Report on an independent review of progress at

HMP Winchester

by HM Chief Inspector of Prisons

14–16 November 2022

Contents

Section 1 Chief Inspector's summary

1.1 HMP Winchester is a small Victorian reception prison that serves the courts in south and central England. At the time of this visit it held about 630 prisoners in the main category B prison and a small, separate category C facility. As seen at our full inspection in early 2022, over half of all prisoners were unsentenced and nearly 90% had been at Winchester for three months or less.

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

Figure 1: HMP Winchester local healthy prison outcomes in 2019 and 2022

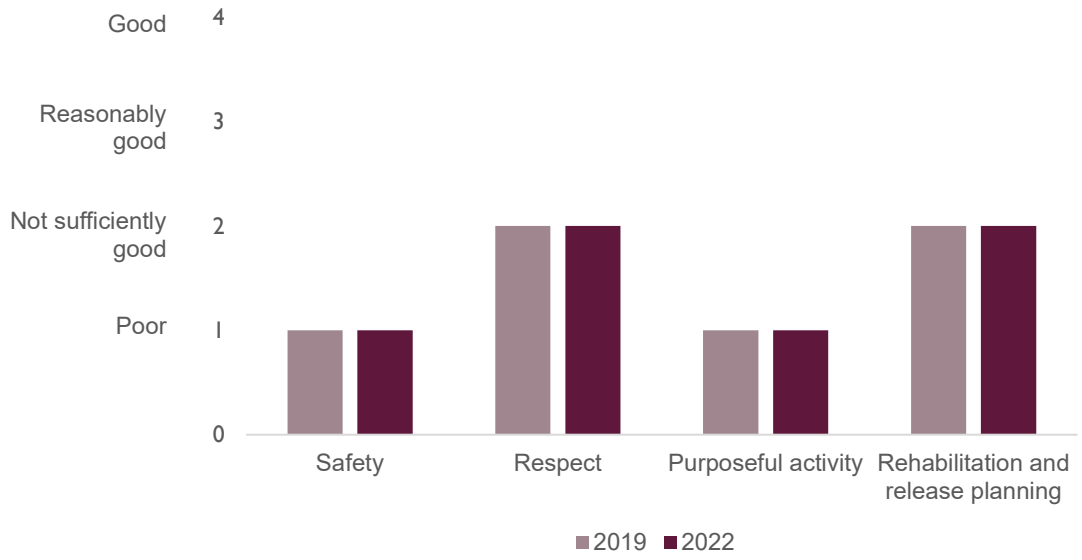
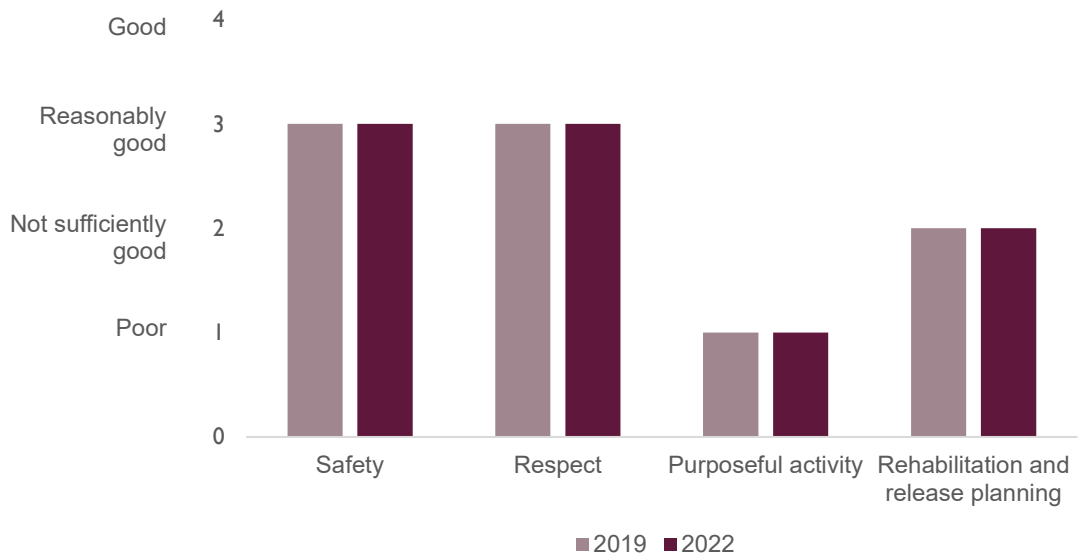


Figure 2: HMP Winchester category C healthy prison outcomes in 2019 and 2022



1.3 When we last inspected in February 2022, we found a prison facing significant challenges, and we judged it to be one of the most violent establishments in the country. The culture of the prison was one of low expectations and apathy among staff and prisoners, and difficulties with recruitment and retention meant that there were not enough staff to offer consistently even the most basic regime. We found that leaders were too complacent about some poor outcomes.

