Report on an independent review of progress at

HMP Elmley

by HM Chief Inspector of Prisons

13–15 February 2023

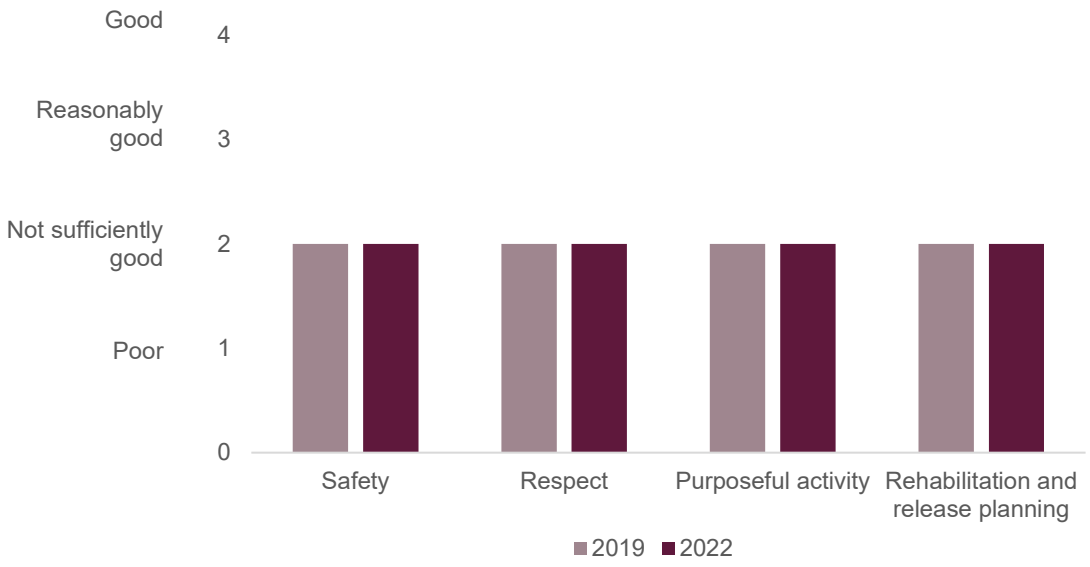
Contents

Section 1 Chief Inspector's summary

1.1 HMP Elmley opened in 1992 and is the largest of the three prisons on the Isle of Sheppey. Since the 2019 inspection, it has changed its role; while its primary function is to receive remand prisoners from the courts, its secondary purpose is now as a training establishment for a large population of sentenced category C prisoners (almost 500 currently).

1.2 At our previous inspections of HMP Elmley in 2019 and 2022, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Elmley healthy prison outcomes in 2019 and 2022



1.3 The establishment holds around 1,100 prisoners, half of whom are unsentenced and most of the rest are category C sentenced prisoners. At the previous inspection, we found that outcomes continued to be not sufficiently good in all four of our healthy prison tests.

1.4 At this independent review of progress, we assessed progress against the 11 key recommendations for improvement, including four themes identified by Ofsted. Our findings were mostly positive; progress was reasonable or better in eight areas and insufficient in three.

1.5 The governor, who had been in post for 10 months, had an accurate view of the progress that the establishment had made. The site faced substantial staff shortages, but leaders (see Glossary) were focused on how to make improvements with the resources they had and were delivering more than many prisons with a similar or better staffing position.

1.6 The governor had prioritised improving purposeful activity, with some success. The quality of induction to education, skills and work was better, which meant that prisoners could be allocated to activities based on their needs and aspirations. In addition, work had been done to improve the quality of teaching, and managers now used data more effectively to monitor progress in education. As a consequence, prisoners, including those with learning difficulties and disabilities, were more likely to stay on their courses and achieve a qualification than at the time of the previous inspection.

1.7 Leaders had worked well to improve the use of body-worn video cameras during use of force incidents. This important safeguard for both staff and prisoners was now used in 95% of incidents, which is far more than we normally see. Managers had used the footage to improve de-escalation and highlight good practice.

