Report on an independent review of progress at

HMP The Mount

by HM Chief Inspector of Prisons

6–8 February 2023

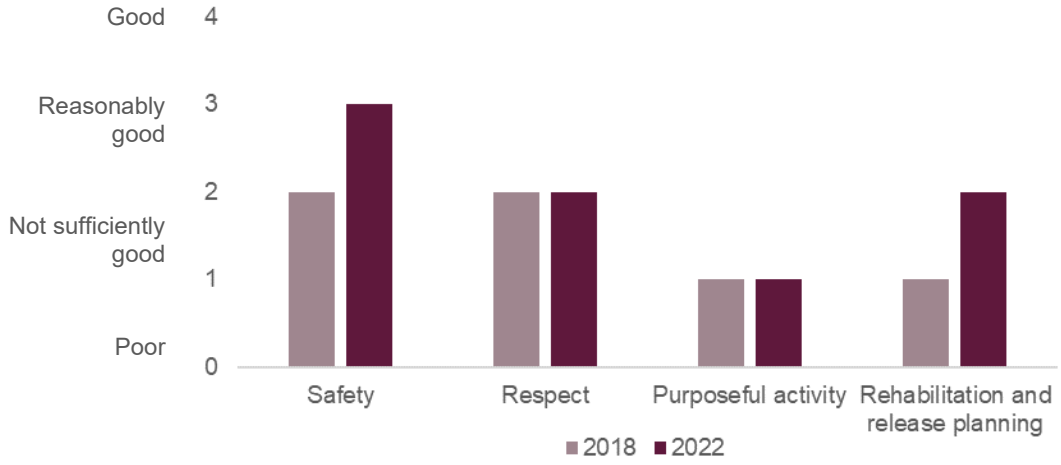
Contents

Section 1 Chief Inspector's summary

1.1 HMP The Mount, near Hemel Hempstead, is a category C adult male training and resettlement prison holding around 1,000 prisoners, many of whom are serving long sentences for serious offences. Opened in the late 1980s, it is a relatively modern prison, with extensive workshop facilities.

1.2 At our previous inspections of HMP The Mount in 2018 and 2022, we made the following judgements about outcomes for prisoners.

Figure 1: HMP The Mount healthy prison outcomes in 2018 and 2022



1.3 At the last full inspection, in March 2022, we reported on improvements in safety, which was now reasonably good, and a slight improvement in rehabilitation and release planning. There had been no improvement in outcomes for respect and purposeful activity. Our colleagues in Ofsted assessed the provision of education, work and skills to be inadequate, their lowest judgement. Such failings were completely undermining the prison's stated purpose as a training establishment. We also found insufficient focus on or support for sentence management, and there were few interventions to help prisoners reduce their risk and make progress.

1.4 Officer shortages were a problem, with a 40% shortfall in staff availability for operational duties. As such, the regime was still severely restricted and time out of cell (see Glossary) was poor, with many prisoners locked up for 22 hours a day. I said at the time of the last full inspection that addressing the weaknesses in purposeful activity and rehabilitation and release planning was a critical priority for this training prison if it was to properly serve the public interest.

1.5 During this review, while it was disappointing to find very little progress throughout much of 2022, there were now some early indications that a newly appointed governor (December 2022), was starting to give the

direction that the prison needed. There was, for example, more effort to engage positively with staff and improve staff retention. We also found 'reasonable progress' with respect to living conditions on the residential units, some positive work to encourage prisoners to maintain contact with their families and more support for those at risk of suicide and self-harm.

1.6 Most concerning, however, was that key weaknesses in purposeful activity and rehabilitation and release planning had still not been addressed. Our Ofsted colleagues gave their lowest grade of 'insufficient progress' to all three themes they reviewed, and found that some areas of education, skills and work had, in fact, deteriorated. For example, the number of purposeful activity places had declined, the curriculum did not meet the needs of a large proportion of the population, and pre-release preparation and collaborative working with potential employers was very limited. Although we found some increase in time out of cell and a regime that was at least now more predictable, there had been 'no meaningful progress' in giving prisoners constructive activities to do. We also found 'no meaningful progress' in support for sentence progression, and prisoners voiced their frustration at the lack of contact with prison offender managers.

