HM Prison & Probation Service

Action Plan Submitted: 26th April 2019

A Response to the HMI Probation Inspection: Bedfordshire, Northamptonshire, Cambridgeshire and Hertfordshire (BeNCH) Community Rehabilitation Company.

Report Published: 3rd May 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 plan 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 annually by HMI Probation.

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: BeNCH 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	Improve the standard of both case management practice and management oversight in assessment, planning, service delivery and reviewing so that actual and potential victims are kept safe.	Agreed	1.1 OAsys workshops will be delivered to all Responsible Officers (RO's) to support continuous improvement of their assessment and planning skills including a specific focus on sentence planning. These workshops will include good practice examples of assessments, risk management plans and sentence plans to provide a suite of materials to support best practice. All training materials to be available to staff via CRC intranet. We will monitor completions of this training to ensure all OASys assessors have completed it.	Deputy Director Quality Lead	October 2019
			1.2 Bespoke training on Domestic Abuse and Risk 'So What Now' will continue to be delivered as part of the core learning and as part of the development plan for all service user facing staff and we will monitor completions of this on a monthly basis through Senior Leadership Team meeting.	Regional Learning and Development Manager	Commenced June 2018
			1.3 Ensure domestic abuse enquiries to the police are completed on **all** service users allocated to the CRC. We will identify the current level of enquiries completed at initial allocation to set a baseline then monitor this on a monthly basis. *(However, we recognise we are reliant on the police and the current protocol is being reviewed nationally.)*	Deputy Director Hub Lead	May 2019
			1.4 Review the current process for 'known person' checks with Children's Social Care on all children of all service users. Ensure that the process is understood including the issue of 'parental consent' through guidance and team meetings. We will use management information to monitor the number of checks	Deputy Director Public Protection Lead	June 2019

			undertaken on a monthly basis which includes setting a baseline on the current position.		
			1.5 Review middle manager's responsibilities and agree an approach to reduce the additional tasks and increase capacity for oversight. This will include dip sampling of case, case discussions with RO, audit activity, countersigning assessments, observations of practice.	Director	September 2019
			1.6 Monitor the quality of recording practice that demonstrates the sentence plan is being delivered. • Monthly full case audit activity, one case per RO per month using the new case management Quality Assurance audit tool agreed and developed by the Sodexo National Quality Assurance Group. • Quarterly operational partner and internal Rehabilitation Activity Requirement (RAR) delivery case audits, 10-20 cases per partnership.	Deputy Director Quality Lead	April 2019
			1.7 Monthly management oversight dip sample audits of 20 cases to be undertaken by the Quality Assurance team and learning shared through the Leadership Forum.	Deputy Director Quality Lead	May 2019
			1.8 Establishment of quarterly OASys Quality Assurance activity by Team Managers, Deputy Directors and Quality Assurance team. Sample equates to 1 OASys assessment per assessor.	Deputy Director Quality Lead	April 2019
			1.9 Learning from audit activity to be disseminated through Leadership forums, team meetings, staff supervision and via the intranet. Improvements to be checked through QA activity.	Deputy Director Quality Lead	April 2019

	Ensure delivery of interventions (especially those to be delivered as part of a rehabilitation activity requirement) is consistent across the organisation.	Agreed	2.1 Review current provision required in each office (following service user needs profile activity as per recommendation 3) and ensure they are available via operational partner or internal delivery. Accountability for delivery will be governed through the operational partnership contract meetings and Senior Leadership Meetings.	Deputy Director Interventions and Partnerships Lead	Sep 2019
			2.2 Undertake a review of current Education Training and Employment (ETE) provision across BeNCH to establish a consistent model of delivery including delivering the 20% target for those subject to Unpaid Work (UPW) requirements. Monitor the increase in ETE delivery for UPW against the current baseline on a monthly basis through the Senior Leadership Team meetings.	Deputy Director CP lead	June 2019
			2.3 Undertake a review of Community Payback placements and develop placements that provide opportunities for personal development of the service user.	Deputy Director CP Lead	June 2019
			2.4 We will consider development of specific interventions that align with service user profiles, this will include: • Work with 4Front to pilot a specific intervention in Luton for black service users which will focus on overcoming adverse experience and managing social and cultural expectations. • Development of a RAR Drink Drive programme.	Deputy Director Interventions Lead	Oct 2019
			2.5 We will continue to monitor the number of RAR delivery days recorded in each location and ensure improvement against the current baseline. • Where gaps in recording are noted through case audit activity we will provide additional training and support for the RO and or RAR provider. • Where there are gaps in delivery of the RAR offer this will be addressed via partnership contract management meetings for operational partners and governance via Senior Leadership Team meeting for internal RAR delivery.	Deputy Director Performance Lead Deputy Director Quality Lead Deputy Director Interventions Lead	April 2019 April 2019 April 2019

