

Use of the Mental Capacity Act and safeguarding procedures in prison and Young Offender Establishment healthcare teams in London

An audit of professional practice

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Summary of overall findings

- Safeguarding is afforded a high priority by offender healthcare services.
- The organisational infrastructures for safeguarding (policies, procedures, training, etc) were rated higher than the infrastructures for the Mental Capacity Act (MCA).
- There are good working relationships between prison authorities and healthcare services around safeguarding, but the role of healthcare staff in safeguarding is limited by the prison context.
- Mental capacity tends to be treated within offender healthcare services as an aspect of safeguarding.
- Knowledge of and practice around the MCA is patchy - senior clinicians tend to have a good grasp of their obligations under the Act and how to apply them, while frontline nursing and other staff generally do not.
- There is a very weak infrastructure to support practice in relation to the MCA (policies and procedures, training, information, guidance, supervision, records).
- It is recommended that priority be given to strengthening the infrastructure to ensure that frontline practice in offender healthcare services is compliant with the MCA and the Care Act.

Summary of findings in relation to use of the Mental Capacity Act

1) Accountability

We found a lack of clarity about where responsibility lies for ensuring that MCA issues are addressed within offender healthcare services. There are three levels at which responsibility needs to be exercised:

1. Strategic leadership at the Board and senior management level
2. Through “champions” within individual services and teams
3. Through supervision and monitoring of individual practitioners

2) General awareness

While there was a good general awareness about the concept of mental capacity, understanding of the policies and procedures that should guide practice was patchy. There appears to be a narrow conception of how capacity should be recognised and dealt with. We found a general lack of awareness about how mental capacity might be considered in relation to the everyday issues that affect prisoners and different areas of their practice other than those in which the issue of mental capacity is most commonly considered, i.e.:

1. Consenting to share information about themselves with healthcare personnel
2. Consent to, and refusal of, treatment(s)
3. Ability to self-medicate
4. Fitness to plead

One reason why mental capacity has such a low profile is that healthcare staff believe that it only applies to prisoners with more severe conditions or who are in crisis. For example one healthcare manager suggested that anyone with a severe enough learning disability to impact upon their ability to make decisions was unlikely to be in prison in the first place.

3) Recording of practice around mental capacity

We found that activities relating to mental capacity were not being recorded systematically. We believe that clear and accurate recording is important because practitioners are obliged under the MCA to account for their actions where a person's capacity is questioned. It is also difficult for services to assure the quality of practice and systems where recording is inconsistent. Where we were able to identify activity from patient records, this was invariably in the form of free text.

4) Support required to enhance practice

The audit suggests that offender healthcare teams would benefit from improved information, guidance and training in the following areas:

- Recognising when mental capacity might be an issue with particular reference to the 'decision-specific' approach that underpins the MCA, and in order to confirm someone has capacity, as well as using it to prove a lack of capacity
- What practitioners need to do to assess capacity in everyday situations
- How practitioners should provide help to enable prisoners to make a decision for themselves
- How to consider the options when it is established that a person lacks capacity to make a decision for themselves and make a 'best interests' decision
- Good practice in recording decisions about mental capacity
- Ensuring that practitioners have access to relevant information (e.g. the MCA Code of Practice, etc), their employing organisations' policies and procedures, and other useful tools, such as AMCAT & BRIDGET.

Any information, guidance or training developed as a result of this audit should:

1. Take account of the context of the prison environment and how that influences the way that healthcare practitioners comply with their duties under the MCA – for example, working with a high turnover of prisoners
2. Prioritise the needs of those staff who do not currently regard themselves as having a role in mental capacity issues such as primary care nursing staff, pharmacists and in-patient staff
3. Emphasise the importance of the MCA in underpinning good safeguarding practice while also highlighting its empowering aspects
4. Enhance the organisational ability of services to manage, to record and to monitor their activity around the MCA.

Summary of findings in relation to safeguarding

1) Dealing with safeguarding concerns

The key safeguarding issues reported by offender healthcare staff were self-harm/suicide, cell-sharing, “vulnerability” due to mental health issues or learning disabilities, gang membership and radicalisation. The primary role of healthcare staff was said to be in raising safeguarding alerts for the prison authorities to manage. The audit heard of several examples of partnership working around training and case management in relation to safeguarding prisoners, although offender healthcare staff reported frustration at not always being privy to the outcomes of safeguarding concerns (which are dealt with by prison staff).

2) Leadership in safeguarding

Overall, services demonstrated strong internal leadership and organisational commitment to safeguarding as well as having an established infrastructure comprising policies and procedures, legal support and support for their workforce (recruitment, staff supervision, training, facilitation of complaints and allegations, and the use of staff feedback). Local managers described good integration of healthcare services into prison safeguarding processes. While some providers have existing links to Local Safeguarding Adults Boards at an organisational level, the relationship with individual offender healthcare services tended to be mediated through their host prison representatives where these had been established.

3) Challenges to auditing safeguarding in offender healthcare

The audit was unable to establish clearly how well services were performing in some of the aspects of safeguarding covered by the audit tool:

- Person-centred care was widely espoused but not well evidenced in relation to safeguarding.
- We found a mixed picture of how well diversity is recorded by services.