1.7 Despite the poor findings of this review of progress, there were encouraging signs that the energetic and committed new governor was giving strong leadership to staff and the senior management team. We were told that fulfilling the prison's potential to offer good training and resettlement opportunities was now a top priority. The challenge remains for leaders to recruit and retain more officers, safely open up the regime and provide the opportunity for prisoners to learn new skills and reduce their risk in preparation for a successful return to the community.

Charlie Taylor
HM Chief Inspector of Prisons
February 2023

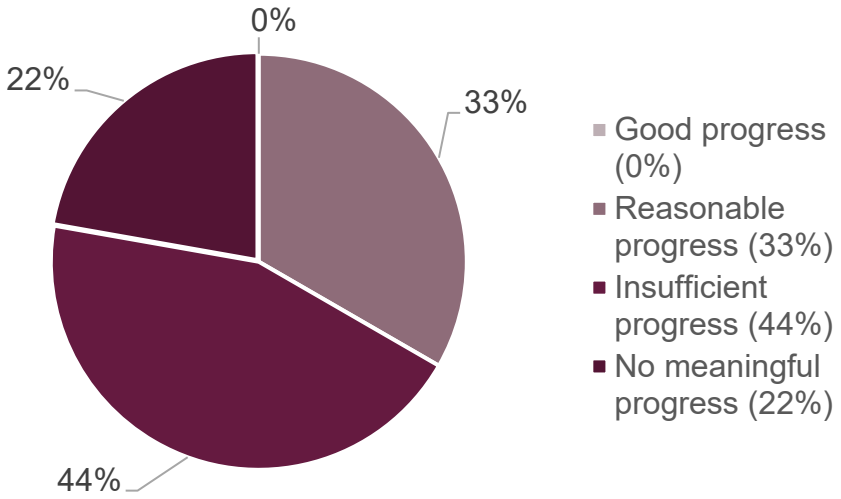
Section 2 Key findings

2.1 At this IRP visit, we followed up nine recommendations from our most recent inspection in March 2022 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 three recommendations, insufficient progress in four recommendations and no meaningful progress in two recommendations.

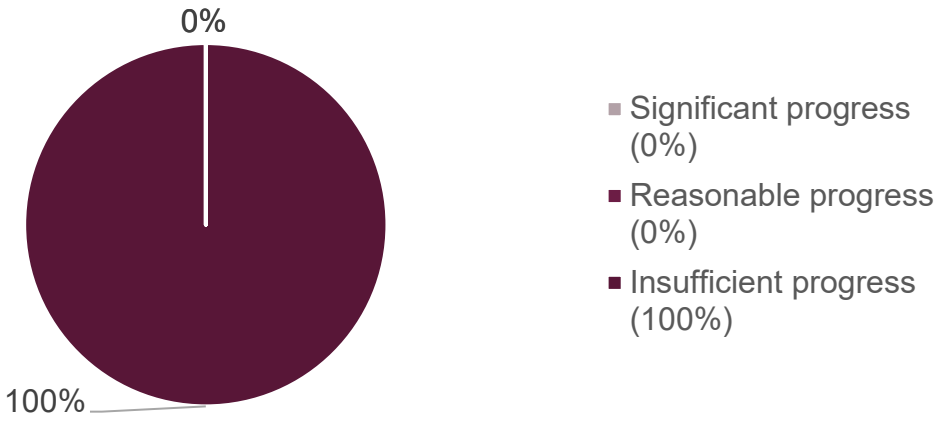
Figure 2: Progress on HMI Prisons recommendations from March 2022 inspection (n=9)

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 no themes, reasonable progress in no themes and insufficient progress in three themes.

Figure 3: Progress on Ofsted themes from March 2022 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 one example of notable positive practice during this independent review of progress.

2.6 The Samaritans provided additional support for prisoners at risk of suicide and self-harm (see paragraph 3.14).

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.

Leadership

Concern: The shortage of officers available to deliver a meaningful day-to-day regime or ensure prisoner access to activities or appointments meant many prisoners remained locked up most of the day and their needs unmet. Staff shortages were caused by several factors, including the high proportion of officers not deployable to operational duties and the significant percentage of new officers who had resigned within their first year.

