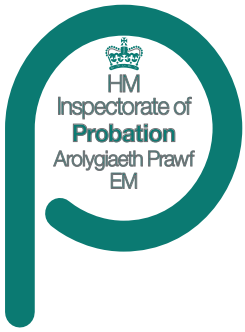

An inspection of

Merseyside

Community Rehabilitation Company

HM Inspectorate of Probation

SEPTEMBER 2018

Contents

This inspection was led by HM Inspector Avtar Singh, supported by a team of inspectors and our 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.

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Foreword

This is the first report in our new series of annual rated inspections of probation service providers in England and Wales.

We have given Merseyside Community Rehabilitation Company (CRC) a 'Requires Improvement' rating. Nevertheless, this CRC has clear strengths. It is performing well against some of our new standards, and its leaders are ambitious to do better still, to improve the life chances of those under probation supervision.

The CRC's innovative operating model is largely embedded, and is understood by staff and others who work with or alongside the CRC. Staff are stretched, as we so commonly find, but they are nevertheless well motivated – a reflection of the quality of leadership here.

However, 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 have not been adequately equipped to deliver high-quality personalised services. Their induction is basic and they have gaps in their knowledge and skills.

This dichotomy is most evident when it comes to managing risk of harm, where the work of case managers is not sufficiently effective. Safeguarding and domestic abuse checks are often seen as administrative tasks rather than essential professional work, and this needs to change. The quality of case supervision compounds matters: it is good in parts, but wanting in other ways, particularly in relation to managing risk of harm. This needs to be addressed urgently as well.

The CRC has a good understanding of the profile of those individuals it supervises, and wider management information is plentiful and helps leaders decide what services to provide. The range of specialist services available is not sufficiently comprehensive, however, despite some strong partnerships, and the CRC's own programmes are underdeveloped and underused.

Services for women are impressive, and Through the Gate services show promise as well. This is so refreshing, when we have often found Through the Gate services wanting elsewhere, and the current contractual arrangements do not incentivise or reward effective provision well enough.

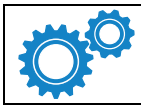
This CRC's senior leaders promote a culture of learning from mistakes, and they respond actively to findings from audits and independent inspection. We welcome that, and hope that the findings and recommendations in this report will be helpful.

Dame Glenys Stacey
Chief Inspector of Probation

Overall findings

Our key findings about the organisation were as follows:

Overall, Merseyside 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:



Organisational delivery

- **There was a strong, hardworking leadership team supporting the delivery of services**

  Merseyside CRC had a strong leadership team committed to improving performance and the quality of services delivered. It had adopted, then reviewed and modified, an operating model based on research evidence. The model supported a personalised, strengths-based approach to changing the lives of service users. The CRC had communicated the model effectively to partners and stakeholders, but had more work to do to explain to them its overarching vision and strategy for optimising the quality of services and of performance.

- **Staff were stretched to deliver high-quality services and not all had been adequately trained**

  Staffing levels were tight. Consequently, when gaps arose (for example, due to sickness or vacancies), these adversely affected performance and the quality of services. Nonetheless, leaders deployed staff carefully to maximise productivity within the resources available. Some training was accessible to staff, but rates of take-up and effectiveness were variable, particularly in relation to training on child safeguarding. Staff were motivated and supported well by accessible managers, although there was a lack of evidence of formally recorded and appropriately targeted management oversight.

- **The range of services to support desistance was not comprehensive**

  There were effective mechanisms in place, including the Reoffending Analysis Tool, to help leaders decide which services to provide. There was an impressive range of provision for some service users, such as women. However, services for others, such as those from black and minority ethnic backgrounds and those undertaking rehabilitation activity requirements, were underdeveloped. The CRC needed to provide more information to sentencers about the services available, and to improve the exchange of information with partners about the risks of harm posed by service users.

- **The range and quality of management information informed a responsive approach to service delivery**

  Senior leaders within the organisation promoted a culture of learning from mistakes and responded proactively to the findings from audit and independent inspection. Staff received appropriate guidance through comprehensive policies shared via a user-friendly intranet platform. Mobile information and communication technology (ICT) equipment was used to provide more flexible working arrangements for practitioners. There had, however, been significant ICT challenges, which had proved problematic and frustrating for staff. A strong understanding of the standard of performance – across the organisation as a whole, and at the individual practitioner level – was helping the organisation to focus on improvement.