Information about safeguarding in offender services was either not available in appropriate formats, such as easy-read, or not available at all. In some instances respondents suggested that there was confusion about who held responsibility for addressing these issues. Similarly, asked to provide information about some of the audit criteria such as outcomes and quality assurance in safeguarding, respondents said they were constrained because their involvement in the wider prison safeguarding process was limited.

Summary of recommendations to NHS England

- We recommend that NHS England investigate further how issues of mental capacity and safeguarding are recorded by offender healthcare services with a view to developing guidance that will support services to ensure they are compliant with their duties under the MCA and the Care Act.

- We recommend that NHS England and service providers identify the most relevant information available online about the MCA and ensure that frontline staff are aware of these resources and able to access them when relevant.
- We recommend that NHS England work with service providers to identify which training programmes about the MCA have proved most relevant to offender healthcare staff working in prisons and to share this across services in London.
- We recommend that NHS England work with service providers to identify the best examples of policies and procedures around mental capacity and to share this across services in London.
- We recommend that NHS England liaise with London Boroughs to ensure that guidance is made available to offender healthcare services about how and when referral to Independent Mental Capacity Advocates (IMCA) services should happen.
- We recommend that all service providers ensure that comprehensive MCA compliant guidance about assessing and recording capacity is available to all staff working in offender healthcare services.
- We recommend that NHS England ensures that training and guidance available to offender healthcare staff is both compliant with the MCA and is tailored to meet the particular needs of practitioners working within a prison environment.
- We recommend that NHS England encourages the sharing of good practice in the use of advanced decisions to refuse treatment between offender healthcare services.
- We recommend that NHS England ensure that service providers have clear guidance for offender healthcare staff about the interface between the MCA and the Mental Health Act.
- We recommend that NHS England place a contractual obligation upon the providers of offender healthcare services to maintain a record of their activity in relation to the use of the Mental Capacity Act and to include such activity in contract monitoring
- We recommend that NHS England ensures that service providers' policies, procedures and guidance around safeguarding are suitable and relevant to offender healthcare services, as well as being compliant with the safeguarding requirements of the Care Act.
- We recommend that NHS England clarify the respective responsibilities of offender healthcare services and prison authorities to supply information about safeguarding to prisoners.

Background to the audit

During the summer of 2014 the House of Lords Select Committee on the Mental Capacity Act published the findings of its post-legislative scrutiny. It concluded that there is still low levels of awareness and understanding of the rights and responsibilities for different stakeholders conferred under the Act and that as a consequence prevailing professional practices often run contrary to the empowering and protective ethos that it is intended to convey. It went on to recommend that “the standards against which the CQC inspects should explicitly incorporate compliance with the Mental Capacity Act (MCA), as a core requirement that must be met by all health and care providers”. At about the same time the Care Act was receiving royal assent meaning that duties relating safeguarding adults will be put onto a statutory footing from April 2015.

In response to this, NHS England (London), the body responsible for commissioning health services in London’s prisons, asked the Mental Health Foundation to carry out an audit of the use of the MCA and Safeguarding Adults procedures across the nine prison and young offender institution healthcare teams in the capital. As well as providing offender healthcare services and NHS England with a current baseline of understanding of the MCA and safeguarding principles, the overarching findings would be used to support practice so that as the Care & Support Act becomes law, stakeholders can be assured that they are meeting the new expectations.

The audit is therefore designed to support managers and staff of healthcare teams to be compliant with the MCA and fulfil their obligations to safeguard vulnerable prisoners. The audit was carried out between July and December 2014 using the methodology described below. In early 2015 each of the offender healthcare services located within London’s prisons and Young Offender Institutions was provided with a report setting out the results of the audit as it relates to their practice (these are summarised at appendix 1). The audit team member responsible for guiding a service through the audit process has also helped that service draw up an action plan to address any areas for improvement that were identified in the report. During the spring of 2015 a small amount of consultancy support is being made available to each service for them to use flexibly to implement their action plans.

The audit team

The Mental Health Foundation (MHF) has been the UK’s leading mental health and learning disability policy, research and service improvement charity for over 60 years. It is recognised as a leading source of expertise on mental capacity, especially in relation to people with mental health problems, learning disabilities, and dementia, their families and staff who work with them. Over the last five years the Foundation has successfully undertaken a wide range of mental capacity projects aimed at evaluating, supporting and developing practice.

The audit team was led by Toby Williamson (Head of Development and Later Life, Mental Health Foundation) who is widely recognised as a leading expert on the Mental Capacity Act. Dr Paul Swift, a researcher with 30 years’ experience in the health and social care field, led the day-to-day work of the audit, while Emma Hewat a training consultant with direct experience of working in prisons took on much of the fieldwork.

How the audit was carried out

The audit team proposed to conduct an audit comprising four tasks: a review of policies and procedures, the completion of an audit tool focusing on the organisational readiness of services, an audit of practice around key elements of the MCA, and a sample of case files. Not all of these tasks could be completed satisfactorily for reasons explained below and, as a consequence, the findings of the audit rely heavily upon information provided directly from service managers in response to the audit tool.

