Report on an independent review of progress at

HMP Hewell

by HM Chief Inspector of Prisons

13–15 November 2023

Contents

Section 1 Chief Inspector's summary

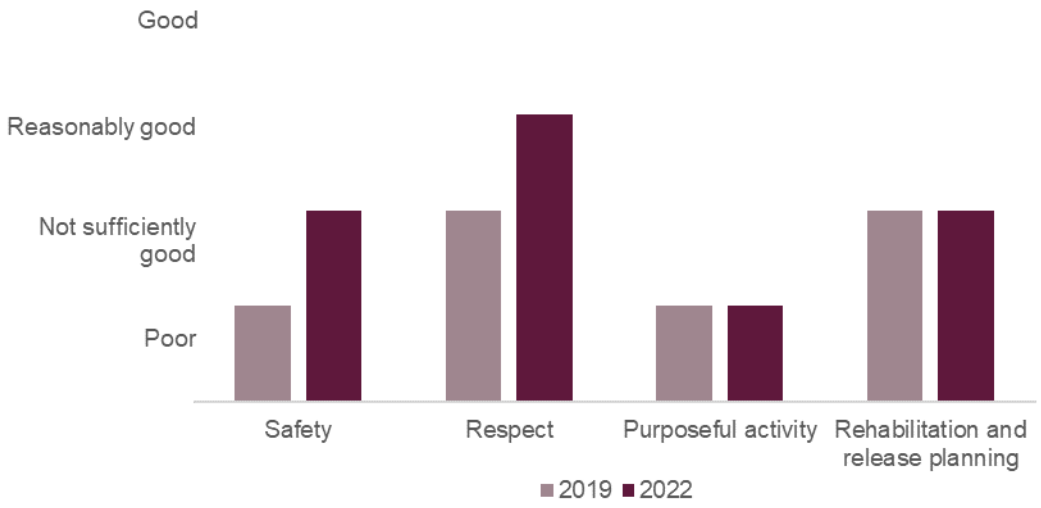
1.1 HMP Hewell in Worcestershire is a large, relatively modern category B prison with capacity for 1,094 adult men, but only 992 prisoners were held when we visited. Although it has been designated as having equally a reception and resettlement function, the prison had been holding more unsentenced prisoners in recent months.

1.2 This review followed up on the concerns we raised at our last inspection of HMP Hewell in 2022.

What we found at our last inspection

1.3 At our previous inspections of HMP Hewell in 2019 and 2022 we made the following judgements about outcomes for prisoners.

Figure 1: HMP Hewell healthy prison outcomes in 2022*



* Rehabilitation and release planning became 'preparation for release' in October 2023.

1.4 At the last full inspection, in December 2022, we found a cleaner, less violent and more respectful prison, but care of prisoners in their early days at Hewell, and the support for those most at risk of self-harm or suicide, remained concerns. Prisoners also spent far too long in their cells, particularly the many unemployed who were locked up for around 22 hours a day, and the overall provision of education, training and work was rated as 'inadequate' by our Ofsted colleagues. Public protection measures were lacking, with no coordinated planning for many high-risk prisoners held at the prison. We also found deficiencies in health care provision for which our partner agency, the Care Quality Commission (CQC, see Glossary), issued a requirement notice; prisoners were waiting too long to see a GP or for a mental health assessment, and medicines management needed to improve.

1.5 I said at the last inspection that in the next year leaders would need to make sure that prisoners were out of their cells for much longer, be involved in purposeful activity and given the opportunity to socialise together. Leaders also had to focus on improving the way prisoners were treated in their early days at the jail, and commit to reducing the risk of suicide and self-harm. With the prison now less violent and with a more competent and motivated staff team in place, there was an excellent opportunity to continue to build on the success we had identified and make further improvements.

What we found during this review visit

1.6 Although it was reassuring that progress identified at our last inspection had been sustained, it was disappointing during this review visit to find that further improvement had largely stalled. We found 'insufficient progress' in the key areas that I had highlighted previously; too many prisoners were still only unlocked for two hours a day, early days in custody arrangements remained not good enough, and too little was being done to reduce self-harm. Leaders told us that further progress had been hampered by prison officer staff shortfalls, and the challenge arising from national prison population pressures that had increased the proportion of unsentenced prisoners received, including a high number redirected from other areas of the country.

