Report on an independent review of progress at

HMP Lewes

by HM Chief Inspector of Prisons

20–22 February 2023

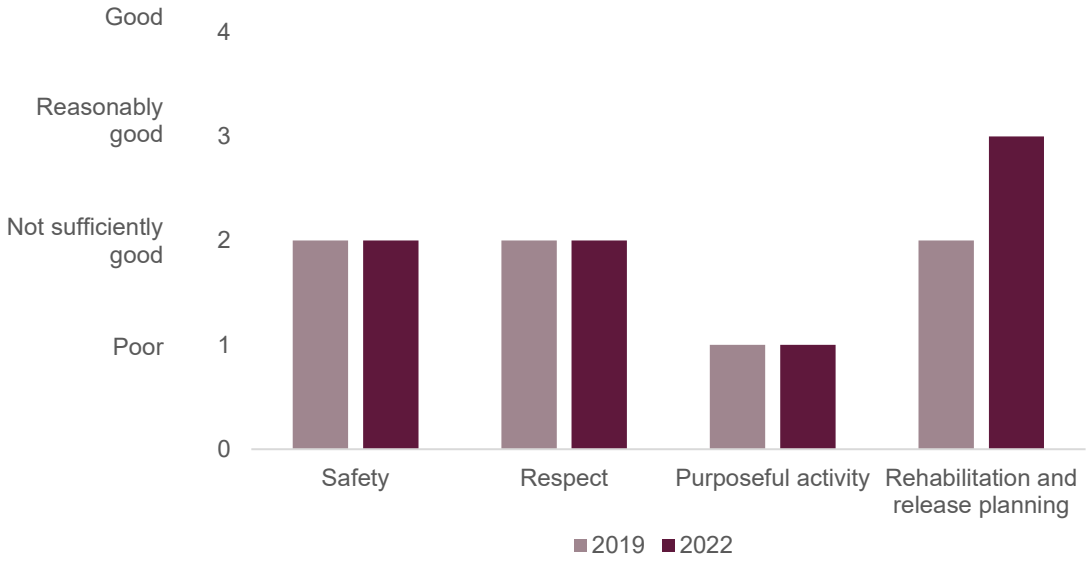
Contents

Section 1 Chief Inspector's summary

1.1 HMP Lewes was built in 1853 and is a category B reception prison, with the primary function of holding prisoners from courts in Kent, Surrey and Sussex. It holds up to 624 prisoners.

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

Figure 1: HMP Lewes healthy prison outcomes in 2022



1.3 In May 2022, we found that outcomes for prisoners remained not sufficiently good in safety and respect, and poor in purposeful activity. A shortfall of staff across different grades and departments was affecting outcomes for prisoners. Retention of staff was also poor. Violence was too high and prisoners at risk of suicide and self-harm were not sufficiently well cared for. Partnership and collaboration arrangements between the prison and the health care provider needed to improve. Living conditions were not good enough and time out of cell (see Glossary) for prisoners was inadequate. Ofsted assessed the overall effectiveness of education, skills and work provision to be inadequate. Allocation to activities was inefficient and attendance was poor.

1.4 At this independent review of progress, we considered whether leaders (see Glossary) had made progress against five of our priority concerns, one of our key concerns and four themes identified by Ofsted. We found good progress against one of our concerns, but there had been insufficient progress against three others and in two of the most critical areas – time out of cell and care for the most vulnerable prisoners – we found no meaningful progress. Ofsted found that there had been insufficient progress against all four themes they reviewed.

1.5 The retention of prison officers and the ability to deploy those still in post had both become critical problems. The governor had introduced a new regime, but it could not realistically be delivered because of staffing shortages. It was not sufficiently ambitious, only aiming to give most men five hours out of their cells. It only allowed prisoners half an hour to exercise and half an hour to undertake basic daily tasks like showering and collecting medication, which was inadequate. About half the population were not allocated to purposeful activity. In addition, the college was very frequently shut and in November, it had not opened at all. It was only open in the mornings during our visit. This meant that, aside from activity such as gym sessions or social visits, at least half the population spent about 23 hours every day in their cells. This represented an unacceptable deterioration since the inspection.

