

An inspection of probation services in

# Humberside, Lincolnshire & North Yorkshire

Community Rehabilitation Company

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HM Inspectorate of Probation

February 2019

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This inspection was led by HM Inspector Avtar Singh, supported by a team of inspectors and operations and corporate staff. The manager responsible for this inspection programme is Helen Rinaldi. We would like to thank all those who participated in any way in this inspection. Without their help and cooperation, the inspection would not have been possible.

Please note that throughout the report the names in the practice examples have been changed to protect the individual's identity.

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## Foreword

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We have given the Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Company (CRC) a 'Requires improvement' rating. Nevertheless, this CRC has clear strengths. It is performing well against some of our standards and has a good understanding of where improvements in service delivery are needed. Senior leaders are capable, dedicated and want to do better to improve the life chances of those under probation supervision. The fieldwork element of this inspection took place a week after the CRC had announced a new change programme, 'Enabling our Future'. This had caused some staff anxiety about their future roles.

The CRC's operating model is now in place and is understood by staff and others who work alongside the CRC. However, the morale of operational staff is low. They report a disconnect between themselves and the aspirations of their senior leaders. They continue to find the pace of change overwhelming and believe it is not communicated well. This has had a negative impact on service delivery and is contributing to staff feeling that their workloads are unmanageable. While a small number of operational staff do have high caseloads, overall, we believe that caseloads are not excessive and that constant change is the main factor that is affecting staff motivation.

There is a clear difference between the quality of services delivered by senior case managers (those qualified as probation officers) and case managers (probation services officers). Case managers are not well equipped to deliver high-quality personalised services. This contrast is most marked in work to manage risk of harm. Here, the work of case managers is not effective and leaves actual and potential victims not fully protected.

There have been, and continue to be, far too many disruptions caused to service delivery by unreliable information and communications technology (ICT). This is affecting morale and contributing to staff across all grades being frustrated. Improving this critical business enabler should be prioritised and the issues affecting service continuity resolved.

Services for women delivered in women's centres are impressive. In addition, the delivery of unpaid work and Through the Gate services is showing promise.

This CRC's senior leaders are committed to promoting a culture of learning from mistakes, and they respond well to findings from audits and independent inspection. We expect that the findings in this report will help to tackle shortfalls in practice and develop the quality of service delivery.



**Dame Glenys Stacey**  
Chief Inspector of Probation

## Overall findings

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Overall, Humberside, Lincolnshire & North Yorkshire CRC is rated as: '**Requires improvement**'. This rating has been determined by inspecting this provider in three areas of its work, referred to as 'domains'. The findings and subsequent ratings in those three domains are described here:



Our key findings about the organisation are as follows:

- **There is a capable leadership team dedicated to improving performance and the quality of services delivered**

The CRC has implemented a functional operating model based on research evidence. The model supports personalisation and building on the strengths of individuals under probation supervision to bring about lasting change. The CRC has communicated the model effectively to partners, stakeholders and staff. The pace of change has overwhelmed some staff, however. There is a culture in place that promotes challenge, inclusion and ideas but there is a disconnect between the aspirations of senior leaders and operational staff.

- **Staff are motivated to deliver high-quality services but, overall, morale is variable**

Staff are motivated to deliver services and supported by accessible managers, although we found minimal evidence of formally recorded and suitably targeted management oversight in many of the cases inspected.

Sickness levels are low. When there are staffing pressures on offices, leaders manage the deployment of staff appropriately to maximise the delivery of high-quality services. While average caseloads are not excessive, staff perceive their workloads to be unmanageable. The new change programme, 'Enabling our Future', has caused some anxiety among staff.

Appropriate training is available and accessible to staff. However, some staff did not consider that it supported them in delivering good-quality work. We found significant gaps in practice, in particular, work related to risk of harm and child safeguarding.

- **The provision of resettlement services is good but not enough interventions are delivered in the community to support desistance**

There are effective structures in place, including the reoffending analysis tool, to inform service provision. For women, there is an impressive range of provision. However, for other individuals and those undertaking Rehabilitation Activity Requirements (RARs), services are underdeveloped. The CRC recognises this gap in its service delivery and has been working to improve the range of provision. A new rate card has recently been issued. This is relevant and the services included have been informed by assessed and projected need.

There are blockages in the supply of information to sentencers about available services and the work of the CRC. The exchange of dynamic information with partners about risks posed by service users needs to improve. Access to programmes and services is available at multiple sites.

- **Ongoing ICT problems had not been fully resolved. This has a negative impact on the quality of service delivery**

Senior leaders within the organisation promote a culture of learning from mistakes and respond well to the findings from audit and independent inspection. Staff have access to appropriate guidance through comprehensive policies on a user-friendly intranet platform (WISDOM). Practitioners have laptops and mobile telephones and this supports flexible working. However, persistent ICT problems across the organisation have led to frustrations. There is a good understanding of performance across the organisation and at individual practitioner level.



Our key findings about case supervision are as follows:

- **Assessments focused appropriately on factors related to offending but analysis of these factors was often weak**

Responsible officers were able to demonstrate an understanding of the reasons why those they were supervising had offended. They provided good, descriptive accounts of current offences, and there was some evidence that they had considered the lived experiences of individuals. Engagement and motivation were assessed well. Information from a range of sources was usually considered in assessments. However, the analysis of reasons for offending and links to historical offending was much weaker.

Assessments completed by senior case managers were better than those by case managers. Attention to diversity factors was good. Responsible officers did not consistently ask individuals why they thought they had offended. The quality of assessment work focusing on keeping other people safe varied considerably.

- **Planning for work to reduce reoffending was generally done well but planning did not fully address how to keep actual and potential victims safe**

Individuals under probation supervision were meaningfully involved in the planning process, and the majority were given opportunities to contribute to producing plans to support their desistance. Responsible officers took care to understand the impact of diversity needs on planning. However, too many plans failed to address how the requirements of the sentence would be delivered.

Additionally, plans did not clearly explain the level and type of contact needed to support positive outcomes. Planning for work to support desistance often did not include the key factors that had led to the individual's offending. Assessed factors were often not prioritised in plans and the sequencing of work was narrow.

Planning did not consistently focus on keeping other people safe, but practitioners were marginally better at setting out constructive and restrictive interventions to manage risk of harm. Dynamic information on risk of harm was not consistently exchanged with service providers. Contingency planning was not always effective.

- **The engagement of individuals was prioritised well but not enough interventions were delivered to support desistance and keep other people safe**

Responsible officers prioritised devoting time to building effective working relationships with vulnerable individuals. They considered the personal needs of individuals well and used professional discretion appropriately to support the successful completion of orders. Interventions were mostly personalised to meet individuals' assessed needs.

However, contact levels were not always sufficient in many cases and not enough interventions to support desistance were delivered. Enforcement decisions were not always taken correctly, but work to re-engage individuals following recall and enforcement was better.

Responsible officers did not pay enough attention to supporting the safety of other people when delivering services. They did not always exchange information on risk of harm with partner agencies and other service providers.

- **Reviewing of work was erratic and significantly let down by responsible officers failing to focus meaningfully on risk of harm issues**

Reviews did not always pay enough attention to compliance and how well individuals had engaged with the requirements of their sentence. A considerable amount of information was often lifted from previous reviews. At best, some reviews provided simple updates with very little analysis. In far too many cases, significant changes in personal circumstances and poor compliance did not prompt a review. Individuals were often not involved in reviewing their progress.

Some responsible officers were using the 'enabling plan' to review improvements and there was a reassuring consideration of strengths and work to build on protective factors. However, practitioners did not always actively seek timely information from other agencies involved with individuals. Reviewing failed to fully identify changes in risk of harm issues and individuals were not routinely challenged to reflect on the risk of harm they presented to others. Management oversight to address gaps in risk of harm work was not always effective.

Our key findings about other core activities specific to CRCs are as follows:

### Unpaid work

- **Organisational delivery of unpaid work was good. Staff delivering these services worked hard to ensure that individuals engaged with them**

Assessments covering motivation, diversity and individuals' personal circumstances were broadly good. The CRC recognised that limited access to public transport and issues related to rurality were barriers to attendance and compliance. Arrangements to collect individuals from pick-up points, to offer travel warrants and to cover expenses gave individuals better access and maximised the number who successfully completed the work.

However, health and safety and the vulnerability of individuals were not routinely examined. The risk of harm classification at the beginning of an order was accurate in almost all cases. Placement coordinators ensured that unpaid work built on the strengths of individuals. Enforcement decisions were generally taken as required. The level of engagement was reviewed well in most cases.

### Through the Gate

- **Through the Gate practice was good**

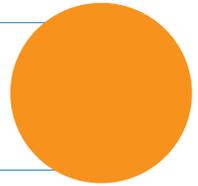
Resettlement plans that addressed assessed resettlement needs were good. However, practitioners did not always draw on all the different sources of information available to them. Additionally, planning to address risk of harm was not carried out consistently well. Communication between prison-based staff and responsible officers in the community, before and at the point of release, was good.

Service: Humberside, Lincolnshire & North Yorkshire  
Community Rehabilitation Company

Fieldwork started: October 2018

Overall rating

Requires improvement



### 1. Organisational delivery

1.1	Leadership	Good	
1.2	Staff	Requires improvement	
1.3	Services	Requires improvement	
1.4	Information and facilities	Requires improvement	

### 2. Case supervision

2.1	Assessment	Requires improvement	
2.2	Planning	Requires improvement	
2.3	Implementation and delivery	Inadequate	
2.4	Reviewing	Requires improvement	

### 4. CRC specific

4.1 <sup>1</sup>	Unpaid work	Good	
4.2	Through the Gate	Good	

<sup>1</sup> CRC aspects of domain three work are listed in *HMI Probation's standards* as 4.1 and 4.2. Those for the NPS are listed as 3.1 and 3.2.

## Recommendations

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As a result of our inspection findings, we have made six recommendations that we believe, if implemented, will have a positive impact on the quality of probation services in Humberside, Lincolnshire & North Yorkshire CRC.