1.4 At this independent review of progress, we assessed progress against 12 recommendations, including four made by Ofsted. Our findings confirmed that overall, progress was being made against most.

1.5 The population had increased, and violence remained high, although encouragingly the rate of violence had declined by about 16% in the six months before our visit, while self-harm had decreased by nearly half. Oversight of the use of force was better developed, but leaders could have made further improvements by developing a greater understanding of local data.

1.6 The reopening of refurbished accommodation was being used as a benchmark to set standards across the prison, providing less experienced staff with the opportunity to gain an understanding of the minimum requirements to which they should be aspiring. This approach by leaders was also helping to address other shortcomings, such as prisoner access to basic amenities.

1.7 Ofsted found that reasonable progress had been made in only one of its assessed themes, while in three, progress was insufficient. Ofsted's findings linked directly to the one recommendation where we judged there to have been no meaningful progress – that of providing prisoners with adequate time out of cell to carry out domestic tasks and engage in purposeful activity. Most prisoners were still spending up to 23 hours a day locked in their cells and enduring all the negative consequences that entailed.

1.8 Many of the issues faced by the prison continued to be linked directly to the challenge of staff recruitment and retention. Leaders had, however, successfully implemented a range of support measures to hopefully drive recruitment. The situation remained fragile but there were some encouraging signs that improvements might be realised in early 2023.

1.9 Winchester is a high-risk institution which we will continue to monitor, but this was a promising review. Leaders were beginning to get to grips with the culture and there seemed to be a renewed sense of purpose at the prison. This report recognises progress, much of it from a low base. The scale of the challenge remained daunting, but leaders had made a start. They need continued support.

Charlie Taylor
HM Chief Inspector of Prisons
November 2022

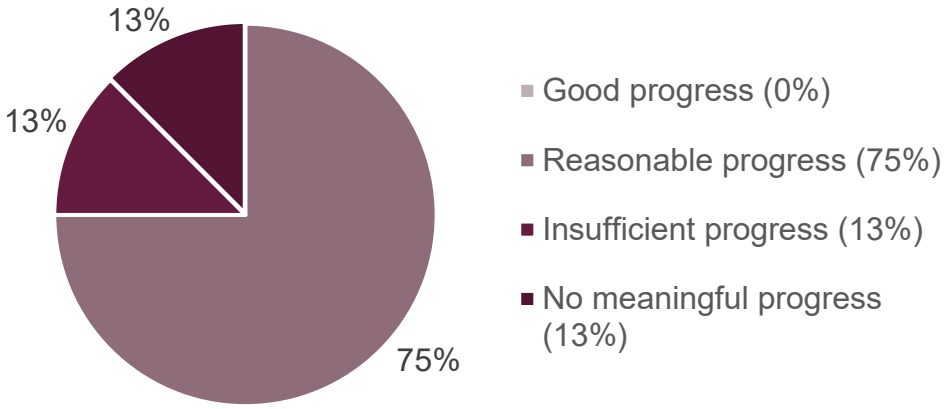
Section 2 Key findings

2.1 At this independent review of progress (IRP) visit, we followed up eight recommendations from our most recent inspection in February 2022 and Ofsted followed up four 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 reasonable progress in six recommendations, insufficient progress in one recommendation and no meaningful progress in one recommendation.

