.3	Do you feel the offending behaviour programme(s) will help you on release?	37%	40%	37%	39%
11.4	Do you go to the library at least once a week?	26%	28%	26%	39%
11.5	Does the library have a wide enough range of materials to meet your needs?	26%	33%	26%	32%
11.6	Do you go to the gym three or more times a week?	25%	23%	25%	28%
11.7	Do you go outside for exercise three or more times a week?	50%	40%	50%	50%
11.8	Do you go on association more than five times each week?	49%	42%	49%	28%
11.9	Do you spend ten or more hours out of your cell on a weekday?	5%	9%	5%	10%
SECTION 12: Friends and family					
12.1	Have staff supported you and helped you to maintain contact with family/friends while in this prison?	24%	31%	24%	40%
12.2	Have you had any problems with sending or receiving mail?	33%	49%	33%	44%
12.3	Have you had any problems getting access to the telephones?	27%	35%	27%	33%
12.4	Is it easy/ very easy for your friends and family to get here?	39%	35%	39%	49%

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SECTION 13: Preparation for release					
	For those who are sentenced:				
13.1	Do you have a named offender manager (home probation officer) in the probation service?	56%	62%	56%	48%
	For those who are sentenced what type of contact have you had with your offender manager:				
13.2	No contact?	64%	43%	64%	57%
13.2	Contact by letter?	19%	28%	19%	28%
13.2	Contact by phone?	12%	13%	12%	2%
13.2	Contact by visit?	22%	36%	22%	23%
13.3	Do you have a named offender supervisor in this prison?	16%	31%	16%	15%
	For those who are sentenced:				
13.4	Do you have a sentence plan?	14%	33%	14%	29%
	For those with a sentence plan:				
13.5	Were you involved/very involved in the development of your plan?	65%	54%	65%	63%
	Who is working with you to achieve your sentence plan targets:				
13.6	Nobody?	65%	46%	65%	54%
13.6	Offender supervisor?	20%	31%	20%	29%
13.6	Offender manager?	15%	26%	15%	11%
13.6	Named/ personal officer?	5%	11%	5%	14%
13.6	Staff from other departments?	25%	18%	25%	14%
	For those with a sentence plan:				
13.7	Can you achieve any of your sentence plan targets in this prison?	37%	52%	37%	62%
13.8	Are there plans for you to achieve any of your targets in another prison?	20%	28%	20%	25%
13.9	Are there plans for you to achieve any of your targets in the community?	42%	31%	42%	27%
13.10	Do you have a needs based custody plan?	5%	7%	5%	7%
13.11	Do you feel that any member of staff has helped you to prepare for release?	6%	11%	6%	16%
	For those that need help do you know of anyone in this prison who can help you on release with the following:				
13.12	Employment?	20%	26%	20%	27%
13.12	Accommodation?	31%	32%	31%	31%
13.12	Benefits?	32%	34%	32%	34%
13.12	Finances?	20%	21%	20%	20%
13.12	Education?	20%	27%	20%	25%
13.12	Drugs and alcohol?	34%	41%	34%	36%
	For those who are sentenced:				
13.13	Have you done anything, or has anything happened to you here to make you less likely to offend in future?	40%	45%	40%	43%

17.1

Diversity analysis

Key question responses (ethnicity) HMP Cardiff 2016

Prisoner survey responses (missing data have been excluded for each question). Please note: where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

	Any percentage highlighted in green is significantly better	Black and minority ethnic prisoners	White prisoners
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		33	154
1.3	Are you sentenced?	59%	75%
1.5	Are you a foreign national?	26%	5%
1.6	Do you understand spoken English?	97%	100%
1.7	Do you understand written English?	93%	99%
1.9	Do you consider yourself to be Gypsy/ Romany/ Traveller?	7%	2%
1.1	Are you Muslim?	54%	0%
1.12	Do you consider yourself to have a disability?	24%	39%
1.13	Are you a veteran (ex-armed services)?	3%	7%
1.14	Is this your first time in prison?	28%	23%
2.6	Were you treated well/very well by the escort staff?	66%	74%
2.7	Before you arrived here were you told that you were coming here?	66%	77%
3.2	When you were searched in reception, was this carried out in a respectful way?	63%	78%
3.3	Were you treated well/very well in reception?	49%	67%
3.4	Did you have any problems when you first arrived?	81%	78%
3.7	Did you have access to someone from health care when you first arrived here?	40%	62%
3.9	Did you feel safe on your first night here?	49%	69%
3.10	Have you been on an induction course?	54%	58%
4.1	Is it easy/very easy to communicate with your solicitor or legal representative?	31%	41%

