Report on an independent review of progress at

HMP Onley

by HM Chief Inspector of Prisons

6–8 January 2026

Contents

Section 1 Chief Inspector's summary

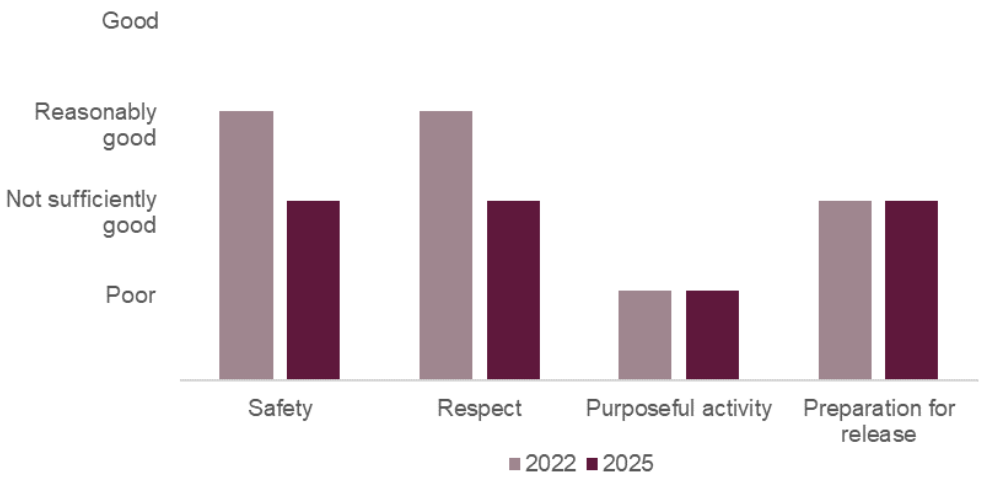
1.1 HMP Onley is a category C training and resettlement prison near Rugby in Warwickshire. It holds over 700 prisoners. It has been part of the East Midlands prison group since 2017 but was previously a resettlement prison for Greater London. As a result, the prison holds many men from the London area, many of whom return there on release.

1.2 This review visit followed up on the concerns we raised at our last inspection of HMP Onley in 2025.

What we found at our last inspection

1.3 At our previous inspections of HMP Onley in 2022 and 2025 we made the following judgements about outcomes for prisoners.

Figure 1: HMP Onley healthy prison outcomes in 2022 and 2025
Note: rehabilitation and release planning became 'preparation for release' in October 2023.



1.4 At the last inspection, we found weaknesses in site security and the prison faced substantial challenges with drones bringing in drugs and other illicit items. Levels of violence had risen and there were high levels of drug misuse.

1.5 There were some good key work sessions. However, prisoners were frustrated that many inexperienced staff were often unable to help them with straightforward requests, resulting in the application and complaints system being overused.

1.6 There was not enough purposeful activity, with insufficient work and education places and slow allocation processes leaving many men unemployed. Many prisoners were demoralised by the inability to

progress in their sentence, with many men waiting months for sentence plans or unable to access the accredited programmes essential for parole or recategorisation.

1.7 Health care provision was weak and there were shortfalls in mental health care. Vulnerable prisoners were often left on long waiting lists for treatment. Scores in our safety and respect tests had fallen.

What we found during this review visit

1.8 Eight months after our full inspection, this review of progress found some encouraging signs of improvement. Oversight of the use of force had improved significantly, and it was good to see that there had been a slight overall reduction in violent incidents. Leadership within the offender management unit (OMU) had improved, resulting in better contact for most prisoners and more effective sentence planning, although there was still some way to go for this to be consistent across the population. Ofsted judged that there had been reasonable progress across all four themes they reviewed, with better attendance and allocation processes in education and work than seen at the last inspection.

1.9 Despite these positive developments, several areas remained problematic. Illicit drug use continued to be a significant problem along with persistent drone incursions. Plans to enhance physical security were developing but, while funding had been agreed, little work had been done to date. Prisoners also reported ongoing frustration with staff who were unable to meet their needs.

