RESPONSE TO MR ATLANTIC INVESTIGATION REPORT

No	Recommendation	Accepted / Partially accepted / Not accepted	Response	Target date for completion	Progress (to be updated after 6 months
1	At an organisational and cultural level, we recommend that further measures are taken to close the perceived gap between the main prison and the Healthcare unit at HMP Pentonville. This should help create a greater sense that HMP Pentonville is functioning as one organisation, comprised of staff and managers working together towards a common goal.	Accepted	This is a joint recommendation for both HMP Pentonville and, the providers of healthcare at the prison (Whittington Health, Camden & Islington NHS Foundation Trust, and Barnet, Enfield and Haringey NHS Mental Health Trust). As a priority for the year ahead, all parties are committed to a closer working relationship at both operational and managerial levels to ensure that any perceived gap is closed. Both the healthcare department and the prison have undergone recent management restructuring which supports such joint working.	Completed	
2	We recommend that at HMP Pentonville all temporary staff receive a prison induction before working in the prison for the first time. As well as covering safety and security issues, this induction should provide coverage of the ACCT Foundation training module (which has since been superseded by 'Introduction to Safer Custody') and the use of a wing's Observation Book. Alternatively, the onus should be placed on the agency/bank to provide only staff who have experience of working in prisons and who have received ACCT Foundation training in the recent	Accepted	All long term bank and agency staff working in HMP Pentonville's healthcare will undergo a prison led induction. From 10 June 2013, this induction has included 'Introduction to Safer Custody' training. It also covers the recording of information in the wing observation books in order to share information. Where agency staff are required at short notice, a local induction, including an explanation of the ACCT process, will be given by experienced prison nursing staff.	Completed	

	past.				
3	We recommend that HMP Pentonville's Healthcare unit keeps a log of temporary staff who have received a prison induction, whether they be booked through NHS Professionals or otherwise. We think it's important that this log is easily accessible and made visible to help promote ownership for the provision of these prison inductions.	Accepted	The healthcare administration department maintains a log of all temporary staff brought into HMP Pentonville to work in Healthcare. The date of their induction is recorded on the log.	Completed	
4	Assuming that it's impractical for non-permanent clinical staff to attend an ACCT training course as permanent staff members do and long-term bank and agency nurses could, we recommend that a protocol be developed at HMP Pentonville to ensure that these staff are at least provided with a systematic ACCT briefing. This could be incorporated into a broader prison induction (see Chapter 13). We recommend that this protocol be developed in collaboration with Safer Custody.	Accepted	All bank and agency staff working in HMP Pentonville's healthcare undergo prison induction. From 10 June 2013, this induction has contained 'Introduction to Safer Custody' training (see comment at 2 above)]. Where agency staff are required at short notice, experienced prison nursing staff will provide a local induction, including an explanation of the ACCT process.	Completed	
5 (a)	We recommend that a single system be introduced at HMP Pentonville that records who has received ACCT training and when the training took place. This system should cover both staff in the main prison and those working on the Healthcare unit. It should also cover both temporary and permanent	Accepted	HMP Pentonville's training department maintains a training database for all staff training**.** The Safer Custody department updates the staff training records for all staff, including healthcare staff, attending safer custody related training after each training session. In addition to this, the Healthcare department also maintains a log of all healthcare staff who undergo the 'Introduction to Safer Custody' training. ACCT training is	Completed	