Case supervision

Our key findings about case supervision were as follows:

- **Assessments focused appropriately on factors related to offending but these factors were not analysed well enough**

  Responsible officers were mostly able to demonstrate an understanding of the reasons why those they were supervising had offended. They provided full descriptive accounts of current offences, and there was some evidence that they had considered historical relevant factors. Information from a range of sources was considered within assessments. However, the analysis of reasons for offending and links to historical offending were much weaker. Assessments completed by senior case managers were better than those of case managers. Attention to diversity factors was good. Responsible officers did not consistently ask individuals why they thought they had offended.

- **Planning for work to reduce reoffending was good but planning did not adequately address how best to keep actual and potential victims safe**

  Individuals were not fully involved in contributing to plans that would support their desistance. Their views about what would prevent them offending again were not routinely explored. The frequency and type of contact necessary to achieve positive outcomes were explained and recorded well. Plans were not always personalised and did not build on service users' strengths and the protective factors that they considered important to them. Planning did not sufficiently focus on addressing issues related to risk of harm. Links with other agencies involved in cases were limited. Contingency planning was weak.

- **Engaging the service user was prioritised but interventions did not effectively support the safety of those at risk of harm**

  Responsible officers were investing time in establishing effective working relationships with vulnerable service users. Interventions were mostly personalised to meet individuals' assessed needs. Enforcement decisions were taken appropriately but professional judgements to manage non-compliance were

not explained or recorded well. Some interventions identified in plans were delivered well, but some were not delivered in the way set out in the plans. Responsible officers did not focus enough on 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.

- **Reviews of work, particularly that relating to risk of harm, were perfunctory**

  The quality of work to review progress in cases was variable and significantly let down by responsible officers failing to focus properly on issues related to risk of harm. Individuals under probation supervision were not consistently involved in reflecting on how their risk of harm had, or had not, changed. Practitioners did not seek timely information from other agencies involved with individuals, and reviews were making very little difference to whether plans were amended, despite significant changes in the individual's circumstances. The purpose of reviewing was not fully understood by many case managers.

Unpaid work and Through the Gate

Our key findings about other core activities specific to this organisation were as follows:

- **Unpaid work arrangements had recently been reorganised. It was too early to make any definitive judgements about effectiveness**

  Assessments generally focused on the critical issues relevant to unpaid work. Personal circumstances and individual diversity needs were appropriately considered in the vast majority of cases. Domestic abuse risks were not assessed fully in all cases. A new system to manage unpaid work had been implemented very recently. We found that case recording was poor. There were delays in individuals starting their unpaid work. It was too early to make any definitive judgements about the reorganisation of unpaid work. There were mixed views about the new arrangements for unpaid work from those involved in overseeing its delivery.

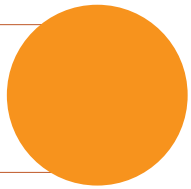
- **The coordination of resettlement activity and communication with responsible officers were not fully effective, but some aspects of Through the Gate delivery were improving**

  Through the Gate provision showed promise. Resettlement plans were completed and individuals could contribute to their plans. Diversity needs were appropriately considered in most cases. Not all plans adequately built on service users' strengths and protective factors. This was a missed opportunity. There were gaps in the delivery of some resettlement services. The coordination of resettlement activity was variable and communication with responsible officers in the community, before and at the point of release, was erratic.

Service:	Merseyside Community Rehabilitation Company
Fieldwork started:	June 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	Good

2. Case supervision

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

4. CRC specific

4.1[1]	Unpaid work	No rating[2]
4.2	Through the Gate	Requires improvement

1 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.

2 The unpaid work standard has not been given a rating on this occassion, due to a misalignment between local recording practices and inspection methodology. The report, however, contains narrative findings in relation to this aspect of work.

Recommendations

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 Merseyside CRC.

Merseyside CRC should:

1. improve the quality and impact of work to manage risk of harm so as to keep actual and potential victims safe.
2. equip all staff with the skills and knowledge necessary to carry out effective work to keep other people safe.
3. better involve service users in producing plans that are personal to them.
4. make sure that all aspects of case management (for example, desistance, safeguarding, and public protection) are reviewed fully to achieve better outcomes for service users.
5. strengthen its relationship with sentencers so that information is exchanged more effectively.
6. further improve the coordination of resettlement services so as to increase the likelihood of successful community reintegration for released prisoners.