1.10 Overall, while much work remained, the prison, under a dedicated governor, had a clear understanding of the issues and was investing in staff to address them.

Charlie Taylor
HM Chief Inspector of Prisons
January 2026

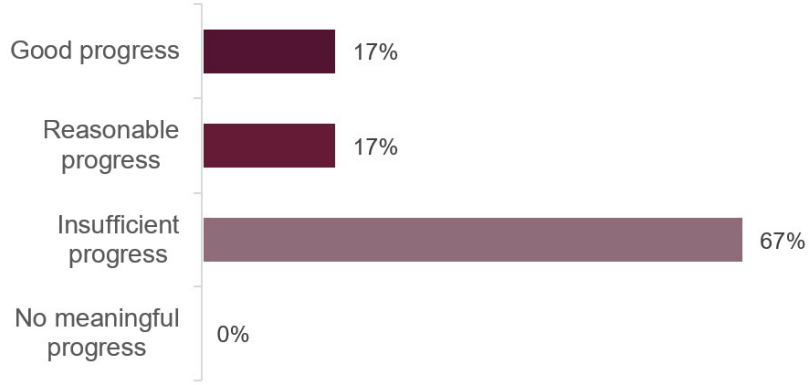
Section 2 Key findings

2.1 At this IRP visit, we followed up six concerns from our most recent inspection in May 2025 and Ofsted followed up four themes based on their latest inspection.

2.2 HMI Prisons judged that there was good progress in one concern, reasonable progress in one concern and insufficient progress in four concerns.

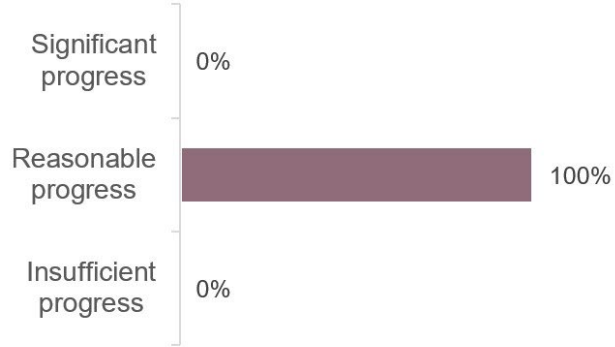
Figure 2: Progress on HMI Prisons concerns from 2025 inspection (n=6).

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



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

Figure 3: Progress on Ofsted themes from 2025 inspection/progress monitoring visit (n=4).



Notable positive practice

2.4 We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for prisoners, and/or particularly original or creative approaches to problem-solving.

2.5 Inspectors found no examples of notable positive practice during this IRP visit.

Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2025.

Security

Concern: Illicit drug use remained a significant concern, driving debt, violence and self-harm. Weaknesses in physical security and insufficient purposeful activity increased boredom and vulnerability, while the lack of regular and meaningful drug strategy meetings meant that these links were not fully addressed.

3.1 The random mandatory drug testing MDT rate (see Glossary) remained high at 36.4% for the year to date, up from 34% at the full inspection. Drone incursions remained a significant problem, the prison recording one of the worst rates nationally.

3.2 Security measures had been extended and now included regular night searches. At the previous inspection, cell windows had been identified as a particularly weak point. Plans to replace some windows and fix grilles had been agreed, as had plans to increase CCTV coverage. Some netting had been installed and monthly meetings with police and specialist agencies were about to start, specifically to enable the use of intelligence to plan tactical moves against drone incursions.

3.3 The management of the drug strategy had improved. A new strategy was in place. Multidisciplinary oversight meetings were now happening and were action-focused and effective. An experienced manager was about to start as drug strategy lead.

3.4 The incentivised substance-free living unit had been moved to a better location and was developing well and allowing for increased prisoner engagement. Voluntary drug testing was being used to support recovery and included the use of frequent drug testing as a rehabilitative intervention when someone was found guilty at adjudication. The waiting time to see a drug worker had halved since the last inspection but, due to staff shortages, was still too long.

