HM Prison & Probation Service

Action Plan Submitted: 12/4/2019

A Response to the HMI Probation Inspection: Cheshire and Greater Manchester Community Rehabilitation Company

Report Published: 3 April 2019

INTRODUCTION

Her Majesty's Inspectorate of Probation is the independent inspector of youth offending and probation services in England and Wales. It reports on the effectiveness of probation and youth offending service work with adults and children.

In response to the report, HMPPS/MoJ are required to draft a robust and timely action plan to address the recommendations. The action plan confirms whether recommendations are agreed, partly agreed or not agreed (see categorisations below). Where a recommendation is agreed or partly agreed, the action plans provides specific steps and actions to address these. Actions are clear, measurable, achievable and relevant with the owner and timescale of each step clearly identified. Action plans are published on the HMI Probation website. Progress against the implementation and delivery of the action plans will be monitored by HMPPS/MoJ and reviewed by HMI Probation via annual inspection.

Term	**Definition**	**Additional comment**
Agreed	All of the recommendation is agreed with, can be achieved and is affordable.	The response should clearly explain how the recommendation will be achieved along with timescales. Actions should be as SMART (Specific, Measurable, Achievable, Realistic and Time-bound) as possible. Actions should be specific enough to be tracked for progress.
Partly Agreed	Only part of the recommendation is agreed with, is achievable, affordable and will be implemented. This might be because we cannot implement the whole recommendation because of commissioning, policy, operational or affordability reasons.	The response must state clearly which part of the recommendation will be implemented along with SMART actions and tracked for progress. There **mus**t be an explanation of why we cannot fully agree the recommendation - this must state clearly whether this is due to commissioning, policy, operational or affordability reasons.
Not Agreed	The recommendation is not agreed and will not be implemented. This might be because of commissioning, policy, operational or affordability reasons.	The response must clearly state the reasons why we have chosen this option. There **must** be an explanation of why we cannot agree the recommendation - this must state clearly whether this is due to commissioning, policy, operational or affordability reasons.

ACTION PLAN: Cheshire and Greater Manchester CRC

1. Rec No	2. Recommendation	3. Agreed/ Partly Agreed/ Not Agreed	4. Response Action Taken/Planned	5. Responsible Owner (including named individuals and their functional role or department)	6. Target Date
1	**The CRC should:** Manage workloads so that responsible officers are assigned cases for which they have the necessary skills and experience and have the time to manage each case according to its needs.	Agreed	1.1 To implement Interchange Resource Allocation Model (IRAM) across Cheshire and Greater Manchester (CGM) by 01.05.19, to ensure resources are being deployed in accordance with expectations via:	Head of Operations	May 19
			1.1.1. Communication of IRAM to all Interchange Managers (IMs) at leadership forum on 01.04.19, to ensure IRAM expectations are understood.	Head of Operations	Completed
			1.1.2. Dissemination of IRAM in all Teams by 01.05.19.	All Community Directors	May 19
			1.1.3 Monitoring of deployment of IRAM 01.05.19 – 30.08.19 using suite of Management Information made available by central team.	Performance Manager	May19 – Aug 19
			1.1.4. Review of IRAM delivery and impact to be undertaken by 01.10.19 and report back through existing governance meetings with the Authority.	Head of Operations	Oct 19
			1.2 Workload Management tool to be reviewed to ensure workload is accurately recorded and reflected and that there is accurate monitoring and understanding on workload demands across the staff group.	Performance Manager	April 19
			1.3 Case Manager (CM) Rolling recruitment established by 01.04.19, with waiting list in place, to ensure availability of new starters when required.	Head of Operations	Completed
			1.4 Schedule for New CM induction programme in place by 01.05.19 to ensure bi monthly new Case Manager starter induction programme available to provide timely onboarding and induction.	Business & Project Manager	May 19
			1.5 Resource review to be integrated into Cluster Management Team meetings by Community Directors (CD) to ensure focus on workload review, using available evidence to inform discussion (specifically Workload Management Tool; sickness	Community Directors	May 19