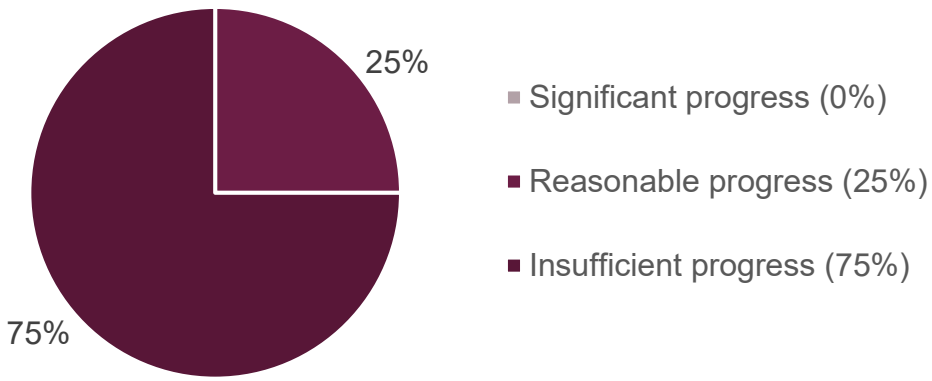
Figure 3: Progress on HMI Prisons recommendations from 2022 inspection (n=8)

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 reasonable progress in one theme and insufficient progress in three themes.

Figure 4: Progress on Ofsted themes from 2022 inspection/progress monitoring visit (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 two examples of notable positive practice during this IRP.

2.6 The work undertaken by the charity Belong, training prison staff to support and train prisoner representatives in mediation, conflict resolution and restorative approaches, promoted positive ways of resolving disputes and preventing future violence. (See paragraph 3.17.)

2.7 The introduction of a tuck shop on the induction wing mitigated the risk of prisoners building up debts during their early days at the prison. (See paragraph 3.27.)

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: Delivery of priorities set at the last inspection was slow, and the plan to deliver the basics of custody had not been executed well or delivered the results intended. Standards were not set sufficiently high, and leaders had become complacent about some poor outcomes.

Recommendation: Leaders should ensure that the basics of custody are delivered consistently and to a high standard. (1.39.)

3.1 The prison reviewed progress regularly against the key concerns and recommendations we made at the inspection. Individual managers provided updates at a monthly management meeting and the recommendations were discussed at assurance visits from the prison group director every two months. Senior leaders (see Glossary) had prioritised work in areas of greatest importance to the well-being of prisoners, for example, safety and living conditions. In both areas, we found that the prison had made improvements. The introduction of the residential assurance team to respond promptly to and rectify cell defects was a good example (see paragraph 3.34).

3.2 While progress had been limited in some areas, particularly developing the regime and education, managers understood this well and had plans to address deficiencies. Some managers had, for example, held staff briefings on the plans to raise awareness.

3.3 The prison had also used the HM Prison and Probation Service standards coaching team to improve staff confidence. During the summer there had been an increase in training to make sure staff had the necessary knowledge and skills to perform their roles.

3.4 The senior leadership team was now well-established with identified areas of responsibility focused on improving outcomes for prisoners. Operational managers were very visible on the wings, and we saw them actively supporting their teams. Staff we spoke to said this had helped to increase their confidence.

3.5 The prison had introduced a structured briefing to enhance communication, supported by checklists for many areas, such as induction and decency, to improve quality and consistency.

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

Concern: Staffing levels were not sufficient to deliver a decent regime and current recruitment did not keep pace with staff departures. Relationships between staff and prisoners inevitably suffered because of a lack of meaningful interaction and frustration caused by the inability to get the simplest tasks done. Fragilities within the management structure limited oversight, role modelling and support for staff.

Recommendation: Staffing at all levels should be sufficient to deliver a full regime, support constructive relationships and facilitate leaders to carry out their line management duties. (1.40.)

3.7 The prison's bid for financial incentives for candidates applying for officer posts at the prison was successful. There had been an increase in the number of officer appointments during the summer, but at the time of the visit more than 70 were still either waiting for a start date or undergoing training and unavailable to work at the prison. The prison had experienced difficulties in recruiting non-operational grades from the local area, leading to staffing deficits in key departments, such as offender management. It had advertised further afield to address the problem.

3.8 Leaders had a good focus on retaining existing staff and had appointed a mentor for new starters as well as a manager with specific responsibility for learning and capability. To build on existing staff support systems the prison ran a staff well-being and consultation day. Despite efforts to recruit and retain staff, at the time of the visit there were still not enough staff to deliver a full regime.

3.9 While relationships were improving, the restricted regime meant there was not enough time for staff to help prisoners with day-to-day tasks. Many prisoners told us when they asked staff to help with an issue, they would then be locked up and were not told whether their request had been processed. Key working (see Glossary) had all but ceased through the summer but had resumed in September, although at the time of our visit very few prisoners were receiving this support.