17.1

Diversity analysis

Key to tables

	Any percentage highlighted in green is significantly better	Black and minority ethnic prisoners	White prisoners
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
4.4	Are you normally offered enough clean, suitable clothes for the week?	24%	19%
4.4	Are you normally able to have a shower every day?	76%	77%
4.4	Is your cell call bell normally answered within five minutes?	12%	16%
4.5	Is the food in this prison good/very good?	12%	24%
4.6	Does the shop /canteen sell a wide enough range of goods to meet your needs?	34%	46%
4.7	Are you able to speak to a Listener at any time, if you want to?	36%	45%
4.8	Do you feel your religious beliefs are respected?	40%	33%
4.9	Are you able to speak to a religious leader of your faith in private if you want to?	54%	42%
5.1	Is it easy to make an application?	49%	62%
5.3	Is it easy to make a complaint?	38%	42%
6.1	Do you feel you have been treated fairly in your experience of the IEP scheme?	28%	36%
6.2	Do the different levels of the IEP scheme encourage you to change your behaviour?	36%	39%
6.3	In the last six months have any members of staff physically restrained you (C&R)?	6%	9%
7.1	Do **most** staff, in this prison, treat you with respect?	51%	75%
7.2	Is there a member of staff you can turn to for help if you have a problem in this prison?	64%	72%
7.3	Do staff normally speak to you at least most of the time during association time? (most/all of the time)	10%	18%
7.4	Do you have a personal officer?	32%	32%
8.1	Have you ever felt unsafe here?	57%	46%
8.2	Do you feel unsafe now?	33%	22%
8.3	Have you been victimised by other prisoners?	23%	28%
8.5	Have you ever felt threatened or intimidated by other prisoners here?	16%	18%
8.5	Have you been victimised because of your race or ethnic origin since you have been here? (By prisoners)	20%	4%
8.5	Have you been victimised because of your religion/religious beliefs? (By prisoners)	16%	3%
8.5	Have you been victimised because of your nationality? (By prisoners)	10%	5%
8.5	Have you been victimised because you have a disability? (By prisoners)	3%	6%

Diversity analysis

Key to tables

		Black and minority ethnic prisoners	White prisoners
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
8.6	Have you been victimised by a member of staff?	49%	24%
8.7	Have you ever felt threatened or intimidated by staff here?	28%	14%
8.7	Have you been victimised because of your race or ethnic origin since you have been here? (By staff)	21%	2%
8.7	Have you been victimised because of your religion/religious beliefs? (By staff)	15%	2%
8.7	Have you been victimised because of your nationality? (By staff)	12%	3%
8.7	Have you been victimised because you have a disability? (By staff)	3%	6%
9.1	Is it easy/very easy to see the doctor?	25%	28%
9.1	Is it easy/ very easy to see the nurse?	47%	64%
9.4	Are you currently taking medication?	43%	61%
9.6	Do you feel you have any emotional well being/mental health issues?	57%	63%
10.3	Is it easy/very easy to get illegal drugs in this prison?	42%	51%
11.2	Are you currently working in the prison?	27%	53%
11.2	Are you currently undertaking vocational or skills training?	13%	4%
11.2	Are you currently in education (including basic skills)?	7%	8%
11.2	Are you currently taking part in an offending behaviour programme?	10%	1%
11.4	Do you go to the library at least once a week?	17%	29%
11.6	Do you go to the gym three or more times a week?	13%	28%
11.7	Do you go outside for exercise three or more times a week?	70%	45%
11.8	On average, do you go on association more than five times each week?	40%	51%
11.9	Do you spend ten or more hours out of your cell on a weekday? (This includes hours at education, at work etc)	3%	5%
12.2	Have you had any problems sending or receiving mail?	50%	30%
12.3	Have you had any problems getting access to the telephones?	46%	24%

Diversity Analysis

Key question responses (disability) HMP Cardiff 2016

Prisoner survey responses (missing data has been excluded for each question). Please note: where there are apparently large differences, which are not indicated as statistically significant, this is likely to be due to chance.

