Report on an independent review of progress at

HMP Swaleside

by HM Chief Inspector of Prisons

18–20 July 2022

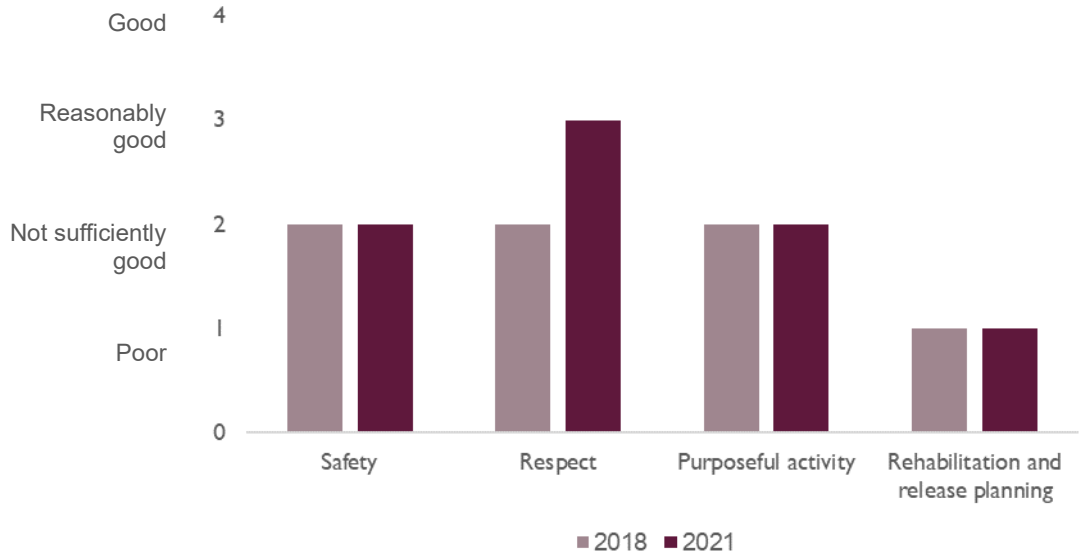
Contents

Section 1 Chief Inspector's summary

1.1 HMP Swaleside is a category B training prison for adult men and is part of HM Prison and Probation Service's long term and high security estate. Built mostly in the late 1980s and located on the Isle of Sheppey in Kent, it can hold more than 1,000 prisoners aged 21 and over.

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

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



1.3 At our last full inspection in October 2021, we reported that, notwithstanding the very real challenges of the COVID-19 pandemic, outcomes for prisoners remained disappointing. In safety and purposeful activity, outcomes were still not sufficiently good, and they had deteriorated in respect to not sufficiently good. In rehabilitation and release planning they remained poor. Progress across many areas was hindered by significant shortages of staff, including those in specialist roles. Much of this was beyond leaders' direct influence, but these weaknesses posed a fundamental strategic risk and should have been key priorities, which needed intervention and support from HM Prison and Probation Service (HMPPS).

1.4 At this visit we found that the shortage of officers was worse than at our last inspection leading to very limited time out of cell (see Glossary of terms) for most prisoners. Leaders (see Glossary of terms) were unable to address the issue locally as the Ministry of Justice (MOJ) controlled officer recruitment, and, despite efforts to improve retention at Swaleside, more staff had left than joined over the previous nine months. Steps taken by HMPPS to provide detached duty staff and additional overtime payment were not long-term solutions.

1.5 Leaders did not harness the prison's strengths effectively to accelerate or sustain progress. Data were not used sufficiently to inform decision-

making and there was a lack of robust planning to make sure priorities were identified and improvements delivered.

1.6 Good progress had been made in addressing the concerns we had about support in prisoners' early days at the prison and it was evident that a significant amount of time and effort had been put into creating a well-thought-out service.

1.7 Little progress had been made in reducing the overall levels of violence and the data were extremely worrying. Some staff and prisoners we spoke to said they felt unsafe, and we saw some overtly aggressive behaviour towards staff on some wings. The shortage of officers was making it difficult for those who remained to manage prisoners adequately or enforce rules.

1.8 The rate of self-harm had declined considerably, but there had been five self-inflicted deaths; four since the last inspection and a fifth two months after this review visit.

1.9 The use of data and oversight of equality and diversity had improved, but too many weak strategies and action plans undermined any progress in equality and diversity. For example, there was no comprehensive analysis of prisoners' equality and diversity needs and equality staff were often redeployed on the wings, which meant that consultation with prisoners remained limited. The new health care provider had responded reasonably well to our concerns.

1.10 Ofsted judged that there had been insufficient progress in the four themes they reviewed. Leaders had been slow to reopen activities and too many prisoners were unemployed. Severe staff shortages affected almost every aspect of the delivery of a purposeful regime and had led to little progress being made in rehabilitation and release planning.

1.11 There had been improvements in the re-categorisation process and the number of category C men held at the prison had declined. Slow progress had been made in the delivery of offending behaviour work and we were still not confident that an appropriate range of interventions was available.