3.10 Peer working was not well used on the wings to support prisoners to carry out everyday tasks. Each wing had a prisoner information desk (PID) worker, but their role was simply to hand out paperwork. The applications process was ineffective, applications were not tracked or monitored, and many prisoners told us they were not answered. We saw many applications in wing offices that were dated more than a week previously. The prison had recently increased managers' visibility in the units to improve how issues were dealt with.

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

Managing behaviour

Concern: Winchester remained one of the least safe prisons in the country. Incidents were not always investigated to help leaders gain a full understanding of the underlying causes of violence to enable them to devise a responsive strategy. Staff were unfamiliar with some key processes and the culture of the prison did not motivate good behaviour.

Recommendation: A thorough analysis of the causes of violence should be used to devise a safety strategy that addresses deep-seated cultural issues to reduce the high levels of violence and make the prison safe. (1.41.)

3.12 The recorded rate of assaults was 16% lower in the six months before our visit than in the six months before the inspection and the rate of assaults on staff had fallen by 20%. Despite rates of violence remaining higher than in most similar prisons, it was encouraging that the number of incidents was falling steadily.

3.13 Through data analysis and consultation, leaders had identified that debt, frustration about a lack of time out of cell (see Glossary) and gang-related attacks or retaliation were causes of much of the violence at Winchester. This was reflected in a relaunched safety strategy and an up-to-date multidisciplinary action plan.

3.14 Staffing in the safety team had improved since the inspection, with a dedicated hub manager now in place and two designated safety officers for three days a week, but some gaps remained. Almost all violent incidents were now investigated, but not always promptly.

3.15 There had been a focus on reducing violence among young people through the development of a new database of gang-related activities, consulting prisoners on the incentives scheme and a young adult summit, hosted by prisoners themselves.

3.16 Leaders were seeking funding for two interventions, which would provide targeted support for young people displaying challenging or violent behaviour.

3.17 The introduction of violence reduction prisoner representatives was positive – the charity Belong trained prison staff to support and train the prisoner representatives, and they were visible and played an active role in mediating conflict and implementing restorative approaches to resolving disputes and avoiding further violence. (See paragraph 2.6.)

Violence reduction representative

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

Use of force

Concern: Documentation to justify the use was force was often incomplete. Body-worn video cameras were not routinely operated during incidents, and recordings of incidents, both planned and spontaneous, were not always retained. Some incidents were not recorded through the HMPPS incident reporting system. Governance of the use of force was poor. As a result of these deficiencies, HMPPS could not be assured that all force used was proportionate, necessary and justified.

Recommendation: Prison leaders should provide rigorous oversight of the use of force, ensuring appropriate accountability through accurate reporting, activating body-worn cameras and retaining footage as evidence and to inform learning. (1.42.)

3.19 The number of reported incidents involving force had increased. During the six months before our visit, the rate per 1000 prisoners had increased from 477 over the same period before our full inspection to 539. Leaders were unaware of the rise and had informed us that the

use of force was declining. The levels of force were also high when compared to other similar prisons. Prison leaders were poorly equipped to determine the causes for the increase, which was concerning, as violence among prisoners was decreasing.

3.20 Nevertheless, the prison had made good efforts to make sure that all use of force was being reported and we were more confident that incidents were now being recorded appropriately and might explain some of the increase.

3.21 Governance had improved and footage of all incidents involving force was now reviewed at a newly introduced weekly scrutiny meeting. The meeting was effective, but it had not been fully embedded as staff from key departments did not always attend. Quality assurance was completed by managers for all incidents of force following the use of PAVA incapacitant spray, or following concerns raised by the prisoner.

3.22 Good efforts had been made to reduce the backlog of staff statements requiring completion, which at the time of our visit was now very low. The standard, however, was mixed, with some lacking any insight into the incident. Many statements, for example, did not provide enough detail about attempts to deescalate the situation.

3.23 We observed that the culture of failing routinely to operate body-worn video cameras remained prevalent and required action. On the occasion that cameras were turned on, it was often long after the incident had begun or there was not a clear line of sight.

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

Safeguarding

Concern: Self-harm rates remained high in comparison with those at similar prisons, and the establishment was not making effective use of available data to understand the underlying causes of self-harm. There was insufficient quality assurance and inadequate peer support for prisoners who were in crisis.

Recommendation: Data analysis should be used to understand the root causes of self-harm, and the results should inform an effective action plan to reduce incidents and support prisoners at times of crisis. (1.43.)