1.7 More positively, though, we found 'reasonable progress' in the management of public protection arrangements and better oversight of prisoners being released who posed a high risk of harm. Health care delivery had also improved; waiting times to see a GP or for a mental health assessment had reduced, and the management of medicines was better. CQC was now satisfied that regulations were being met.

1.8 Ofsted found some 'reasonable progress' in the identification of prisoners with learning needs and disabilities, but leaders had not introduced any new accredited qualifications in work areas, and too few prisoners were receiving careers information advice and guidance, limiting opportunities for their employment on release.

1.9 Although disappointing overall, some recently implemented improvements were encouraging. A pilot to increase the time prisoners were out of their cells was now under way on one house block, and leaders told us that this would be rolled out rapidly across the prison (see paragraph 3.25). A full quota of prison officers was also anticipated, with an influx of newly recruited staff currently in training. There will be no excuse then for further delay to instituting progress, and I urge leaders to give urgent attention to the care of its high-risk, vulnerable and frequently displaced population, especially during their early days at the prison.

Charlie Taylor
HM Chief Inspector of Prisons
November 2023

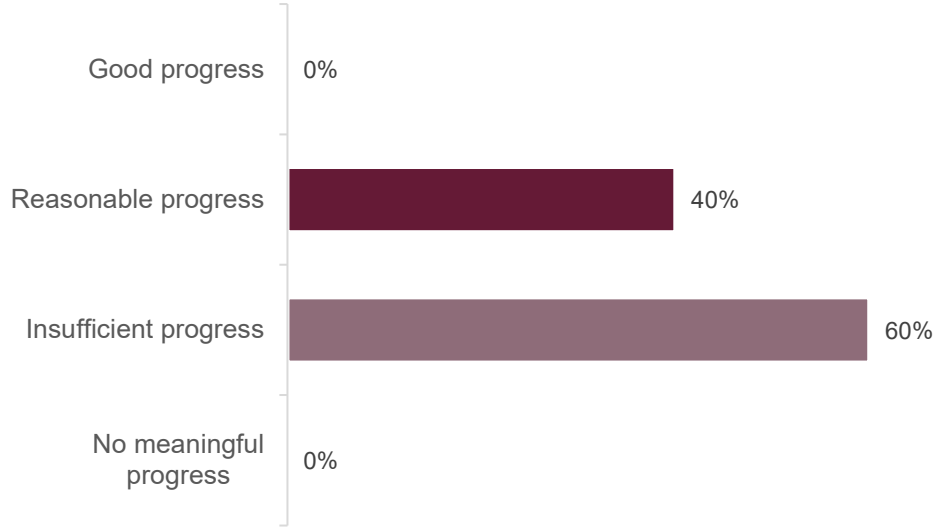
Section 2 Key findings

2.1 At this IRP visit, we followed up five concerns from our most recent inspection in December 2022 and Ofsted followed up three themes based on their latest inspection or progress monitoring visit to the prison, whichever was most recent. The Care Quality Commission followed up one requirement notice.

2.2 HMI Prisons judged that there was reasonable progress in two concerns and insufficient progress in three concerns.

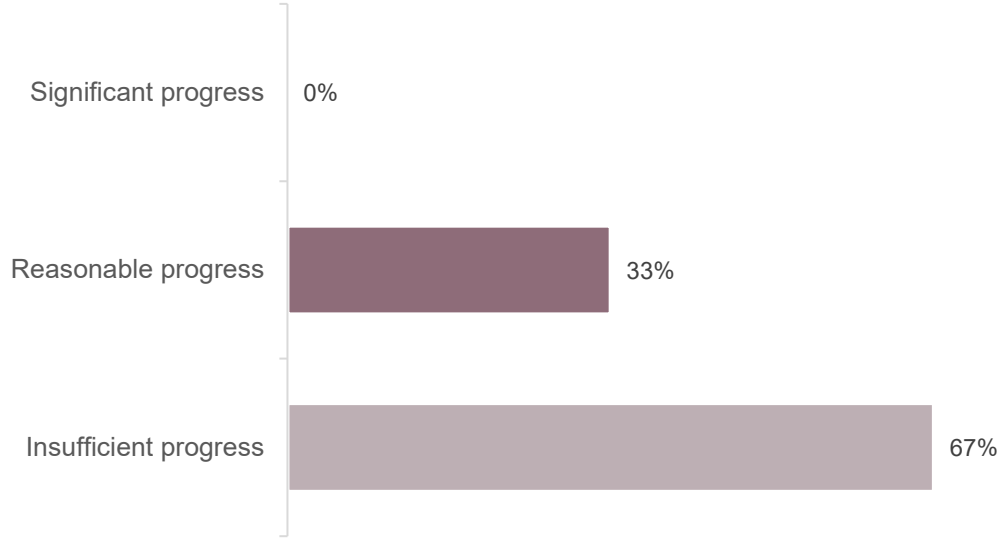
Figure 2: Progress on HMI Prisons concerns from December 2022 inspection (n=5)