1.12 The overall message from this independent review of progress visit was that no meaningful progress had been made in addressing staff shortfalls, which meant staffing was now at crisis point and was having an impact of on all aspects of the regime. More needed to be done to retain staff and the MOJ needed to take immediate action to make sure Swaleside had more new officers if progress was to be made. The scale of the task is huge, but I strongly urge leaders at all levels to find solutions, as without continued vigour, outcomes for the prison and the public will deteriorate even further.

Charlie Taylor
HM Chief Inspector of Prisons
July 2022

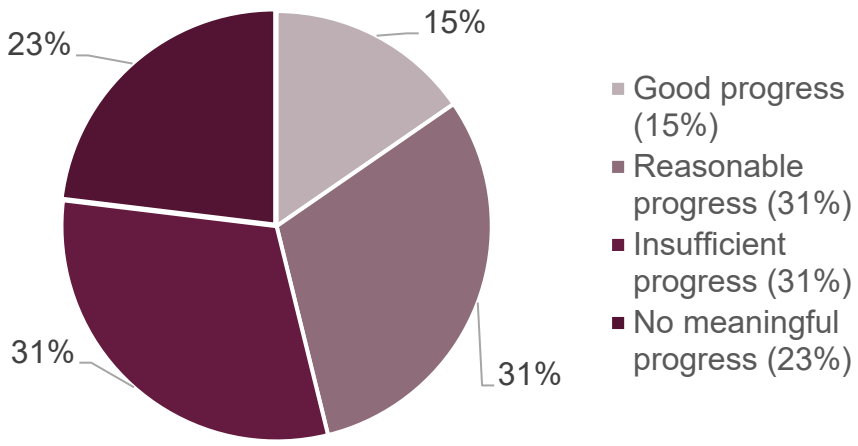
Section 2 Key findings

2.1 At this independent review of progress (IRP) visit, we followed up 13 recommendations from our most recent inspection in October 2021 and Ofsted followed up four themes based on their latest inspection or progress monitoring visit to the prison, whichever was most recent.

2.2 HMI Prisons judged that there was good progress in two recommendations, reasonable progress in four recommendations, insufficient progress in four recommendations and no meaningful progress in three recommendations.

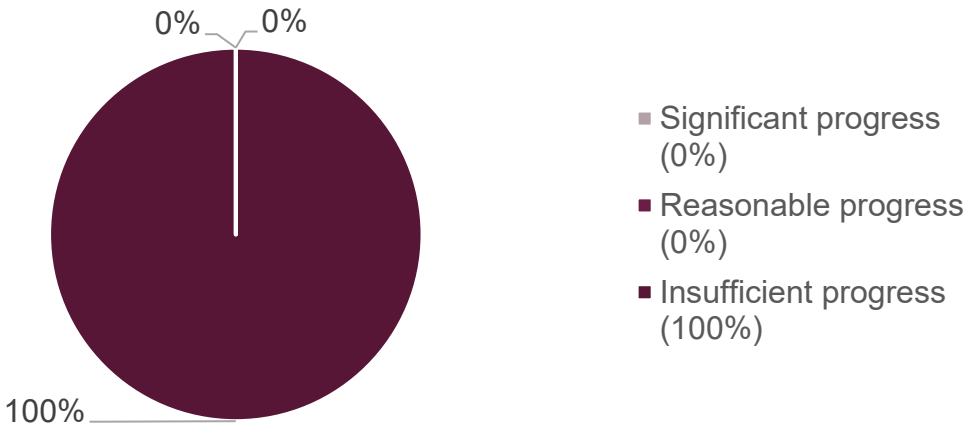
Figure 2: Progress on HMI Prisons recommendations from October 2021 inspection (n=13)

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



2.3 Ofsted judged that there was insufficient progress in all four themes.

Figure 3: Progress on Ofsted themes from October 2021 inspection/progress monitoring visit (n=4).



Notable positive practice

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

2.5 Inspectors found one example of notable positive practice during this IRP.

2.6 The ambassador post continued to support new officers, and a development manager assisted staff in their work. They both attended universities and job fairs and other events in Kent to attract new recruits. (See paragraph 3.3.)

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

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

Leadership

Concern: A staffing shortfall was limiting the ability to reinstate purposeful activity and support prisoners' progression. Only around three-quarters of prison officers were available and there was a severe shortage of workshop instructors, programme delivery facilitators, health care staff, probation officers, operational support grades and caterers. Leaders had been proactive in trying to address the high level of attrition and inexperience among prison officers by, for example, recruiting a 'Swaleside ambassador' to support new recruits, but wider systemic issues relating to recruitment and retention needed to be addressed by HMPPS.

Recommendation: There should be support and clear measures implemented as a matter of urgency to recruit and retain sufficient operational and specialist staff to reinstate purposeful activity and support prisoners' progression. (1.48.)

3.1 The staffing problems we reported at our inspection in October 2021 had become worse. Some progress had been made in health care and programme teams staffing, but significant shortages persisted in workshop instructors, probation officers and caterers. As for officers and operational support grade (OSG) staff, the situation was now in crisis, and we were told that the forecast for the coming months was extremely alarming. At our last inspection, only three-quarters of officers were available, and this had now declined to two thirds. Only just over half of the required number of OSG staff were currently in post.