1.8 Where less progress had been made, it was in areas which needed good systematic oversight from leaders to support outcomes for prisoners. For example, Investigations into violent incidents were not good enough, which meant action taken to support victims and challenge perpetrators was often ineffective. In additions a weak interdepartmental risk management team meeting meant that risks to the public were not always identifies or managed as prisoners approached release.

1.9 Oversight meetings were not structured with enough focus on assessment, planning, taking action and monitoring progress. Too often, key decision-making forums did not take place, and when they did, they were sparsely attended, poorly recorded and did not lead to action. It was also unacceptable that leaders in security had changed meeting records before giving them to inspectors. These weak processes meant that when leaders established potentially good initiatives, they were not part of a wider plan. These shortcomings undermined progress in safety and public protection.

1.10 This is a positive report that describes a leadership team and staffing group that is achieving more progress with less resource than many establishments. However, if these gains are to be sustained and built on, oversight of key systems and processes will need to be more robust.

Charlie Taylor
HM Chief Inspector of Prisons
February 2023

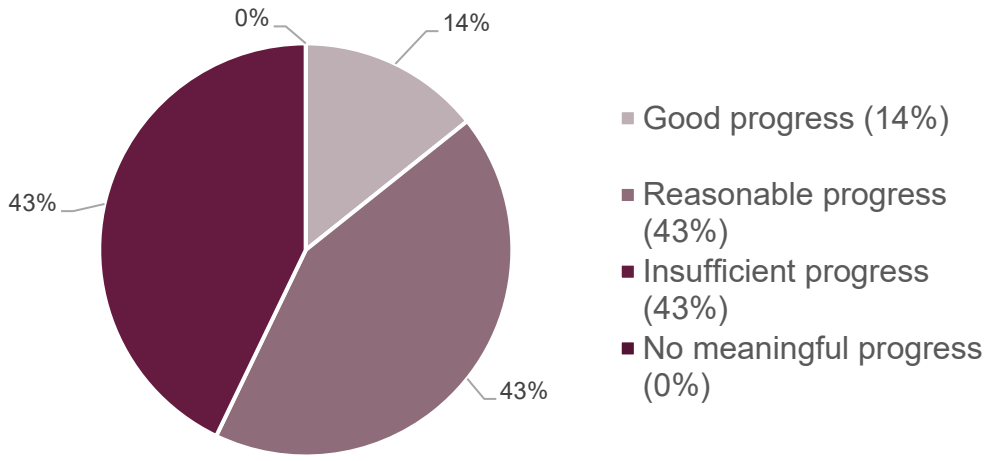
Section 2 Key findings

2.1 At this IRP visit, we followed up seven recommendations from our most recent inspection in March 2022 and Ofsted followed up four themes based on their latest inspection of the prison.

2.2 HMI Prisons judged that there was good progress in one recommendation, reasonable progress in three recommendations, insufficient progress in three recommendations and no meaningful progress in none of the recommendations.

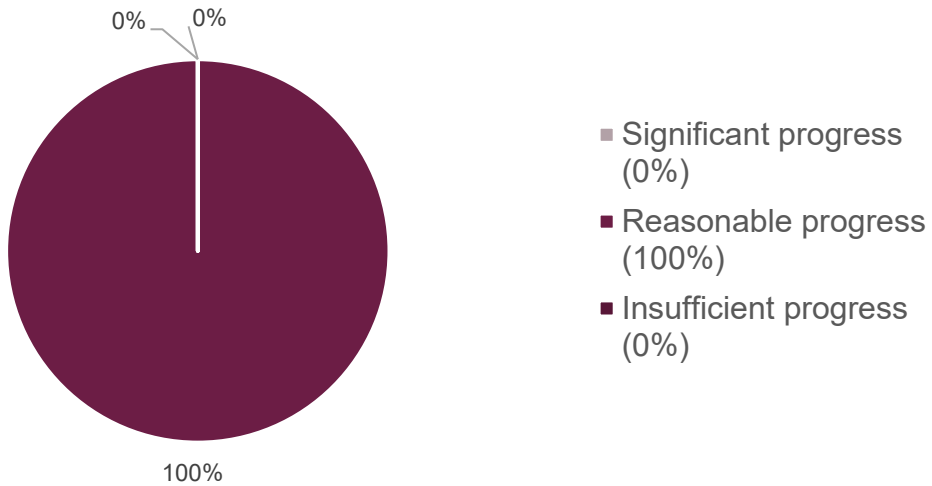
Figure 2: Progress on HMI Prisons recommendations from March 2022 inspection (n=7)

This pie chart excludes any recommendations that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.



