

**Action Plan – Richard Wiggins at HMP Bedford on 15/09/2016**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	<p>The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular:</p> <ul style="list-style-type: none"> <li>• All staff should have adequate ACCT training and refresher training;</li> <li>• All known risk factors of newly-arrived prisoners should be considered and recorded when determining their risk of suicide and self-harm, using all available information such as that from Person Escort Records;</li> <li>• Staff should set effective care map objectives which are specific, time bound and meaningful, aimed at reducing risk and updated at each case review;</li> <li>• Staff should ensure prisoners at risk of suicide or self-harm are not placed on the basic level of the incentives and earned privileges scheme unless all other options have been considered and excluded, and there are fully documented reasons to explain the exceptional circumstances;</li> <li>• All staff are reminded of their responsibility to start suicide and self-harm measures if a prisoner self-harms or states their intent to die, and ensure information is fully recorded.</li> </ul>	Accepted	<p>In December 2016, the Safer Custody team introduced a robust quality assurance system to evidence that a multi-disciplinary approach is conducted for all ACCT reviews, and that the objectives set in the caremap are specific, time bound and meaningful, and are aimed at reducing risk for the prisoner and updated at each case review. The quality assurance system for caremaps and multi-disciplinary case reviews will be closely monitored by the Head of Safer Custody.</p> <p>All staff were reminded through a Governor’s notice in February 2017 that they must manage prisoners at risk of suicide or self-harm in line with PSI 64/2011, Safer Custody.</p> <p>In February 2017, all staff were also reminded via a global email that they are responsible for reporting any information they receive regarding risk, if a prisoner self-harms or makes a statement of intent to do so. Staff were reminded that they must report any such risk to the wing staff, update the observation book and NOMIS and open or update the ACCT document.</p> <p>A notice will be issued in May 2017 to remind all staff that in line with PSI 07/2015-Early Days in Custody, they must examine and record all relevant information about newly arrived prisoners when determining their risk of suicide and self-harm, using all information available to them, such as prisoner escort records and suicide and self-harm warning forms, so that risk is appropriately identified. Staff have been informed that any action taken must be recorded on NOMIS and other relevant documentation to provide a clear audit trail. Assurance checks are now completed daily by the Reception Manager.</p> <p>Local guidance will be published by the Head of Safer Custody to</p>	<p>Governor Head of Healthcare Head of Safer Prisons Head of Residence and Safety Head of Business Assurance June 2017</p>

**Action Plan – Richard Wiggins at HMP Bedford on 15/09/2016**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
			<p>accompany this notice to assist staff in identifying prisoners at risk of self-harm and suicide and the procedures to be followed to manage and support them and recording information on this. The guidance will include information directing managers to check that prisoners at risk of suicide or self-harm are not placed on the basic level of the incentives and earned privileges scheme unless all other options have been considered and excluded, and there are fully documented reasons to explain the exceptional circumstances.</p> <p>A new training package has been devised through the national Suicide and Self-Harm (SASH) project which is currently being delivered to local trainers at the prison. All tutors will be trained by the end of June 2017 to enable delivery within the establishment, and training for staff will begin in July 2017 to ensure they have a full understanding of the triggers and risks for prisoners who are at risk of suicide or self-harm.</p> <p>All ACCT case managers will receive additional local training about the importance of case reviews having a multi-disciplinary approach to case management. The case manager training outlines best practice to achieve meaningful actions on a caremap and how this reduces the risk of harm. The training reminds staff that any incident that increases the risk of harm to a prisoner should result in an immediate case review being conducted, including where the prisoner refuses to engage.</p>	
2	The Governor and Head of Healthcare should establish a clear process so that the prison administration team sends copies of pre-sentence health reports to healthcare administrators to be uploaded on prisoners' medical records for clinical reference.	Accepted	In April 2017, all staff working in the Offender Management Unit were instructed via email and through team briefings that all pre-sentence health reports must be sent to the healthcare administrator for inclusion in the prisoner's electronic records. A management check of the prisoner's record provides assurance that this system is being followed. The assurance process checks are undertaken by the Head of Healthcare monthly to ensure compliance with the protocol.	Governor Head of Offender Management Head of Healthcare Completed

**Action Plan – Richard Wiggins at HMP Bedford on 15/09/2016**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
3	<p>The Head of Healthcare should ensure the implementation of the Mental Health Pathway that includes:</p> <ul style="list-style-type: none"> <li>• Appropriate initial specialist assessment;</li> <li>• Communication between the visiting psychiatrist and resident psychiatrist team;</li> <li>• Delivery of a personality disorder pathway with supporting psychotherapy service;</li> <li>• Mental health assessments take into account all relevant information, use standard mental health assessment tools, and assessment and treatment are in line with NICE guidelines.</li> </ul>	Accepted	<p>In October 2016, the Head of Healthcare approved an updated mental health referral process to ensure that accurate and timely assessment of need takes place where there are indications that a prisoner is asking for support. All relevant staff were updated on the agreed process in October via training and verbal and written communication. The updated process ensures that all prisoners will be initially assessed by the mental health team within a set time frame of seven working days, except where the referral is deemed urgent where the prisoner will be assessed on the day of referral or as soon as possible. Any prisoner that has been assessed or referred previously will automatically receive an up-to-date mental health assessment. All mental health assessments will take into account relevant information using standard mental health assessment tools, ensuring that assessment and treatment are in line with NICE guidelines.</p> <p>All prisoner assessments are completed using a Northamptonshire Healthcare Foundation Trust (NHFT) agreed format and standardised risk assessment templates. Prisoners with previous known mental health concerns will be interviewed and the triage template completed. For prisoners with no previous mental health concerns the mental health screening tool will be completed. All cases are then discussed at a weekly multi-disciplinary mental-health team meeting, where actions are agreed by the team and recorded on the patient's electronic medical record.</p> <p>In December 2016 the Head of Mental Health Services agreed an action plan that will improve the system of communication between the team and the visiting psychiatrist and resident psychiatrist team, so that communication becomes more transparent and can be evidenced on SystmOne.</p>	Head of Healthcare Head of Mental Health Completed