3.2 Leaders (see Glossary of terms) had prioritised recruitment and retention and had dedicated resources to both areas but, despite some positive action, more staff had left since October 2021 than had started. Recruitment was under the control of the Ministry of Justice, but it had not taken any effective action to make sure Swaleside received an adequate number of new officers to alleviate the crisis. HM Prison and Probation Service (HMPPS) had provided temporary help, such as 14 detached duty officers and overtime payments, but neither provided anything but very short-term temporary relief and did not solve the problem. Officers in specialist functions were often redeployed to provide much needed cover on the wings, which limited the amount of time they had to take forward their own work. Many of the officers we spoke to were exhausted and under considerable pressure, and some

said they were on the brink of resigning. The crisis was apparent on the wings, and we were concerned about volatility and staff's lack of control over prisoners.

3.3 The ambassador post continued to support new officers, and a development manager assisted staff in their work, particularly helping them to achieve promotion. They also attended local universities and job fairs as well as other events in Kent to attract new recruits. (See paragraph 2.6.)

3.4 We considered that the prison had made no meaningful progress against this recommendation.

Concern: Although leaders spoke of their aims for the future, strategic thinking supported by a meaningful analysis of data was very limited. In too many areas leaders lacked clarity or specific measurable plans for how improvement might be achieved. Governance and oversight were, too often, similarly lacking; undermining the prison's ability to sustain improvement. This applied to many important areas of operational delivery, for example, violence reduction, use of force, the promotion of equality and rehabilitation and release planning.

Recommendation: Prison leaders should develop longer-term plans for improving outcomes for prisoners against their identified priorities. The governor and his team should introduce robust data and evidence-based governance arrangements to give them assurance that work is taking place on time, that progress is monitored, and that there are clear lines of accountability. In addition, there should be a robust process for reviewing plans. (1.49.)

3.5 Too many strategies remained limited in scope and some leaders did not fully appreciate the importance of evidence-based and outcome-focused plans to take forward priorities. Some strategies were overly descriptive or simply offered an overview of processes rather than a clear vision for what needed to be done and why. Data on the population was not always used well enough to make sure strategies were based on evidence or were specific to Swaleside. Action plans lacked measures of success to provide assurance that the work was effective and too many had not been implemented and were out of date.

3.6 Some departments, for example safer custody, had a better understanding of what the data revealed, but leaders did not use data well enough to demonstrate achievements or address gaps. Oversight across all departments had improved through more comprehensive performance and assurance reports and monthly meetings that reviewed progress and provided accountability.

3.7 Strategic planning and delivery were hindered by the need to react to day-to-day officer shortages. Senior leadership team meetings had not been held regularly over the previous few months and the governor was aware of the need to refocus them to make them effective. The

senior leadership team had been working with a consultant to develop a business plan and undertaking HMPPS training to improve its approach to developing strategies and action plans.

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

Early days in custody

Concern: New arrivals, particularly those isolating because of COVID-19, spent long periods locked up with little to do during their induction period. First night cells were shabby and did not give a positive first impression of the prison. Initial assessments involving the discussion of personal information were not conducted in private. Additional first night checks did not always take place. In our survey, only around a third of respondents said that induction covered everything they needed to know about the prison. Prisoners described issues with telephone credit and numbers, and property that they could not resolve while spending so much time locked up. Some of these weaknesses were a consequence of COVID-19 arrangements intended to keep staff and prisoners safe, but they needed to be addressed.

Recommendation: All new arrivals should be able to access good-quality, proactive and consistent support and advice from staff and peer workers during their induction period, following a thorough, private assessment of their needs (1.50.)

3.9 Early days provision had improved considerably, and a significant amount of time and effort had been put in to creating a well-thought-out service. However, the day-to-day regime remained relatively poor, and prisoners only had 3.5 hours unlocked due to a severe lack of officers.

3.10 Comprehensive safety interviews were undertaken at the earliest opportunity. The reception area had been refurbished to make initial contact less formal. A comfortable private area for interviews was available, and staff and peer workers provided preliminary information and helped settle new arrivals in, explaining what was going to happen over the coming days.

3.11 Cells in the first night centre were clean and well-prepared for new arrivals. Initial night-time safety checks, informed by a risk assessment of the prisoner, were now routinely carried out.

Prepared first night cell

3.12 A new induction programme was in place. It started on the following working day after arrival and normally took 10 days to complete. An impressive new induction and resettlement hub, where staff from all agencies could meet prisoners, had opened on the first day of our visit.

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

Managing behaviour

Concern: Levels of violence were high and were on an upward trajectory. The number of assaults against staff was higher than at similar prisons and many were serious. In our survey, more than a third of prisoners said that they currently felt unsafe. There were limited incentives to encourage positive behaviour.

Recommendation: **Leaders should introduce effective measures to reduce violence and improve the safety of prisoners and staff.** (1.51.)

