Report on an independent review of progress at

HMP Hull

by HM Chief Inspector of Prisons

14–16 March 2022

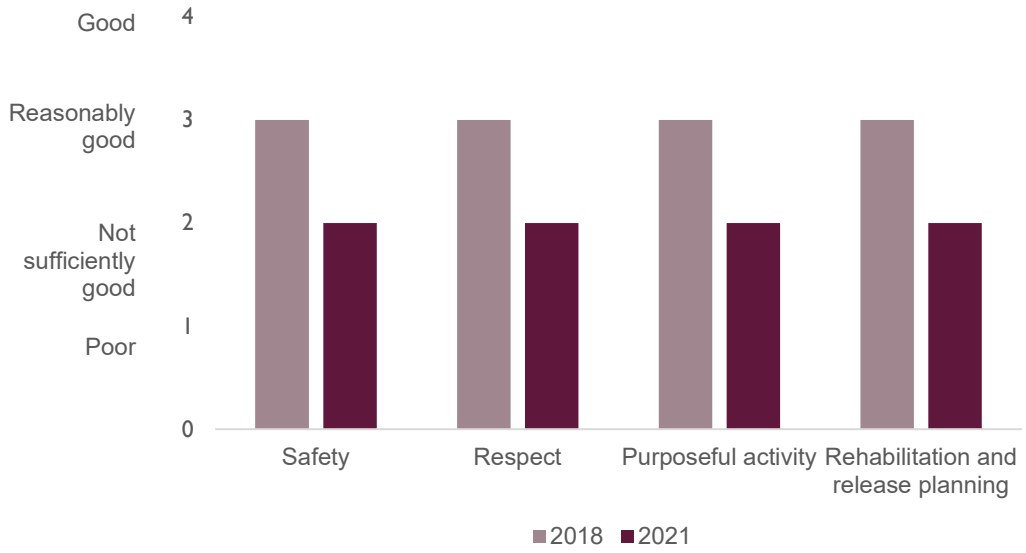
Contents

Section 1 Chief Inspector's summary

1.1 HMP Hull is a large, inner-city prison of two halves. The older wings, built in the 19th century, receive remanded or newly convicted men from the local community, while the newer wings largely hold vulnerable prisoners, many of whom are convicted of sexual offences. At the time of this review visit, the prison had a reduced capacity of around 900 prisoners while a wing was closed for fire improvement works.

1.2 At our previous inspections of HMP Hull in 2018 and 2021, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Hull healthy prison outcomes in 2018 and 2021



1.3 At our last visit, in July 2021, we reported on a prison where standards and outcomes had slipped after a succession of more positive inspections. Our findings were disappointing, with evidence of shortcomings and deterioration in all four of our healthy prison assessments, which were judged to be not sufficiently good. Violence had begun to increase, and we were not confident that the use of force was necessary, proportionate or safe in every case. Our concern at the incidence of eight self-inflicted deaths and two non-natural deaths was compounded by a lack of evidence that important recommendations made by the Prisons and Probation Ombudsman had led to sustained change, particularly in relation to health care. In fact, health care services were failing in some critical areas. We were not confident that partnership working was providing sufficient oversight and governance, and mental health services were inadequately resourced. There were serious risks and unmet need which needed immediate attention. Disappointingly, we found most prisoners locked in their cells for 23

hours a day, which was worse than we had seen in similar prisons. Offender management had also deteriorated, with very poor contact between prison-based offender managers and prisoners, and insufficient oversight of high risk of harm prisoners approaching release.

1.4 The situation at the time, however, seemed eminently retrievable, subject to some meaningful planning which focused on improved outcomes and more rigorous oversight. The prison had retained some core strengths and generally remained a capable institution. Staff were experienced and prisoners appeared to have considerable confidence in them. With the recent arrival of a new governor, our sense was that this was a time of potential and opportunity for the prison.

1.5 During this review visit, we examined nine key recommendations and our colleagues in Ofsted addressed three themes. Our findings were encouraging. There had been good or reasonable progress against eight of the 12 recommendations and themes, although there remained insufficient progress against four of these. Health care services were still of considerable concern. While governance had been strengthened, staff shortages continued to have a negative impact on the delivery of safe patient care.

