Report on an independent review of progress at

HMP Isle of Wight

by HM Chief Inspector of Prisons

5–7 June 2023

Contents

Section 1 Chief Inspector's summary

1.1 HMP Isle of Wight is a large category B men's training prison comprising two sites, Albany and Parkhurst. It is part of the long-term high security estate. At the time of our visit, there was a population of 1,083 prisoners, mostly convicted of sexual offences, but about 70% of the population were now category C; a proportion that was continuing to grow. The prison also runs a small, separate unit for prisoners remanded or given short sentences locally.

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

Figure 1: HMP Isle of Wight healthy prison outcomes in 2019 and 2022

1.3 When we inspected HMP Isle of Wight in September 2022, the population had changed significantly and was mostly category C prisoners because of wider pressures across the prison estate. At that time leaders had yet to adjust to this new situation and there was far too little to help prisoners progress and address their risk of further sexual offending. A lack of programme delivery and staff in specialist roles, notably probation officers, undermined the prison's rehabilitative purpose. Levels of self-harm were too high and there had been seven self-inflicted deaths. The regime was very limited and staff shortages were affecting time out of cell badly. Access to work and education was poor and men could not easily learn to read or plan for employment on release. Health care was undermined by a lack of mental health support and poor control of medicines. Release planning for high-risk prisoners was a real weakness.

1.4 It is pleasing to report that at this review of progress, we found good or reasonable progress across all but one concern we raised. Plans to

turn the Albany site into a dedicated environment more suited to category C prisoners had moved ahead rapidly. Managers had improved data analysis, routinely comparing their performance against category C prisons and those holding prisoners convicted of sexual offences. Despite continuing staffing challenges, a more reliable regime was being delivered and access to work and education was considerably better. Levels of self-harm were still high but there were improvements in care. Health care leaders had a much better grasp of the potential risks they faced and problems with the control of medicines had been addressed. There were still considerable gaps in specialist staffing; there were no more probation officers than at the inspection and there was still too little mental health support for such a complex population. However, the delivery of accredited programmes was moving ahead with some confidence. Several steps had been taken to manage better the release of high-risk prisoners.

1.5 The achievements of the governor and his team in such a short space of time were impressive. They had listened to the difficult messages delivered at the inspection, recognised the drift that we identified and had not been afraid to be self-critical. They had acted quickly and delivered some tangible outcomes. Some of this progress was fragile and it will always be a challenge to recruit enough staff, both uniformed and specialist, on the island. The tension between the prison's stated function and the reality of a category C population also needs to be resolved by national leaders in the longer term. But for now, managers had done a great deal to start improving outcomes for prisoners.

Charlie Taylor
HM Chief Inspector of Prisons
June 2023

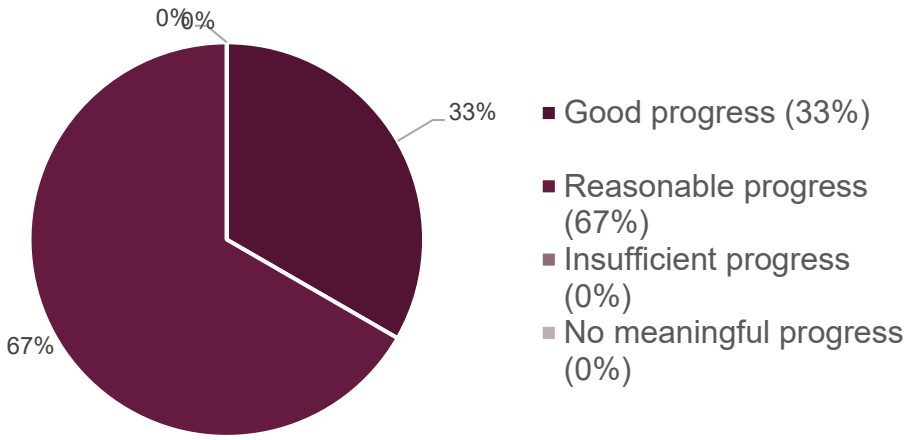
Section 2 Key findings

2.1 At this IRP visit, we followed up six concerns from our most recent inspection in September 2022 and Ofsted followed up three themes based on their latest inspection.