3.14 Little progress had been made in reducing levels of violence. The shortage of officers was making it difficult for those who remained to manage prisoners adequately or enforce rules on the wings. Staff and prisoners we spoke to said they felt unsafe, and we witnessed some overtly aggressive behaviour towards staff on some wings. This was often due to frustrations about restricted regimes running late and a lack of staff enabling prisoners to get things done. Rates of violence, including serious assaults, were higher than the average for the type of prison with prisoner-on-prisoner assaults having risen by almost 50%.

The number of assaults on staff had decreased slightly in recent months.

3.15 Analysis of safety data had improved considerably and had been used to inform the new safety strategy. Action identified included establishing new initiatives, such as a young prisoner project and work on conflict resolution. While these were promising, they had yet to have a significant impact on the level of violence. A revised incentives scheme had been introduced but had not yet led to any discernible improvements in outcomes. Action planning in this area was weak and it was hard to see what had been implemented.

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

Safeguarding

Concern: The level of self-harm had almost doubled since the previous inspection and had been rising in the 12 months prior to this inspection. Data were not used well enough to inform work to reduce self-harm. There were gaps in the quality of support delivered by staff through assessment, care in custody and teamwork (ACCT) case management and too few prisoners in crisis felt supported by staff.

Recommendation: The prison should develop and implement an effective plan supported by specific measures to reduce self-harm and deliver consistently good care for at-risk prisoners. (1.52.)

3.17 There had been five self-inflicted deaths; four in the eight months since our last full inspection and a fifth two months after this review visit. The prison was waiting for the outcome from Prisons and Probation Ombudsman investigations into the deaths. However, a comprehensive review was underway regionally and some areas for improvement had been addressed, such as changes to the prescribing of medication.

3.18 There had been a significant reduction in the number of self-harm incidents recorded since our last inspection. The total had declined by 46% – there had been 571 incidents in the six months before the last inspection compared to 304 incidents in the previous six months, and the rate was now lower than in similar prisons.

3.19 Monthly safety meetings were better attended, and data analysis had improved. Leaders had made progress in identifying and addressing the risks and triggers associated with self-harm, such as the increase in the use of ligatures since the prison had removed razor blades. Further analysis had been completed and leaders had raised awareness of this and other issues through weekly full staff safety briefings. However, the safety action plan was not kept up to date or used to record or drive forward improvement.

3.20 The standard of ACCT documentation for prisoners at risk of suicide or self-harm that we reviewed remained poor – reviews were not

multidisciplinary, action plans were inadequate and there were gaps in recorded observations. However, leaders had recently taken steps to improve the documentation through additional training and ongoing support from the regional safety team. Many of the prisoners we spoke to said staff did not have time to have meaningful conversations with them about their well-being, which meant they still did not always feel well supported.

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

Equality, diversity and faith

Concern: The promotion of equality lacked a plan and there was little clarity about how outcomes and well-being among minority groups resident in Swaleside might be improved. There was a poor understanding of needs and priorities, data analysis was weak and consultation with prisoners with protected characteristics (see Glossary of terms) very limited.

Recommendation: **The prison should develop and implement a comprehensive equality strategy, including clear milestones for delivery, that is informed by the views and experiences of prisoners.** (1.53.)

3.22 The equality strategy remained too limited. It consisted of a description of protected characteristics and was not specific to the population held at the prison. It was not underpinned by a comprehensive needs analysis and lacked clear objectives on how prisoners' needs would be met.

3.23 The use of data and oversight of equality and diversity had improved but the action plan was too limited to be of use in driving improvements, with the only action outlined having been drawn from our last inspection. There was no link to the monthly equality meeting or the strategic long-term vision leaders spoke about during our visit.

3.24 The equality meeting had been held more regularly than in the months leading up to our last inspection, but attendance was often poor. Data had identified a reduction in the number of discrimination incident reporting forms being submitted since the last inspection and other equality issues were considered, but it was not clear how action that was to be implemented would improve outcomes for prisoners.

3.25 Due to the severe shortage of officers, equality staff were often redeployed to work on the wings so consultation with many prisoners remained limited. There had been two consultation meetings with black and minority ethnic prisoners, one with Gypsy, Romany and Traveller prisoners and some one-to-one discussions with LGBT prisoners, but it was still not clear what was discussed or whether there would be any follow-up action from the meetings.

3.26 We considered that the prison had made no meaningful progress against this recommendation.

Health, well-being and social care

Concern: The primary care service often operated below the set staffing level. Consequently, to cover essential services, the interim head of health care often had to carry out clinical duties and could not always focus on the strategic aspects of their role. Managerial supervision was lacking, and complaints were not always responded to on time. There were no nurse-led long-term condition clinics and few such prisoners had a care plan.

Recommendation: The prison should work with the local delivery board, in conjunction with NHS England, to make sure that there are sufficient health care staff to meet the health needs of the population. (1.54.)

3.27 Oxleas NHS Foundation Trust became the provider of health services in April 2022. The service was well led, having implemented an effective mobilisation plan before April. There was a suitably paced and systematic approach to service development.

3.28 While there were still some staff shortages, Oxleas took steps to make sure recruitment was sufficient with agency staff used to fill gaps. The staff vacancy rate had fallen from 80% in March 2022 to 44% in July 2022, which was impressive. There were enough staff to offer a clinical service without cancellations.