1. Review of policies and procedures

Healthcare teams were asked to provide copies of organisational and local policies and procedures relating to the use of the MCA and Safeguarding Adults in offender institutions. These were used to evidence responses to the audit tool (below).

2. Completion of an audit tool

The audit tool was created by merging elements of a self-completion audit tool for mental capacity designed for use in North East England, and the 'Safeguarding Adults at Risk Audit Tool' developed for use by Safeguarding Adults Boards (SABs) in London. NHS England requested the use of the SAB tool as it had been adopted across London as the standard method for auditing safeguarding in health and social care services across the capital.

The audit tool provides an overview of the infrastructure that supports practitioners to use the MCA and safeguarding procedures. It covers issues such as training, policies and procedures, local partnership structures, record-keeping and so on, within in which more detailed questions can be asked about systems, culture and practice. The tool uses a simple Red, Amber, Green (RAG) rating system to code the status of an action or step in a process:

- **Red** indicates a problem needs serious attention and action now
- **Amber** indicates an action is not complete, in progress, a risk but not an issue yet
- **Green** indicates on track, in progress and complete to plan, no issues.

Using the audit tool, a set of structured interviews took place in each prison with personnel with responsibility for, or interest in, mental capacity issues and/or safeguarding adults. Further information was gathered from any relevant personnel within the wider organisational structure of the service provider. The purpose of these interviews was to gather information for NHS England about services' state of readiness to support practice within offender healthcare as well as identifying the factors that either help or hinder the

use of the MCA and the application of proper safeguarding procedures. The overall results of the rating exercise are laid out in the findings section below.

3. Audits of practice in assessing capacity and best interests decision making

Members of staff within the offender healthcare services were invited to complete a self-audit of their individual practice where they were either assessing a prisoner's capacity to make a decision and/or a best interests decision. Links were provided to the Mental Health Foundation's online tools for auditing assessments of capacity

([AMCAT](http://www.amcat.org.uk/)¹) and best interests decisions ([BRIDGET](http://www.bestinterests.org.uk/)²), which allow practitioners to enter information anonymously and receive a confidential report about what they have done. The purpose of this part of the audit was to illustrate frontline practice across the prison sector in London and within individual prisons/YOIs.

Although the audit tools have been used successfully in other audit and evaluation work carried out by the Mental Health Foundation, too few practitioners chose to take part in this audit to make a useful contribution to the overall findings. We heard anecdotally that offender healthcare staff had used the tools and found them useful (the tool remains free and open for anyone to use anonymously at any time) and it may have been the case that these practitioners preferred not to identify themselves for the purposes of the audit. The audit team attempted to mitigate the loss of this source of information by prompting respondents to the audit tool for examples of practice and these are reported in the findings sections below. However the low use of these tools may also be a reflection of the low levels of awareness and understanding of the MCA as it related to many practitioners' everyday practice.

4. Case file sampling

The final part of the audit methodology was an analysis of a sample of patient records held on SystmOne. The analysis aimed to gauge the scale of activity by offender healthcare teams on mental capacity issues and gain an understanding of how mental capacity issues are recorded. The audit team assumed that data about mental capacity and safeguarding concerns around offender healthcare would be recorded routinely on SystmOne, but this did not prove to be so.

SystmOne is a central database of NHS patient records held in Leeds. A patient record is created or accessed at the point of reception into an establishment. Each of the offender healthcare services has access to the system although they only have full access to the records for any prisoners currently in their establishment and limited rights to view and amend records for prisoners who had previously been in their establishment.

The system contains a number of mandatory fields and areas dedicated to teams and activities (such as vaccinations) and information is recorded in forms and templates which may have free text fields or drop down option menus. The key to data retrieval and searching is the use of Read Codes which signify activity (e.g., types of assessment) conditions (e.g., learning disability), concerns (e.g., safeguarding), outcomes etc. There may be a multiplicity of codes covering similar items described in very different ways, such as “learning difficulties”, “mental retardation” and “learning disabilities” as well as sub-categories such as Downs Syndrome. Our search for “mental capacity” generated 24 separate Read Codes on SystmOne while “safeguarding” yielded 17 codes.

Fields (either free text or drop-down options) can have codes embedded which means that as data is entered the codes are automatically generated, selected and attached to that file. However, it seems that many notes are written up in free text which does not have such codes embedded meaning that the only way to identify activity is to use a key word search for each file.

There is a list of templates that each team may add to its dedicated area on SystmOne. For example, one prison healthcare service has access to a Mental Health Assessment template which includes a question regarding concerns regarding

¹ <http://www.amcat.org.uk/>

² <http://www.bestinterests.org.uk/>

capacity and prompts practitioner to use 'the capacity assessment tool', yet this template was not included on the mental health team's area of the system. Further enquiries suggested that only one prison has a discrete Assessment of Capacity Template available to healthcare teams there. This template has an opening page which reminds practitioners about the presumption of capacity and then takes them through the process of assessment.