3.25 Recorded rates of self-harm in the six months before our visit were 46% lower than in the same period before the full inspection. Levels were continuing to fall, but rates of harm remained higher than in many similar prisons.

3.26 Leaders used a variety of methods to try to better understand the causes of self-harm. They identified debt and frustration with the lack of purposeful activity and amount of time spent locked up as some of the

main drivers. As with the approach to reducing violence, these issues were reflected in the relaunched strategy and action plan (see paragraph 3.13).

3.27 Leaders had focused on reducing the risk of self-harm during prisoners' early days in custody. Additional measures had been introduced in the new induction wing to help prevent prisoners from building up debt, for example by providing advances for those who came into custody without money and setting up a tuck shop so prisoners could make purchases shortly after their arrival (see paragraph 2.7). Staff were encouraged to identify prisoners' risks and vulnerabilities and to document them in induction passports, which also directed prisoners to available sources of support around the prison.

3.28 However, documented support for prisoners in crisis remained a weakness. The assessment, care in custody and teamwork (ACCT) case management approach for those at risk of suicide and self-harm remained insufficient in too many cases, and quality assurance processes were not fully effective. Access to Listeners (prisoners trained by the Samaritans to provide confidential emotional support to other prisoners) had improved, particularly on the local site.

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

Daily life

Concern: Too many prisoners on the local site lived in cold, poorly equipped and dirty cells. Many cells were overcrowded. The 'decency policy' was not being implemented, and staff and many prisoners had become desensitised to the poor conditions that many prisoners were held in. Access to basics, such as a daily shower, cleaning materials, clean bedding, clothing and stored property, was too often very poor.

Recommendation: All prisoners should have access to the basics of custody, including in-cell furniture, daily showers, cleaning materials, clean bedding and clothing, and their own stored property. (1.44.)

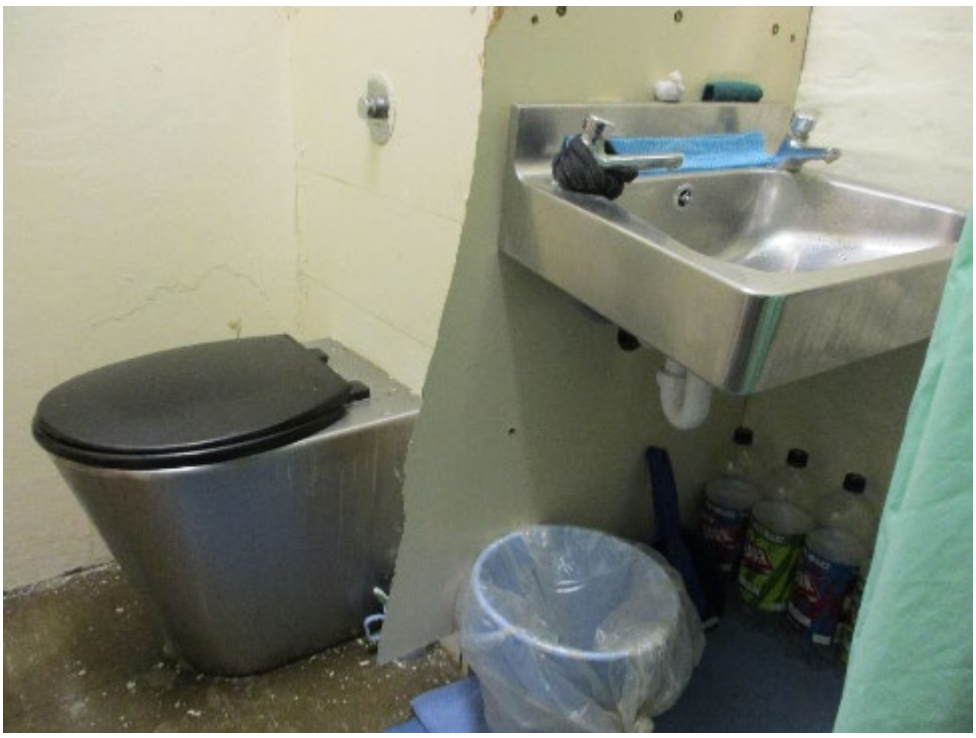
3.30 Improvements to the living conditions on the local site were clearly evident. The most significant changes were seen on A wing following its reopening after a complete renovation. It was clean, cells were appropriately equipped, and landings were well decorated.