3.29 Staff from the mental health team and health and social care charity Change Grow Live covered some elements of medicines administration, which took them away from their main duties, but most staff we spoke to said the situation was improving.

3.30 During our visit, a whole day of health clinics had been cancelled owing to a lack of prison officers. Such cancellations took place far too often. Hospital appointments were also cancelled frequently because of the lack of officers to escort patients.

3.31 The complaint response time was now 20 working days and responses were suitable.

3.32 Nurse-led clinics for patients with long-term conditions and for immunisations and vaccinations had begun. Care plans in the cases we sampled were good.

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

Medicines optimisation and pharmacy services

Concern: Several aspects of medicines management were poor. There was no pharmacy input into any clinics because of staff shortages. Some risk assessments for in-possession medicines had not been updated when circumstances changed, or on a regular basis. The prescribing of medicines liable to abuse was high and some were given in-possession, against national guidelines, which increased the risk of diversion. The inconsistent management of the medicine queues also posed a risk for diversion. The method of transporting medicines to the wings was unsafe, and secondary dispensing and a lack of a second checker for controlled drugs were not in line with national professional standards. The lack of a prescription chart and the administration of medicines at the cell door or through a gate which was in constant use were inappropriate and unsafe.

Recommendation: The prison should work with the local delivery board, in conjunction with NHS England, to make sure that prisoners receive their medication safely and in full accordance with correct clinical standards. (1.55.)

3.34 A full review of medicines management was undertaken once the new health care contract had been implemented to address concerns identified at the last inspection. The prison now had effective strategic and local oversight, governance systems and processes to improve the safe management and storage of medicines.

3.35 Prison and health care leaders worked in partnership to make sure patients were safe and outcomes good. For example, there were joint procedures for undertaking medicines in-possession spot checks and plans to install additional medication hatches on the wings.

3.36 Action to address identified risks had been prioritised and implementation was in progress. For example, all eligible prisoners now had a medicines in-possession risk assessment in place. (In March 2022, 200 patients were without risk assessments.) Compliance with medicines management training, competency checking, and newly devised controlled drug administration training was good. The management of long-term conditions had improved.

3.37 Officer supervision at medication hatches remained variable and the lack of staff increased the risk of diversion. A proactive response had been taken to better manage tradeable medicines, such as co-codamol, and attendance at regional medicines management meetings was good.

3.38 The restricted prison regime affected the timeliness of medicines administration. There were occasions when patients did not receive their lunchtime medicines, decreasing their effectiveness.

3.39 A second person to check for accuracy was not always available during the administration of controlled drugs, although secondary dispensing

(taking medicines out of their original container and placing them in a different one, with a handwritten label) no longer took place.

3.40 There were signs of improvement in the pharmacy team following the recruitment of a senior part-time GP pharmacist, who was ready to deliver medicine use reviews and medicines optimisation clinics once another pharmacist vacancy was filled. However, vacancies for pharmacy technicians persisted, which meant that nurses covered pharmacy staff duties, affecting nurses' availability for other tasks.

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

Time out of cell

Concern: Although at stage 2 of the recovery plan (see Glossary of terms), time unlocked for many prisoners remained limited, at around three and a half hours a day on weekdays. Employed prisoners could be unlocked for around five hours a day, but few prisoners were engaged actively in any purposeful activity for any length of time. Leaders had not maximised the opportunities to increase places for activities, and during an afternoon session of the inspection, we found just one prisoner engaged in any work in the vocational workshops. While in-cell worksheets had proved a success for many, they took far too long to be provided and subsequently assessed.

Recommendation: Leaders should prioritise urgently increasing time unlocked and the provision of regular education, skills and work activities. (1.56.)

3.42 The acute shortage of officers meant that leaders were unable to deliver a full and meaningful regime, for example, there was a lack of staff to escort prisoners to work or education placements. As at the last inspection, time out of cell (see Glossary of terms) for most prisoners remained far too low at between just 2.5 and 3.5 hours a day. Routine delays in the regime often reduced this time further, and we saw an afternoon activity period starting over an hour late on some wings.

3.43 Leaders had been unable to recruit sufficient instructors, so some workshops remained closed. Over half the population were unemployed and attendance at open workshops was very poor. For example, one morning during our visit, just 27 out of 76 prisoners had attended. One clearly frustrated workshop instructor told us of days when no prisoners were brought over from the wings. There was a lack of commitment from wing staff to encourage prisoners to attend activities, and electronic case notes did not demonstrate that they had been challenged formally or sanctioned if they refused to go.

3.44 The capacity of the gym had been increased to 70 men for three sessions a day, but it was often closed with gym staff redeployed to work on the wings.

3.45 We considered that the prison had made no meaningful progress in this area.

Education, skills and work

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

Theme 1: What progress had leaders and managers made to make sure that prisoners receive appropriate information, advice and guidance, enabling them to make informed choices about their education, skills and work activities? What progress had been made to make sure advice and guidance staff take into account prisoners' sentence plans, aspirations and abilities when they devised useful plans for their activities while at the prison?

