Report on an independent review of progress at

HMP/YOI Rochester

by HM Chief Inspector of Prisons

20–22 September 2022

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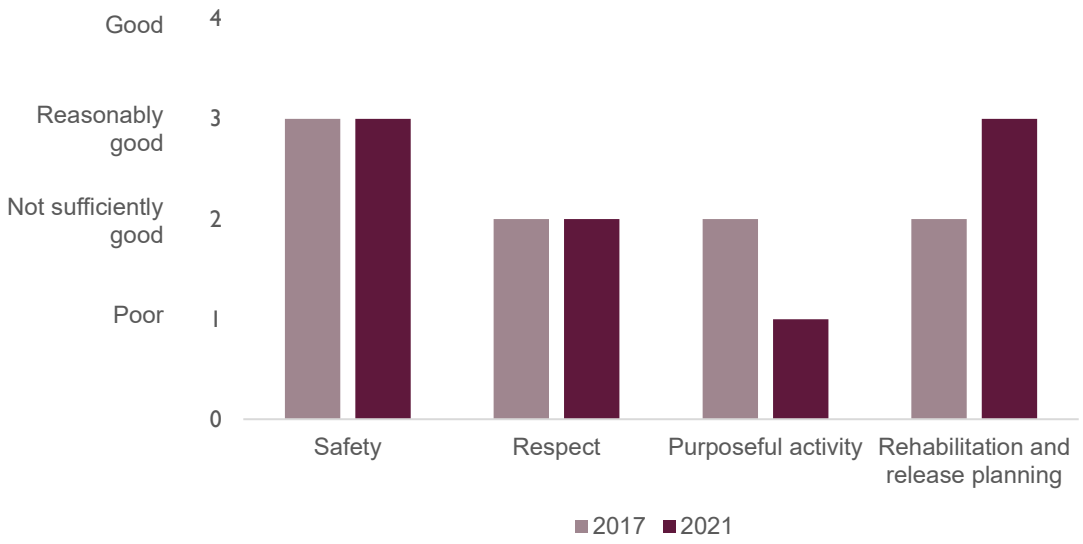
Section 1 Chief Inspector's summary

1.1 HMP/YOI Rochester is a category C training and resettlement prison for adult and young adult men in Kent, with a population of 670 at the time of this visit. It comprises one older set of buildings, being the location of the original borstal, and a lower site with more modern buildings which were not designed for long-term use. Uncertainty has hung over the site since a planned closure was rescinded in 2017.

1.2 At our previous inspections of HMP/YOI Rochester in 2017 and 2021 we made the following judgements about outcomes for prisoners.

Figure 1: HMP/YOI Rochester healthy prison outcomes in 2017 and 2021



1.3 In the context of the restrictions then imposed by the COVID-19 pandemic, we concluded that following our 2021 inspection, outcomes for prisoners at Rochester were reasonable, although we noted some significant caveats concerning the state of the buildings and the quality of the regime. Outcomes in safety remained reasonably good and work in support of rehabilitation and release planning had improved so that outcomes against that test were reasonably good. Purposeful activity had gone in the other direction, with too few prisoners in 2021 involved in education, work or other constructive activity.

1.4 A key issue from the 2021 report was leadership. Progress was too slow in increasing purposeful activity, restoring a full regime and addressing the chronic shortage of staff. I wrote that 'it was hard to avoid the sense… that with greater confidence, ambition and clarity of purpose from leaders, more could have been achieved'.

1.5 At this review there was evidence that attention, albeit often quite recent, was being paid to some of these issues, but our primary message, after 11 months, remains the same: "more could have been achieved." We did not find evidence of good progress with respect to

any of the concerns we had raised and reasonable progress in only one. Regarding all our remaining concerns, for three quarters of them we judged progress to be insufficient, and for a concern we had about safety, there had been no meaningful progress at all.

1.6 There are considerable challenges at HMP/YOI Rochester, with its poor physical environment and problems in attracting and retaining staff. In addressing these challenges leaders have focussed on involving more prisoners in work and education, with some positive results, but in almost every other area about which we raised a concern in 2021, not enough has been done to give confidence that outcomes are likely to improve.