Fully equipped cells on A wing following refurbishment

3.31 Leaders had used the opening of accommodation on A wing to encourage less experienced staff to gain an understanding of the minimum standards aspired to for prisoner accommodation.

3.32 Many communal areas were notably cleaner than at the inspection, but there was still much to do. While work had started on C wing but conditions remained unacceptable. Many cells were stark and did not have appropriate furniture, and standards were poor.

C wing landing at the last inspection (top) and at this IRP visit



Poor cell on C wing

3.33 Elsewhere, cells were better furnished than at our last inspection and good efforts had been made to repair damage, such as broken observation panels, of which there were only two at the time of our visit. However, this was not consistent across the prison.

C wing cell at the last inspection (previous page) and at this IRP

3.34 The introduction of the residential assurance team, which involved prisoners in carrying out basic repairs, was excellent, allowing for a swift response to maintenance issues. The team members were enthusiastic, responsive, and visible on the wings, and it gave prisoners participating in the process a sense of purpose. (See paragraph 3.1.)

3.35 Access to basic amenities, such as a daily shower and cleaning materials, were slowly improving. Prisoners on all wings on the local site could have daily access to personal care and hygiene items. A new process for managing prison bedding and clothing had been devised and, while positive, processes needed to be embedded further to offer a consistent approach and determine if they helped improve outcomes.

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

Health, well-being and social care

Concern: The prison and health care staffing challenges were having a detrimental impact on the delivery of mental health and pharmacy services, as well as on access to clinics and secondary care. This resulted in delays for mental health assessment, limited access to a pharmacist and delays in treatment.

Recommendation: The partnership board should assure itself that patient care is not compromised as a result of inadequate staffing; that there is appropriate support, training and clinical supervision of staff; and that delays in accessing services are prioritised, and that, where necessary, services are applying duty of candour where deficits are identified. (1.45.)

3.37 The prison and health care teams continued to experience staff shortages, which affected access to care. The partnership board met regularly and focused on the risks faced. Governance and risk management systems had been reviewed and many positive changes introduced across the service to improve outcomes for patients, such as the introduction of an early days in custody mental health assessment for all prisoners arriving at the prison. Joint working and information sharing had improved, and both teams worked collaboratively to address issues.

3.38 The new head of health care provided strong leadership. They had good oversight of the service and understood what needed to be done. Daily operational challenges, such as staff sickness and inadequate officer support to facilitate health clinics and external hospital appointments, were discussed every day with prison managers to make sure resources were focused on health care priorities.

3.39 While staffing gaps continued to have an impact on the range of treatments and therapies offered by the mental health team, systems were now effective in making sure prisoners had timely access to mental health services from the point of reception. Compliance with mandatory training and clinical supervision had improved with action planned to address deficits.

3.40 Vacancies in the pharmacy team continued and the lack of an onsite pharmacist adversely affected daily oversight of the service, creating risks and additional pressure on existing staff. Recruitment was ongoing and agency staff were used to fill gaps.

3.41 Cancelled hospital and clinic appointments were reviewed and rescheduled according to patients' needs and access to specialist clinics prioritised. Further data analysis was required to identify the underlying reasons why an appointment had not been fulfilled.

3.42 The process for making sure staff met duty of candour obligations needed strengthening. Senior health staff were making improvements so that all incidents were captured.

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

Time out of cell

Concern: Prisoners had insufficient time out of cell and access to purposeful activity. Many prisoners on the local site spent about 23 hours a day locked in their cells, and some even longer. There was insufficient activity across both sites, which led to frustration and a detrimental impact on mental and physical well-being.

Recommendation: All prisoners should have adequate time out of cell to conduct domestic tasks, engage in purposeful activities and socialise with peers. (1.46.)

3.44 Time out of cell for most prisoners on the main site remained poor, with many locked up for 23 hours a day. During the brief period when they were unlocked, prisoners had to complete applications, have a shower and exercise. There was little else to occupy prisoners and, while the prison had a stock of recreational items, such as table tennis and pool tables, they had not been put out onto the wings.

3.45 The regime remained poor due to continuing staff shortages. Leaders had decided not to use occasional increases in staffing levels to enhance the regime as they were aware that this could not be maintained, and the inconsistency would frustrate prisoners further. There were still times when the prison had insufficient staff to offer any regime at all, such as on the weekend before our visit. The prison had plans to introduce a new regime in January once new officers arrived.

