

**Action Plan: Raymond Mills , HMP Wandsworth**

**Action Plan**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Head of Healthcare should ensure that there are appropriate records in ACCT documents of all clinicians' contact with prisoners identified as at risk of suicide and self-harm, particularly assessments of risk. Where possible a member of healthcare staff who is involved in the prisoner's care should attend ACCT case reviews.</p>	Accepted	<p>All healthcare staff are receiving ACCT refresher training via a rolling training programme, which will address the requirement to record all relevant contact with prisoners in their open ACCT. This requirement will also be addressed by healthcare managers and staff during performance / development reviews.</p> <p>ACCT case manager training is also taking place for all appropriate grades, which will re-iterate the need for multi-disciplinary attendance at case reviews, and specifically to include healthcare staff at first ACCT case reviews and future ACCT case reviews where appropriate.</p> <p>The deputy Head of Healthcare has also provided assurance that healthcare staff will attend ACCT case reviews to which they are invited to provide a contribution.</p>	<p>Head of Healthcare &amp; Head of Safer Prisons</p> <p>Ongoing training programme</p>	
2	<p>The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm</p>	Accepted	<p>A rolling training programme has commenced to ensure all staff receive ACCT training at the required levels, including case manager, assessor or</p>	<p>Head of Healthcare &amp; Head of Safer</p>	

<p>in line with national guidance, including in particular:</p> <ul style="list-style-type: none"> <li>▣ All staff, including healthcare staff, should record relevant information about risk, observations and interactions with prisoners in ACCT records and any action taken.</li> <li>▣ Triggers for suicide and self-harm should be identified and recorded</li> <li>▣ All case reviews should be multidisciplinary with continuity of case management. A member of healthcare staff should attend all first case reviews.</li> <li>▣ Caremap actions should be specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.</li> <li>▣ Assessment of risk should take into account all available information. The level of observations should reflect the prisoner's risk, which should be discussed at each case reviews.</li> <li>▣ Checks should be completed at the required frequency.</li> <li>▣ All staff, particularly case managers, should have relevant ACCT training</li> </ul>		<p>awareness training.</p> <p>Training records will be maintained and all the areas highlighted within this recommendation will be discussed and re-iterated during the training.</p> <p>The prison has introduced an audit process which includes a management check of the ACCT within 72 hours of it being opened, and weekly management checks to ensure compliance with the ACCT process.</p> <p>A notice to staff will be issued to remind all staff of the need to ensure that they record relevant information (including risks, triggers, and observations) about risk in the ACCT, and of the importance of completing the ACCT observations as agreed by the ACCT case review team.</p> <p>It is accepted that healthcare staff should attend the first ACCT case review, and further reviews if deemed appropriate and healthcare staff have information to share. Case managers will be reminded of the need to ensure healthcare staff are aware of when ACCT reviews are taking place to ensure attendance or that significant information can be shared.</p> <p>Case managers will also be reminded of the need to ensure that their assessment of risk, and the required</p>	<p>Prisons</p> <p>Ongoing training programme</p> <p>29 February 2016</p> <p>Head of Safer Prisons</p>	
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			<p>level of observations, takes into account any available risk related information, and that they explore possible triggers with the prisoner and record this information.</p> <p>As part of the training for case managers, the requirement of meaningful care maps and ensuring that all actions have been completed, and the requirement for post closure interviews will be re-iterated.</p> <p>The random management checks will consider all of these requirements in each instance.</p>		
3	<p>The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs.</p>	Accepted	<p>Although Wandsworth no longer operates a formal personal officer scheme due to the transient prisoner population, it is accepted that staff should ensure that they have regular and meaningful contact with prisoners and record any significant contact with them.</p> <p>PSI 75/2011 “Residential Services” requires residential staff to ensure that prisoners are supported and their daily needs are met, and describes the key role that they play in spotting any signs of distress, anxiety or anger which might lead to prisoners harming themselves. Staff are reminded, through regular team briefings and local training, of the need to build good relationships with prisoners, interacting with them regularly and providing positive role models, and that ‘every contact</p>	<p>The Governor</p> <p>All functional heads</p> <p>ongoing</p>	

		<p>matters'. Staff have also been reminded of the national policy requirement in the national NOMIS policy (PSI 23/2014) which states that " <i>All staff who have contact with an offender and who have access to Prison-NOMIS must update case notes on a regular basis.</i> HMP Wandsworth have recently introduced a new staff profile / shift pattern to assist with providing continuity of staff in all areas, enabling positive relationships to build between both staff and prisoners.</p>		
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