Report on an unannounced inspection of

HMP Onley

by HM Chief Inspector of Prisons

23–24 May and 6–10 June 2022

Contents

Introduction

HMP Onley is a category C training and resettlement prison in rural Northamptonshire.

The work of this jail was being constrained by the staffing situation which was one of the worst I have seen. The nearby convergence of two motorways meant that there were many local employers to compete with. The jail is also next to a private prison which was able to pay a substantially higher starting salary to new officers and operational support grades. It is not far from the recently opened Five Wells, which again pays more and to the south, prisons such as Aylesbury and Woodhill (both themselves struggling with staffing levels), are able to pay a market supplement.

The prison was unable to deliver a proper category C regime. Out of a population of 732, less than half were working or attending education, and because the prison was operating a split regime even these prisoners were only spending half the day off the wing. Moreover, this restrictive regime wasn't always being carried out; short staffing was leading to it being frequently curtailed, a situation that was worse during the weekends.

The education provider had underperformed and had been unable to recruit enough staff, meaning that most of the workshops were empty. The extensive greenhouses in the market garden were falling apart and beds were overgrown with weeds. The quality of teaching was poor and the allocation system did not work – for example, prisoners at GCSE level were in the same maths class as those at entry level.

Despite poor provision of purposeful activity, we were pleased to see significant improvement in safety. Led by the conscientious governor and his team, staff at Onley should be congratulated for the work they had put into reducing the supply of drugs and bearing down on the high levels of violence that we found at our last inspection when we awarded our lowest score for safety.

Violent incidents against prisoners had reduced by 65% and by 24% against staff, and 38% of prisoners in our survey, against 55% last time, told us that they had felt unsafe sometime during their time at the prison. Similarly, there had been a 19% fall in the number of prisoners who said it was easy to get drugs in the jail. Levels of violence however, still remained higher than in similar prisons.

The prison was also better maintained and much cleaner than at our last inspection with new showers fitted on many of the wings and most cells were in better condition.

Sentence progression should be at the heart of a category C training prison, but the offender management unit was, in most cases, providing little more than piecemeal support and prisoners said they rarely heard from their prison offender managers. There was a good team delivering accredited programmes, but the range was not wide enough to cover the needs of many prisoners, affecting their progression. Leaders had worked hard to restart key work, and

although it was still inconsistent, Onley had made more progress than other prisons we had recently inspected.

The jail largely serves a London population, despite being a considerable distance from the capital, and although the prison had worked hard to restore visits to pre-pandemic levels – it remained a difficult and expensive place for families to get to. Despite this distance, the prison had worked hard to navigate the complexities of the various probation services it interacts with to provide a decent resettlement service.

With a high proportion of ethnic minority prisoners, the governor had taken personal responsibility to improve the responses to discrimination incident report forms and to address disproportionate outcomes.

Lower levels of violence, and the end of COVID-19 restrictions, offer a springboard for leaders at Onley to open up the regime and motivate prisoners, many of whom have become indolent after two years of lockdowns, so that the prison can really fulfil its function as a category C prison. Unless the dire staffing situation improves however, it is hard to see to see how this can be achieved.

Charlie Taylor
HM Chief Inspector of Prisons
July 2022

What needs to improve at HMP Onley

During this inspection we identified 14 key concerns, of which five should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **Staff shortfalls in many areas limited progress in achieving better outcomes for prisoners.**

2. **Governance of medicines management was limited and lacked effective oversight.**

3. **Prisoners did not have sufficient access to education, skills and work activities to improve their resettlement chances.** More than half of prisoners were unemployed and spent too much time locked in cells. The allocations process was inefficient and leaders did not use classroom and workshop places well enough. Too few prisoners had the opportunity to complete accredited qualifications.

4. **The quality of education was inadequate.** The curriculum was not planned effectively, or the delivery of subjects sequenced well enough, to enable prisoners to build on their skills, knowledge and behaviour.

5. **Prisoners were rightly frustrated that they could not make progress in addressing their offending behaviour.** They had insufficient contact with prison offender managers and there was too little access to offending behaviour programmes.

Key concerns

6. **Some escorting arrangements were poor.** We found prisoners who had taken over 24 hours on transfer from London.

7. **Oversight and accountability for use of force against prisoners was not good enough.**

8. **The quality and amount of food provided for prisoners was poor.**

9. **There was too little support for foreign national prisoners and their specific needs were unmet.**

10. **Support for prisoners needing social care was underdeveloped.** There was no up-to-date memorandum of understanding setting out procedures for making social care referrals, which potentially led to unmet need.

11. **Prisoners did not have sufficient or fair access to the gym.** We found prisoners who had had eight gym sessions during the previous week, while others were limited to nearer one a month.

12. **Attendance at education or workshop activities was poor.** Leaders and prison staff did not encourage or motivate prisoners well enough to attend their activities. Too often prisoners chose, and were permitted, to remain on their wings.

13. **Careers advice and guidance provision was insufficient for the prison population.** Too many prisoners had not received any advice for their next steps or future career goals. Leaders had not developed sufficient links with external employers.

14. **There was no tailored provision for those serving indeterminate sentences.** The lack of progression opportunities, combined with the absence of a suitable living environment, caused many to feel frustrated.

About HMP Onley

Task of the prison/establishment
HMP Onley is an adult male category C prison.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 732
Baseline certified normal capacity: 742
In-use certified normal capacity: 742
Operational capacity: 742

Population of the prison

- 82 foreign national prisoners
- 66% of prisoners from black and minority ethnic backgrounds
- 21 prisoners released into the community each month
- 205 prisoners actively engaging with support for substance use
- An average of 32 prisoners referred for mental health assessment each month.

Prison status (public or private) and key providers
Public

Physical health provider: Northamptonshire Health NHS Foundation Trust
Mental health provider: Northamptonshire Health NHS Foundation Trust
Substance use treatment provider: Phoenix Futures
Prison education framework provider: PeoplePlus
Escort contractor: GeoAmey

Prison group/Department
Midlands

Brief history
Built as a Borstal in 1968, Onley held young offenders until 1998. The juvenile population was replaced by sentenced adults in March 2004. The establishment was re-roled to a full adult category C training establishment in March 2010. In July 2011, it was announced that it would be market tested, allowing private operators, as well as HM Prison and Probation Service, to tender for the contract to operate the prison. Onley was removed from the bid in October 2012. From 2013, it was designated as a resettlement prison for Greater London. Owing to a reconfiguration of establishments in 2017, the prison has moved back into the Midlands cohort, although still largely holds a London population. Its primary function currently is as a category C training prisoner (80%) and a resettlement prison (20%).

Short description of residential units
A to H wings are the older, original wings. A, B, C, D and E wings each provide general accommodation for 60 prisoners.
F wing is the segregation unit, consisting of 15 cells.
G wing is the resettlement wing.
H wing is the first night and induction unit, both providing accommodation for 60 prisoners.
I wing provides general accommodation, for 100 prisoners.

J wing is the substance recovery wing, for 75 prisoners.
K wing is the incentivised substance-free living wing, for 75 prisoners.
L wing is a normal population wing, providing accommodation for 72 prisoners, but has the benefit of an integral shower and toilet in the cells.

Governor/director and date in post
Matthew Tilt, April 2018

Leadership changes since last full inspection
None

Prison Group Director
Paul Cawkwell

Independent Monitoring Board chair
Leslie Leeson

Date of last inspection
12–23 November 2018

Section 1 Summary of key findings

1.1 We last inspected HMP Onley in 2018 and made 64 recommendations, six of which were about areas of key concern. The prison fully accepted 54 of the recommendations and partially (or subject to resources) accepted seven. It rejected three of the recommendations.

1.2 Section 8 contains a full list of recommendations made at the last full inspection and the progress against them.

Progress on key concerns and recommendations [from the full inspection]

1.3 Our last inspection of HMP Onley took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for prisoners at the time. Although we recognise that the challenges of keeping prisoners safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to follow up on recommendations about areas of key concern to help leaders to continue to drive improvement.

1.4 At our last full inspection, we made four recommendations about key concerns in the area of safety. At this inspection, we found that all of these recommendations had been achieved.

1.5 We made one recommendation about a key concern in the area of purposeful activity. At this inspection, we found that this recommendation had not been achieved.

1.6 We made one recommendation about a key concern in the area of rehabilitation and release planning. At this inspection, we found that this recommendation had not been achieved.

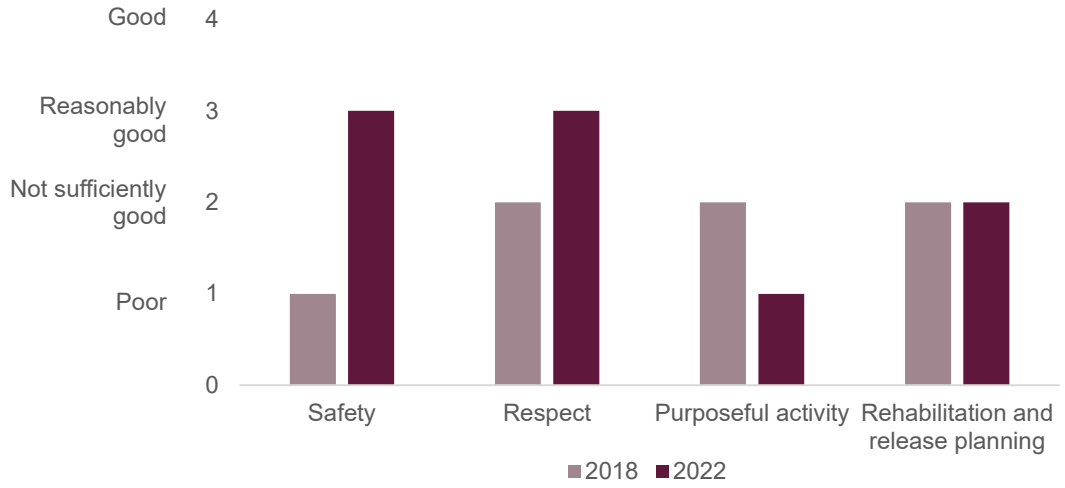
Outcomes for prisoners

1.7 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.8 At this inspection of HMP Onley, we found that outcomes for prisoners had stayed the same in one healthy prison area, improved in two and declined in one.

1.9 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the prison's recovery from COVID-19 as well as the 'regime stage' at which the prison was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMP Onley healthy prison outcomes 2018 and 2022



Safety

At the last inspection of HMP Onley, in 2018, we found that outcomes for prisoners were poor against this healthy prison test.

At this inspection, we found that outcomes for prisoners were now reasonably good.

1.10 Early days provision was much improved and appropriately focused on safety. Reception was welcoming, but property from sending prisons often did not arrive for several weeks. Some escorting arrangements were poor; we found prisoners who had taken over 24 hours to reach the establishment from a London prison. Staff shortages in reception often led to further delays before property was issued. First night accommodation was clean, and most prisoners in our survey said that they had undergone an induction that covered what they needed to know.

1.11 Overall levels of violence had decreased considerably since the last inspection, and prisoners' perceptions of safety had improved. The number of assaults against fellow prisoners was lower than at similar prisons, but against staff was higher, and around one-fifth of the latter were serious.

1.12 The updated violence reduction strategy was specific to the issues at the establishment. It highlighted that most violence was due to the lack of a regime and poor access to work, creating frustration among prisoners.

1.13 All incidents of violence were investigated, and challenge, support and intervention plans (see Glossary) were starting to be used. Oversight of prisoners who were self-isolating had improved, although they did not always receive a daily regime.

1.14 The incentives to encourage and motivate prisoners to behave well were limited and the time limit for some adjudication charges had expired, which meant that some poor behaviour went unchallenged.

1.15 The use of force had decreased slightly since the previous inspection. Body-worn cameras were used reasonably well, but too few incidents were scrutinised.