Key to tables

	Any percentage highlighted in green is significantly better	Consider themselves to have a disability	Do not consider themselves to have a disability
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
Number of completed questionnaires returned		68	119
1.3	Are you sentenced?	72%	72%
1.5	Are you a foreign national?	8%	10%
1.6	Do you understand spoken English?	100%	99%
1.7	Do you understand written English?	97%	98%
1.8	Are you from a minority ethnic group? (Including all those who did not tick white British, white Irish or white other categories.)	12%	21%
1.9	Do you consider yourself to be Gypsy/ Romany/ Traveller?	3%	3%
1.1	Are you Muslim?	8%	11%
1.13	Are you a veteran (ex-armed services)?	9%	4%
1.14	Is this your first time in prison?	21%	25%
2.6	Were you treated well/very well by the escort staff?	70%	75%
2.7	Before you arrived here were you told that you were coming here?	73%	77%
3.2	When you were searched in reception, was this carried out in a respectful way?	64%	81%
3.3	Were you treated well/very well in reception?	60%	66%
3.4	Did you have any problems when you first arrived?	92%	70%
3.7	Did you have access to someone from health care when you first arrived here?	53%	60%
3.9	Did you feel safe on your first night here?	60%	69%
3.10	Have you been on an induction course?	60%	56%
4.1	Is it easy/very easy to communicate with your solicitor or legal representative?	34%	41%

17.1

Diversity Analysis

Key to tables

		Consider themselves to have a disability	Do not consider themselves to have a disability
	Any percentage highlighted in green is significantly better		
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
4.4	Are you normally offered enough clean, suitable clothes for the week?	19%	20%
4.4	Are you normally able to have a shower every day?	71%	80%
4.4	Is your cell call bell normally answered within five minutes?	13%	17%
4.5	Is the food in this prison good/very good?	23%	21%
4.6	Does the shop /canteen sell a wide enough range of goods to meet your needs?	44%	45%
4.7	Are you able to speak to a Listener at any time, if you want to?	38%	46%
4.8	Do you feel your religious beliefs are respected?	24%	39%
4.9	Are you able to speak to a religious leader of your faith in private if you want to?	32%	49%
5.1	Is it easy to make an application?	49%	65%
5.3	Is it easy to make a complaint?	37%	43%
6.1	Do you feel you have been treated fairly in your experience of the IEP scheme?	21%	42%
6.2	Do the different levels of the IEP scheme encourage you to change your behaviour?	27%	44%
6.3	In the last six months have any members of staff physically restrained you (C&R)?	18%	3%
7.1	Do **most** staff, in this prison, treat you with respect?	67%	73%
7.2	Is there a member of staff you can turn to for help if you have a problem in this prison?	67%	73%
7.3	Do staff normally speak to you at least most of the time during association time? (most/all of the time)	14%	19%
7.4	Do you have a personal officer?	29%	35%
8.1	Have you ever felt unsafe here?	55%	44%
8.2	Do you feel unsafe now?	28%	22%
8.3	Have you been victimised by other prisoners?	33%	23%
8.5	Have you ever felt threatened or intimidated by other prisoners here?	24%	15%
8.5	Have you been victimised because of your race or ethnic origin since you have been here? (By prisoners)	5%	8%
8.5	Have you been victimised because of your religion/religious beliefs? (By prisoners)	6%	4%
8.5	Have you been victimised because of your nationality? (By prisoners)	6%	5%
8.5	Have you been victimised because of your age? (By prisoners)	2%	1%
8.5	Have you been victimised because you have a disability? (By prisoners)	14%	1%