1.6 The amount of time that prisoners spent unlocked was still very poor for many prisoners. There had been little progress since the last inspection for those who were unemployed. Although a prolonged COVID-19 outbreak and national restrictions had hindered the prison's ability to improve the regime, the time unlocked for prisoners at Hull was considerably worse than we have seen recently in comparable prisons that face similar challenges.

1.7 For the minority of prisoners who were engaged in education, however, Ofsted found that there had been reasonable progress. More learners had completed qualifications and there was better information, advice and guidance. Identification and support for those with learning difficulties and disabilities had also improved.

1.8 There had been considerable effort by the senior team in response to our recommendation that clear and up-to-date strategies were needed, along with rigorous oversight, to drive improvement. We found impressive progress in outcomes for prisoner safety that was underpinned by a revised strategy and better use of data. Incidents of violence and use of force had reduced since the last inspection, and scrutiny of use of force had markedly improved. The progress we found in offender management also reflected a prison that had renewed its sense of purpose and had clearer direction.

1.9 Overall, this was a positive review. The governor, his senior team and staff should be congratulated on what they have achieved so far in addressing the shortcomings we identified at the last inspection. As COVID-19 restrictions are lifted, the renewed confidence in the prison now needs to be translated into a much greater ambition in the amount of time that prisoners are unlocked from their cells.

Charlie Taylor
HM Chief Inspector of Prisons
March 2022

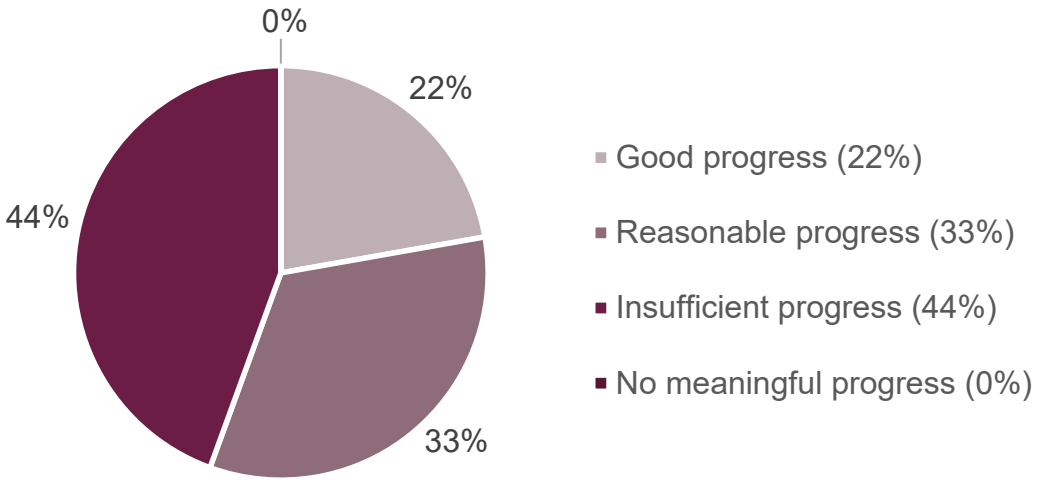
Section 2 Key findings

2.1 At this IRP visit, we followed up nine recommendations from our most recent inspection in July 2021 and Ofsted followed up three themes based on their latest inspection or progress monitoring visit to the prison, whichever was most recent.

2.2 HMI Prisons judged that there was good progress in two recommendations, reasonable progress in three recommendations and insufficient progress in four recommendations.