Recommendation: Leaders should improve staff retention and significantly reduce the proportion of officers not deployable to operational duties. (1.37)

3.1 There had been a slight reduction in the proportion of the prison's complement of officers unavailable for deployment to operational duties, with 32% now unavailable, compared with around 40% at the time of the inspection. However, at the time of our visit, the ongoing shortage of officers still limited the regime.

3.2 A recent focus on improving staff retention included a comprehensive strategy with the governor prioritising staff engagement through a 'people plan' which focused on staff well-being, development and consultation. A pilot of structured supervision for around 30 officers was ongoing.

3.3 The rate of attrition of band 3 to 5 officers remained high, but there were early indications that the number of resignations was reducing. A shortfall in operational support grade staff remained a challenge.

3.4 The proportion of inexperienced officers had increased; over 60% of prison officers had less than two years in service, compared with 43% at the time of the inspection. More support for new staff had recently been introduced, through a 'buddy' scheme and the recruitment of a new colleague mentor.

3.5 The prison had successfully filled some middle management vacancies by supporting staff to achieve custodial manager accreditation. There were also plans to provide leadership training and coaching for middle managers.

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

Concern: Continuous improvement was difficult to evidence as too many workstreams lacked a coherent strategy and action plan against which to monitor progress made.

Recommendation: The focus on continuous improvement should be strengthened by having clear plans, against which progress can be monitored. These plans should be subject to rigorous oversight. (1.38)

3.7 Leaders (see Glossary) had started to update strategies and develop more robust action plans which, we were told, would be subject to more rigorous oversight.

3.8 The safety strategy was not informed by analysis of data to understand the causes of self-harm and violence, and action planning had started only recently.

3.9 There was early evidence of some progress with a promising new reducing reoffending strategy, but analysis of an extensive prisoner survey to inform the overall strategic priorities had not yet been completed.

3.10 A residential continuous improvement plan was effectively monitoring living conditions and driving a programme of work on the residential units.

3.11 The drug strategy and action plan were comprehensive.

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

Suicide and self-harm prevention

Concern: Many prisoners at risk of self-harm or suicide were left locked in cell for almost the entire day with little access to support, interventions or activities to help them manage their crisis. Care plans were sometimes closed without prisoners having been given the help they needed. The Samaritans phone number was incorrectly advertised, and the Listener (see Glossary) suite was not in use.

Recommendation: Prisoners at risk of self-harm or suicide should have access to a broad range of support, interventions and activities, which are delivered through well-coordinated care plans. (1.39)

3.13 Many prisoners at risk of self-harm or suicide remained locked in their cells for too long (see section on time out of cell). However, these prisoners told us that the regime was now more reliable, which had alleviated some of their frustrations. The recorded number of self-harm incidents in the last 12 months were lower than the same period before

the last inspection and continued to be on a downward trajectory. There had been one self-inflicted death since our inspection.

3.14 Good support was available to prisoners, such as face-to-face contact each week with the Samaritans, who attended the weekly safety intervention meeting and then walked around the wings, talking to prisoners. Some prisoners told us that they received good support from one-to-one meetings with the mental health and psychology teams. New in-cell laptop computers also offered good information to support and provide distraction for prisoners. Staff were knowledgeable about the prisoners in their care, and prisoners we spoke too said that they felt supported.

3.15 Management of assessment, care in custody and teamwork (ACCT) case management documents was mixed; all case reviews had good input from mental health teams, but care planning remained weak and there were some deficiencies in the recording of conversations between staff and prisoners. Quality assurance of ACCT documents was not always regular, but actions to address deficiencies were in place.

3.16 The Samaritans telephone number was now correctly advertised and the number of telephone calls made to them had increased sharply since the inspection. The Listener suite had recently been refurbished and was available, although there was no evidence that it had been used.

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

Living conditions

Concern: Many residential units needed major refurbishment. Cells were often poorly furnished, and many had broken furniture, unscreened toilets and no curtains for the windows.