Background

Probation services

More than 260,000 adults are supervised by probation services annually.[3] 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.[4]

To protect the public, probation staff assess and manage the risks that offenders pose to the community. They help to rehabilitate them 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 that provide services under contract. Government intends to change the arrangements for delivering probation services, and is consulting on some aspects of the future arrangements, at the time of writing.

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.

Merseyside CRC

Purple Futures took formal ownership of the Merseyside CRC on 01 February 2015. The five Purple Futures CRCs[5] work collaboratively with one another, sharing learning and resources wherever practicable. The Chief Executive Officer of Merseyside CRC is the senior leader of both Merseyside and the neighbouring Cheshire and Greater Manchester (CGM) 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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[3] Offender Management Caseload Statistics as at December 2017, Ministry of Justice. https://www.gov.uk/government/collections/offender-management-statistics-quarterly

[4] 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.

[5] The five CRCs owned by Purple Futures comprise Cheshire & Greater Manchester; Hampshire & Isle of Wight; Humberside, Lincolnshire & North Yorkshire; Merseyside; and West Yorkshire.

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

The standards against which we inspect are based on established models and frameworks that are grounded in evidence, learning and experience. These standards are designed to drive improvements in the quality of work with people who have offended.[6]

[6] HM Inspectorate of Probation's standards can be found here: https://www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/

Key facts

158,727 — The total number of individuals subject to probation supervision by CRCs across England and Wales[7]

6,512 — The number of individuals supervised by Merseyside CRC[7]

5 — The number of CRCs owned by Purple Futures

4.7% — The rate of unemployment in Merseyside. This is higher than the average for England (4.3%)[8]

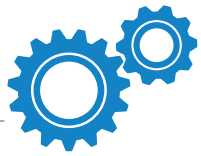
40% — The adjusted proportion of Merseyside CRC's service users who reoffend[9]

83% — The proportion of individuals who were recorded as having successfully completed their community orders or suspended sentence orders for Merseyside CRC. The performance figure for all England and Wales was 78%, against a target of 75%[10]

94% — The proportion of resettlement plans completed by the CRC. The performance figure for all England and Wales was 96%, against a target of 95%[11]

7 Offender Management Caseload Statistics as at 31 December 2017, Ministry of Justice.
8 Regional labour market statistics, Office for National Statistics, July 2018.
9 Proven reoffending, Payment by results, April-June 2016 cohort, Ministry of Justice, April 2018.
10 CRC Service Level 8, Community Performance Quarterly Statistics, October–December 2017, Q3, Ministry of Justice.
11 CRC Service Level 13, Community Performance Quarterly Statistics, October–December 2017, Q3, Ministry of Justice.

1. Organisational delivery



Merseyside CRC has strong leaders who are focused on the need to improve the quality of services on offer. Staff are stretched, and not all are adequately trained to deal with the challenges of their caseloads. Partnership working is strong, but some services are underdeveloped or under used. Services for women are impressive.

Strengths:
• There is a committed senior management team which has a clear vision. • Staff receive regular supervision from their line managers. • There are strong partnerships in place that support service delivery. • Management information across a range of business areas is sound. • Staff are dedicated 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, but are improving. • Induction and training for new staff on public protection and safeguarding are underdeveloped. • Management oversight lacks focus on how to improve the quality of practice, particularly in relation to public protection and safeguarding work. • Rehabilitation activity requirements are underdeveloped and those which are in place are under-used. • Despite strong partnership working, the dynamic exchange of risk of harm information with service providers is limited. • The collection of data on diversity is patchy.

Organisations that are well led and well managed are more likely to achieve their aims. We inspect against four standards.

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.	

Leaders have a clear vision and strategy, incorporated into the annual service plan, to deliver effective services to support rehabilitation, reduce reoffending and protect the public. The service plan is reviewed appropriately and there is an active commitment to continuous improvement from senior leaders.

Opportunities for contribution, consultation and challenge are provided internally in various ways. These include senior managers attending service delivery offices, cluster meetings, business unit meetings, information from the Service User Council, regular question and answer sessions with a senior manager from Interserve, and staff meetings at all levels.

Senior leaders had recognised that governance arrangements, including the function of the change control board, had not been working well for a considerable period. This self-critical analysis provided a catalyst for change, and governance arrangements have now improved. We saw examples of operational and strategic difficulties being addressed appropriately through good governance arrangements. This included increasing staff mobility to support sites in particular need, and the use of practice briefs to communicate changes to service delivery.