2.3 Ofsted judged that there was significant progress in none of the themes, reasonable progress in four themes and insufficient progress in none of the themes.

Figure 3: Progress on Ofsted themes from March 2022 inspection (n=4)



Notable positive practice

2.4 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

2.5 Inspectors found one example of notable positive practice during this independent review of progress.

2.6 Leaders' effective oversight of staff drawing and activating body-worn cameras was excellent. (See paragraph 3.7)

Section 3 Progress against the key concerns and recommendations and Ofsted themes

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2022. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Behaviour management

Concern: Systems to understand and respond to the causes of violence were underdeveloped. Not all violent incidents were investigated and there was little evidence that lessons were learned from those that were. In the sample of investigations we reviewed, there was usually a lack of inquiry into why the incident happened and how it could have been prevented.

Recommendation: Investigations into incidents of violence should be sufficiently thorough to understand and respond to the causes of violence, ensuring that perpetrators and victims are managed and supported appropriately. (1.42)

3.1 Levels of violence were comparable to those at similar prisons, but higher than at the time of the previous inspection. Challenge, support and intervention plan (CSIP; see Glossary) processes had been implemented. Although investigations into violence were now conducted, most were not thorough enough and did not always establish the causes of violent incidents. This meant that leaders (see Glossary) did not have reliable data to understand the nature of the violence at the prison.

3.2 Fifteen prisoners were on a CSIP during our visit. Plans to help them address violent behaviour were mostly ill-defined and it was unclear how they linked to supporting prisoners. Behaviour targets in most plans were not bespoke and prisoners were sometimes subjected to plans for too long. One prisoner had been on a CSIP for a year without a recorded explanation.

3.3 While there were some examples of good support and challenge by wing staff and managers, leaders were not using the CSIP process to make sure that this was always the case. As a consequence, prisoners' experience varied substantially from wing to wing.

3.4 Leaders were considering introducing some new initiatives, including a debt management strategy and a conflict resolution process to address gang-related problems. However, as neither was in place during our visit, it was too soon to assess impact.

3.5 We considered that the prison had made insufficient progress in this area.

Use of force

Concern: Use of force documentation was not always fully completed and, although body-worn video cameras were readily available, too many staff failed to activate them during an incident to provide evidence and support de-escalation.

Recommendation: Leaders should make sure that staff routinely switch on body-worn cameras during use of force incidents, and there is proper oversight of documentation. (1.43)

3.6 Leaders had addressed previous problems with incomplete use-of-force documentation and there was no longer a backlog of forms. Scrutiny of these was good and leaders provided feedback to staff to drive continuous improvement.

3.7 Nearly all (95%) incidents were recorded by staff on body-worn cameras. Leaders' oversight of recorded images was excellent and used effectively to monitor the de-escalation of incidents. The number of body-worn cameras drawn and used by staff every day and for each incident was closely scrutinised. This enabled leaders and managers to provide appropriate support to staff, where needed, and recognise staff for managing incidents well. Impressively, all the incidents we reviewed in our sample had been recorded on body-worn camera and catalogued.

3.8 We considered that the prison had made good progress in this area.

Body-worn camera sign

Security

Concern: There were weaknesses in the governance of adjudications, segregation and security. Records of the key meetings providing scrutiny in these areas did not give assurance that important issues were discussed or that the right people were in attendance. Poor assessment of data undermined the prison's understanding of some of the challenges it faced.

Recommendation: There should be effective oversight of all aspects of safety in the prison. Governance meetings should be well attended, and discussion and action should focus on key priorities in each area informed by good data analysis. (1.44)

3.9 Weaknesses remained in the governance of some areas of safety. We received the minutes from several security meetings, but became aware that these were not accurate and did not reflect the content of the meetings themselves. The actions that were decided at these meetings did not sufficiently address the key areas of concern that were highlighted, and issues such as high levels of violence had continued to be listed as significant risks, without being addressed, for over a year.