3.5 We considered that the prison had made insufficient progress against this concern.

Use of force

Concern: The rate of use of force was high and oversight was weak. Staff did not always wear or turn on their body-worn cameras, and leaders did not routinely review restraint incidents.

3.6 Between June and November 2025, there had been 313 use of force incidents; 296 unplanned and 17 planned. Although use of force remained high, incidents had reduced by 8% compared to our observations at the inspection. PAVA (see Glossary) had been drawn three times and deployed once, and extendable batons had been drawn twice being used once. About 60% of incidents involved limited interventions such the application of guiding holds, personal protection techniques or the use of rigid bar handcuffs whilst escorting prisoners.

3.7 Oversight had improved significantly since the full inspection. A dedicated use of force coordinator and a custodial manager had strengthened governance, created a comprehensive use of force log and reduced the backlog of incidents pending review. There were now regular use of force meetings with a good understanding of the drivers of the use of force. Training for staff had been adjusted to better reflect local challenges.

3.8 The safety team had successfully promoted the use of body-worn cameras through assurance checks, briefings and individual challenge. Footage coverage had improved from 71.9% before the last inspection to 85.7% in the last six months, reaching 96.8% in November 2025.

3.9 We considered that the prison had made good progress against this concern.

Prisoner consultation, applications and redress

Concern: Staff did not routinely address men's legitimate day-to-day concerns, resulting in overuse of the application and complaint systems, and frustration for prisoners.

3.10 Prisoners continued to express frustration that staff did not address their day-to-day concerns and there remained a lack of confidence in the application and complaint systems.

3.11 Managers had reintroduced the role of supervising officer on some wings to support inexperienced officers. This was a positive initiative, although it was too soon to assess the impact.

3.12 Prisoner council meetings were well established but attendance by senior leaders and prisoner wing representatives was inconsistent. Monthly forums had recently been introduced on some wings, with plans in place to roll these out across all wings. Minutes we reviewed

showed the structure and content of these meetings varied and outcomes were not well communicated to prisoners.

3.13 The number of complaints had increased since the full inspection and remained high compared to similar prisons. Managers had implemented a robust quality assurance process to monitor responses. A senior manager checked a sample of responses and feedback was provided to staff.

3.14 Leaders had introduced a new process for tracking prisoners' applications, but this was not consistently followed and was not working as intended. Many prisoners complained that their applications did not receive a response.

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

Mental health

Concern: The mental health service did not meet the needs of the population. There were insufficient staff to deliver a full range of interventions and there was no psychology input. The oversight and governance of the service were weak.

3.16 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found breaches of regulations and issued requests for action plans following the inspection (see Appendix III).

3.17 The mental health provider, Practice Plus Group, had enhanced the clinical management of its services and there were now regular multidisciplinary care meetings which had improved decision making and efficiency of care. As a result, there was progress in the governance and oversight of some elements of patient care including physical health monitoring, medication reviews and application of the care programme approach. Oversight of the content of records still required improvement.

3.18 Half of patients requiring care under mental health legislation were transferred to hospital within 28 days. Although this was an improvement since the last full inspection, some patients still faced long waits.

3.19 Not all revised governance processes were yet fully embedded, and we found inadequacies in the narrative and quality of patient records we sampled. There were plans to introduce regular mental health awareness for prison officers, but the training had yet to begin.

3.20 Recent recruitment had been successful, but several nursing and psychology staff had yet to start, so there were still gaps in the service. Nurses continued to be occupied with the triage of new referrals and

ACCT (see Glossary) reviews, which meant they were unable to prioritise their therapeutic responsibilities due to reactive operational demands. The clinical lead had introduced a day of locum psychology, and an art therapist was now working so that 12 patients were receiving individual or group psychological therapies. Despite these interventions, too many patients remained on the waiting list. At the time of our review, 57 patients had been waiting up to 25 weeks for treatment.

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

Fair treatment and inclusion

Concern: Some prisoners with protected characteristics experienced worse outcomes, and this was not always properly explored or responded to. Some needs, particularly among disabled and foreign national prisoners, went unmet.