1.6 Levels of violence remained similar to the inspection and not enough was done to investigate incidents or challenge perpetrators. The rate of self-harm had increased and was high. Not enough support, interventions or time unlocked were available for the most vulnerable prisoners and those we spoke to did not feel well cared for. There had been improvements in cleanliness but overall leaders had been too slow to improve living conditions and were hampered by an unhelpful repairs and maintenance contract.

1.7 Health care was more encouraging. Many of the failures we identified at the inspection had been addressed, and, despite the departure of some managers, staffing had improved. We had confidence in the way the service was being led. There was more to do but good progress had been made.

1.8 Eight months on from the full inspection, our latest visit found a worrying lack of overall progress at Lewes. Time out of cell was among the worst we have seen outside pandemic restrictions, and we were left concerned for prisoners' well-being. It was notable that the number of calls to the Samaritans was escalating. Without significant further action to stabilise officer numbers, this situation was unlikely to improve.

Charlie Taylor
HM Chief Inspector of Prisons
February 2023

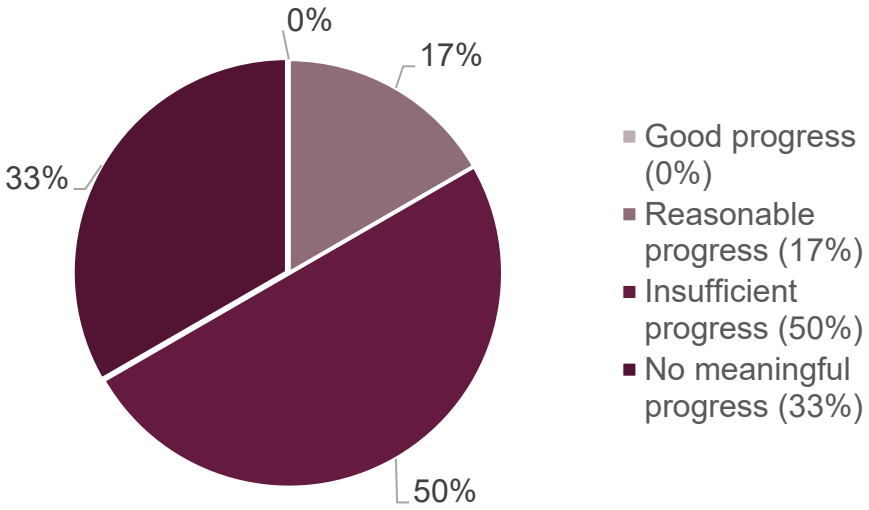
Section 2 Key findings

2.1 At this independent review of progress (IRP) visit, we followed up five priority concerns and one key concern from our most recent inspection in May 2022 and Ofsted followed up four themes based on its latest inspection.

2.2 HMI Prisons judged that there was reasonable progress in one concern, insufficient progress in three concerns and no meaningful progress in two concerns.