### **Humberside, Lincolnshire & North Yorkshire CRC should:**

1. urgently address the disconnect between operational staff and the aspirations of senior leaders in order to achieve better staff engagement and improve morale
2. improve the quality and impact of work to manage risk of harm to keep actual and potential victims safe
3. resolve the ICT availability issues so that staff can perform their roles better
4. make sure that planned interventions are delivered so that work to reduce reoffending and manage risk of harm to others is effective
5. make sure that all operational staff receive regular and effective supervision that makes a difference to service delivery, in particular risk of harm work
6. strengthen its relationship with sentencers so that information is exchanged more effectively.

## Background

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### **An explanation of probation services**

Over 260,000 adults are supervised by probation services annually.<sup>2</sup> Probation services supervise individuals serving community orders, provide offenders with resettlement services while they are in prison (in anticipation of their release) and supervise for a minimum of 12 months all individuals released from prison.<sup>3</sup>

To protect the public, probation staff assess and manage the risks that offenders pose to the community. They help to rehabilitate these individuals by dealing with problems such as drug and alcohol misuse and lack of employment or housing, to reduce the prospect of reoffending. They monitor whether individuals are complying with court requirements, to make sure they abide by their sentence. If offenders fail to comply, probation staff generally report them to court or request recall to prison.

These services are currently provided by a publicly owned National Probation Service (NPS) and 21 privately owned community rehabilitation companies (CRCs) that provide services under contract. The government intends to change the arrangements for delivering probation services, and has given notice to CRCs of its intention to terminate their contracts early, by October 2020. It is currently considering alternative models of delivery of probation services, following a consultation exercise.

The NPS advises courts on sentencing all offenders, and manages those who present a high or very high risk of serious harm or who are managed under Multi-Agency Public Protection Arrangements (MAPPA). CRCs supervise most other offenders who present a low or medium risk of harm.

### **Humberside, Lincolnshire & North Yorkshire CRC**

Purple Futures took formal ownership of Humberside, Lincolnshire & North Yorkshire CRC on 01 February 2015. The five Purple Futures CRCs work collaboratively with one another, sharing learning and resources wherever practicable. The Humberside, Lincolnshire & North Yorkshire Chief Executive Officer (CEO) is the senior leader of both Humberside, Lincolnshire & North Yorkshire CRC and West Yorkshire CRC.

Purple Futures is a consortium led by Interserve. It comprises Interserve Justice (a subdivision of Interserve, a global support service and construction company); 3SC (a company managing public service contracts on behalf of third-sector organisations); P3 (People Potential Possibilities, a charity and social enterprise organisation); and Shelter (a charity focusing on homelessness and accommodation issues).

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<sup>2</sup> Ministry of Justice. (2018). Offender management caseload statistics as at 30 June 2018.

<sup>3</sup> All those sentenced, for offences committed after the implementation of the *Offender Rehabilitation Act 2014*, to more than one day and less than 24 months in custody are supervised in the community for 12 months post-release. Others serving longer custodial sentences may have longer total periods of supervision on licence.

The CRC's organisational priorities reflect the enduring requirements of probation services. They include reducing reoffending and managing the risk of harm that offenders pose to others. The CRC takes a 'strengths-based' approach to its work. This means it focuses on the positives in individuals' lives, to encourage them to desist from offending.

For more information about this CRC, including details of its operating model, please see Annex 3 of this report.

### **The role of HM Inspectorate of Probation**

Her Majesty's Inspectorate of Probation is the independent inspector of youth offending and probation services in England and Wales. We report on the effectiveness of probation and youth offending service work with adults and children. We inspect these services and publish inspection reports. We highlight good and poor practice, and use our data and information to encourage high-quality services. We are independent of government, and speak independently.

### **HM Inspectorate of Probation standards**

Organisations that are well led and well managed are more likely to achieve their aims. We inspect against ten standards. These standards are based on established models and frameworks, which are grounded in evidence, learning and experience. They are designed to drive improvements in the quality of work with people who have offended.<sup>4</sup>

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<sup>4</sup> HM Inspectorate of Probation's standards can be found here:  
<https://www.justiceinspectrates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/>

## Contextual facts

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**154,471**

The total number of individuals subject to probation supervision by CRCs across England and Wales.<sup>5</sup>

**5,347**

The number of individuals supervised by Humberside, Lincolnshire & North Yorkshire CRC.<sup>5</sup>

**5**

The number of CRCs owned by Purple Futures.

**50.9%**

The adjusted proportion of Humberside, Lincolnshire & North Yorkshire CRC's service users with a proven reoffence.<sup>6</sup>

**76%**

The proportion of individuals who were recorded as having successfully completed their community orders or suspended sentence orders for Humberside, Lincolnshire & North Yorkshire CRC. The performance figure for all England and Wales was 79%, against a target of 75%.<sup>7</sup>

**70%**

The proportion of positive compliance outcomes with licences and, where applicable, post-sentence supervision periods for Humberside, Lincolnshire & North Yorkshire CRC. The performance figure for all England and Wales was 71% against a target of 65%.<sup>8</sup>

**91%**

The proportion of positive completions of unpaid work requirements for Humberside, Lincolnshire & North Yorkshire CRC. The performance figure for all England and Wales was 88%, against a target of 90%.<sup>9</sup>

<sup>5</sup> Ministry of Justice. (2018). Offender management caseload statistics as at 30 June 2018.

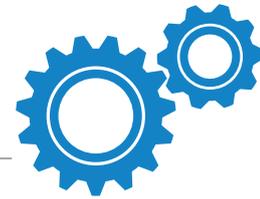
<sup>6</sup> Ministry of Justice. (2018). Proven reoffending, Payment by results, October to December 2016 cohort.

<sup>7</sup> Ministry of Justice. (2018). CRC Service Level 8, Community Performance Quarterly Statistics, April 2017 - June 2018 Q1.

<sup>8</sup> CRC Assurance metric J, Community Performance Quarterly Statistics, April 2017 - June 2018, Q1, Ministry of Justice"

<sup>9</sup> Ministry of Justice. (2018). CRC Service Level 10, Community Performance Quarterly Statistics, April 2017 - June 2018"

# 1. Organisational delivery



Humberside, Lincolnshire & North Yorkshire (HLNY) CRC has capable and dedicated senior leaders who are committed to delivering services that will make a lasting impact on individuals under probation supervision. However, there is a disconnect between the aspirations of senior leaders and the actions many operational staff believe are needed to improve service delivery. Morale is low and the pace of change is reported by some staff to be overwhelming. The recent introduction of the CRC's 'Enabling our Future' programme has caused concern among some staff. There have been too many internal and external disruptions in ICT, which have hampered the effective management and delivery of services. Partnership working is strong, but interventions are underdeveloped or underused. Services for women at women's centres are impressive.

## Strengths:

- There is a dedicated senior management team, which has a clear vision.
- There are strong partnerships that support service delivery.
- Management information across a range of business areas is available to inform decision-making.
- Staff are committed to delivering high-quality, personalised services.
- The interchange operating model is well understood.

## Areas for improvement:

- Relationships and communication with sentencers have been difficult since the *Transforming Rehabilitation* split.
- There are too many disruptions in ICT, which have an impact on service delivery and staff workloads.
- Management oversight lacks focus on how to develop the quality of practice, particularly in relation to public protection and safeguarding work.
- RARs are underdeveloped and those interventions that are in place are underused.
- Despite strong partnership working, the dynamic exchange of risk of harm information with service providers is limited.

1.1. Leadership	Good
The leadership of the organisation supports and promotes the delivery of a high-quality, personalised and responsive service for all service users.	

Senior leaders are enthusiastic and skilled. They have a well-defined vision and strategy, assimilated into the annual service plan, to deliver high-quality services that support rehabilitation, reduce reoffending and protect the public. The service plan is monitored appropriately and senior leaders are committed to continuous improvement.

Opportunities for developing the work of the organisation, consultation and challenge are provided through various means. These include the CEO and community directors personally engaging with staff through their visits to local delivery units, information gathered from the Service User Council, regular question and answer sessions with a senior manager from Interserve, and staff meetings across all grades. However, there is a disconnect between the aspirations of senior leaders and what many operational staff believe is needed to improve service delivery. The pace of change has left some staff feeling overwhelmed and powerless. This has affected morale.

Within the context of a large geographical area, the CRC has worked hard to consolidate effective partnership arrangements at the level of criminal justice boards and local children’s safeguarding boards. Senior leaders from the CRC are committed members of these boards and their voice is respected and heard. They actively engage in work aimed at reducing reoffending and report on projects that they are involved in and leading.

One such project is the Alcohol Abstinence Monitoring Requirements (AAMR) pilot, which has been extended to cover a number of areas in Humberside, Lincolnshire and North Yorkshire. The early indications are that the pilot is having a positive impact on supporting rehabilitation.

There is a comprehensive governance framework, with delivery plans in place to ensure that the vision and strategy are integrated into practice. The pan-CRC women’s strategy, which is reviewed appropriately, is impressive and has led to positive outcomes for women.

The CRC has dynamic systems in place to manage business risks to service delivery. Business continuity plans are in place at all sites. Significantly, there have been ongoing interruptions to ICT this year, and these have had a negative effect on staff and on service delivery. These difficulties have resulted from internal and external factors. The introduction of remote working and use of mobile ICT has included appropriate training on information assurance and other support and safety controls.

The organisation has a risk register, and this is reviewed by the senior management team. Business risks, for example estates, are well understood, owned and responded to by senior leaders.

The interchange operating model is based on research on desistance and well understood by staff internally and externally. It focuses on service users’ strengths and on each individual’s need to address behaviours that will lead to positive, lasting

change. The six modules – induction, dynamic assessment, planning, networking, reviewing, and planning for the longer-term future – are integrated into the relevant areas for effective desistance work. In December 2017, the model was refreshed and changes in the way it was applied were communicated well.

Practice guidance on the interchange model has recently introduced the 'enabling plan' to better support personalisation of services. We found some promising examples of emerging good practice that supported purposeful interaction with individuals under probation supervision and continuity of contact with them.

1.2. Staff	Requires improvement
Staff within the organisation are empowered to deliver a high-quality, personalised and responsive service for all service users.	

There is an effective process in place to plan and review staffing levels. This allows the CRC to respond to the changing needs of service users. Management information focuses on resourcing needs, allowing leaders to determine the resources needed. Just under two-thirds of responsible officers who were interviewed reported that their workloads were unmanageable. A similar viewpoint was articulated in focus groups that we held with different grades of staff. Average caseload numbers, in our opinion, were not excessive.