To assess the value of running a full survey of records across the nine services, we conducted a pilot search of all prisoners registered to the offender healthcare teams of one service provider between 1st May and 31st October 2014. A search was made for those Read Codes relating to assessment of capacity, the outcome of any assessment (e.g. "lacks capacity") or where a best interests decision had been made. Significantly there is not a code for the outcome that someone has capacity following an assessment (see below). Using this core group of codes we found no activity at any of the prisons except in one team which had recorded 97 examples of "lacks capacity to give consent (Mental Capacity Act 2005)" which was an unexpectedly high figure for a six month period.

Further investigation found that this figure was entirely due to a software coding error in the standard reception screening tool where it asks if there any concerns that the person may lack capacity. A "yes" response is supposed to alert the primary care manager of the need to carry out an assessment of capacity. However, answering the question either way generates the Read Code for "lacks capacity". Excluding these mis-coded cases, the search threw up no other examples of MCA activity at this particular prison at all; in line with the other offender healthcare teams.

As a further check on the reliability of the data we extended the search to look at activity against these Read Codes before the prisoners covered by the search period had arrived at one of the 6 prisons. This showed that, for example, at two other services 7 and 16 prisoners had been coded as lacking capacity in some respect prior to arriving at those prisons, although there was no indication that this information had prompted those teams to consider the issue of capacity.

We then took a few files at random and used a facility to search within each for a few key words, such as "capacity". This revealed that there is activity going on and it is being recorded, albeit in a haphazard way. For example, there was one record where the mandatory field about consent to treatment is marked 'yes' but the consultant involved also talks about using a best interests process to decide whether or not the treatment should be carried out.

We ran a similar search using 4 of the safeguarding Read Codes (the excluded ones mostly relate to children) and again this generated nothing for any of the prisons except one which had recorded 7 "adult safeguarding concerns".

While the searches related just to services provided by one care provider, the results do suggest that practice around mental capacity and safeguarding is not routinely recorded nor is it recorded consistently. This means that it is very difficult to assess how many prisoners are vulnerable and that concerns about them may not be shared as they move within the prison system. Our impression, gained from spending time with managers and practitioners within the services, is that the high turnover of prisoners within the London establishments mitigates against healthcare staff being able to detect and react to concerns in some cases. Where they are able to form a longer term relationship with potentially vulnerable prisoners, issues of capacity in particular tend to be picked up by those practitioners with an interest in it who record their practice in personalised formats. One interviewee commented that she prefers

not to use standard forms and would rather encourage people to “think for themselves”.

We recommend that NHS England investigate further how issues of mental capacity and safeguarding are recorded by offender healthcare services with a view to developing guidance that will support services to ensure they are compliant with their duties under the MCA and the Care Act.

Findings

The following sections of the report deal with the findings generated by the use of the audit tool. The findings are set out under the headings used in the tool, each of which covers an aspect of the infrastructure to mental capacity or safeguarding and which usually entailed the audit team rating the service against several audit criteria. The results presented here are summarised for the nine services as a whole although individual services are mentioned where good practice or useful examples were identified by the audit team. We have made recommendations where we suggest that NHS England has a role to play in ensuring that services are compliant with their statutory duties.

1. Support for and implementation of the MCA

Access to relevant information

Six of the nine teams were rated Green meaning that staff and service users have easy access to relevant information about the MCA, while the remaining three were rated Amber because while information about the MCA is relevant, it is not easily accessible to staff and service users. In most instances staff and service users were directed to the internet to find out about the MCA and only one team was able to evidence that it had taken steps to make information available in a range of formats that would cater for the varying communication needs of its service users. We were unable to test how effective this was in practice and there was no clear or consistent guidance available to staff about where to find relevant information about the MCA.

We recommend that NHS England and service providers identify the most relevant information about the MCA available online and ensure that frontline staff are aware of these resources and able to access them when relevant.

Training

Four of the nine teams were rated Green meaning that all members of staff have access to relevant MCA training programmes, the other five were rated Amber meaning that a majority of staff have access to such programmes. The MCA was also included in other training programmes in eight of the nine prisons. A detailed analysis of the content of training programmes and how they are delivered was not undertaken as part of audit process although it was apparent that in most services training about the MCA was provided as part of the standard staff induction while some specialist staff had received separate training related to their role within teams. Individual practitioners with a particular interest in the MCA had also provided training to teams within local services.

We recommend that NHS England work with service providers to identify which MCA training programmes have proved most relevant to offender healthcare staff working in prisons and to share this across services in London.

Policies

Respondents reported a mixed picture in terms of policies guiding practice about the MCA within their services. Four were rated Green for evidence of the existence of policies relating to the MCA, three were rated Amber for the lack of specific policies but instead making reference to the MCA Code of Practice and two were rated Red for having no policies or guidance at all. None of the services rated Green for integration of the MCA into all other relevant policies and procedures.

We recommend that NHS England work with service providers to identify the best examples of policies and procedures around mental capacity to share this across services in London.

Independent Mental Capacity Advocates (IMCAs)

Eight of the nine services were rated Amber for appropriate staff understanding the eligibility criteria for the use of an IMCA service, but having no means of referring their service users to one should the need arise. Just one prison healthcare team was rated Green for evidencing that staff there had a system in place for making a referral.