3.46 Since the previous inspection, leaders had changed the information, advice and guidance (IAG) provider, but at the time of the visit there was no service because the new provider was not due to start until the end of August 2022. Leaders relied on peer mentors to provide advice and guidance to prisoners when they arrived at the prison. Although leaders had increased the number of IAG mentors, they had not provided them with training or guidance, and only one was qualified. As a result, mentors did not provide appropriate guidance to their peers.

3.47 Too few prisoners received the appropriate advice and guidance to help them make informed choices about their activities while at the prison. However, the few prisoners who accessed education received useful advice and guidance about their next steps. There remained a significant backlog in the delivery of induction and many prisoners were waiting for IAG support. This meant too many prisoners were unsure about their future plans or the steps they needed to take to achieve their long-term goals. IAG mentors struggled to get access to prisoners, and too often they were expected to hold discussions at the cell door, which did not provide a confidential environment.

3.48 Prisoners' personal learning plans produced by mentors were poor. They did not identify useful targets, and the information recorded was often vague. Mentors did not provide meaningful advice or guidance to prisoners on their options while in the prison or in preparation for release. Too few plans were reviewed.

3.49 Leaders had recently opened a new employment hub with the intention of providing collaborative support from employers and other agencies for prisoners nearing release. However, this resource was not available to vulnerable prisoners and was too new to gauge its impact.

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

Theme 2: What progress had leaders and managers made to make sure that prisoners' requests for education, skills and work activities receive a swift response and that teachers in education provide useful feedback to prisoners on their work more promptly?

3.51 Leaders had been overly cautious in reopening activities and allowing prisoner cohorts to mix. Prisoners waited too long to access education or work activities. There were long waiting lists for almost all activities. Too many prisoners remained unemployed with over half of the population not allocated to any activity, despite education classes and workshops not being filled to their capacity. Too few prisoners chose to participate in education.

3.52 Staff did not consider prisoners' long-term goals or career plans when allocating them to activities. Prisoners self-selected their activities. For education allocations, staff checked prisoners' existing qualifications to make sure they met the entry requirements of the course they had applied for.

3.53 Work opportunities for prisoners were severely limited and not equitable. The wing on which a prisoner resided dictated the workshop that they had access to. Too many prisoners did not gain new skills or knowledge from their work roles.

3.54 Education and workshops were often closed due to staff shortages restricting the delivery of the planned regime. Education, for example, had been closed more often than it had been open over the last three months. Attendance, even when education and workshops were running, was far too low.

3.55 Prisoners still waited too long to receive feedback on their in-cell learning work and it took too long for their in-cell learning packs to arrive when they requested them. Too often, packs were not delivered to prisoners or education staff as a result of being lost in transit within the prison.

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

Theme 3: What progress had leaders made to make sure that there is sufficient support to meet the needs of prisoners with the lowest levels of English and mathematics and to make sure that opportunities for prisoners to receive accreditation for their learning and skills development were sufficiently broad, particularly for those in workshops and work roles in the prison?

3.57 Substantial staff shortages had limited prisoners' access to English and mathematics education classes. Prisoners had to wait too long for places on these courses. Only a small number of prisoners benefited from in-cell packs that helped them develop their pre-entry English skills and no prisoners had access to resources or help to improve their basic mathematics skills. Leaders and managers had developed new resources to help prisoners with low-level English skills, but it was too early to judge their impact.

3.58 Leaders and managers had introduced a beneficial programme and a useful reading group since the previous inspection to help prisoners to develop their literacy skills. Leaders and managers had also introduced helpful new accredited Stepping Stones courses to help prisoners improve aspects of their English and mathematics, such as calculating volume and improving grammar. However, only a small number were able to access the new initiatives because of a limited number of places and staffing shortages.

3.59 Leaders and managers had increased the number of peer mentors and Shannon Trust mentors (prisoners who help others to learn to read) since the previous inspection. Shannon Trust mentors spoke positively about their work and training. However, they and the prisoners the worked with were frustrated because staff shortages reduced the frequency of their support sessions.

3.60 Leaders had maintained their broad range of accredited courses in education and vocational training since the previous inspection. They had enhanced the provision by adding useful new information technology and warehousing qualifications. Vulnerable prisoners could now also access accredited courses through education classes. However, prisoners did not have access to enough accredited courses. Leaders and managers had well-developed plans to introduce more qualifications in workshops and work roles, but it was not possible to measure the impact yet.

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

Theme 4: What progress had leaders and managers made to introduce a meaningful curriculum to help prisoners develop their understanding and knowledge in relation to personal development? What progress had managers and instructors made to make sure that prisoners' progress is monitored and tracked in unaccredited activities and that teachers and instructors help prisoners to further their understanding of the importance of wider topics, such as the values of tolerance and respect, equality and inclusivity?

3.62 Leaders and managers did not have an effective strategy to help prisoners with their personal development. As a result, most teachers and instructors were not sure what skills prisoners needed to develop or how to help them do so.