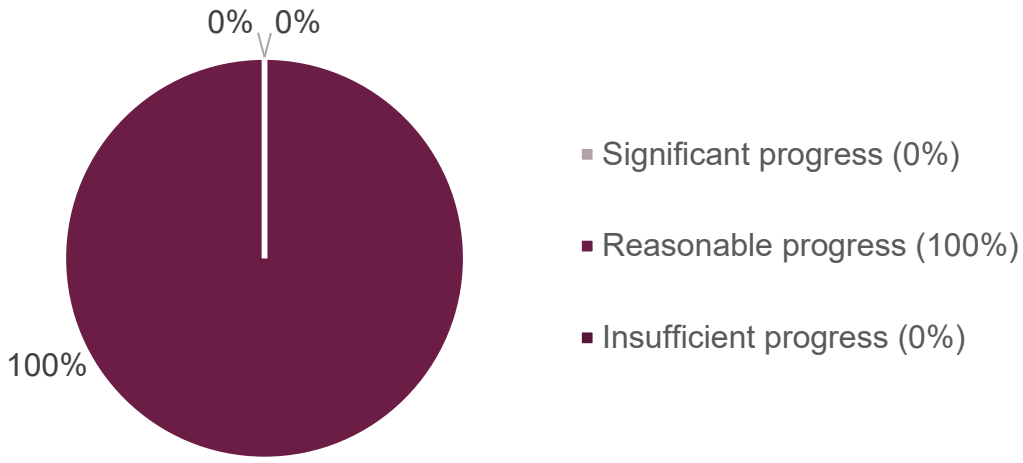
Figure 2: Progress on HMI Prisons recommendations from 2021 inspection (n=9)

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



Ofsted judged that there was reasonable progress in all three themes.

Figure 3: Progress on Ofsted themes from 2021 inspection (n=3).



Notable positive practice

2.3 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.

2.4 Inspectors found no examples of notable positive practice during this independent review of progress.

Section 3 Progress against the key concerns and recommendations and Ofsted themes

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2021. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Leadership

Concern: Leadership (see Glossary) and progress was hindered by the insufficient or inadequate strategies and action plans to effect improvement. Some were out of date and others, such as the safety strategy, did not set out a clear vision for success or steps to be taken to improve outcomes. This meant that there was a lack of a shared vision or agreement across the prison about the priorities and next steps.

Recommendation: Outcomes for prisoners should be improved. Clear and up-to-date strategies and action plans should be implemented to achieve improvement. The strategies should be regularly reviewed to monitor progress and to ensure oversight arrangements are in place to sustain delivery and provide accountability. (1.33)

3.1 The senior team had made considerable effort to improve strategic planning and oversight arrangements. Key strategies had been updated as part of a 12-month plan that included a training programme to improve managers' skills in writing strategy documents, business planning and driving continuous improvement.

3.2 The revised strategies for safety, reducing reoffending, offender management, diversity and inclusion, staff well-being and rehabilitative culture were tailored to the needs of the establishment. Action plans detailed how priorities would be achieved, but not always by whom and by when.

3.3 Regular quarterly review of each strategy by the senior management team had begun in January 2022, providing governance and oversight. The monthly performance and assurance meeting monitored the key performance indicators from each strategy to provide assurance and better accountability. The meeting also considered whether the strategies had the right priorities to sustain improved delivery and outcomes for prisoners.

3.4 The safety strategy used good analysis of data to inform decisions on priorities, and outcomes for prisoners had improved in some important areas since the last inspection (see paragraphs 3.7 and 3.14). However, other strategies were not yet sufficiently embedded to demonstrate tangible improvements in outcomes.

3.5 An establishment annual business plan, based on the key priorities in each strategy, had been developed for launch in April 2022.

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

Safety

Concern: Management oversight of the use of force and segregation was inadequate. For example, some incidents of force we reviewed were not proportionate to the risk and they were not always carried out safely. The segregation unit provided a poor daily regime and the management of those suspected of secreting illicit items was worrying as they were denied time out of cell (see Glossary) and access to medication.

Recommendation: The number of times force is used should be reduced. When used it should be proportionate and undertaken safely. (1.34a)

Recommendation: Outcomes for prisoners in the segregation unit should be improved through the provision of a purposeful regime. Those suspected of secreting illicit items should not be denied access to any part of the regime or necessary support. (1.34b)

3.7 Use of unplanned force had reduced by around 25% in the previous six months, compared with the same period before the inspection, and the number of planned incidents had fallen by 55%. The frequency of incidents, which had been lower than at similar prisons at the time of the inspection, had dropped even further.

3.8 Oversight and governance of use of force were regular and much improved. A weekly scrutiny panel reviewed all such incidents, took remedial action where required and reported its findings to the well-structured monthly use of force meeting. A large range of data was reviewed at the monthly meeting to monitor emerging trends and identify hotspots. Clear actions were identified and followed up, with the outcomes presented at subsequent meetings.

