Report on an unannounced inspection of

HMP Grendon

by HM Chief Inspector of Prisons

2–19 May 2023

Contents

Introduction

Under the leadership of the excellent governor, Grendon, a therapeutic community in Buckinghamshire, continued to be a unique, pioneering jail. Prisoners, many of whom were serving indeterminate or life sentences and who had extremely troubled pasts, made remarkable progress in an environment in which therapy ran through every aspect of life in the prison. The levels of expertise and skill among the staff were much higher than other prisons, with the well-trained and supported officers critical to its success. Therapy was not limited to the hour-long daily sessions but was woven into almost all activities. Prisoners described excellent relationships with staff, who were there to support them through an often long and painful journey to make sense of their past and learn to regulate their emotions and behaviour in the future. Close cooperation between leaders from health and prison backgrounds created a seamless, therapeutic offer, with a shared set of goals and values across the different disciplines.

These achievements happened despite taking place in a building which looked old and, in places, dilapidated. A programme of refurbishment was slowly improving the fabric of the jail, including the showers, but there continued to be night sanitation which meant that prisoners who needed to use the lavatory at night – including older men or those with medical conditions – either had to put up with long waits, or use a plastic pot, some of which did not even have a lid. There were no sinks in the cells, so prisoners were unable to wash their hands.

The prison was one of the safest in the country, which was remarkable given the histories and offences of the prisoners, and assaults and use of force were very rare. Discipline was maintained not through traditional prison systems such as adjudication, but by standards that were set by prisoners and staff through democratic meetings in which sanctions could be imposed. Prisoners were allocated jobs on the wing as part of their responsibility to the community, but many complained that the part-time wages were not adequate for those who had no other source of income, with recent price rises giving them even less to spend.

Some of the outdoor areas of the prison were neglected; gardens had become overgrown and paving was cracked or crumbling. This was a missed opportunity to involve more prisoners in maintenance.

The provision of education at Grendon was disappointing, and our purposeful activity score dropped from good to not sufficiently good. Leaders had understandably focused on reinstating the therapeutic community after the hiatus caused by the pandemic, in which group work was not permitted, but this meant they had paid insufficient focus to education, training and work. Some prisoners told us they were bored in the afternoon and the education provider's own assessment showed there was a widespread hunger to do vocational training, even for those who had substantial time left to serve.

The education provider was simply failing to deliver a service that was good enough, and this was not helped by ongoing vacancies. The teaching of reading

was non-existent, except through a third-sector organisation, although the very good librarian worked hard to find ways to help prisoners develop some breadth in their reading. The wing for prisoners with learning difficulties provided an adapted therapeutic programme to support prisoners, but the environment did not reflect their needs. For example, notices on the wall contained dense print and there was no use of adaptations such as a visual timetable. Many prisoners rarely went outside, and despite the inspection taking place in good weather, only a quarter were using the exercise yard. Prisoners were inexplicably not allowed to use the wing gardens that contained some good quality exercise equipment. Opportunities for team sports were limited and nothing had replaced football, which had been banned because of injuries to players and staff.

Recent changes to Parole Board rules meant that rather than moving to category D jails, some prisoners were now being released straight from Grendon. This created a new challenge in supporting prisoners – some of whom had served very long sentences – to make the transition back into the community.

The challenge for Grendon is to make substantial improvements to the provision of education, and to the fabric of the building and grounds, to raise them to the standards of the rest of the jail. Education should be dynamic and complimentary to the therapeutic aims of the prison, focusing on the varied needs and aspirations of this group of prisoners. With the current governor in post, I am confident that very good progress will be made.

Charlie Taylor
HM Chief Inspector of Prisons
June 2023

What needs to improve at HMP Grendon

During this inspection, we identified nine key concerns, of which four 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. **Some residential facilities were not fit for purpose or conducive to a therapeutic environment.** Maintenance and repairs often took too long.

2. **Key elements of the governance of health services were being adversely impacted by staffing challenges.** Although the issues were being managed, there was inconsistent access to GPs and a lack of professional oversight in pharmacy, leading to avoidable risks in the delivery of patient care.

3. **The overall curriculum was not broad enough to meet the needs of the many prisoners who wanted to develop their vocational expertise alongside their therapeutic programme, such as in construction-related skills. Prisoners told inspectors they were bored in the afternoons.**

4. **The education, skills and work provision had not been rigorously managed, monitored or quality assured over time and too much of the improvement work that leaders had commissioned was very recent and so far had had little impact.** The quality of education provision had deteriorated compared with the previous two inspections.

Key concerns

5. **Prisoners' pay had not increased in line with the cost of shop items, and some could no longer afford to buy what they needed.**

6. **Most prisoners spent very limited amounts of their leisure time outside.** Wing gardens were rarely used and outdoor sports activities were infrequent.

7. **Careers information, advice and guidance was not provided in a sufficiently timely manner at the start of prisoners' therapeutic programme.**

8. **Prisoners with additional learning support needs did not receive the support they needed and made slow progress.**

9. **There had been very slow progress in implementing a reading strategy as part of the education offer, particularly for those with very-low-level or no reading skills.** There was effectively no support available for such prisoners at the time of the inspection.

About HMP Grendon

Task of the prison/establishment
HMP Grendon is a category B adult male training prison, providing accredited therapeutic interventions across five wings.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 171
Baseline certified normal capacity: 248
In-use certified normal capacity: 218
Operational capacity: 188

Population of the prison

- Approximately 70 prisoners transferred in each year.
- Six foreign national prisoners.
- 116 prisoners serving indeterminate sentences.
- 54 prisoners serving determinate sentences.
- 20% of prisoners from black and minority ethnic backgrounds.
- 5–10 prisoners released into the community each year.

Prison status (public or private) and key providers
Public

Physical health provider: Practice Plus Group
Mental health provider: Oxford Health NHS Foundation Trust
Substance use treatment provider: Midlands Partnership NHS Foundation Trust
Prison education framework provider: Milton Keynes College
Escort contractor: Serco

Prison group/Department
South Central

Prison Group Director
Andy Lattimore

Brief history
Opened in 1962, Grendon was initially used as an experimental psychiatric prison for prisoners with antisocial personality disorders. It developed into a series of discrete therapeutic communities (TCs), one of which was dedicated to prisoners convicted of a sexual offence. In 2014, a TC plus (TC+) unit for prisoners with learning disabilities (who had previously been excluded from treatment) was opened, complementing similar provision at HMPs Dovegate and Gartree. Grendon has been one of the most researched forensic establishments in the world. Studies have shown lower levels of reoffending for men who stay longer than 18 months. Grendon and the adjacent HMP Spring Hill, an open prison for adult men, are managed jointly by a single senior management team.

Short description of residential units
A wing – 40-bed TC for prisoners convicted of a sexual offence only
B wing – 45-bed TC (currently closed for fire improvement work)
C wing – 43-bed TC
D wing – 45-bed TC
F wing – 20-bed TC+ for men with mild learning disabilities
G wing – 40-bed assessment and induction unit

Name of governor and date in post
Becky Hayward, January 2019

Changes of governor since the last inspection
Jamie Bennett, 2012–2019

Independent Monitoring Board chair
Christoff Lewis

Date of last inspection
8–18 May 2017

Section 1 Summary of key findings

Outcomes for prisoners

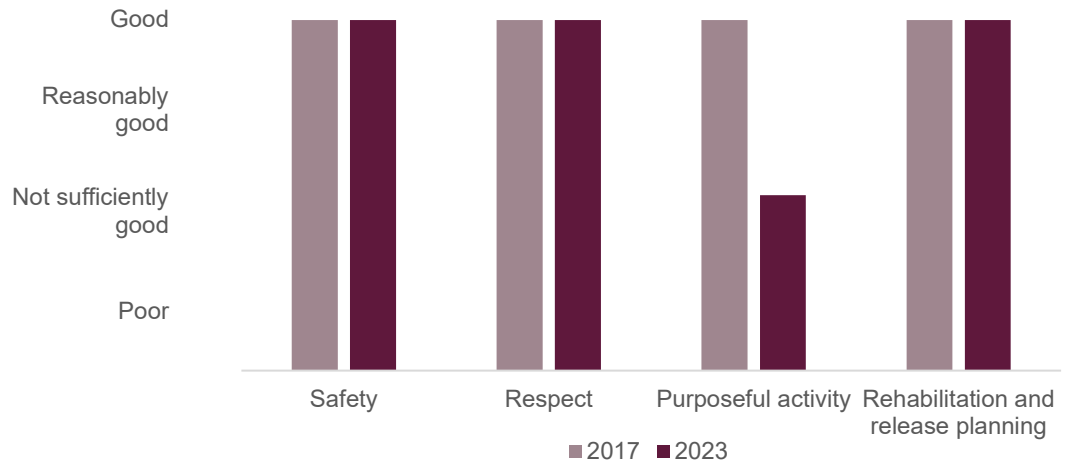
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and rehabilitation and release planning (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of HMP Grendon, we found that outcomes for prisoners were:

- good for safety
- good for respect
- not sufficiently good for purposeful activity
- good for rehabilitation and release planning.

1.3 We last inspected HMP Grendon in 2017. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 1: HMP Grendon prisoner outcomes by healthy prison area, 2017 and 2023



Progress on key concerns and recommendations from the full inspection

1.4 At our last inspection, in 2017, we made 22 recommendations, none of which were about areas of key concern. The prison fully accepted 19 of the recommendations and partially (or subject to resources) accepted one. It rejected two of the recommendations.

Progress on recommendations from the scrutiny visit

1.5 In March 2021 during the COVID-19 pandemic, we conducted a scrutiny visit (SV) at the prison. SVs focused on individual establishments and how they were recovering from the challenges of

the COVID-19 pandemic. They were shorter than full inspections and looked at key areas based on our existing human rights-based *Expectations*. For more information on SVs, visit https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/.

1.6 At the SV we made two recommendations about areas of key concern. At this inspection we found that one recommendation had been achieved and one was no longer relevant.

Notable positive practice

1.7 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.