3.22 Managers had increased consultation with prisoners in protected groups and there was a renewed commitment to understanding their needs. Forums for each protected characteristic group had been introduced, but most were yet to deliver meaningful improvements.

3.23 Equality meetings were well established and took place every two months. The meeting discussed detailed data on outcomes for protected groups, including use of force, complaints and discrimination incident reporting forms (DIRFs). Managers' understanding of the data was improving, but actions were not always addressed promptly.

3.24 Prisoner equality representatives had recently been recruited on most wings and their role was developing.

3.25 In the previous six months, 30 DIRFs had been submitted, compared to over 100 at the full inspection. Oversight by the deputy governor ensured investigations and responses were courteous and professional.

3.26 As at the full inspection, we found some disabled prisoners and men who required additional support had unmet needs. We met some prisoners with additional needs whose location on the wings meant they were not easily able to access staff offices or cooking facilities. Not all staff were aware of prisoners' personal emergency evacuation plans (PEEPs) or the support individuals may need in the event of an evacuation.

3.27 Access to translated materials for foreign national prisoners was limited and the use of interpretation services remained inadequate. Many staff we spoke with were unaware of the availability of telephone interpretation services, equipment to access the service was lacking and usage was not being monitored locally. Some staff relied on other foreign national prisoners to translate on behalf of their peers.

3.28 We considered that the prison had made insufficient progress against this concern.

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: There were insufficient activity places to meet the needs of a training prison, and too few opportunities for prisoners to develop relevant knowledge and skills. The allocations process was not effective in making sure that prisoners accessed their choice of activity. There were too few roles in vocational training and waiting lists were too long. Approximately a quarter of the prisoners were unemployed.

3.29 Leaders had increased available activity spaces to ensure that most prisoners participated in education, skills and work activities. This had reduced the unemployment rate. While leaders acknowledged that they needed to make further improvements, two workshops were closed due to issues with reinforced autoclaved aerated concrete, and this limited the amount of space available for additional activities.

3.30 Leaders and managers had improved the allocations process since the previous inspection. With the exception of a few popular courses, such as hospitality, rail and construction, leaders had reduced the significant waiting lists. Most prisoners felt that they received their first choice of activity in a reasonable timescale. A few prisoners remained unhappy with their allocated activity. However, this was often due to their poor behaviour that resulted in reduced security levels.

3.31 Leaders had introduced additional outreach and in-cell learning opportunities that met prisoners' learning needs. Since October 2025, prisoners had collectively achieved around 500 modules that had given them confidence in topics such as health and safety, understanding mental health and 'minute maths'. Prisoners said that these would help them to progress to their next stages of learning and/or work.

3.32 Leaders had started to use learner forums effectively to tailor new curriculums to meet prisoners' needs and future ambitions. For example, they had introduced new qualifications to previously unaccredited activities, such as in construction, employability skills, first aid, mental health, fire safety, food hygiene and industrial cleaning. However, leaders acknowledged that prisoners wanted more

accredited courses to help them to gain employment after release. Leaders were developing an independent living skills workshop to help prisoners to support themselves in their communities. However, this was in the early stages of development.

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

Theme 2: Attendance in education, skills and work was too low and punctuality in vocational subjects and workshops was poor.

3.34 Leaders had improved the induction process and how staff assessed prisoners' starting points. The allocations team used this information together with prisoners' discussions with the careers team effectively to ensure that most prisoners were allocated to appropriate activities and wanted to attend.

3.35 The allocations team and careers staff worked together closely to identify any changes in prisoners' preferences for activities. Careers staff reinterviewed prisoners at frequent stages of their stay, including those on waiting lists, to reaffirm their suitability for their choices. This helped to ensure that prisoners were allocated to the correct activity and attended.

3.36 Leaders had introduced celebration events and financial incentives to encourage improved attendance and punctuality. Prisoners allocated to the 'contracts' workshops, where work was often mundane, valued these opportunities. They identified progression opportunities and appreciated the financial bonuses they received for 'worker of the week' and 'worker of the month'. Prisoners also recognised that they gained additional skills, such as improved social interaction, confidence and working as a team, and enjoyed attending.