Interchange managers (senior probation officer equivalents) informed us that their spans of control were generally manageable. We found this group of staff to be committed, knowledgeable and professional. However, the generic nature of their role and the inclusion of responsibility for buildings, finance, and health and safety meant that they were less able to focus on quality and provide meaningful, reflective supervision of responsible officers.

We were encouraged to note that senior leaders had recognised the increasing demands placed on interchange managers. During our fieldwork, interviews were taking place to appoint interchange support officers to directly assist this staff group.

Most responsible officers (85 per cent) in our survey advised us that they possessed the skills and training required to deliver high-quality services. However, we found variable skills among case managers (probation service officer equivalents) in particular. Available training provided a foundation, but this did not sufficiently develop these staff in key areas, such as how to manage those posing a risk of harm to others. Many case managers reported that they felt exposed because they did not fully understand what was required of them in carrying out effective child protection work.

Three-quarters of responsible officers interviewed reported that cases were appropriately allocated to match their training and experience. Where they felt unsure about their ability to manage the allocated case effectively, they were able to discuss their concerns openly with their interchange manager.

The induction programme and opportunities for continuous development for volunteers are good. Staff have clear job descriptions to support their responsibilities.

Succession planning is not supported by a strategy, although there are development opportunities for all staff.

The CRC has a comprehensive supervision policy, which outlines the responsibilities of managers and practitioners. Two-thirds of responsible officers interviewed reported that the supervision they receive from their line managers enhances and sustains the quality of their work with individuals. We found, however, that, while supervision meetings were taking place, these were irregular and did not focus sufficiently on developing practice, particularly in relation to safeguarding and public protection work. Line managers were sensitive to pastoral needs, but they did not all always provide effective guidance to improve the quality of work to keep other people safe.

The introduction of enhanced management oversight (EMO), where interchange managers are now more actively involved, is a promising development. It shows that the organisation recognises the shortfalls in the previous oversight arrangements.

There is a new appraisal system in place that incorporates performance development objectives. These are reviewed appropriately to monitor progress. Poor performance is managed well for the small number of staff who are undergoing formal capability procedures. Management information is used effectively to identify staff who are underperforming.

Arrangements for learning and development are inconsistent. There is a high-level training plan, as well as personal development plans for staff. These classify training needs, but operational staff report that the quality of the online training they receive is *"not consistent"* and does not always improve their knowledge and implementation skills. New staff describe the centrally-designed induction experience as *"too basic"*. They say it does not prepare them for the casework that lies ahead. They welcome opportunities to shadow more-experienced staff, but report that this is often not enough.

Senior leaders have invested in pre-qualifying training routes (that is, apprenticeships) to support the delivery of services that will lead to positive outcomes. However, responsible officers remain unconvinced that these will help new staff sufficiently, suggesting that there are very limited opportunities.

Almost two-thirds of responsible officers interviewed reported that the organisation does not fully promote and value a culture of continuous improvement. This view is not shared by senior leaders and is an example of the disconnect between the views of practitioners and those of senior leaders. Access to in-service training is available, and this is enhanced by practice development workshops and functional group meetings. However, operational staff say they do not see tangible evidence of their organisation improving.

Staff can complete a variety of training modules through the 'virtual college' and Skype. These have been designed internally and externally. Feedback from focus groups suggests that the content is often too basic and the quality of the modules varies enormously.

Across the organisation, we found committed and determined staff who want to provide an effective service. They are enthusiastic about their work and want to make a difference to the lives of the vulnerable people with whom they are engaging. However, operational staff remain disillusioned, feeling that they are not

always listened to by their leaders. Here, we found a disconnect between the optimism expressed by senior leaders and what operational staff told us. Interchange managers reported good levels of engagement with their senior leaders.

The CRC has access to a range of awards to reward exceptional work. However, only one-third of responsible officers interviewed reported that managers recognised and rewarded exceptional work to inspire improvement. Nonetheless, we found examples of staff (individuals and teams) who had received 'any time' awards, and examples of staff being nominated for carrying out exceptional work.

Over half of responsible officers interviewed reported that not enough attention is paid to their wellbeing. These responsible officers told us that the impact of unmanageable workloads and a disconnect between themselves and senior leaders is contributing negatively to their emotional wellbeing. Peer support was common, and valuable, among all grades of staff.

Of the 18 staff who told us they needed reasonable adjustments in the workplace, 9 said that there had been lengthy delays in accessing the necessary software packages for their laptops.

1.3. Services	Requires improvement
A comprehensive range of high-quality services is in place, supporting a tailored and responsive service for all service users.	

Information is gathered from a range of sources, including Her Majesty's Prison and Probation Service's (HMPPS) performance hub, local data within the Offender Assessment System (OASys) and risk of harm classifications. This enables the CRC to understand the profile of the individuals it supervises. The analysis is not wholly comprehensive, but there is sufficient information for decisions to be made on the type of interventions and services that are needed to effect change.

The first Interchange Quality Assurance Model (IQAM) management report on protected characteristics was prepared in December 2017. This showed gaps in the recording of some diversity data and a disparity in service delivery between different groups. We were pleased to see that this report prompted an appropriate response from the operational and quality group across the Interserve CRCs. For HLNy CRC, this led to better reviewing of work with women, for example.

Regular reports are produced on public protection and safeguarding concerns, and these are examined by a range of practice development groups. This is a robust reporting system, but adjustments have not always been made promptly. We believe that this has contributed to the weaknesses we found in risk of harm and safeguarding work.

The CRC, through its quality and performance management information, uses analysis of local patterns of sentencing and offence types to inform its decisions on the services it provides. At the same time, it recognises the need to be more proactive so that it can better understand local sentencing trends.

In HLNy CRC, Interserve has preserved its level of investment to ensure that services to meet the assessed needs of service users are protected. However, it recognises that it has much more to do. There has been an improvement in reviews and evaluations of services but this approach is not yet embedded.

Services in women’s centres are effective and producing positive outcomes. Services supporting other RARs are underdeveloped. In far too many of the inspected cases, we found limited interventions being delivered. The secondment of an interchange manager to develop RAR activities and the production of a RAR directory of interventions to support responsible officers in their delivery of services are promising. The newly produced rate card is much more relevant than the previous one.

The interchange model is clearly understood by service providers. They have welcomed an approach to developing and delivering services built on strengths of individuals and maximising personalisation. It is to the CRC’s credit that this has been accomplished.

Relationships with providers and other agencies are generally effective. In particular, the number of responsible officers accessing P3 provision (mentoring), where available, is good. We inspected a significant number of cases where this intervention had led to reduced reoffending and improved engagement. Relationships with mental health providers were inconsistent. We saw a significant number of cases where the emotional wellbeing needs of individuals had not been adequately met.

In the sample of Through the Gate cases we inspected, we spotted the positive difference that partnership working was making. The wrap-around service to support desistance for women is impressive.

We noted some weaknesses in partnership working, however, in that responsible officers did not routinely exchange information about emerging or actual risk of harm. This potentially places service users and service providers at risk.

We found some difficulties in communication between the CRC and sentencers. This had led to some difficult and uncomfortable relationships. For example, we saw evidence of sentencer newsletters prepared by the CRC, with some excellent information about services and examples of case studies highlighting work carried out by the CRC. The sentencers we interviewed reported that they had not seen any of these newsletters. Whatever the causes of these communication difficulties, sentencers’ confidence in the CRC was low.

1.4. Information and facilities	Requires improvement
Timely and relevant information is available and appropriate facilities are in place to support a high-quality, personalised and responsive approach for all service users.	

There are wide-ranging policies and practice guidance, including practice briefings, available on the WISDOM (intranet) platform. The organisation monitors how frequently pages are opened, through ‘click counters’. Staff interviewed reported that

there is a considerable amount of information to absorb. Just over half of responsible officers interviewed believed that the policies and guidance are not communicated effectively. This is a worry.

Not all sections of the CRC WISDOM intranet were up to date when we inspected. We found uncertainty about who was responsible for keeping which section refreshed. Additionally, new staff joining the organisation are not routinely shown how to navigate their way around WISDOM. This means that valuable time is often lost in the completion of other service delivery tasks.

Three-quarters of responsible officers interviewed told us that the organisation has a clear policy about case recording that supports defensible decision-making and effective communication. It is therefore disappointing to find that the quality of recording is variable and the narrative to support professional discretion is often weak or lacking.

For individuals being supervised by the CRC, information about services and expectations is available on the organisation's website. Referral processes are in place and these are mostly clear. Some providers report that the quality of referrals is improving, but information on the risk of harm posed by individuals is not always included with the referrals.

In relation to P3, the referral process is robust. Early in the referral stage, the responsible officer making the referral meets with the P3 practitioner to go through the content of the referral. Any gaps in risk of harm information are picked up before allocation. This enables the P3 practitioner to have a full understanding of the nature of risk and who may be at risk of harm. Suitable guidance is available to practitioners on the range of services available to those whom they are supervising.

There is a professional interface relationship between the NPS and the CRC. This relationship is particularly strong at the interchange manager level. The central practice team is responsible for reviewing policies. We found that policies are largely reviewed as and when required.

Given the geography of HLNy CRC, arrangements are in place to make programmes more accessible for service users, with groups running across various locations. The CRC makes the necessary transport arrangements for those individuals who live considerable distances from sites delivering programmes. This ensures that individuals have the best chance of attending and engaging with interventions to address their offending behaviour.

Security measures for staff safety are evident and working. All operational staff are issued with personal safety devices. This allows their location to be electronically monitored. Additionally, there is a 'pool' of personal safety devices that other staff can access. Incidents relating to staff safety are recorded and monitored, and remedial action is taken. Health and safety training arrangements are in place and first aid training and refresher training are rolled out regularly. The premises used by the CRC are mostly conducive to delivering personalised services.

Most women service users are seen in female-only offices to support a personalised approach. Female-only unpaid work placements are available to all women. There is never an occasion when there is only one woman on a group placement. More generally, unpaid work collection points are available across different sites.

There have been a series of significant historical and current ICT challenges for staff in delivering services. In our focus groups with operational staff and meetings with responsible officers we found that the ICT system was fragile.