3.9 As a supplement to the annual refresher training, staff also received instruction on the de-escalation of incidents in order to reduce use of force, which was a good initiative. Almost all records of use of force were complete. Those we reviewed were comprehensive, completed on time and demonstrated an appropriate focus on resolving the incident as quickly and safely as possible.

3.10 We had found routine use of handcuffs and a lack of use of body-worn cameras at our last inspection. Actions had been taken to address these issues and there was clear evidence of ongoing improvement in both.

3.11 Managerial oversight of the segregation unit had improved. A regular segregation monitoring and review group now met to review data on segregation use, and consider and develop practice on the unit.

3.12 The regime on the unit had been improved with the introduction of in-cell learning, supported by education staff. In addition, in-cell workouts and PE programmes on the exercise yard had been introduced. Exercise bikes were also available for use. The regime for those subject to the secreted items policy was equitable with that for others held on the unit, and the management of those subject to the policy was now appropriately authorised and overseen by a senior manager.

3.13 We considered that the prison had made good progress against these recommendations.

Segregation unit exercise bicycles

Concern: The challenge, support and intervention plan (CSIP) casework approach to supporting victims and managing perpetrators of violence was not operating effectively. Too many investigations were completed late. Few intervention plans were individualised and some prisoners we spoke to were not aware of them. Staff we spoke to were not confident about the purpose and application of CSIPs and reviews were not sufficiently multidisciplinary.

Recommendation: Safety should be improved by making sure that perpetrators of violence and other types of anti-social behaviour are managed robustly and that victims receive the support they need. (3.17)

3.14 Incidents of violence against staff and prisoners alike had fallen sharply (by 60% and 55%, respectively) since the last inspection and there were far fewer than at similar prisons.

3.15 The safety team had worked hard to raise awareness of the CSIP process (see Glossary). One-to-one training had been provided to those responsible for managing cases, and a useful 'how to' guide had been produced and issued individually to landing staff. The process was now much more widely understood and integrated into behaviour management. Managerial oversight had improved and records we reviewed showed that most investigations were now undertaken in good time.

3.16 Staff on some wings demonstrated a good understanding of those in their care who were subject to a CSIP. This was not always the case, however, and information identifying which prisoners were on CSIPs, the reasons why and the actions needed to manage and support them was not consistently available. Not all prisoners subject to monitoring had individually tailored plans to underpin their management and support.

3.17 The impressive weekly safety intervention meeting considered prisoners presenting a wide range of vulnerabilities. This included victims of violence, those who had been under assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm who required a level of additional support, and those with social care needs. Support plans for these individuals were formulated and monitored at the meeting.

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

Concern: There had been eight self-inflicted deaths and two further non-natural deaths in the previous three years. Investigations by the Prisons and Probation Ombudsman (PPO) had generated a large number of recommendations and some highly negative findings about treatment and conditions. We were concerned to find that there had not been sufficient focus on achieving many of these recommendations, particularly those relating to health care.

Recommendation: All Prisons and Probation Ombudsman recommendations should be implemented and sustained over time to help prevent further self-inflicted deaths. (1.35)

3.19 The strategic oversight of PPO recommendations by the prison had improved. Recommendations were now subject to monthly assurance checks, led by a custodial manager, and were discussed at the monthly 'safe and secure' meeting.

3.20 Our analysis showed that health care leaders did not attend the safe and secure meetings, despite being invited, and we were told that clinical pressures prevented them from doing so. This meant that key

recommendations which health care managers were responsible for were not subject to multidisciplinary oversight with prison colleagues.

3.21 We found several examples of health recommendations which had still not been implemented or reviewed. Worryingly, one repeat recommendation, which had featured since 2018, for monitoring the deteriorating patient using the National Early Warning Score (NEWS) 2 had not been implemented. Our analysis of records showed that clinical staff were not routinely using NEWS2 observations for the deteriorating patient in line with policy and NICE guidelines, and only 27% of clinical staff were compliant with NEWS2 training, which was now mandatory.

3.22 Despite some assurances from City Health Care Partnership that PPO recommendations were subject to corporate oversight, we were not confident that actions to drive up service improvement were always implemented or embedded in practice.