3.63 Although managers had introduced ways of recording and tracking the development of prisoners' skills in areas, such as confidence, listening to and working with others, most staff did not use them effectively or consistently. As a result, few prisoners were aware of the skills they were developing or which areas they needed to improve. However, instructors in waste management and industrial cleaning tracked the development of prisoners' skills effectively in areas, such as communication, teamwork and taking initiative. They helped prisoners identify weakness and worked closely with them to improve these skills.

3.64 Prisoners who attended the structured on-wing activity sessions, including philosophy and fine cell work, could explain in detail how their skills in areas, such as respect for others, understanding different viewpoints and listening had improved. Prisoners who were able to take part in the new neurodiversity programme improved their behaviour and their skills when listening to others and seeing and understanding different points of view. However, only small numbers of prisoners attended these activities as they were not available on all wings.

3.65 Peer mentors understood the importance of being tolerant, respectful and inclusive when supporting prisoners. However, very few other prisoners, recalled any knowledge of topics, such as equality, diversity and inclusivity.

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

Reducing risk, rehabilitation and progression

Concern: The strategic management of reducing reoffending remained poor and had not improved since the last inspection. In our survey, only 44% of respondents said that their experience at the prison had made them less likely to reoffend. The offender management unit (OMU) continued to be under-staffed, which affected all aspects of its work. Too many prisoners did not have an up-to-date assessment of their risk and needs, which meant that sentence plans were often out of date. The amount of meaningful in person contact that prisoners had with their prison offender manager was insufficient, and among the worst we have seen. Both of these issues hindered a prisoner's ability to feel included in their rehabilitation and progression, as well as making it difficult for prisoners to demonstrate progress against their sentence plan.

Recommendation: The prison should understand fully the needs of its prisoners across all resettlement pathways and support them to reduce their risk of harm and progress through their sentence plan. (1.57.)

3.67 There had been little improvement in the strategic management of reducing reoffending. Meetings now took place, but attendance was poor, and they did not cover all resettlement pathways. The strategy was still not informed by an up-to-date, comprehensive understanding of the needs of the population and data were not used effectively to promote coordinated action planning.

3.68 Offender management staffing remained insufficient, which continued to affect most aspects of the unit's core work. There should have been 15.5 probation offender managers (POMs) but there were only 7.5 because of recruitment difficulties. Leaders had recently begun discussions with Kent, Surrey and Sussex probation to address this deficit, but because of the lack of probation officers in the region, we were told shortages would likely continue for some time.

3.69 Leaders continued to use the help of operational staff to help with offender management work, but they were frequently redeployed to provide cover on the wings, often at very short notice. Of the 2.75 non-uniformed POMs who were meant to be in the unit, only 1.75 were in post and some were still working remotely for part of the time, which continued to affect their ability to see prisoners in person.

3.70 Despite this, recorded levels of contact between offender managers and prisoners had slightly improved since our inspection, but they were mostly in response to events and were still too infrequent to promote sentence progression effectively.

3.71 Staff were working hard to address the backlog in offender assessment system reports and the number was gradually being reduced, but, at the time of this visit, it remained high and too many prisoners continued

to arrive at Swaleside without one, placing an immediate burden on the already overstretched OMU.

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

Categorisation and transfers

Concern: We were not confident that re-categorisation decisions were sound, proportionate, fair or consistent. Prisoners expressed concern about re-categorisation decisions and were not involved routinely in the process. Once re-categorised, prisoners were not moved promptly to lower security establishments because of space shortages and the prison's poor management of transfer holds.

Recommendation A: Prisoners should be moved promptly to the appropriate lowest security prison. (1.58.)

Recommendation B: Re-categorisation decisions should be based on the professional judgement of risk factors. (1.58.)

Recommendation A

3.73 The application of transfer holds for some prisoners was now much more defensible and measures had been put in place to regularly review them to make sure decisions remained valid and appropriate.

3.74 There had been a reduction in the number of category C prisoners held at the prison (from 25% to 16%) since our inspection. However, some still waited too long to move on, but this was for reasons beyond the prison's control such as lack of prison places nationally or the availability of transport.

3.75 We considered that leaders had made reasonable progress against this recommendation.

Recommendation B

3.76 Good progress had been made to improve the re-categorisation process. Prisoners were now routinely offered the opportunity to submit a written report for their review and uptake was gradually increasing. The number of complaints about unfair decision making had decreased slightly.

3.77 Reviews considered a good range of important information and decisions were now based on the professional judgement of risk factors. Boards and standardisation meetings had been introduced shortly after our 2021 inspection to provide better governance and oversight of decisions and most offender manager recommendations were upheld.

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

Interventions

Concern: Group programmes had stopped in March 2020 and had not yet restarted on a large scale. Only a small number of prisoners had access to one-to-one work, and most would not be able to access any accredited medium-intensity group programmes until at least April 2022 because of staffing shortages. There was a lack of analysis of whether the prison was offering the right interventions, and large groups – for example, category C prisoners – were excluded from waiting lists, which meant that we could not assure ourselves that there would be enough programme spaces. Most prisoners, therefore, had been unable to access interventions that were important for their rehabilitation and progression.