3	Improve the use of management information, intelligence and data drive service planning, delivery and commissioning	Agreed	We will review our current caseload data to further enhance it to ensure our services meet the needs of our service users to reduce offending and harm.		
			3.1 During 2018 we identified priority needs of service users from each office using Justice Star data. We will build on this activity by using OASys data to ensure we have current information to monitor trends and ensure services reflect the need.	Deputy Director Performance Lead and Deputy Director Interventions & Partnerships lead	May 2019
			3.2 We will review current intervention delivery and availability in each office to meet the identified priority needs.	Deputy Director Performance Lead and Deputy Director Interventions & Partnerships lead.	June 2019
			3.3 We will review OASys needs data matched against intervention availability on an annual basis in order to be responsive to changes in need	Deputy Director Performance Lead and Deputy Director Interventions & Partnerships lead	Commence Jan 2020
			3.4 We will improve recording of equality and diversity data on our case management system (NDelius) with the relaunch of clear guidance and recording practice. This will enable a better understanding of our cohort of service users and development of interventions to meet diverse needs	Deputy Director Performance Lead and Deputy Director Interventions & Partnerships lead	September 2019

4	Improve the coordination and delivery of resettlement services to increase the likelihood of successful community reintegration for released prisoners.	Agreed	April 2019 saw the mobilisation of the enhanced through the gate model. This model has increased the levels of Through the Gate (TTG) staff within, service user facing roles, administration support and managers with responsibility for overall delivery. The new model will improve the delivery of pre-release interventions and support, as well as better integration between custody and community.		
			4.1 Implementation of the new TTG model as above	Deputy Director TTG Lead	April 2019
			4.2 Communicate effectively the TTG model, roles and responsibilities in order for all parties to be aware of their role within the management of the case. This will include sharing and implementation of the Sodexo TTG practice standards and Probation Instruction 07/2018 – TTG Instructions and Guidance, which outlines responsibilities/tasks and critical information sharing points.	Deputy Director TTG Lead	April 2019
			4.3 There are regular meetings including quarterly Tripartite meetings and monthly telecoms with Prisons, CRC, National Probation Service (NPS), Contract Management Team (CMT) and operational partners to track progress against delivery.	Deputy Director TTG Lead	April 2019
			4.4 A data-set for performance and outcomes has been agreed and will be reported on from 1st April 2019 . E.g. completions of Basic Custody Screening Tool 2 (BCST2) and resettlement plans, positive outcomes in custody interventions to address areas such as accommodation, ETE, finance benefit and debt.	Deputy Director TTG Lead	April 2019
			4.5 Where practicable attendance and participation of TTG managers at prison reducing re offending boards in their lead prisons to support joint working and share good practice.	TTG Managers	April 2019
			4.6 Monitoring the quality of resettlement practice through case audit activity and quarterly audits of a sample of BSCT2 completions across each establishment where we are responsible for their completions. Learning to be disseminated through Leadership forums, team meetings and staff supervision	Deputy Director Quality Lead	Sep 2019

			4.7 Mobilisation of our new mentoring scheme which includes support for resettlement and meet at the gate services.	Deputy Director Mentoring Lead	Sep 2019
5	Ensure that all premises and facilities are accessible and provide a safe environment for individuals under probation supervision and staff	Agreed	We acknowledge that we have one office - Cambridge where there are concerns in relation to accessibility and safety. We have a clear action plan in place to address this. • All staff have a solo protect device which is a lone working fully managed all-inclusive safety service assigned to them • Access control issues have been resolved • Programmes are due to be delivered from an alternative venue. • Plans to end the current arrangements in Cambridge and move to more suitable premises. 5.1 Continue to implement current plan to make all reasonable steps to secure alternative premises.	CEO	January 2020

Recommendations	
Agreed	5
Partly Agreed	0
Not Agreed	0
Total	**5**