1.16 The use of segregation had increased since the previous inspection. The environment on the segregation unit was run down and in need of refurbishment, but staff supported prisoners reasonably well.

1.17 Security was well managed and there was good collaborative work with the safety department to address violence, especially in relation to gang culture.

1.18 The concerning use of psychoactive substances that we found at the last inspection had reduced, and in our survey fewer prisoners than previously said that drugs were easily available. The prison's drug strategy was comprehensive.

1.19 There had been no self-inflicted deaths since before the last inspection, and there were investigations into all serious incidents of self-harm. The level of self-harm was much lower than at the time of the last inspection, and the safety strategy was focused on reducing self-harm.

1.20 Support documents were reasonably well completed and staff knew who was subject to assessment, care in custody and teamwork (ACCT) case management procedures for prisoners at risk of suicide or self-harm, and the care they needed.

Respect

At the last inspection of HMP Onley, in 2018, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection, we found that outcomes for prisoners were reasonably good.

1.21 In our survey, 75% of respondents said that staff treated them with respect, and 71% that there was a member of staff they could turn to if they had a problem. We saw positive and supportive interactions, but some staff did not engage meaningfully with prisoners, choosing instead to sit in offices.

1.22 The amount of key work (see Glossary) delivered was far more than at other prisons we have inspected recently, but sessions were not always of a good quality or delivered by consistent staff.

1.23 Living conditions had improved since the last inspection and prisoners in our survey said that access to cleaning materials and fresh bedding was good. Cells on some of the oldest wings were small and cramped,

with some in poor condition, but showers across the prison had recently been refurbished. Communal areas and cells were clean and free from graffiti.

1.24 Prisoners' perceptions of the food provided were very poor, and they told us that the shop did not cater for all their personal and cultural needs.

1.25 Consultation with prisoners was effective. Responses to the applications that we saw were of good quality, but there was little oversight or quality assurance of the system. The complaints process was well managed.

1.26 Two quarterly equality meetings – one focused on race and the other on the remaining protected characteristics – scrutinised a wide range of data to identify potential disproportionality and generated appropriate actions to resolve any issues. However, there was little support for prisoners who identified with some protected characteristics, such as Gypsy, Roma and Traveller; foreign national; disabled and LGBTQ+ prisoners.

1.27 Corporate worship took place each week for all the major denominations, and leaders were actively seeking ministers for faiths such as Rastafari.

1.28 The new contract for health care provision had recently been awarded, which had prompted some staff to resign, further increasing the number of vacancies. A shortfall in officers had led to missed appointments, wasted clinical time and extended waiting lists, although there were early signs of improvement. Patient access to primary care services was good.

1.29 Prison staff were unclear of the social care pathway and continued to defer responsibility to health care staff, with no strategic oversight.

1.30 Mental health services were working hard to provide an adequate service, despite several vacancies and cross-prison working arrangements.

1.31 Clinical and psychosocial substance misuse services were safe and effective. Pharmacy and medicines management lacked oversight, governance systems and processes, which created risks to their safe handling and storage.

1.32 Waiting times for routine dental care were too long, at 12 weeks for a follow-up appointment.

Purposeful activity

At the last inspection of HMP Onley, in 2018, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection, we found that outcomes for prisoners were poor.

1.33 Prisoners spent too little time engaged in purposeful activity. There were insufficient activity places and more than half of prisoners were unemployed. On a weekday, unemployed prisoners could expect two and a half hours out of cell, and those who were employed up to six and a half hours. Time unlocked was, on average, around three hours per day at weekends for most prisoners. The regime was regularly restricted because of staff shortages.

1.34 Prisoners had better use of the library than at most other prisons we had visited recently, but access to the gym was limited and unfair.

1.35 The curriculum did not meet the needs of prisoners in a training and resettlement prison. Too few had access to accredited courses and too many workshops were closed. Allocation of prisoners to education, training and work activities was ineffective and attendance was poor.

1.36 The quality of the education provided was not of a good enough standard to make sure that prisoners gained the knowledge and skills they needed to make good progress. Too many sessions lacked structure and learning was not sequenced well enough to enable prisoners to retain and recall knowledge.

1.37 The use of peer mentors in lessons was ineffective. They did not offer the support and guidance that their fellow prisoners needed.

1.38 The provision of careers advice and guidance also needed further development. Not all prisoners benefited from advice and guidance on what their next steps might be. The new employment hub had yet to be fully established and too few prisoners moved into sustainable employment or further training on release.

Rehabilitation and release planning

At the last inspection of HMP Onley, in 2018, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection, we found that outcomes for prisoners were still not sufficiently good.

1.39 The length of visits had been increased to two hours, which was helpful to the large proportion of visitors who travelled a long distance, but the railway station is some distance from the jail and there was no transport available apart from expensive taxis. Monthly family visits had

restarted and the family support service contacted new visitors beforehand, to answer any questions about the practicalities of visiting.

1.40 Secure video calling (see Glossary) was in use, although there were some technical issues, and mail was regularly delayed through lack of support staff to process it on arrival.

1.41 Work had begun on updating the reducing reoffending strategy, action plan and needs analysis, but this area had lost coordination and momentum since the last inspection, during which time the population profile had changed.

1.42 Many prisoners told us that they had little contact from the offender management unit. Although the probation-employed prison offender manager team had recently been strengthened, it remained under pressure through the large proportion of high-risk prisoners. There was a persistent backlog of offender assessment system (OASys) assessments, and the quality of these was variable.

1.43 Public protection procedures were reasonably good and the monitoring of telephone calls and mail was carried out efficiently. A monthly interdepartmental risk management meeting reviewed plans thoroughly for those approaching release, although attendance at the meetings was poor.

1.44 Those serving indeterminate sentences were frustrated at the lack of provision for them, but there were plans to revive a lifers' forum.

1.45 Categorisation reviews were carried out on time, but there had been major delays in moving those designated as category D to open prisons, although this was beginning to improve.

1.46 A well-motivated interventions team had delivered relevant work through the pandemic and had moved quickly to run groups for the thinking skills programme, and for Resolve until the imminent national withdrawal of this programme. However, there were no firm plans to introduce any other programmes and prisoners were increasingly frustrated about this.

1.47 The resettlement team, although depleted, had continued its work and wrestled effectively with the challenges of a population mostly released to the London area. Around 80% of prisoners had been released to sustainable accommodation in the last year.

1.48 A 'departure lounge' in the visitors centre had been used by 59% of released prisoners in the last year, providing practical items and help in contacting key services.

Notable positive practice

1.49 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.

1.50 Inspectors found two examples of notable positive practice during this inspection.

1.51 Two nurses from the integrated drug treatment service had undertaken additional training: one in sexual health and the other in wound care. (See paragraph 4.88)

1.52 Prison Advice and Care Trust (PACT) staff contacted people planning to visit the prison for the first time in advance, to answer any questions about the practicalities of visiting. They also offered to accompany new visitors through the entry and search process. (See paragraph 6.1)

Section 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for prisoners. (For definition of leaders, see Glossary)

2.1 Good leadership helps to drive improvement and should result in better outcomes for prisoners. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.

2.2 Since the last inspection, leaders had focused successfully on improving safety and security and effective drug strategy had been implemented.

2.3 Leaders had driven up standards of cleanliness and decency on the residential units. Most showers had improved following refurbishment, but a more suitable alternative to the Perspex window screens fitted in the cells on the older units was needed.

2.4 Leaders struggled with acute staffing shortfalls in many areas that were impeding further progress; there was a shortfall of around 40 prison officers, 20 operational support grades and nine workshop instructors, and less than half of the catering staff were in post. HM Prison and Probation Service (HMPPS) was giving support through some detached duty and overtime bonus schemes, as well as piloting innovative ways to retain staff. This included the 'Shaping a New Employee Offer' (SANEO) initiative for more flexible working via new rostering technology, and a part-time prison officer recruitment and training programme. However, the establishment did not attract the same 'market supplement' paid at nearby prisons.

2.5 The rate of staff attrition, which had dipped during the pandemic, from 19% to 5%, had risen again to 14%, while recruitment of new prison officers had slowed. However, since the previous inspection, leaders had strengthened staff support with a dedicated custodial manager and an increase from two to three prison officers on each wing. A group supervision scheme had also been introduced.

2.6 Time out of cell was poor and the 'split' regime was often curtailed because of insufficient prison officers. Managers worked well to minimise these disruptions fairly and keep prisoners informed, but not enough was done to make sure that prisoners attended education, skills and work.

2.7 Prison and education leaders were failing to deliver high-quality education and enough purposeful activity, which was undermining the core function of this category C training and resettlement prison. Ofsted judged the overall effectiveness of education to be inadequate. There were insufficient activity places and a lack of accredited courses, allocation was haphazard and attendance was too low.

2.8 Strong leadership by the governor in the promotion of equality had led to some action following the identification of disproportionality in relation to race.

2.9 There was good use of data to inform the strategic management of safety and equality, but reducing reoffending had no up-to date-needs analysis. This function had lacked direction until the very recent appointment of a head of reducing reoffending into a post that had been upgraded.

2.10 Leaders faced the additional challenge of managing, at a considerable distance, the resettlement needs of a population that was mostly from London. Outcomes, such as accommodation on release, were relatively good, but families had to travel long distances to the prison.

2.11 There were effective custodial managers in a number of areas, including safety, visits and early days.

2.12 The governor kept prisoners informed via regular bulletins and broadcasts on 'Way Out TV'. However, in our prisoner survey, only 16% of respondents said that they could talk to a manager or governor if they wanted to, and only 24% of those who had shared a problem with one said that they had tried to help.

2.13 Although there was a weekly bulletin for staff, leaders had not done enough to convey a clear vision and plan to fulfil the purpose of the prison. More than half of the staff who responded to our survey said that the top priorities of the prison were not very clearly, or not at all clearly, communicated to them.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

Expected outcomes: Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

3.1 The early days experience for prisoners was much improved, with all areas clean and well maintained, and an appropriate focus on the safety and well-being of new arrivals.

3.2 Most prisoners arrived from London prisons around 100 miles away. They often left sending prisons so late in the afternoon that they had to stop at other prisons overnight, which was unacceptable. We witnessed the arrival of one escort, which had left HMP Thameside over 24 hours earlier, reaching Onley at a time when there were no staff in reception, causing further disruption and delay. We also saw evidence of escorts arriving without the appropriate warrants and supporting paperwork necessary for legal detention, again leading to long delays while these were requested and faxed from the sending establishment.

3.3 The purpose-built reception building was clean, in good order and provided a welcoming environment to new arrivals. Staff acted quickly to engage with prisoners to put them at ease. Reception processes, including a health screening interview and the use of a body scanner to detect contraband, were timely and most prisoners we spoke to said that they had spent less than two hours in reception. Noticeboards in holding rooms provided some useful information.

3.4 All new arrivals were offered either a vape or grocery pack to tide them over until their first order from the prison shop (see paragraph 4.22).

3.5 There were delays in receiving prisoners' property from sending prisons which sometimes took several weeks to arrive, and was exacerbated by frequent staffing shortages in reception (see also paragraph 4.15). During the inspection, we saw reception staff working hard to try to clear the backlog of requests.

3.6 The initial safety interview was conducted in a private office on the first night centre. It was appropriately focused on safety and asked about gang affiliations and concerns, which were then shared with the appropriate departments.

3.7 In our survey, more prisoners than at the time of the previous inspection said that they had felt safe on their first night. Peer supporters were an integral part of the team on the unit and, together

with the staff, provided a welcoming and relatively comfortable environment.

3.8 Staff made sure that sufficient space was available for new arrivals on the 'induction landing'. First night cells were thoroughly cleaned and prepared for occupation. All new arrivals were subject to additional checks throughout the night, but these took place hourly, rather than being based on any presented risk.