3.10 Weekly tasking meetings took place, where leaders focused on a specific localised area of concern, such as contraband being thrown into the prison for collection. Actions were often successful in addressing issues, including the supply of drugs, but this work did not link to any coordinated strategy to maintain these successes in the long term.

3.11 The security department received a large number of information reports and was able to respond more swiftly than previously to those assessed as needing immediate action. Records showed an increase of around 20% in the number of information reports that were actioned than at the time of the previous inspection. Around 50% of searches resulted in a find, which was impressive.

3.12 The safety intervention meeting was well attended and a large number of prisoners were discussed there, including all those on CSIP and assessment, care in custody and teamwork (ACCT) case management documents. It was clear from the contributions of those in attendance that they knew these prisoners well and were well sighted on the issues affecting them. However, these meetings resulted in few decisions or actions, limiting any positive impact for prisoners.

3.13 On one of the wings, there was some good, imaginative work being done with young adults to reduce violence. This included a book club, dominoes sessions and extra gym time, with bee-keeping due to start soon. Access to these facilities promoted pro-social behaviour in this cohort of prisoners. However, again, this good initiative was not part of a wider strategy or coordinated approach to help reduce violence across the prison.

3.14 We also could not be certain that some key safeguarding visits from the governor, duty managers and health care staff to prisoners held on the segregation unit took place regularly. In addition, on two occasions the health care safety algorithm, which determines if a prisoner is medically fit for segregation, was signed outside of the two-hour timeframe mandated by HM Prison and Probation Service (HMPPS), which was inappropriate.

3.15 We considered that the prison had made insufficient progress in this area.

Equality and diversity

Concern: The absence of a needs analysis and clearly defined equality strategy left leaders without a sense of direction or the ability to monitor progress or assess outcomes for prisoners with protected characteristics. There was little evidence that the needs of these prisoners were understood or met. Recent consultation with protected groups lacked purpose, direction and focus.

Recommendation: The prison should have a clear strategy to identify and meet the needs of prisoners from all protected characteristic groups, ensuring there is no disproportionate treatment. (1.45)

3.16 Leaders had conducted a needs analysis of the population, to determine areas of concern for prisoners who identified with one or more of the protected characteristics (see Glossary). They had used their findings to inform a new diversity and inclusion strategy.

3.17 Functional heads now each took the lead on work for one of the protected characteristics and monthly forums took place with all groups. These were tracked and monitored by the diversity manager. The records of the forums that we viewed showed good attendance and that leaders were using them to identify areas of concern and gain ideas from those present about how to improve things that were not working well.

3.18 There was a foreign nationals lead and an immigration officer was on site four days a week to provide advice to prisoners who were of interest to the Home Office. Leaders had also made progress with translation and interpreting services and prisoners could access more information in their own language.

3.19 Prisoners with disabilities told us that they still felt disadvantaged and struggled to get access to all areas of the prison, as the lift did not work.

3.20 There had been some improvements in the amount and types of data that leaders viewed in the monthly diversity and inclusion meeting, but this needed further development to enable leaders to identify and address potential discriminatory treatment effectively. The data presented were not reviewed consistently. For example, there had

been concerns about potential discriminatory allocation of prisoners to work, dependent on ethnicity. Although data had been viewed and actions raised, this was not followed up at subsequent meetings to make sure that the issue was not continuing.

3.21 There was now a consolidated diversity and inclusion action plan, which drew actions from each meeting and forum, and looked to drive change. At the time of our visit, there were 112 actions on the plan, which was unwieldy and could potentially hamper leaders' efforts to address the areas of key concern to themselves and prisoners.

3.22 We considered that the prison had made reasonable progress in this area.

Health, well-being and social care

Concern: Staffing shortages in primary health care had led to weaknesses in governance, a reduction in the services available and long waiting times. Staffing shortfalls across the prison also affected prisoner access to internal and external health appointments.