Charlie Taylor
HM Chief Inspector of Prisons
October 2022

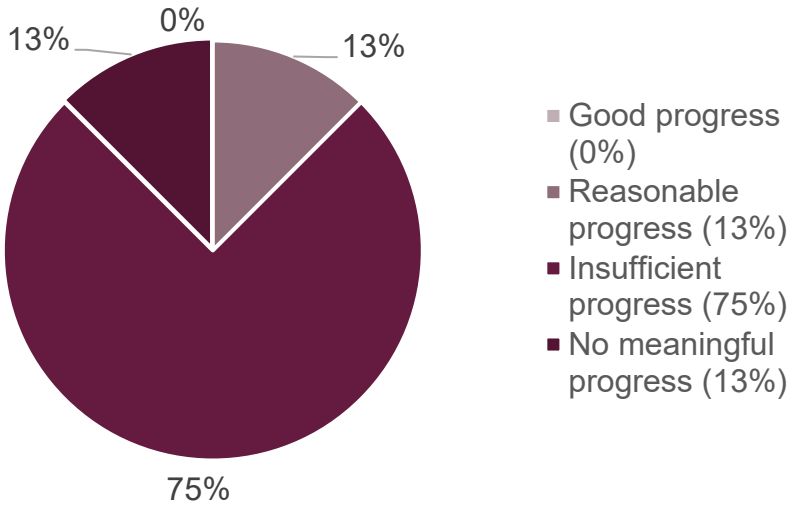
Section 2 Key findings

2.1 At this independent review of progress (IRP) visit, we followed up eight recommendations from our most recent inspection in October 2021 and Ofsted followed up three themes based on their latest inspection or progress monitoring visit to the prison, whichever was most recent.

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

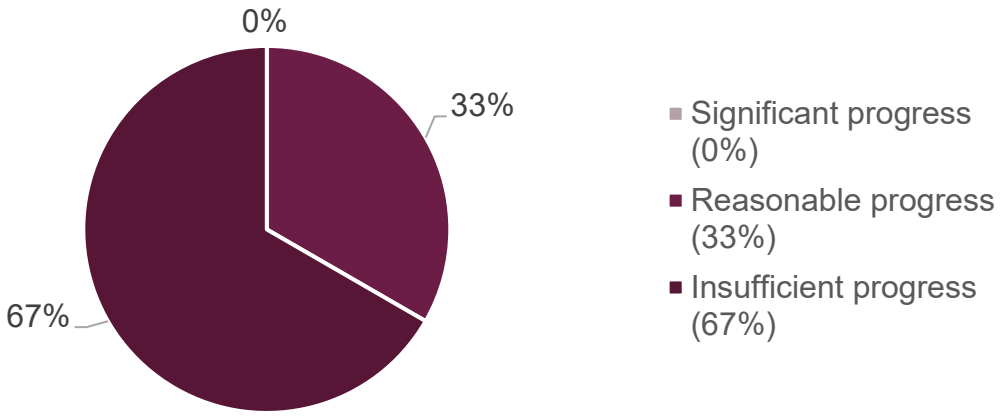
Figure 2: Progress on HMI Prisons recommendations from 2021 inspection (n=8)

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 one theme and insufficient progress in two themes.

Figure 3: Progress on Ofsted themes from 2021 inspection/progress monitoring visit (n=3).



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 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 2021. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Early days in custody

Concern: There were weaknesses in the support provided to new arrivals. First night interviews did not assess prisoners' immediate risks and vulnerabilities thoroughly enough to ensure that staff could provide appropriate support. The regime on the reverse cohorting units (see Glossary) was poor, which limited opportunities for staff to identify prisoners at risk of self-harm. There was no formal induction programme, and prisoners did not have access to Listeners or other peer workers to help them understand what to expect from their early days in custody, or how to access sources of support.

Recommendation: Safeguards should be in place to ensure that all prisoners arriving at Rochester are kept safe, including a thorough risk assessment of their needs, and have access to relevant information and proactive support from staff and peer workers during their early days in custody. (1.42.)

3.1 The first night screening process had been reviewed and now assessed prisoners' immediate risks and vulnerabilities, with interviews being completed in a private room. We were satisfied that this was happening routinely, although recording was inconsistent. We found some interviews being documented when a prisoner first entered custody, including three safety checks on their first night, but other prisoners had limited or no information recorded.