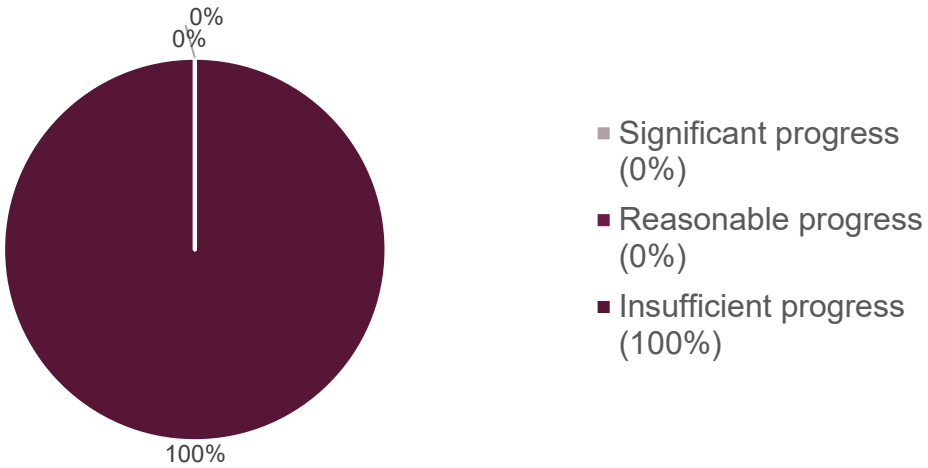
Figure 2: Progress on HMI Prisons concerns from 2022 inspection (n=6)

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



2.3 Ofsted judged that there was insufficient progress in all four themes.

Figure 3: Progress on Ofsted themes from 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 no examples of notable positive practice during this IRP.

Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2022.

Leadership

Priority concern: Staff shortfalls in many areas had slowed progress in achieving better outcomes for prisoners.

3.1 Leaders (see Glossary) had made very determined efforts to recruit staff since the inspection, which had led to some increases. About 80% of operational support grade prison staff were in post and available for work, which was an improvement. Permanent staffing in the health care department had increased from just under half of the required number at the inspection to about 70% at the time of our visit. Sometimes, however, gains were precarious. We were told that all administration posts would soon be filled, but before our visit had ended, there were two more vacancies.

3.2 Some useful innovations had been introduced to engage and support newly recruited staff. For example, a 'new colleague mentor' had started in October and he provided some very good practical help. The retention of officers and ability to deploy those remaining in post had become critical challenges and only about 60% of the total number of officers required to run Lewes were available every day. This undermined the new regime and had a substantial impact on prisoners' time out of cell (see Glossary), access to education and well-being.

3.3 Since the inspection, 53 officers had resigned and only 58 had been recruited, a net gain of only five. Of those officers in post, about a third could not be deployed for reasons such as training, sickness, restricted duties, suspension and temporary promotion. The number of working days lost among uniformed staff had been trending upwards since the inspection. There was significant pressure on the remaining officers, and the number of staff who were willing to work extra shifts to keep the regime running had declined. Although a smaller proportion of officers lacked experience compared to the inspection, we still observed a lack of confidence, notably in challenging low level poor behaviour on wings and making sure that prisoners attended activities.

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

Managing behaviour

Key concern: Violence at the prison was still too high and there was limited understanding of the causes and how to respond to them. The strategy and action plan for dealing with violence were not informed by thorough analysis of available data, or of available intelligence.

3.5 Overall recorded rates of violence since we last visited Lewes were similar to those found at the inspection and were comparable to other reception prisons. Levels of prisoner-on-prisoner assaults had been increasing over the previous eight months, but the rate of assaults against staff was now lower than at the inspection.

3.6 With the help of a dedicated analyst in the safety department, leaders had started to gain a better understanding of the causes of violence and attributed the increasing rate of prisoner-on-prisoner assaults to frustrations with the regime and a lack of purposeful activity.

3.7 Members of the safety team were still regularly redeployed to run the wings. This meant that not all incidents of violence, some of which were serious, were investigated promptly or in sufficient detail. Some incidents took weeks to be investigated. These delays meant that challenge, support and intervention plans (CSIPs) (see Glossary) were not used effectively to manage perpetrators of violence. Only two plans were established during our visit. They contained targets, such as 'gain employment', which were unrealistic for many prisoners. There was an insufficient range of other interventions available for perpetrators and to support victims of violence.

3.8 Leaders had reviewed the safety strategy, but it was not clear how success would be measured. They had also introduced a weekly safety action meeting a few weeks before our visit. This had the potential to improve joint working between security, safety and residential teams and the prison's response to incidents of violence.