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

Respect

Concern: Prisoners with protected characteristics (see Glossary) had little direct support and the analysis of data to identify disproportionate treatment remained limited. Promoting positive outcomes for each protected characteristic group was not seen as a priority by all departments, so the work was not given sufficient attention.

Recommendation: Leaders should deliver a coordinated and well-resourced approach to promoting equality and inclusion in all aspects of prison life, and make sure that prisoners are consulted frequently to strengthen the support available. (1.36)

3.24 A new diversity and inclusion strategy had recently been developed, along with a useful and meaningful plan focused on addressing the shortfalls identified in the last inspection. The strategy and plan laid out a clear vision as to what success would look like and was due to be launched imminently.

3.25 A feature of this plan was the need to recruit additional staff from across the prison to engender a whole-prison approach to help promote and drive diversity and inclusion work. Residential middle-managers and officer-grade champions had very recently been identified but their roles were not yet fully defined, or their work embedded. Too much of the existing officer time profiled to support this area of work continued to be lost to undertake other prison duties.

3.26 The diversity and inclusion action team had resumed in January 2021, after a year-long period of suspension during the pandemic, but had met only three times since the last inspection. There were plans to refresh and broaden the scope of the meeting's focus but these had not yet come into effect.

3.27 The consideration of monitoring data to identify and act on potential disparities in treatment for protected groups across all key aspects of prison life remained limited, and still did not drive meaningful action planning.

3.28 COVID-19 restrictions had hindered the ability to bring mixed groups of prisoners together from across the establishment, but consultation forums for protected groups had begun to resume on individual wings. Good work had been done to engage with LGBT prisoners, resulting in action leading to some positive change. However, in most cases, forums had minimal attendance, were not reflective of the needs and experiences of all and did not take place sufficiently often.

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

Concern: The lack of clinical and operational leadership, inadequate GP capacity and chronic staff shortages meant that patients' changing needs, including the management of long-term conditions and mental health, were not being assessed or met in a timely manner. This was creating serious risk.

Recommendation: The local delivery board, in conjunction with NHS England and Improvement, should undertake an urgent health needs analysis to ensure that adequate resources are in place to meet the needs of all patients safely. (1.37)

3.30 Spectrum Community Health Community Interest Company (CIC) had been awarded a contract in December 2021 to work alongside its partner, Tees, Esk and Wear Valleys NHS Foundation Trust, to provide strategic oversight and support to City Health Care Partnership CIC to drive forward its improvement plan.

3.31 While there had been additions to the clinical and operational leadership team, some management arrangements were disjointed, which meant that lines of accountability were not always clear.

3.32 Governance and risk management systems had been reviewed, and many positive changes introduced across the service to support improving outcomes for patients. However, it was too early for us to be confident that the recently implemented systems would be effective in achieving their aim.

3.33 Some governance processes needed strengthening – for example, to ensure that service delivery was consistently informed by effective clinical audits. Furthermore, systems to ensure staff compliance with mandatory training, appraisals, and clinical and managerial supervision needed improvement. We were particularly concerned that compliance with critical training, such as life support and the management of deteriorating patients, was very low; 46% of registered clinical staff were out of date with intermediate life support training. Nevertheless,

staff felt supported and there was a dedicated and committed staff team, who mostly felt well informed of areas of change.

3.34 There had been some improvements in staffing arrangements with the recruitment of an additional GP, increased access to a psychiatrist, and remote pharmacy support. Staff shortages remained challenging, however, and the high level of unfilled nurse and health care assistant shifts continued to affect the delivery of safe care – for example, in the timeliness and range of treatments and therapies offered by mental health services. At the time of this review visit, 114 prisoners were waiting for assessment or allocation to a clinician for mental health treatment.

3.35 Core services continued to be delivered and progress had been made in the clinical prioritisation of patients waiting for care and treatment in both mental health and primary care. Work had begun to ensure improvement in the management of patients with long-term conditions and with changing and complex needs, and in care planning. Not all care was delivered in line with guidance; in addition, governance systems, compounded by staff shortages, did not always operate effectively to support the delivery of safe and effective patient care.

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

Purposeful activity

Concern: The daily regime was far too restricted, and most prisoners continued to spend 23 hours a day locked in their cells. Opportunities to engage in purposeful activity remained limited and too many prisoners were unemployed.