Recommendation: There should be a programme of refurbishment of the residential units, prioritising the worst. (1.40)

3.18 The prison had responded to our findings and had made improvements across the site. The older wings, which we had found to be in a particularly poor state at the time of the inspection, were now cleaner and much better equipped. Most cells had been repainted and had curtains fitted, but toilets in the small, overcrowded doubled cells remained unscreened and still had insufficient furniture for two people. Some of the in-cell furniture was in poor condition, although the prison had invested in new items, which were due to arrive imminently. Prisoner work parties were used on each wing to install the replacement furniture and redecorate. Further investment to upgrade flooring, cell windows, lighting and fire prevention equipment was planned for later in the year.

3.19 Communal areas, including showers across much of the prison, were now in much better condition. However, during our visit we found some areas that were dirty, such as the landings on Nash and Dixon units and some unhygienic self-cook facilities.

Brister unit landing

Ellis unit shower

Dixon unit self-cook area

3.20 All residential areas had ‘decency action plans’, which then fed into an overarching improvement plan. A scheme of monthly decency checks of cells by managers had been introduced, but not all were routinely completed.

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

Dental services and oral health

Concern: The dental needs of the population were not being met due to the lack of aerosol-generating procedures, too few dental sessions and the overwhelming requirement for urgent rather than routine treatments. As a result, many patients were left in pain for several months.

Recommendation: Leaders from the prison and the health partnership board should make sure that the dental needs of prisoners are addressed immediately. (1.41)

3.22 Since the inspection, demand for dental services had increased sharply as a result of the introduction of in-cell laptop computers (see also paragraph 3.14), which prisoners could use to self-refer to the dentist.

3.23 The Community Dental Services dental nurse was now available five days per week. She triaged up to 70 patients each week, which was impressive. Urgent dental treatments took place within five working days. Prisoners we spoke to complained about dental waiting times and discomfort, rather than pain.

3.24 Air conditioning had been installed in the dental surgery, creating sufficient airflow to enable safe aerosol generating procedures to be carried out, which meant that a full range of NHS treatments was now available. However, 57 patients had been waiting for follow-up, 50% of whom had waited for over eight weeks (the longest wait being 37 weeks). Although the average wait had been shortened by 15 weeks, it was still too long. The prison could not enable all patients to attend for their appointments, which meant that dental clinic capacity was routinely underused (by 40–60%), which was unacceptable.

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

Mental health care

Concern: Not all patients requiring assessment and treatment under the Mental Health Act had been transferred to hospital within the government guideline target (28 days).

Recommendation: All transfers under the Mental Health Act should be completed within the current NHS England and NHS Improvement guidelines. (4.69)

3.26 Since the inspection, two patients had been transferred to hospital under the Mental Health Act, but neither transfer had been completed within the transfer guideline of 28 days. However, the 14-day target for the gateway assessment (required second medical opinion) was consistently achieved, as a result of robust management of the process.

3.27 Improved multidisciplinary working and guidance for wing officers providing support to patients meant that all reasonable options for treatment in prison were now explored, making referrals more likely to result in transfer.

3.28 Delays were due to the lack of availability of secure hospital beds. A regular meeting of the 'provider collaborative' (secure bed management consortium) had direct NHS commissioner involvement and provided shared information on secure bed availability.

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

Time out of cell

Concern: Many prisoners continued to be locked in their cell for 22 hours on a weekday and longer at weekends, which affected their well-being. Prisoners were very frustrated by their limited access to some key areas of support, such as the lack of opportunities to go to the library and the gym, few social visits and the ongoing suspension of corporate worship.

Recommendation: Prisoners should have far more time out of their cell each day and be able to engage in a meaningful range of constructive activities to promote their well-being. (1.42)

3.30 The introduction of daily association periods for all had led to an increase in the minimum time unlocked to just over three hours, but this remained inadequate for a training prison. Around a quarter of the population were engaged in full-time activities, which gave them around seven hours a day out of cell during the week, and part-time workers had between five and six hours a day.