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

Safeguarding

Priority concern: The most vulnerable prisoners were not sufficiently well cared for. The quality of ACCT documentation was poor, including weaknesses in the case management of prisoners on constant supervision. Serious incidents of self-harm were not investigated routinely to understand the causes.

3.10 Since the inspection, recorded rates of self-harm had increased and were now high compared to other reception prisons. Leaders had not done enough to determine or address the causes of self-harm. Improvement plans were dominated by processes rather than practical

measures better to support and care for prisoners at risk of suicide or self-harm. There were still not enough interventions to support the most vulnerable prisoners.

3.11 Most prisoners in crisis we spoke to continued to feel uncared for and inadequately supported. We found significant evidence to support their poor perceptions. Many were locked up in substandard conditions for prolonged periods without anything meaningful to do. Some had not been provided with in-cell phones, which meant they were unable to maintain contact with family and friends or call the Samaritans, if needed. This was a particular issue in the first night centre, where staff did not provide prisoners with a free weekly outgoing letter so they could write to their families. Many prisoners told us that not being able to get basic things done caused them significant frustration and we observed problems like a lack of application forms and broken washing machines during our visit. Staff did not respond to emergency cell bells for unacceptably long periods.

3.12 Efforts to improve the quality of assessment, care in custody and teamwork (ACCT) documentation for prisoners at risk of suicide or self-harm had not yet been effective, and those we reviewed contained too many weaknesses. Immediate action plans, assessments and case reviews were sometimes delayed, and they often lacked input from different departments. Care plans were not meaningful and, in some instances, had not been completed at all. None of the care plans we reviewed included interventions that might have helped. Prisoners were not always checked at the required frequency and records showed that interactions were limited. Constant supervision still took place too often in the segregation unit, which remained unsuitable.

3.13 Until we asked for data, leaders were not aware that the number of calls to the Samaritans had increased dramatically in the previous three months. There were not enough Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) to meet men's needs.

3.14 Leaders only investigated serious cases of self-harm that resulted in hospitalisation. This threshold was too high, and some other very concerning incidents would have benefited from closer scrutiny. The two investigations completed since the inspection were adequate and one had identified some lessons.

3.15 We considered that the prison had made no meaningful progress in this area.

Daily life

Priority concern: Areas of the prison were unacceptably dirty. Cleaning standards and routines were inconsistent, some communal spaces were grubby. Many cells contained graffiti and toilets were filthy.

3.16 The age of most wings at Lewes made it a challenging prison to maintain. Leaders had made some improvements to the environment, but progress had been too slow.

3.17 Funding had been secured to improve some of the showers and damaged flooring and some of this refurbishment had taken place since the inspection, with more to come. After a recent concerted effort, communal and outside areas were generally cleaner, but ingrained dirt remained on doors and stairwells and around the entrances to cells. There were enough wing cleaners unlocked on the landings, but, as at the inspection, we rarely saw them working productively. They had not all been trained and did not routinely have enough cleaning equipment or materials. Staff did not supervise them, and standards of cleanliness remained inconsistent. Some cages outside cell windows were full of rubbish.