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



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

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



Notable positive practice

2.4 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice. Inspectors did not find any examples of notable positive practice during this independent review of progress.

Section 3 Progress against our concerns and Ofsted themes

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

Early days in custody

Concern: Early days in custody arrangements were not good enough. First night risk assessments were not always thorough or complete, and some cells on the early days centre not clean or fully equipped.

3.1 Since our last inspection, there had been around a 40% increase in new arrivals at the prison each month, with a high number redirected to Hewell from outside the prison's normal catchment area. Despite the efforts of leaders to streamline reception and induction processes, the management of risk for this vulnerable cohort remained too weak.

3.2 As at our last inspection, we observed some reception staff and peer mentors who were welcoming and put prisoners at ease, but the initial safety interviews for new arrivals remained cursory and lacked sufficient depth when exploring potential vulnerabilities. We also found a few instances where new arrivals had received no interview at all.

3.3 An assurance process had been introduced to improve oversight of a prisoner's early days, but, crucially, it overlooked these initial safety interviews, as well as some other important entitlements, such as a shower and phone call on arrival. There was no oversight for new arrivals held on the vulnerable prisoner wing (a unit which held mostly prisoners convicted of sexual offences).

3.4 It was reassuring that health care providers had introduced a 'twilight shift' for reception nurses so that they could see all new arrivals, even late into the evening. Along with a pilot mental health screening programme for new arrivals (see paragraph 3.17), the increase in health care support was an important safeguard.

3.5 Cells in which prisoners spent their first night at Hewell were now clean and well equipped with basic provisions. However, after their first night, prisoners moved to another cell on the early days unit. We found some of these cells to be in a poor state and containing graffiti. Leaders told us they were part-way through a programme to improve all cells on the unit.

First night cell

Early days centre toilet

3.6 Prisoners in their early days still spent far too long locked up and with little to do. Some continued to wait far too long to have numbers added to their telephone accounts so they could phone their families.

3.7 We considered that the prison had made insufficient progress in response to this concern.

Suicide and self-harm prevention

Concern: Too little was being done to reduce self-harm levels across the prison. There was no strategy or action plan, limited data analysis and investigation of serious self-harm incidents, and poor oversight of implementation of Prisons and Probation Ombudsman [PPO] recommendations.

3.8 The recorded rate of self-harm had not changed since the inspection and was now on an upward trend. There had also been two self-inflicted deaths and a high number of incidents of serious self-harm. There was still no specific strategy to reduce self-harm at the prison, although an action log was now in place.

3.9 Leaders now routinely analysed a wider range of data, which provided them with a useful insight into the drivers of self-harm and emerging issues. However, data was mostly considered on a monthly basis, and was not used to look at trends over time or to underpin an action plan. We found some examples of data prompting lines of enquiry or informing change, such as the holding of a focus group with prisoners to understand why mental health was a common factor in self-harm. The key worker model (see Glossary) had also been reconfigured to meet the needs of more vulnerable cohorts in response to findings from the analysis of the data.

3.10 Despite good multidisciplinary work with individuals, the quality of assessment, care in custody and teamwork (ACCT) case management documents remained too variable. Leaders now assessed individual incidents of self-harm to deem their seriousness and investigated all those they categorised as serious. However, there was scope for more learning, both in the quality of investigation and by investigating more incidents that had not reached the threshold of seriousness. Lessons learned also needed to be cascaded more effectively to all prison staff.