3.46 Prisoners could not collect their lunch packs because they were delivered to their cells, which was not decent and further reduced their time out of cell. While prisoners could collect their hot meal from the servery, they were eaten in their cell and the prison had no plans to allow prisoners to eat their meals with their peers to promote a community ethos, even when staffing levels increased.

3.47 Prisoners taking part in activities had more time unlocked, although about a third of prisoners were not allocated to meaningful activities. We also identified several instances when prisoners were not unlocked to attend their allocated area of work, for example, to carry out wing cleaning. Some prisoners allocated to part-time education only had lessons for a couple of hours each week, so spent most of their time locked up.

3.48 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 should make sure that they evaluate fully the quality of teaching and assessment. They should identify and implement actions that will improve teachers' and instructors' teaching practices.

3.49 Managers had put in place an appropriate professional development schedule for staff from education to help them to improve their skills in teaching and assessment. The schedule included useful updates on topical matters, such as phonics and reading, and was informed by issues arising from visits to lessons. Prison instructors took part in useful development activities, supported by education managers, including an away day to a local prison to see best practice in action. Most teachers and instructors valued their professional development.

3.50 Managers in education worked closely with teachers to identify areas for development and to support improvements in teaching practices. For example, managers frequently visited lessons and had a presence in classes to provide support in real time. As a result, teachers in education set individual, challenging and effective targets for prisoners, linked to their needs and abilities.

3.51 Senior leaders from the education provider completed useful quality review visits to support managers in making improvements to the quality of teaching and assessment. Leaders accurately identified during their most recent visit areas for further development, including the use of digital technologies, and recognised the needs of those with learning difficulties and disabilities (LDDs).

3.52 Prisoners in wing worker roles lacked supervision. Staff did not set prisoners targets or challenge them to make progress in their work roles. Too many prisoners were not unlocked during working hours due to staff shortages on the wings.

3.53 Managers from education and from the prison worked together effectively to identify areas for development in the quality of education in prison-led workshops. As a result, in most workshops, instructors used trackers well to record prisoners' progress and to set challenging targets for future development. However, the improvements in prison-led workshops were not consistently effective.

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

Theme 2: Leaders should maximise prisoners' opportunities to access education and work and enable them to attend their allocated activities on time.

3.55 Leaders had been too slow to reopen education and work fully. Restrictions on the regime caused by severe staff shortages and a lack of instructors had a detrimental impact on the breadth of education and work available to prisoners, and on the frequency at which activities were available.

3.56 While they had been increased since the previous inspection nine months ago, there were still too few activity spaces for the size of the prison population. Too many of the spaces that were available remained unallocated, particularly in education. However, for more popular work roles, such as cleaners, there were long waiting lists. Too few prisoners on the category C site chose to engage with education, skills and work activities. About one third of the population were unemployed.

3.57 The vocational training and workshop offer was still too narrow and had not improved since the previous inspection. The offer of activities for vulnerable prisoners remained too small. Prisoners on the main site could only access the textiles workshop, vulnerable prisoners only the tailors' workshop and those on the category C site were limited to waste management and the gardens and kitchens. Vocational training was only available in very small numbers to prisoners on the category C site.

3.58 Senior leaders at the prison had improved their attendance monitoring and reporting since the previous inspection and had recently introduced free flow (allowing prisoners to move about the prison unescorted) on the main site. As a result, attendance at education had increased significantly, and prisoners arrived at their activities on time. However, overall attendance at education, skills and work activities remained too low, particularly on the category C site.

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

Theme 3: Leaders should allocate prisoners to activities fairly, taking into account their needs and aspirations, and give them equal access to essential services, including induction and careers advice and guidance.

3.60 Induction to education was not yet effective. Managers had recently reinstated face-to-face induction sessions. However, staff did not provide prisoners with useful information or guidance on their education, skills and work options. Induction sessions focused too

much on the completion of assessments and paperwork, without helping prisoners to make informed choices.

3.61 Prisoners did not receive sufficient information, advice and guidance (IAG) about their activity options at the prison, or to help them establish realistic future career goals. Too many prisoners were not aware of the IAG service available to them. Prisoners were required to request this service, and few chose to do so. IAG staff did not have access to information about the prisoner gathered during induction.