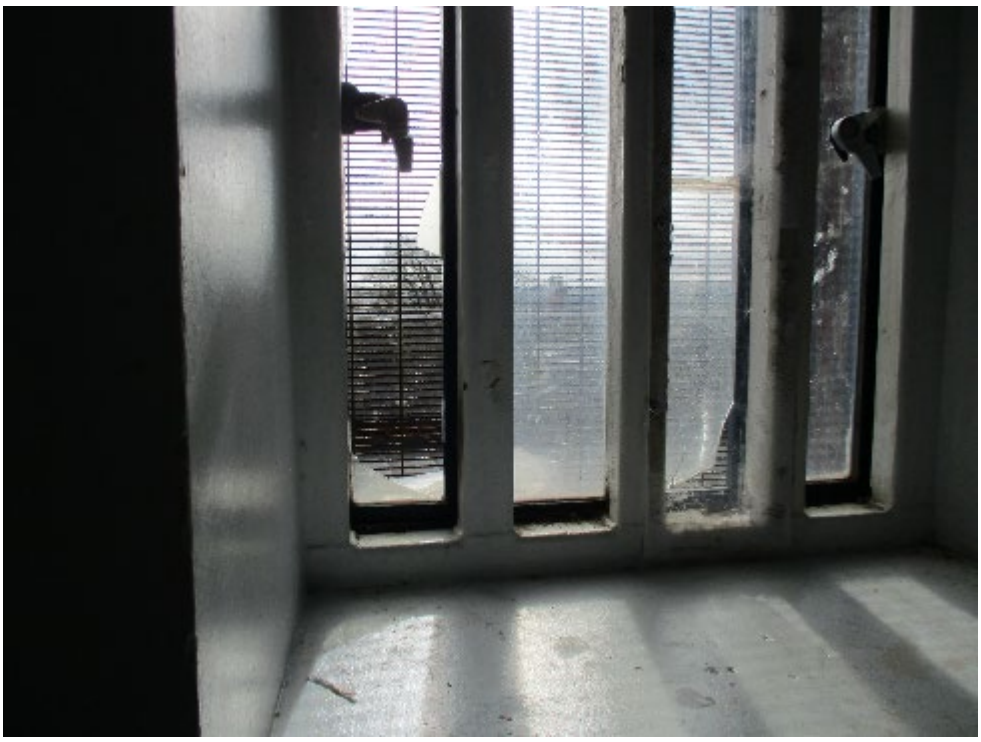
3.18 There had been some piecemeal improvements to cells, but too many remained in a poor state. A number contained large amounts of graffiti, including some that was offensive.

Heavily graffitied cell on M wing

3.19 Despite efforts to clean toilets, many remained scaled and dirty, and some were still in a filthy state. Such poor conditions were particularly concerning given the long periods of time prisoners spent locked up.

Toilet on M wing

3.20 There were deficiencies in the Government Facilities Services Limited (GFSL) maintenance contract, which limited the prisons' ability to deliver a comprehensive painting programme and complete necessary repairs in a timely way. A lack of GFSL staff meant untrained prisoners had to paint cells and communal areas. The project was also hampered by the limited time prisoners spent unlocked and the poor materials with which they were provided. Many cells also contained damaged flooring and windows, and GFSL took too long to carry out repairs. We found a cell housing a prisoner at risk of suicide and self-harm, which contained a damaged window that prison staff had reported numerous times. GFSL had not yet made it safe or repaired it.



Broken window of a cell where a man at risk of suicide and self-harm was living

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

Health, well-being and social care

Priority concern: Patient care was deficient because of ineffective partnership arrangements, leading to poor communication with prisoners, reduced nurse staffing levels and inconsistent prisoner escort arrangements.

3.22 Deficiencies in care in several key areas had been resolved, in part because the prison had very recently enabled more patients to attend their health appointments. The non-attendance rate for the GP clinic had fallen by about two thirds since May 2022.

3.23 Strategic and operational partnership working between the prison, NHS commissioners and Practice Plus Group (PPG) had improved. They now had a shared agenda and regular meetings, and agreed on action. An approachable health care governor had strengthened communications between the prison and PPG staff. The refurbishment of clinical areas had yet to start, although cleanliness was better. Recent audits of infection control compliance showed signs of improvement, although some practices required fine-tuning.

3.24 A PPG patient engagement lead staff member was now routinely available to prisoners on the wings. Her role had improved communication with patients, and she addressed their concerns using an effective ‘You said, we did’ approach, which was communicated via

posters on the wings and in face-to-face meetings. The January PPG patient survey indicated that 84% of patients had confidence in the service. There were also fewer health care complaints.