Diversity Analysis

Key to tables

	Any percentage highlighted in green is significantly better	Consider themselves to have a disability	Do not consider themselves to have a disability
	Any percentage highlighted in blue is significantly worse		
	Any percentage highlighted in orange shows a significant difference in prisoners' background details		
	Percentages which are not highlighted show there is no significant difference		
8.6	Have you been victimised by a member of staff?	43%	21%
8.7	Have you ever felt threatened or intimidated by staff here?	26%	12%
8.7	Have you been victimised because of your race or ethnic origin since you have been here? (By staff)	11%	3%
8.7	Have you been victimised because of your religion/religious beliefs? (By staff)	10%	2%
8.7	Have you been victimised because of your nationality? (By staff)	11%	1%
8.7	Have you been victimised because of your age? (By staff)	2%	1%
8.7	Have you been victimised because you have a disability? (By staff)	11%	2%
9.1	Is it easy/very easy to see the doctor?	28%	26%
9.1	Is it easy/ very easy to see the nurse?	59%	62%
9.4	Are you currently taking medication?	79%	45%
9.6	Do you feel you have any emotional well being/mental health issues?	92%	44%
10.3	Is it easy/very easy to get illegal drugs in this prison?	43%	53%
11.2	Are you currently working in the prison?	43%	51%
11.2	Are you currently undertaking vocational or skills training?	7%	5%
11.2	Are you currently in education (including basic skills)?	7%	8%
11.2	Are you currently taking part in an offending behaviour programme?	2%	3%
11.4	Do you go to the library at least once a week?	21%	30%
11.6	Do you go to the gym three or more times a week?	12%	33%
11.7	Do you go outside for exercise three or more times a week?	43%	54%
11.8	On average, do you go on association more than five times each week?	43%	53%
11.9	Do you spend ten or more hours out of your cell on a weekday? (This includes hours at education, at work etc)	2%	7%
12.2	Have you had any problems sending or receiving mail?	42%	29%
12.3	Have you had any problems getting access to the telephones?	41%	21%

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Cardiff and Vale University Health Board

Mental Health and Capacity Legislation committee Draft Work Plan 2016-2017	April	July	October	Jan-18
Patient Story	Mental Health Measure	Mental Health Act S117	Mental Health Act	Mental Capacity Act
Clinical Board review of ensuring MCA compliance (remitted from HSMB 19.2.15)	Clinical Board MCA compliance report: Medicine / Special	Clinical Board MCA compliance report: Surgery / PCIC	Clinical Board MCA compliance report: Women & Children / Dental	Clinical Board MCA compliance report: CD&T / Mental Health
Mental Health Act				
MHA Monitoring Exception Report (CRAF 8.1.2, risk rating 16) *Standing item*	X	X	X	
Section 117 Compliance	X			
Section 136 Partnership arrangements	X			
Monitoring MHA impact of changes to community services	X			
HIW MHA Annual Report		X		
HIW MHA Inspection Reports (as received)	X	X	X	
Hospital Managers Power of Discharge sub-Committee Annual Report				
Hospital Managers Power of Discharge sub-Committee minutes	X	X	X	
Mental Health Measure				
Mental Health Measure Monitoring Report	X	X	X	
Part 1 – Compliance update	X	X	X	
Part 2 - Quality of Care & Treatment Plans	X	X	X	
Provision of Mental Health Support to Prisoners (CRAF ref 5.1.16, risk rating 12) *Last update October 2014*		X		
Mental Capacity Act				
MCA Monitoring Report (CRAF 8.1.3) *Risk rating 16*	X	X	X	
MCA Training update (now merged with the above item)	X	X	X	
DoLS Monitoring Report	X	X	X	
Deprivation of Liberty Safeguards: Implications of Supreme Court Ruling (now merged with ablve item)				
DoLs Audits				
Committee Governance				
Committee Work planner			X	
Review of Effectiveness	X	X		X
Review of Hospital Managers Power of Discharge sub-Committee Terms of Reference			X	
Review of Terms of Reference			X	
Policy & Procedures - As and when	X	X	X	

MINUTES OF THE MEETING OF THE MENTAL HEALTH ACT HOSPITAL MANAGERS POWER OF DISCHARGE SUB COMITTEE HELD AT 10AM ON 18TH JULY 2017 IN THE MENTAL HEALTH SEMINAR ROOM AT HAFAN Y COED.