Recommendation: Staffing levels should be sufficient to ensure that prisoners have timely access to the full range of primary health services and appointments. (1.46)

3.23 A new provider had taken over health care provision since the last inspection, delivering a wide range of primary care clinics led by GPs, nurses and allied health professionals. Waiting times for these clinics were reasonable.

3.24 Despite the provider increasing the primary health care staffing from around 30% to 60% of the full complement and an active recruitment strategy being in place, the sustainability of these services remained at risk because of staff shortages.

3.25 GPs were able to focus on their main role and held regular clinics. The clinics had emergency appointments available daily for urgent issues. Nurses triaged patients on the house blocks, which helped prisoners' health concerns to be addressed in a timely way, by the appropriate health care professional.

3.26 The patient application process was ineffective, and many prisoners told us that they often did not get a response when trying to make an appointment. Health care leaders were aware of this and had plans to introduce a more effective system.

3.27 A health care governor and custodial manager were now co-located with the health care leadership team and were focused on driving down non-attendance rates. Clinic attendance was discussed at the governor's briefing every morning. Two detailed officers were now attached to the health care department daily, to help improve patient attendance.

3.28 Clinical governance was improving, and more robust than at the time of the previous inspection. Regular, well-attended meetings, along with an overarching health improvement plan, were driving service improvement. We saw good oversight of reported incidents and lessons learned were shared. Mandatory training compliance was now acceptable and supervision arrangements were improving. However, more work was needed to make sure that primary health care staff were engaging with supervision.

3.29 Processes for checking emergency equipment were now embedded and subject to monthly audit.

3.30 We considered that the prison had made reasonable progress in this area.

Education, skills and work

This part of the report is written by Ofsted inspectors. Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the prison's previous inspection report or progress monitoring visit letter.

Theme 1: Leaders should take rapid action to address the poor quality of teaching in classroom-based education, for example through improved training and quality assurance. They should make sure that prisoners have opportunities to develop substantial new knowledge and skills and, as a result, to achieve accredited qualifications at high rates. (1.47)

3.31 Since the previous inspection, leaders and managers had taken decisive actions that had ensured considerable improvements in teaching and learning. They prioritised training and support, to improve the quality of education swiftly. Managers had put in place a suitable professional development programme to help teachers to improve their skills in teaching and assessment. Teachers benefited from sessions based on Rosenshine's principles (see Glossary). Teachers and instructors valued the sessions on individual target setting and planning learning and assessment that enabled prisoners to make progress. As a result, most prisoners remained in learning and achieved their qualifications.

3.32 Leaders and managers from the education provider and the prison were highly collaborative. They worked effectively together to identify concerns with the quality of education and gaps in the curriculum. Monthly 'learning walks' were used well to monitor the impact of

training on improving the quality of teaching and assessment. This enabled them to take swift action to provide support or further training for teachers and instructors.

3.33 Leaders and managers had reviewed the curriculum and introduced project-based activities for prisoners who had personal, social or behavioural issues. Projects were designed to support prisoners' engagement in activities such as team working, to develop their speaking and listening skills, and behaviour such as respect and tolerance. From the initial cohort, most prisoners had progressed onto an accredited course or into work.

3.34 Leaders and managers had taken decisive action to broaden the curriculum, including introducing more vocational qualifications. Education and prison managers had reviewed teacher opportunities, some of which had been vacant for long periods. Leaders had changed the teaching posts from specialist to generalist, and as a result had recently been successful in recruitment. These teachers would now facilitate learning support and engagement, both in the classroom and on the wings.

3.35 Ofsted considered that the prison had made reasonable progress against this theme.

Theme 2: Leaders should make more effective use of data to scrutinise the performance of learners on education courses. (1.48)

3.36 Leaders and managers had used data effectively to understand the needs of the prison population. Their analysis of data was used to make well-informed revisions to the curriculum for most prisoners. They recognised the poor pace of progress for too many prisoners attending English as a second language lessons. They had redesigned the curriculum, enabling all prisoners, regardless of their level, to make progress in their lessons.