First night cell

3.9 Induction, delivered by staff and peer workers, started on arrival in the first night centre, or the next morning for those arriving after 4pm. In our survey, 85% of respondents said that they had undergone an induction and all those we spoke to said that it had provided them with sufficient information.

Managing behaviour

Expected outcomes: Prisoners live in a safe, well ordered and motivational environment where their positive behaviour is promoted and rewarded. Unacceptable conduct is dealt with in an objective, fair, proportionate and consistent manner.

Encouraging positive behaviour

3.10 Overall levels of violence had reduced considerably since the previous inspection. Violence against prisoners had reduced by 65% since the previous inspection and by 24% against staff. In the last 12 months, there had been 148 incidents of violence, including 66 assaults against

staff, which was higher than at comparator prisons. There had been 82 assaults against fellow prisoners, which was relatively low. Almost one-fifth of assaults against staff had been serious, which was a concern.

3.11 Since the previous inspection, prisoners' perceptions of safety at the establishment had improved considerably across a range of questions in our survey. For example, fewer respondents said that they had felt unsafe at some point during their time at the prison (38% versus 55%), that they had experienced physical assault (9% versus 23%) or theft of canteen or property (9% versus 24%), and that they had experienced some form of victimisation from other prisoners (28% versus 44%).

3.12 The safety department was relatively well resourced. The violence reduction strategy had been updated recently and reflected the issues specific to the establishment. It had incorporated information obtained through investigations into violence and highlighted that most violence that took place was due to the lack of a regime and poor access to work, which created frustration among prisoners.

3.13 All incidents of violence were investigated, most to a reasonable standard. Some custodial managers and wing staff were starting to use challenge, support and intervention plans (CSIPs; see Glossary) effectively to manage perpetrators and victims of violence. The safety department had planned training sessions to develop further the quality of CSIP reviews with prisoners and individual targets on their plans. Support for prisoners following incidents of violence was improving with the introduction of violence reduction representatives on each wing, some of whom had just started to carry out mediation following violent incidents.

3.14 Leaders had improved oversight of prisoners who were self-isolating (often for fear of their own safety or through being in debt), through weekly discussions at the safety intervention meeting. However, the self-isolating prisoners we spoke to said that they did not always receive a daily regime, and recordings on P-Nomis (electronic case notes) reflected this.

3.15 The incentives to encourage and motivate prisoners to behave well were limited. In our survey, only 38% of respondents said that the incentives in the prison encouraged them to behave, and 31% that they had been treated fairly in the behaviour management scheme. There was insufficient difference between the standard and enhanced levels of the scheme to encourage good behaviour. In addition, those who refused to attend education or work placements were not given negative warnings by staff, which allowed poor attendance to go unchallenged.

Adjudications

3.16 There had been 1,553 adjudications in the previous 12 months. Most were for being in possession of illicit items such as drugs, mobile phones and hooch (alcohol brewed by prisoners), and around 54% were proven. Although the number of remanded adjudications had

reduced in recent months, it remained too high, with 54 at the time of the inspection. This meant that the time limit for some of the charges had expired because of delays in obtaining evidence from camera footage and in attendance from the reporting officer, and therefore some poor behaviour by prisoners went unchallenged. The quarterly adjudication standardisation meeting had identified this issue and there was a plan to reduce the number of remanded adjudications further.

3.17 In the sample of adjudications that we reviewed, awards were generally proportionate and, when it was available, evidence was considered appropriately. A 10% quality assurance check by the deputy governor helped to ensure consistency and identify areas for improvement.

Use of force

3.18 The use of force had decreased slightly since the previous inspection. This was reflected in our survey, in which fewer prisoners than previously said that they had been physically restrained by staff in the last six months (6% versus 17%). There had been 343 incidents of use of force in the last 12 months, which was similar to levels at comparator prisons we have inspected recently.

3.19 Body-worn cameras were used reasonably well, with 73% of incidents over the last 12 months having footage available to view. Despite this, oversight of the use of force was not sufficiently good. The monthly committee meeting reviewed only around two incidents, which meant that leaders were poorly placed to identify learning for staff in how to improve their practice. This was particularly concerning, given the high number of serious assaults against staff (see paragraph 3.10). In the last 12 months, 31 members of staff had received injuries following a use of force incident.

3.20 In the footage that we viewed, most staff used verbal de-escalation techniques well. Around 40% of incidents had used rigid-bar handcuffs and in most cases this had prevented further escalation. However, there was also evidence of some poorly managed incidents and a lack of confidence in some members of staff which had, at times, led to injuries among staff.

3.21 Batons had been drawn on four occasions in the last 12 months and used once, which was much lower than at similar prisons. Following the incident involving the use of a baton, the prisoner had been appropriately placed in the special accommodation for around four hours.

Segregation

3.22 The use of segregation had increased since the previous inspection. There had been 241 instances of segregation over the previous 12 months and the average length of stay on the unit was around 10 days. The environment was run down, and showers and the floor in cells were in particular need of refurbishment.

Segregation shower in need of refurbishment

3.23 The daily regime on the segregation unit was limited to around one hour out of cell each day, which included a shower, telephone call and exercise. During regime curtailments, prisoners on the unit did not always receive this daily regime; in our survey, only 55% of those who had spent one or more nights in the unit in the last six months said that they had been able to have a daily shower, and the same percentage had been able to exercise outdoors each day. Apart from a small selection of books, segregated prisoners had little to occupy them during long periods of time locked up. There were no in-cell workbooks and education staff did not visit the unit.

3.24 Staff on the unit supported prisoners reasonably well and had a good knowledge of them. It was positive that, in the last six months, 82% of prisoners had returned to normal location following time on the unit. However, targets on reintegration plans were often generic and did not focus on the individual needs of prisoners.

3.25 Oversight of segregation was reasonable. A quarterly meeting discussed segregation trends over time, monitored data in relation to disproportionality and made sure that segregation paperwork was completed within the correct timescales.

Security

Expected outcomes: Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. Prisoners are safe from exposure to substance use and effective drug supply reduction measures are in place.

3.26 The security department was well managed and the team worked well to mitigate the threats to the establishment. Links to other key departments, such as the safety team, were strong. Collaborative work underpinned the prison's response to violence, which often linked to the complex gang culture from across London.

3.27 Security procedures, such as the movement and accounting of prisoners, searching procedures and items allowed in possession, were reasonable for the category of the prison, although we were concerned at the lack of staff on landings during many unlock periods (see also paragraph 4.2).

3.28 There was a good flow of security information from most areas of the prison, with an average of around 650 reports being received each month. Key themes from these reports were violence, illicit substances and other contraband. Information was quickly analysed and triaged for attention. Responses were good, with around 75% of all requested searches carried out within 48 hours and a success rate of around 60%, which was testimony to the high quality of the intelligence. There was also a strong focus on the risks presented by extremism and staff corruption.

3.29 Drug testing had only just restarted following the easing of the pandemic restrictions, which meant that there were insufficient data to measure the level of drug use across the site. Nevertheless, in our survey, fewer prisoners than at the time of the last inspection said that illicit drugs were easy to get hold of, and the concerning widespread use of psychoactive substances (PS; see Glossary) that we found at the last inspection had reduced considerably. There had been just 10 emergency responses due to PS in the previous six months, against 200 in three months before the last inspection.

3.30 The prison had augmented security measures, including the use of electronic detection equipment, enhanced gate security and a well-trained and efficient dog team. The emerging picture was of an increase in hooch use, with responsive searches and general staff awareness contributing to the recovery of some large amounts of this and other contraband. The security department was introducing some innovative strategies to increase the number of finds further, such as a dogs versus wing staff competition, to see which of these discovered the most hooch each month.

3.31 The monthly security meeting was well attended, and structured to focus on the key threats to the prison and make it safer. Contributions from across the prison were collated to provide a wide range of data and present a clear picture of potential problem areas. High-level objectives were set routinely, but these did not filter down to frontline staff in any meaningful way and none of the 10 staff (of differing grades) we selected at random knew what the current objectives were.

3.32 A supporting drug strategy meeting was based on a dynamic strategy that was amended monthly to include issues raised and reflected in a comprehensive action plan. The regular meetings, chaired by the deputy governor, rotated the focus monthly between supply reduction, prevention and treatment.

Safeguarding

Expected outcomes: The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

Suicide and self-harm prevention

3.33 There had been no self-inflicted deaths at the establishment since before the last inspection. The prison maintained a focus on findings from previous investigations into deaths at the prison and routinely reviewed procedures to ensure continued compliance and focus. All serious incidents of self-harm were investigated, to identify issues and influence future practice.

3.34 There had been 255 self-harm incidents in the previous 12 months, which was much lower than in the same period at the time of the last inspection. The level of self-harm at the prison was 25% lower than the average for similar jails and had continued on a downward trend throughout the previous 12 months.

3.35 The safety strategy was comprehensive and focused on the causal factors of self-harm. The safety committee held regular, well-formulated meetings to review current practice, analyse incidents and drive improvement in the care of prisoners at risk of self-harm.

3.36 At the time of the inspection, there were just five prisoners subject to assessment, care in custody and teamwork (ACCT) case management procedures. This reflected the situation in the preceding months and we considered the prison to have a balanced and reasonable approach to implementing such measures. We spoke to all of the prisoners on an ACCT and they were generally satisfied with the care and support they received.

3.37 ACCT documents we reviewed were well laid out and mostly well detailed. All periods of supervision were recorded, but we found some

of the commentary to be sparse and not to reflect the level of interaction that we saw, or that prisoners on an ACCT told us took place. All residential staff that we spoke to knew who was subject to ACCT support and what care they needed.

3.38 There was a large team of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners), who operated on a callout roster. They told us that they were well supported by the prison and the local Samaritans coordinator, who met them weekly. There were no specific Listener suites, but those we spoke to were content with the arrangements that the prison had put in place for these sessions.

Protection of adults at risk (see Glossary)

3.39 The adult safeguarding policy had been reviewed and relaunched only recently, following a hiatus during the COVID-19 pandemic. There had been some recent referrals to the regional adult safeguarding board, but the prison was not currently represented there.

3.40 Initial screening took place, to identify any safeguarding issues. However, subsequent processes to address concerns were weak and few staff we spoke to demonstrated an acceptable level of understanding of what safeguarding meant beyond social care for older prisoners.

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

Expected outcomes: Prisoners are treated with respect by staff throughout their time in custody and are encouraged to take responsibility for their own actions and decisions.

4.1 In our survey, 75% of respondents said that staff treated them with respect, and 71% that there was a member of staff they could turn to if they had a problem. Many prisoners we spoke to could name a helpful member of staff and we saw some positive, patient and supportive interactions throughout the inspection.

4.2 However, we also saw some staff who did not always engage meaningfully with prisoners, choosing instead to sit in staff offices, and we were concerned at the lack of staff on landings during unlock periods (see also paragraph 3.27). Furthermore, staff did little to motivate prisoners to engage in purposeful activity. In our survey, fewer prisoners than at the time of the last inspection said that staff encouraged them to attend education, training or work (41% versus 56%).

4.3 The prison had made good efforts in resuming the delivery of key work (see Glossary), and more sessions had been delivered than at other prisons we had inspected recently. Over the previous six months, around 53% of allocated key worker sessions had taken place. In our survey, 80% of respondents said that they had a key worker, and 65% of these said that this individual was very or quite helpful, which was better than at similar prisons (50%).

4.4 Despite this, sessions were not always of good quality and some staff described key working as a casual catch-up or a conversation with a prisoner at their cell door. Further to this, sessions were often delivered by different members of staff, some of whom were unfamiliar with the prisoner's individual circumstances, which meant that prisoners had to repeat their problems to a range of staff.

Daily life

Expected outcomes: Prisoners live in a clean and decent environment and are aware of the rules and routines of the prison. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

Living conditions

4.5 Prisoners' perceptions of living conditions had improved. In our survey, 63% of respondents said that the communal areas of the wing were normally very or quite clean, which was far better than at the time of the previous inspection (44%). In addition, more said that they could get cleaning materials (73% versus 53%) and had clean sheets (60% versus 45%) every week.