Present:

Mr John Owen	Chair PoD Group
Mr Jeff Champney - Smith	Vice Chair, PoD Group
Mrs Mary Williams	PoD member
Mr John Copley	PoD member
Mrs Mair Rawle	PoD member
Mr Rashpal Singh	PoD member
Mrs Patricia Hallett	PoD member
Mr Mike Lewis	PoD member
Mr Alan Parker	PoD member
Mrs Sharon Hopkins	PoD member
Mrs Teresa Goss	PoD member
Mrs Elizabeth Singer	PoD member
Mr Simon Williams	PoD member

In attendance:

Professor Marcus Longley	Vice Chair, Cardiff and Vale UHB
Ms Sunni Webb	Mental Health Act Manager
Mrs Bianca Simpson- Lepore	Mental Health Act Admin Manager

Apologies:

Mr Owen Baglow	Clinical Lead for Quality, Safety and Governance
Mr Huw Roberts	PoD member
Mrs Elaine Gorvett	PoD member
Mr Tony Summers	PoD member
Mrs Wendy Hewitt - Sayer	PoD member
Mr John Jackson	PoD member

1 Welcome and Introductions

The Chair introduced and welcomed Simon Williams to the PoD group and explained that he has around thirty years experience in mental health services.

2 Apologies

All apologies were received and noted.

3 Members points for open discussion

Benchmarking data
The Benchmarking data collated by the MHA Manager was discussed between the group. The data analyses trends in Mental Health Act Activity across the Welsh Health Boards and is intended for information purposes only for the PoD group. The PoD members present noticed that no hospital managers from any Health Board discharged any patients during the previous quarter. It was also noted that there seems to be a high number of patients discharged prior to their managers hearing or Tribunal going ahead.

Feedback from Betsi Cadwaladr training day
The Vice Chair of the PoD group and the MHA Administration Services Manager recently undertook a visit to Colwyn Bay to speak to their counterparts in Betsi Calwaladr Health Board. The visit was made with the purpose of discussing our good practices with their hospital managers. The Vice Chair discussed matters such as chairing skills, conflict resolution and appraisals. Some differences were picked up between Cardiff and Vale UHB's practices and Betsi Cadwaladr's. Whereas in Cardiff and Vale we rarely have solicitors attend manager's hearings, it was estimated that around 80% of Betsi's hearings have solicitors input. The hospital managers in Betsi Cadwalader UHB carry out scrutiny of section papers and as such need a good knowledge of the process of recognising nearest relatives. They consequently had a long presentation detailing the process that AMHP's go to on detention. There is also a difference in the terms used for the hospital managers. In Cardiff and Vale UHB the term Power of Discharge Group is used. In Betsi Cadwalader hospital managers are known as associate hospital managers. The PoD members commented that they would like to see an all Wales hospital managers meeting convened if at all possible. Some of the long standing members remember such a meeting taking place a number of years ago and all remember the meeting was beneficial to all.

PoD Members conveying decision
One PoD group member voiced concerns at having to retire after every managers hearing in order to make a decision about whether to continue a patients detention. He was concerned that on some occasions where the outcome is definitely going to be to continue a detention that retiring may cause a patient extra distress. He felt that retiring may prolong the process and give the patient the impression they may get discharged even if this is not the case. This view was contrasted by some other hospital managers. They felt that retiring is a useful process and allows each PoD members views to be expressed and discussed. Some of the newer members felt that retiring gives them valuable experience in terms of deciding how to convey the

decision fairly and properly to the patient. Some also felt that retiring gives the professionals and patient confidence to know that the hospital managers are considering the case thoroughly and making an informed and considered decision. It was agreed by all that the panel members need to communicate effectively at each hearing and that the process of retiring after a hearing is flexible. If it is felt to be too distressing for the patient then the panel may take the decision not to retire. However it was agreed that good practice would be to retire unless the panel agreed otherwise. It was felt that these situations would not be a regular occurrence.