The CRC has active processes in place to manage business risks to service delivery. Business continuity plans are in place at all sites. There have been significant disruptions to ICT this year and these, combined with office moves, have adversely affected staff and service users. These difficulties have been managed well by senior leaders. The introduction of remote working, using mobile ICT, has included appropriate training on information assurance, and other support and safety controls. Business partners escalate issues presented by staff; problems are resolved within realistic timeframes.

The organisation has a risk register, and this is reviewed at senior management team level. Business risks, such as staffing, are well understood and responded to by senior leaders. It was encouraging to learn that, although the number of assistive technology users was small, the organisation had planned for these diversity needs very early on in the roll-out of the mobile technology.

The CRC had not been fully aware that induction and training for new staff did not adequately cover public protection and safeguarding. Although this issue has now been recognised and actions are in place to address it, new staff have been left unprepared to manage the needs of potential and actual victims effectively.

The interchange operating model is rooted in research on desistance and generally 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 change. The six modules – induction, dynamic assessment, planning,

networking, reviewing, and planning for the longer-term future – are integrated into the relevant domains 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 encouraging examples of emerging good practice to support meaningful interaction and continuity of contact with service users.

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 a robust system in place via which staffing levels are planned and reviewed to respond to the changing needs of service users. Management information is up to date and relevant, allowing leaders to make decisions about resourcing within tight business restrictions. Most staff are stretched. Only half of the responsible officers who were interviewed reported that their workloads were manageable. A similar view was expressed in focus groups that we held with different grades of staff.

We were encouraged to note that senior leaders had recognised, in particular, the rising demands placed on interchange managers (senior probation officer equivalents). A new interchange support officer role had been created to directly support this staff group. While this role is relatively new, a sizeable number of interchange managers reported that it was making a difference.

Staff in the professional services centre and the community payback (unpaid work) hub had particularly high workloads. In the past, high levels of sickness absence have had a negative impact on service delivery, with practitioners reporting that many individuals have not been supervised effectively. In our case assessments, we found lengthy gaps in supervision in a considerable number of cases. Senior leaders have recognised this problem and have used several strategies to address staffing deficits. For example, they have redeployed staff and used agency staff to respond to local pressures.

Nine out of ten responsible officers who were interviewed reported that they had the skills to deliver high-quality services. However, while some casework skills were evident, such as planning which focused on desistance work, responsible officers had a limited understanding of public protection and safeguarding work. This was particularly true of case managers. New staff joining the organisation had a very limited understanding of court work and what was involved in supervising individuals in the community and in custody.

A banding system is used centrally to allocate cases. This is unsophisticated according to interchange managers, who have the authority to reallocate cases. The induction programme and support for continuous development for volunteers are good and the accredited programme for mentors is impressive. Staff have clear job descriptions to support their responsibilities but these are not all up to date. There is

some evidence of succession planning for specialist staff (for example, those delivering women's services) and for interchange managers.

Four out of five responsible officers interviewed reported that the supervision they receive from line managers enhances and sustains the quality of their work with individuals. We found, however, that while supervision meetings were taking place and these were generally regular, there was insufficient focus on developing practice, particularly in relation to safeguarding and public protection work. Line managers were supportive, but they did not always provide effective guidance to improve the quality of work to keep other people safe.

The introduction of enhanced management oversight, where interchange managers are now more actively involved, is a promising development. It demonstrates that the organisation recognises the deficiencies in the previous oversight arrangements. There is a new, robust appraisal system in place, which includes 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 under-performing.

Arrangements for learning and development are variable. There is an organisational plan, as well as personal development plans for staff. These identify training needs, but operational staff report that the quality of the online training they receive is *"inconsistent"* and does not improve their knowledge and skills. New staff describe their 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 not enough. Input from quality officers, when provided, is valuable but not always accessible.

Senior leaders have committed to investing in pre-qualifying training routes (that is, apprenticeships) to support the delivery of services that will make a lasting difference. However, some case managers remain unconvinced that this will help new staff sufficiently, suggesting that there are very limited opportunities.

Just over half of the responsible officers interviewed believed that the organisation has a culture in which learning and continuous development are valued. Access to in-service training is available, and this is supplemented by regular functional group meetings. For example, all case administrators attend a meeting at the CRC's head office in Liverpool every three weeks. This combines training with addressing operational issues. Case managers welcome this meeting and consider it to be effective in supporting them to carry out their responsibilities.