4.6 Access to showers had also improved, and was better than at comparable prisons, with 97% of survey respondents saying that they could have a shower every day, compared with 89% at the time of the last inspection. The showers across the prison had been refurbished to a good standard and were clean and easy to maintain.

Refurbished showers

4.7 The condition of cells varied considerably. A to E wings were the oldest and held around 60 prisoners each. Some of the cells on these wings were in poor condition, with flaking paint and broken toilets, which prisoners found frustrating as most kept their cells clean and well-ordered. Prisoners did not have enough space for basic furniture such as a desk and a cupboard, and some had resorted to breaking and restructuring cupboards to be able to fit them in.

A wing cell

4.8 The windows in these cells needed refurbishment. Leaders had provided a quick fix, which amounted to a piece of Perspex containing ventilation holes, fitted across the old windows. However, these did not provide a long-term solution and made what was already a cramped and confined space uncomfortably warm for the occupant.

4.9 The cells on the newer wings (G to L) were more spacious, with better fixtures and fittings. Some also had integral showers, and, appropriately, older and less mobile prisoners were given priority for these.

L wing double cell (top) and toilet and shower

4.10 There was little graffiti, either in the cells or in the communal areas, but the offensive displays policy was largely ignored by prisoners and we found some cells with many inappropriate pictures on the walls.

4.11 There was a laundry located on each unit and an orderly was employed to wash and dry prisoners' personal clothing. Prisoners and orderlies on nearly all wings complained that there were not enough machines for the washing that needed to be done, and we shared this view. Orderlies found it difficult to attend other activities, such as the gym, because of the pressure they were under to finish their peers' laundry.

A wing laundry

4.12 There were no microwave ovens or toasters on any of the wings, to allow prisoners to prepare food that they bought from the shop. This was disappointing, especially in the light of prisoners' poor perceptions of the prison food (see paragraph 4.16).

4.13 The exercise areas were generally litter free. Some contained exercise equipment and benches, but there were not enough of the latter and their condition varied greatly.

4.14 Cell call bells were generally answered promptly, and leaders had regular oversight, with a proactive process that challenged staff when standards slipped. In our survey, more respondents than at the time of the last inspection and at comparable prisons said that their cell bell was normally answered within five minutes (48% versus 26% and 31%, respectively).

4.15 Access to stored property was poor and a major cause of complaint for prisoners. As a result of staff shortages, leaders could not give prisoners a date for collecting their property and we found some cases where prisoners had waited for several months.

Residential services

4.16 Prisoners' perceptions of the food provided were very poor. In our survey, only 20% of respondents said that the quality of the food was very or quite good, and 22% that they got enough to eat at most mealtimes, both responses being far worse than at comparable establishments.

4.17 We saw several meals being served, and their quality and portion size varied considerably. The menu catered for both cultural and medical diets, but supply issues limited the quantities of some items, such as chicken, which were popular with prisoners. A meal choice was substituted at least once a week as the ingredients could not be sourced.

4.18 Acute staff shortages in the kitchen also had a negative impact on the quality of the food provided, and leaders relied on agency staff to cover any staffing shortfalls.

4.19 Food safety and handling training was given to all kitchen workers, but not all servery workers, who should have completed this training before working with food.

4.20 Prisoners' perceptions of the shop had deteriorated. In our survey, only 39% of respondents said that the shop sold the things that they needed, which was worse than at the time of the last inspection (55%) and in comparable prisons (58%).

4.21 Substitutions occurred regularly, as a result of supply issues, and prisoners told us that these were sometimes unsuitable. Refunds took too long to be returned to prisoners' accounts. Black and minority ethnic prisoners told us that some cultural products were in short supply and that they regularly had difficulty in ordering them.

4.22 Deliveries arrived once a week and were brought to prisoners' cells, reducing opportunities for theft and bullying. Depending on their day of arrival, new prisoners could wait up to 12 days to access the shop, increasing the chances of debt and subsequent bullying.

Prisoner consultation, applications and redress

4.23 Consultation with prisoners was good. An established prisoner council met each month and was well attended by leaders and staff who could resolve issues raised by prisoners. The governor usually chaired the meeting and suitable actions were generated that could improve outcomes for prisoners. These actions were tracked and reported on at subsequent meetings, with appropriate responses given in reply to prisoners' concerns.

4.24 In addition, each wing held a minuted monthly meeting. These were also well attended and aimed at dealing with more specific wing issues than the prisoner council.

4.25 Each wing had a prisoner information desk (PID), staffed by an orderly who provided advice. An office located on each unit should have held all the applications and information for this task, but we found that most of these offices had had fallen into disuse and were in poor condition, with little information held or displayed for prisoners, and some PID workers were working from their cells.

4.26 PID workers issued applications and recorded where they were sent. They should also have recorded when they were returned, but this did not happen. Although the small number of applications we saw being returned were of good quality, there was no tracking of these, and no quality assurance of responses. This meant that leaders were unable to identify any trends or make sure that applications were answered properly.

4.27 The complaints process was well managed. The various types of complaint form were available in good supply on the wings. Submitted complaints were collected by staff from the complaints office each morning and most were handed to the appropriate members of staff at the morning meeting on the same day.

4.28 Responses were timely and there was a good quality assurance process, whereby the head of function checked 10% of all complaints and provided written feedback to the respondents.

4.29 While there was good analysis of complaints each month, which identified trends and any issues that needed addressing, no actions came from this analysis. The results were not discussed at any meetings, such as the senior management team meeting, which meant that the causes of complaints were not addressed. The number of complaints submitted was high, with 2,261 over the previous 12 months.

4.30 Prisoners had good access to their legal representatives. There were five private booths in the visits area that could be booked on three days a week and all prisoners also had an in-cell telephone. Four new video-link booths were being installed which would allow prisoners to see their legal teams before meetings such as parole hearings, and would help with access for prisoners who came from the London area.

Equality, diversity and faith

Expected outcomes: There is a clear approach to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relationships. The distinct needs of prisoners with particular protected characteristics (see Glossary) and any other minority characteristics are recognised and addressed. Prisoners are able to practise their religion. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and rehabilitation.

Strategic management

4.31 The strategic management of equality and diversity was good. There were two quarterly meetings, both of which were chaired by the governor, and they were well attended. One focused on race specifically, and the other looked at all other areas of diversity and the remaining protected characteristics.

4.32 These meetings looked at comprehensive amounts of data, which allowed leaders to identify any potential disproportionate behaviour and put actions in place to address it. Equality and diversity peer mentors had been re-established since the relaxing of the pandemic restrictions and there were 11 in place at the time of the inspection. They provided support to prisoners who identified as having a protected characteristic and attended both strategic meetings, providing a 'prisoner voice'.

4.33 Both meetings generated actions that fed into an overarching equality action plan, which was updated routinely as actions were completed. There was also a detailed diversity and inclusion policy which covered the nine protected characteristics, but this was not informed by a local needs analysis.

4.34 Investigations into discrimination incident report forms (DIRFs) were thorough and the quality of responses was good. In most cases, the relevant individuals were interviewed and there was a good record of the investigation. The governor quality assured all responses before they were returned, and the timeliness of returns was good. There was no independent analysis of DIRFs, but the head of equality had approached some local statutory bodies and was hopeful that this would be rectified.

Protected characteristics

4.35 In our survey, there were few areas where prisoners from protected characteristics reported more negative perceptions than others.

4.36 In our survey, 59% of respondents identified as coming from a black and minority ethnic background. There was regular, good consultation with this group, including some that focused on areas such as rewards and sanctions, to allow leaders to get a better understanding of the perceptions of these prisoners.

4.37 Gypsy, Roma and Traveller prisoners had little support. There had been no consultation with this group, despite several of them speaking to the equality team and asking about this. It was also disappointing to note that literature, such as the *Travellers' Times*, that we normally see on the wings and in the library was absent.

4.38 The establishment held 81 foreign national prisoners, representing about 11% of the total population. Again, there was little to support this group. No consultation had taken place with them, and Home Office immigration staff had not yet returned to hold any clinics since the removal of the COVID-19 restrictions. These prisoners could exchange visiting orders for an additional £5 telephone credit, but there was little other support for them. For those for whom English was not their first language, a professional telephone interpreting service was available, but this was used rarely and there was little information provided in languages other than English.

4.39 Around 10% of the population was over 50 and several had reached retirement age. Most of the retired prisoners lived on G wing (see also paragraph 4.9), and a recent forum had taken place for older prisoners. By contrast, about a third of prisoners were under 29 and little had been done to understand their specific needs or issues.

4.40 Work to support disabled prisoners was underdeveloped. In our survey, 37% of respondents identified as having a disability and the prison had identified around 8% of the total population who needed a personal emergency evacuation plan in the event of a serious incident. There were no forums to enable these prisoners to raise their views. We saw some having to rely on the goodwill of their peers to help them with tasks they found difficult, in the absence of any formal support such as a trained peer support orderly. In our survey, fewer disabled prisoners than others said that they felt they were treated like an individual in the prison.

4.41 One percent of respondents to our survey said that they identified as homosexual, bisexual or other sexual orientation. There was little in place to support this group, and the prison had yet to forge links with local or national LGBT support networks.

4.42 Trained managers held transgender case review boards for a prisoner who told us she felt supported by this process and welcomed the chance to discuss her issues directly. However, it was disappointing to note that, after nine months, female prison-issue clothing was still not available and only limited access to products such as make-up and other gender-appropriate items had been granted.

Faith and religion

4.43 The chaplaincy facilities included a large chapel and a multi-faith room. However, both lacked any ablution facilities or a toilet, which led to frequent disruptions as staff had to allow prisoners into other areas of the prison when necessary. The team covered several faiths, and for the less common faiths there were sessional chaplains. However, the

prison had struggled to find a Rastafari and Buddhist minister, despite leaders actively seeking to recruit them, causing some frustrations for prisoners of those faiths.

4.44 Weekly corporate worship had resumed for all the major denominations as soon as COVID-19 restrictions were lifted, and large numbers of prisoners attended. Muslim prayers on a Friday had to be divided across both the chapel and multi-faith room, as average attendances were around 140.

4.45 Faith groups and the Sycamore Tree programme (a volunteer-led, non-accredited victim awareness programme) were slow to resume and there was not an established programme of religious events planned, although there were credible plans to reintroduce this work.

Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

4.46 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 issued 'requirement to improve' notices following the inspection (see Appendix III).

Strategy, clinical governance and partnerships

4.47 Northamptonshire NHS Foundation Trust (NHFT) provided primary health care, mental health and clinical substance misuse services; Phoenix Futures provided psychosocial substance misuse services; and Time for Teeth was responsible for dental services.

4.48 Senior leaders and strategic oversight had not identified the poor practice that we found in pharmacy services and had only recently taken steps to mitigate the vacant clinical and administrative posts.

4.49 The UK Health Security Agency told us that the health care provider and prison had worked effectively to manage COVID-19 outbreaks. This partnership had been effective in delivering the COVID-19 vaccination and booster programme.

4.50 At the time of the inspection, the health care service was in preparation for a change of contract to a new provider, which had caused some concern for health care staff and had resulted in some resignations. The combined impact of longstanding vacancies and the continuing loss of staff compounded the already stretched staffing resources. We were confident that business contingencies were being put in place to manage this situation effectively.

4.51 The recovery of health services following the pandemic restrictions had focused on restoring the number of clinic appointments, thereby improving response times and the availability of services.

4.52 Health care managers had not provided a consistent leadership presence, and we raised this with the head of health care while we were on-site. We observed conscientious staff, who knew the patients well. Clinical supervision had been maintained throughout the pandemic. Mandatory training rates had fluctuated but a recent focus on this had started to improve completions, which supported safe practice.