3.2 Deployment and attendance by Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) in reception was similarly inconsistent, even though there was meant to be a system in place to ensure this happened. Outdated information about the prison was still being displayed in the holding rooms, although this was mitigated by the introduction of a new and up-to-date induction booklet. Peer workers were confident in greeting new arrivals on the induction wing, and explaining how the prison works.

3.3 An induction programme had recently been reintroduced, providing new prisoners with valuable information. It was delivered three times a week, and the sessions took place in a dedicated room, with information leaflets available about a variety of prison services. Although it was still in its early stages, staff and peer workers were working hard to make these sessions informative. The chaplaincy

always attended, but staff from other departments did not, requiring that prisoners be directed to other sources of information during sessions.

3.4 We considered that the prison had made reasonable progress against this recommendation.

Leadership

Concern: Rates of attrition and staff shortfalls impacted on the prison's ability to deliver a full regime. Drugs were identified as a key threat but there were insufficient staff to carry out mandatory drug testing (MDT) and target searching. External hospital appointments were restricted, and some were cancelled. The prison could not deliver enough courses to meet the needs of the population. Staffing shortfalls were likely to delay progress to a full regime until at least spring 2022.

Recommendation: There should be clear measures to recruit, train, and retain operational staff to keep prisoners safe and healthy and deliver a full rehabilitative regime. (1.43.)

3.5 Staffing levels remained a concern and leaders (see Glossary) were still unable to deliver a full regime. There had been some success with the recruitment of operational support grade staff (see Glossary) and twenty new prison officers were due to arrive at Rochester shortly after our visit but, despite this, there remained an inability to recruit to the level required to replace the number of staff who were leaving. Some work had begun on understanding why the staff attrition rate was high (15% per year), for example through exit interviews, and a range of measures to support staff well-being and improve job satisfaction.

3.6 The misuse of drugs remained a concern, but owing to staffing shortages, there had been no random mandatory drug testing (MDT) for over a year. Leaders were not able to gather adequate data on drug use, and MDT processes were undermined as a possible deterrent to substance misuse. Suspicion testing was not always carried out – in the previous six months, 193 tests had been requested by the security department but only 37 (19%) had been carried out. Similarly, targeted cell searches were not always undertaken owing to staff shortages. In the previous six months, 391 had been requested and only 121 (31%) carried out. Half of the 121 searches had led to illicit items being found. Staff shortages had also resulted in 29 hospital appointments being cancelled in the previous three months.

3.7 Ongoing staffing challenges in the programmes team meant that the delivery of group offending behaviour programmes had not resumed, although some one-to-one work had taken place.

3.8 We considered that the prison had made insufficient progress against this recommendation.

Managing behaviour

Concern: There were weaknesses in the prison's approach to maintaining safety. The policy was out of date, data was not analysed to determine the risks of rising violence and self-harm as restrictions eased and there were no plans to counteract these risks. There were few proactive interventions to manage the perpetrators of violence and little support for victims. There were no arrangements for logging or monitoring referrals made to the safer custody team and we found one case of bullying that was not acted on for this reason.

Recommendation: The strategy to improve safety outcomes should be informed by good data analysis and include an effective action plan to reduce violence and self-harm. (1.44.)

3.9 The rate of violent incidents in the six months before our review visit was similar to the same period before our last inspection. Prisoner-on-prisoner assaults had declined, but prisoner-on-staff assaults had increased.

3.10 The overarching safety strategy had not been updated since our last inspection. As a result, there remained a lack of focus on the specific issues affecting Rochester. For example, drugs remained a key threat and yet there was not enough drug testing or targeted searching of cells (see paragraph 3.6). HM Prison and Probation Service's own data-reporting tool found the top three reasons for violence at Rochester were non-compliance, retaliation, and debt, but they had not been explored further. Two new policies, on debt and on bullying, had been introduced recently, but they were not based on analysis of data and it was not yet clear whether they would be effective.

3.11 The safety action plan, which was annexed to the overarching safety strategy, was not timebound, and in the absence of data analysis it was unclear on what evidence the planned action was based.