Staff can complete various training modules through the 'virtual college'. These have been designed internally and externally. Feedback from focus groups, however, suggested that the quality of the modules varies enormously.

Across the organisation we found hard-working, committed and motivated staff who want to deliver the best possible service. They are passionate about their work and want to make a difference to the lives of the vulnerable people with whom they are working. Staff reported that they do not always feel they are listened to by their Interserve leaders. Here, we found a disconnect between the optimism about staff engagement expressed by senior leaders and what operational staff told us.

Interchange managers reported good levels of engagement with the wider organisation.

Exceptional work is recognised by managers, who use both formal and informal procedures to reward good practice. We found examples of staff (individuals and teams) who had received 'any time' awards, and numerous examples of staff nominations for carrying out exceptional work.

Two-fifths of responsible officers interviewed reported that not enough attention is paid to their well-being. For example, they said they were given additional cases when they were already struggling to keep up with the demands of their caseload. This has led to anxiety and resulted in sickness absence. Peer support was a common valuable ingredient we found among all grades of staff.

Of those 21 staff who told us they needed reasonable adjustments in the workplace, one-quarter said that there had not yet been a positive outcome. However, those for whom reasonable adjustments had been made reported that their needs had been handled well and with sensitivity.

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 collected 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 helps the CRC understand the profile of its service users. The analysis is not 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 produced in December 2017. This showed large gaps in the recording of some diversity data and variance in service delivery across diverse groups. We were pleased to see that this report prompted appropriate action from the operational and quality group across the Interserve CRCs. This has led to better engagement with women who have offended, for example.

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

The CRC makes effective use of analysis of local patterns of sentencing and offence types, to inform its decisions on the services it provides.

In Merseyside, Interserve has maintained 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. Reviews and evaluations of services are being undertaken more routinely but this approach is not yet embedded.

Services for women are strong and the development of the Women's Alliance is positive. Services in support of other rehabilitation activity requirements (RAR) are underdeveloped, however; this is particularly so for those from black and minority ethnic backgrounds. The secondment of an interchange manager to develop RAR activities and the production of a RAR performance dashboard are promising.

The interchange model is well understood by service providers. They have embraced an approach to developing and delivering services that is based on strengths and personalisation. It is to the CRC's credit that this has been achieved.

The CRC has healthy working relationships with the different safeguarding boards in Merseyside, combined with effective liaison with the area's Police and Crime Commissioner. There is good representation at meetings, where the needs and views of the CRC are communicated well. The reducing reoffending board is chaired by the CRC's head of operations. Notes from these meetings show evidence of effective partnership working.

In the sample of Through the Gate cases we inspected, we saw the positive difference that partnership working was making. The wrap-around service to support desistance for women is impressive. An effective working relationship with Rotunda College is now established and providing additional personalised services to service users.

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

Interface relationships with the NPS are generally strong and issues are dealt with respectfully. Sentencers reported that, until recently, they lacked up to date information about the services available; this hindered decision-making on sentencing. Newsletters were irregular and often the information provided lacked quality and substance.

1.4. Information and facilities	Good
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 comprehensive 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 was a lot of information to take in, but they were satisfied with the different communication tools that the organisation used to disseminate information. Not all sections of the Merseyside CRC WISDOM intranet were up to date when we inspected, however. We found some confusion about who was responsible for keeping which section refreshed.

Senior managers were aware that their safeguarding policy needed to be reviewed, for instance, but we were assured that this was being addressed. We were pleased

to discover that there is a development group looking at how WISDOM can be improved, using feedback from staff.

For service users, information about services and expectations is provided on the organisation's website, and some had been involved in designing posters regarding available services. Some of the telephone numbers on the organisation's website were either out of date or no longer working, however.

Referral processes are in place and these are mostly clear. Some providers report that the quality of referrals is improving, but information on the risks of harm posed by individuals is not always included with the referrals. Suitable guidance is available to practitioners on the range of services available to those they are supervising.

Arrangements are in place to make programmes more accessible for service users, with groups running across various locations. Individuals can choose their preferred location. Programmes run in the morning, afternoon, evening and on weekends to offer flexibility to those with employment and childcare commitments.

There is an ambitious estates strategy. Offices managed entirely by the organisation are impressive. They provide an environment for effective engagement with service users. Security measures for staff safety are evident and working. Health and safety training arrangements are in place and first aid training and refresher training are rolled out regularly. The Prescot office, a model for future offices, has open plan facilities with quiet areas for assistive technology users.