3.37 Leaders and managers made the necessary alterations to the curriculum to meet the need of remand prisoners. As a result, these prisoners were able to complete units towards their English and mathematics qualifications. Teachers were proactive in providing information on initial assessment and progress to the establishment that prisoners transferred to, enabling them to continue with their learning.

3.38 Leaders and managers used data to determine employers' needs and gaps in the labour market to inform curriculum plans. In response to the recognised skills shortages in construction and warehousing, prisoners studied for the Construction Skills Certification Scheme card and the forklift licence. Leaders had recently introduced tracking of employment offers. It was too early to make a judgement on the effectiveness of these programmes supporting prisoners into work. However, leaders' early analysis of data had identified that prisoners were being offered

relevant employment opportunities in warehousing and construction through the employment hub.

3.39 This analysis of data also indicated that participation by prisoners aged under 25 was the lowest among the prison population. Leaders had not analysed prisoners' screening and assessment data. Consequently, they did not have a good enough understanding of the barriers to education and work for younger prisoners to inform curriculum planning.

3.40 Ofsted considered that the prison had made reasonable progress against this theme.

Theme 3: Leaders should make sure that prisoners benefit from a good-quality induction, carried out sensitively, that helps them to make informed choices about their work or study options, and that allocations to courses match prisoners' career. (1.49)

3.41 Leaders had made effective changes to the induction programme. As a result, prisoners were better prepared for assessments and more informed about the options and benefits of education, skills and work. However, attendance was often too low because of conflicting appointments, such as health care and visits.

3.42 Leaders had astutely changed the timing and location of induction. Inductions were now held from the seventh day, giving prisoners time to settle and adapt to the prison regime. Sessions were held at the college, enabling prisoners to see learning taking place in nearby classrooms. They discussed courses with their peers and as a result engaged more readily in English and mathematics courses.

3.43 Staff provided prisoners with good careers guidance during induction. Information, advice and guidance staff conducted purposeful discussions with them about their prior knowledge, skills and wider interests. They used this information to create meaningful personal learning plans which were shared with staff responsible for allocations. Prisoners received up-to-date and relevant information about the opportunities available to them in education classes. Consequently, they made informed choices about their education activities based on their current skills levels, interests and aspirations.

3.44 Leaders and managers had not made sure that prisoners received high-quality, objective information on a few of the industry courses. Prisoners applied for these courses with little appreciation of the training, assessment and practical skills they would learn. This meant that some – for example, in dry lining – left their courses shortly after starting them.

3.45 Peer mentors supported prisoners well during their induction and careers interviews. However, mentors did not receive sufficient training for these advisory roles. Leaders had not yet put in place qualifications

such as mentoring or information, advice and guidance to support peer mentors in their roles.

3.46 Ofsted considered that the prison had made reasonable progress against this theme.

Theme 4: Leaders should make sure that prisoners with learning difficulties and/or disabilities needs receive appropriate support that enables them to make good progress in education, skills and work activities. (1.50)

3.47 Staff had benefited from support and training through a well-planned staff development programme. The neurodiversity support manager had worked with staff across the prison to help them to improve their understanding of the range of learning difficulties and/or disabilities. Staff now had an increased understanding of how these individuals' thinking, learning, perception of the world, interactions and processing of information functioned differently to others.

3.48 Rigorous assessments of prisoners' ability in English and mathematics, along with self-declarations of any learning difficulties, took place during the education induction. Those with additional learning needs were encouraged by the sensitive approach of staff and readily disclosed their support needs and, where appropriate, their learning difficulty and/or disability.

3.49 Staff made sure that the information they gathered was readily available to teachers and instructors. Teachers used information from initial learning needs assessments to identify and plan practical strategies to help those with learning difficulties and/or disabilities to make progress.

3.50 Staff carefully used in-depth screeners to identify prisoners' additional needs accurately. Teachers and instructors used their increased understanding of neurodiversity to plan individual support strategies for prisoners' leaning difficulties and/or disability needs. They effectively adapted their teaching practices and methods to include a variety of strategies that enabled prisoners to participate successfully in education classes. For example, they provided those with attention-deficit hyperactivity disorder with a range of 'fidget' items (small objects that help to keep their hands occupied), to help them concentrate during lessons. As a result, these prisoners achieved their qualifications as well as their peers. However, for a minority of prisoners participating in short courses such as barista training, screening was not done early enough to make sure that they benefited from timely support.