3.11 Recommendations arising from the investigations of previous deaths in custody by the Prisons and Probation Ombudsman (PPO) were now reviewed at a designated six-monthly forum, but some recurring themes indicated that actions were not yet sufficiently embedded. Plans for a multi-agency suicide prevention partnership were encouraging. Leaders planned to bring together key stakeholders within the prison and wider community to work proactively and ensure a continued focus on suicide prevention.

3.12 We considered that the prison had made insufficient progress in response to our concern.

Health, well-being and social care

Concern: Waiting times to see a GP or for a mental health assessment were too long.

3.13 Since our last inspection, waiting times to see the GP had reduced considerably from 11 weeks to an average of 11 days for a routine appointment. However, the length of wait varied between two and 17 days, depending on the prisoner's house block.

3.14 A local operating procedure introduced during the last inspection had been embedded into practice. In addition, managers had recently introduced a dedicated nurse to clinically triage all applications; this worked well, and applications were reviewed daily. This approach enabled the service to respond appropriately to patients' needs, including same-day review by a nurse or allocation to an alternative health care practitioner; such as a GP, advanced nurse practitioner or non-medical prescriber.

3.15 Oversight by managers had improved and the monitoring in place enabled the early identification of any emerging issues or increases in waiting times. Information was discussed in quality assurance meetings and shared with the prison.

3.16 Waiting times for a mental health assessment had also improved overall, although some patients were still waiting too long. Data showed some patients were still waiting longer than 48 hours for an urgent assessment during June, July and August 2023, and during September and October 2023, 33 patients were not assessed within the expected timescale.

3.17 The early days in custody pilot had restarted. Under this scheme, mental health clinicians based on the induction unit saw all new arrivals for an initial triage and, if required, a full mental health assessment, which was positive (see paragraph 3.4).

3.18 Data supplied by the mental health provider, Midlands Partnership Foundation Trust, was inconsistent with that held by the health care provider and submitted to NHS England commissioners. This required prompt resolution.

3.19 CQC reviewed its Regulation 17 requirement notice issued at the last inspection and found that the regulation was now being met. As well as the reduction in waiting times to see a GP and for some mental health assessments, the CQC found that oversight of medicines management had improved.

3.20 We considered that the prison had made reasonable progress in response to this concern.

Time out of cell

Concern: Prisoners spent too much time locked in their cells with half the population let out for around two hours a day. There were not enough activity spaces available to meet the needs of the population and prisoners were not always allocated to the relevant purposeful activity.

3.21 Our roll checks found almost a third of prisoners locked up during the working day compared to about a half at the inspection, but approximately 43% of the population still spent only two hours a day out of their cell. On Fridays, prisoners not in activity were only unlocked for one hour of domestic activity and association. The weekend regime was also poor; prisoners told us that sometimes they were only out of their cell for an hour on a Saturday or Sunday.

3.22 There were still insufficient activity spaces for the population, and only 41% of prisoners had been allocated to education or work. Almost a quarter of the population were classified as 'unemployed', and approximately 200 more prisoners had finished their two-week induction and were still not allocated to a purposeful activity.

3.23 Most activities places, however, were full-time and gave prisoners up to eight and a half hours a day out of their cell, which was positive. For those allocated to activities, attendance had also improved. This was partly due to recent work to identify absences and hold prisoners to account, as well as better use of the incentives. There was some evidence that the allocations process was giving more consideration to prisoners' skills, experience and preferences, and a new activity board was also focusing on prisoners who refused to engage. While this recent work was positive, it was not yet fully embedded.

3.24 Some evening activities for a small number of prisoners had been introduced, but there remained too little to do on the wings, especially on weekdays. There was still only opportunity for 30 minutes of outdoor exercise, which was too short. However, attendance at the library had almost doubled over the year, which was encouraging.

Exercise yard (top) and window art in the walkways

3.25 Progress on improving the regime for prisoners not engaged in activities had been far too slow; for the majority, the regime was unchanged from the previous inspection. A pilot was under way on one of the house blocks to increase time out of cell to a minimum of three hours, which was encouraging, but this had been running for less than a month and had not yet been rolled out across the prison.