4.53 The recent NHFT infection control audit had identified a range of issues, which included some that we had highlighted at the last inspection and had not been remedied.

4.54 Patient consultation had stopped during the pandemic and had yet to resume. NHFT and Phoenix Futures attended the prisoner council, so that any health care concerns could be addressed. Phoenix Futures had sought feedback from the peer recovery champions (see paragraph 4.91) on aspects of the drug strategy action plan, which was positive.

4.55 Health care application and complaint forms were not readily available on all wings, with some stored in the wing office. Health care post boxes were not clearly labelled. Prisoners and officers told us that application and complaint forms were handed to staff, and both groups said that, as a result, the communication was not confidential. Some officers provided prisoners with an envelope in which to submit the application or complaint form, but this did not happen consistently.

4.56 The responses to complaints addressed the concerns raised. They were written in plain English and respectful in tone and content.

4.57 There were SystmOne clinical records for all patients and the standard of record keeping was reasonable.

4.58 Emergency resuscitation equipment was in good order and checked regularly. The emergency red bags were heavy and presented a health and safety risk to staff carrying them during an emergency call.

Promoting health and well-being

4.59 There was a limited range of health promotion material visible across the prison and none of it had been translated into foreign languages.

4.60 There were no health champion peer workers, other than for substance use; although some volunteers had been recruited, a start date for training had not been confirmed, and this needed action.

4.61 NHS age-related health checks and screening programmes were delivered appropriately and any delays were well managed.

4.62 A registered nurse in the integrated drug treatment service (IDTS) team led on sexual health and offered blood-borne virus and dry spot testing.

4.63 Health care staff actively promoted the uptake of COVID-19 vaccinations among prisoners.

Primary care and inpatient services

4.64 All new arrivals received a health assessment in reception, where they were screened for urgent medical needs and referred to clinical substance misuse or mental health services. A secondary screen, providing a comprehensive assessment, was booked to take place within seven days of arrival; prisoners could not always attend a secondary screening in this timeframe, but heath care staff ensured that this took place as soon as possible.

4.65 A wide range of primary care services were available each day, including weekends. Reduced numbers of officers allocated to escort prisoners to health care appointments during COVID-19 restrictions had led to missed appointments, wasted clinical time and extended waiting lists in some areas. The recent lifting of restrictions saw an increasing number of prisoners enabled to attend their appointment. Waiting times for services were variable, with long waits for physiotherapy, dental care and the optician, and some providers had started to address the backlog.

4.66 Prisoners could request an appointment via a paper application system, and received confirmation of an appointment time or a request for further information.

4.67 Nurse-led clinics and effective triage helped to reduce the GP waiting list. Wait times for a routine GP appointment were good, at under two weeks. Urgent, same day appointments were available if needed. Out-of-hours support was available through the NHS 111 telephone line.

4.68 'Did not attend' rates were too high, but there was a consistent approach to follow-up and the rebooking of appointments as needed.

4.69 All prisoners with complex health needs had a care plan which reflected their current care and national clinical guidance. A range of specialist nurses, such as a diabetes specialist nurse, reviewed prisoners in line with guidance, and additionally as needed. Work with those with a chronic condition who were non-compliant with their medication had recently begun, with the aim of increasing their understanding of their health needs, which was a positive initiative.

4.70 As a result of limited prison staff numbers, there had been an increase in the number of external hospital appointments that had to be cancelled and rearranged. These were managed effectively. Prisoners needing urgent treatment were prioritised. However, prisoners were not routinely told if an appointment, either internal or external, had been cancelled or rearranged.

4.71 Prisoners received an appropriate pre-release assessment and most needing medication on release were given seven days' supply.

Social care

4.72 Health care staff screened new prisoners for physical and mental capability on arrival and those needing further assessment were referred to the local authority. However, the prison was reliant on the health care provider to undertake these referrals.

4.73 Prisoners and officers were not aware of the social care referral pathway, but prison staff told us that they would generally defer concerns to their health care colleagues.

4.74 There was a memorandum of understanding, from 2019, which clarified responsibilities, but this was out of date and lacked details of the single point of contact for both the local authority and the prison, and who the domiciliary provider would be if needed. There was also a lack of understanding of who was responsible for the assessment for social care and physical aids by the prison.

4.75 No prisoners were in receipt of a social care package (see Glossary) at the time of the inspection and we found no unmet need. However, we were concerned that, with the lack of understanding of the referral pathway by prison staff, this might not always be the case.

4.76 There were policy documents for peer support, but there were no official peer support workers employed, other than for substance use; however, we spoke to one prisoner who was providing domestic support to another prisoner. He did not have any training or supervision for this role, which created potential risks.

Mental health care

4.77 In our survey, 49% of respondents said that they had a mental health problem, just over a third of whom said that they had been helped with this at the prison.

4.78 Mental health services were available seven days a week. Referrals were picked up daily and assessments were managed by the duty worker.

4.79 Staffing levels were below requirements, with vacancies for 2.6 full-time equivalent (FTE) clinical staff and one administrator post. The mental health team had no dedicated administrative support which staff told us impacted their clinical work. It was unclear why NHFT had not recruited to this post, which was currently being covered by the already depleted clinical team. This deficit was having a direct impact on face-to-face time with patients, and had delayed the reintroduction of groups and reduced the available time to manage the service. There was a six-week wait for a non-urgent appointment with the psychiatrist but these appointments were also prioritised so some patients could wait longer for a routine assessment.

4.80 The team also had access to nurse prescribers. Most staff had flexible working arrangements, covered two different prisons and worked from home, making oversight and presence inconsistent. Staff reported feeling supported, but some described the service as reactive, making planned care difficult to schedule.

4.81 Some of the additional psychology staffing deficits had been covered by the reallocation of staff from the recently closed secure training centre next door. The provision of psychological interventions represented good progress and patients were complimentary about the care they received. However, no cover had been sourced for the 2.6 whole-time equivalent vacancies and the administrator vacancy.

4.82 New prison officers received both mental health awareness and assessment, care in custody and teamwork (ACCT) case management training on arrival. However, refresher training for mental health awareness had not been delivered in the last 12 months.

4.83 Physical health checks for mental health patients were in place; most were overdue, but within small margins. The expectation was that this would not improve, as a result of the cross-deployment of staff.

4.84 All prisoners were transferred from other prisons, so community mental health records had already been sourced, although the 'GP2GP' process was still in transition, with the recent loss of the practice and performance manager. Therefore, not all community GP records were available and the process remained fragile.

4.85 There were comprehensive templates for care plans and risk assessments. These were used by mental health staff, and we saw good-quality care plans and risk assessments in place for those under their care. The mental health notes we saw were clear and well written. It was evident that interventions were being undertaken, but high caseloads for some mental health staff were having an impact on the frequency of appointments.

4.86 There was evidence of joint working for those with complex health conditions and a dual diagnosis (the co-existence of mental health and substance use problems). The close proximity of most of the health provision enabled regular joint discussions to take place. Mental health care managers did not always attend strategic meetings.

4.87 There had been no transfers under the Mental Health Act in the previous six months.

Substance misuse treatment

4.88 Both the IDTS and psychosocial support were of a good standard. The clinical substance misuse team had remained on-site throughout the pandemic. The IDTS was led by a band 7 nurse, who was a non-medical prescriber, and two band 6 nurses, who had specialisms in sexual health and wound care. Following an initial withdrawal from the prison, to work from home, Phoenix Futures staff had returned, and

patients were seen on a one-to-one basis. Limited group work had restarted.

4.89 There were 205 patients (28% of the prison population) on the psychosocial support caseload. This included 39 patients who were also receiving clinical treatment. Referrals to the psychosocial service were not consistently received for new receptions, so the team reviewed the reception ledger each day to make sure that no prisoners had been missed. Referrals could also be made by any prisoner or staff member.

4.90 Alcoholics Anonymous had restarted regular meetings at the prison. Narcotics Anonymous had not been established on-site before the pandemic and plans to progress this had stalled, creating a gap in provision.

4.91 Recovery champion peer workers had recently been recruited and supported patients on the substance misuse caseload. They told us that they had received good training and support from the team.

4.92 The clinical team saw patients in receipt of opiate substitution therapy (OST) on their arrival and made sure that they received medication in line with their prescription without delay. Most of the prisoners receiving OST were on a maintenance programme. Prescribing was flexible and patient led, with regular reviews. We observed competent administration of OST but officer supervision of the medicine administration queues was variable.

4.93 The service manager and a recovery and well-being practitioner attended monthly drug strategy meetings and had contributed to the development of the prison drug strategy and action plan.

4.94 J wing was the designated recovery wing, and an incentivised substance-free living wing had been identified; however, progress to implement the project fully had been halted during the pandemic. Prisoners did not have to sign a specific compact to live on either wing, which was a deficit; we raised this with leaders during the inspection and it was addressed. Additional activities focused on the particular needs of patients in recovery were limited, and several prisoners resided on the wing for other reasons.

4.95 The substance misuse team offered prisoners harm minimisation advice when officers were concerned that illicit substances had been used.

4.96 Pre-release planning was good, with arrangements made to continue OST if needed, and naloxone (an opiate reversal agent) was provided.

Medicines optimisation and pharmacy services

4.97 There was no regular on-site pharmacist supervision and medicines management oversight was limited. Medicines were supplied from a community pharmacy. Prisoners were unable to have appointments with a pharmacist or a member of the pharmacy team. Medicines

reconciliation was undertaken by pharmacy technicians following initial reception screening, and prescribing was tasked to GPs. Medicines competency assessments were up to date.

4.98 Medicines were administered from dedicated hatches and queues were supervised. As a result of the regime structure, not-in-possession medicines were administered twice a day, in the morning and late afternoon. Medicines for in-possession use were ordered through the repeat system by pharmacy staff. Prisoners were not encouraged to order their routine medicines, which was a missed opportunity to encourage self-management. Those on topical medicines could reorder them, which meant that the system was inconsistent.

4.99 Medicines were received in a dedicated pharmacy room in the health care department. Although the floors were included in the cleaning schedule, the room was not clean and, along with the cupboards, needed a deep clean. Medicines were disposed of in large bins which were not tamper proof. The temperatures of the room and the refrigerator were monitored.

4.100 All aspects of stock management systems were poor: there was no robust system for monitoring stock levels or turnover, there was no evidence that orders were checked on receipt and we were not confident that there was an audit trail for stock management.

4.101 Prescriptions, orders and delivery notes were not stored in line with national guidance.

4.102 Controlled drugs (CDs) were stored securely, and a record was kept of who used the keys and when. A review was needed, to make sure that medicines in sealed bags were checked regularly. Controlled stationery was stored securely, but checks were not completed robustly.

4.103 Medicines were available for supply against a prescription. While records were available, they did not match with stock on the shelves, and when medicines were issued a record was not always made. In addition, once medicines were dispensed, the prescriptions were not kept, so it was not possible to track them.

4.104 There were medicines risk assessments and compact agreements for the patients whose records we checked. Before the pandemic, there had been a system for cell checks, but this had not been restarted.

4.105 Governance arrangements were inadequate and policies were under review as they were not always service specific, and we could not be sure that they met service requirements. The medicines management committee did not have clear terms of reference for the numbers participating and we could not be sure that attendance was representative.

Dental services and oral health

4.106 A full range of NHS dental treatments was provided, and oral health care was promoted.

4.107 Waiting times for an initial dental assessment was 22 weeks, and for a routine follow-up appointment was 12 weeks, both of which were too long. An effective triage system of waiting lists made sure that prisoners with the greatest clinical need were prioritised for treatment, and same-day slots enabled urgent referrals to be seen promptly. Waiting lists had grown because of a combination of COVID-19 dental restrictions and changes to the prison regime which had led to fewer patients being escorted to their appointment. There was a high number of complaints about waiting times and only 10% of respondents to our survey said that it was quite or very easy to see the dentist.