Indeed, almost three-quarters of responsible officers interviewed told us that there were often whole days when they could not access recording systems. This affected their ability to record information that supported defensible decision-making and to communicate effectively with partners. This contributed to their feelings of having unmanageable workloads. Senior leaders reported that they too had experienced difficulties with ICT.

Staff have welcomed access to personal laptops and mobile telephones to enable flexible working. Their experience of these technologies is mixed. There are unacceptable difficulties with connectivity and hardware for many. Some staff do, however, report that they can better plan, record and deliver services.

Information is exchanged with partners and providers, largely by email. When staff use email, this system works; but when they do not, gaps result in incomplete information being shared. We found evidence of many gaps in recording during our casework assessments.

Those responsible for ICT told us that the current ICT systems, due to their unreliability, do not fully support the timely production of the required management information. This often limits capability and affects quality.

The Open Tool, which produces performance information in a user-friendly format, allows staff to access a range of information to improve services. This system is well established but not used consistently by all staff.

There are sophisticated systems in place to monitor and drive improvement. We found a significant number of examples where, through auditing, piloting, monitoring and quality assurance, the organisation had started to implement changes. Last year, a service user survey showed that individuals were not routinely seeing their sentence plan. This meant that enforcement could have become problematic. This prompted the CRC to address this issue. More plans are now being seen by individuals.

The last two IQAM reports show that there has been a steady, albeit slow, improvement in safeguarding work. This directly corresponds with plans implemented by the CRC over the past six months. Safeguarding practice development events were delivered to all operational staff covering assessment and risk management work.

The CRC identified some instances where safeguarding checks were not being made in all cases on commencement of community orders. This was particularly pertinent in relation to adults where there were no known children/safeguarding concerns. The CRC proactively addressed this with its partners through the local safeguarding children board's children's social care services. This demonstrates a commitment to driving improvement in a key area of practice.

The Service User Council is an effective platform where the views of service users are heard and actions agreed. It is chaired by the CRC's CEO. We found several examples of how the organisation has listened to the views of individuals and implemented change. For example, a directory of services has been produced for those leaving custody, and many staff have undertaken first aid mental health

training, delivered by the mental health charity, MIND. This has helped staff to better understand the emotional wellbeing needs of individuals.

While these examples provide evidence of a learning organisation, the CRC is aware of the challenges of embedding good practice and accepts that there is some way to go. Staff are increasingly aware of gaps in their own performance in casework. The organisation has a healthy culture of learning from mistakes. It takes prompt action in response to inspection and audit findings. For instance, the CRC recently (August 2018) ran two-day workshops for all staff on risk of harm work, because this had been identified as an area for improvement in both audit findings and other inspection reports.

## 2. Case supervision



The quality of case supervision varies considerably between senior case managers and case managers. While there is shared eagerness across these two staff groups to support desistance and keep other people safe, many case managers have not been equipped with the skills, knowledge and experience to deliver the sentence of the court effectively. Management oversight is not robust. There are significant gaps, notably in those cases managed by case managers rather than senior case managers, in all aspects of work to support effective safeguarding and public protection.

### Strengths:

- Assessments appropriately focus on engaging individuals under probation supervision.
- The views of individuals are considered well in plans to support desistance.
- Engagement work with service users is appropriately prioritised.
- Reviews of work to support desistance are mostly done well.

### Areas for improvement:

- Analysis of offending behaviour does not consistently include the individual's views on why they have offended.
- Planning for work to keep actual and potential victims safe is limited.
- Not enough interventions are delivered to support desistance and the safety of those at risk of harm.
- The reviewing of risk of harm work is limited; responsible officers fail to fully analyse progress made and to adjust planning accordingly.

2.1. Assessment	Requires improvement
Assessment is well-informed, analytical and personalised, actively involving the service user.	

In almost nine out of ten cases inspected, we found that responsible officers had given appropriate attention to how willing and motivated service users were to engage with the requirements of their sentence. Induction procedures, including self-assessments, were generally used well. Where there had been a history of non-compliance, this had largely been investigated.

In just over three-quarters of inspected cases, there was a good examination of the service user’s diverse needs and individual circumstances. Practitioners had appropriately considered how these assessed factors might impact on the individual’s capacity to engage with interventions to support their desistance. In a small number of cases, this had not been done well. Additionally, responsible officers did not consistently ask individuals to explain what circumstances had triggered their offending. This meant that not all of the potential information was taken into account when formulating a holistic assessment.

In the majority of inspected cases, assessments focused on factors connected with offending and desistance. These assessments were completed in a timely manner. Practitioners used a mixture of information from a variety of sources to support their assessments. This enabled them to pinpoint the areas they needed to focus on to bring about positive change. We largely agreed with the offence-related factors they had identified.

Analysis of offending was much weaker. Often there was a disproportionate amount of descriptive information about the current offence, taken from Crown Prosecution Service documents, and insufficient attention was paid to understanding and correlating past behaviours to current offending. We found some good examples of strengths and protective factors being acknowledged by responsible officers in the assessment process. This is evidence of good and personalised assessments.

The quality of assessment work focusing on keeping other people safe varied considerably. It was better where assessments had been completed by senior case managers. In these cases, actual and potential victims had been appropriately identified and there was good detail about the nature of risk. In just over one-third of the inspected cases, risk of harm to others had not been analysed sufficiently, and it was not clear who was at risk or the nature of the risk.

We broadly agreed with the majority of risk classification decisions and found that responsible officers had taken into account past behaviours and convictions. However, responsible officers had not sought information from other agencies to support assessment, when and where appropriate, in just under half of the inspected cases. This meant that critical information on risk of harm could have been missed.

2.2 Planning	Requires improvement
Planning is well-informed, holistic and personalised, actively involving the service user.	

Three-quarters of service users in the inspected sample were meaningfully involved in the planning process. We were pleased to find that just over four-fifths of individuals under supervision were given the opportunity to express their ideas on what should be included in their plan. Diversity needs and personal circumstances were generally considered well to maximise engagement and compliance.

Both senior case managers and case managers had a good understanding of how motivated service users were and the barriers that might affect their engagement and compliance. Disappointingly, just over two-fifths of plans failed to cover how the

requirements of the sentence would be delivered. Similarly, just over half of the plans did not identify the level and type of contact necessary to support positive outcomes.

Plans to support desistance did not consistently include the key factors that had contributed to the individual’s offending behaviour. Over one-third of the cases failed to adequately prioritise the assessed factors that had contributed to the individual’s offending. This meant that critical needs were not given the required attention. This was particularly pertinent in work to address attitudes to offending.

The sequencing of work focusing on desistance was limited. Assessed emotional wellbeing needs were not covered well and often omitted from plans. Where relevant, strengths and protective factors were recognised and featured in around six out of ten assessments, but not all were suitably integrated into plans to support desistance. This restricted the level of personalisation and work to build on strengths. The majority of plans were timely and set out the services that were most likely to reduce reoffending and support desistance. However, the quality of plans and recording was variable.

Planning did not satisfactorily focus on keeping other people safe in just under half of the inspected cases. In these, domestic abuse concerns and safeguarding issues were not examined effectively. Additionally, plans failed to address risk of harm factors adequately, and there was limited evidence that risk of harm issues, when identified, were prioritised. Again, the greater deficiencies were in cases supervised by case managers.

Practitioners were marginally better at setting out constructive and restrictive interventions (internal and external) to manage risk of harm. Links with other agencies involved with those under probation supervision were sufficient in just under two-thirds of the inspected cases. However, the exchange of risk of harm information was often not dynamic. Contingency arrangements to manage assessed risk were lacking in most cases.

2.3. Implementation and delivery	Inadequate
High-quality, well-focused, personalised and coordinated services are delivered, engaging the service user.	

The requirements of the sentence were implemented promptly in just over three-quarters of inspected cases. This helped to maximise the service user’s motivation, which is commonly higher at the start of a sentence. Responsible officers took active responsibility in maintaining effective working relationships with individuals. The flexibility they showed in taking their personal needs into account was impressive. This included the positive use of information gathered from self-assessment questionnaires, timely responses to missed appointments (via telephone calls, texts and letters) and the affirmation of positive goals being achieved.

We found examples where responsible officers had worked hard to personalise their interventions to meet assessed needs. Often, vulnerable individuals were seen several times a week, diversity needs were appropriately considered, motivational

work was carried out, and individual circumstances were taken into account so that individuals could complete their sentence. On the other hand, we found many examples where the level of contact was insufficient, emotional wellbeing needs were not addressed well and insufficient interventions were delivered to support desistance.

In post-custody cases, just under one-third of individuals had a proportionate level of contact before release. This was a missed opportunity, especially within the context of understanding the reasons for repeat offending or breaches in sentence requirements. We were encouraged that responsible officers were open to our reflections and said that they could have done more in these cases.

Responsible officers had, in most cases, explored individuals' past responses to probation supervision and identified what would help to support compliance. In almost 40 per cent of cases in the sample where compliance actions were needed, we found that enforcement decisions were not always taken correctly. Work to re-engage individuals following recall and enforcement was generally done well.

Services to support desistance were not delivered well across many areas of assessed need. For example, the individual's attitudes to offending and work to manage alcohol misuse was limited. Too often, even where responsible officers had included clear objectives in plans, interventions were not delivered. This was disappointing, especially since just under three-quarters of responsible officers told us that they had access to the services needed to support desistance.

Responsible officers had accurately identified the services most likely to reduce reoffending in the majority of cases, but the sequencing of interventions was not always well informed. We found heartening evidence of responsible officers trying to build on individuals' strengths and protective factors. There was a commendable focus on motivational work and a drive to encourage individuals to remain in employment. Where other agencies were involved, the coordination of services showed promise.

More work was needed to engage with key people in the lives of service users. This would have given responsible officers a better understanding of the dynamic lived experiences of those they were supervising.

In almost one-quarter of the cases we inspected, there was not enough supervisory contact offered. We noted lengthy delays in reporting, with very little explanation about why individuals were not being seen. This meant that these service users were left unsupervised, some for weeks and months.

The engagement of local services during the course of statutory supervision was inconsistent and responsible officers did not pay sufficient attention to reintegrating individuals into the community once their sentence had been served.