3.37 Leaders and managers monitored absences closely. They had trained all staff to ensure that they used the incentives scheme effectively and consistently across the prison to promote attendance.

3.38 Leaders' initiatives had started to improve attendance across education, skills and work activities. However, at the time of the visit, the accuracy of the attendance monitoring software did not reflect the actual attendance at activities.

3.39 Only a few prisoners refused to attend education, skills and work activities. Attendance was mostly high during the visit. Absences were often due to prisoners attending additional short courses, healthcare visits and appointments related to their release. Leaders recognised that they needed to further improve their management of appointments and visits so that they took place outside activities where possible.

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

Theme 3: Leaders and managers had only recently developed a reading strategy, and the implementation was in the very early stages. Prisoners who struggled to read were not supported well enough to develop their skills. Prisoners who could not speak English did not receive support from tutors in education, skills and work to improve their language skills.

3.41 Leaders had revised the reading strategy to ensure that it was relevant to the needs of prisoners. Prison leaders and the education provider worked closely together to ensure that the strategy was implemented across the prison. They had trained residential staff in their responsibilities to support the development of prisoners' reading skills. Prisoners appreciated the individual support they received from the prison's reading specialist. However, the range of reading material available on accommodation units was too narrow.

3.42 Staff promoted a variety of initiatives to encourage prisoners to want to read. These included poetry and short story competitions, 'bookflix', book clubs and focused themes on topics, such as the 'Great Big Bird Watch'. Prisoners had scheduled frequent visits to the library. However, a minority did not routinely attend.

3.43 Education staff were well-qualified to assess prisoners' reading levels and skills. Most of the education staff involved in supporting the reading strategy were phonics trained. This helped prisoners who could not read or had English as an additional language to develop their reading skills at the level they needed. This was either through entry level functional skills courses or courses designed specifically for those with English as a second language. Education staff provided additional peer mentors in entry level lessons to support prisoners with their reading skills.

3.44 Since the withdrawal of the Shannon Trust provision from the prison, leaders had created reading champion positions to replace the Shannon Trust mentors. Staff across the prison referred non- and emergent readers to 'the reading thing' and to the newly appointed reading champions for support. Most sessions provided clear strategies to help prisoners to learn to read. The strategies had already supported a minority of prisoners to move from low-level reading skills to achieving level 2 functional skills in English.

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

Theme 4: Too many prisoners in wing work roles and workshops were not able to develop relevant workplace skills.

3.46 Leaders had begun to work closely with employers to help prisoners develop career-specific skills and pathways. These were well-established in the hospitality, catering and rail industries, with prisoners moving into paid employment after release or on transfer to their next

establishment. Leaders had implemented plans to emulate this model with other employers. However, at the time of the visit, these were in the early stages of development.

3.47 Leaders had introduced 'progress-in-work' booklets to help record prisoners' development of skills in workshops. These were well-established in most workshops and recorded vocational skills as well as personal skills, such as the use of initiative.

3.48 Since the previous inspection, leaders had restricted the length of time that prisoners could work as wing-workers to a maximum of six months. They monitored the quality of the wing-work provision closely and had successfully established 'best wing' competitions. Around two thirds of wing-workers had completed qualifications or internal assessments for their roles. They mostly progressed to new activities that further developed relevant workplace skills, such as in construction, food preparation, and barbering. However, leaders had not yet implemented the use of the progress-in-work booklets to monitor prisoners' skills development across wing work.

3.49 Leaders had introduced a variety of new courses through their subcontracted funding to promote the development of prisoners' workplace and life skills. These included employability and self-employment courses, level 3 first aid, and a stoicism course. Prisoners welcomed these courses and appreciated how they broadened their wider knowledge and skills and often helped them come to terms with being in prison. A few prisoners, particularly those who had been at the prison longer, were unaware of the activities available to help them to develop the skills that they needed for their next stages of learning or employment after release.