Recommendation: All prisoners should have sufficient time out of cell, including longer in the open air, and be engaged in activities that support their rehabilitation. (1.38)

3.37 There was still too little time out of cell for many prisoners, at around 1.5 hours per day, which included just 30 minutes in the open air. This had hardly increased since the last inspection and was much poorer than we have recently seen at similar prisons.

3.38 A prolonged COVID-19 outbreak and HM Prison and Probation Service restrictions had hindered the prison's ability to improve the regime. Despite plans to introduce a range of activities, too few had yet been actioned. It was unclear from these plans whether the time unlocked for unemployed prisoners would be increasing. We were concerned that prisoners would still be locked up for far too long when COVID-19 restrictions were lifted.

3.39 In our roll checks, 40% of the population were locked up, which was only slightly better than the 48% that we had found at the last inspection. Too few prisoners were engaged in purposeful activity and

only around 14% of the population were engaged in off-wing activity at any given time, with a similar number employed in wing-based work, although this was often for relatively short periods.

3.40 We visited some of the workshops and were surprised to find that not all available workspaces were filled. Similarly, the gym was operating well below capacity, despite the number of prisoners locked up. It was also disappointing that attendance at the gym was offered only to those already unlocked during their limited domestic time.

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

Education, skills and work

This part of the report is written by Ofsted inspectors. Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the prison's previous inspection report or progress monitoring visit letter.

Theme 1: A greater number of learners should complete qualifications, in particular on vocational and functional skills courses.

3.42 As a result of continuing pandemic-related restrictions, most education was still delivered to individuals or small groups on the wings, rather than in classes. Despite this, the number of prisoners enrolling on education courses had increased by almost 60% since the previous year.

3.43 Vocational qualifications had been reintroduced to workshop areas such as cleaning, catering and horticulture in January 2022. In the current year, around 16% of the prisoners had completed qualifications in workshops. Two-thirds of these related to very short courses, such as manual handling, but a small number of prisoners had achieved awards in recycling and horticulture. Managers had well-developed plans to introduce new vocational courses such as textiles and video editing shortly.

3.44 Managers had increased the number of workshop places by 65 in the last year, to a total of 388 places, which was enough for 40% of the population. These included courses such as welding, which provided useful skills and purposeful activity but did not offer accreditation. Approximately 18% of the prison population had completed non-accredited courses in 2021/22.

3.45 Completion and success rates were high on vocational and functional skills courses. Since the last inspection, the number of prisoners completing an accredited course had increased, and there were more than twice as many completions of functional skills qualifications. The number of passes had increased considerably across all qualifications, but especially on functional skills courses.

3.46 Despite these gains, the number of prisoners taking qualifications remained well below pre-pandemic levels, and most were not engaged on accredited courses. The proportion of unemployed prisoners had reduced to about a third since the last inspection, but only around 15% were enrolled on part-time education courses at the time of this review visit, and there were long waiting lists for some courses.

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

Theme 2: The needs of all prisoners with learning disabilities and difficulties should be identified and addressed.

3.48 Strategies to identify prisoners with learning difficulties and disabilities (LDDs) had improved. Systems to collect self-declared information were similar to those at the previous inspection. These were complemented by effective communication established between the LDD manager and prison and health care staff. Collectively, they identified the LDD needs of prisoners who had chosen not to self-declare during the induction process. This ensured that further conversations could take place with them, to help them to succeed when they participated in education, vocational training or work.

3.49 Prisoners received timely screening of their additional needs, and support was swiftly put in place. Adaptive equipment was readily available for them. This included weighted and left-handed pens to aid writing, and fidget foam tools to reduce anxiety and help concentration, along with a range of other adaptive tools.

3.50 Instructors in industries were well attuned to prisoners' learning needs. They had recently received specialist training to help them support different LDDs and manage their associated behaviour. These prisoners were well supported in developing their skills.

3.51 Support plans clearly identified the practical support and teaching strategies that tutors could use to help prisoners to succeed. The LLD lead worked well with other professionals, such as the mental health nurse, to identify the barriers to learning that prisoners faced. Together, they devised strategies to meet these needs. Prisoners with LDDs benefited from this support, and a large proportion achieved as well as their peers.