In just under half of inspected cases, we found that the level and nature of contact that responsible officers had with individuals was not enough to keep others safe from harm. This meant that concerning behaviours remained unaddressed and left actual and potential victims with limited protection. These deficiencies were greater in cases managed by case managers.

In just over two-fifths of those cases where other service providers were involved, the coordination of work by responsible officers to manage risk of harm was weak. In

these cases, there was very little recorded information to demonstrate that practitioners were exchanging information on actual or emerging risk of harm with service providers.

A number of partners we spoke to told us that changes in the assessment of risk of harm were not systematically shared with them in a timely manner and they had to chase responsible officers. This needs to be addressed.

Responsible officers failed to liaise adequately with significant individuals in the service user's life when managing risk of harm in just under one-half of inspected cases. Practitioners did not habitually carry out home visits where risk of harm had been identified.

2.4. Reviewing	Requires improvement
Reviewing of progress is well-informed, analytical and personalised, actively involving the service user.	

Work to review progress was erratic and significantly let down by responsible officers failing to focus meaningfully on risk of harm issues. When done well, reviews were making a tangible difference in engaging service users and maximising compliance. Work produced by case managers was weaker than that of senior case managers. In around three in ten cases, reviewing did not pay enough attention to compliance and engagement levels.

Additionally, practitioners did not pay enough attention to what was preventing individuals from complying with their sentence. We found very little evidence of changes being made following reviews. Often, much of the narrative had been lifted from previous reviews. Many of the reviews simply provided very brief updates, with little analysis of the changes that had taken place. Significant changes in personal circumstances or poor compliance levels did not always trigger a review.

In just under half of the inspected cases individuals had not been involved in reviewing their sentences in a purposeful way. Reviews were frequently regarded as an administrative process rather than an opportunity to reflect on progress and plan for adjustments that were necessary to bring about lasting change.

Case managers did not always grasp the purpose of reviews, with most suggesting that they were an opportunity to summarise the current position. In just over two-thirds of inspected cases, we found that written reviews had been completed but much of this work did not support the delivery of effective services. New objectives had not been set and existing ones had not been modified where necessary. In a number of cases, senior case managers were using the local 'enabling plan' well to decide the changes that were needed to maximise compliance. This was encouraging.

Reviews of work that concentrated on supporting the service user's desistance were better. Although changes in behaviour and factors linked to offending behaviour were mostly identified, this did not consistently lead to adjustments to service users' plans. Again, accounts were too descriptive, and were often just an administrative sequential summary of work undertaken. Reviews did, however, provide a reassuring

consideration of strengths and work to build on protective factors. This approach was consistently evidenced in much of the work with individuals.

Where other agencies were involved in delivering services, we found that, in around one-third of the inspected cases, responsible officers had failed to effectively gather and include material from them to inform the reviewing of progress. This was a missed opportunity, as the lack of integration was limiting the quality of these reviews. This meant that not all services required to support desistance could be discussed and explored with individuals.

Reviewing failed to adequately identify changes in risk of harm issues in just under half of the inspected cases. This led to over half of the reviews remaining largely the same in substance, despite evidence in case files showing changes in circumstances. Examples included changes of address, loss of contact, and new relationships being formed.

In too many cases, there was very little evidence of information from other agencies being included to support the review of risk of harm work. We did see some examples of information being exchanged in emails and interchange managers making a formal record of the problems so that this evidence could be used to escalate safeguarding concerns.

Service users were often not sufficiently involved in exploring and addressing the risks that had been identified, neither was there much evidence of dialogue with key people in the individual's life. This was a worrying gap in practice, as individuals were not always encouraged to reflect on their progress in reducing the risks of harm they posed to others. This missed opportunity meant that planning did not take place for further interventions to mitigate the risk of harm.

Recording of judgements and decisions relating to risk management was not done consistently well in many cases. Management oversight was ineffective in these cases.

## 4. Unpaid work and Through the Gate

A new system to manage unpaid work has recently been implemented. The management of standalone unpaid work orders is much weaker than that of combined orders. Overall, practitioners pay attention to engagement, and this ensures that unpaid work orders are more likely to be completed successfully. There are opportunities for individuals to develop personal and employment skills. A range of placements are available.

Through the Gate provision is good. Resettlement plans are completed and individuals can contribute to their plans. Plans address desistance issues well but practitioners do not use all the information available to them. Diversity needs are not always considered appropriately and not all plans adequately build on individual strengths and protective factors. This is a missed opportunity. The coordination of resettlement activity is variable. Communication between prison-based staff and responsible officers in the community, before and at the point of release, shows promise.

### Strengths:

- Practitioners consider individuals' personal circumstances and diversity needs well when managing unpaid work orders.
- Arrangements for unpaid work largely take account of risk of harm.
- The planning for resettlement work is good and the key factors associated with individuals' offending behaviour are clearly understood.
- Resettlement plans identify the critical areas of work to support desistance.

### Areas for improvement:

- The management of standalone unpaid work orders is poor.
- Resettlement activity is not coordinated well in all cases.

4.1. Unpaid work	Good
Unpaid work is delivered safely and effectively, engaging the service user in line with the expectations of the court.	

A new operating model to coordinate unpaid work was introduced in April 2018. All the cases we inspected were managed under the new arrangements.

Assessments of an individual's motivation to comply with the requirements of their unpaid work order and of their diversity and personal circumstances were completed well in just over three-quarters of the cases inspected. The CRC recognised that limited access to public transport and issues of rurality were barriers to attendance

and compliance. Arrangements to collect individuals from pick-up points, to offer travel warrants and to cover expenses gave individuals better access and maximised the number who successfully completed the work. Available sources of information contributed to assessments in almost two-thirds of the cases. Health and safety and vulnerability needs of individuals were not always considered systematically. This meant that the quality of their experience on placements was variable.

The risk of harm classification at the start of an order was accurate in almost all of the inspected cases. Assessments of risk of harm to other service users, staff or members of the public were carried out well in almost three-quarters of the cases.

The allocation of work to individuals was generally suitable. However, we found some examples where individuals for whom English was not their first language were given less complex tasks because supervisors could not effectively communicate health and safety instructions to them. We were advised by staff involved in the coordination of unpaid work that the provider the CRC uses for interpreters was unreliable. This had a negative effect on the quality of service delivery.

The arrangements for unpaid work largely motivated individuals to engage and comply with the requirements of their orders. Additionally, these arrangements appropriately considered risk of harm issues in almost three-quarters of the inspected cases. We found cases where risk of harm had not been properly considered. In many cases, previous offending had not been taken into account.

The quality of work with standalone unpaid work orders was much weaker. The administration provided by the Professional Services Centre (PSC) was erratic. Practitioners repeatedly told us that the introduction had caused more problems than it had solved. We found a significant number of examples where individuals subject to unpaid work orders could not reach or obtain replies from the PSC. This needs to be addressed, as there is potential for information to be missed and other people to be placed at risk of harm.

We were pleased to find that placement coordinators had worked hard to build on the strengths of individuals in order to enhance their protective factors. The majority of placements were in groups but the variety available had been actively sought. This ensured that those undertaking unpaid work had some access to developing new skills and consolidating others.

The sentence was implemented appropriately in most cases, with first appointments offered promptly. Enforcement decisions were generally taken as required, and when professional judgements were taken about missed appointments, explanations were largely clear. The level of engagement was reviewed well in most cases, and where individuals had to be transferred from one placement to another, this was mostly done effectively.

4.2. Through the Gate	Good
Through the Gate services are personalised and coordinated, addressing the service user's resettlement needs.	

Overall, the delivery of Through the Gate services is good, with potential to be even better. Resettlement plans to address assessed need were clear and timely in 25 out of the 26 inspected cases. Resettlement practitioners did not always routinely draw on available information. This left some gaps in the quality of assessments. Individuals were consistently and intentionally given opportunities to contribute to pinpointing their resettlement needs and their motivation to change was assessed well. We saw evidence in case files of specific needs identified by service users being included in plans.

However, plans did not fully, and always, include the individual's strengths and factors that they believed supported their desistance and resettlement needs. This was a missed opportunity and meant that possibilities to build on positives were sometimes overlooked. Resettlement planning to address risk of harm was much weaker. Key issues were often missed, potentially leaving actual and potential victims unprotected.

The planning for resettlement work was good and the key factors associated with service users' offending behaviour had been identified accurately. However, there were gaps in the delivery of some resettlement services. We found some evidence of needs being prioritised but around one-quarter of individuals did not receive the necessary attention to their assessed needs. There was a better focus on understanding and addressing diversity factors. Resettlement activity did not consistently take account of issues related to risk of harm, however. We found that practitioners did not give adequate attention to risk of harm factors in almost one-quarter of inspected cases.

In around one-fifth of inspected cases, resettlement activities were not well coordinated with other services being delivered in prison. Encouragingly, communication between prison-based staff and responsible officers in the community, before and at the point of release, was good. The handover to local service providers in the community was effective. This ensured that those being released had access to relevant and up-to-date information on the services available to them.

## Annex 1: Methodology

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The inspection methodology is summarised below, linked to the three domains in our standards framework. We focused on obtaining evidence against the standards, key questions and prompts in our inspection framework.

### **Domain one: organisational delivery**

The provider submitted evidence in advance and the CRC's CEO delivered a presentation covering the following areas:

- How does the leadership of the organisation support and promote the delivery of a high-quality, personalised and responsive service for all service users?
- How are staff in the organisation empowered to deliver a high-quality, personalised and responsive service for all service users?
- Is there a comprehensive range of high-quality services in place, supporting a tailored and responsive service for all service users?
- Is timely and relevant information available, and are there appropriate facilities to support a high-quality, personalised and responsive approach for all service users?
- What are your priorities for further improvement, and why?

During the main fieldwork phase, we interviewed 58 individual responsible officers, asking them about their experiences of training, development, management supervision and leadership. We held various meetings and focus groups, which allowed us to triangulate evidence and information. In total, we conducted 21 meetings with staff in strategic roles. The evidence explored under this domain was judged against our published ratings characteristics.<sup>10</sup>

### **Domain two: case supervision**

We completed case assessments over a two-week period, examining service users' files and interviewing responsible officers. The cases selected were those of individuals who had been under community supervision for approximately six to seven months (either through a community sentence or following release from custody). This enabled us to examine work in relation to assessing, planning, implementing and reviewing. Where necessary, interviews with other people closely involved in the case also took place.