3.12 We considered that the prison had made no meaningful progress against this recommendation.

Staff-prisoner relationships

Concern: In our survey significantly fewer prisoners than last time said staff treated them with respect (66% compared with 78%). Limited time out of cell restricted the time available for positive relationships to develop. Staff had little time to help prisoners with day-to-day issues. Key work duties were cancelled which compounded this problem. There was no evidence of key workers supporting prisoners on ACCT case management or challenge, support and intervention plans (see Glossary).

Recommendation: Staffing levels and prisoners' time out of cell should be increased to facilitate the development of productive and positive relationships. (1.45.)

3.13 Staff interaction with prisoners remained mixed. Some prisoners told us that staff did not always speak to them in a positive manner, while on some wings we saw poor behaviour amongst prisoners going unchallenged.

3.14 Time out of cell (see Glossary) had increased substantially for one wing each week following the introduction of a new pilot regime (see paragraph 3.35) but staff still had insufficient time to assist prisoners with day-to-day issues.

3.15 The reintroduction of the key worker scheme (see Glossary) was in its very early stages. Most prisoners still did not have any reliable, regular contact with a key worker to help them address any personal well-being issues and support their progression. In the six months to 30 August 2022, just over 11% of the planned number of key work sessions with prisoners were recorded as having taken place, but the actual rate was believed to be even lower owing to recording faults. Key work sessions were sometimes cancelled as staff were required to cover other duties, such as visits and escorts. The prison had recently introduced overtime payments for prison staff to target this work for a limited period.

3.16 We considered that the prison had made insufficient progress against this recommendation.

Living conditions

Concern: The cells in the older accommodation blocks were dingy and dilapidated and in need of continual repair, leaking plumbing was commonplace, and in some cells the electricity wiring appeared to be in a dangerous state. There was an ongoing problem with a rodent infestation that affected most prisoners. None of the single cells had toilet screens, which was undignified. Most windows across the prison needed to be repaired or replaced as the ventilation hatches could not be opened, which meant it was difficult to regulate the temperature in the cells.

Recommendation: Cells in the older part of the prison should be taken out of commission and refurbished or replaced to ensure that all prisoners live in cells that are safe, decent and comfortable. (1.46.)

3.17 Since our full inspection, there had been some promising efforts to improve living conditions in cells in the older part of the establishment. Leaders had secured funding to replace 25 broken windows on B wing, and exposed electrical wiring had been covered. Prisoners on A wing had recently been employed as part of a painting party and had redecorated several cells using anti-damp paint, which had improved the conditions.

3.18 However, many cells on B, D and E wings remained poor – we saw a few cells with broken plumbing, including leaking taps and toilets that did not flush, windows in disrepair, which meant prisoners could not adequately control the temperature or ventilation in their rooms, and damaged flooring, which posed a trip hazard. Single cells still did not have toilet screens, and the toilets were in direct view of the observation panels, which undermined prisoners' dignity.

A sink in a single cell with broken plumbing

A single cell with an unscreened and broken toilet

Damaged cell floor which a prisoner had attempted to repair

3.19 There was an ongoing issue with vermin, which the establishment had been unable to bring under control. Many prisoners complained about mice entering their cells at night. An outside area close to B wing had a significant rat problem. Pest control were making weekly visits to the prison, but this had not yet led to a positive outcome, and while leaders were attempting to identify alternative ways to address infestations, the problem continued to affect many prisoners.

3.20 The prison's facilities management department still received a large number of maintenance requests – about 500 a month in the three months leading to our visit. Most of them were addressed promptly, but much of the heavy demand for repairs was due to the persistent problems associated with old and run-down buildings, such as difficulty in sourcing spares.

3.21 We considered that the prison had made insufficient progress against this recommendation.

Daily life

Concern: Prisoners told us about problems accessing their stored property, and, in 2021, almost a third of all complaints related to the issue. There were delays in processing property and answering prisoners' queries, leading to frustration. Records were not always complete, which meant it was not possible to find items. Some prisoners waited months to receive items sent in by post.

Recommendation: Prisoners should have ready access to their stored property. Requests for access should be dealt with within agreed and published time scales following consultation with prisoners. (1.47.)