3.52 Reviews of the support that prisoners received was weak. Leaders and managers gave little attention to evaluating the effectiveness of support strategies and how these might be developed for the next stage of

learning. Prisoners did not receive copies of their support plans, which meant that, in a few cases, they did not know that their declared disabilities had been inaccurately recorded.

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

Theme 3: All prisoners should benefit from comprehensive information, advice and guidance.

3.54 Managers had implemented a new contract for the information, advice and guidance (IAG) service, which had led to considerable improvements. These included an increase in the number of adviser posts, from one to four full-time advisers, and the introduction of new electronic personal learning plans for prisoners. The new staff had been recruited and were currently undertaking the qualifications needed for their job roles.

3.55 Managers had made good progress with the introduction of learning plans. These provided much better access to information and advice for prisoners and staff, and allowed information about prisoners' needs to be transferred immediately when they moved to another prison. Leaders had built demanding performance targets into the new contract, to improve the quality of the IAG service.

3.56 Prisoners' short duration of stay meant that many were transferred to other prisons immediately after their COVID-19 quarantine period and before they could be interviewed by IAG staff. In the two months before this review visit, a small minority of new receptions had been transferred or released before the IAG service could contact them. About half of these prisoners had been discharged to the community, with the rest transferred to other prisons.

3.57 The remaining prisoners were seen soon after their COVID-19 quarantine period. Staff conducted interviews with these prisoners well, making good use of an attractive prospectus to inform them of the education and work opportunities available. Recognising that many prisoners would quickly transfer to other prisons, they also provided prospectuses from other prisons in the region. This information was additionally available from prisoner mentors on the wings and via the in-cell television channel.

3.58 IAG staff and prisoners found the new learning plans easier to engage with and used them well to record prisoners' prior experience and aspirations. COVID-19 safety restrictions meant that prisoners could not yet access the computer facilities to create their plans, so these were uploaded onto the system by IAG staff instead. The prison had been authorised to reopen computer rooms in the week after this review visit, to provide this access.

3.59 Exit interviews were not yet sufficiently effective. Managers planned for these to take place 15 weeks before release. Although records showed

that some had taken place, not all prisoners were receiving them. Prisoners we spoke to who were close to their release date, including some with mental health needs, told us that they had not received this support.

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

Rehabilitation and release planning

Concern: The sharing of information and handover of responsibility for prisoners' risk management were inadequate. Multi-agency public protection arrangements (MAPPA) were not always agreed, and some risk management plans were out of date. The interdepartmental risk management meeting was poorly conducted and there was no strategic oversight of these cases. At the time of the inspection, there was no resettlement planning for high risk of harm prisoners.

Recommendation: All MAPPA-eligible prisoners approaching release should have a multidisciplinary plan agreed in sufficient time to fully manage risks and address resettlement needs. (1.39)

3.61 The establishment continued to hold a complex population of both remand and sentenced prisoners, and about 130 were released each month. At the time of this review visit, just over half of the population were MAPPA eligible and nearly three-quarters of those convicted were assessed as presenting a high risk of harm.

3.62 Managers in the offender management unit (OMU) had recently implemented a far more robust approach to the timely risk management release planning for these prisoners. Since January 2022, the inter-departmental risk management meeting had been considering, at a minimum, high-risk and MAPPA-eligible prisoners both at 12 months and 12 weeks before their release, and discussions and contributions were thorough. While there were some gaps for short-term recalled prisoners, mitigated somewhat by oversight from offender managers in the community, these new arrangements provided a much improved and appropriate strategic oversight of these cases.

3.63 Efforts by the senior probation officers (SPOs) to engage proactively with probation staff in local delivery units had increased levels of engagement from community offender managers. Joint resettlement planning arrangements, including the handover of responsibility for prisoners' risk management, were steadily improving, although still not always timely.

3.64 We considered that the prison had made good progress against this recommendation.

Concern: Progress against sentence plan targets varied. Contact was poor and in almost a quarter of cases that we reviewed there was no recorded contact. There was not enough focus on progression and work with prisoners concentrated on completing tasks relating to parole reports or categorisation reviews.