2.2 HMI Prisons judged that there was good progress in two concerns and reasonable progress in four concerns.

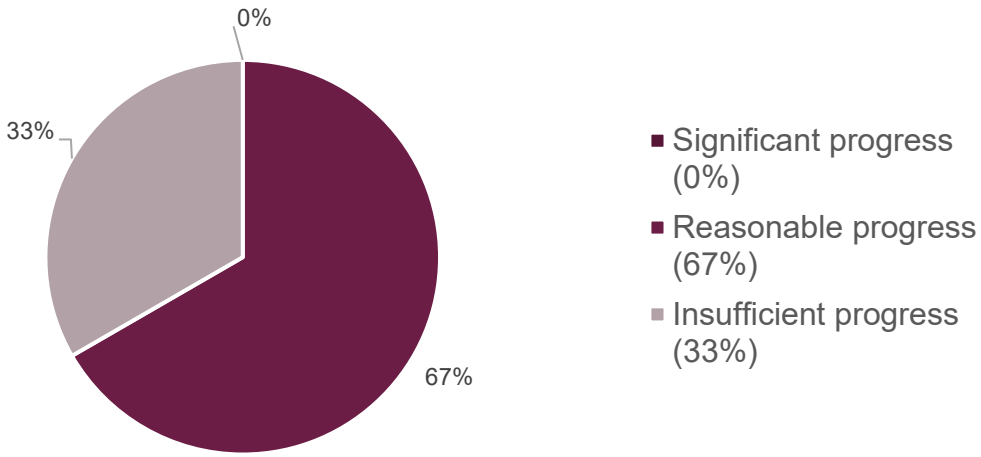
Figure 2: Progress on HMI Prisons concerns from September 2022 inspection (n=6)

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



2.3 Ofsted judged that there was reasonable progress in two themes and insufficient progress in one theme.

Figure 3: Progress on Ofsted themes from September 2022 inspection (n=3).



Notable positive practice

2.4 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

2.5 Inspectors did not find any examples of notable positive practice during this independent review of progress.

Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2022.

Leadership

Concern: The therapeutic and rehabilitative purpose of the prison was not sufficiently prioritised. Leaders had not developed the environment or regime in a way that sought to ensure needs and risks of the sex offender population were addressed. This was compounded by a failure to respond to the new reality of a much larger population of category C prisoners. Specialist staff shortages further worsened this situation.

3.1 Leaders had taken the findings of the inspection very seriously and had acted swiftly. Soon after the inspection, they had consulted widely on the next steps with about 370 staff and prisoners. They had also visited similar establishments to learn about different ways of managing prisoners convicted of sexual offences. We were confident that data analysis had improved and leaders were now in a better position to measure and understand their performance.

3.2 Managers had relocated most of their category C prisoners to the Albany site and plans for a more appropriate environment and regime were developing well. Self-catering kitchen facilities had been introduced on one unit, with plans to open more. Additional gym sessions were available and a two-week resettlement course had recently started. Our time out of cell checks reflected this with fewer prisoners on the Albany site (12%) locked up during the day compared to Parkhurst (25%). About 200 category C prisoners were still located in Parkhurst, most of whom were serving longer sentences.

3.3 The proportion of the population with category C status had further increased to 70% since the inspection, but Isle of Wight remained a high security category B prison. We spoke to many category C men who still felt frustrated, believing that this prevented them from demonstrating progression adequately, for example to the Parole Board.

3.4 There were still not enough staff in specialist roles. The work of the offender management unit (OMU) remained considerably compromised with less than half the required probation officers in post, a situation unchanged since the inspection. Caseloads were much too high: one offender manager oversaw 218 prisoners. A relocation scheme had very recently been launched to attract five new probation officers to the Isle of Wight with the offer of financial incentives (see paragraph 3.33). Staff shortages also remained in the mental health team, limiting help for some very complex prisoners (see paragraph 3.14).