We recommend that NHS England liaise with London Boroughs to ensure that guidance is made available to offender healthcare services about how and when referral to IMCA services should happen.

2. Use of the MCA in services

Support for decision-making

All of the teams were rated Green for having systems in place to help people to make decisions, notably access to interpreters and language lines, and these are widely known about amongst team members. For example, one prison has access to interpreters via 'Language Line' as well as face to face; 18% of prisoners do not have English as a first language, in which case an interpreter is offered. All healthcare staff had been trained in the use of language line during the month prior to the audit being carried out.

Assessing and recording capacity

Just one team was rated Green for having clear MCA compliant guidance on assessing and recording capacity, five teams were rated Amber as they do not have their own guidance but do signpost their staff to the MCA Code of Practice, while the remaining three were unable to evidence providing either guidance or signposting to staff members and were therefore rated Red.

During the fieldwork carried out for the audit we gained a good understanding of the main reasons why capacity is assessed in offender healthcare services. The two most common decisions about which capacity was said to be considered were a prisoner's consent to staff sharing his or her information with other professionals and gaining their consent treatment. Another major area of concern for healthcare staff centred on the ability of individual prisoners, especially those with chronic conditions, to 'self-medicate' and to understand the consequences of not taking medication as prescribed.

“For many of the lads who may have a learning disability the issue is whether or not they are able to manage their own meds. If they do not have the capacity to understand why and how to administer their meds themselves, then we may decide that nursing staff will visit them daily to administer the meds. One boy had a life threatening condition and it appeared he was able to administer the drugs he needed to manage this condition. However, he failed to reorder them which alerted us to the fact that he might not be taking them. Twice I offered him a consultation to discuss it, which he refused to take up so we decided we had to move him onto a nurse managed regime. That prompted him to complain that he was ‘being treated like a child’, but it was clear he hadn’t fully understood the consequences of not taking them. It was agreed that he should return to self-medication but with regular supervision from nursing staff”. (Pharmacist)

We also heard a number of examples of assessments of capacity being triggered by a prisoner’s unusual or injurious behaviour. For example, we were told of a prisoner who had been biting his arm continuously and then removing surgical dressings applied during treatment to gnaw at the wound. His behaviour was so serious there was a danger that his arm might have to be removed. The GP worked with the Mental Health Team to assess the prisoner’s capacity to understand the consequences of continuing this behaviour and consider whether or not to act in his best interests.

Because some of the London prisons hold a large remand population, calls are made upon senior clinicians within offender healthcare teams to assess prisoners’ fitness to plead in court. One consultant psychiatrist described the assessment process as being closely aligned to those outlined in the MCA and welcomed the Law Commission’s current work to clarify this.

We recommend that all service providers ensure that comprehensive MCA compliant guidance about assessing and recording capacity is available to all staff working in offender healthcare services.

Making Best Interests decisions

The services were particularly weak in their use of Best Interests principles and practices. Four teams were rated Amber and five Red for having only some or no guidance on identifying the decision-maker when a Best Interests decision was required, while six teams were rated Amber and three Red for ensuring that staff are aware and implement the Best Interests principles as set out in the MCA Code of Practice. At one prison, healthcare staff felt there was mixed level of knowledge about best interests principles and this was dependent on job role and length of service; so mental health nurses, social workers and psychiatrists had good knowledge, others had some knowledge, while older members of staff had more knowledge than newer members of staff. Interviewees felt more training was needed in this area. Staff at one healthcare service felt that senior staff had a better understanding than junior staff and that more training was needed. They felt that there was less understanding about best interests principles among the more junior staff but felt confident that they would know when to escalate an issue for team discussion and that when this happened the principles were applied informally.

A number of respondent spoke about the relevance of the MCA in a prison context where prisoners freedom to make decisions for themselves was already circumscribed. One of the limitations placed upon healthcare staff working in a prison environment and using the MCA was said to be the lack of options available to treat patients who lack capacity in their best interests. For example, one prisoner suffering severe depression and lacking capacity to make decisions about his treatment would have benefited from moving to a specialist mental health facility but this option was not available to the clinician who considered this to be in his best interests.

We recommend that NHS England ensures that training and guidance available to offender healthcare staff is both compliant with the MCA and is tailored to meet the particular needs of practitioners working within a prison environment.

Checks for Advanced Decisions to Refuse Treatment (ADRT)

Just one service was rated Green for having specific guidance about checking for ADRTs, two were rated Amber and six were rated Red. The most likely explanation for this poor performance is that offender healthcare services consider it unlikely that prisoners will have an ADRT. However, we came across examples of prisoners making advanced decisions while in the care of offender healthcare services. In one example, at a Young Offender Institution, a prisoner chose to refuse a particular type of treatment in situations where he lacked capacity to decide for himself;

One prisoner presented as suffering from epilepsy even though healthcare staff were suspicious that this was a 'fake condition'. Nursing staff were called to his cell where he appeared to be having an epileptic episode and administered diazepam rectally. When he recovered he asked why he had been treated in this way, making it very clear that he was unhappy for anyone to touch that part of his anatomy and threatening to make a complaint about the incident. The staff explained that they had been obliged to consider what would be in his best interests as he was believed to be unconscious at the time and requiring emergency treatment. It was agreed that his preference not to be treated rectally would be flagged in his medical notes for future reference.