3.22 There was no longer a backlog with respect to prisoner property. The storeroom had been organised effectively and a system for providing prisoners with access had been put in place. However, this had only been achieved in recent weeks by a new leader, who had worked hard to get the system working to this level of efficiency, often clearing backlogs personally. It was too early to be sure of a sustainable improvement in outcomes for prisoners.

3.23 The property storeroom was not always staffed, and prisoners continued to feel frustrated about the excessive time it took to obtain their stored property and items sent in by post. We spoke to one prisoner who was able to access his property after almost 10 months of waiting. Delays in other establishments forwarding prisoners' property to HMP/YOI Rochester continued to be an issue.

3.24 Despite an initial decrease in the number of complaints about property since our last inspection, they had started to increase again in recent months. Almost a third of all complaints related to property. Applications about property were not always answered on time, and lost and damaged items continued to be a problem. Communication with prisoners about their property was poor. Prisoners could still not be certain about when they could receive or have access to their property.

3.25 We considered that the prison had made insufficient progress against this recommendation.

Health, well-being and social care

Concern: Clinical governance systems and processes were underdeveloped across primary care and dental services. This included the management of complaints, infection prevention and control oversight and learning lessons from incidents. We were not confident that factors affecting patient safety were identified or addressed in a timely manner.

Recommendation: Robust governance procedures, including consistent incident reporting and investigation, should be implemented to ensure that concerns affecting patient safety are promptly addressed. (1.48.)

3.26 There was now a governance and quality manager, along with governance structures, including a range of forums that had the potential to provide oversight. However, best use was not made of these initiatives, and governance did not identify patient safety issues consistently. For example, not all adverse incidents were being reported, such as a lack of medicine availability, which meant information submitted was not comprehensive enough for managers to identify trends effectively or to inform quality improvement plans. As a result, there had been little improvement in tackling issues raised consistently at patient forums, or in relation to complaints and incidents.

3.27 Lessons learned were only shared in a limited way, bulletins on incidents at Rochester were not yet in place and minutes from governance meetings were vague, without enough detail to give staff adequate information. We saw staff talking about incidents during handovers, but lessons learned were not recorded.

3.28 Deficits in dental governance had been resolved through effective management of infection prevention and control, and necessary repairs in the dental suite had been completed.

3.29 There was a new system for recording complaints and incidents, but low staffing levels limited its efficacy. Complaints were not logged and did not receive a response within expected timeframes. Many were not answered at all and where responses were provided, they were poorly written and did not address the problem. The number of complaints was much higher than expected because there were repeated submissions caused by the failure to respond, as well as a lack of quality improvement, which might have followed an analysis of complaints.

3.30 Although CQC found that some improvements had been made, due to the lack of progress Oxleas NHS Foundation Trust continued to be in breach of Regulation 17, Good Governance. A further requirement notice has been issued to the provider.

3.31 We considered that the prison had made insufficient progress against this recommendation.

Time out of cell

Concern: Most prisoners were locked in their cells for over 22 hours a day, with little to keep them occupied, which was having a detrimental effect on their well-being. The prison had been slow to expand the regime, partly because of staff shortages. The prison did not have a clear plan for a complete regime recovery.

Recommendation: All prisoners should have adequate time out of cell to participate in a regime that includes purposeful activity, time to complete domestic chores and the opportunity to socialise with their peers. (1.49.)

3.32 Up to 80% of prisoners were now involved in activities (see paragraph 3.38) which was a significant increase compared to the time of our inspection. Most places were full time, and prisoners participating were out of their cells for about eight hours a day. Prisoners who were in full-time activities told us they generally received evening association, but not always consistently, and staff shortages meant that, on some occasions, evening association could be cancelled or cut short.

3.33 Unemployed prisoners, including those who were willing to work and were on a waiting list for activities, continued to be locked in their cells for up to 22 hours a day, with little to keep them occupied, particularly on Fridays and at weekends. Very recently, this had sometimes been extended to four hours out of cell for some unemployed men. Leaders could not provide accurate records of how long prisoners had been out of their cells on any given day, so we could not verify the exact amount of time they spent unlocked.