	staff. We suggest that the same system be used to monitor when refresher ACCT training is due.		now part of the mandatory training suite for healthcare staff and is monitored via prison and healthcare HR for compliance.		
5 (b)	We recommend that a system-owner be assigned to ensure that action is taken, and that ongoing monitoring takes place. We suggest this owner should be the Safer Custody Senior Officer (SO). We also suggest that a member of staff in Healthcare is made responsible for liaising with the Safer Custody SO to provide this person with the information they need. We suggest that both individuals are involved in the design of the system to help promote clear ownership and to ensure the system is not perceived by users to be burdensome.	Accepted	A Healthcare Nursing Manager keeps log of all healthcare staff who have received the required ACCT training, this is replicated by the Safer Custody Manager. They both place staff on ACCT refresher training when it is due.	Completed	
6	We recommend that part of the ACCT training (Foundation and Case Manager) should be modified by the Prison Service to convey an understanding of prisoner non-communication and how this should be interpreted, particularly when formulating risk assessments.	Accepted	The current Introduction to Safer Custody training module, which all new staff who work directly with prisoners have to attend, includes a session on recognising distress as well as where an individual "withdraws". There are also sessions in both the case manager and assessor training to address the issue of an apparent at-risk prisoner who will not engage with the ACCT process. There are no current plans to revise the Introduction to Safer Custody training.	N/A	
7	We recommend that the views of clinical staff with respect to ACCT are sought when they attend ACCT training at HMP Pentonville. By understanding in what regard ACCT is held, ACCT trainers will be better	Accepted	There is shared ownership of the ACCT document by both clinical and discipline staff at HMP Pentonville. Both parties support the premise of regular feedback in respect to the ACCT process and its management, and will work together to develop this further.	Completed	

	placed to explore with those attending how shared ownership of ACCT might be best promoted. We recommend that serious consideration should then be given to acting on the outcomes of these discussions as a means of creating further buy-in for ACCT and of promoting shared ownership among discipline and clinical staff.		PSI 64/2011 'Management of prisoners at risk of harm to self, to others and from others (safer custody)' promotes the multi-disciplinary approach to managing at-risk prisoners in terms of both training and support.		
8	We recommend that HMP Pentonville's Healthcare unit takes steps to understand why ACCT triggers are not always given due consideration in prompting Case Conferences and documented discussions among staff. With this understanding, steps should be taken to improve the current situation. We recommend that any steps identified go beyond simply reminding or telling staff that triggers should be given consideration and that other mechanisms for changing behaviour are formulated and implemented.	Accepted	The Healthcare department at HMP Pentonville has completed an audit of ACCT entries and outcomes. ACCT training, which covers triggers, is now part of the mandatory training for healthcare staff. New healthcare staff will attend ACCT foundation training with current healthcare staff attending refresher training. Furthermore, the healthcare department at Pentonville will work closely with the safer custody team to identify any issues concerning ACCT entries being made which are then discussed with the relevant member/s of staff at their monthly supervision meeting.	Completed	
9	To improve current audit trails, we recommend making it a requirement at HMP Pentonville that all staff print their name on the ACCT On-going Record rather than relying on initials or signatures to identify who has made each respective entry. We suggest that amendments are	Accepted	The ACCT document was revised and reissued in May 2012 and now includes a separate column to print the name of any member of staff who makes an entry. Additionally, there is now a quality assurance checklist in the ACCT that asks if entries are clear with the staff member's name.	Completed	

	made to the prison's 'Guide to Management Checks of Open ACCTs' to reflect this change.				
10	We recommend that existing mechanisms for ensuring that quality ACCT entries are made at HMP Pentonville be enhanced. This process may involve: • making the process easier for staff by OSRR providing guidance notes to accompany the ACCT document. These guidance notes should make explicit what is being looked for and not looked for, providing examples to help convey the key messages • praising individuals who are providing quality entries • utilising the power of peer pressure by making it public when good entries are being made • identifying deterrents against making poor quality entries • increasing staff's sense of involvement by providing a forum for individuals to talk about what using ACCT is like • connecting staff with the outcomes of their work, i.e. finding a way of demonstrating how quality ACCT entries have actually made a difference. This should help reinforce the idea	Accepted	PSI 64/2011 'Management of prisoners at risk of harm to self, to others and from others (safer custody)' requires prisons to implement both quality assurance and learning procedures to ensure the ACCT process is effective in their prison. At HMP Pentonville quality ACCT entries are discussed as a significant part of the ACCT training. Managers are informed, via e-mails and during monthly meetings, when staff are not recording conversations satisfactorily.	Completed	