3.31 In our roll checks, we found just over a quarter of the population locked up, which was better than the 38% that we found at the inspection. However, only 20% of the population were off the wings, engaged in any form of work or educational activities (see section on education, skills and work). A further 10% were employed on the residential units as cleaners, servery workers or orderlies, but were underemployed (see paragraph 3.35) and not well supervised.

3.32 The length of association periods was around two and a half hours, which included open access to exercise yards for an hour. There was little structured activity during these periods (see paragraph 3.41) and on some wings recreational equipment was either broken or missing.

Pool table on Nash unit

3.33 Free-flow movement to activities had not yet been reintroduced following the lifting of pandemic restrictions, and this was having an impact on the time available for work and education. Access to the two gyms was good and most prisoners could attend at least twice a week. For those on the enhanced level of the incentives scheme, four sessions a week were available. Access to some corporate worship remained too limited and there were still no weekend services. Use of the library was poor, with only around 40 prisoners attending each week.

3.34 We considered that the prison had made no meaningful 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 should provide enough purposeful activity places to engage all prisoners and keep them fully occupied. Allocation arrangements should include effective scrutiny of decisions and minimise any delay in prisoners starting activities. (1.43)

3.35 Leaders and managers had not provided enough activity places to meet the needs of the prison population. The number of full- and part-time places had declined since the inspection, although the proportion of prisoners participating in part-time activities had increased. The percentage of unemployed prisoners had fallen, but remained high for a training prison. Activity attendance rates had improved, but remained too low. The large number of prisoners participating in accommodation unit work were underemployed.

3.36 Allocation of prisoners to activities included consideration of their career aspirations on release. However, around a third of prisoners had not received help in formulating their future career aims. Consequently, they were not always matched with activities designed to support their resettlement goals. This frustrated prisoners, who often became demotivated and asked to transfer to a more appropriate activity linked to their rehabilitation and resettlement needs.

3.37 Leaders and managers had stopped the activity allocation of prisoners based on their accommodation location. This meant that prisoners were allocated more swiftly to their activities. This process was now subject to appropriate managerial oversight; however, sentence plans were not routinely used to inform allocations.

3.38 Since the inspection, the length of activity waiting lists had been reduced. All lists were managed effectively. Some waiting lists were still long, where the number of available places failed to match demand or there was no availability because of staffing shortfalls. Pay rates incentivised prisoners' participation in classroom-based sessions. However, the small proportion of prisoners studying Open University courses were paid at a lower rate.

3.39 Long-term shortage of education staff was a significant factor in the cancellation of activities or delays in their introduction. For example, the

absence of a vocational trainer had led to the closure of the well-appointed bricklaying training area.

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

Theme 2: Leaders should review and develop the curriculum so that it meets the needs of the prison population, including an effective literacy, numeracy and digital skills strategy. They need to make sure that arrangements to record and recognise prisoners' skills and knowledge development is subject to effective quality assurance and improvement processes. (1.44)

3.41 Leaders and managers had not provided a curriculum that met the development needs of a large proportion of prisoners. For example, a curriculum review had identified a significant need for an extended construction curriculum, but this had yet to be realised. No progress had been made in implementing a curriculum specifically for long-term prisoners. Few prisoners could study beyond level 1. As noted at the inspection, there was insufficient accredited training available in workshops and work. For example, prisoners in waste management and horticulture were not able to gain sector-specific qualifications. Prisoners had little access to accommodation unit-based activities to develop their wider interests.

3.42 The curriculum failed to provide prisoners with sufficient opportunities to develop their English, mathematics and digital skills. This was particularly the case for the large proportion of prisoners who undertook workshop and work activities. Prisoners with learning difficulties and disabilities received insufficient help to overcome the barriers to their development. It was too early to assess the impact of initiatives to provide specialist support to those in workshops and work.

3.43 Prisoners studying part-time activities did not always complete their course before leaving the prison or struggled to retain learning over a protracted period. Those studying the theory of establishing and maintaining rail tracks were not given the opportunity to apply their learning in practical situations.

3.44 Leaders and managers had established a reading strategy, but this was at an early stage of implementation. The Shannon Trust (which provides peer-mentored reading plan resources and training to prisons) had eight trained mentors at the prison, but, as a result of insufficient staffing, prisoners were not yet receiving support.