			absence data) with evidence of remedial and contingency planning both across the team and with individual staff when needed.		
			1.6 Mobility Meeting (CRC resource management meeting) format to be reviewed by 01.04.19 to ensure clear visibility of evidence-based workload review, and deployment of resources to meet identified and anticipated needs.	Head of Operations	Completed
			1.7 In accordance with Interchange Banding and Allocation framework – review of Professional Services Centre self-service data by end May 2019 to ensure that allocation is taking account of staff needs and experience.	Performance Manager	May 19
			1.8 Implementation of Quality Observations framework by June 19 which is currently being developed centrally, so as to ensure Managers review quality of engagement and delivery.	Head of Operations	June 19 TBC NB dependant on provision of framework from Central Team which is currently in development
			1.9 Process for communicating/feeding back the output of quality assurance outcomes following completion of the Interchange Quality Assurance Model (IQAM), to be reviewed and revised by 01.06.19 to ensure effective communication of IQAM learning. This process to feature a mechanism for ensuring staff have received relevant feedback.	Head of Operations	June 19
			1.10 To effectively mobilise the Suite of Interventions across CGM, with each unit to have available at least 5 Rehabilitation Activity Requirement (RAR) interventions by May 19.	Community Director/Interventions lead	May 19
2	Provide responsible officers with the time to participate in appropriate training and development activities that meet their learning needs and styles.	Agreed	2.1 Revised training calendar to be introduced, to provide a schedule of training (multi-faceted training approaches using face to face and IT training methods) based on needs of relevant staff and relevant staff groups. (Note: selected essential training will be mandated for all; targeted training for some staff based on individual training needs analysis)	Community Director with Training Lead	May 19
			2.2 A register/tracker capturing all responsible officer staff training to be in place by 01.06.19.	Community Director with Training Lead	June 19
			2.3 Review of key training materials to be finalised by 01.05.19 to ensure availability of quality training. Strategic leads to ratify training packages; further assessment of quality via participant feedback.	Risk and Quality Manager/Business and Project Manager	May 19
			2.4 Participant training feedback to be reintroduced to provide clear mechanism for feedback in terms of training effectiveness in accordance with participant needs.	Risk and Quality Manager/Business and Project Manager	May 19

			2.5 All staff communication to be issued emphasising the priority to attend training and development, with all non-attendance to be agreed by Managers.	Head of Operations	May 19
			2.6 With effect from April 19 process to be introduced for any non-attendance at training events to be communicated directly to Community Directors (CDs) by trainers (following events) who will seek an explanation as to non-attendance.	Business and Project Manager	Completed
			2.7 Practice development day quality assurance process to be implemented by June 19. *Note: Practice Development Days provide a consistent vehicle and approach to delivering key communication and for facilitating practice development in Units, with a key focus on the development of risk and quality practice.*	Risk and Quality Manager/Business and Project Manager	June 19
			2.8 Senior Case Manager (SCM) development programme, to be introduced aimed at maximising the role of SCMs in supporting and mentoring new staff, which will consist of:	Head of Operations	July 19
			2.8.1 Establishment of new SCM development group by April 19.	Business and Project Manager	Completed
			2.8.2 Meeting with all SCMs with a view to implementing SCM coaching and mentoring role across CGM by July 19.	Community Director/Risk Lead	July 19
3	Make sure that management oversight reflects the needs of individual cases and responsible officers.	Agreed	3.1 Undertake assurance of the Effective Management Oversight process (EMO), which provides structured management oversight and/or formal review of risk of serious harm, to ensure the quality of risk and safeguarding practice. The assurance to include the following relevant process/trackers: • Completion in every relevant case. • Quality of EMO review (with a focus on ensuring victim focused assessments and actions are being completed in relevant cases; use of range of information, including 3rd party information to inform assessments and planning). • Quality of actions and review that actions have taken place. *NB Below is a list of cases that must receive EMO however it should be encouraged that this is not an exhaustive list; professional judgement should be applied to individual cases when deciding whether EMO is required.* • *National Probation Service (NPS) has identified a risk review need at allocation.* • *Risk escalation has been considered; before formal escalation takes place, measures have been added to the Risk Management Plan to try and stabilise risk.* • *Risk has been escalated to NPS but NPS has made a decision that risk has not increased to high.* • *All Child Protection Cases*	Community Director/Risk Lead	May 19