In another example a prisoner was refusing treatment for a serious medical condition which prompted an assessment of his capacity;

Mr W had developed a seriously ulcerated leg and would not agree to have it treated even though he had been told that the likely consequence of refusing treatment would be amputation. A thorough assessment determined that he had capacity to refuse treatment and his leg was eventually amputated.

Staff at one prison said they take a multi-disciplinary approach to ADRT's which when they arise are discussed in clinical review meetings, weekly meetings and daily healthcare meetings. They cited a case from approximately 3 years ago where a patient who was refusing food and had requested that he not be resuscitated, was assessed as having full capacity.

We recommend that NHS England encourages the sharing of good practice in the use of advanced decisions to refuse treatment between offender healthcare services.

Interface between the Mental Capacity Act and the Mental Health Act

Only one team was be rated Green for having specific guidance and systems in place on the relationship between the MCA and the Mental Health Act, three were rated Amber and four rated Red (one was not rated).

The general uncertainty we recorded about this area of practice was reflected in a report of a foreign national awaiting deportation who became severely depressed and developed a deep vein thrombosis. Although virtually catatonic and refusing to speak he was able to communicate in writing his wish not to be treated. Two clinicians assessed his mental capacity but came to different conclusions. Following further deliberations they agreed that he lacked capacity and were able to use a Best Interests process to treat him. They suggested that it would have been quicker and easier to treat him under the Mental Health Act.

We recommend that NHS England ensure that service providers have clear guidance for offender healthcare staff about the interface between the MCA and the Mental Health Act.

3. Monitoring use of the Mental Capacity Act

Training

Services were generally able to say how many of their staff had undertaken training on the MCA specifically; seven were rated Green and two Amber.

Policies and procedures

Fewer services were rated Green (three) for reviewing their policies and procedures in accordance with local agreements to ensure they comply with the MCA, while two were rated Amber and one was rated Red.

Support for decision-making and accessibility of information

Services were not good at monitoring their use of decision making support services/tools, such as translators and signers; just two were rated Green while six were rated Red (one was not rated). Similarly, only one service was rated Amber for reviewing the accessibility of its information about the MCA with four being rated Red (four were not rated).

Assessments of capacity and use of Best Interests principles

All bar two of the services were rated Red for not having systems & processes in place to monitor & ensure that assessments of mental capacity are undertaken by all appropriate staff & these assessments & subsequent recording complies with the MCA Code of Practice. Typically discussions around MCA do take place during ward rounds and monthly meetings, as reported by the in-reach team at one prison, but this is usually led the Psychiatrists who carry out assessments and there is no system in place for monitoring this activity.

The same services were also rated Red for not having systems in place to ensure staff are following best interests principles both in terms of best practice and recording as stated in the MCA Code of Practice.

We recommend that NHS England place a contractual obligation upon the providers of offender healthcare services to maintain a record of their activity in relation to the use of the Mental Capacity Act and to include such activity in contract monitoring.

Safeguarding procedures

4. Leadership, strategy, governance and organisational culture around safeguarding

Leadership for safeguarding

All services have a nominated person who 'champions' safeguarding throughout the organisation. The four services rated Green have a champion who has received training in Adult Safeguarding, and where appropriate, Prevent; ii) keeps Senior Managers informed of all issues relevant to safeguarding and promoting wellbeing; iii) has sufficient time to carry out this role; iv) has a job description reflecting this specific role. The other services were rated Amber because they have champions with two or three of these accomplishments.

Organisational and strategic commitment to safeguarding

All services (bar two which were not) were rated at least Amber by demonstrating commitment to Safeguarding Adults and promoting wellbeing through explicit references in the organisation's mission statement /guiding principles as well as in strategic documents. Those rated Green (three) were further able to evidence how they are implementing the strategic aims of their boards safeguarding strategy. It was more difficult to ascertain each service's strategic commitment to safeguarding and five services were not rated. The others were all rated at least Amber, meaning they were able to demonstrate commitment at Board level (or equivalent) to Safeguarding Adults through one of the following, while two were rated Green for demonstrating all of the following: i) a linkage between governance arrangements and organisational concerns relevant to safeguarding (such as complaints and serious incident reviews); ii) the existence of a system for reviewing alerts and referrals which is integrated with complaints and serious incident reviews; iii) integration of safeguarding to quality and best practice.

Transparency in relation to safeguarding

All the services that were rated (three were not rated) showed good transparency in relation to safeguarding through candour and openness internally and in their relationship to the Local Safeguarding Board, with just one rated Amber for not evidencing transparency in their relationship with the Local Safeguarding Board. The safeguarding lead for one healthcare service described to us a good working relationship with the local safeguarding board by attending meetings, some of which are prison specific, and is in regular email contact with the local authority, who contributed to a recent audit of safeguarding within the wider organisation.

Legal support in relation to safeguarding

All services were rated at least Amber for ensuring that high quality legal advice is made available to staff on both Safeguarding Adults and the Mental Capacity Act, although only one service provides managers and staff with regular relevant legal updates to allow it to achieve a Green rating.