3.5 There was still not enough key work to support sentence progression and only about 20% of allocated key work sessions had taken place since the inspection.

3.6 The delivery of accredited programme group work was now proceeding well and plans for the current year were ambitious. The range of programmes available for prisoners convicted of sexual offences was about to expand to include 'Living as New Me' and 'New Me Strengths', and overall delivery had improved. Since the inspection, 86 prisoners had started an accredited programme and 49 had completed it, with a further 118 prisoners due to start a programme during the coming year. There remained a lack of qualified psychologists to support the programmes team but recruitment for these roles was planned in the coming months.

3.7 The trauma-informed wing on the Parkhurst site was developing well. Therapy sessions and community meetings had resumed and most prisoners we spoke to described a positive community ethos. Additional sessions were also available such as peer-led book groups and art classes. Staff were now less likely to be cross-deployed to work in other areas of the prison which meant that the regime could be delivered more reliably.

3.8 We considered that the prison had made reasonable progress in this area.

Suicide and self-harm prevention

Concern: The level of recorded self-harm was very high and there had been seven self-inflicted deaths since our last inspection.

3.9 The recorded rate of self-harm since the inspection showed a slight downward trend but remained high. A handful of prisoners continued to account for almost 50% of incidents. There had been no self-inflicted deaths since the inspection.

3.10 Improved data analysis helped leaders to understand the causes of self-harm. They now compared themselves to category C prisons and other establishments holding prisoners convicted of sexual offences.

3.11 Progress had been made in embedding the recommendations of the Prisons and Probation Ombudsman but local investigations into serious incidents of self-harm were not completed quickly enough to learn lessons. One incident in January 2023 was only being investigated during the week of our visit.

3.12 Leaders were starting to improve care for prisoners in crisis and the safety team were making determined efforts to address deficiencies. They were, however, hindered by continuing negative and unsupportive attitudes from wing staff. Leaders were delivering a range of training to raise staff awareness and improve care for prisoners at risk of suicide and self-harm.

3.13 The quality of ACCT case management (assessment, care in custody and teamwork case management of prisoners at risk of suicide and self-harm) was starting to improve but some frailties were still evident, including weak care planning and the lack of consistent case management. Managers had introduced robust quality assurance processes and were aware of and managing these weaknesses. Most prisoners subject to ACCT support were engaged in purposeful activity, which was positive.

3.14 Some prisoners on ACCTs were supported by the mental health or psychology teams but overall staff shortages prevented some extremely complex prisoners from receiving adequate support. Other than the trauma-informed wing on the Parkhurst site, there was too little targeted support for prisoners who self-harmed (see paragraph 3.7).

3.15 Listeners (trained by the Samaritans to provide emotional support to fellow prisoners) were generally well used but we were told that access to Listeners was sometimes difficult. This was mitigated in part by access to the Samaritans on in-cell telephones.

3.16 Constant supervision was used regularly for those deemed at high risk of suicide. These prisoners were sometimes placed in anti-ligature clothing without adequate justification. We spoke to those who had had their own clothes removed who told us that this demeaned them and made them feel worse.

3.17 We considered that the prison had made reasonable progress in this area.

Health care

Concern: The health provider had identified risks to service delivery and patient outcomes, but improvements had not taken place quickly enough.

3.18 Overall governance and oversight of health services and ongoing risks had improved. An up-to-date risk register reflected the prevailing risks and included relevant mitigation actions. Risks were regularly reviewed and escalated to regional quality assurance meetings and partners at the local delivery board. There was a good process for ensuring that actions were implemented to prevent deaths.

3.19 All clinical leads had been trained in the auditing process and understood their responsibilities. An audit tracker was signed off by senior staff to provide oversight and check progress. The effective use of audits and resulting actions provided more assurance that patients would receive a safe and effective service.

3.20 Oversight of the pharmacy service was managed through an improvement plan progressed by local and regional pharmacists.

3.21 Staff training had improved to make sure that competent staff were professionally developed to provide better care outcomes.