4.108 The decontamination of equipment took place in the main dental clinical room; this did not comply with best practice.

4.109 The dental room met current infection control standards, and dental equipment was maintained and serviced regularly. However, the dental chair was faulty on one day during the inspection, which caused the dental clinic to be cancelled.

Section 5 Purposeful activity

Prisoners are able and expected to engage in activity that is likely to benefit them.

Time out of cell

Expected outcomes: All prisoners have sufficient time out of cell (see Glossary) and are encouraged to engage in activities which support their rehabilitation.

5.1 Time out of cell was poor for most prisoners. Those who were not engaged in any purposeful activity could expect around two and half hours out of their cell on a weekday and three hours at weekends. In our survey, 34% of respondents said that they usually spent less than two hours out of their cell on a typical weekday, and 19% on a Saturday or Sunday. Prisoners were locked in their cells every evening from 5pm, seven days a week.

5.2 In our roll checks, we found 25% of prisoners locked up during the day, and only 24% had left the wings to attend purposeful activity such as work or education. Less than half were involved in work or educational activities. Of the remainder, 41% were simply unlocked with little to occupy them, and a further 10% had paid work on the wings. Some wing workers, such as laundry orderlies, had labour-intensive tasks, but most had little to do for long periods.

5.3 Prisoners who attended work or education spent considerably more time unlocked; those in morning activity could expect to spend six and a half hours out of their cells, and those in afternoon activity five and a half hours. However, this was still insufficient and, for a training and resettlement prison, too few prisoners were engaged in activity.

5.4 Despite leaders prioritising the weekend regime, prisoners had an average of only around three hours out of cell per day on Saturdays and Sundays, as a result of frequent staff shortages.

5.5 Staff shortages were the main reason for the limited regime, and a well-managed rota of wing lockdowns, for when there were too few staff, was drawn up weekly. Leaders made sure that prisoners had ample notice of any curtailments, and restrictions were shared evenly between the wings, which helped to reduce tensions.

5.6 Although national COVID-19 restrictions had been lifted, the wings were still subject to cohorts unnecessarily, further reducing time out of cell for prisoners.

5.7 Prisoners had better access to the library than at most of the similar prisons we had visited recently. In our survey, more respondents than at similar prisons said that they were able to visit the library (56%

versus 24%) or have library materials delivered to them (49% versus 24%) once a week or more. The library was a welcoming environment and library staff made sure that prisoners were aware of the facilities available and helped them with their queries.

5.8 There was a wide range of books and DVDs available. However, at the time of the inspection only one of the six available computers was working, which meant that some prisoners could not complete tasks such as Open University coursework or applications for a driving licence.

5.9 The gym provided a good exercise space and there was a suitable range of equipment, as well as a sports hall for badminton and an artificial grass sports area for football. However, access to these facilities was too limited and unfair for most prisoners. We found that some prisoners who were working on the induction unit had been able to access eight sessions during the previous week, while unemployed prisons on I wing could access the gym only around once a month. Prisoners told us about their frustrations with this during the inspection, and in our survey only 15% of respondents said that they could go to the gym or play sports twice a week or more, which was far worse than at comparator prisons (30%).

Education, skills and work activities

This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the areas of concern, provided in the summary section of this report, this constitutes Ofsted's assessment of what the establishment does well and what it needs to do better.

5.10 Ofsted made the following assessments about the education, skills and work provision:

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Requires improvement

Personal development: Requires improvement

Leadership and management: Inadequate

5.11 Leaders and managers had not implemented an ambitious or appropriate curriculum to meet the needs of prisoners in this training and resettlement prison. Leaders did not have a clear rationale for the curriculum offer. They aimed to provide opportunities for prisoners to gain qualifications which would benefit them on their release. However, too few opportunities were available because of workshop closures and a lack of accredited courses. Too few prisoners had access to accredited courses which led to a qualification. Leaders had not made sure that there were enough activity spaces for the population.

5.12 Leaders used their knowledge of the education, skills and work provision appropriately to evaluate the quality of education provision. They accurately identified the areas needing swift and substantial improvement. However, they had been too slow to implement the actions needed to raise the quality of education, and particularly prisoners' access to suitable accredited qualifications. Many deficits identified at the previous inspection had still not been addressed.

5.13 The allocation of prisoners to education, training and work activities was ineffective. Information taken from their initial assessments was not used well enough. In some cases, this resulted in prisoners from entry level 3 to level 2 being taught in the same mathematics class. Tutors struggled to keep the whole group occupied, with many prisoners venting their frustrations as they could not make progress with their learning.

5.14 Since the previous inspection, following the lifting of the COVID-19 restrictions, leaders and managers had not acted swiftly enough to provide sufficient training and resettlement activities. A large proportion of prisoners were unemployed as a result of the lack of activity places offered across the prison. Less than half of the population could attend activities or had been allocated a suitable activity to meet their resettlement needs. Too many practical workshops were closed and prison leaders offered only part-time activities across the establishment; this was also detrimental to the pay that they received, restricting their options when buying items from the shop or in making telephone calls home.

Disused horticulture polytunnels

5.15 The planning, delivery and sequencing of the curriculum was not good enough to enable prisoners to gain the knowledge, skills and behaviour that would help them in their resettlement.

5.16 Attendance at education, skills and work was too low. Too often, prisoners did not attend their allocated activity, opting to remain on their wings. Leaders and prison staff did not encourage or motivate them well enough to appreciate the benefits of attending their activities.

5.17 The vocational curriculum did not prepare prisoners effectively for the next stage of their education, training or employment. For example, only a small minority on the automotive training course intended to seek work in the sector on their release. There were too few opportunities to gain new skills and knowledge, as too many workshops and vocational training courses were closed. Prisoners who attended simply considered the workshop environment to be a calm place to be, and respite from their cells for a short while.

5.18 Prisoners were not incentivised to attend education or work activities by a fair pay structure. Leaders and managers had been slow in ensuring that those attending their education classes and training workshops were rewarded fairly against their peers who had prison jobs. For example, the recently introduced commercial white goods reconditioning workshop had very low rates of pay. Prisoners received a much better rate of pay for carrying out straightforward wing work, such as wing cleaning, than those opting to attend education classes.

5.19 Prisoners who attended activities were too often unsure of their learning outcomes or what their targets for completion involved. Many did not know or understand their targets or what to do to achieve them.

Objectives set often did not have any links with future employment opportunities or aspirations, and did not concentrate on plugging gaps in prisoners' knowledge. Several prisoners completed lower-level qualifications because classes were amalgamated to meet capacity needs. Leaders and tutors did not use information about prisoners' starting points in English, mathematics and automotive training effectively enough to identify their learning needs.

5.20 The quality of education provided by prison leaders was not of a good enough standard to enable prisoners to gain the knowledge and skills they needed to make good progress and gain new knowledge and understanding. Too many sessions lacked structure and learning was not sequenced or planned well enough to enable prisoners to retain and recall knowledge. Tutors failed to plan and deliver their subjects in a logical manner to enable prisoners to build on previous understanding and make progress from their starting points. Too many tutors had low expectations of what prisoners could achieve.

5.21 Tutors did not routinely have a good enough understanding of the levels that prisoners were working towards or how far they had progressed through their qualification. Most prisoners worked towards the completion of the qualification criteria and did not gain a wider range of skills that would help them on release.

5.22 Tutors did not use information well enough for those who had been identified as needing support, leading to prisoners becoming frustrated with their slow progress. For example, tutors did not use the information from support plans to break learning down into small, 'bite-sized' elements.

5.23 Prisoners did not benefit from useful developmental feedback to help them improve the standard of their work and make better progress with their studies. For example, they continued to make the same spelling mistakes in subsequent submitted work.

5.24 Peer mentors in lessons did not carry out the role well enough. They did not offer the support and guidance that their peers needed and often disrupted the learning taking place.

5.25 Most prisoners who attended lessons and workshop activities participated in their learning, despite their frustrations with the curtailed regime. Those in education and vocational training were mostly respectful to each other, staff and visitors. They felt safe in workshops and recognised that most of their peers in attendance wanted to learn and were focused on their learning programmes.

5.26 Prisoners participated in conversations about topical news items in lessons. For example, they started a conversation about the recent vote of confidence on the Prime Minister. However, tutors did not take opportunities to encourage further debate to help prisoners, some of whom had been in prison for long periods, to develop a better understanding of life in modern Britain.

5.27 The provision of careers advice and guidance needed further development. Not all prisoners had benefited from advice and guidance on what their next steps might be, either while in the prison or on their release. Too many had not had any discussion about their future career prospects. Leaders and managers had been too slow in ensuring that prisoners close to their release date had access to job search facilities or were supported to complete their CV.

5.28 Too many prisoners chose not to attend the Ready for Work course provided for them when they were close to release. The recently instigated employment hub had yet to be fully established and had not yet demonstrated sufficient impact. For example, leaders had not made sure that prisoners due for release had any useful contact with prospective employers, to help them make informed choices about their future employment options. The few links with employers identified at the previous inspection had been lost. Too few prisoners on their release moved into sustainable employment or further training.

Section 6 Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

Children and families and contact with the outside world

Expected outcomes: The prison supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

6.1 The visitors centre was bright and well-equipped. Prison Advice and Care Trust (PACT) staff welcomed all visitors and contacted those planning to visit for the first time to answer any questions. They also offered to escort new visitors through the entry and search process.

6.2 The visits hall was in reasonable condition, and a permanent operational manager had brought continuity and consistency to the running of visits. PACT staff and prisoner workers created a good atmosphere, working also with the Phoenix Futures family worker. The café provided hot drinks and snacks. Visitors said that the visits experience was positive and that the staff were helpful.

6.3 The length of visits had been increased to two hours, which was helpful to the many who travelled long distances. No assistance was available with transport between the prison and the railway station.

6.4 A programme of monthly family visits had restarted, the first having taken place successfully, shortly before the inspection. There were plans for events throughout the current year. No structured activities, such as homework clubs or new-baby support, had yet been re-introduced after the COVID-19 period to support parent–child relationships during the sessions. However, the family days, running from 11am to 3pm, were organised creatively on topical themes.

6.5 Secure video calling (see Glossary) was in use through laptops on the wings, although prisoners found the frequent technical faults frustrating. The usage had settled to a relatively low level.

6.6 There were often delays to incoming mail, sometimes of up to a week, as staff were often not available for the mail room. The installation of in-cell telephones had recently been completed.

Reducing risk, rehabilitation and progression

Expected outcomes: Planning for a prisoner's release starts on their arrival at the prison. Each prisoner has an allocated case manager and a custody plan designed to address their specific needs, manage risk of harm and reduce the risk of reoffending.

6.7 The population had changed since the last inspection: almost half were now deemed high risk, around 90% were serving sentences of more than four years and there were many more serving an indeterminate sentence for public protection (IPP) or life sentence.

6.8 Work had recently begun to re-establish coordination and strategic leadership of the prison's work to reduce reoffending, which had slipped since our independent review of progress (IRP) in 2019. An outline strategy document and action plan had been produced and a monthly multi-departmental meeting had restarted. These moves, mainly following the recent appointment of a senior manager of the appropriate grade, indicated an intent to put the individual progression of prisoners at the heart of the establishment's life, but so far there had been little impact on outcomes. The complaints that many prisoners made to us about the lack of opportunities for progression, often with upcoming parole reviews in mind, were largely justified, especially in relation to the lack of offending behaviour programmes (see paragraph 6.20). Many prisoners spoke to us about their frustration at their lack of contact with the offender management unit (OMU). One prisoner in our survey said, in this context, 'Being here, it's like trying to race a horse with no legs. This gaol is not going to change'.

6.9 Prison offender managers (POMs) described a sense of lack of support for their work from the wider establishment, in practical matters such as arranging interviews on the wing.

