

**Action Plan - Piotr Jarosz at HMP Leicester on 22/10/2017**

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 or self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> <li>• Staff have a clear understanding of their responsibilities and the need to record relevant information about risk.</li> <li>• Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.</li> <li>• Prison and healthcare staff work jointly to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first review.</li> <li>• Staff hold multidisciplinary ACCT reviews, with continuity of case management and involving all staff who can contribute to a prisoner's</li> </ul>	Accepted	<p>All staff were reminded at a full staff briefing in May 2018 that they must manage prisoners at risk of suicide or self-harm in line with national guidelines, and were reminded of the importance of their responsibilities to clearly record all relevant information received from various sources about any newly arrived prisoners that may be at risk Staff were also reminded that any SASH (Suicide and Self-Harm) identification forms completed on a prisoner at reception must be forwarded to Healthcare staff before they conduct their health screens.</p> <p>A new booking system was developed and launched on 29 April 2018. This system ensures a member of Healthcare attends every case review, including the first ACCT case review and ACCT closure. A notice to staff was also published in May 2018 to remind staff that no ACCT document should be closed in isolation and of the importance of multi-disciplinary case reviews. On occasions where Healthcare are unable to attend a case review, a written report will be provided to assist the ACCT review.</p> <p>All ACCT case managers will receive refresher ACCT training and newly promoted case managers will receive the two day Initial ACCT training by June 2018. This will reinforce best practice and give clear direction on how case managers must complete care maps at the first ACCT case review, setting specific and meaningful care map actions, identifying who is responsible for them and reviewing progress at each review. Care maps will also be given to prisoners to view to allow them to have more ownership and promote better relations with their dedicated ACCT case managers.</p>	Governor Head of Safer Custody Head of Healthcare June 2018

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	<p>care.</p> <ul style="list-style-type: none"> <li>Case managers complete care maps at the first ACCT case review, setting specific and meaningful care map actions, identifying who is responsible for them and reviewing progress at each review.</li> </ul>		<p>Weekly Quality Assurance checks are in place to assess all ACCT processes, such as the initial opening of an ACCT, first case reviews and care maps. This is monitored by the Hub Manager in Safer Custody. Any issues identified are shared with the relevant case managers.</p>	
2	<p>The Prisons Group Director, Midlands Prisons, should satisfy herself that effective action is taken to implement these recommendations</p>	Accepted	<p>The Prison Group Director (PGD) will monitor delivery of PPO recommendations on their visits to the establishment, and this will form a standing agenda for discussion with the Governor. The PGD will review compliance against projected outcomes and notify the Governor of any areas of improvement that will need to be followed up with an expected time of completion. The next visit by the PGD to the establishment is scheduled for June 2018.</p>	<p>The Prisons Group Director, Midlands Prisons, June 2018</p>
3	<p>The Governor and the UK Visa and Immigration Service should develop and implement a system to ensure that wing staff are informed of any potential changes to the immigration status of foreign national prisoners and that wing staff consider whether this might affect their risk of suicide and self-harm.</p>	Accepted	<p>A Sharing of Information protocol between the Immigration Service, OMU (Offender Management Unit) and Safer Custody was put into practice in May 2018.</p> <p>The OMU manager and the Immigration officer are responsible for identifying and monitoring any potential changes to the immigration status of foreign national prisoners and to consider whether this might affect their risk of suicide and self-harm. An IISR (Immigration Information Sharing Report) is completed by the OMU manager and emailed to the Safer Custody Inbox where the information will be picked up by the Safer Custody Team and passed to relevant ACCT case managers. This information is also</p>	<p>Governor Head of Offender Management May 2018</p>

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			inputted onto the prison NOMIS system, so that it is readily available to all staff. A notice to all staff was published in May 2018 informing them of the new protocol.	
4	The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate, in line with NHS England and HM Prisons and Probation Service's resuscitation policy issued in September 2016.	Accepted	The NHS England and HM Prisons and Probation Service resuscitation policy was re-issued to all Healthcare staff in December 2017 to remind them of the circumstances in which resuscitation is inappropriate. The guidance also forms part of the induction for new staff.	Governor Head of Healthcare Completed
5	The Governor should ensure that when a prisoner dies, a member of Prison Service staff informs the next of kin in person if possible and without undue delay.	Accepted	The Senior Management Team were reminded by the Safer Custody Functional Head at a Senior Management meeting in November 2017 that when a prisoner dies, a prison staff member must inform the next of kin, in person if possible, and without undue delay.	Governor Duty Governor Completed
6	The Head of Healthcare should review the management of the mental health waiting lists on SystemOne to ensure that referrals are not lost on the system.	Accepted	All referrals to mental health are reviewed and audited on a weekly basis by the clinical matron for mental health to ensure that the appropriate pathway has been followed. Where the pathway has not been followed this is addressed with staff and the appropriate appointments are made for the patient. The waiting lists are also printed and discussed in weekly mental health service management and allocation meetings to ensure that patients are prioritised appropriately. This has led to improved pathway coordination. This recommendation will be monitored by the Head of Healthcare.	Head of Healthcare Completed

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7	The Governor and Head of Healthcare should review the case for provision of psychosocial interventions as part of the primary mental health care service offered at HMP Leicester.	Accepted	<p>In April 2018, the mental health team structure was reviewed due to the change in contract provider to Nottinghamshire Healthcare NHS Trust. All staff were made aware of the change of contract provider through staff briefings at the time. The restructure of the mental health team in April 2018 now enables a clear service for both primary and secondary mental health services to provide group and one to one psychosocial interventions for prisoners.</p> <p>In April 2018, a training plan was developed to support staff in delivering the new mental health care service. Following this review, additional staff posts are being recruited, including a team leader for secondary mental health, a psychological wellbeing practitioner and an assistant practitioner for mental health.</p> <p>Service delivery and performance of this recommendation will be monitored via Health and Justice indicators of performance (HJIP), patient feedback and treatment outcomes.</p>	Governor Head of Healthcare Completed