3.22 Health care records that we reviewed had improved which assisted better continuity of care. However, some records lacked detail or did not reflect whether a face-to-face review had taken place. We no longer found instances of missing entries.

3.23 It was still too difficult for prisoners to access mental health support because of staff shortages. A temporary psychiatrist had recently been recruited, but there was a shortage of psychology, occupational therapy and nursing staff, and no counselling pathways.

3.24 The newly commissioned mental health service was working to prioritise care based on risk but was not yet meeting patients' needs. There was a considerable number of referrals for a long-term population. Thresholds for face-to-face assessments and admission to nurse caseloads were too high which created unknown risks. Most patients with an identified need only received short interventions before being discharged, only to often refer themselves again later. This created an unsatisfactory revolving door of care.

3.25 We considered that the prison had made reasonable progress in this area.

Concern: There was insufficient oversight of, and control over, medicines creating risks to staff and patients.

3.26 The CQC Regulation 17 breach identified at the inspection had been resolved. There had been considerable investment and changes in work practices. This had led to improved security for controlled drugs and safer working practices.

3.27 Governance processes had been reviewed and improved. They were now linked at local, regional and national level to make sure that oversight of pharmacy practices was comprehensive. Audits and associated action plans provided improved oversight and accountability. We identified improvements to the service which stemmed from these changes.

3.28 Oversight of pharmacy medicines, including controlled drugs, had improved. New technology, processes and equipment had been installed and updated. For example, daily controlled drug balance checks and auditing for compliance were evident and there were new controlled drug cabinets and secure transport cases.

3.29 Improved policies and procedures resulted in minimal out-of-date stock or unused medications being stored on site and they were destroyed in a timely and appropriate manner.

3.30 The pharmacy team followed up patients who missed their medication with a telephone call or face-to-face visit if appropriate.

3.31 Incidents and near misses within the pharmacy department were well recorded and reviewed at monthly meetings.

3.32 We considered that the prison had made good progress in this area.

Time out of cell

Concern: Over a third of officers were not available for work in the units, which limited the delivery of the day-to-day regime and led to prisoners spending too long locked in cells.

3.33 Leaders were trying a variety of methods to recruit staff and had recently been given permission to advertise nationally for some roles, using financial incentives. However, it was a constant struggle given the location of the prison. There had, however, been a modest increase in the number of uniformed staff since the inspection. Rates of resignation and absenteeism were also lower. Two new roles had been created to support recruitment and retention efforts.

3.34 Since our inspection the regime had improved considerably and was much more reliable. This was largely because managers had been given permission on a temporary basis to offer existing staff overtime payments. At the time of our visit, the equivalent of an additional 17 officers had become available across the prison, using these resources. Regime planning meetings were effective.

3.35 Leaders had sensibly prioritised attendance at work, education, the library and gym. Slippages in the regime and activity was proactively monitored each day and purposeful activity was now seldom cancelled as a result of a shortage of prison officers. For example, priority had been given to a dedicated library prison officer and attendance at the library had considerably improved. During our roll checks,18% of prisoners were locked up during the core day, compared to 32% at the inspection. We found more prisoners locked up on the Parkhurst site (see paragraph 3.2) and the Parkhurst regime was also subject to more curtailments.

One of the prison's libraries

3.36 A substantial number of prisoners were consistently not required at their workplace, either because of over-allocation to workshops and courses or because instructors were on holiday and the workshop was closed. Managers had introduced a policy for enhanced category C prisoners to be unlocked during the core day in these situations, but we were told by staff that shortfalls on the wings often prevented this.

3.37 The regime still only allowed for 30 minutes' exercise in the open air very early in the morning, which was not good enough. Prisoners were often unlocked later than advertised and many told us they had too little time to complete domestic tasks.

3.38 Staff shortages were particularly acute at weekends when the regime was regularly curtailed.

3.39 We considered that the prison had made reasonable progress in this area.

Education, skills and work

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

Theme 1: What progress have leaders and managers made to ensure that prisoners have good access to work and study, and that they attend regularly, promptly and do not return to their cells early?