We examined 120 cases from across three local delivery units. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of five), and

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<sup>10</sup> HM Inspectorate's domain one ratings characteristics can be found here: <https://www.justiceinspectors.gov.uk/hmiprobation/wp-content/uploads/sites/5/2018/05/Probation-Domain-One-rating-characteristics-March-18-final.pdf>

we ensured that the ratios in relation to gender, type of disposal and risk of serious harm level matched those in the eligible population.

### **Domain three: unpaid work and Through the Gate**

We completed case assessments for two further samples: (i) unpaid work and (ii) Through the Gate. As in domain two, sample sizes were set to achieve a confidence level of 80 per cent (with a margin of error of five).

#### **Unpaid work**

We examined 39 cases with unpaid work requirements that had begun at least three months previously. The sample included cases managed by the NPS as well as cases managed by the CRC. We ensured that the ratios in relation to gender and risk of serious harm level matched those in the eligible population. We used the case management and assessment systems to inspect these cases.

We also held meetings with the following individuals/groups, which allowed us to triangulate evidence and information:

- the senior manager with overall responsibility for the delivery of unpaid work
- middle managers with responsibilities for unpaid work
- a group of supervisors of unpaid work, from a range of geographical locations.

#### **Through the Gate**

We examined 27 custodial cases in which the individual had been released on licence or post-sentence supervision six weeks earlier from the CRC's resettlement prisons, over a two-week period. The sample included those entitled to pre-release Through the Gate services from the CRC who were then supervised post-release by the CRC or the NPS. We used the case management and assessment systems to inspect these cases.

We also held meetings with the following individuals/groups:

- the senior manager in the CRC responsible for Through the Gate services
- a small group of middle managers responsible for Through the Gate services in specific prisons
- a group of CRC resettlement workers directly responsible for preparing resettlement plans and meeting identified resettlement needs.

## Annex 2: Inspection results: domains two and three

### 2. Case supervision

Standard/Key question	Rating/% yes
<b>2.1. Assessment</b>	<b>Requires improvement</b>
Assessment is well-informed, analytical and personalised, actively involving the service user	
2.1.1. Does assessment focus sufficiently on engaging the service user?	78%
2.1.2. Does assessment focus sufficiently on the factors linked to offending and desistance?	72%
2.1.3. Does assessment focus sufficiently on keeping other people safe?	58%
<b>2.2. Planning</b>	<b>Requires improvement</b>
Planning is well-informed, holistic and personalised, actively involving the service user.	
2.2.1. Does planning focus sufficiently on engaging the service user?	74%
2.2.2. Does planning focus sufficiently on reducing reoffending and supporting the service user's desistance?	63%
2.2.3. Does planning focus sufficiently on keeping other people safe? <sup>11</sup>	54%
<b>2.3. Implementation and delivery</b>	<b>Inadequate</b>
High-quality, well-focused, personalised and coordinated services are delivered, engaging the service user	
2.3.1. Is the sentence/post-custody period implemented effectively with a focus on engaging the service user?	73%
2.3.2. Does the implementation and delivery of services effectively support the service user's desistance?	48%
2.3.3. Does the implementation and delivery of services effectively support the safety of other people?	40%

<sup>11</sup> Please note: percentages relating to questions 2.2.3, 2.3.3 and 2.4.3 are calculated for the *relevant* sub-sample – that is, those cases where risk of serious harm issues apply, rather than for the *total* inspected sample.

<b>2.4. Reviewing</b>	<b>Requires improvement</b>
Reviewing of progress is well-informed, analytical and personalised, actively involving the service user	
2.4.1. Does reviewing focus sufficiently on supporting the service user's compliance and engagement?	65%
2.4.2. Does reviewing focus sufficiently on supporting the service user's desistance?	60%
2.4.3. Does reviewing focus sufficiently on keeping other people safe?	53%

#### 4. CRC-specific work

Standard/Key question	Rating/% yes
<b>4.1. Unpaid work</b>	<b>Good</b>
Unpaid work is delivered safely and effectively, engaging the service user in line with the expectations of the court	
4.1.1. Does assessment focus on the key issues relevant to unpaid work?	67%
4.1.2. Do arrangements for unpaid work focus sufficiently on supporting the service user's engagement and compliance with the sentence?	72%
4.1.3. Do arrangements for unpaid work maximise the opportunity for the service user's personal development?	79%
4.1.4. Is the sentence of the court implemented appropriately?	79%
<b>4.2. Through the Gate</b>	<b>Good</b>
Through the Gate services are personalised and coordinated, addressing the service user's resettlement needs	
4.2.1. Does resettlement planning focus sufficiently on the service user's resettlement needs and on factors linked to offending and desistance?	81%
4.2.2. Does resettlement activity focus sufficiently on supporting the service user's resettlement?	81%
4.2.3. Is there effective coordination of resettlement activity?	76%

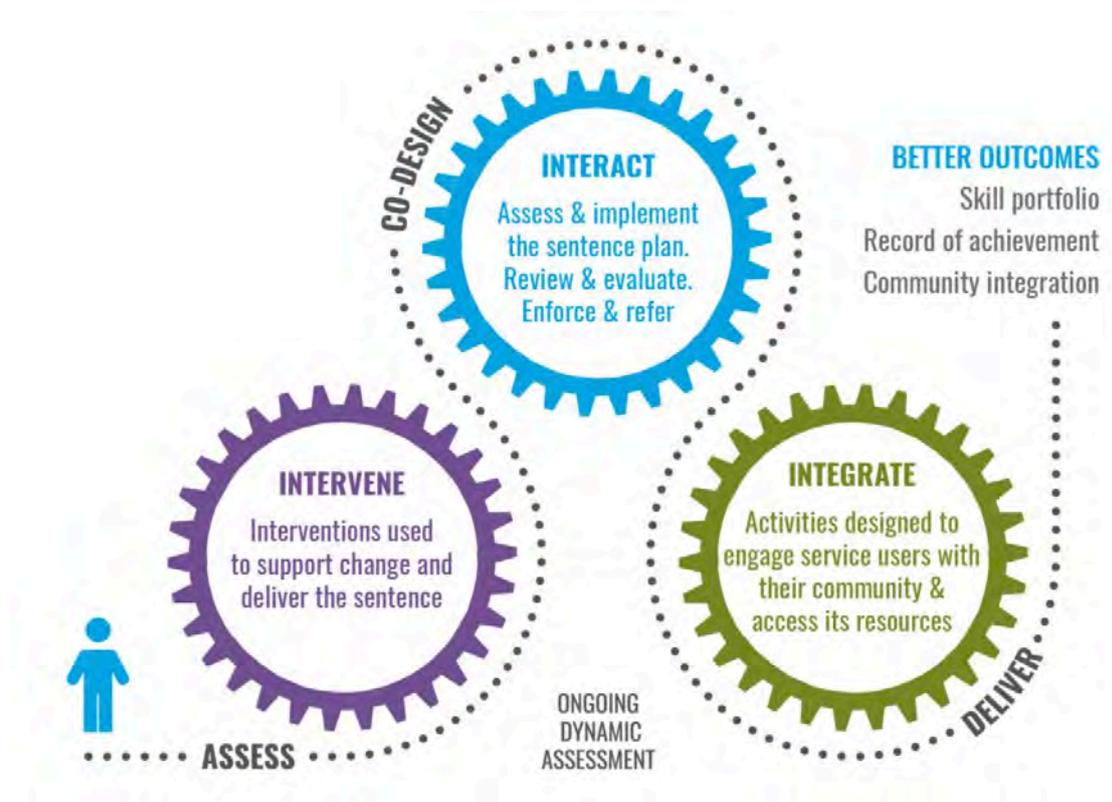
## Annex 3: Operating model

### ***The operating model in practice – as described by Humberside, Lincolnshire & North Yorkshire***

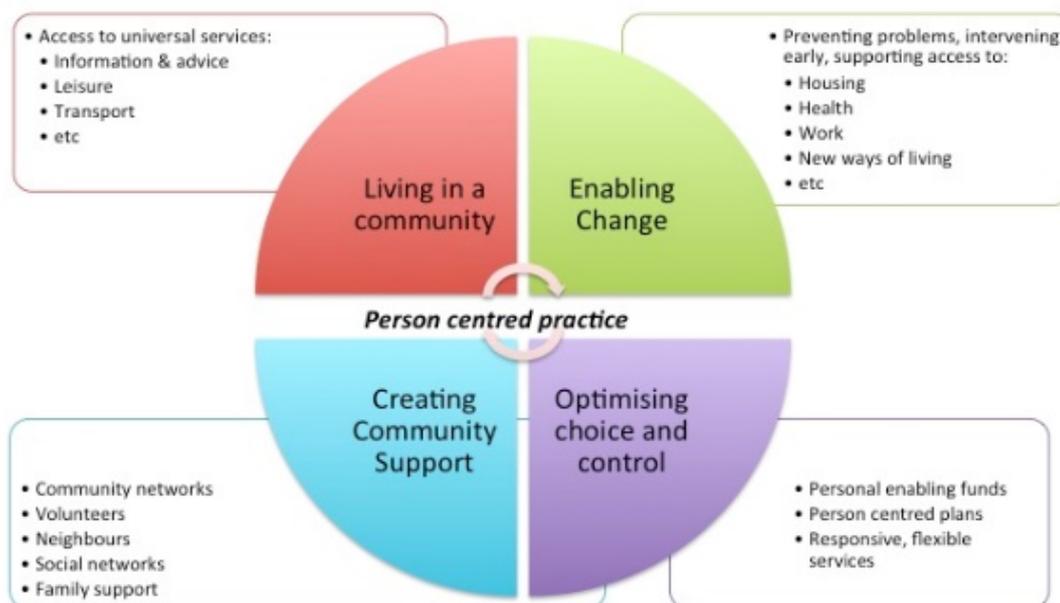
Service users within HLNy are allocated to Senior Case Managers / Case Managers by administrative staff based in our Professional Services Centre (PSC). The allocation is made to a flex team according to the geographic location of the service user. The allocation to either Senior Case Manager or Case Manager (S/CM) is informed by the Interserve Banding and Allocation tool (IBAT). The allocation is predominantly based on OGRS score with a number of outlined exceptions. Furthermore, Interchange Managers will override allocation decisions where necessary.