11	We recommend that HMP Pentonville moves away from the regime of hourly ACCT entries to help encourage the recording of more meaningful entries.	Accepted	As part of the ACCT training and during monitoring and quality assurance checks of ACCT documents by the Safer Custody department at HMP Pentonville, it is highlighted that staff must make meaningful entries about observations and conversations held with the prisoner on the ACCT document.	Completed	
12	We recommend that HMP Pentonville's Healthcare unit reviews its use of 'Special Observation forms' and clarifies what value, if any, they are adding to the care and management of a prisoner who is on an observation regime.	Accepted	The Healthcare department at HMP Pentonville has confirmed that it uses the ACCT ongoing record to document conversations and observations when a prisoner is on an ACCT plan. It is recorded on SystmOne if a patient is subject to the ACCT process.	Completed	
13 (a)	We recommend that more is done at HMP Pentonville to make it easier for staff conducting ACCT Case Reviews by clarifying for them what they are trying to achieve and how to fill in the form. We suggest this could be achieved by providing accompanying guidelines. Although it's in a different context, a good example of this approach can be found in the form of the Guidance Notes that 14 accompany the PER form (Person Escort Record form). These guidelines should provide greater clarity and promote greater consistency of approach.	Accepted	The case manager training modules address the aims and outputs associated with effective case management. The ACCT document was revised and re-issued in April 2013 and contains a guidance sheet on how to complete case reviews.	Completed	
13 (b)	We also recommend that staff	Accepted	At HMP Pentonville the organisation and effectiveness	Completed	

	involvement is enhanced by seeking out their view about how well or otherwise the Case Reviews are working. There is an opportunity to disseminate this feedback to other prison staff and make ongoing changes to this element of the process. Encouraging involvement should also promote greater transparency and encourage individuals to challenge existing ways of doing things.		of case reviews is regularly discussed by the custodial managers and the equivalent healthcare managers. These discussions will include issues of attendance and contributions by members of the multi-disciplinary team. Additionally, these issues are discussed at the safer custody meetings with outcomes disseminated to staff via staff information notices, weekly newsletters and by wing managers during staff briefings.		
14	We recommend that some impetus be created at HMP Pentonville to ensure that the option of using discipline staff for one-to-one supervision is explored (see Chapter 13). Providing clear accountabilities and a timeframe for getting this piece of work done will go some way towards creating this impetus.	Accepted	The Governor of HMP Pentonville has conducted a review of the one-to-one supervision arrangements. Prison officers will not usually be used to carry out constant supervision for prisoners located in the healthcare unit. However, where a healthcare assistant is being sought to carry out the constant supervision then a prison officer may provide this cover until the healthcare assistant arrives.	Completed	
15	We recommend the ongoing use of the record-keeping audit tool being used on HMP Pentonville's Healthcare unit, whilst ensuring that it continues to make a tangible difference and informs decision-making, rather than being seen as a paper-filling exercise. Showing staff exactly how it is making a difference should further encourage its uptake, giving them a clear reason for doing what they have been asked to do.	Accepted	The regular record keeping audit tool being used on HMP Pentonville's Healthcare Unit has recently been modified to ensure that it remains fit for purpose. Feedback to staff from the audits will take place at regular healthcare staff meetings.	Completed	

16 (a)	We recommend that guidelines be developed and implemented at HMP Pentonville as to what should and shouldn't be recorded in ACCT and SystmOne. These guidelines could be integrated into existing documentation. To make it easier for staff, we recommend that these guidelines include examples of what should and shouldn't be recorded. We suggest that an explicit acknowledgment is made that some overlap of information may be inevitable, but that it is important that discipline and clinical staff alike have as full a picture as possible of prisoners in their care.	Accepted	A revised ACCT document was re-issued in April 2013 and contains guidance on what should be recorded on the on-going record. The relevant healthcare and prison managers at HMP Pentonville will keep this matter under review and will consider whether further guidance needs to be provided to their staff. PSI 64/2011 'Management of prisoners at risk of harm to self, to others and from others (safer custody)' contains a chapter on information sharing. It recognises that information sharing is key to delivering safer custody that is coordinated around the needs of the individual. The chapter sets out that all work and contacts with the prisoner, including healthcare staff, are to be recorded on the NOMIS case recording system, as well as on healthcare systems where appropriate.	Completed	
16 (b)	Before developing these guidelines, we suggest that work is done to understand both the clinical and discipline staff's perspective with respect to accessing what information they need. We suggest that consideration is made to making changes that don't increase the existing burden of work, but that do ensure that the 'right' information is recorded in the right place.	Accepted	NHS England has advised that the Healthcare provider and prison have reviewed how the ACCT process is applied by operational and clinical staff and have agreed on the input required of clinical staff in addition to information inputted on SystmOne. NHS England has agreed that the ACCT documentation is what should serve as the multidisciplinary "care/case management record" for the individual in question. Additionally, the safer custody department at HMP Pentonville conducts regular quality assurance checks and monitoring to ensure that the 'right' information is recorded on the ACCT document.	Completed	
17	To make better use of pre-existing information, we recommend that psychiatric assessment guidelines used on HMP Pentonville's	Accepted	The Healthcare Department at HMP Pentonville systematically requests collateral from healthcare providers to assist in the on-going care and assessment of patients.	Completed	