3.45 Leaders still did not adequately quality assure the education and training in workshops and work. They did not collect and analyse data on prisoners' destinations following release, to improve the curriculum.

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

Theme 3: Leaders and managers should make sure that prisoners receive suitable and effective pre-release preparation, including use of the virtual campus, where relevant. (1.45)

3.47 Leaders and managers had been slow to introduce adequate pre-release support arrangements. Current processes had been implemented two weeks before our visit and were largely untested. Consequently, it was not possible to evaluate their usefulness in preparing prisoners for successful resettlement. Those within 12 weeks of release were invited to an individual session to discuss and plan the help they needed. However, prisoners' participation in these sessions was low, mainly because of regime restrictions.

3.48 Most prisoners did not have access to the virtual campus (see Glossary). They were therefore unable to develop the digital skills needed to function effectively in the community. Those participating in pre-release preparations had adequate access to the virtual campus. This allowed them to complete appropriate research and job applications.

3.49 A large proportion of prisoners had not received an appropriate induction to the available education, skills and work curriculum. Leaders were taking appropriate action, but tutors and instructors had not yet received comprehensive information to allow them to support prisoners' needs effectively.

3.50 Partnership working with employers, to enhance prisoners' chances of successful resettlement, was weak. Progress in establishing links had recently generated a few useful outcomes, such as guaranteed job interviews on release. However, this benefited only a few prisoners. Leaders had made insufficient use of employers to develop the curriculum and improve the relevance of career progression routes. Few provided a clear route to the achievement of the high-level skills and knowledge needed for success on release. Many prisoners had not followed their preferred career pathway. Consequently, prisoners were often poorly prepared to engage with pre-release preparation.

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

Children and families

Concern: In our survey, only 15% said staff encouraged them to keep in touch with family and friends. The visits provision was still not good enough and the prison had not yet consulted prisoners or their visitors on how it could be improved. There were no additional visits for prisoners on the highest incentives level, which reduced the opportunities to motivate positive behaviour. Problems with the booking system meant that some visitors were turned away at the prison gate on the day of the visit.

Recommendation: Leaders should prioritise and encourage prisoners to maintain relationships with their family and friends and make sure they have easy access to regular visits. (1.46)

3.52 Work to encourage prisoners to maintain relationships with their family and friends had improved in some areas. A programme of popular family days had taken place and these were available to all prisoners, regardless of their level on the incentives scheme.

3.53 The 'Family Links' course, run by the education department, had resumed. Thirteen prisoners had recently completed the course, which covered topics such as parenting skills and relationships. A day-long 'graduation' celebration event for these prisoners and their families was due to take place shortly after our visit, to mark the occasion.

3.54 Consultation with prisoners had resulted in some improvements to the visits experience, including an increase in the length of sessions by half an hour and the removal of limits on the number of children who could attend.

3.55 An online booking system had been reintroduced. This had made the booking of social visits easier and reduced the number of complaints about this.

3.56 Social visits took place in the afternoons, from Saturday to Thursday, and three additional visits slots in each session were now available for prisoners on the enhanced level of the incentives scheme. However, there was not always enough capacity to meet demand and there was no guarantee that prisoners could access their full monthly visits entitlement.

3.57 The use of in-cell technology to broadcast engaging videos and regular prisoner information notices was helpful in promoting and encouraging family contact, and to generate interest in the Official Prison Visiting Scheme.

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

Reducing risk, rehabilitation and progression

Concern: There was insufficient focus on, and opportunities for, sentence progression. Many prisoners waited far too long to receive a sentence plan, contact between (POMs) and prisoners was too infrequent and there was little evidence that POMs carried out structured one-to-one work with them. There were few interventions, other than accredited offending behaviour programmes, to help prisoners reduce their risk and make progress.

Recommendation: Prisoners should have a range of opportunities to demonstrate a reduction in their risk of harm and likelihood of reoffending and progress through their sentence, including structured contact with prison offender managers. (1.47)

3.59 The offender management unit (OMU) was still short of staff and prison offender managers (POMs) were still carrying high caseloads. Four recently recruited POMs were due to take up post imminently, but the team would still be left short of four probation-trained POMs.