			• *All Case Manager domestic abuse cases* • *Senior Case Manager domestic abuse cases with a Domestic Violence (DV) register and Offender Group Reconviction Score (OGRS) over 75%* • *All cases involving stalking* • *All cases involving concerns around gangs, guns and/or organised crime* • *All cases where there are any child sexual exploitation concerns (victim or perpetrator)* • *Non-registered Sex Offenders / those who have committed an index offence of a sexual nature or where there are ongoing concerns regarding previous offences or behaviour of a sexual nature or motivation* • *All cases related to PREVENT (counter-terrorism initiative), trafficking and/or modern slavery* • *Media interest cases* • *On-going Serious Further Offence (SFO) cases*		
			3.2 IMs to receive 'effective supervision' training and quality standards to ensure focus and assurance of staff practice development and performance. (To be integrated into the quality observations roll out due June 19.)	Head of Operations	June 19
			3.3 CDs to undertake a review of supervision in each Cluster, specifically a stocktake confirming supervision completion rates by end May 2019.	All Community Directors	May 19
			3.4 CDs to undertake a Review of supervision quality, focussing on evidence of management oversight of quality issues, and using the quality assurance framework to provide a consistent quality assurance approach.	All Community Directors	Oct 19 (NB timing dependant on provision of framework from Central Team which is currently in development)
4	Improve work to manage and reduce risk of harm, paying particular attention to measures to protect victims of domestic abuse and safeguard children.	Agreed	4.1 Review of key risk training materials to be finalised by 01.05.19 to ensure availability of quality training materials. Strategic leads to ratify training packages; further assessment of quality via participant feedback.	Community Director/Risk Lead	May 19
			4.2 Register/tracker capturing all responsible officer staff training to be in place by 01.06.19.	Community Director/ Training lead	June 19
			4.3 All available Case Managers to complete revised core mandatory suite of risk training (Risk of harm, Domestic abuse, Spousal Assault Risk Assessment (SARA3), safeguarding).	All Community Directors	July 19
			4.4 (See 3.1 above) Undertake assurance of Effective Management Oversight process (EMO) which provides structured management oversight and/or formal review of risk	Community Director/ Training lead	May 19

				of serious harm, to ensure the quality of risk and safeguarding practice. The assurance to include the following relevant process/trackers: • Completion in every relevant case. • Quality of EMO review (with a focus on ensuring victim focused assessments and actions are being completed in relevant cases; use of range of information, including 3rd party information to inform assessments and planning). • Quality of actions and review that actions have taken place.		
			4.5	Review of all risk delivery in accordance with Risk of Harm (ROH) Strategic briefing, via a monthly review at the Senior Management Team Meeting	Chief Executive	May 19
5	Take timely action to enforce sentence compliance in all appropriate instances.	Agreed	5.1	Enforcement tracker (which contains key information regarding enforcement performance) communicated to Managers on a fortnightly basis (monitoring of communication between 01.04.19 and 01.07.19). Managers are expected to use this data to engage with staff regarding enforcement practice. Community Directors to review the use of trackers and actions completed in Cluster Management Team meetings.	Performance Manager	April 19 – July 19
			5.2	Breach of Enforceable Contacts - All Community Order (CO)/ Suspended Sentence Orders (SSO) (Breach Initiated or Management Oversight [MO Contact]) to be increased from 83% to at least 88% by 01.07.19. Use of Management Information reports to inform progress.	Community Directors	July 19
			5.3	Acceptable Absences Management oversight contacts to be increased from 21.2% to 30% by 01.07.19. Use of Management Information reports to inform progress.	Community Directors	July.19
			5.4	Enforcement Practice Development day delivered in each Unit by 10.5.19.	Community Directors	May 19
6	Enhance the coordination of resettlement services to increase access to mainstream services by, and keep others safe from, those released from custody.	Agreed	6.1	Embed the enhanced Through the Gate (TTG) specification across all CGM resettlement prisons (which includes having dedicated prison managers to drive performance and ensure engagement from Responsible officers). This will include ensuring that the primary provider (Shelter) has access to CRC case management systems.	Strategic Managers/Community Director/TTG Lead	Sept 19
			6.2	Develop the role of the resettlement (Senior) Case Managers to ensure integration of service delivery through the gate including:	TTG Lead Interchange Managers/Strategic Managers	Sept 19
				6.2.1 Giving access to ‘email a prisoner’ to all Responsible Officers (ROs) to enable ease of communication, which will assist in the release planning process	TTG Lead Interchange	Completed