3.26 We considered that the prison had made insufficient progress with this concern.

Education, skills and work

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

Theme 1: What progress have leaders and managers made in ensuring that prisoners with learning difficulties and disabilities consistently receive the support needed to learn and work effectively?

3.27 Leaders and managers had introduced more comprehensive and accurate arrangements to identify prisoners with learning difficulties and/or disabilities (LDD). The process was effective and indicated a very high level of LDD need in the prison population.

3.28 Leaders had improved inter-departmental working significantly. The support for prisoners was better coordinated and targeted to respond to their specific needs. For example, the neurodiversity support manager worked well with the health care team to signpost prisoners to receive relevant assistance. As a result, prisoners with LDD needs were rapidly referred for additional help.

3.29 Support for prisoners studying accredited courses was readily available and deployed well by managers to help them progress rapidly. The prisoners who received LDD support achieved their qualification. Additional learning support for prisoners in workshops and work areas had been strengthened and was well-established and effective.

3.30 Leaders had yet to implement comprehensive arrangements to ensure that prisoners assessed with specific condition, such as autism spectrum or attention deficit hyperactivity disorder, received specialist support.

3.31 In workshops and work areas, leaders and managers had been slow to introduce sufficient resources, such as coloured overlays, fidget bands and distraction packs. Paper-based information was not always available in a format that was accessible to all prisoners. For example, some induction information was difficult to read because it was poorly reproduced or contained inappropriate text colours.

3.32 Staff working for Novus, the education and vocational training provider, had received an appropriate range of training and development. However, instructors and accommodation unit staff had not participated in similarly comprehensive development opportunities.

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

Theme 2: What progress have leaders and managers made in ensuring there are sufficient accredited qualifications in work areas, and the employability skills prisoners gain are recognised?

3.34 Leaders and managers had not introduced any additional accredited qualifications in work areas since the previous inspection, and so the weakness identified then in the availability of accredited training opportunities had not been resolved. This significantly limited the contribution that prisoners' participation in work activities made to their successful resettlement on release.

3.35 Leaders had been too slow to ensure the effective introduction of the 'progress in workshops' documentation process. Very few prisoners were completing the documents to recognise and record their skills and knowledge development. Consequently, many prisoners were unaware of how effectively they were developing their personal and employment-related competences. For example, instructors were generally good at developing prisoners' work ethic, but this achievement was not routinely recorded.

3.36 The newly appointed leader in charge of education, skills and work had implemented a comprehensive review of the workshop and work curriculum. This included the rigorous monitoring of targets to accelerate improvement in the availability of accredited qualifications and recognition of prisoners' skill development. Appropriate staff training, including increasing the number of instructors qualified to assess, had been given suitable priority. However, it was too early to evaluate the impact of this and other improvement initiatives.

3.37 Leaders and managers had identified that they had insufficient oversight of the quality of the prisoner experience when attending workshops and work. A suitable strategy to rectify this weakness had been formulated. However, progress in implementing these quality assurance procedures was at an early stage.

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

Theme 3: What progress have leaders and managers made in ensuring that prisoners receive sufficient high-quality careers education, information, advice and guidance (CEIAG) to enable them to make informed decisions about the careers available to them?

3.39 Leaders and managers acknowledged that a high proportion of prisoners still failed to participate in education, skills and work induction sessions. As a result, they did not receive CEIAG when it was most needed. The proportion of prisoners not receiving CEIAG had reduced

since the previous inspection but was still too high. For these prisoners, decisions about which activities they participated in were often inadequately matched to their career aspirations.

3.40 Career pathways were poorly defined and did not support effective CEIAG. They failed to provide prisoners with a suitably detailed overview of the skills and knowledge needed to achieve their personal goals. The promotion of career pathways throughout the prison was weak.

3.41 Since the previous inspection, leaders had increased the number of CEIAG advisers to improve the service available to prisoners. Most prisoners who attended induction sessions participated in a useful CEIAG session. Advisers used their skills and knowledge effectively to ensure that prisoners received an appropriate standard of CEIAG. Advisers did not have access to sentence plans and never used them in their discussions with the few prisoners who had them.