1.8 Inspectors found four examples of notable positive practice during this inspection.

1.9 The cultural awareness roadshow was a positive initiative which involved prisoners sharing their cultural experiences and histories, recipes, food and music. (See paragraph 4.31)

1.10 The popular weekly 'Friday drop-in' enabled prisoners of different religions and beliefs to spend social time together and speak to chaplains. (See paragraph 4.45)

1.11 Substance misuse services implemented evening and annual events to provide stories of recovery by peer support organisations. (See paragraph 4.85)

1.12 Arrangements for clinical supervision and peer support were excellent, including careful managerial oversight and access to independent counselling for staff. (See paragraph 6.20)

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 The well-respected governor, who was also responsible for the neighbouring open prison (HMP Spring Hill), was seen as approachable and supportive by both staff and prisoners and had given continuity of leadership for more than four years.

2.3 She had provided good collaborative leadership with the director of clinical services to restore the democratic therapeutic community following interruption to therapy during the COVID-19 pandemic.

2.4 Leaders modelled the values of a democratic therapeutic community, and consultation and communication with both staff and prisoners were a strength. Although changes were often slow to implement, the democratic processes provided prisoners with a genuine say in the running of their community.

2.5 This alternative approach to management through community processes meant that formal disciplinary measures were rarely used. The prison was very safe, and relationships between staff and prisoners were excellent.

2.6 Clinical leadership was visible and well integrated within each of the five wing-based therapeutic communities and the assessment centre. Each community was led jointly by a custodial manager, a psychologist and a therapy manager, and staffed by both band 4 specialist officers and non-operational facilitators.

2.7 The band 4 specialist prison officers were specially selected, had comprehensive training for their role and were well supported with regular clinical supervision and group sensitivity meetings to address the emotional demands of working in a therapeutic environment. Leaders had developed succession pathways to address staffing shortfalls that included training band 3 prison officers to fulfil this specialist role.

2.8 Although HM Prison and Probation Service (HMPPS) had been slow to improve the worn and dated fabric of the prison, a programme of works was now under way that included an upgrade to the night sanitation system. However, most cells still had no toilet or running water, which was unhygienic.

2.9 Leaders had not done enough, or involved prisoners sufficiently, to maintain the external areas – some of which were overgrown and neglected.

2.10 The overall management of security was balanced and supported the ethos of a therapeutic community, but prisoners were not allowed regular access to the wing gardens, which seemed unnecessarily risk averse and counter to the culture of the prison.

2.11 Partnership working with the health care team was good, but education, skills and work had not been given sufficient priority by leaders and provision had deteriorated since the previous inspection. Leaders had not developed sufficient education and training opportunities to complement or augment the therapeutic offer, and Ofsted graded the leadership and management as 'Requires improvement'.

2.12 There was well-established engagement by leaders with a wide range of external partners offering enrichment activities.

2.13 Leaders had well-developed plans to open a progression unit in response to parole board decision changes and national prison capacity issues. There were long delays in transport being provided by HMPPS for those waiting for a move from the prison, which, in turn, was limiting new intake and having a negative impact on the functioning of the establishment.

2.14 Good strategic planning and effective governance across most functions of the prison were underpinned by scrutiny of data.

2.15 Leaders had a strong focus on continuous improvement of the prison's therapeutic provision and invited regular 'Community of Communities' peer review and the 'Grendon advisory panel' to give assurance.

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 Only around six prisoners a month were received. Prisoners had to apply to come to the prison and were selected mainly on the basis of their potential suitability for therapy. Although none arrived during the inspection, prisoners told us that staff in reception were friendly and welcoming. In our survey, 91% of respondents said that they were well treated in reception, which was better than we usually see.

3.2 The reception area was small, but the space was sufficient, given the small number arriving. Although clean, the area was sparsely decorated and not particularly welcoming. Prisoners were usually subject to a strip-search (see also paragraph 3.20) and body scanner, irrespective of whether this had already been done at the sending prison, which was excessive. The two holding cells were stark, but most new receptions did not spend long there. In our survey, 81% of respondents said that they had spent less than two hours in reception on arrival.

3.3 New arrivals were taken to the assessment unit on G wing, while those with a learning disability were assessed on the therapeutic community 'plus' unit on F wing. They were greeted both by wing staff and the prisoner community chair and vice chair, which underlined the ethos of the prison.

3.4 Prison staff conducted risk interviews in private, and prisoners could usually contact their families once on their wings. For prisoners transferring from private prisons, there were sometimes delays in carrying over permitted telephone numbers. Some recently arrived prisoners said that staff called their families in such circumstances.

3.5 Cells were mostly in a reasonable state, although some of the cell floors and furniture on G wing were in poor condition. Staff conducted regular well-being observations of new arrivals during their first night at the prison. In our survey, 89% of respondents said that they had felt safe on their first night.

3.6 Induction took place over two afternoons. It was mainly peer led, but supervised by staff. Prisoners were subsequently introduced to the

assessment process for admission to the therapeutic communities, which aimed to establish whether they were suitable for therapy.

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

3.7 Prisoners lived in a safe and supportive environment. The recorded number of violent incidents was very low, with no assaults against staff and only one prisoner-on-prisoner assault in the last 12 months. In our survey, 11% of respondents said that they currently felt unsafe, which was the same as at the time of the previous inspection.

3.8 Relationships established within the wing community developed a sense of belonging and trust, and prisoners learned to manage their behaviour positively. Community groups were convened on Monday and Friday mornings, chaired by a prisoner who was elected to the role for a period. The community took decisions during meetings that included voting on the allocation of jobs and positions of trust.

3.9 The incentives scheme did not operate in the usual way, as a result of the therapeutic nature of the prison. All prisoners engaging in therapy were automatically assigned to the enhanced level, and behaviour was managed through democratic community processes. Community groups were encouraged to support one another, talk about their difficulties, and challenge inappropriate behaviour, disputes or concerns. Prisoners were supported to find new behaviour strategies instead of expressing themselves antisocially. They were also encouraged to take responsibility for the consequences of their behaviour, and sanctions for breaches of rules were made collectively, as a group.

3.10 When a serious issue was raised within the community, such as risk of harm or an incident of violence or drug misuse, an emergency 'special' meeting was convened to explore the concern (see also paragraph 3.23). These meetings continued to be held until the community was satisfied that risks could be managed safely. Although this could take several weeks, prisoners we spoke to said that ongoing meetings were necessary to support one another, take responsibility for their behaviour and regain trust, so that they could continue their therapy as a group. In serious cases that were disruptive to the therapeutic community, a 'commitment vote' was held by staff and prisoners. This could result in a prisoner having to leave the prison as a consequence of their behaviour.

3.11 There was good multidisciplinary work and targeted support for prisoners who were vulnerable or had allegedly been involved in

violence or bullying. If deemed appropriate, a challenge, support and intervention plan (see Glossary) referral was made. Documentation we viewed showed that incidents were investigated well and plans were individualised to support and meet prisoners' needs. Prisoners we spoke to told us that they felt supported by the process.

3.12 The joint monthly safer custody and safety intervention meeting had an appropriate focus on safety-related matters. A good and up-to-date safety strategy was underpinned by analysis of data and a prisoner survey, and there was a longer-term action plan to reduce risks further.

Adjudications

3.13 Formal disciplinary procedures were rarely used. In the last 12 months, there had been 62 adjudication hearings. Around a third had been appropriately dismissed because a positive result in a mandatory drug test (MDT) had been triggered by a prescribed medication. There were no hearings outstanding at the time of the inspection.

3.14 Hearings were usually held on the prisoner's wing and records we viewed showed a good level of enquiry. Prisoners were also encouraged to discuss matters in their therapy group.

Use of force

3.15 Use of force was rare. There had been only three recorded incidents in the last 12 months, although one took place during the inspection which led to the use of full control and restraint. Written records of the earlier incidents were good and showed that de-escalation techniques had been applied effectively, and none had escalated to the use of full control and restraint. The prison had recently introduced PAVA incapacitant spray (see Glossary), and during the inspection it was carried by around 50% of operational staff. There had been no recorded incidents involving the use of PAVA or batons.

3.16 Governance arrangements were good. Despite the small number of incidents, the use of force committee met quarterly to oversee processes, particularly training. Only 70% of staff were up to date with their basic control and restraint training, but training days had been arranged.

3.17 As part of the therapeutic nature of the prison, only one specialist officer on each wing carried a body-worn video camera. These were not permitted to be worn during therapy sessions.

Segregation

3.18 Grendon did not have a segregation unit and we found no evidence that prisoners had been segregated on the residential wings. Poor behaviour was usually resolved through therapeutic meetings; in the rare cases of extremely poor behaviour, prisoners were transferred to another prison.

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.

3.19 Security arrangements were generally proportionate and supported the ethos of a therapeutic community, but there were some exceptions. For example, prisoners were not allowed regular access to the wing gardens and strip-searches were carried out routinely on new arrivals (see also paragraph 3.2).

3.20 Security meetings were well attended, regular and well structured. Monthly local tactical assessments and briefings were provided to all managers and gave an overview of key security concerns. The governor and deputy governor also participated in a monthly tactical tasking coordination committee meeting.

3.21 The prison received a reasonable flow of intelligence and information sharing was collaborative. Fortnightly meetings between security and wing therapy managers were an effective means of discussing problems and exchanging information. Security managers also met wing staff when there were concerns within the community, and they implemented security measures jointly.

3.22 Compact-based drug testing had been introduced to encourage a drug-free environment. All prisoners were tested regularly and any positive results were discussed in therapy groups and wing meetings.

3.23 In our survey, 19% of respondents said that it was easy to get illicit drugs at the prison. During the inspection, several ‘special’ meetings were held to discuss recent illicit drug misuse (see also paragraph 3.10), and two prisoners were transferred out of the prison as a result of intelligence that they were supplying drugs. The random MDT positive rate for the last 12 months was low (2.5%). The drug strategy had been updated recently and the live action plan focused appropriately on supply, demand and building recovery.

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

3.24 There had been two deaths in custody since the previous inspection, one of which had been self-inflicted. The prison had accepted and implemented recommendations made by the Prisons and Probation Ombudsman.