3.62 Leaders and managers had improved the process for allocating prisoners to activities since the previous inspection, and now considered all prisoners equitably. However, as too few prisoners received useful IAG, staff did not know what prisoners' aspirations were and could not make sure that allocations matched prisoners' future ambitions. Prisoners were not allocated to wing work fairly or equitably. Prisoners reported favouritism in allocations to these roles.

3.63 Leaders and managers had reviewed and broadened the responsibilities of the activities review board. Senior leaders had introduced clear lines of accountability for prison managers with regards to attendance, allocation and punctuality at education and work. Leaders had reduced the proportion of prisoners waiting for induction to a manageable level – it had been very high during the previous inspection.

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

Theme 4: Leaders should make sure that teachers and instructors adapt their teaching practices to take account of prisoners' known learning needs. Support staff should make sure that they identify appropriate support strategies, which they share with teachers and instructors, so that prisoners make good progress in their learning and training.

3.65 Too few prisoners who required learning support received the help they needed to make good progress in their learning. For the very small minority of prisoners who received an in-depth screening with specialist staff, there were sensible support plans in place. Teachers in education developed an awareness of neurodiversity through training and useful guides. As a result, they were more aware of the types of needs learners might have. Teachers and instructors were required to identify support for individual prisoners with LDD needs. However, the strategies identified varied too much in their effectiveness. Teachers did not share their insights consistently with each other, and too little information was shared with instructors and other prison staff.

3.66 Leaders introduced a range of assessments for prisoners to complete during induction in order to establish their English and mathematics levels, their learning needs and employability skills. However, too many prisoners did not carry them out accurately due to the volume of assessments they were required to complete. Teachers did not use the

results consistently to adapt their teaching to meet the needs of their learners, particularly of those with LDD.

3.67 Managers in education provided teachers with a useful 'toolkit' to use with prisoners, should they become agitated or anxious, including tactile aids, such as stress balls and fidget spinners. Teachers reported that these resources helped to keep the classroom environment calm and conducive to learning.

3.68 Leaders had put in place a useful reading strategy that outlined their intended response to helping prisoners improve their reading skills. However, it was not yet embedded and therefore did not yet have any impact.

3.69 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

Leaders should ensure that the basics of custody are delivered consistently and to a high standard.
Reasonable progress

Staffing at all levels should be sufficient to deliver a full regime, support constructive relationships and facilitate leaders to carry out their line management duties.
Insufficient progress

A thorough analysis of the causes of violence should be used to devise a safety strategy that addresses deep-seated cultural issues to reduce the high levels of violence and make the prison safe.
Reasonable progress

Prison leaders should provide rigorous oversight of the use of force, ensuring appropriate accountability through accurate reporting, activating body-worn cameras and retaining footage as evidence and to inform learning.
Reasonable progress

Data analysis should be used to understand the root causes of self-harm, and the results should inform an effective action plan to reduce incidents and support prisoners at times of crisis.
Reasonable progress

All prisoners should have access to the basics of custody, including in-cell furniture, daily showers, cleaning materials, clean bedding and clothing, and their own stored property.
Reasonable progress

The partnership board should assure itself that patient care is not compromised as a result of inadequate staffing; that there is appropriate support, training and clinical supervision of staff; and that delays in accessing services are prioritised, and that, where necessary, services are applying duty of candour where deficits are identified.
Reasonable progress

All prisoners should have adequate time out of cell to conduct domestic tasks, engage in purposeful activities and socialise with peers.
No meaningful progress

Ofsted themes

Leaders should make sure that they evaluate fully the quality of teaching and assessment. They should identify and implement actions that will improve teachers' and instructors' teaching practices.
Reasonable progress

Leaders should maximise prisoners' opportunities to access education and work and enable them to attend their allocated activities on time.
Insufficient progress

Leaders should allocate prisoners to activities fairly, taking into account their needs and aspirations, and give them equal access to essential services, including induction and careers advice and guidance.
Insufficient progress

Leaders should make sure that teachers and instructors adapt their teaching practices to take account of prisoners' known learning needs. Support staff should make sure that they identify appropriate support strategies, which they share with teachers and instructors, so that prisoners make good progress in their learning and training.
Insufficient progress

Appendix I About this report

Her 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 January and February 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 (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:

Ian Dickens	Team leader
Lindsay Jones	Inspector
David Owens	Inspector
Nadia Syed	Inspector
Dawn Angwin	Lead health and social care inspector
Tania Osborne	Health and social care inspector
Helen Lloyd	Care Quality Commission inspector
David Baber	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

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

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

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

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.

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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