3.25 The Care Quality Commission (CQC) (see Glossary) determined that previous breaches of health regulations had been resolved. Patients with long-term conditions had timely reviews, and a new care plan hub made sure clinicians and patients jointly managed care, which was safe and well-coordinated. Some patients had yet to migrate to the new care plan format. Governance of medicines optimisation was more robust than at the inspection. For example, local operating procedures and patient group directions were now available, although clinical supervision of staff was inconsistent. In-possession medication checks were conducted regularly and suitably audited.

3.26 Other parts of the health care service, including the in-patient regime and mental health services had not seen such good progress. Since May 2022, 50% of prisoners who needed a transfer under the Mental Health Act had not been moved within the target time of 28 days, which was unacceptable.

3.27 About 70% of permanent health care posts had been filled (compared with about 50% at the inspection) and reliance on agency nursing had declined by 20%. In order to consolidate the precarious staffing gains, work to retain staff and improve their welfare had started. Substantial on-site support from regional and national PPG teams was designed to offset the impact of several recent, rapid changes within senior clinical and managerial personnel.

3.28 A new population health needs assessment had been produced by the NHS, to guide commissioning and improve services for patients.

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

Time out of cell

Priority concern: Time out of cell for prisoners was inadequate. Although COVID-19 restrictions were lifted during the inspection, there were no plans to increase time out of cell for the many unemployed prisoners.

3.30 Leaders had introduced a new regime the month before our visit, which was intended to prioritise prisoners' attendance at purposeful activity. It was not sufficiently ambitious, only aiming to give most men five hours out of their cells a day. However, there was little realistic prospect of even this being regularly offered. The daily regime was critically undermined because not enough prisoners were allocated to activities, attendance was poor and there were prison officer shortages, which frequently led to education being cancelled, notably for an entire month in November.

3.31 Aside from activity such as gym sessions or social visits, about half the population (sometimes more when the college closed) only had an hour out of their cell each day. This took place from 7.45am. Many prisoners chose not to exercise in the yard and were consequently locked up for the first half hour. This meant their time out of cell was reduced to a 30-minute period to carry out domestic tasks. This did not give them enough time to shower, collect medication, submit applications or clean their cells. Prisoners were frustrated by the poor regime, and some described the impact that it was having on their well-being and levels of motivation.

3.32 Our roll checks found about 60% of prisoners locked up during the core day, a poorer outcome than at the inspection. The college was shut in the afternoons on the week we visited. This meant that only 15% of prisoners were participating in purposeful activity away from the wing, no better than at the inspection.

3.33 The regime was equally poor at weekends. Due to staff shortages, most prisoners at Lewes had only received one hour out of their cell on a Saturday and Sunday since August 2022.

3.34 Prisoners could go to the gym twice during the week, but sessions clashed with work and education. They mostly used the weights equipment as the sports hall was not in use. Access to outdoor team sports was too limited as it depended on the availability of physical education staff who were sometimes redeployed due to staff shortages. Prisoners could not visit the gym at weekends.

3.35 Access to the library was very poor for most prisoners. It was based in the education department, which meant it was frequently shut. In January 2023, about 80% of planned library sessions had been cancelled.

3.36 We considered that the prison had made no meaningful 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: What progress have leaders and managers made in making sure that there are sufficient spaces available for the population and that prisoners are allocated to activities that meet their needs?

3.37 Leaders had not increased the number of spaces available to prisoners sufficiently since the inspection. Too many spaces that were available were not filled. Only about half the population had been allocated to work or education. There remained too many prisoners on waiting lists for activities. Staff did not monitor or manage these lists effectively.

3.38 Leaders had reviewed and made changes to induction since the inspection. However, they had not put the new induction process into place fully, and prisoners still completed paper-based initial assessments on wings. Consequently, leaders and staff could not be sure of the needs of individuals at the prison due to unreliable results from assessments.