3.25 The level of self-harm, which had been low at the previous inspection, had reduced further. There had been 32 instances in the previous 12 months, with very few serious. The last serious incident had occurred more than a year before the inspection. A timely internal investigation had been completed, and recommendations acted on.

3.26 In the past 12 months, 39 assessment, care in custody and teamwork (ACCT) case management documents for prisoners at risk of suicide or self-harm had been opened. The multidisciplinary support provided to prisoners was better than we usually see. The documents were generally well completed, with thorough assessments and case reviews, identification of risks and triggers, and care plan targets that reflected prisoner needs.

3.27 Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) did not operate in the prison because of the limitations placed on confidentiality in the therapeutic environment. Instead, prisoners were both encouraged and facilitated to share their thoughts and feelings in therapy sessions, and they supported each other informally outside of these sessions. Prisoner safer custody representatives and safer custody officers also offered support, and there were Samaritans telephones on each wing.

3.28 A constant observation cell had been used only twice and a safer cell once during the previous 12 months. Data on the use of both cells was not readily available as it was aggregated and did not record the length of time they were used. This was rectified by prison leaders during the inspection.

Protection of adults at risk (see Glossary)

3.29 The rigorous selection process, together with the in-depth initial assessment, was central to identifying prisoners' safeguarding needs. The therapeutic process and excellent supportive relationships among prisoners and staff also made sure that adult safeguarding issues were identified and could be addressed appropriately.

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 Relationships between staff and prisoners, and prisoners and their peers, were excellent. In our survey, 90% of respondents said that staff treated them respectfully, and 91% said that they had a member of staff they could turn to if they had a problem.

4.2 The therapeutic environment helped foster good communication, respect and trust, and allowed prisoners and staff to challenge each other's behaviour constructively. Staff demonstrated a depth of knowledge of the personal circumstances of those in their care, and prisoners were highly complimentary about the treatment and support they received.

4.3 As a result of the prison's unique function, a bespoke model of personal officers had been implemented. In the sample of case note entries we reviewed, interactions were mostly frequent, thorough and meaningful, and far better than we usually see (see also paragraph 6.9).

4.4 Opportunities for prisoners to contribute to their community were plentiful. They all had voluntary roles and responsibilities which were discussed, supported and approved by their peers and 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 The worn and dated physical fabric of the prison was being improved through a long-awaited programme of works to upgrade fire safety and night sanitation systems, and redecorate living accommodation.

4.6 Residential and communal areas were clean, and features such as artwork, fish tanks and plants made areas more pleasant. Group and therapy rooms were spacious and comfortable.

Communal area with fish tank

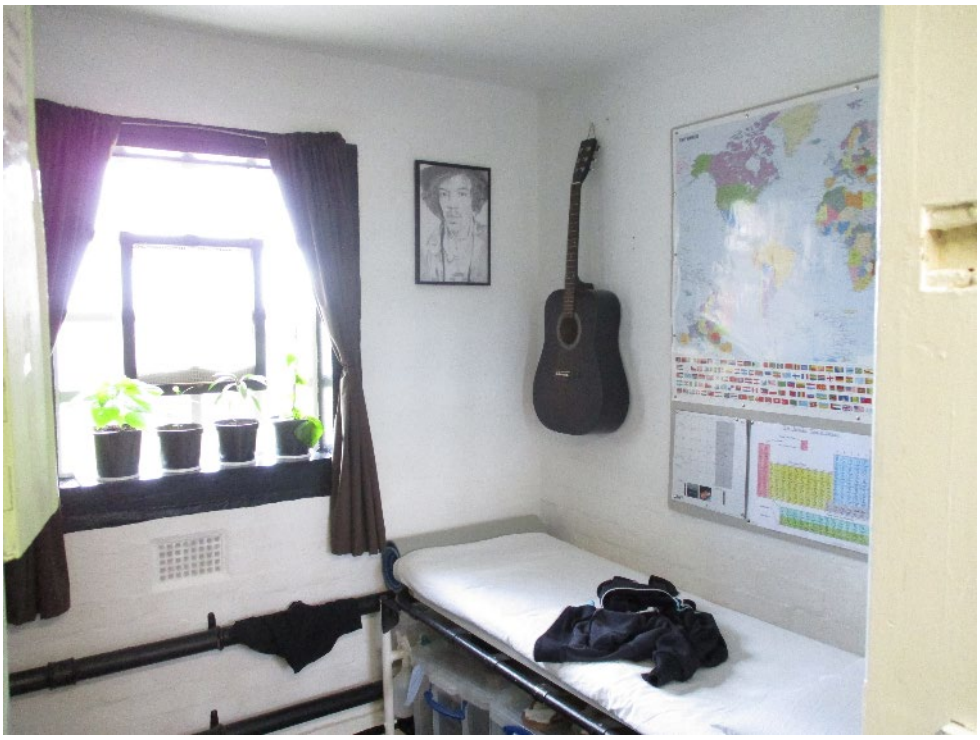
Community room

Artwork

4.7 However, the exterior of wings, such as communal corridors, was bland and in need of decoration. Outdoor areas were mostly free of rubbish, but not enough attention had been given to making them more welcoming and reflective of the ethos of the therapeutic environment.

Communal corridor

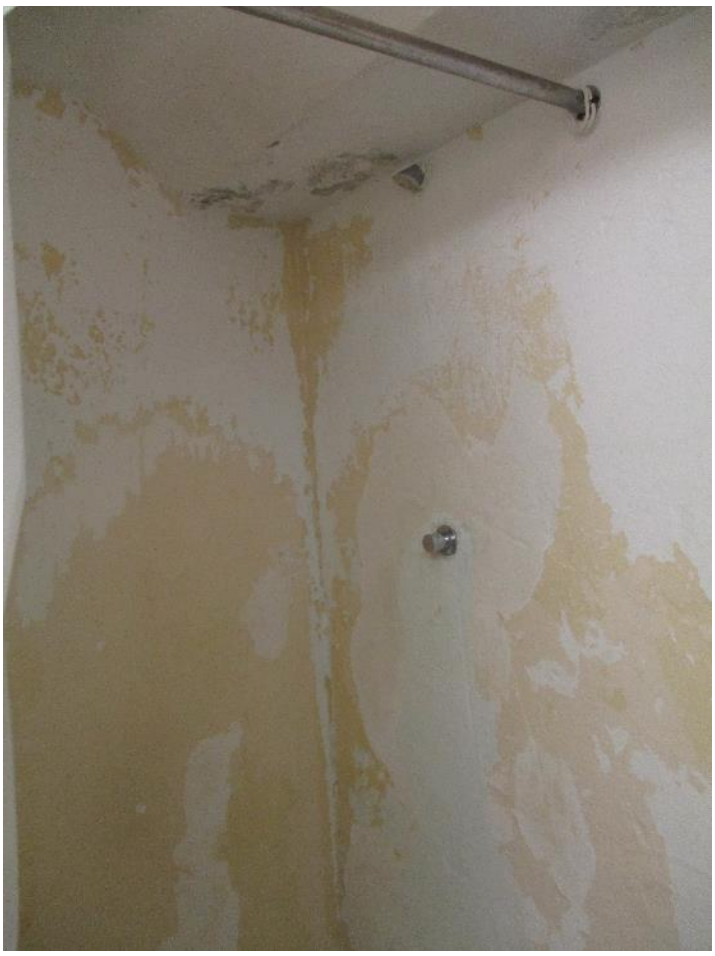
4.8 Five of the six residential wings were in use at the time of the inspection. All prisoners had a single cell, and these were generally well equipped, although many had damaged floors. Cells were free of graffiti and offensive displays, and some prisoners had personalised them, which helped to create reasonably homely, comfortable living conditions.



Personalised cell

4.9 Prisoners reported positively on access to cleaning materials, and clean clothing and bedding. All wings had a laundry, but washing machines and dryers broke regularly and response times for general maintenance repairs of equipment and fittings often took too long.

4.10 Almost all respondents to our survey said that they could shower daily. All communal showers were clean, but some were mouldy and many were in need of repair.



Shower in need of repair

4.11 Most prisoners did not have in-cell sanitation. They relied on an electronic keypad system when they were locked up, which required them to press a button and queue before being unlocked for the eight minutes allowed to use the toilet facilities. For some prisoners, this was not a problem, but many others told us of delays to use the toilet, particularly in the morning and on landings which housed larger numbers of prisoners. Although prisoners had been provided with plastic pots to use in their cell for this purpose, this was not decent and they were unable to wash their hands.

Electronic keypad

Plastic pot used as a makeshift toilet

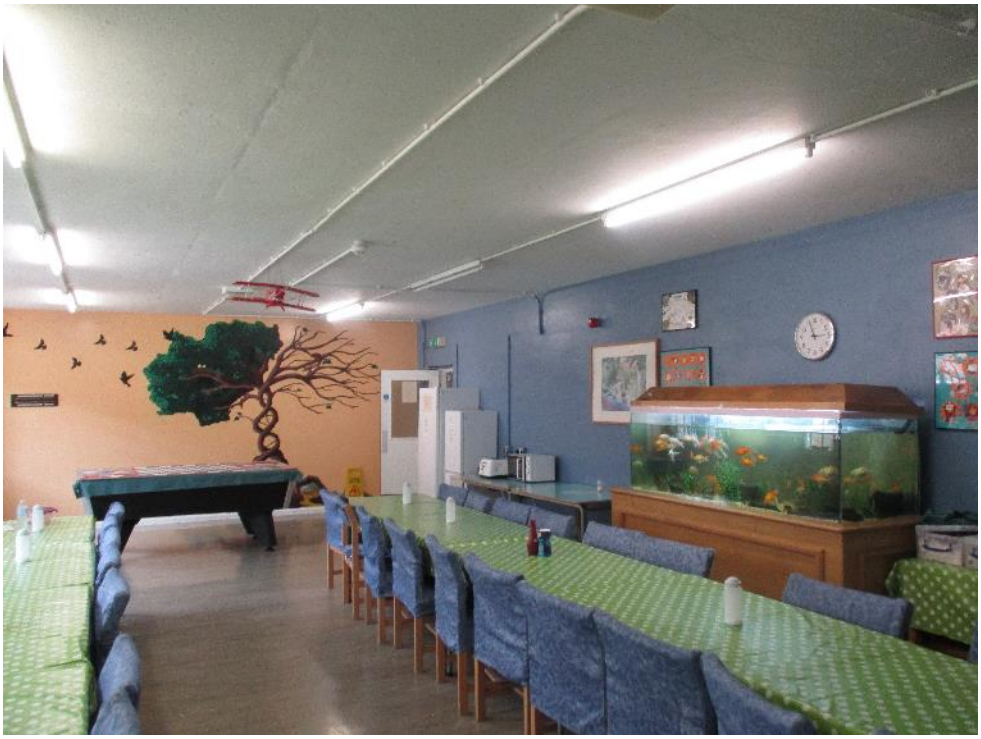
Residential services

4.12 The catering was impressive and 79% of respondents to our survey said that the food was good, which was much better than at other prisons. Prepared food was brought from the main kitchen each day and cooked in wing kitchens (known as 'pods'). Meals were usually served at appropriate times. The varied menu included a range of

healthy options and catered well for different dietary requirements. Wings had a range of self-catering facilities, such as microwave ovens, toasters and grills, which prisoners appreciated and were able to use throughout the day.