3.60 Too many prisoners arrived at the establishment without an offender assessment system (OASys) assessment, placing an immediate burden on an already overstretched team.

3.61 At the time of our visit, about 80 initial OASys assessments were outstanding and 70% of all prisoners had had a review of some sort in the last 12 months – a slightly improved position than at the time of the inspection. Concerted efforts to reduce these backlogs were taking place and some temporary agency support, funded by the Probation Service, had been drafted in to help. However, too many prisoners still did not have an up-to-date OASys assessment and waited too long to receive a sentence plan.

3.62 Recorded levels of contact between POMs and prisoners varied, but remained mostly minimal and task driven. The lack of regular support from the OMU continued to be one of prisoners' main complaints. There was little evidence that POMs carried out structured one-to-one offence-related work with them, but there were exceptions where we saw some excellent case work taking place. Key work (see Glossary) sessions were mostly infrequent and not supportive of sentence progression.

3.63 The prison was commissioned to deliver three accredited offending behaviour programmes: the Thinking Skills Programme, Building Better Relationships and Identity Matters. Staffing vacancies critical to programme delivery, such as treatment facilitators, had hindered the prison's ability to deliver these programmes and the number of places had been reduced.

3.64 In our case sample, progress for some prisoners was reflected through sustained employment, positive engagement with the prison regime and improved behaviour. A few had completed in-cell work packs, covering topics such as victim awareness. However, overall, there was

little evidence of prisoners completing other structured work to reduce their risk and address their offending behaviour.

3.65 Some work had begun to offer other, non-accredited interventions. For example, POMs and two key worker 'champions' had been trained in the use of new toolkits, including the 'general offending workbook' and 'choices and changes', which were in the early stages of being rolled out.

3.66 Much more needed to be done to promote, encourage and enable prisoners' use of release on temporary licence.

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

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

Leaders should improve staff retention and significantly reduce the proportion of officers not deployable to operational duties.
Insufficient progress

The focus on continuous improvement should be strengthened by having clear plans, against which progress can be monitored. These plans should be subject to rigorous oversight.
Insufficient progress

Prisoners at risk of self-harm or suicide should have access to a broad range of support, interventions and activities, which are delivered through well-coordinated care plans.
Reasonable progress

There should be a programme of refurbishment of the residential units, prioritising the worst.
Reasonable progress

Leaders from the prison and the health partnership board should make sure that the dental needs of prisoners are addressed immediately.
Insufficient progress

All transfers under the Mental Health Act should be completed within the current NHS England and NHS Improvement guidelines.
Insufficient progress

Prisoners should have far more time out of their cell each day and be able to engage in a meaningful range of constructive activities to promote their well-being.
No meaningful progress

Leaders should prioritise and encourage prisoners to maintain relationships with their family and friends and make sure they have easy access to regular visits.
Reasonable progress

Prisoners should have a range of opportunities to demonstrate a reduction in their risk of harm and likelihood of reoffending and progress through their sentence, including structured contact with prison offender managers.
No meaningful progress

Ofsted themes

Leaders and managers should provide enough purposeful activity places to engage all prisoners and keep them fully occupied. Allocation arrangements should include effective scrutiny of decisions and minimise any delay in prisoners starting activities.
Insufficient progress

Leaders should review and develop the curriculum so that it meets the needs of the prison population, including an effective literacy, numeracy and digital skills strategy. They need to make sure that arrangements to record and recognise prisoners' skills and knowledge development is subject to effective quality assurance and improvement processes.
Insufficient progress

Leaders and managers should make sure that prisoners receive suitable and effective pre-release preparation, including use of the virtual campus, where relevant.
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, 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 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:

Sara Pennington	Team leader
Natalie Heeks	Inspector
Jade Richards	Inspector
Paul Rowlands	Inspector
Dionne Walker	Inspector
Paul Tarbuck	Health and social care inspector
Nigel Bragg	Ofsted inspector
Tony Gallagher	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

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.

Listeners
Prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners.

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.

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.

Virtual campus
internet access for prisoners to community education, training and employment opportunities.

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

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