3.39 Leaders were too slow to review the allocations process and make changes. They recognised the need for improvement and had set out a clear process in theory. However, as it had not yet been fully implemented, prisoners were still not allocated to activities effectively. Too often allocations to activities were based on prisoners' requests. Staff made sure that allocations took into account information provided by advice and guidance staff where this was available. However, too few prisoners had completed assessments or learning plans and so their needs were not known.

3.40 Leaders and managers did not make sure that there was sufficient resource to meet the needs of the population with lower levels in literacy and numeracy. Leaders had identified a need for more entry level provision and for shorter courses. They had, for example, introduced a non-accredited food safety entry level programme, and English and mathematics were offered as full functional skills qualifications or through modular learning. However, not enough prisoners who would have benefited from these courses could access them.

3.41 Ofsted considered that the prison had made insufficient progress against this theme.

Theme 2: What progress have leaders and managers made in improving the quality of education, skills and work and their oversight of quality?

3.42 Leaders were too slow to reopen fully education and work and to remove cohorting from the regime. It was too soon to gauge the impact of the new regime due to frequent disruptions.

3.43 The quality of provision was significantly affected by the unpredictable regime and frequent closure of education. Education did not run with sufficient regularity due to significant staff shortages in the prison. As a result, prisoners' education was disrupted and disjointed. Too often prisoners struggled to retain knowledge. They found the unpredictable and infrequent contact with staff demotivating, and too many prisoners refused to participate in education. Leaders made sure that work areas ran more consistently and more frequently than they did at the time of the inspection.

3.44 Attendance at education was too low. Prisoners' appointments and gym sessions too often clashed with education and work. Prisoners were often not where teachers expected them to be for outreach appointments, and staff struggled to maintain regular contact with them. Prisoners too often refused to attend due to high levels of apathy created by the unpredictable regime.

3.45 Leaders and managers did not monitor effectively the quality of teaching and training, or the progress that prisoners made, in workshops and work areas. Managers had plans to improve their oversight in these areas but had yet to take any action. Leaders and managers in education had completed limited quality monitoring of activities since the inspection. However, education leaders were in the process of providing a series of informative professional development sessions for education staff on teaching skills.

3.46 Education and prison managers met frequently to review formally the education provision. However, meetings between education and prison leaders and managers still focused on performance and data, and not sufficiently on the quality of provision.

3.47 Ofsted considered that the prison had made insufficient progress against this theme.

Theme 3: What progress have leaders and managers made in making sure that prisoners in work areas complete the basic training or qualifications that are important for their roles?

3.48 Too few prisoners were able to access training or complete qualifications in work areas. Leaders had increased training and the availability of qualifications since the inspection. For example, a small proportion of prisoners had the opportunity to complete food safety while working in the tea packing workshop. They had introduced a non-accredited food safety entry level programme, from which a very small proportion of prisoners progressed to the full level 2 food hygiene certificate. More recently, they began to provide individual units of training in industrial cleaning. However, only a small proportion of prisoners could access these opportunities.

3.49 There remained too few prisoners in work areas who had completed the basic training required for their roles. The new provision leaders had introduced did not run frequently enough to maintain a trained prisoner workforce.

3.50 Prisoners in work areas did not receive sufficient training to fulfil their roles to a high standard. Staff did not use any learning plans or progress tracking systems to record prisoners' training needs or progress. Most prisoners chose to work in areas, such as tea packing, as they enjoyed being out of their cell. However, they did not gain new skills or knowledge in their work roles.

3.51 Prisoners in wing worker roles, particularly cleaners, did not have access to the resources required to complete their work effectively. They did not have personal protective equipment and had only limited cleaning products and chemicals. Too often, they were using faulty or broken equipment.

3.52 Ofsted considered that the prison had made insufficient progress against this theme.

Theme 4: What progress have leaders and managers made in enabling prisoners to access high-quality careers information, advice and guidance (CIAG) so that prisoners are clear about their next steps and future career goals?