4.13 Prisoner representatives in each community collated weekly menu choices. Food surveys were carried out twice a year, but staff did not routinely review feedback given by prisoners in the food comment books on each wing. Cultural and religious festivals were catered for and halal products, and cooking and serving utensils were appropriately kept separately.

4.14 Each community had its own pleasant communal dining area, and kitchens were clean, organised and well equipped.



Communal dining area

Wing kitchen

4.15 All kitchen workers in the pods and main kitchen were required to complete a nationally recognised level 2 food hygiene qualification, but no vocational catering qualifications were offered.

4.16 Newly arrived prisoners could wait up to two weeks to receive their first prison shop order, although this was mitigated to some extent by the opportunity to obtain a vape and basic grocery pack on arrival.

4.17 Prisoners told us that their pay had not increased in line with the cost of shop items, and some could no longer afford to buy what they needed (see also paragraphs 5.3 and 5.17).

4.18 Prisoners could order items from a range of approved catalogues, but because of staffing shortfalls in the business hub, there were often long delays in their orders being placed and received.

Prisoner consultation, applications and redress

4.19 Consultation arrangements were excellent and an integral part of the therapeutic and democratic environment. Various structured meetings took place on each wing to provide prisoners with opportunities to raise issues and express their views. These included a community meeting held on Monday and Friday mornings in which prisoners were elected to take the roles of chair and vice chair. Purposeful inter-wing consultation meetings were held every two weeks, which led to some positive outcomes, although the pace of change could sometimes be slow.

4.20 In our survey, most respondents said that it was easy to make applications and that these were dealt with fairly, but only 49% said that

they received responses to requests within seven days, which was far fewer than at the time of the previous inspection (76%). We found that tracking of applications did not take place systematically on all wings and that very limited monitoring was undertaken.

4.21 Prisoners were encouraged to resolve issues at community and inter-wing meetings before resorting to the formal complaints procedure. Most complaints related to property issues. The number of complaints submitted in the previous 12 months was 345, which was low, and had been reducing over this period.

4.22 In our survey, only 35% of respondents said that their complaints were dealt with within seven days. The prison attributed delays to staff shortages in the business hub.

4.23 Although only 54% of respondents to our survey said that complaints were dealt with fairly, in the sample we reviewed appropriate enquiries had usually been undertaken, responses were generally comprehensive and decisions were mostly justified. Responses to confidential complaints were particularly well articulated. Quality assurance, undertaken by the head of business administration, was reasonable and we saw evidence that poor responses were identified, with those responsible challenged constructively.

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

4.24 Work to support and promote diversity and inclusion had improved since our scrutiny visit and was developing well. A dedicated equality manager, who had been in post for a year, had given renewed energy to this area of work. Since her departure, a senior manager had taken over responsibility, supported by a custodial manager, an administrator and staff diversity champions.

4.25 The up-to-date, tailored delivery plan clearly outlined the prison's vision, priorities and areas for development across all the protected characteristics. The governor chaired regular, reasonably well-attended diversity and inclusion action team (DIAT) meetings, and the scope of these had recently broadened to give more oversight of the delivery plan's priorities. Excellent interrogation of a wide range of data took place to understand and act on potential differences in prisoners' treatment and progression.

4.26 Senior leaders, along with support from the Grendon advisory panel, had revived work to explore outcomes for black and minority ethnic prisoners with regard to therapeutic selection. Data were monitored routinely in relation to the number of these prisoners moving on from assessment to undertake therapy.

4.27 Most wings had elected prisoner diversity representatives, who were responsible for promoting awareness of equality within their community. A small team of well-trained and supported peer equality mentors (PEMs) worked with the DIAT to organise and hold events, but more PEMs were needed to ensure an equitable spread across the prison.

4.28 A calendar of cultural events was celebrated, including Black History Month, during which prisoners enjoyed a film night and steel pan performance, along with a finale evening of food, music and games. Some focus groups with prisoners from protected groups had resumed, but were intermittent. There were plans to increase the regularity of these over the coming months. Where forums had taken place, discussions were not always well documented, but they had led to some good initiatives, such as the introduction of a monthly over-50s club, a football night for young adults and a prison-wide cultural awareness roadshow (see below).

4.29 Alleged discrimination incidents were managed appropriately, discussed and usually resolved through the therapeutic process. Few discrimination incident report forms were submitted, with only 24 in the last 12 months, and oversight and investigations had improved. Investigating staff had received a package of training, and generally well-considered responses reflected a good understanding of the prisoner's perspective. Most prisoners we spoke to said that they had trust in the process. Arrangements for external scrutiny of responses had been introduced recently.

Protected characteristics

4.30 Around 20% of the population identified as black and minority ethnic, and 20% as Muslim. In our survey, these groups reported similar perceptions to white and non-Muslim prisoners, respectively, in most areas.

4.31 Black prisoners we spoke to were mostly positively about life at the prison. They greatly appreciated the cultural awareness roadshow that had been held on all wings in the previous year, which had involved prisoners sharing their cultural experiences and histories, recipes, food and music, and were enthusiastic about plans to hold it again later in the year.

4.32 Prisoners did not express views of inappropriate discriminatory banter as they had at our scrutiny visit. However, some felt that there was a lack of cultural understanding among some of the staff, although they sensed a genuine willingness to learn. Other black prisoners wanted

more frequent opportunities to come together with their peers as a cultural community.

4.33 There were only six foreign national prisoners. They were given telephone credit for a five-minute call home every month, irrespective of whether they received a visit. Professional telephone interpreting services were available, but they were rarely used as it remained a requirement of therapy that prisoners were able to speak and understand English well.

4.34 In our survey, 39% of respondents identified as having some form of disability. Those we spoke to were broadly satisfied with their treatment and care, despite some negative responses in our survey. There were no formal peer support orderlies, but named prisoners helped those with mobility difficulties to undertake daily tasks (see also paragraph 4.73).

4.35 Only a small number of ground floor cells had in-cell toilets and there were too few adapted showers, which did not lend itself well to the needs of the few with mobility issues. When the need for aids had been identified, such as toilet and shower seats, handrails and walking aids, they had been provided, although prisoners sometimes waited too long to receive them.

4.36 Prisoners' personal emergency evaluation plans contained relevant information, including who their named helpers were and where they were located. They were readily available, and day and night staff knew where to find them and what support would be needed in an emergency.

4.37 Some prisoners with a learning disability were located on the specialist therapeutic community 'plus' unit on F wing. Staff working on this unit undertook additional training to work with this group, and prisoners there received good care. The D&I team had led on work to raise the profile of neurodiversity, including marking autism awareness month, and hosting discussion ('Let's Talk') and hidden disability events. A neurodiversity support manager was soon to take up post to drive this area of work further forward.

4.38 Some good progress had been made in engaging with the prison's older population, resulting in over-50s gym sessions, clubs and regular games nights being established. More needed to be done to engage with younger adults, and the identification of care leavers was underdeveloped.

4.39 Efforts had been made to promote LGBT+ history month, but there were no forums and no links with community organisations to support these prisoners. However, the few we spoke to reported feeling safe and supported by both staff and their peers.

Faith and religion

4.40 The chaplaincy was visible, active and well regarded by prisoners. The team knew prisoners well and provided good care and pastoral support.

4.41 There was good access to weekly communal worship and 84% of our survey respondents said that they could attend religious services if they wanted to. Christian and Islamic studies were undertaken on a one-to-one basis by request and classes were due to resume imminently.

4.42 Previous staffing shortfalls had mostly been addressed, and a Roman Catholic managing chaplain had taken up post nearly a year earlier. Almost all prisoners had access to a chaplain of their own faith, but there were difficulties in recruiting a Rastafarian minister and the Buddhist chaplain was only accessible once a month via video-link.

4.43 The chapel provided a decent space for worship and private contemplation, and a new carpet had recently been fitted to improve the environment. The small multi-faith area we had reported critically about following the previous two full inspections had been moved. The new area was sparse, but large enough to cater for Muslim prayers and contained ablution facilities.

The chapel

Ablution facilities

Multi-faith room

4.44 Religious occasions were celebrated and there were plans to reintroduce the opportunity for Muslim prisoners to invite another prisoner as a guest to share food in celebration of the upcoming Eid al-Adha festival. In the previous year, four prisoners had been confirmed by the Bishop of Buckingham.

4.45 The popular weekly ‘Friday drop-in’ was a good initiative to enable prisoners of different religions and beliefs to spend social time together and speak to chaplains.

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 Health services were provided by Practice Plus Group (PPG), with subcontracts with Oxford Health NHS Foundation Trust (‘Oxford Health’) for mental health services, Inclusion for the substance misuse service and Time for Teeth for dental provision.