6.10 The probation-employed POM team had recently reached almost its full strength, having previously struggled to cope with a part-time manager and only two probation officers. The new team still had high caseloads, of 75. This resulted from the welcome ending of an emergency system, whereby many high-risk cases had been simply placed on hold. The team of prison-employed POMs was too separate from the rest of the OMU team and needed both to support the probation staff in managing their high caseloads and to develop their skills through working with probation colleagues. Their output also suffered from a decreasing but still high level of cross-deployment to other duties, such as hospital escorts and daily allocation to supervising prisoner movements to and from work.

6.11 There was a persistent backlog of offender assessment system (OASys) assessments. This had been reduced since the last inspection, from 150 to 100, but remained too high. Of the 12 cases which we reviewed in depth, a third had not had an OASys review within the last 12 months, while only two had been seen by a POM, as

required, within 14 days of arrival. The quality of the OASys assessments that had been completed was variable, but, in general, POMs prepared full, comprehensive OASys reports and engaged effectively with their colleagues in the community on issues of safe release.

6.12 More key work (see Glossary) sessions were taking place than in many establishments we had inspected recently, but they were not yet contributing substantially to progression in the sentence. In addition, the level of contact between POMs and prisoners was generally inadequate, although many of the latter were able to name their POM.

6.13 With the change in the population profile, the number eligible for home detention curfew had reduced. There were delays in release for these prisoners, mainly through waits for police checks, and also for Bail Accommodation and Support Services residential places to become available.

Public protection

6.14 Public protection procedures were sound. At the time of the inspection, 55% of prisoners were registered as needing multi-agency public protection arrangements (MAPPA) on release. The monthly interdepartmental risk management meeting reviewed plans thoroughly for these individuals, considering each at six months and one month before release, and produced detailed individual information. However, attendance at the meetings was poor; for example, the mental health team and the substance misuse treatment provider did not attend, and the security department generally submitted some outline information rather than being present to comment on detail.

6.15 There were difficulties in working with London probation offices to make release preparations for high-risk prisoners, as they were under great pressure. For example, of 22 prisoners who had been approaching their release date in the last four months, only six had had their MAPPA management level notified to the prison by the required date, six months before release, despite requests a month earlier and reminders thereafter. The reports written by OMU staff for MAPPA meetings were of variable quality, and because of the low level of personal contact by POMs, they were often prefaced by the caveat that the author had not met the prisoner.

6.16 Checks on new arrivals, with actions to manage risk, were carried out well, although vigilance was needed as we found one case where key information had not been acted on. A small number were generally identified for monitoring of telephone calls and mail, and this was done promptly by the security department.

Categorisation and transfers

6.17 Categorisation reviews were carried out on time, and the prisoner was given the opportunity to make representations. There had been a major problem with those designated as category D not being able to

progress to an open prison. However, this had been reduced in 2022, from around 100 in January to just over 50, and more transport was now becoming available. At the time of the inspection, no such prisoners had been waiting more than five months, except a handful, for whom there were special reasons (such as insisting on one particular open prison).

6.18 Those recategorised to B were dealt with reasonably quickly, through referral to the population management team of the high-security and long-term estate.

6.19 Those serving indeterminate sentences were frustrated at the lack of provision for them. During the height of the pandemic, forums for lifers had stopped. These prisoners told us that staff were not trained to support them. There were plans to revive a regular lifers forum, but these were at an early stage. Some IPP prisoners and lifers were beginning to be moved to residential locations which were more suitable for them, but most were scattered around the prison, without scope for mutual support, input from staff with relevant training, or opportunities to develop or refresh their skills in independent living.

Interventions

Expected outcomes: Prisoners are able to access interventions designed to promote successful rehabilitation.

6.20 There was a strong interventions team of nine, which had delivered relevant work through the pandemic, running offender behaviour programmes in groups of four at its height before recently returning to full groups of 10. The thinking skills programme (TSP) ran regularly and a Resolve programme was in progress, with one more to come before the national withdrawal of this programme. Ninety-one programme completions were planned for the current year. However, there were no firm plans to introduce any other programmes, even though a skilled team was available. There were suggestions that Kaizen (an accredited offender behaviour programme for men who have been convicted of violent or sexual offences) or a similar high-intensity intervention would be appropriate, and a needs analysis was being carried out at regional level for the gang-related intervention, Identity Matters. However, the situation seemed not to have changed since our IRP in 2019.

6.21 Moving prisoners elsewhere for courses was also problematic because of too few spaces, and also a lack of transport. There was no intervention for the many prisoners with a history of domestic violence.

6.22 There was an effective psychology team of one registered and two trainee psychologists. They attended the safety intervention meeting, assessed individual cases and gave advice to operational staff on the management of some prisoners with complex and challenging behaviour. They were also working with some serving IPP sentences who were finding it impossible to make progress towards release, and

fulfilled a consultancy function, addressing issues as requested by senior managers.

6.23 An adviser from the Department for Work and Pensions attended the prison four days a week, helping with benefits applications and allied issues. There had been continued work by the resettlement team on helping prisoners to open bank accounts; the system with Barclays was continuing to work well, with 99 accounts opened in the last year. They also helped prisoners to obtain proof of identification and copies of their birth certificates; apply for credit checks; pay their court fines and address debt problems. This area was shortly to be handed over to the information, advice and guidance team.

6.24 There had been no use of release on temporary licence (ROTL), a possible additional way for those who felt stuck in long sentences to make and demonstrate progress. The priority, rightly, was to move them to open conditions, where ROTL was a normal part of the regime, but some access to it at Onley would have been a useful resource.

Release planning

Expected outcomes: The specific reintegration needs of individual prisoners are met through an individual multi-agency plan to maximise the likelihood of successful reintegration into the community.

6.25 Since the unification of probation services in mid-2021, there had been better continuity in resettlement work than in many prisons we had inspected recently, as three of the seven staff had originally worked for the community rehabilitation company resettlement team. Resettlement staff liaised with all prisoners 12 weeks before release. With most released to the London area, the main partnerships in practice were with the London-based agencies St Mungo's, which had previously had a full-time accommodation worker based at the establishment, and Catch-22.

6.26 As in other prisons releasing prisoners to the London area, there were often problems with finding housing on release due to late allocation of pre-release cases to a local probation officer. However, the resettlement team worked hard to help prisoners find accommodation. They also followed up prisoners on the day after their release, to check on the outcome. There was a proactive approach to housing released prisoners by some London boroughs, such as Tower Hamlets and Islington, which became involved pre-release and allocated a council housing worker. Prison data showed that about 80% of prisoners had been released to sustainable accommodation in the past year.

6.27 There were also good links with Switchback, a charity providing 'through-the-gate' mentoring for young adults from the London area, and, in cooperation with the chaplaincy, with London faith community initiatives, such as Caring for Prison Leavers and The Welcome Directory. However, the pre-release course had been discontinued.

6.28 G wing was in process of being re-established as a ‘resettlement wing’, and the resettlement team was located there. The new employment hub would also be based there when it began to operate.

6.29 The ‘departure lounge’ had been introduced during the pandemic, and was continuing. The resettlement team staffed it, providing facilities in the visitors centre on the morning of release, with a supply of donated new clothing and toiletries, and a mobile phone when needed. The team also helped prisoners to call the local council or probation services about housing, and so on. In the last year, 59% of released prisoners had made use of the departure lounge.

Section 7 Summary of priority and key concerns

The following is a list of the priority and key concerns in this report.

Priority concerns

1. **Staff shortfalls in many areas limited progress in achieving better outcomes for prisoners.**

2. **Governance of medicines management was limited and lacked effective oversight.**

3. **Prisoners did not have sufficient access to education, skills and work activities to improve their resettlement chances.** More than half of prisoners were unemployed and spent too much time locked in cells. The allocations process was inefficient and leaders did not use classroom and workshop places well enough. Too few prisoners had the opportunity to complete accredited qualifications.

4. **The quality of education was inadequate.** The curriculum was not planned effectively, or the delivery of subjects sequenced well enough, to enable prisoners to build on their skills, knowledge and behaviour.

5. **Prisoners were rightly frustrated that they could not make progress in addressing their offending behaviour.** They had insufficient contact with prison offender managers and there was too little access to offending behaviour programmes.

Key concerns

6. **Some escorting arrangements were poor.** We found prisoners who had taken over 24 hours on transfer from London.

7. **Oversight and accountability for use of force against prisoners was not good enough.**

8. **The quality and amount of food provided for prisoners were poor.**

9. **There was too little support for foreign national prisoners and their specific needs were unmet.**

10. **Support for prisoners needing social care was underdeveloped.** There was no up-to-date memorandum of understanding setting out procedures for making social care referrals, which potentially led to unmet need.

11. **Prisoners did not have sufficient or fair access to the gym.** We found prisoners who had had eight gym sessions during the previous week, while others were limited to nearer one session a month.

12. **Attendance at education or workshop activities was poor.** Leaders and prison staff did not encourage or motivate prisoners well enough to attend their activities. Too often prisoners chose, and were permitted, to remain on their wings.

13. **Careers advice and guidance provision was insufficient for the prison population.** Too many prisoners had not received any advice for their next steps or future career goals. Leaders had not developed sufficient links with external employers.

14. **There was no tailored provision for those serving indeterminate sentences.** The lack of progression opportunities, combined with the absence of a suitable living environment, caused many of them to feel frustrated.

Section 8 Progress on recommendations from the last full inspection

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2018, prisoners were not well supported during their first days at the prison. Levels of violence remained high and too many prisoners said that they felt unsafe. Causes of violence were not well understood and actions to make the prison safer were reactive and poorly coordinated. Neither the incentives and earned privileges scheme nor the adjudication system was used effectively to challenge poor behaviour. Levels of segregation were relatively low but a considerable number of prisoners were self-isolating or confined to the wings. Levels of use of force were high but managerial oversight was weak. Security arrangements were undermined by a huge backlog of intelligence reports. Drugs, particularly new psychoactive drugs, were easily available but supply reduction lacked coordination. Support for prisoners at risk of suicide and self-harm was weak. Outcomes for prisoners were poor against this healthy prison test.

Key recommendations

The first night environment should be welcoming and reassuring. New arrivals should be supported and informed by staff and peer workers. Cells should be clean and fully equipped. (S62)
Achieved

Robust strategic action should be taken to reduce levels of violence and make the prison safer. This should include an analysis of violent incidents; a local violence reduction strategy, with associated action plans; and improved violence management and victim support processes which are well known to all staff and implemented reliably. (S63)
Achieved

Security intelligence should be promptly and fully analysed, and effective action taken in response to the concerns identified. (S64)
Achieved

A comprehensive drug supply reduction strategy and action plan should be implemented and monitored for effectiveness. (S65)
Achieved

Recommendations

Violent incidents should be promptly investigated, and findings shared with safer custody and security staff as appropriate. (1.20)
Achieved

The management of prisoners who self-isolate in their cell and those who do not leave their wing should include regular reviews of their status, and plans for their reintegration. (1.21)
Achieved

The incentives and earned privileges scheme should be used consistently to challenge poor behaviour. (1.22)
Not achieved

Managerial oversight of disciplinary procedures should focus on ensuring that hearings are held and completed within a reasonable time. (1.26)
Not achieved

All use of force incidents should be fully documented and reviewed by managers, with the findings shared with relevant departments. (1.31)
Not achieved

The standard of video-recording of planned use of force should be good enough to enable meaningful review by managers. (1.32)
Achieved

The regime for segregated prisoners should be enhanced, subject to individual assessments. (1.38)
Not achieved

Reintegration plans for segregated prisoners should challenge the reasons for poor behaviour and detail how they will be reintegrated back to a residential unit. (1.39).
Not achieved

Security objectives should be set and shared with staff. (1.47)
Not achieved

Prisoners should only be strip-searched on the basis of intelligence or specific suspicion. (1.48)
Not achieved