3.42 Following the previous inspection, leaders and managers had established an 'employment hub'. This provided prisoners with relevant pre-release help, such as CEIAG, CV preparation and interview practice. Available employment opportunities on release for which prisoners could apply were on display. In addition, managers had established regular events that allowed prisoners to raise their awareness of job opportunities and expectations through discussion with a small group of visiting employers. Leaders had not provided prisoners with access to the 'virtual campus' to allow them to use the internet to conduct independent job searches or investigate available training and education courses. The prison had credible plans to install the computers to resolve this shortfall.

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

Public protection

Concern: There were shortfalls in public protection arrangements. The interdepartmental risk management meeting did not routinely consider all prisoners who presented the greatest risk before their release. There were gaps in arrangements for those subject to public protection monitoring.

3.44 Since our last inspection, leaders had made some changes to the oversight of the release of prisoners at high risk of harm, and the management of public protection was improving. There had been frequent management changes within the offender management unit (OMU), which had hindered progress, and many of the changes were recent, which meant it was difficult to fully evaluate the outcome or their impact.

3.45 The interdepartmental risk management team meeting now took place at least monthly, but attendance from prison representatives remained mixed. Positively, community offender managers now attended the

meeting, which gave them the opportunity to input meaningful contributions and make release planning more robust.

3.46 At the last inspection, prison leaders told us that they were going to introduce an additional 'light' meeting to capture information on prisoners on short sentences and new arrivals. The first meeting did not take place until October 2023, but it was a promising development. Overall, OMU leaders had better oversight of which prisoners were being released, and were able to make pragmatic and defensible decisions about who should be discussed at each meeting.

3.47 Following a change in national policy, the number of prisoners subject to phone and mail monitoring had reduced from 101 at our last inspection to 19 at this visit. This meant there was no longer a backlog in listening to calls, and reviews were completed on time. However, we saw some evidence that the prison's threshold for monitoring had been raised too high, and that there were gaps in the oversight of decisions.

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

Section 4 Summary of judgements

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

HMI Prisons concerns

Early days in custody arrangements were not good enough. First night risk assessments were not always thorough or complete, and some cells on the early days centre were not clean or fully equipped.
Insufficient progress

Too little was being done to reduce self-harm levels across the prison. There was no strategy or action plan, limited data analysis and investigation of serious self-harm incidents, and poor oversight of the implementation of Prisons and Probation Ombudsman recommendations.
Insufficient progress

Waiting times to see a GP or for a mental health assessment were too long.
Reasonable progress

Prisoners spent too much time locked in their cells with half the population let out for around two hours a day. There were not enough activity spaces available to meet the needs of the population and prisoners were not always allocated to the relevant purposeful activity.
Insufficient progress

There were shortfalls in public protection arrangements. The interdepartmental risk management meeting did not routinely consider all prisoners who presented the greatest risk before their release. There were gaps in arrangements for those subject to public protection monitoring.
Reasonable progress

Ofsted themes

What progress have leaders and managers made in ensuring that prisoners with learning difficulties and disabilities consistently receive the support needed to learn and work effectively?
Reasonable progress

What progress have leaders and managers made in ensuring there are sufficient accredited qualifications in work areas, and the employability skills prisoners gain are recognised?
I**nsufficient progress**

What progress have leaders and managers made in ensuring that prisoners receive sufficient high-quality careers education, information, advice and guidance (CEIAG) to enable them to make informed decisions about the careers available to them?

Insufficient progress

Appendix I About this report

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

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

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

The aims of IRPs are to:

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

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

IRP methodology

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

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

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

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

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

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

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

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

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

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

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

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

Inspection team

This independent review of progress was carried out by:

Sara Pennington	Team leader
Sumayyah Hassam	Inspector
Alice Oddy	Inspector
Rick Wright	Inspector
Shaun Thomson	Health and social care inspector
Janie Buchanan	Care Quality Commission inspector
Joanne White	Care Quality Commission inspector
Nigel Bragg	Ofsted inspector
Tony Gallagher	Ofsted inspector

Appendix II Glossary

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

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

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

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

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

Time out of cell
Time out of cell, in addition to formal 'purposeful activity', includes any time prisoners are out of their cells to associate or use communal facilities to take showers or make telephone calls.

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