4.48 Leadership, partnership working and most strategic oversight were good. Despite risks associated with staffing pressures being clearly identified, not all risk mitigation was adequate for the GP and pharmacy shortfalls (see sections on primary care and inpatient services, and medicines optimisation and pharmacy services).

4.49 There were regular partnership, contract and local delivery board meetings, where reports and data were presented on the current delivery of care. Quality assurance meetings and medicines management were in place for local and regional issues.

4.50 Unless urgent, all health provision was delivered around the prison therapeutic regime, which had an impact on the effective use of clinical time for health providers.

4.51 An audit programme created continuous oversight, and action plans were in place to rectify any identified deficits. Complaints were recorded and tracked. The responses to these were compassionate, and apologetic where required. Face-to-face resolution was in place, but this was recorded in the patient record, which was not appropriate. The recent responses we looked at were undertaken in a timely manner. Quality assurance meetings identified patient incidents and shared learning across both sites.

4.52 A patient engagement lead was providing a visible and accessible method to give patient feedback to health providers regularly.

4.53 Staffing pressures were limiting the ability of some services to deliver a full range of interventions, but staff used contingencies and prioritised care as much as possible. However, pressures at HMP Spring Hill also affected care at Grendon as staffing covered both sites.

4.54 Clinical records were stored on SystmOne (the electronic clinical record). However, actions and tasks undertaken in relation to patient care were not articulated in the body of the records, which meant that there was poor chronology of events and missing records.

4.55 Competent, trained and supervised staff provided good-quality care. We observed caring and helpful interactions with patients. Prisoners were positive about the quality of the care they received. In our survey, 53% of respondents said that the overall quality of the health services provided was very or quite good, which was better than at other prisons.

4.56 There appeared to be sufficient rooms for the number of clinics scheduled, but not all were fully infection prevention and control compliant. This had been recognised in the health audits recently undertaken.

4.57 We saw examples of safeguarding incidents that had been reported and staff were aware of how to deal with these.

4.58 Suitably trained health care staff responded to emergencies on both sites, equipment checks were robust and prison staff understood the process.

Promoting health and well-being

4.59 There was a prison-wide approach to health promotion and the health care provider had a well-organised structured programme of health promotion activity linked to national campaigns.

4.60 A well-attended world health promotion day provided prisoners with a range of information, including advice on healthy eating, smoking, sexual health and blood-borne virus infections. Health promotion material was displayed across the prison and a monthly newsletter contained topical information, such as guidance for prisoners partaking in Ramadan, to raise awareness of the impact of fasting on long-term conditions and taking medication.

4.61 An enthusiastic patient engagement lead held regular patient forums to aid communication with the health care team. The recruitment of health care champions was under way.

4.62 Prisoners could access a range of disease prevention measures and screening, including for sexual health issues and blood-borne viruses, which were offered routinely during reception or secondary health screening. They were also identified for national programmes, such as bowel cancer screening.

4.63 The service had a policy on managing outbreaks of communicable diseases and followed national guidance on the management of COVID-19.

Primary care and inpatient services

4.64 All prisoners arriving at the establishment received an initial health screening. This was followed by a more detailed secondary screening within seven days, enabling clinical risk to be identified and patients with long-term health needs to be reviewed and to access treatment.

4.65 Nurses were available seven days a week, from about 7.30am until early evening. Vacancies in the team meant that they were often stretched and, while regular agency staff were employed when available, gaps in the rota had resulted in the cancellation of 33 nurse-led clinics in March 2023. Urgent services, such as medicines administration and emergency response, continued to be prioritised. Clinics were also often cancelled as a result of the community group therapy and unplanned meetings held each weekday morning.

4.66 Prisoners made health care appointments through paper applications, which were collected every day from the wings and triaged by a nurse. The 'task' function on SystmOne was used to record the triage process, but this did not make sure that patient records were clear or contemporaneous. Prisoners with an urgent clinical need were prioritised for a same day or following day appointment. Some delays arose in the scheduling of routine nurse-led clinic appointments because of gaps in staffing, and a further delay could arise if a GP appointment was needed, which meant that some patients waited two to three weeks to be seen. While there was not a waiting list for a GP appointment, the triage process was not always effective in ensuring timely access to treatment.

4.67 In our survey, 33% of respondents said that it was very or quite easy to see the doctor. However, because of a shortage of available GPs in March 2023, there had been a 40% reduction in the number of available appointments, which carried a serious risk.

4.68 Managers monitored non-attendance rates, which were reasonable across the service. Prisoners who failed to attend were followed up to find out why, and no appointments were booked during wing therapy or reflection time.

4.69 A PPG regional specialist nurse visited the prison twice a month to oversee the management of long-term conditions. The role guaranteed an appropriate level of scrutiny and patient contact, and made sure that needs were clearly identified, and clinical review arrangements established. However, care planning was underdeveloped. Not all care plans were completed in a timely way, identified clear goals to mitigate risk or guided staff in the delivery of care. Furthermore, not all staff knew how to locate the templates on SystmOne.

4.70 There was no pain management clinic, although the visiting physiotherapist had reasonable waiting times and liaised with the GP about treatment plans. Other primary care services, such as the optician and podiatrist, did not have excessive waits and there was now a consistent audiology service.

4.71 The prison worked closely with the health care team to make sure that access to external hospital appointments was prioritised. Arrangements were closely monitored, and few appointments were cancelled by the prison. However, several appointments for non-urgent consultant appointments had exceeded the 18-week threshold because of cancellation by the hospital. Where a delay presented a potential risk, prisoners were discussed in the weekly multi-professional complex case clinic.

Social care

4.72 The prison and Buckinghamshire Council ('Bucks') had a clear memorandum of understanding about the provision of social care at the prison. This contained a relevant information sharing agreement and mechanism for referral.

4.73 Since January 2022, Bucks had received seven referrals for social care assessments, all of which had been completed within target (28 days); independent advocacy was available as needed. Most assessments resulted in the supply of suitable self-care equipment. There were no prisoners in receipt of a social care package (see Glossary) at the time of the inspection. Two residents with mobility and safety aids told us that they were satisfied with their care and received support from informal peer supporters (see also paragraph 4.34).

4.74 Chemotherapy had been facilitated, although no prisoner had needed palliative care. A relevant palliative care pathway and links with the local hospice were in place.

Mental health care

4.75 Working relationships between PPG, Oxford Health and the prison were excellent.

4.76 Since taking on the contract in 2022, Oxford Health had introduced a more supportive management structure, integrated primacy care and in-reach teams, and extended daytime hours and weekend working for HMPs Grendon and Springhill. These improvements better served the needs of patients.

4.77 The Oxford Health team was small (approximately 3.0 whole-time-equivalent practitioners) and included highly experienced, trained and supervised practitioners in mental health and learning disability nursing, psychiatry and psychology. The new team was co-located with PPG clinicians, which ensured good communications. The prison had separately contracted Barnet, Enfield and Haringey NHS Trust to provide mental health services to the assessment unit. The two part-

time practitioners were not co-located with the other health teams, which hindered communication.

4.78 Patients were encouraged to take tensions and anxieties into their wing communities for resolution. Practitioners offered a range of therapies, including using eye movement desensitisation and reprocessing psychotherapy, trauma-related therapy and solution-based interventions for those on their caseload.

4.79 The establishment admitted patients in stable treatment for attention-deficit hyperactivity disorder and enduring mental health disorders. Treatments were coordinated with therapeutic community clinicians at weekly multidisciplinary meetings, where shared understanding enabled good management of mental health crises. There had been no transfers to hospitals under the Mental Health Act.

Substance misuse treatment

4.80 The integrated substance misuse team was well led and enthusiastic, and provided an effective service to optimise recovery. The team had good working relationships with the prison and a clear joint commitment to the prison's drug strategy and action plan.

4.81 There was little evidence of abuse of illicit substances and no prisoners were on opiate substitution treatment (OST). Contingencies were in place for those arriving unexpectedly on OST or who needed detoxification.

4.82 Newly arrived prisoners who needed ongoing psychosocial interventions to maintain recovery were identified effectively. Records were comprehensive and clearly set out planned care, risk and interventions. Staff were visible and knew their patients well, and interventions were undertaken as set out in their written plans.

4.83 Group work was restricted by the prison as therapy was prioritised; such work was only permitted in the weeks when there was a break in therapy. Other appointments were often cancelled because of the unplanned nature of the therapeutic community urgent meetings. However, staff worked creatively to navigate this by providing one-to-one care and rebooking appointments in a timely manner.

4.84 An independent provider was used for service user feedback, which informed service improvements.

4.85 Substance misuse services implemented evening and annual recovery events ('Recovering Together and the Recovery Stories'), whereby visitors and those in recovery were invited into the prison to talk to prisoners in treatment to provide stories of recovery by peer support organisations and supporting information and advice. This gave hope to those hoping to remain drug free and lead a healthier life.

4.86 Substance misuse appointments were frequent, and records were comprehensive and clearly set out planned care, risk and interventions.

Medicines optimisation and pharmacy services

4.87 Medicines were supplied by an external provider (Sigcare) in a timely manner, with on-site pharmacy services provided by a PPG pharmacy technician two days a week and an experienced pharmacy dispenser who was administering medicines four days a week – which was not sufficient to cover leave and sickness. Prescriptions were not clinically screened, which was not in line with good practice. The regional pharmacist attended the regional medicines management meetings and provided data to demonstrate prescribing trends and incidents. However, they visited the prison infrequently, which meant that there was insufficient staff supervision, local oversight and patient contact.

4.88 Medicines administration took place on the health care wing and was led by a qualified dispenser, with support from nurse colleagues and a part-time pharmacy technician, but nursing staff admitted that when the pharmacy dispenser was not at work, they struggled to manage and administer medicines as effectively.

4.89 Most medicines were provided on a named-patient basis. Those that were not in-possession (IP) were issued twice a day and staff made provision to administer these more often if necessary. Medicines were administered correctly and, despite the absence of officers to supervise queues, prisoners self-regulated by remaining behind the partition, to provide privacy. Prisoners were able to store their medicines safely.