3.40 Leaders and managers had ensured that prisoners were able to access planned education, skills and work activities regularly and on time and stay until the planned end of sessions.

3.41 Leaders and managers had successfully prioritised and greatly improved the efficiency of movements of prisoners from houseblocks to education, skills and work activities. As a result, prisoners attended activities in a consistent pattern which supported well the development of their knowledge and skills. Roll calls still interrupted learning but these took place far less frequently than at the previous inspection.

3.42 Managers had put in place comprehensive systems which monitored attendance, punctuality and early finishes for all morning and afternoon education, skills and work activities. Senior managers analysed these data each day and put in place remedial action when performance fell below acceptable standards.

3.43 Leaders and managers had ensured that more prisoners were able to access work and study. During our visit, the number of prisoners who attended purposeful activities had increased by around a fifth compared with the inspection. Moreover, detailed plans existed to increase places by a further fifth so that all prisoners could be involved in a purposeful activity.

3.44 Leaders and managers had not been successful in ensuring that all prisoners attended activities regularly. Attendance at purposeful activities remained too low. Overall, a quarter of prisoners were absent from education and industries. On the other hand, staff over-allocated prisoners to a few popular industries, in one case by more than 50%. As a result, prisoners moved from their houseblocks expecting to work and learn, only to find no places left in the workshop. They had to return to their cells. These prisoners became demotivated and did not make the progress of which they were capable.

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

Theme 2: What progress have leaders and managers made to ensure that prisoners can access education promptly enough to make progress towards their career aspirations?

3.46 Leaders and managers had reviewed and improved the process of allocating prisoners to education, skills and work activities. The labour board had widened its membership to include, for example, two newly appointed custodial managers and psychologists. As a result, waiting lists for most subjects had declined from their previous very high levels.

3.47 However, managers had not succeeded in reducing waiting lists in English, mathematics and ESOL (English for speakers of other languages) to acceptable levels. For example, prisoners wishing to develop their English skills from a low level had to wait a number of months and some prisoners wishing to study English and mathematics at higher levels had been waiting for a year.

3.48 Leaders and managers had not provided enough opportunities for prisoners to make progress towards their career aspirations. They had been slow to increase the number of vocational training places. For example, very few opportunities existed for prisoners to develop skills in construction and catering despite these being the career goals of many prisoners. Too many prisoners were employed on the wings or as orderlies. Prisoners engaged in this work developed few new skills and knowledge which would have been of benefit when seeking employment on release.

3.49 Managers had not ensured that the allocations process sufficiently took into account prisoners' career goals which had been informed by professional information, advice and guidance (IAG). The labour board did not routinely consider career aspirations when making allocations to activities.

3.50 Leaders and managers had ensured that IAG at induction had improved. Enthusiastic and trained IAG mentors supported men well during their sentence. The resettlement hub had recently been introduced to address the acknowledged deficit in pre-release IAG, but it was too soon to judge its impact.

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

Theme 3: What progress have leaders and managers made to prioritise reading and literacy across prison activities?

3.52 Leaders and managers had introduced a well-considered whole-prison strategy which had raised the profile of reading and literacy. Since the previous inspection, managers had trained a large number of energetic Shannon Trust mentors (provides peer-mentored reading plan resources and training to prisons). They were supported by a full-time facilitator who built mentors' confidence and skills which they used well to benefit their peers in houseblocks, workshops and lessons.

3.53 Mentors were proactive and worked across most of the prison. They had access to prisoners' learning plans as well as English diagnostic results. Mentors used this knowledge to understand each prisoner's starting point and to plan relevant activities to develop their literacy skills.

3.54 Prisoners' access to libraries had greatly increased since the last inspection. Managers had designated specific prison staff to ensure that all prisoners had regular opportunities to visit the libraries. As a result, many more prisoners visited the libraries, membership had increased and the number of withdrawals of basic literacy books had risen considerably.

3.55 Managers had introduced pop-up libraries and wing libraries which prisoners very much valued. Many prisoners participated in book clubs. Well-produced promotional videos about the value of literacy and reading were regularly transmitted through in-cell television. As a result, the profile of reading was high.