4 Minutes of meeting held on 11 April 2017

The title of the Vice Chair of the Health Board is to be amended to read Professor rather than Mr.

5 Matters Arising

All the matters arising were looked into and acted upon accordingly.

6 MHA Activity Monitoring report April- June 2017

PoD Activity
It was noted that the proportion of advocate attendance at hearings has reduced since last quarter. It was thought that perhaps a change in the advocate allocated to Cardiff and Vale UHB may explain this but the matter will be investigated by the MHA Office. The high number of patients discharged prior to hearings was commented on again. PoD members voiced an interest in knowing the reasons behind these figures- i.e. whether patients were discharged because of the upcoming managers hearing. It was agreed that this kind of information would be difficult to obtain and the group were reassured that continued detention is assessed regularly by the MDT.

ACTION – Look into advocacy representation during the period April – June 2017

MHRT Activity
A similar trend in discharges prior to Tribunals was noticed. It was agreed that the figures must be looked at in a holistic way. The Mental Health Act Admin Manager noted that this quarter has seen a high number of section 2 hearings and that this may go some way to explain the higher than normal discharges prior to hearings.

7 Recommendations from Power of Discharge Group hearings- April- June 2017

One PoD member explained that at a hearing she recently attended she was told that the PARIS system we use to create and maintain Care Plans makes it very difficult to keep CTPs up to date. She was informed that if a care plan is signed off it cannot be amended and that therefore when any changes occur a whole new care plan must be created. This is why PoD members sometimes receive what appear to be out of date CTPs. She was informed that the nursing intervention plans are often the working documents. This is obviously of concern to the PoD members as it is

causing confusion. It was agreed there seems to be a lack of understanding about the care coordinator role. A training programme is being introduced to help overcome this. One PoD member with a keen interest in CTPs has concerns that fairly often band 5 nurses are often named as care coordinators. The Care Coordinator is meant to be able to question and analyse a patients care and treatment and it was feared that a band 5 nurse may not feel confident to do this. One PoD member referenced the code of practice and it was agreed that the code does state CTPs should be updated prior to a managers hearing or Tribunal. For this reason it is particularly important that this issue is looked into further.

ACTION – An update on the situation with PARIS to be provided and a resolution found if necessary

8 Training

The next training session will be on 26/09/2017 from 10.00hrs until 14.00hrs. Topics covered will be:

- Role and Remit of PoD group- Professor Richard Jones
- Care and Treatment plans- Dave Semmens

It is thought these two topics are likely to take up the whole session so the planned code of practice update will wait until the next session. One hospital manager would like more information about the differences between mental illness and mental disorder and what conditions the latter term actually encompasses. Any suggestions for the training session on 05/12/2017 should be submitted to the Mental Health Act Manager.

9 Any other business

MHA Office appointment

The Mental Health Act Manager informed all those present that Simon McDonald would be returning to the team. All the PoD members seemed very pleased with this news. Simon will take the role of MHA Coordinator and Sharon Todd and David Seward will undertake the role of MHA Administrators.

Vice Chair – Expressions of interest

Elizabeth Singer was nominated as the new Vice Chair of the PoD group- she has accepted this position. She was thanked for taking on this role.

Vice Chair of the UHB

The Chair of the PoD group informed everyone that the Vice Chair of the Health Board would soon be moving to the role of Chair for Cwm Taf Health Board. The Chair of the PoD Group thanked the Vice Chair of Cardiff and Vale UHB for his commitment to the group over the years and praised him for the hard work that has gone into making the relationship a successful one. The Vice Chair in turn praised all the PoD group members and commented that they have kept up good practice. The advert for the Vice Chairs replacement should go up soon and the role advertised

will be the same so the PoD members should expect similar enthusiasm from the Vice Chairs replacement.

10 Date of future meetings to be held at 10.00hrs in the Seminar Room, First Floor, HYC, UHL:

17 October 2017
09 January 2018