3.51 Ofsted considered that the prison had made reasonable progress against this theme.

Public protection

Concern: Public protection arrangements were inadequate. The scope of the inter-departmental risk management meeting was too limited to consider the risks of all high-risk prisoners approaching release. There was a six-week backlog of phone calls made by high-risk prisoners waiting to be monitored.

Recommendation: Leaders should enforce robust arrangements to protect the public by identifying and managing effectively the risks posed by all high-risk prisoners in custody and before their release. (1.52)

3.52 Shortages of staff had impacted negatively on progress in public protection. There had periods where there was no senior probation officer and gaps in the administration team since out inspection. There were frailties with the interdepartmental risk management team (IRMT) meeting. Since the previous inspection, attendance had not been consistently multidisciplinary, this reduced its ability to identify prisoners risks accurately as they were approaching release and ensure there was a plan in place to protect the public. Records of discussions were not available for all the scheduled meetings, and actions to be taken forward were not sufficiently detailed. The recent arrival of a senior probation officer to the public protection team was positive but it was too soon to assess any impact.

3.53 Leaders had identified the risk that delays in the court system posed to release planning and had started to discuss remand prisoners who posed a high risk and were likely to be released from court at the IRMT.

3.54 Identification of prisoners who needed to have restrictions placed on their contact with people in the community was continued to be prompt. Far fewer prisoners than at the time of the inspection were subject to communications monitoring following the introduction of a new HMPPS policy. Monitoring was up to date for the small number now subject to it.

3.55 We considered that the prison had made insufficient progress in this area.

Interventions

Concern: There was insufficient focus on, and opportunities for, sentence progression by prisoners. Contact between prison offender managers and prisoners was too infrequent, and many of the targets in prisoners' sentence plans were not specific about the work they needed to do to reduce their risk. Very few prisoners had been able to complete accredited offending behaviour programmes at Elmley or elsewhere, and POMs did not undertake one-to-one offending behaviour work with prisoners.

Recommendation: Prisoners should be able to access appropriate offending behaviour interventions to reduce their risk and progress through their sentence. (1.51)

3.56 In the period since the previous inspection, there had been an improvement in the number of prisoners completing an accredited offending behaviour intervention. The programmes team was fully staffed, although only half of the interventions facilitators had been fully trained to deliver the two interventions offered, the Thinking Skills Programme and Building Better Relationships. Training for the remaining staff had been arranged.

3.57 Three separate intervention groups had been run, with 27 prisoners successfully taking part. Intervention facilitators from Elmley were currently running a group at another prison which did not have sufficient facilitators. The establishment had realistic plans to meet identified need by increasing the number of accredited intervention places available in the coming year, once all members of the programmes team had been fully trained.

3.58 There were no interventions available for prisoners convicted of sexual offences. Few transfers had been possible to enable this group of prisoners, or others who needed interventions not offered at Elmley, to complete relevant offending behaviour work.

3.59 As a result of vacancies in the prison offender manager team, they each had increased caseloads. In addition, the need to prioritise work such as offender assessment system (OASys) assessments, home detention curfew applications and parole reports hindered their ability to undertake regular one-to-one offending behaviour work with prisoners. However, there were some examples of this having taken place, and of in-cell workbooks being used to help prisoners to progress. Some key worker sessions (see Glossary) included some mention of sentence progression and managers identified a possible way to improve key workers' access to sentence plan targets during our visit.

3.60 We considered that the prison had made reasonable progress in this area.

Section 4 Summary of judgements

A list of the HMI Prisons recommendations and Ofsted themes followed up at this visit and the judgements made.