3.34 For those who were unemployed, and at weekends, the regime was too limited considering the prison's stage in the COVID-19 recovery process, and many prisoners told us they were bored and frustrated by long periods locked in cells. We were told that this was due to understaffing, but leaders had not yet developed a clear plan for expanding the regime. They recognised that staff deployment was not fully efficient and were beginning to address this.

3.35 The prison had been conducting a pilot where one wing each week was unlocked in the morning, afternoon and evening. Prisoners appreciated this and told us it had led to the wings being more settled. A small amount of data gathered by leaders since the pilot began indicated a drop in violence and aggression.

3.36 We considered that the prison had made insufficient progress against this recommendation.

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 and managers must urgently prioritise increasing the number of face-to-face places in education, skills and work activities so that a significantly larger number of prisoners are able to access and attend activities.

3.37 Since the inspection, leaders had substantially increased the number of activity places available in work and education – all were face-to-face and had been since early in 2022. There was a good range of job roles for prisoners on the wings. More job roles had been created in the kitchens and in the more recently reopened laundry and waste management areas.

3.38 While there were still not enough spaces for the whole population and not all available spaces were filled, there were more activities than there had been prior to the pandemic, and leaders were continuing to expand education, skills and work. Approximately 80% of the population were attending activities and most were full time. However, leaders faced difficulties recruiting to vacant teaching posts in construction, which resulted in too many of these courses not currently running.

3.39 Leaders had carefully considered the curriculum available to prisoners. It was broad and varied and included a good range of qualifications. Leaders used their funding well to secure a range of subcontracted provision, such as art, rail track maintenance, roofing and stewarding courses. They placed an appropriate emphasis on the importance of English and mathematics skills. Many prisoners in the recent cohorts had gained their functional skills qualifications. Managers made sure that there was appropriate support in place for prisoners accessing education who had a known learning difficulty or disability.

3.40 Tutors and instructors used their knowledge and skills effectively to plan and implement their curriculum. They considered the order in which they taught the content to make sure that prisoners gained underpinning knowledge at the start of the course. For example, in tiling, staff designed the programme to focus first on relevant knowledge in health and safety before moving on to basic tiling skills. Prisoners then applied this to practical wall and floor tiling tasks. As a

result, prisoners developed new knowledge and skills in work or in education.

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

Theme 2: Leaders and managers must make sure that the induction to education and training and initial advice and guidance support is fully effective to enable prisoners to plan their learning and potential next steps more comprehensively.

3.42 Leaders had reduced the backlog of prisoners awaiting an education induction. Most prisoners had a personal learning plan, and there were no learning reviews outstanding. However, attendance at face-to-face education inductions was too low since they had restarted in April 2022.

3.43 Education inductions were poorly planned, and prisoners wasted too much time waiting for others to attend. Staff and peer mentors did not provide prisoners with a confidential environment when discussing sensitive personal information. While staff prepared effectively for each induction cohort, information about prisoners' levels, learning needs and other pertinent information was only shared with teachers working for the education provider and not with other prison staff. This meant prison instructors were not informed about prisoners' potential learning needs quickly enough.

3.44 Prisoners did not receive effective information, advice and guidance (IAG) on how best to use their time at the prison, or for the longer term when released. Untrained peer mentors provided the majority of IAG. They did not establish prisoners' career aspirations or existing skills effectively. IAG advisors and peer mentors did not set meaningful targets for prisoners or take account of prisoners' sentence plans.

3.45 Education induction staff and the IAG provider did not work together effectively to share information. As a result, prisoners did not make fully informed choices about their education, skills and work activities. However, prisoners were well informed about the range of learning and work opportunities available at the prison.

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

Theme 3: Leaders must increase prisoners' access to and the provision of technology, such as the virtual campus, to enable prisoners to develop vital digital skills to support their resettlement.

3.47 Leaders and managers had been too slow to ensure that the curriculum and resources available at the prison enabled prisoners to develop vital digital skills. The information and communications technology (ICT)

infrastructure at the prison did not yet support the virtual campus (prisoner access to community education, training and employment opportunities via the internet). As a result, prisoners did not have access to the range of resources designed to help them find employment on release. However, leaders had introduced Way Out TV (a prison TV channel) since the previous inspection as a means of providing additional resources to support education.