	Healthcare unit reference the need to source and consider the results of medical and psychiatric assessments that may have been conducted by other institutions.				
18	We recommend that at HMP Pentonville recently-made entries in the ACCT document, including triggers, are checked by a member of staff attending morning briefings so that any pertinent issues are identified and discussed in this forum.	Accepted	The prison residential managers at HMP Pentonville conduct daily ACCT checks on entries made over the previous 24hr period. Any actions which need following up are picked up from these checks and taken forward with the individuals concerned.	Completed	
19	We recommend that officers' attendance at ward rounds is embedded as a norm on HMP Pentonville's Healthcare unit, if this is not already the case. This should help further improve understanding and promote a sense of collegiate working among discipline and clinical staff.	Accepted	Officers at HMP Pentonville now attend ward rounds as a matter of routine.	Completed	
20	We recommend that, as a matter of course, escort officers at HMP Pentonville are provided with a briefing as to the nature of the circumstances of the prisoner in their charge and what has been learned about that prisoner. This should provide further clarity for the escort officer as to what he/she is being tasked to do, and help to reduce levels of ambiguity and the risks associated with this.	Accepted	Staff are regularly briefed about prisoners on ACCT documents in their care and the dangers they pose to themselves. At HMP Pentonville, when an officer escorts a prisoner who has an ACCT plan open from one location to another within the prison, they will be given a handover by the wing staff so that any particular concerns can be raised.	Completed	
21	We recommend that following	Accepted	Healthcare has reviewed the process for any Serious	Completed	

	serious incidents, measures are taken at HMP Pentonville to ensure that support is provided, and information is actively disseminated, beyond the day of the incident itself. Responsibility for how this support is provided and how information is disseminated should be agreed at the post-incident hot debrief so that respective responsibilities are clear, rather than hoping that individuals will take the initiative. This action should help to reinforce the message that the organisation cares about the welfare of its staff.		Untoward Incident (SUI). This includes support for staff and feedback to the entire staff group following the outcome of any investigation. The Safer Custody monthly meeting will discuss any serious safer custody incidents and ensure further information is disseminated to relevant staff after the hot incident debrief. The on-going safer custody action plan will record action taken and/or to be taken.		
22	We recommend that steps are taken at HMP Pentonville to share findings of future internal investigations, whether these investigations are formal or otherwise, with the relevant audience(s). We would encourage the use of face-to-face fora for this, rather than simply circulating investigation reports. This approach should help enhance the feeling of staff involvement and would send a clear signal about how transparency is valued and promoted in the prison.	Accepted	The prison healthcare at HMP Pentonville has reviewed the process for any SUI, including providing feedback to the entire staff group following the outcome of any investigation. At HMP Pentonville, the findings of internal investigations into safer custody incidents, e.g. self-harm or assault incidents, will be shared at the monthly safer custody meetings. This information will then be disseminated to staff by their managers at individual staff briefings. The safer custody training sessions will also share the findings of relevant investigations.	Completed	
23	We recommend that efforts are made to ensure that representatives from Healthcare units across the Prison Estate meet on a regular basis. We feel that the key to	Accepted	NHS England has re-established a London Heads of Healthcare forum which will cover prisons and Immigration Removal Centres. The inaugural meeting was held on 4 July 2013.	Completed	

	making this a reality is ensuring that the agenda for such meetings is clear and agreed as a group. Meetings should then be perceived to be productive and therefore worthwhile attending. We suggest that a champion for this initiative be found from either inside or outside HMP Pentonville's Healthcare unit.				