Recommendation: Prisoners should have timely access to the right interventions to aid rehabilitation and progression throughout their sentence. (1.59.)

3.79 Slow progress had been made in the delivery of programmes, but achievable plans had recently been agreed to maximise this over the coming year. Places would be prioritised based on the prisoner's imminent release or parole eligibility date, and category C prisoners were now included.

3.80 Concerted efforts to address staffing shortages and training deficits within the programmes department had led to improvements. The team now had more staff, and training for new starters was nearing completion.

3.81 Despite staff shortages, some POMs had delivered a few one-to-one and small group sessions to support prisoners with their sentence progression. Eight prisoners convicted of sexual offences had completed Maps for Change (an intervention to address their sexual offending) work and a further eight were nearing completion. A fortnightly pilot project was underway involving three prisoners who were unsuitable for accredited interventions, to engage them in topics such as conflict resolution, thinking skills and anger management.

3.82 However, there was still a lack of analysis on whether the prison was offering enough programme places, or the right range of interventions. This remained a significant gap given the prison's role as a long-term training prison. The ongoing development of a database to address this gap was positive. It aimed to centralise all prisoners' information, such as their risk levels, likelihood of reoffending, previous programme completions, offence type, sentence length and suitability for treatment. Over time, it would provide detailed information about their treatment needs to inform future planning, including their need for non-accredited interventions.

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

Section 4 Summary of judgements

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

HMI Prisons recommendations

There should be support and clear measures implemented as a matter of urgency to recruit and retain sufficient operational and specialist staff to reinstate purposeful activity and support prisoners' progression.
No meaningful progress

Prison leaders should develop longer-term plans for improving outcomes for prisoners against their identified priorities. The governor and his team should introduce robust data and evidence-based governance arrangements to give them assurance that work is taking place on time, that progress is monitored, and that there are clear lines of accountability. In addition, there should be a robust process for reviewing plans.
Insufficient progress

All new arrivals should be able to access good-quality, proactive and consistent support and advice from staff and peer workers during their induction period, following a thorough, private assessment of their needs.
Good progress

Leaders should introduce effective measures to reduce violence and improve the safety of prisoners and staff.
Insufficient progress

The prison should develop and implement an effective plan supported by specific measures to reduce self-harm and deliver consistently good care for at-risk prisoners.
Reasonable progress

The prison should develop and implement a comprehensive equality strategy, including clear milestones for delivery that is informed by the views and experiences of prisoners.
No meaningful progress

The prison should work with the local delivery board, in conjunction with NHS England, to make sure that there are sufficient health care staff to meet the health needs of the population.
Reasonable progress

The prison should work with the local delivery board, in conjunction with NHS England, to make sure that prisoners receive their medication safely and in full accordance with correct clinical standards.
Reasonable progress

Leaders should prioritise urgently increasing time unlocked and the provision of regular education, skills and work activities.
No meaningful progress

The prison should understand fully the needs of its prisoners across all resettlement pathways and support them to reduce their risk of harm and progress through their sentence plan.
Insufficient progress

Prisoners should be moved promptly to the appropriate lowest security prison.
Reasonable progress

Recategorisation decisions should be based on the professional judgement of risk factors.
Good progress

Prisoners should have timely access to the right interventions to aid rehabilitation and progression throughout their sentence.
Insufficient progress

Ofsted themes

Theme 1: What progress had leaders and managers made to make sure that prisoners receive appropriate information, advice and guidance, enabling them to make informed choices about their education, skills and work activities? What progress had been made to make sure advice and guidance staff take into account prisoners' sentence plans, aspirations and abilities when they devised useful plans for their activities while at the prison?
Insufficient progress

Theme 2: What progress had leaders and managers made to make sure that prisoners' requests for education, skills and work activities receive a swift response and that teachers in education provide useful feedback to prisoners on their work more promptly?
Insufficient progress

Theme 3: What progress had leaders made to make sure that there is sufficient support to meet the needs of prisoners with the lowest levels of English and mathematics and to make sure that opportunities for prisoners to receive accreditation for their learning and skills development were sufficiently broad, particularly for those in workshops and work roles in the prison?
Insufficient progress

Theme 4: What progress had leaders and managers made to introduce a meaningful curriculum to help prisoners develop their understanding and knowledge in relation to personal development? What progress had managers and instructors made to make sure that prisoners' progress is monitored and tracked in unaccredited activities and that teachers and instructors help prisoners to further their understanding of the importance of wider topics, such as the values of tolerance and respect, equality and inclusivity?
Insufficient progress

Appendix I About this report

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

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

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

The aims of IRPs are to:

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

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in October 2021 for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

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

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

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

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

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

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

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

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

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

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

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

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

Inspection team

This independent review of progress was carried out by:

Sandra Fieldhouse	Team leader
Natalie Heeks	Inspector
Jade Richards	Inspector
Paul Rowlands	Inspector
Paul Tarbuck	Health and social care inspector
Helen Lloyd	Care Quality Commission inspector
Lynda Brown	Ofsted inspector
Malcolm Bruce	Ofsted inspector

Appendix II Glossary of terms

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

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

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.

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

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

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

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

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