5. Clarity of organisational responsibilities around safeguarding

Policies and procedures

Only one of the services did not have in place specific policies and procedures reflecting the organisation's responsibility to safeguard and promote the wellbeing of adults at risk. Four others were rated Amber because their policies and procedures

include at least one of the following, while four were rated Green for including all of the following: i) reference to the Pan London Policy and Procedures; ii) clear lines of accountability, from an individual employee up to the most senior person; iii) reference to the importance of keeping accurate records as well as guidance to support staff in this (which in turn links in to the organisation's policy on sharing information). In addition, of the six services we were able to rate, four were rated Green for making reference to safeguarding in other policies and procedures and four were rated Amber because references to safeguarding were missing in some policies and procedures where they should have been included.

As with the findings for mental capacity, concerns were expressed about the adequacy of some service providers' general safeguarding infrastructure to the prison context. This was being addressed at one service by drafting a local policy on Adult Safeguarding as a collaboration between the prison and healthcare team. It gives specific examples of behaviours that would help identify vulnerable women and provides clear guidance on staff role in safeguarding.

We recommend that NHS England ensures that service providers' policies, procedures and guidance around safeguarding are suitable and relevant to offender healthcare services.

References to the MCA and safeguarding in contracts

It was difficult to rate services in this domain because of a lack of knowledge among respondents about the details of their organisations' sub-contracting arrangements. Of those we were able to rate, three were rated Green because agreements reflect the requirement between commissioners and providers to have regard to the need to safeguard, and promote the wellbeing of people who use services. Invitations to tender, contracts and contract monitoring reflect this and reflect relevant standards and regulations. The two services we were able to rate with regard to the MCA were rated Amber because agreements mention but do not specify the requirement to comply with the MCA.

6. Workforce issues and safeguarding

The services are particularly strong in relation to a range of workforce issues and safeguarding. Against five audit criteria relating to recruitment, staff supervision, training, facilitation of complaints and allegations, and the use of staff feedback, two thirds of the ratings were Green and only one of the forty-five separate ratings was Red.

While respondents felt that staff had ample opportunity to raise and discuss safeguarding concerns, this was not always borne out by more junior staff we spoke to. At one prison the head of healthcare stated that in addition to regular supervision staff are also able to raise safeguarding issues in multi-disciplinary meetings and at other appropriate forums (daily meetings, handover, staff meetings etc). A team leader within the service suggested that these issues are discussed as and when they arise, while a healthcare assistant told us she had been in post for 7 months and despite requesting it, no supervision had yet been provided. While it was acknowledged that the other forums for raising these issues were available they were described as very hierarchical, which was not considered helpful.

Evidencing how the service deals with complaints and allegations, some staff interviewed at one prison healthcare service pointed to the Prison Serious Incident Reports (SIRs) as a way to “whistleblow” confidentially in addition to their employer’s own whistleblowing policy.

The one area for attention identified by the audit was staff training for safeguarding where seven of the nine services were rated Amber meaning those services could evidence only one of the following: that training i) is appropriate to their role to ensure competence to meet the needs of adults at risk of harm and to respond to safeguarding concerns; ii) includes training on the MCA and (where relevant) ‘Prevent’ and also equality and diversity issues; or iii) competency in safeguarding and the MCA is integrated into existing supervision and appraisal. An example of good practice was staff being required to complete an online e-learning module on safeguarding. Additionally the head of healthcare for that service has introduced an hour long Friday afternoon teaching session that looks at ‘Lessons Learnt’, for example from coroners’ reports about deaths in custody.

7. Inter-agency working to promote safeguarding

Insufficient information meant that we were not always able to rate services against the four audit criteria for inter-agency working between services and other to promote safeguarding. While six of the services were rated Green because their organisation is represented on a Local Safeguarding Adults Board (LSAB), this does mean that offender healthcare services themselves play an active role in those boards. One interviewee felt that the local safeguarding board were not fully appreciative of the importance of a robust relationship with the prison and healthcare team. This is somewhat evidenced by the recent request for training from the healthcare team which the board initially agreed to and then declined, and the reported ‘weird reaction’ towards the prison.

We were able to rate just one service (rated Green) for demonstrating that it appropriately recognises and reports adult safeguarding concerns to the local authority for coordination of response. The same service was also rated Green for the way that it shares information with partners, while two of the other three we were able to rate were scored Red because they could not evidence how they share information with partners despite being represented on the LSAB.

In one prison we were told how offender healthcare staff had resolved amongst themselves how to deal with situations where they felt their concerns were not being addressed properly by counterparts on the wings. This arose when a prisoner revealed to healthcare staff that he was thinking of drinking bleach and this information was relayed to prison staff on his unit. Healthcare staff were concerned that their counterparts in the unit did not appear to treat the issue seriously and so raised it with the prison’s safer custody team. However this did not produce an immediate resolution and the healthcare staff were worried that they had to leave the prisoner in what they considered a risky situation. They convened a forum which agreed that in similar situations in the future healthcare staff attend and remain on the wing until a healthcare manager is able agree with the safer custody team about how to manage the issue.