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

Preparation for release

Concern: Governance of the offender management unit was not good enough and this had had a significant impact on prisoner outcomes. There was insufficient contact between prisoners and their offender manager and too many either did not have a sentence plan or were unable to complete the set objectives within it.

3.51 Leadership in the OMU had improved. The two managers worked closely together and carried out more, and better quality, analysis of performance and outcomes than we saw at the full inspection. This contributed to better engagement by the prisoner offender managers (POMs).

3.52 Wing surgeries hosted by OMU staff had been introduced and were taking place across the prison. All prisoners were now being seen by a duty POM in the induction process, and almost all met their allocated POM within two weeks of arrival. With the aid of AI and good use of

Microsoft Teams, managers were tracking the number and quality of contacts and ensuring that the minimum expected number of contacts was completed.

3.53 However, because of the shortage of probation POMs, over 100 prisoners serving longer sentences with no key milestones in the next two years were not allocated a POM at all. This practice was due to cease within the next month, with the arrival of a new probation officer, but it was causing considerable frustration among prisoners.

3.54 The backlog of offender assessment system (OASys, see Glossary) reviews had been reduced, with almost all now completed on time. Completions of accredited programmes had fallen since the last inspection due to the implementation of the new Building Choices programme, which had far fewer spaces for prisoners. This caused frustration among prisoners who felt it was limiting their progress, including achieving a move to open conditions.

3.55 Arrangements for public protection and recategorisation had improved significantly. Initial risk screenings were taking place promptly, and categorisation reviews were up to date.

3.56 We considered that the prison had made reasonable progress against this concern.

Section 4 Summary of judgements

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

HMI Prisons concerns

Illicit drug use remained a significant concern, driving debt, violence and self-harm. Weaknesses in physical security and insufficient purposeful activity increased boredom and vulnerability, while the lack of regular and meaningful drug strategy meetings meant that these links were not fully addressed.
Insufficient progress

The rate of use of force was high and oversight was weak. Staff did not always wear or turn on their body-worn cameras, and leaders did not routinely review restraint incidents.
Good progress

Staff did not routinely address men's legitimate day-to-day concerns, resulting in overuse of the application and complaint systems, and frustration for prisoners.
Insufficient progress

The mental health service did not meet the needs of the population. There were insufficient staff to deliver a full range of interventions and there was no psychology input. The oversight and governance of the service were weak.
Insufficient progress

Some prisoners with protected characteristics experienced worse outcomes, and this was not always properly explored or responded to. Some needs, particularly among disabled and foreign national prisoners, went unmet.
Insufficient progress

Governance of the offender management unit was not good enough and this had had a significant impact on prisoner outcomes. There was insufficient contact between prisoners and their offender manager and too many either did not have a sentence plan or were unable to complete the set objectives within it.
Reasonable progress

Ofsted themes

There were insufficient activity places to meet the needs of a training prison, and too few opportunities for prisoners to develop relevant knowledge and skills. The allocations process was not effective in making sure that prisoners accessed their choice of activity. There were too few roles in vocational training and waiting lists were too long. Approximately a quarter of the prisoners were unemployed.
Reasonable progress

Attendance in education, skills and work was too low and punctuality in vocational subjects and workshops was poor.
Reasonable progress

Leaders and managers had only recently developed a reading strategy, and the implementation was in the very early stages. Prisoners who struggled to read were not supported well enough to develop their skills. Prisoners who could not speak English did not receive support from tutors in education, skills and work to improve their language skills.
Reasonable progress

Too many prisoners in wing work roles and workshops were not able to develop relevant workplace skills.
Reasonable progress

Appendix I About this report

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

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

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

The aims of IRPs are to:

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

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in May 2025 for further detail on the original findings (available on our website at Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)).

IRP methodology

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

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

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

No meaningful progress
Leaders had not yet formulated, resourced or begun to implement a realistic improvement plan to address this concern.

Insufficient progress
Leaders had begun to implement a realistic improvement strategy (for example, with better and embedded systems and processes), but prisoner outcomes were improving too slowly or had not improved at all.