3.53 Since the previous inspection, leaders had put in place an employment lead staff member and an employment hub, and employment advisory board meetings had been introduced. However, they were too new to have any impact on the quality of advice and guidance prisoners received or their preparation for employment when released. The employment hub, for example, was not yet ready for use. It did not have access to the systems required, such as the virtual campus (prisoner access to community education, training and employment opportunities via the internet). As a result, it was highly underused.

3.54 Leaders were too slow to bring about improvements to induction. While they had commissioned a new induction wing at the prison, it was not yet fully operational. Induction to education was still held on wings and staff did not consistently inform prisoners about their options for education, skills and work while at the prison.

3.55 There were too few information, advice and guidance (IAG) advisers in place. Consequently, too many prisoners did not receive any CIAG or have the opportunity to discuss their future career goals and aspirations. Too many prisoners did not have a personal learning plan. Plans were too generic and lacked a useful record of the discussions that had taken place between the prisoner and the IAG adviser.

3.56 Leaders did not make sure that the curriculum in place provided clear pathways through education and work. Staff did not prepare prisoners effectively for progression through the secure estate or towards release and employment.

3.57 Ofsted considered that the prison had made insufficient progress against this theme.

Section 4 Summary of judgements

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

HMI Prisons concerns

Priority concerns

Staff shortfalls in many areas had slowed progress in achieving better outcomes for prisoners.
Insufficient progress

The most vulnerable prisoners were not sufficiently well cared for. The quality of ACCT documentation was poor, including weaknesses in the case management of prisoners on constant supervision. Serious incidents of self-harm were not investigated routinely to understand the causes.
No meaningful progress

Areas of the prison were unacceptably dirty. Cleaning standards and routines were inconsistent, some communal spaces were grubby. Many cells contained graffiti and toilets were filthy.
Insufficient progress

Patient care was deficient because of ineffective partnership arrangements, leading to poor communication with prisoners, reduced nurse staffing levels and inconsistent prisoner escort arrangements.
Reasonable progress

Time out of cell for prisoners was inadequate. Although COVID-19 restrictions were lifted during the inspection, there were no plans to increase time out of cell for the many unemployed prisoners.
No meaningful progress

Key concern

Violence at the prison was still too high and there was limited understanding of the causes and how to respond to them. The strategy and action plan for dealing with violence were not informed by thorough analysis of available data, or of available intelligence.
Insufficient progress

Ofsted themes

What progress have leaders and managers made in making sure that there are sufficient spaces available for the population and that prisoners are allocated to activities that meet their needs?
Insufficient progress

What progress have leaders and managers made in improving the quality of education, skills and work and their oversight of quality?
Insufficient progress

What progress have leaders and managers made in making sure that prisoners in work areas complete the basic training or qualifications that are important for their roles?
Insufficient progress

What progress have leaders and managers made in enabling prisoners to access high-quality careers information, advice and guidance (CIAG) so that prisoners are clear about their next steps and future career goals?
Insufficient 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 in addressing HM Inspectorate of Prisons' concerns 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 concerns raised 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 priority and key concerns
- 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 concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in [MONTH, YEAR] 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 concerns we intend to follow up (usually no more than 15). Depending on the concerns 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 concern. Sources of evidence include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

Each concern 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 to address this concern.

Insufficient progress
Managers had begun to implement a realistic improvement strategy to address this concern 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 to address this concern 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 to address this concern 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 of Prisons
Jonathan Tickner	Team leader
Kellie Reeve	Inspector
Rebecca Stanbury	Inspector
Paul Tarbuck	Health and social care inspector
Mark Griffiths	Care Quality Commission inspector
Dianne Kopitt	Ofsted inspector
Rebecca Perry	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.

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.

Time out of cell
Time out of cell, in addition to formal 'purposeful activity', includes any time prisoners are out of their cells to associate or use communal facilities to take showers or make telephone calls.

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