In all the prisons cell-sharing could be a safeguarding issue. We heard of one situation where healthcare staff had raised serious concerns with the prison about a cell-sharing arrangement based on what a prisoner had said to them. The prison came back and said “we’ve heard you - we’ve assessed the situation and made the decision not to do anything”. The healthcare staff were philosophical, pointing out that the ultimate responsibility for safeguarding lies with the prison and in making their decision they will have taken into account factors that the healthcare staff would not be privy to. Perhaps these examples also illustrate that in the future such audits ought to pay more attention to the relationship between healthcare teams and the prison.

One service was rated Green demonstrating active engagement with raising alerts and multi-agency partnership working for ‘Prevent’. The service provider has a Risk of Radicalisation policy and audit respondents talked about the importance of addressing the threat of radicalisation (either susceptibility or threat of radicalising others) amongst a young prison population and offender healthcare staff work closely with the prison to do this through a Behaviour Management Group. The mental health team are charged with assessing prisoners for fixation upon religion. Three other services were rated Amber for raising alerts but are not actively working with partners about ‘Prevent’.

8. Addressing issues of diversity

The services provided a mixed picture of how well diversity is recorded in offender healthcare. Two services were rated Green for recording protected characteristics where a safeguarding response is necessary or offered, and can show that this is used to inform their safeguarding strategy. For example, at one prison respondents emphasised how important an understanding of diversity is to working in the prison. The offender healthcare team there records personal details of prisoners on SystemOne at reception and respondents were able to give a breakdown of the demographic profile of the prison population from memory. Healthcare personnel contribute to the group which manages gang activity within the prison and which relies on good information about diversity. Respondents also mentioned a shared role in challenging wider cultural aspects of safeguarding such as FMG and attitudes towards women. Five services were rated Red and two Amber in this respect.

9. Informing and empowering service users in safeguarding

Person-centred care

All but one of the eight services rated were scored Amber for espousing the principle of person centred care in safeguarding, but not being able to demonstrate the difference it makes. Just one service was rated Green because the safeguarding lead said that transparency with prisoners was important when raising safeguarding issues, especially disclosing the need to refer a concern to the prison authorities. He explained that without transparency it was impossible to have the trust required to work with prisoners.

For many the translation of aspirations into practice remained a work in progress. For example, we were told that it is the ambition of one service provider to deliver a good, person centred service and the newly appointed diversity manager will be looking at individualising the existing generic care plans. However, some of that provider’s staff felt that lack of time can prevent person centred care from being put into practice on

a daily basis. Staff are more able to deliver person centred care in the in-patient facility and clinics than on the house blocks.

Competence in using the MCA

All of the services were rated at least Amber for demonstrating an understanding of the MCA, but the four rated Green were able to show a clear competence in applying the core principles of the Act. Respondents demonstrated a good level of knowledge about the MCA and familiarity with how it should be applied in practice at the level of the offender healthcare teams. Nevertheless there were areas where more could be done to support frontline staff in the provision of information and guidance about recognising capacity issues and recording their responses to them.

Provision of information about safeguarding

Services performed poorly when audited for the provision of information about safeguarding. Only healthcare team was rated Green for providing adequate information to adults at risk and their families about Safeguarding Adults in a variety of formats, while five services were rated Red for having no information at all. This appears to stem from a confusion about who should take the lead in providing such information and a fear amongst some offender healthcare staff that they might be “stepping on people’s toes” by providing their own information to prisoners.

We recommend that NHS England clarify the respective responsibilities of offender healthcare services and prison authorities to supply information about safeguarding to prisoners.

Outcomes and quality assurance in safeguarding

Services were unable to provide us with information to audit whether and how information is obtained from individuals who use the service about what outcomes they wish from the safeguarding process. A major problem for the London prisons is the ‘churn’ or turnover of prisoners, many of whom stay a very short time (sometimes only 2-3 weeks) before moving on. Many of the people we spoke to in offender healthcare felt that while it is part of their role to raise alerts, it is not within their remit to follow them through.

Similarly, just three services could provide us with information about quality assurance in safeguarding. Some findings were inferred from information gathered earlier in the audit process; at one healthcare service for example, although no quality assurance process was identified, the testimony of respondents from the prison and the offender healthcare teams indicated that safeguarding has a very high priority in the day-to-day operation of offender healthcare services and that staff display a respectful attitude towards prisoners while understanding their duties to recognise issues and raise alert.

Conclusions

While it is positive that the offender healthcare teams that took part in the audit displayed a good understanding of their role in safeguarding prisoners, a role that at the time of the audit was not a statutory one, it is perhaps ironic that their awareness of the Mental Capacity Act fell short of that required by law. This reflects the situation reported by the House of Lords. The view of the audit team is that the best way to improve this is not solely through the provision of more (and separate) training and guidance on the Mental Capacity Act, but also by emphasising how important the Mental Capacity Act is in underpinning good safeguarding practice. We hope that this report audit will assist NHS England and service providers of offender healthcare services to address the issues highlighted by the audit and ensure that in the future offender healthcare services are compliant with both mental capacity and safeguarding law.