4.90 Prescribing and administration were recorded on SystmOne. Approximately 98% of prisoners were prescribed their medication IP. There was an IP policy, and IP risk assessments were routinely completed at reception and recorded on patient records. The policy stipulated that routine reviews should take place every 12 months. Staff we spoke to were able to find a patient's immediate IP status using SystmOne, but did not know how often a risk assessment should be reviewed. Medicines were labelled, but the label was often attached to the outer container, which meant that if this was discarded or retained by the staff administering them, such as for insulin pens, medicines would not be properly labelled.

4.91 The pharmacy provided a stock of medicines for use in an emergency. These were stored in a locked cabinet in the pharmacy and could be accessed by anyone holding keys to the health department. There was no record of medicines administered from stock medicines and no audit trail or reconciliation of the medicines accessed, or by whom, or of which patient they had been provided to, which was poor. Senior staff told us that this would be rectified.

4.92 Team members made a record on SystmOne if a prisoner failed to attend for their medicines administration and referred them to a prescriber if more than three doses of essential medicines were missed. Patients who failed to collect IP medicines were contacted; however, there was evidence that uncollected IP medicines remained in the treatment rooms for some time without follow-up or proper reconciliation. There was also evidence of an incorrectly labelled pack

of insulin in the refrigerator, which meant that pharmacy staff did not always follow the correct procedure for receiving and logging medicines when they arrived at the pharmacy.

4.93 The pharmacy had a robust process for ordering and managing repeat prescriptions. Errors were recorded and reviewed. Controlled drug management was robust.

Dental services and oral health

4.94 Time for Teeth provided a full range of NHS-equivalent treatment. Dental sessions took place twice weekly. A new dentist had recently been recruited and had reviewed all the patients on the waiting list to make sure that treatment plans were appropriate. The longest wait for routine treatment was 16 weeks, although most prisoners had reasonable wait times. Those needing urgent care were seen on the same day or during the dentist's next visit.

4.95 Dental records included patient treatment plans, updated medical histories and consent. The dentist promoted education on oral hygiene and disease prevention during clinics.

4.96 The dental suite was clean and in good physical condition. All equipment had been properly maintained and tested appropriately. Governance and oversight arrangements, including staff training and incident reporting requirements, were robust.

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 Prisoners undergoing therapy had 11 hours unlocked on weekdays. Those not in therapy were locked up during the therapy sessions, but still had 9.5 hours out of their cells on weekdays. All prisoners were unlocked for eight hours at weekends, which was more than we usually see.

5.2 Most therapy sessions took place in the morning, followed by an hour of quiet reflection, while most other activities took place in the afternoon and evening. All prisoners had unpaid roles in their communities that complemented their formal therapy and gave them the opportunity to practise skills such as leading, taking responsibility and supporting others.

5.3 Although all prisoners were allocated a job, rates of pay were low (see also paragraphs 4.17 and 5.17). Many told us that they were bored in the afternoons, and some wanted more opportunities to gain vocational skills while at the prison.

5.4 Prisoners were offered 45 minutes of outdoor exercise a day during the week, and up to an hour at weekends. Prisoners from all wings exercised together in the outdoor sports area. Fixed exercise equipment had recently been installed. To the frustration of many prisoners, they rarely had access to the wing gardens that had been used for outdoor exercise during the COVID-19 pandemic, even though exercise equipment had also been installed.

5.5 Prisoners opting to take advantage of outdoor exercise during the week had to stay outside for the full allotted time, although at weekends they could return to their wings after 30 minutes. Even though the weather was reasonable during the inspection, we noted that only a minority of prisoners took outdoor exercise. Leaders had neither sought to understand nor respond to the low take-up.

5.6 There was a good range of recreational equipment available on the wings, such as table football, table tennis and pool tables as well as board games. All were for use only in the late afternoon and evening, and at weekends. Some enrichment activities could be accessed by prisoners from all of the wings (see below).

5.7 Prisoners had good access to the library, which was open for day and evening sessions four days a week and on alternate Saturday afternoons. In our survey, 97% of respondents said that they were able to visit the library at least once a week, which was far more than at the time of the previous inspection (70%). The active librarian was supported by a team of well-trained and highly motivated prisoner orderlies.

5.8 The library, run by Buckinghamshire Council, was well stocked and offered a variety of magazines, and fiction and non-fiction books. In addition, a good supply of audio books, music CDs and film DVDs was available. Items could also be secured quickly through inter-library loans from other Buckinghamshire Council libraries. However, in our survey, fewer minority ethnic than white respondents said that the library had a wide enough range of materials to meet their needs (58% versus 86%).

5.9 The library hosted and facilitated reading groups. There were other activities to promote literacy, including creative writing workshops, facilitated by writers, which took place every few months (see also paragraph 5.29).

5.10 Sports facilities consisted of a gym with two large rooms – one used mainly for weight training, and the other for cardiovascular training. There was also a separate, small sports hall and a hard-surfaced outside area that we were told could be used in the warmer months. Five prison exercise instructors (PEIs) were shared with HMP Spring Hill.

5.11 Most wings were allocated at least four PE sessions a week, usually including two sessions in the weights room, and one session each in the cardiovascular room and sports hall. In addition, there were some sports and activities, such as circuit training and badminton, which could be accessed from across the prison. Wing-based peer representatives were responsible for compiling lists of participants for all activities, although this was overseen by wing staff and PEIs to ensure fairness.

5.12 In our survey, 69% of respondents said that they typically went to the gym or played sport at least twice a week, which was more than we usually see, and many prisoners we spoke to commented positively about this. However, team sports were extremely limited. In the past, football had been played in both the sports hall and outdoors, but concerns by leaders about the potential for injury had stopped both. Similarly, an outdoor basketball court had not been used for several years.

5.13 Educational activities organised by the PE department had not resumed, but a first-aid course had recently started.

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.

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

Overall effectiveness: Requires improvement

Quality of education: Requires improvement

Behaviour and attitudes: Good

Personal development: Good

Leadership and management: Requires improvement

5.15 Leaders and managers had made slow progress in tackling areas for improvement in the education, skills and work provision that had been identified at the previous inspection and the scrutiny visit. One aspect that still needed to improve was the provision of earlier access to high-quality information, advice and guidance. This consisted only of support for prisoners within 12 weeks of release, which did not help the majority of prisoners define their long-term career ambitions. Further, the provision still did not meet prisoners' needs for vocational training. Prisoners still had too few opportunities to study accredited qualifications above level 2. Additional learning support was not in place to meet the needs of all prisoners on education courses who needed it. Leaders had formally discussed these areas for improvement over the past two years, but had still taken little concrete action to tackle them. However, leaders and managers had recently initiated a change and improvement programme for education, skills and work, although most improvement actions were in their infancy. By contrast, leaders had focused strongly and largely successfully on maintaining the quality of the therapeutic provision, which involved all

prisoners and which leaders regarded as the overriding purpose of the prison.

5.16 Leaders had made sure that there were more than sufficient activity spaces available in education, skills and work to occupy prisoners, in addition to therapeutic sessions. However, many of the roles, particularly the 100 or so involving wing work, were generally menial and mundane, and prisoners could complete them quickly. Leaders had not provided sufficient other opportunities to complement or augment the therapeutic offer. For example, there was little to meet the aspirations of the large number of prisoners who wanted to develop specific occupational skills, such as for construction trades. Outside of the therapy sessions during weekday mornings, too many prisoners did too little during the afternoons, and were bored.

5.17 Pay rates were equitable. The pay and incentives policy did not deter prisoners from attending activities. However, they complained that overall pay rates were too low for them to meet daily personal expenses (see also paragraphs 4.17 and 5.3). The relatively small number of prisoners attending education classes received higher pay than those attending work or industries.

5.18 The main prison education framework provider, Milton Keynes College, had established an appropriate curriculum for English and mathematics. Progression routes included access to higher-level qualifications through Open University and distance learning, although few chose this option of study. Those who did were frustrated that links to additional learning materials on the virtual campus (see Glossary) had been removed. Teachers did not use the information gathered at the start of courses about prisoners' prior experience, knowledge and interests sufficiently well to set appropriate targets for their subjects, personal skills and, where relevant, English and mathematics. Leaders and managers struggled to recruit to crucial vacancies, such as inclusion practitioner and business teacher. As a result, there was a backlog of prisoners waiting for initial screening and a waiting list for business courses.

5.19 While catering sufficiently for those wanting to improve their lower-level language and mathematics skills, leaders had not made sure that the curriculum was sufficiently ambitious for the large minority of prisoners with high levels of prior achievement. An inclusion practitioner had just started in post, but there was still a backlog of prisoners waiting for initial screening. Prisoners had not been able to access business training for more than nine months.

5.20 A lack of staffing in education, skills and work had contributed to the slow progress in improving the provision. A new head of education, skills and work had been appointed, but was not going to take up the post until September 2023. A new learning and skills manager had started only four weeks earlier, filling a post vacant since the previous year, and had not yet had the time to make any substantial impact.

5.21 Prisoners did not benefit from consistently high-quality learning in education classes because leaders' and managers' quality assurance of teaching and assessment lacked impact. For example, observations of teaching and learning did not always identify the impact of teaching on learning for prisoners. Leaders and managers had recognised that the establishment needed its own quality improvement arrangements which were separate from those at HMP Springhill. A dedicated quality improvement group was being formed, but had yet to meet.

5.22 Teachers' support for prisoners with additional needs was ineffective because most did not have appropriate support plans in place so that teachers could plan and adapt their teaching and training. Screening was insufficiently thorough. Teachers did not use the limited information available to identify and implement timely support.

5.23 Leaders and managers had made very slow progress in implementing a strategy to promote reading across the prison, particularly for those with very-low-level or no reading skills. They had not carried out specific reading assessments and did not have specialist staff trained to teach reading. Leaders had started to promote reading for pleasure by timetabling library sessions during education classes, and had introduced reading areas in education classes, where prisoners had access to a very limited range of books.