Reasonable progress
Leaders were implementing a realistic improvement strategy, with evidence of sustainable progress and some early improvement in outcomes for prisoners.

Good progress
Leaders had already implemented a realistic improvement strategy to address this concern and had delivered a clear improvement in outcomes for prisoners.

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

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

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

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

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

Inspection team

This independent review of progress was carried out by:

Martin Lomas	Deputy chief inspector
Chelsey Pattison	Team leader
Rachel Badman	Inspector
Martin Kettle	Inspector
Fiona Shearlaw	Inspector
Paul Tarbuck	Health and social care inspector
Bev Gray	Care Quality Commission inspector
Suzanne Wainwright	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.

ACCT
Assessment, care in custody and teamwork; case management for prisoners at risk of suicide or self-harm.

Building Choices
An accredited HMPPS cognitive-behavioural programme, delivered through group and one-to-one sessions. It focuses on developing skills in emotion management, healthy thinking, relationships, sense of purpose, and, where relevant, healthy sexual behaviour. The programme is tailored to individual risk and need, including those with learning disabilities or challenges, and aims to support positive change and reduce reoffending.

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.

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

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.

End of custody supervised licence (ECSL)
A scheme intended to tackle overcrowding, which entails prisoners being released up to 70 days early and having their supervised licence in the community extended. Restrictions apply for certain categories of offences. ECSL started in October 2023 and ended in September 2024 (see SDS40).

Family days
Many prisons, in addition to social visits, arrange ‘family days’ throughout the year. These are usually open to all prisoners who have small children, grandchildren, or other young relatives.

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.

Mandatory drug testing (MDT)
Enables prison officers to require a prisoner to supply a urine sample to determine if they have used drugs.

Offender assessment system (OASys)
Assessment system for both prisons and probation, providing a framework for assessing the likelihood of reoffending and the risk of harm to others.

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

PAVA
Pelargonic acid vanillylamide – incapacitant spray classified as a prohibited weapon by section 5(1) (b) of the Firearms Act 1988.

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

Protection of adults at risk
Safeguarding duties apply to an adult who:
- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

SDS40
A scheme intended to tackle overcrowding where prisoners serving a standard determinate sentence only spend 40% of their sentence in prison instead of 50% and their time on probation in the community is extended. Restrictions apply for certain categories of offences. SDS40 replaces ECSL and releases commenced in September 2024.

Secure social video calling
A system commissioned by HM Prison and Probation Service (HMPPS) to enable calls with friends and family. The system requires users to download an app to their phone or computer. Before a call can be booked, users must upload valid ID.

Thinking Skills Programme (TSP)
Cognitive skills programme addressing offenders' thinking and behaviour.

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.

Appendix III Care Quality Commission action plan request

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 Onley was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see Working with partners – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)). The Care Quality Commission issued requests for action plans following this inspection.

Action Plan Request

Provider: Practice Plus Group Health and Rehabilitation Services Limited
Location: HMP Onley
Location ID: 1-13454107727
Regulated activities: Diagnostic and screening procedures and treatment of disease, disorder or injury.
Action we have told the provider to take: This notice shows the regulations that were not being met. The provider must send CQC a report describing what action it is going to take to meet these regulations.

Regulation 12 – Safe care and treatment

How the regulation was not being met:

- The lack of psychology staff meant too many patients with known mental health needs were not offered care following triage assessment.
- Patients did not always have suitable care plans or risk assessments in place to guide staff when delivering care. Records we viewed lacked structure or a focus on the patients known mental health needs. Nursing staff told us they spent the majority of their time completing Assessment, Care in Custody and Teamwork (ACCT) reviews and triages.
- There were not enough mental health interventions delivered by nurses.
- Discharge planning for patients was not always documented on the patient record system.

Regulation 17 – Good governance

How the regulation was not being met:

- There was a lack of oversight over the number of patients waiting for therapy.
- Staff failed to identify poor quality of records through the completion of audits.

Regulation 18 – Staffing

How the regulation was not being met:

- There were insufficient numbers of nursing, therapy and support staff to provide a meaningful mental health service.

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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HM Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England