3.48 The ICT curriculum did not include important digital skills, such as the use of modern electronic devices, to help prepare prisoners for life when released. Leaders from the prison and the education provider worked together closely to review the digital curriculum. They had identified new provision and qualifications to help prisoners improve their digital skills ahead of release. However, these courses were not yet in place.

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

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

Safeguards should be in place to ensure that all prisoners arriving at Rochester are kept safe, including a thorough risk assessment of their needs, and have access to relevant information and proactive support from staff and peer workers during their early days in custody.
Reasonable progress

There should be clear measures to recruit, train, and retain operational staff to keep prisoners safe and healthy and deliver a full rehabilitative regime.
Insufficient progress

The strategy to improve safety outcomes should be informed by good data analysis and include an effective action plan to reduce violence and self-harm.
No meaningful progress

Staffing levels and prisoners' time out of cell should be increased to facilitate the development of productive and positive relationships.
Insufficient progress

Cells in the older part of the prison should be taken out of commission and refurbished or replaced to ensure that all prisoners live in cells that are safe, decent and comfortable.
Insufficient progress

Prisoners should have ready access to their stored property. Requests for access should be dealt with within agreed and published time scales following consultation with prisoners.
Insufficient progress

Robust governance procedures, including consistent incident reporting and investigation, should be implemented to ensure that concerns affecting patient safety are promptly addressed.
Insufficient progress

All prisoners should have adequate time out of cell to participate in a regime that includes purposeful activity, time to complete domestic chores and the opportunity to socialise with their peers.
Insufficient progress

Ofsted themes

Leaders and managers must urgently prioritise increasing the number of face-to-face places in education, skills and work activities so that a significantly larger number of prisoners are able to access and attend activities.
Reasonable progress

Leaders and managers must ensure that the induction to education and training and initial advice and guidance support is fully effective to enable prisoners to plan their learning and potential next steps more comprehensively.
Insufficient progress

Leaders must increase prisoners' access to and the provision of technology, such as the virtual campus, to enable prisoners to develop vital digital skills to support their resettlement.
Insufficient progress

Appendix I About this report

His Majesty's 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, police and 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 October 2021 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 (see Glossary) 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:

Martin Kettle	Team leader
Rebecca Mavin	Inspector
Chelsey Pattison	Inspector
Tamara Pattinson	Inspector
Fiona Shearlaw	Inspector
Tania Osborne	Health and social care inspector
Joanne White	Care Quality Commission inspector
Jane Hughes	Ofsted inspector
Rebecca Perry	Ofsted inspector

Appendix II Care Quality Commission Requirement Notice

Care Quality Commission (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

The inspection of health services at HMP/YOI Rochester was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/working-with-partners/). The Care Quality Commission issued 'requirement to improve' notice/s following this inspection.

Provider

Oxleas NHS Foundation Trust

Location

HMP YOI Rochester

Location ID

RPG

Regulated activities

Diagnostic and Screening Procedures

Treatment of disorder, disease or injury

Action we have told the provider to take

The table below shows the regulations that were not being met. The provider must send CQC a report that says what action it is going to take to meet these regulations.

Regulation 17 Good Governance

1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to:

(a) Assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services).

(b) Assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

How the regulation was not being met

Systems or processes in place were not effective in assessing, monitoring and improving the quality and safety of the services being provided. In particular:

- An established framework of regular meetings was in place, however; the minutes of these meetings were not always available to staff and the quality of recording was poor.
- Managers did not maintain accurate records of staff training.
- Staff did not consistently report all incidents and shared learning following incidents was limited.
- Complaints were high and the service did not always investigate and respond to complaints in a timely manner.
- Managers did not analyse data sufficiently to identify patient safety concerns, gaps in service provision and opportunities for service improvement.

Systems or processes in place were ineffective in assessing, monitoring and mitigating the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- Medicines were not available for some patients to collect for three consecutive days.

Appendix III 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, being rolled out across the closed male prison estate, 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.

Operational support grade staff
Uniformed staff who perform important functions, e.g. in relation to mail or property, but do not directly supervise prisoners.

Reverse cohort unit (RCU)
Unit where newly arrived prisoners are held in quarantine for between seven and 10 days.

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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