5.24 The majority of staff in education had an appropriate teaching qualification, but too few had an appropriate qualification or expert knowledge in the subjects they taught, particularly for English and mathematics or supporting neurodiversity. Teachers and teaching lacked ambition. Teachers stuck narrowly to the syllabus and relied on text-heavy resources, many of which learners were expected to complete independently or in small groups, with limited tutor support. Some of the teaching resources used were of poor quality, and sometimes not age appropriate. Too few teachers planned their lessons taking into consideration what prisoners had learned already or where they needed to improve. Leaders had recently implemented an induction plan to upskill staff, but it was too soon to judge its impact.

5.25 Some small groups of prisoners, such as those working in gardens, waste and recycling roles, acquired and applied new practical skills in horticulture, teamwork, employability and behaviour. Their prison instructors all had suitable industry experience and a relevant adult teaching qualification, which they used to enrich learning. The small number of prisoners working in orderly roles, such as in the library, gym and kitchens, benefited from a well-structured schedule that kept them focused and engaged during afternoon sessions. They learned how to work effectively with their peers from other wings and developed basic employability skills, such as following instructions. Prisoners who had completed their functional skills qualifications at level 2 were able to progress to mentor roles. Most completed the level 1 mentor qualification and some progressed to level 2. A small minority of prisoners used their information and communications technology skills productively to support activities in their prison jobs. For example, the prison shop orderly had developed complex spreadsheets that were

used to track orders, price increases and stock shortages. This individual used the information to make reports to the governor on the impact of increases in the cost of living on prisoners, and to request additional items to meet the needs of transgender prisoners. Most prisoners who completed their education courses achieved their qualifications, although most did so having passed their planned end dates. None of the prisoners were eligible for release on temporary licence, by virtue of their long sentences.

5.26 Leaders and staff shared a clear and ambitious vision for providing high-quality, inclusive therapeutic programmes. These involved all prisoners. All prison staff working in the therapeutic environments received comprehensive therapy community assessment training.

5.27 Prisoners had to apply to join the prison. Once selected, their allocation to therapeutic activities was fair because it was individualised and considered carefully by staff and the 'wing community' using a democratic process. Prisoners were assigned to activities that stretched and challenged them. Officers had developed a very good rapport with the prisoners in their care and exercised sensitivity and discretion while interacting with them. Prisoners were very positive about the care and understanding that therapeutic staff provided. They developed their personal and social skills well and were being prepared for the next steps in their rehabilitation.

5.28 Prison leaders and managers had successfully promoted a calm and respectful therapeutic environment. Prisoners developed a good understanding of their offending behaviour and how to take measured steps to help reduce their likelihood of reoffending. They were polite, well behaved and courteous. The relationship between prisoners and prison officers was cordial, and they were mostly on first-name terms. Many prisoners were greeted with handshakes by prison staff. The atmosphere in the wings and classrooms was relaxed and respectful. However, those following education courses did not always attend all classroom sessions. This was either because they were attending wing-based discussions or because a few wing staff did not prioritise education activities as part of prisoners' therapeutic experience. However, overall, the good relationships between prisoners and staff (see also paragraph 4.1) contributed strongly to the positive impact of the therapeutic process.

5.29 Almost all prison staff facilitated a culture in which prisoners felt able to voice an opinion, ask questions and be listened to, often for the first time in their lives. Therapeutic staff recorded individual prisoners' development over time. These records charted how prisoners developed their personal responsibility and became active and respectful members of their therapeutic communities. Most prisoners spoke enthusiastically and eloquently about the significant gains they had made in their personal confidence, resilience and character directly as a result of the therapeutic regime. They noted in particular how they had become able to talk openly with, and trust, others while at the establishment. Some effective enrichment activities had been implemented within the prison, which further enhanced prisoners'

opportunity to expand their personal development. Most activities were facilitated by the library staff and included an artist in residence programme and an art gallery, poetry readings and discussion groups.

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 visits areas were welcoming, with a number of rooms and spaces that could be used while maintaining staff supervision. There were play facilities for both younger and older children, and the outside area was well used. An energetic lead was given by the visits development manager, and play workers from the Prison Advice and Care Trust (PACT) were generally present at visits, especially at the weekends. There was good use of prisoners to staff the refreshments facility, which offered a basic range of snacks and drinks. Other services offered included producing family photographs and making birthday cakes to order, at a reasonable cost.

6.2 Good progress had been made in restoring the varied programme of events to involve families in the process of personal change for prisoners. This included family days, which brought families onto the wing, children's days and social afternoons.

6.3 PACT gave good support to the planning and delivery of the children's days, and also contributed in other ways, such as analysing data and giving support to those who did not receive visits. However, there were no specific courses available, such as in parenting skills.

6.4 Staff encouraged family ties and engaged families, where possible, in supporting and marking progress for prisoners. The family days were offered twice a year on each wing, and the powerful 'visits with a difference', in which prisoners described their progress in therapy to family members and others, were soon to resume.

6.5 There were no issues with communications. In our survey, only 27%, 33% and 23% of respondents, respectively, said that they had had any problems with sending or receiving emails, letters or parcels. Installation of in-cell telephones began during the inspection. The provision of secure video calls (see Glossary) at weekends was well used.

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.

6.6 Although the offender management unit was not fully staffed, the prison offender managers (POMs) delivered a consistently good quality of work; they were all probation officers, and caseloads were reasonable. The sentence planning process was well aligned with the therapeutic process in reducing the risks of reoffending, especially where the current offender assessment system (OASys) assessment had been undertaken by one of the prison's own POMs.

6.7 Almost all the 20 prisoners whose cases we examined in detail had their progression underpinned by good-quality assessments, and all but two of the 12 we interviewed told us that the prison offered a positive rehabilitative environment. This was one of the most positive perceptions from a prisoner group that we had seen since the COVID-19 pandemic. Although the frequency of review was less than we often see, this was justified as prisoners were serving long sentences, with little to be gained from a full review while they were in the therapy programme. Almost all prisoners in the sample we reviewed had a good-quality sentence plan, although two had not been reviewed since arriving at the prison. Most prisoners, and more than we generally find, had demonstrated strong progress against their targets.

6.8 POMs were each allocated to a wing, which was effective in providing good visibility and regular contact, and bringing them within the therapeutic team. All prisoners we spoke to were able to name their POM and most described a positive working relationship. One prisoner serving an indeterminate sentence for public protection described his POM as a 'godsend'. Another, whose path through therapy had not been smooth, said that they had 'butted heads a few times', but that the POM was very committed.

6.9 Supportive ongoing contact was delivered primarily by personal officers, based on the same wing as the prisoner (see also paragraph 4.3). In most cases, we saw monthly entries in electronic case notes which reflected purposeful contact and a good understanding of each prisoner's situation. Monthly management entries from the wing custodial manager provided oversight and quality assurance.

6.10 In our survey, more prisoners than in other prisons were aware of having a plan and a much higher proportion said that staff were helping them to achieve their targets.

Public protection

6.11 Public protection measures were thorough, and were supported by identifying and addressing risk factors in the course of group therapy.

The interdepartmental risk management meeting was not well attended, but risks were mitigated effectively by other means.

6.12 Although only a few prisoners were nearing the possibility of release, the work to manage risk from these prisoners was generally good. POMs attended all multi-agency public protection arrangements (MAPPA) meetings for the cases needing multi-agency planning. The senior probation officer also attended the community meetings in preparation for release of the highest-risk prisoners.

6.13 All the prisoners in our sample had the required risk management plans, most of which were of good quality. Some reports for MAPPA meetings were excellent, but others lacked detail.

Categorisation and transfers

6.14 Many prisoners who had finished or discontinued participation in therapy were not able to move elsewhere within a reasonable timescale. This was mainly because of issues at a national level, including delays in the parole process, and the difficulty of moving to open prisons, especially for those serving indeterminate sentences.

6.15 However, there were now options for graduated progression, for example, to a psychologically informed planned environment (PIPE) unit in another prison or, when possible, a move to neighbouring HMP Spring Hill, where informed support could be given. A longer-term plan to create an in-house progression PIPE would provide more continuity of support while waiting for a prison transfer.

Interventions

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

6.16 The programme of therapy had been fully restored to the level established before the COVID-19 pandemic. Leaders were clear that the ‘therapeutic culture’, built up over many years and upheld by experienced ‘culture carriers’ of both staff and prisoners, had suffered and would take longer to recover completely. Nevertheless, there was an impressive level of commitment and enthusiasm for the therapy programme and the prison’s ethos.

6.17 The democratic therapeutic communities (TCs) were part of the national offender personality disorder (OPD) pathway. Many prisoners spoke vividly and with conviction about the exploration of their past and present lives, and about personal change.

6.18 The TCs were accredited by the Community of Communities (a national group based in the Royal College of Psychiatrists) and were subject to peer reviews from other OPD units. Three audits by external peers had recently been completed, identifying good practices and offering constructive criticism and suggestions for development.

6.19 The prison had received the Enabling Environments (EE) award, the first whole-male prison to do so. EE standards were observable in practice in relationships between prisoners and staff. All staff were specially trained within a relevant rolling programme.

6.20 Arrangements for clinical supervision and peer support were excellent. These included careful managerial oversight, to make sure that staff members' practices were appropriately motivated and safe, and access to independent counsellors, enabling staff to discuss challenging thoughts and feelings arising from work in the communities in a safe place. Psychologists and psychotherapists met mental health care team clinicians each week to coordinate the care of prisoners.

6.21 Those applying to Grendon were interviewed via secure video call and were able to speak to an outreach representative – an elected prisoner from one of the communities. However, entry to and progression from the assessment TC was being hampered by the slow progression of graduates out of the prison.

6.22 New arrivals stayed for up to six months, but usually less, on the assessment TC, where they began to familiarise themselves with community living. When ready, prisoners would transfer to one of the wing communities.

6.23 At the time of the inspection, there were two residential TCs and one for prisoners convicted of a sexual offence, with a nominal stay of two years. Additionally, a TC 'plus' unit had been introduced (a smaller unit for residents with neurodiverse needs). Some of the underpinning group techniques differed within the communities to encompass specialist functions, and one-to-one therapy varied according to a prisoner's individual profile. Within each TC, prisoners and staff attended morning meetings each weekday.