The gang affiliations of prisoners should be better understood and shared, to provide effective management of these individuals and prevent violent behaviour. (1.49)
Achieved

The mandatory drug testing programme should be sufficiently resourced to undertake all types of testing within the required timescales. (1.50)
Not achieved

The prison should implement an evidence-based strategy which identifies the main causes of self-harm and actions to reduce it. Measures to drive improvement should be monitored over time. (1.56)
Achieved

All prisoners should have good, well-promoted access to Listeners 24 hours a day, and every wing should have a working Samaritans telephone. (1.57)
Achieved

The prison should implement effective processes to identify and protect adults at risk of harm, abuse or neglect. (1.60)
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2018, staff–prisoner relationships were adversely affected by constant regime challenges and some staff inexperience. Outside areas were consistently littered and many communal areas were grubby. Prisoners struggled to get access to clean clothing and bedding. They were dissatisfied with the food provided, and the supervision of serveries was poor. The application system was ineffective. Complaints were mostly well managed. Equality work was underdeveloped and the needs of some prisoners with protected characteristics were not being met. Faith provision was very good. Health services were reasonable overall. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Recommendations

Staff should be skilled and confident in confronting and controlling poor prisoner behaviour and should be supported in undertaking their role. (2.6)
Not achieved

Outside and internal communal areas should be kept clean. (2.14)
Achieved

Cells should be maintained to a consistent standard and all toilets and showers should be screened to ensure privacy. (2.15)
Not achieved

All cell windows should be in good condition. (2.16)
Not achieved

Prisoners should have sufficient clean clothes and bedding for the week. (2.17)
Achieved

Prisoners should have prompt access to their property. (2.18)
Not achieved

Breakfast should be served on the day it is to be eaten and the evening meal should be served after 5pm. (2.23)
Not achieved

The serving of food, including the issuing of breakfast packs, should be supervised by staff. (2.24)
Not achieved

New prisoners should be able to receive a prison shop order within two days of arrival. (2.25)
Not achieved

Applications should be tracked and quality assured. (2.33)
Not achieved

Confidential access complaints should be responded to promptly. (2.34)
Achieved

There should be clear personal leadership and accountability at senior level for ensuring that the needs and treatment of prisoners from minority groups are monitored and action taken to ensure their needs are met. (2.39)
Achieved

Prisoner forums should take place for all protected characteristics. (2.47)
Not achieved

Prisoners requiring a personal emergency evacuation plan should have one, and all staff having contact with prisoners should be aware of their responsibilities in relation to this procedure. (2.48)
Not achieved

A representative health forum should be set up, to inform service developments and enable collective concerns to be addressed. (2.62)
Not achieved

All clinical areas should comply with infection control standards and offer a decent, safe and confidential environment. (2.63)
Not achieved

There should be a systematic, prison-wide strategy to promote prisoner well-being. (2.66)
Not achieved

All prisoners should have a secondary health screen within seven days of arrival. (2.76)
Not achieved

There should be a memorandum of understanding and information sharing agreement between agencies, to outline appropriate joint service provision of social care. (2.81)
Not achieved

Needs-led psychological interventions should be available. (2.90)
Achieved

Transfers to hospital under the Mental Health Act should take place within Department of Health transfer target timescales. (2.91)
Not achieved

Prisoners starting clinical treatment for stabilisation should be monitored in accordance with national guidance. (2.102)
Achieved

Drug refrigerator temperatures should be monitored effectively and action taken when appropriate. (2.112)
Achieved

All prisoners should have lockable cabinets in which to store their prescribed medicines safely. (2.113)
Not achieved

Medicines should be prescribed and administered at clinically appropriate times, to ensure optimal treatment. (2.114)
Not achieved

A pain management policy should be implemented in line with national guidance. (2.115)
Not achieved

Purposeful activity

Prisoners are able, and expected, to engage in activity that is likely to benefit them.

At the last inspection, in 2018, a restricted regime had been in place for over four years and continued to reduce the amount of time that prisoners were unlocked, particularly in the evenings and at weekends. Too many prisoners were locked up during the working day. Access to the library was mostly good but literacy was not well promoted. Access to PE was too limited. The management of education, skills and work required improvement. There were some good, commercially focused workshops but insufficient activity places for the population. Many prisoners allocated to activities failed to attend. The quality of teaching and learning was good. Too few activities provided accredited qualifications. Prisoners who completed their courses generally achieved well but some courses had high withdrawal rates. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendation

There should be sufficient education, training and work places for the population, and prisoners should attend their allocated activity. (S66)
Not achieved

Recommendations

The prison should operate a full regime, including evening and weekend association. (3.11)
Not achieved

Efforts to promote literacy should be reintroduced and sustained across the prison. (3.12)
Not achieved

Attendance at PE and the library should be routinely analysed, to understand if any groups are excluded and develop provision. (3.13)
Not achieved

All prisoners should be able to access weekly gym sessions without interrupting work or education classes. (3.14)
Not achieved

The provision in mathematics and English should be adequate to ensure that all prisoners are able to improve these skills. (3.23)
Not achieved

The operation of the assembly shop should be reviewed, to make it effective in improving prisoners' attitudes and skills. (3.32)
Not achieved

Classroom teaching should be of adequate quality to motivate learners, so that they can progress. (3.33)
Not achieved

The importance of regular attendance in preparing for employment after release should be emphasised to prisoners in activities. (3.38)
Not achieved

Peer mentors should be appropriately trained and effectively deployed by teachers and instructors. (3.39)
Not achieved

There should be opportunities for all prisoners to gain vocational qualifications when working in a prison job, including the gym. (3.44)
Not achieved

Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

At the last inspection, in 2018, not enough was being done to support family relationships. Offender management was undermined by staff shortages. Too many prisoners lacked an up-to-date offender assessment system (OASys) assessment. Contact with offender supervisors was inadequate

and prisoners struggled to progress. Home detention curfew, categorisation and public protection arrangements were well managed. Too little offending behaviour work was provided. Release planning was good. A wide range of support was provided to help prisoners into accommodation but not all prisoners needing help with financial issues received assistance before release. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendation

All prisoners should have an up-to-date OASys assessment and sentence plan. Contact between prisoners and offender supervisors should be regular and meaningful, and should encourage and monitor progress against targets and actions to reduce offending. (S67)
Not achieved

Recommendations

Multi-agency public protection arrangements (MAPPA) levels should be confirmed by offender managers at least six months before release. (4.19)
Achieved

Prisoners should be supported to maintain and re-establish family ties. (4.5)
Achieved

Prison managers should take into account distance from home in developing the children and families' pathway, and take steps to alleviate transport difficulties for visitors to the prison. (4.6)
Not achieved

A comprehensive reducing reoffending strategy should be developed, based on a full analysis of offending-related needs and supported by a detailed action plan which is monitored and updated rigorously. (4.15)
Not achieved

Progressive transfers to another prison should be clearly prioritised with the full involvement of offender supervisors. (4.22)
Not achieved

The full extent of the need for offending behaviour work should be evidenced, and an appropriate range of interventions and places should be provided to meet this. (4.29)
Not achieved

All prisoners should receive sufficient help with finance, benefit and debt problems, in a timely manner, when such need is identified following their arrival at the prison. (4.30)
Achieved

Appendix I About our inspections and reports

Her Majesty's Inspectorate of 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 inspections 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.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review Suicide is everyone's concern, published in 1999. For men's prisons the tests are:

Safety
Prisoners, particularly the most vulnerable, are held safely.

Respect
Prisoners are treated with respect for their human dignity.

Purposeful activity
Prisoners are able, and expected, to engage in activity that is likely to to benefit them.

Rehabilitation and release planning
Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release into the community.

Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by Her Majesty's Prison and Probation Service (HMPPS).

Outcomes for prisoners are good.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

Outcomes for prisoners are reasonably good.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for prisoners are not sufficiently good.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for prisoners are poor.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for prisoners. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list 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.

Five key sources of evidence are used by inspectors: observation; prisoner and staff surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council (GPhC). Some are also conducted with HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report provides a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). Section 7 summarises the areas of concern

from the inspection. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of prisoners and a detailed description of the survey methodology can be found on our website (see Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief Inspector
Sara Pennington	Team leader
Paul Rowlands	Inspector
Martin Kettle	Inspector
Rebecca Stanbury	Inspector
David Foot	Inspector
Liz Calderbank	Offender management inspector
Sarah Goodwin	Lead health and social care inspector
Tania Osborne	Health and social care inspector
Fiona Atkinson	CQC pharmacist
Helen Lloyd	Care Quality Commission inspector
Stephen Hunsley	Lead Ofsted inspector
Suzanne Wainwright	Ofsted inspector
Beverley Ramsell	Ofsted inspector
Rahul Jalil	Researcher
Rachel Duncan	Researcher
Emma King	Researcher
Isabella Raucci	Researcher

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

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, although this is not mandated.

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).

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).

Psychoactive substances
Psychoactive substances are either naturally occurring, semi-synthetic or fully synthetic compounds. When taken they affect thought processes or individuals' emotional state. In prisons, these substances are commonly referred to as 'spice'. For more information see https://www.gov.uk/guidance/psychoactive-substances-in-prisons#what-are-psychoactive-substances.

Recovery plan
Recovery plans are published by HMPPS and aim to ensure consistency in decision-making by governors, by setting out the requirements that must be met for prisons to move from the most restricted regime to the least as they ease COVID-19 restrictions. (https://www.gov.uk/government/publications/covid-19-national-framework-for-prison-regimes-and-services)

Secure video calls
A system commissioned by HM Prison and Probation Service (HMPPS) that requires users to download an app to their phone or computer. Before a visit can be booked, users must upload valid ID.

Social care package
A level of personal care to address needs identified following a social needs assessment undertaken by the local authority (i.e. assistance with washing, bathing, toileting, activities of daily living etc, but not medical care).

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 Requirement Notice

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

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

Provider

Northamptonshire Healthcare NHS Foundation Trust

Location

HMP Onley

Location ID

RP1M9

Regulated activities

Treatment of disease, disorder, or injury; Diagnostic and screening procedures; and Surgical Procedures

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 that says what action it is going to take to meet these regulations.

Regulation 12 (1)(g)

Care and treatment must be provided in a safe way for service users and the proper and safe management of medicines to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met

- There was no proper and safe management of medicines. In particular: There was no robust system for monitoring stock levels or turnover: There was no evidence that orders were checked on receipt; although a stock level document was in place, quantities varied and there was not a robust audit trail for stock management.

- Prescriptions, orders and delivery notes were not stored in line with national guidance.

- Medicines stored in the controlled drug cupboard in sealed bags were not checked regularly. Checks of controlled stationery were not completed robustly.

- Over-labelled medicines were available for supply against a prescription; however, records did not match with stock on the shelves and a record was not always made when medicines were issued. Prescriptions were not

  retained when medicines were dispensed meaning there was no audit trail of medicines.

- Patients were not encouraged to order their routine medicines.

- The dedicated pharmacy room presented an infection, prevention and control risk; the room and cupboards required a deep clean.

- Medicines were disposed of in large disposal bins that were not tamper proof.

- A pharmacy assistant was being trained by a B5 technician. As pharmaceutical practice was not in line with regulation the training required review.

- Staff were not always using a safe method to transport medicines around the prison, including at times when prisoners were unlocked.

Regulation 17 (1)(2)(b) and (c)

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met

- Pharmacy policies were not always service specific. Medicines management committee terms of reference was not clear on quoracy to ensure attendance was representative.

- There had not been consistent oversight of sub-contracted provider's services; such as the dentist to ensure wait times were being managed and addressed.

Appendix IV Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the prison). For this report, these are:

Prison population profile

We request a population profile from each prison as part of the information we gather during our inspection. We have published this breakdown on our website.

Prisoner survey methodology and results

A representative survey of prisoners is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

Prison staff survey

Prison staff are invited to complete a staff survey. The results are published alongside the report on our website.

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

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England