				Managers/Strategic Managers	
			6.2.2 Quarterly quality pan CRC workshops to look at best practice, to inform the continuous improvement of the delivery model	TTG Lead Interchange Managers/Strategic Managers	March 20
			6.2.3 Monthly Interchange Manager /Strategic Manager led quality practice development team meetings in clusters	TTG Lead Interchange Managers/Strategic Managers	March 20
			6.2.4 Discharge boards to be established in all resettlement prisons; with surgeries for shorter term prisoners where appropriate. Processes embedded to ensure ROs attend and engage in pre-release planning and risk management activity.	Strategic Managers	Sept 19
			6.3 Increase the use of partners (such as P3) to ensure complex cases are supported from the gate; as a meet at the gate service where needed or community-based support.	Strategic Managers	Sept 19
			6.4 RO to ensure pre-release risk management activity is undertaken in line with minimum expectations defined in the CRC operating guidance (home visits/Police Public Protection Unit/safeguarding/additional licence conditions)	TTG Lead Interchange Managers	July 19
			6.5 All Initial Sentence Plans (ISPs) to directly follow from the Basic Custody Screening Tool 2 (BCST2)/ISP. This will be evidenced through: • Improved quality outcomes on TTG assurance audits (IQAM) • Monthly Practice Development Group audits to show quality improvement (including risk assessment and management/Initial Sentence Plans) • Increased evidence of engagement with service user's pre-release. Evidence through contact logs on the Case Management System (prison visit contacts/telephone/email) • Increased quality review of the BCST2/Resettlement Plans • Increase in P3 (other agency) referrals • Feedback from service user council	TTG Lead Interchange Managers	July 19
7	Improve the ability of responsible officers to access policies and guidance effectively.	Agreed	7.1 Briefings for staff to be undertaken to provide information about how to access policy on WISDOM (CRC knowledge management repository) – between 01.05.19 – 01.09.19.	Community Directors	May 19 – Sept 19
			7.2 Line Managers to validate in supervision that staff have the knowledge and skills to access relevant information on the systems, in accordance with their roles and responsibilities (dip sample x1 per staff member to confirm this is being undertaken).	Community Directors	Oct 19

			7.3 Survey monkey to be completed during April 2019 to benchmark current understanding. Further survey monkey to be completed September 2019 to checkpoint progress and to determine any required next steps	Business and Project Manager	April 19 with checkpoint Sept 19
8	**Purple Futures should:** Make sure that the CRC has appropriate time and resources to introduce organisational change in a way that meaningfully engages staff and enables practitioners to maintain their focus on effective case management.	Partly agreed (resourcing need and affordability will need to be balanced)	8.1 CGM will stage delivery of briefings monthly, these will cover all practice briefs released from the Change Control Board. This will be completed with a One-page information sheet for staff dissemination to increased staff engagement. These will have a short summary of the practice brief contents and be released to the Heads of Operations to disseminate locally in CRCs. These will be sent in PDF format.	Quality, Policy and Performance Unit	June 19
			8.2 Chief Executive and/or Senior Leadership team to • undertake meetings in each location (at least 1 per Annum to engage with staff) • Provide briefings to all staff group and to engage in at least 3 all staff Question and Answer sessions per Annum	Chief Executive	Dec 19
			8.3 Develop practice that is where possible resource neutral, this will be completed by ensuring an impact assessment is completed for all potential practice changes considering resource impact on frontline practitioners.	Quality, Policy and Performance Unit	June 19
			8.4 Ensure a clear consultation process and timescales as per Change Control Board (CCB). Each Change request will have a minimum of 2 weeks consultation (best practice 4 weeks). This will be completed by those who attend the CCB, which includes representatives from each CRC.	Quality, Policy and Performance Unit	June 19
			8.5 Prompt CRCs through the Change Control Board to prepare for potential change. This will be achieved by clearly recording and disseminating a list of documents in consultation and clear dates for release for implementation. This will allow CRCs to prepare and plan for any change.	Quality, Policy and Performance Unit	June 19