HMI Prisons recommendations

Investigations into incidents of violence should be sufficiently thorough to understand and respond to the causes of violence, ensuring that perpetrators and victims are managed and supported appropriately.
Insufficient progress

Leaders should make sure that staff routinely switch on body-worn cameras during use of force incidents, and there is proper oversight of documentation.
Good progress

There should be effective oversight of all aspects of safety in the prison. Governance meetings should be well attended, and discussion and action should focus on key priorities in each area informed by good data analysis.
Insufficient progress

The prison should have a clear strategy to identify and meet the needs of prisoners from all protected characteristic groups, ensuring there is no disproportionate treatment.
Reasonable progress

Staffing levels should be sufficient to ensure that prisoners have timely access to the full range of primary health services and appointments.
Reasonable progress

Leaders should enforce robust arrangements to protect the public by identifying and managing effectively the risks posed by all high-risk prisoners in custody and before their release.
Insufficient progress

Prisoners should be able to access appropriate offending behaviour interventions to reduce their risk and progress through their sentence.
Reasonable progress

Ofsted themes

Leaders should take rapid action to address the poor quality of teaching in classroom-based education, for example through improved training and quality assurance. They should make sure that prisoners have opportunities to develop substantial new knowledge and skills and, as a result, to achieve accredited qualifications at high rate.
Reasonable progress

Leaders should make more effective use of data to scrutinise the performance of learners on education courses.
Reasonable progress

Leaders should make sure that prisoners benefit from a good-quality induction, carried out sensitively, that helps them to make informed choices about their work or study options, and that allocations to courses match prisoners' career.
Reasonable progress

Leaders should make sure that prisoners with learning difficulties and/or disabilities needs receive appropriate support that enables them to make good progress in education, skills and work activities.
Reasonable progress

Appendix I About this report

HM Inspectorate of Prisons (HMI Prisons) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, court custody and military detention.

All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations in between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny and focus on a limited number of the recommendations made at the inspection. IRPs do not therefore result in assessments against our healthy prison tests. HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

The aims of IRPs are to:

- assess progress against selected key recommendations
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our main concerns at the full inspection.

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in February to March, 2022] for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

IRPs are announced at least three months in advance and take place eight to 12 months after a full inspection. When we announce an IRP, we identify which recommendations we intend to follow up (usually no more than 15). Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

During our three-day visit, we collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

Each recommendation followed up by HMI Prisons during an IRP is given one of four progress judgements:

No meaningful progress
Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.

Insufficient progress
Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken since our inspection had had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

Reasonable progress
Managers were implementing a realistic improvement strategy for this recommendation and there was evidence of progress (for example, better and embedded systems and processes) and/or early evidence of some improving outcomes for prisoners.

Good progress
Managers had implemented a realistic improvement strategy for this recommendation and had delivered a clear improvement in outcomes for prisoners.

When Ofsted attends an IRP its methodology replicates the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted is given one of three progress judgements.

Insufficient progress
Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.

Reasonable progress
Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.

Significant progress
Progress has been rapid and is already having considerable beneficial impact on learners.

Ofsted’s approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook*, available at https://www.gov.uk/government/publications/education-inspection-framework.

Inspection team

This independent review of progress was carried out by:

Charlie Taylor	Chief Inspector
Angus Jones	Team leader
Esra Sari	Inspector
Angela Johnson	Inspector
David Foot	Inspector
Shaun Thompson	Health and social care inspector
Si Hussain	Care Quality Commission inspector
Carolyn Brownsea	Ofsted inspector
Dave Baber	Ofsted inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Care Quality Commission (CQC)
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk

Challenge, support and intervention plan (CSIP)
Used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

Key worker scheme
The key worker scheme operates across the closed male estate and is one element of the Offender Management in Custody (OMiC) model. All prison officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

Leader
In this report the term ‘leader’ refers to anyone with leadership or management responsibility in the prison system. We will direct our narrative at the level of leadership which has the most capacity to influence a particular outcome.

Offender management in custody (OMiC)
The Offender Management in Custody (OMiC) model, which has been rolled out in all adult prisons, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1 October 2019. On 31 March 2021, a specific OMiC model for male open prisons, which does not include key work, was rolled out.

Protected characteristics
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Rosenshine's principles
Teaching instructions, identifying the approaches and strategies that are features of the most successful teachers’ practice (https://www.futurelearn.com/info/courses/early-career-teachers/0/steps/164331).

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

Printed and published by:
HM Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England