3.56 Reading and literacy were not prioritised consistently across the prison. A minority of industries and houseblocks had not engaged fully with the prison-wide strategy. This restricted the capacity of peer mentors to support the development of prisoners' reading and literacy skills in these areas.

3.57 Induction did not emphasise the role of mentors in helping prisoners to develop reading and literacy skills. Some prisoners were anxious about their reading ability but did not understand how mentors could help them.

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

Release planning

Concern: There were significant gaps in release planning for prisoners, many of whom posed a high risk of serious harm to the public.

3.59 Leaders had been receptive to learning and the oversight of high-risk releases was improving. Since the inspection, some useful external support had been provided to managers in the OMU to help establish and improve important processes such as the interdepartmental risk management meeting (IRMM).

3.60 The IRMM now reviewed most high-risk prisoners before release. Attendance from departments such as safety and security was improving which enabled detailed discussions of prisoners' behaviours. Community offender managers sometimes dialled into the meeting, which was positive.

3.61 There were now more robust processes to make sure that prisoners moved back to a resettlement prison in sufficient time to access help before release. During the eight months before the previous inspection, only 17 prisoners had moved to other prisons for this purpose whereas since the inspection 56 prisoners had transferred. This was a considerable achievement.

3.62 Eleven high-risk prisoners had been released from the Isle of Wight since the inspection. Six high-risk prisoners were due to be released in the next six months and, in the sample of four that we checked, there was evidence of reasonably good casework and discussions about these prisoners in sufficient time at the IRMM.

3.63 During the visit, high-risk prisoners on the remand unit were allocated to a prison offender manager, which was a sensible step to provide OMU managers with some oversight of their release arrangements. These prisoners were now also seen by a visiting community probation service officer each week, which helped to address resettlement needs, including housing.

3.64 The good progress observed at this visit was vulnerable to continuing acute short staff shortages and very high caseloads in the OMU.

3.65 We considered that the prison had made good progress in this area.

Section 4 Summary of judgements

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

HMI Prisons concerns

The therapeutic and rehabilitative purpose of the prison was not sufficiently prioritised. Leaders had not developed the environment or regime in a way that sought to ensure needs and risks of the sex offender population were addressed. This was compounded by a failure to respond to the new reality of a much larger population of category C prisoners. Specialist staff shortages further worsened this situation.
Reasonable progress

The level of recorded self-harm was very high and there had been seven self-inflicted deaths since our last inspection.
Reasonable progress

The health provider had identified risks to service delivery and patient outcomes, but improvements had not taken place quickly enough.
Reasonable progress

There was insufficient oversight of, and control over, medicines creating risks to staff and patients.
Good progress

Over a third of officers were not available for work in the units, which limited the delivery of the day-to-day regime and led to prisoners spending too long locked in cells.
Reasonable progress

There were significant gaps in release planning for prisoners, many of whom posed a high risk of serious harm to the public.
Good progress

Ofsted themes

Prisoners had very limited access to work or study. Planned access was severely undermined by poor attendance, poor punctuality and prisoners returning to their cells early.
Reasonable progress

Leaders did not make sure that prisoners could access education promptly enough to make progress towards their career aspirations.
Insufficient progress

Leaders had not prioritised reading or literacy.
Reasonable progress

Appendix I About this report

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

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

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

The aims of IRPs are to:

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

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in [MONTH, YEAR] for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

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

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

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

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

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

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

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

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

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

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

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

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

Inspection team

This independent review of progress was carried out by:

Martin Lomas	Deputy Chief Inspector
Jonathan Tickner	Team leader
Sumayyah Hassam	Inspector
Kellie Reeve	Inspector
Rebecca Stanbury	Researcher
Tania Osborne	Health and social care inspector
Mark Griffiths	Care Quality Commission inspector
Allan Shaw	Ofsted inspector
Dave Baber	Ofsted inspector

Appendix II Glossary

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

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

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.

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.

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.

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