**Action Plan – Richard Wiggins at HMP Bedford on 15/09/2016**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
			<p>A full time assistant psychologist and a part time clinical psychologist at the prison support prisoners with complex needs. In addition training has been delivered to the nursing staff during weekly team meetings to enable them to work with prisoners living with personality disorders, so support and psychotherapy can be provided to them through the mental health pathway.</p> <p>All the measures introduced will be closely monitored by the Head of Healthcare by means of a monthly audit assurance programme.</p>	
4	The Governor should ensure vulnerable prisoners are appropriately separated, have access to a safe regime and are not exposed to intimidation and bullying.	Accepted	<p>All staff were reminded at a staff briefing in December 2016 that vulnerable prisoners must be appropriately separated, have access to a safe regime and be protected from possible intimidation and bullying, and the process for doing this.</p> <p>At initial reception, all vulnerable prisoners are risk assessed under the cell share risk assessment process, and located in either the vulnerable prisoner wing, the First Night Centre or Healthcare Centre and appropriately separated from the main population, where necessary.</p> <p>The current Violence Reduction strategy highlights the processes for managing violence, intimidation and bullying, and is displayed for reference in all staff areas. The strategy has been reinforced to staff through the full staff meeting in January 2017 and daily staff briefings. All acts of violence, intimidation and bullying are recorded, logged and investigated appropriately through to completion and all incidents are investigated by the designated wing manager. All incidents of bullying and intimidation will be assessed by the Head of Safer Custody and discussed at the Safer Custody meetings</p>	Governor Head of Residence and Safety Completed
5	The Head of Healthcare should ensure substance	Accepted	All healthcare staff were reminded in April 2017 via staff briefings to	Head of

**Action Plan – Richard Wiggins at HMP Bedford on 15/09/2016**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
	<p>misuse services are effective and provide:</p> <ul style="list-style-type: none"> <li>• Swift access to appropriate support;</li> <li>• Assessments take into account all relevant information (including the validity of drug tests) and use standard assessment tools;</li> <li>• Communication with mental health team and prison staff about individuals' presentation and needs;</li> <li>• Details of all interventions from substance misuse services which are fully recorded in prisoners' records.</li> </ul>		<p>report any concerns regarding a prisoner who is thought to have taken substances or is at risk of substance misuse, and reminded that they must be offered swift access to appropriate support. A weekly multi-disciplinary meeting is held by the Head of Healthcare and Mental Health to discuss prisoners who are at risk of substance misuse, or who present with complex needs. Representatives from various disciplines attend the meetings to discuss the prisoner's presenting needs. Assessments will take into account all relevant information (including the validity of drug tests) and use standard assessment tools. All meetings are minuted.</p> <p>Any concerns about a prisoner who is at risk of substance misuse or at risk of self-harm and suicide, will be logged in the observation book following these meetings and an ACCT document opened where appropriate. Concerns will also be reported to the wing orderly officer.</p> <p>Those prisoners requiring prompt nursing and drug support are now supported by a specialist nurse, a doctor and general nurse, especially during their initial reception and induction process to ensure their medical needs are met.</p> <p>HMP Bedford also offers a range of psychosocial therapies to prisoners who are at risk of substance misuse. Staff trained in these therapies will pick up any referrals from reception regarding any substance misuse. The psychosocial team will then assess the patient using a standardised template, within an agreed time frame, and enter the information onto the patient's electronic medical to ensure all departments in Healthcare have access to the information.</p> <p>All members of the mental health team have undertaken training on how to use SystemOne to record all interventions used, and on how to</p>	<p>Healthcare Head of Mental Health Completed</p>

**Action Plan – Richard Wiggins at HMP Bedford on 15/09/2016**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
			retrieve all relevant information. In March 2017, two standardised assessment templates were created and are now being used in line with the other NHFT prisons and the community. One template is used for patients that have not previously had any contact with mental health services. The other is a standardised triage template for patients who have had previous contact with mental health services. All non-urgent assessments take place within five working days, which is monitored by the Mental Health Lead to ensure compliance.	
6	The Governor and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency and that control room staff call an ambulance immediately a medical emergency code is received.	Accepted	<p>Staff were reminded at a full staff briefing in March 2017 of the appropriate code to communicate a medical emergency, and control room staff were also reminded of the need to call an ambulance immediately a medical emergency code is received. Information about the use of medical emergency codes is on display throughout the establishment as a continuous reminder for staff.</p> <p>The monthly Safer Custody meeting provides assurance that the correct procedures are being followed, which are minuted.</p>	Head of Healthcare Head of Safer Prisons Completed
7	The Governor should consider instigating a Prison Service investigation, as detailed in PSI 06/2010 & AI 05/2010 Conduct and Discipline, into the circumstances surrounding the apparent altering of the control room log.	Accepted	The Governor has reviewed the circumstances surrounding the apparent altering of the control room log on the 30 April 2017 and a management enquiry will be commissioned in June 2017.	Deputy Governor June 2017
8	The Governor should ensure that all staff, irrespective of status, position or experience, are provided with formal support from the prison, following a death in custody.	Accepted	Staff will be signposted through line managers to all support services available to them following a death in custody. From April 2017 all staff will also have access to a support worker on a monthly basis who will provide support with any issue they wish to discuss, following a death in custody.	Governor Head of Business Assurance Completed