6.24 In addition to the large daily meetings, smaller meetings were held for specific purposes, such as job allocations, in which democratic decisions were made and individuals held to account. The governor and clinical director were appropriately able to veto decisions in exceptional circumstances. Special meetings could take place at any time and were the main element in supporting members of the community in crises, or in defending the community from antisocial behaviour. One-to-one therapy took place in the afternoon for some.

6.25 Prisoners were well supported by custodial staff, who were able to maintain safe boundaries while exploring reasons for antisocial behaviour. Psychologists explored specific issues using cognitive therapy, eye movement desensitisation and reprocessing, and trauma-related therapies.

6.26 A highly skilled psychotherapy team was available, and prisoners were able to join creative therapies at suitable points during their stay. Prisoners told us that the art, drama and music therapies enabled them to express themselves and understand the origins of their feelings and behaviour.

6.27 There were frequent approaches from external agencies, some international, wishing to learn from the Grendon TC experience, which indicated the high regard held by others for the expertise of officers and clinicians at the prison.

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.

6.28 Very few prisoners were released directly from the prison. When this happened, the resettlement team from HMP Spring Hill gave assistance. In practice, all went to approved premises, and there were often delays in finding a place.

6.29 Release planning began with a discharge board 12 weeks before release; arrangements tended to be ad hoc in each case, and leaders were aware that a more structured and consistent approach would be helpful.

Section 7 Progress on recommendations from the last full inspection and scrutiny visit reports

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 2017, prisoners were positive about the escort experience. Reception staff were welcoming and the assessment and induction process had been enhanced since our last visit. The prison was safe and there was very little violence. Nearly all problems were dealt with through the therapeutic community. Some very good support was provided to men in crisis. The security team managed risks very well and supported the therapeutic aims of the prison. Formal disciplinary measures were used appropriately, but were rarely needed. Support for men with substance misuse issues was good. Outcomes for prisoners were good against this healthy prison test.

Key recommendations

None

Recommendations

Prisoners should not be kept waiting in vans on arrival.
Achieved

The prison should ensure that procedures to support prisoners at risk of self-harm at night are robust and well understood by staff.
Achieved

Prisoners should only be strip-searched when there is sufficient intelligence to suggest it is necessary.
Not achieved

Hand-cuffing prisoners in the prison grounds should be justified by an individual risk assessment.
Achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2017, despite night sanitation and shabby accommodation, living conditions were reasonable. Cleanliness was good, and men were provided with what they needed to live decently. All men had a single cell and responses to applications were excellent. Relationships at Grendon were outstanding. Equality and diversity work and faith provision were generally good. Complaints were well managed and legal rights services were adequate. Health care was good. Men were very positive about the food and the canteen list had recently been enhanced. Outcomes for prisoners were good against this healthy prison test.

Key recommendations

None

Recommendations

The facilities should be maintained in good condition and any repairs and refurbishment completed promptly.
Partially achieved

The EMT should disaggregate data for HMPs Grendon and Spring Hill.
Achieved

All DIRFs should receive a formal written response explaining how the incident has been investigated and resolved.
Achieved

Managers should routinely monitor the proportion of black and minority ethnic men in the population and their attrition rate from assessment and therapy.
Achieved

The multi-faith room should be extended and provide suitable facilities for Muslim prisoners.
Partially achieved

F wing should have ready access to an AED.
Achieved

The in-possession policy and in-possession risk assessment arrangements should be updated to ensure they provide prescribers and nurses administering medication with current guidance.
Achieved

Medicine queues should be managed to ensure consistent patient confidentiality, and prison staff should supervise all medication administration.
Not achieved

Pharmacy advice and support should be routinely available to patients and specialist oversight of medicine management arrangements should be provided.
Not achieved

Effective governance processes should be developed to monitor the quality and safety of dental services and all dental equipment should comply with infection prevention standards. Procedures should not compromise patient safety.
Achieved

Prisoners requiring treatment in hospital under the Mental Health Act should be transferred within established NHS guidelines.
No longer relevant

Meals should not be served before 12 noon and 5pm during the week.
Achieved

Purposeful activity

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

At the last inspection, in 2017, time out of cell was very good, and an impressive range of extracurricular activities was offered. Therapy remained the main purposeful activity. Ofsted found that learning skills and work had improved and rated it as good overall. Leaders and managers had worked well to drive improvements, and partnership work was strong. The work allocation process was fair and equitable. There were sufficient activity places but many activities were mundane. The skills the prisoners developed were not sufficiently recognised and more vocational training was needed. Teaching and learning were good, and achievements were high for those on formal courses. Prisoners had good access to the library and gym and made good use of them. Outcomes for prisoners were good against this healthy prison test.

Key recommendations

None

Recommendations

The self-assessment process should cover work and the NCS.
Achieved

Work should be structured so it provides prisoners with the opportunity to acquire enhanced skills and knowledge and gain accredited qualifications.
Not achieved

Staff should ensure all learners receive appropriate feedback to help them improve their written English and vocational competence.
No longer relevant

Tutors should provide learners with challenging activities so they can attain their full potential and take responsibility for their own learning. Progress should be recognised and recorded.
No longer relevant

All prisoners should receive guidance to help them make decisions about their next steps, including higher education study options.
Not achieved

Resettlement

Prisoners are prepared for their release back into the community and effectively helped to reduce the likelihood of reoffending.

At the last inspection, in 2017, Grendon met its core aim of providing therapy to men with serious offending behaviour. All men had a meaningful sentence plan, and there were regular discussions about the issues outlined in them. Nearly all men felt well supported. Public protection was well managed, and release planning for the small number of men released from the prison was appropriate. There were some delays in 'end-of-therapy' reports and ongoing challenges in organising moves to other prisons. Children and families work remained very good. A wide range of therapeutic interventions was offered, and many men felt they made good progress at the prison. Outcomes for prisoners were good against this healthy prison test.

Key recommendations

None

Recommendations

Children should not be routinely rub-down searched.
Achieved

Recommendations from the scrutiny visit

The following is a list of the recommendations made in the scrutiny visit report from 2021.

There should be robust oversight, effective monitoring and action planning for equality work so that the individual needs of prisoners with protected characteristics are consistently identified and met. The strategic management of equality and diversity work should identify and address discriminatory treatment and make sure that prisoners have confidence in the discrimination reporting system.
Achieved

HMPPS and the governor should work together to support and apply tailored measures for managing the COVID-19 pandemic at Grendon that aim to protect the ongoing viability of the therapeutic community.
No longer relevant

Appendix I About our inspections and reports

HM 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, 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 HM 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 outlines the priority and key concerns from the inspection and our judgements 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 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
Natalie Heeks	Inspector
Jade Richards	Inspector
Martin Kettle	Inspector
Christopher Rush	Inspector
Helen Downham	Researcher
Alexander Scragg	Researcher
Emma King	Researcher
Grace Edwards	Researcher
Tania Osborne	Lead health and social care inspector
Paul Tarbuck	Health and social care inspector
Chris Barnes	Pharmacist
Helen Lloyd	Care Quality Commission inspector
Jacob Foster	Care Quality Commission inspector
Nick Crombie	Ofsted inspector
Carolyn Brownsea	Ofsted inspector
Jai Sharda	Ofsted inspector
Diane Koppit	Ofsted inspector
Teresa Kiely	Ofsted inspector
Daisy Agathine-Louise	Ofsted inspector
Martyn Griffiths	Offender management 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.

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.

Enabling Environment
Enabling Environments are accredited by the Royal College of Psychiatrists as meeting a set of standards based on 10 values, all of which are believed to be factors in positive psychosocial environments.

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.

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

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

Protection of adults at risk
Safeguarding duties apply to an adult who:

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

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 call 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.

Virtual campus
Internet access for prisoners to community education, training and employment opportunities.

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 Grendon 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.

Requirement Notices

Provider

Practice Plus Group

Location

HMP Grendon

Location ID

1-4053555946

Regulated activities

Treatment of disease, disorder, or injury and Diagnostic and screening 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 17 (1) (2) (a) (b) and (c)

Systems and processes must be established and operated effectively to ensure compliance with the requirements in this Part. Such systems or processes must enable the registered person to – assess, monitor, and improve the quality and

safety of services provided in the carrying on of the regulated activity; and assess, monitor and mitigate the risks relating to the health, safety welfare of service users and others.

How the regulation was not being met:

Systems and processes were not always effective in assessing, monitoring, and improving the quality and safety of services. In particular:

A care plan audit was not effective in ensuring all care plans were completed in a timely way, were person centred, identified clear goals to mitigate risk, or guided staff in the delivery of care.

The storage of care plans on the clinical system was not consistent and not all staff were aware of where they were stored, meaning we were not assured that there was proper oversight of care planning.

Systems did not consistently ensure that the triage of patient's healthcare applications resulted in timely access to the GP.

Pharmacy services lacked sufficient oversight and controls to ensure that medicines were managed effectively. In particular:

Contingency arrangements to access remote prescribing when no on-site GP or regional pharmacist was available were not always followed when required.

The regional pharmacist visited the prison infrequently which meant that staff supervision and local oversight was insufficient. Systems did not ensure there was evidence within a patient's record that prescriptions were clinically screened. Patients had no access to a pharmacist for advice or medicines use reviews.

When the qualified dispenser was not available, nursing staff reported they 'struggled' to manage and administer medicines as effectively as when they were present. Staff undertook in-possession (IP) risk assessments at reception but did not know how often an IP risk assessment should be routinely reviewed.

The correct procedure for receiving and logging medicines when they arrived at the pharmacy was not always followed as an incorrectly labelled insulin pen was found in a fridge. There was no reconciliation procedure or audit trail of emergency medicines or homely remedies (medicines that do not need to be prescribed). Patient's uncollected IP medicines remained in the treatment rooms for too long without follow up or appropriate reconciliation.

Medicines were labelled, but the label was often attached to the outer packaging which meant that if the outer container was discarded or retained, medicines were not properly labelled.

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/

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