Recommendation: All eligible prisoners should have regular contact with an appropriately trained prison offender manager focused on promoting their sentence progression. (6.19)

3.65 The number of prison-based offender managers (both from a prison and probation background) in the OMU was adequate and due to increase in the coming months. Prisoners continued to be appropriately allocated by risk, and offender manager caseloads were not excessive. However, the lack of key work activity (see Glossary) with prisoners meant that the offender managers were having to respond to higher levels of general enquiries and basic tasks, often outside of their remit, which should ordinarily have been carried out by key workers. This hampered their ability to carry out more meaningful and regular sentence progression work with prisoners.

3.66 Recorded levels of contact were gradually improving but remained too varied. Contact was still mainly reactive to milestone events and time-limited tasks, but there were some very early signs of proactive engagement to drive sentence progression, which was promising.

3.67 In response to our findings at the last inspection, the SPOs had very recently implemented good measures to ensure greater assurance and oversight of the quality and frequency of contact between prison-based offender managers and prisoners.

3.68 Since January 2022, a random sample of prisoner cases had been discussed in each offender manager's six-weekly supervision session, to assess if contact had taken place and how meaningful it had been. More recently, steps had been taken to consult these prisoners directly for their feedback, which was a positive initiative to help drive improvements, although it was too early to judge its effectiveness.

3.69 We considered that the prison had made reasonable 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

Outcomes for prisoners should be improved. Clear and up-to-date strategies and action plans should be implemented to achieve improvement. The strategies should be regularly reviewed to monitor progress and to ensure oversight arrangements are in place to sustain delivery and provide accountability.
Reasonable progress

The number of times force is used should be reduced. When used it should be proportionate and undertaken safely.
Good progress

Outcomes for prisoners in the segregation unit should be improved through the provision of a purposeful regime. Those suspected of secreting illicit items should not be denied access to any part of the regime or necessary support.
Good progress

Safety should be improved by making sure that perpetrators of violence and other types of anti-social behaviour are managed robustly and that victims receive the support they need.
Reasonable progress

All Prisons and Probation Ombudsman recommendations should be implemented and sustained over time to help prevent further self-inflicted deaths.
Insufficient progress

Leaders should deliver a coordinated and well-resourced approach to promoting equality and inclusion in all aspects of prison life, and make sure that prisoners are consulted frequently to strengthen the support available.
Insufficient progress

The local delivery board, in conjunction with NHS England and Improvement, should undertake an urgent health needs analysis to ensure that adequate resources are in place to meet the needs of all patients safely.
Insufficient progress

All prisoners should have sufficient time out of cell, including longer in the open air, and be engaged in activities that support their rehabilitation.
Insufficient progress

All MAPPA-eligible prisoners approaching release should have a multidisciplinary plan agreed in sufficient time to fully manage risks and address resettlement needs.
Good progress

All eligible prisoners should have regular contact with an appropriately trained prison offender manager focused on promoting their sentence progression.
Reasonable progress

Ofsted themes

A greater number of learners should complete qualifications, in particular on vocational and functional skills courses
Reasonable progress

The needs of all prisoners with learning disabilities and difficulties should be identified and addressed.
Reasonable progress

All prisoners should benefit from comprehensive information, advice and guidance.
Reasonable 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 July 2021 for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

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

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

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

No meaningful progress
Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.

Insufficient progress
Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken since our inspection had had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

Reasonable progress
Managers were implementing a realistic improvement strategy for this recommendation and there was evidence of progress (for example, better and embedded systems and processes) and/or early evidence of some improving outcomes for prisoners.

Good progress
Managers had implemented a realistic improvement strategy for this recommendation and had delivered a clear improvement in outcomes for prisoners.

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

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

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

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

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

Inspection team

This independent review of progress was carried out by:

Martin Lomas	Deputy Chief Inspector
Sara Pennington	Team leader
Jade Richards	Inspector
Paul Rowlands	Inspector
Shaun Thomson	Health and social care inspector
Dr Vanessa Doel	GP specialist adviser
Cat Raycraft	Care Quality Commission inspector
Helen Lloyd	Care Quality Commission inspector
Steve Oliver-Watts	Lead Ofsted inspector
Sheila Willis	Ofsted inspector

Appendix II Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Care Quality Commission (CQC)
CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: http://www.cqc.org.uk

Challenge, support and intervention plan (CSIP)
Used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

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

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

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

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

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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