To further inform the allocation to the correct case manager, there are identified staff with specific specialisms and it is the responsibility of Interchange Managers to ensure that the PSC are aware of these specialisms within each flex team. The specialisms include identified S/CM's for women and for Integrated Offender Management (IOM) cases.

All our work with service users is based on the Purple Future Interchange model, which offers a personalised, co-produced service user pathway to define and achieve goals and reduce reoffending. All activity is goal orientated, asset based, and places service users at the centre of their plan.



## A personalisation model for criminal justice – what it means for service users



**Core modules:** Key elements of practice that guide our co-developed personalised approach. Enabling service users to understand their sentence, play a role in their assessment, co-develop their plan and work collaboratively to establish positive networks, review achievements and prepare for their life beyond our time working together. The modules are Induction, Assessment, Plan, Networks, Review and Exit. Each are explained fully in the Interchange practice guidance.

**Banding and allocation:** Effective banding and allocation is reliant on the PSC and CRCs working effectively together, sharing information in a timely and efficient way to ensure it is right first time. The service user should remain at the heart of the process, be well communicated with, and feel that we are professional and that we will work flexibly to deliver the sentence of the court to achieve positive changes. Cases are allocated as per geographical address, to the closest possible delivery unit unless a better service can be delivered elsewhere, such as in the women's offer. Cases are generically allocated unless there are concentrator modules within the LDU such as women's, intensive community orders, resettlement specialist.

<b>Band 1</b>	<ul style="list-style-type: none"> <li>• OGRS 0-49</li> <li>• RSR 0-2.9 and no risk exceptions</li> <li>• Standalone CP (UPW)</li> </ul>
<b>Band 2</b>	<ul style="list-style-type: none"> <li>• OGRS 0-49 / RSR 0-2.9 with risk exception</li> <li>• OGRS 0-49 / RSR 3+ with no risk exceptions</li> <li>• OGRS 50-74 / RSR 0-2.9 with no risk exceptions</li> </ul>
<b>Band 3</b>	<ul style="list-style-type: none"> <li>• OGRS 50-89 / RSR 0-2.9 with risk exception</li> <li>• OGRS 50-89 / RSR 3+ with or without risk exception</li> </ul>
<b>Band 4</b>	<ul style="list-style-type: none"> <li>• OGRS 90+</li> <li>• RSR 0-2.9 with risk exception</li> <li>• RSR 3+</li> <li>• IOM Cases</li> </ul>

Banding and allocation are based on several risk-related factors, which allow for the allocation of cases between case manager and senior case manager. Following testing, a revised Banding and Allocation Tool has been created. This takes into account the removal of SARA 2 scoring, but allows for auto allocation by the PSC. The revised **IBAT** directs that any cases with the following exceptions will be allocated to a senior case manager:  
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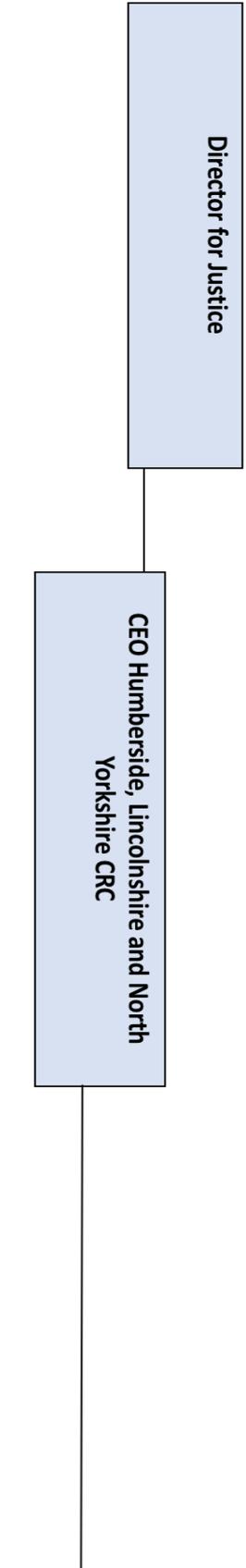
- PREVENT: The case is being managed under the Government’s PREVENT Strategy
- CSE: Any case where there is evidence of Child Sexual Exploitation
- The case has a current Safeguarding Child Protection Register
- The case has a current or previous offence of a sexual nature
- The case has a current Gangs and Guns register
- DA register and 75+ OGRS
- NPS identified Risk Review case
- Index offence involved stalking behaviour

**Community payback (unpaid work):**

Stand-alone cases that have RSR 3.0 or above will be allocated to a case manager within the Community Payback Unit with practice oversight and management oversight from a community payback manager.

**Domestic abuse:**

- Cases that are not stand-alone, considered Band 1 with a current domestic violence offence, will be automatically allocated to a case manager. Where the SARA highlights medium (intimate partner violence) risk then the band should be changed to **Band 2**.
- Where SARA has not been completed prior, the case manager will complete this as part of the assessment module.
- Following a domestic abuse (DA) case being allocated to a case manager, it is essential that the case manager has a discussion with the Interchange manager and formally records this as a management oversight contact (Enhanced Management Oversight process). The SARA assessment needs to be completed prior to the discussion. If the assessment or any information gained post-sentence suggests a potential risk increase, or increased risk factors, the practice discussion must make an informed professional judgment as to whether the case should be re-allocated.



Community Director	Community Director	Community Director	Community Director and Head of Operations
<b>(WEST YORKSHIRE LEADS)</b>	<b>GREATER LINCOLNSHIRE</b>	<b>YORK AND NORTH YORKSHIRE</b>	<b>HULL AND EAST RIDING</b>
<ul style="list-style-type: none"> <li>Community Payback</li> <li>SFO's</li> <li>NPS Court Interface</li> <li>Risk Interface</li> <li>Veterans</li> <li>Death of an Offender</li> <li>Accommodation</li> <li>Drugs and alcohol</li> <li>Electronic Monitoring</li> <li>Foreign Nationals</li> <li>HDC &amp; ROTL</li> <li>Safeguarding / SCR Through The Gate</li> <li>Victims &amp; Restorative Justice</li> <li>Prevent / Serious Organised Crime / Hate Crime</li> </ul>	<ul style="list-style-type: none"> <li>Children and Families</li> <li>Domestic Abuse</li> <li>Women</li> <li>Equality and Diversity</li> <li>Health</li> <li>Domestic Abuse</li> <li>Youth Transition / Leaving Care</li> <li>IOM</li> <li>Service User Involvement</li> <li>Mentoring</li> </ul>	<ul style="list-style-type: none"> <li>Accredited / Non Accredited Programmes</li> <li>ETE</li> <li>RAR</li> <li>Senior Attendance</li> <li>Business Development</li> </ul>	<ul style="list-style-type: none"> <li>P3</li> <li>Commissioning</li> <li>Corporate and Legal</li> <li>Partnership</li> <li>Performance</li> <li>Quality</li> <li>Rate Card</li> <li>Reducing Reoffending</li> <li>Workload Management Tool</li> </ul>

## **Available services and involvement of the third sector – as described by Humberside, Lincolnshire & North Yorkshire CRC**

Accredited programmes, non-accredited interventions and UPW are all delivered by HLNy staff.

In addition, HLNy has commissioned women's services from the following providers; Together Women (Hull and East Riding) Humankind (were Disc) (York and North Yorkshire) and Lincolnshire Action Trust (Greater Lincolnshire).

User Voice are contracted to support the delivery of Service User services (including the Service User Council).

Empower are contracted to provide mentoring services in North and North-East Lincolnshire (which includes TTG through the gate support).

Shelter is the TTG provider for all five of HLNy's prisons.

The HLNy Alcohol Abstinence Monitoring Requirement Pilot (AAMR) launched in June 2017- this is a two-year pilot funded by the three area PCCs. HLNy CRC are commissioned to fit and maintain electronic transdermal 'sobriety tags' as part of AAMR requirements linked to Suspended Sentence Orders and Community Orders. The requirement is available to CRC and NPS service users, CRC staff have been trained to work with the technology which is provided by Scram Systems UK.

### ***Geographic coverage and number of sites:***

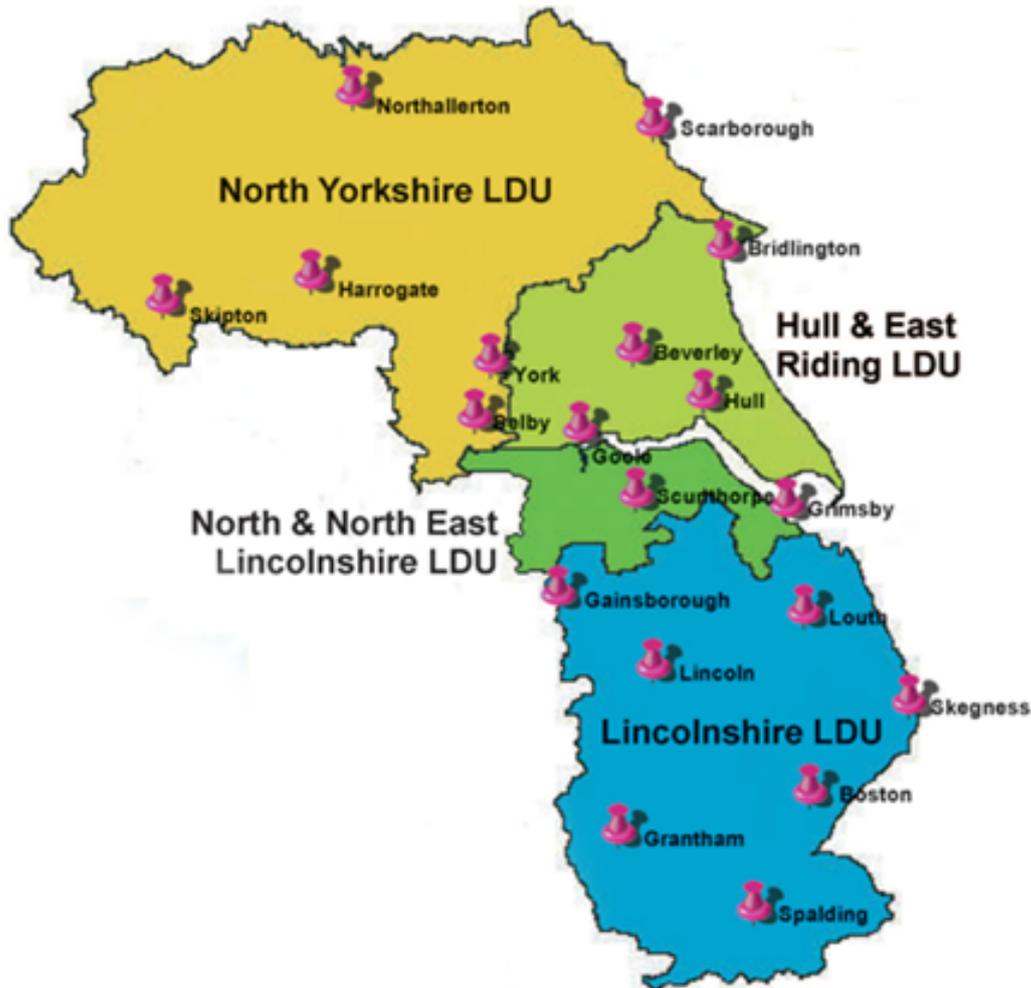
The HLNy CRC covers a very large geographical area of around 7,500 square miles and manages approximately 5,500 offenders at any one time. Geo-political boundaries for Local Government, DWP, NHS England, PCCs, LEPs or ESF are not co-terminus with the HLNy operational area. In addition, there are 3 PCCs (York/North Yorkshire, Humberside and Lincolnshire) and 3 LEPs. With regards to local authorities across the HLNy area these are:

- **North Yorkshire:** North Yorkshire County Council; Richmondshire District Council; Craven District Council; Hambleton District Council; Harrogate Borough Council; Selby District Council; Ryedale District Council; Scarborough Borough Council; City of York Council
- **Humberside:** Hull City Council; East Riding of Yorkshire Council; North Lincolnshire Council; North East Lincolnshire Council
- **Lincolnshire:** Lincolnshire County Council; City of Lincoln Council; Boston Borough Council; South Holland District Council; East Lindsey District Council; West Lindsey District Council; North Kesteven District Council; South Kesteven District Council

HLNy works across 3 Local Delivery Units (LDUs); York and North Yorkshire, Hull and East Riding and Greater Lincolnshire. Within York and North Yorkshire there are main offices (hubs) in York and Scarborough. In addition, there are small offices (spokes) within Northallerton, Skipton and Harrogate. Hull and East Riding has one main office

based in the city of Hull. Female service users are seen in the premises of the Together Women Project. In Greater Lincolnshire, there are larger hubs found in Scunthorpe, Grimsby and Lincoln and smaller offices found in Skegness, Spalding and Boston. Our Senior Case Managers and Case Managers (S/CMs) are organised in flex teams by postcode and often work out in the community, attending home visits and working from partner sites such as community hubs, improving engagement and local knowledge through being embedded within their community. For the purposes of Through the Gate (TTG), HLNy is responsible for the delivery of services in HMP Askham Grange (North Yorkshire), HMP Humber and HMP Hull (Hull and East Riding), HMP Lincoln and HMP North Sea Camp (Greater Lincolnshire).

**Map**



**Website Link**

<http://www.hlnycrc.co.uk>

## Annex 4: Glossary

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<b>Accredited programme</b>	A programme of work delivered to offenders in groups or individually through a requirement in a community order or a suspended sentence order, or as part of a custodial sentence or a condition in a prison licence. Accredited programmes are accredited by the Correctional Services Accredited Panel as being effective in reducing the likelihood of reoffending
<b>Allocation</b>	The process by which a decision is made about whether an offender will be supervised by a CRC or the NPS
<b>Approach</b>	The overall way in which something is made to happen; an approach comprises processes and structured actions within a framework of principles and policies
<b>Assessment</b>	The process by which a decision is made about the things an individual may need to do to reduce the likelihood of them reoffending and/or causing further harm
<b>Barriers</b>	The things that make it difficult for an individual to change
<b>Breach (of an order or licence)</b>	Where an offender fails to comply with the conditions of a court order or licence. Enforcement action may be taken to return the offender to court for additional action or recall them to prison
<b>Case manager</b>	The term used by some CRCs, e.g. Purple Futures' CRCs, for the probation services officer grade who holds lead responsibility for managing a case
<b>Child protection</b>	Work to make sure that all reasonable action has been taken to keep to a minimum the risk of a child coming to harm
<b>Child safeguarding</b>	The ability to demonstrate that a child or young person's well-being has been 'safeguarded'. This includes – but can be broader than – child protection. The term 'safeguarding' is also used in relation to vulnerable adults.
<b>CRC</b>	Community Rehabilitation Company: 21 CRCs were set up in June 2014 to manage most offenders who present low or medium risk of serious harm
<b>Desistance</b>	The cessation of offending or other antisocial behaviour
<b>Diversity</b>	The extent to which people within an organisation recognise, appreciate and utilise the characteristics that make an organisation and its service users unique. Diversity can relate to age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sex
<b>Empower</b>	Giving people the authority or power and/or confidence to make and implement decisions
<b>Enforcement</b>	Action taken by a responsible officer in response to an individual's non-compliance with a community sentence or licence. Enforcement can be punitive or motivational

<b>Enhanced management oversight</b>	A process by which interchange managers are better able to monitor case work and provide more effective feedback on work
<b>Flex team</b>	A team of people in the Purple Futures' CRCs made up of operational and management staff supervising service users
<b>HMPPS</b>	Her Majesty's Prison and Probation Service: from 01 April 2017, HMPPS became the single agency responsible for delivering prison and probation services across England and Wales. At the same time, the Ministry of Justice took on responsibility for overall policy direction, setting standards, scrutinising prison performance and commissioning services. These used to fall under the remit of the National Offender Management Service (the agency that has been replaced by HMPPS)
<b>IOM</b>	Integrated Offender Management: a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together
<b>Interchange manager</b>	A member of staff within Purple Futures' CRCs equivalent to a senior probation officer in the NPS
<b>Interchange model</b>	An individualised approach to rehabilitation that meets the needs and recognises the diversity of all service users; the model takes a modular approach to working to support desistance
<b>Intervention</b>	Work with an individual that is designed to change their offending behaviour and/or to support public protection. A constructive intervention is where the primary purpose is to reduce likelihood of reoffending. A restrictive intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others. With a sexual offender, for example, a constructive intervention might be to put them through an accredited sex offender treatment programme; a restrictive intervention (to minimise their risk of harm to others) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. Both types of intervention are important
<b>Licence</b>	This is a period of supervision immediately following release from custody, and is typically implemented after an offender has served half of their sentence. Any breaches to the conditions of the licence can lead to a recall to prison where the offender could remain in custody for the duration of their original sentence
<b>Lived experience</b>	This refers to an individual's experience of the criminal justice system and/or offending history

<b>Local delivery unit</b>	An operational unit comprising an office or offices, generally coterminous with police basic command units and local authority structures
<b>Local safeguarding children board</b>	Set up in each local authority (as a result of the <i>Children Act 2004</i> ) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
<b>MAPPA</b>	Multi-Agency Public Protection Arrangements: where NPS, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others. Level 1 is ordinary agency management where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This compares with Levels 2 and 3, which require active multi-agency management
<b>Mentoring</b>	The advice and guidance offered by a more experienced person to develop an individual's potential
<b>MIND</b>	A national mental health charity providing advice and support to those experiencing mental health problems and campaigning to improve services and raise awareness
<b>NPS</b>	National Probation Service: a single national service that came into being in June 2014. Its role is to deliver services to courts and to manage specific groups of offenders, including those presenting a high or very high risk of serious harm and those subject to MAPPA in England and Wales
<b>OASys</b>	Offender Assessment System: currently used in England and Wales by the CRCs and the NPS to measure the risks and needs of offenders under supervision
<b>Partners</b>	Partners include statutory and non-statutory organisations, working with the participant/offender through a partnership agreement with a CRC or the NPS
<b>Probation officer</b>	Probation officer: this is the term for a responsible officer who has completed a higher-education-based professional qualification. The name of the qualification and content of the training varies depending on when it was undertaken. They manage more complex cases
<b>Professional Services Centre</b>	This provides for the centralisation of a number of administrative functions within the Purple Futures CRCs, including, from April 2018, the administration of unpaid work
<b>Probation services officer</b>	Probation services officer: this is the term for a responsible officer who was originally recruited with no professional qualification. They may access locally determined training to qualify as a probation services officer or to build on this to qualify as a probation officer. They may manage all but the most complex cases, depending on their level of training and experience. Some PSOs work within the court setting, where their duties include writing pre-sentence reports

<b>Providers</b>	Providers deliver a service or input commissioned by and provided under contract to a CRC or the NPS. This includes the staff and services provided under the contract, even when they are integrated or located within a CRC or the NPS
<b>Rate card</b>	A directory of services offered by the CRC for the NPS to use with its offenders, detailing the price
<b>RAR</b>	Rehabilitation Activity Requirement: from February 2015, when the <i>Offender Rehabilitation Act 2014</i> was implemented, courts can specify a number of RAR days within an order; it is for probation services to decide on the precise work to be done during the RAR days awarded
<b>Responsible Officer</b>	A senior case manager or case manager
<b>Senior probation officer</b>	First line manager within the NPS
<b>Stakeholder</b>	A person, group or organisation that has a direct or indirect stake or interest in the organisation because it can either affect the organisation or be affected by it. Examples of external stakeholders are owners (shareholders), customers, suppliers, partners, government agencies and representatives of the community. Examples of internal stakeholders are people or groups of people within the organisation
<b>Through the Gate</b>	Through the Gate services are designed to help those sentenced to more than one day in prison to settle back into the community upon release and receive rehabilitation support so they can turn their lives around
<b>Transforming Rehabilitation</b>	The government's programme for how offenders are managed in England and Wales from June 2014
<b>Unpaid work</b>	A court can include an unpaid work requirement as part of a community order. Offenders can be required to work for up to 300 hours on community projects under supervision. Since February 2015, unpaid work has been delivered by CRCs
<b>Women's centre</b>	A centre dedicated to services for women. These may include education, training and interventions to help with confidence and self-esteem



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