Staff speak highly of these facilities. Service users have been involved in designing the new premises and reception areas. 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. More generally, unpaid work collection points are available across different sites.

There have been a range of historical and current ICT challenges for staff in delivering services. In our focus groups with operational staff, there were reports that the organisation's ICT upgrade had made the system more fragile. There were often whole days when staff could not access recording systems. This affected their capacity to record information that supported defensible decision-making and effective communication.

Problems involving access to recording systems have largely been resolved, with only intermittent difficulties now being experienced. Some staff reported that the organisation's ICT helpdesk was often slow in responding to their difficulties. We did, however, see evidence suggesting that difficulties were now being resolved more efficiently.

Staff have overwhelmingly welcomed and embraced access to personal laptops and mobile telephones to enable community-based working. While there are still problems with remote working and access to Wi-Fi, and technological difficulties in some locations, staff report that they can better plan, record and deliver services.

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

The ICT systems produce relevant management information. For example, the Open Tool, which produces performance information in a user-friendly format, enables staff to access a range of information to enhance their service delivery. This system is well established but not always used consistently by all staff.

There are sophisticated systems in place to monitor and drive improvement. This is a clear strength in the organisation. We found a significant number of examples where, through auditing, piloting, monitoring and quality assurance, the organisation had identified areas that needed to improve. Last year, a risk management audit showed inconsistencies in practice. This prompted the CRC to implement a shorter template for risk management oversight and to appoint interchange support officers to assist interchange managers.

A new case management system to give service users a more personalised service has been trialled and recently been given provisional approval by the Ministry of Justice. Results from IQAM reports have been used to inform continuous improvement.

A pilot was recently commissioned at HM Prison Styal that looked at the organisation's frequent returners into custody. This resulted in multi-agency meetings with the prison governor, the head of the offender management unit, the head of drugs and alcohol services and others to better understand this reoffending and explore what would support desistance. The CRC has also piloted placing a responsible officer into HM Prison Liverpool to try and improve communication.

While all these examples provide evidence of a learning organisation, the CRC recognises the challenges of embedding good practice and admits that there is some way to go. Staff are increasingly aware of gaps in their own performance across a range of practice areas. The organisation has a healthy culture of learning from mistakes. It takes prompt action in response to inspection and audit findings, as evidenced, for instance, in its response to our recent thematic inspection report on new psychoactive substances.[12] The CRC has invested heavily in listening and responding to the voice of service users for several years.

[12] *New psychoactive substances: the response by probation and substance misuse services in the community in England*, HMI Probation (November 2017).

2. Case supervision

The quality of case supervision varies considerably between senior case managers and case managers. While there is shared enthusiasm 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. Case managers have shared their vulnerabilities with us and the impact of their concerns has been seen in their work with service users. Management oversight is not consistently effective. 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 factors related to offending. • Planning for work to reduce reoffending is mostly effective. • 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 always explore the individual's perspective on why they have offended. • Planning for work to keep actual and potential victims safe is limited. • There is a lack of focus on supporting the safety of those at risk of harm when delivering services. • The approach to reviewing risk of harm work is limited; responsible officers fail to fully analyse progress made and to adjust planning accordingly.

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

In two-thirds of the cases we 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 used well. Where there had been a history of non-compliance, this had been explored carefully.

Similarly, in the majority of inspected cases, there was a good analysis of the service user's diverse needs and individual circumstances. Appropriate consideration had been given to how these assessed factors might affect the individual's capacity to engage with interventions to support their desistance. In a small number of cases, responsible officers did not fully take diverse needs into account when planning services. Additionally, they did not always ask individuals to explain why they had offended. This meant that their views were not fully considered in order to formulate a holistic assessment.

In the vast majority of inspected cases, assessments focused on factors associated with offending and desistance. These assessments were completed in a timely manner. Practitioners used a variety of information from a range of sources to support their assessments. This had enabled them to identify the areas they needed to focus on to bring about change. We largely agreed with the offence-related factors they had identified. Analysis of offences was weaker. Often there was too much description of the current offence, taken from Crown Prosecution Service documents, and insufficient attention was paid to understanding and linking past behaviours to recent offending. We found some good examples of strengths and protective factors being recognised by responsible officers in the assessment process. This supported personalised assessments.

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

We agreed with the vast majority of the 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 two-fifths of inspected cases. This meant that important 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.	

Nearly half of the service users in the inspected sample were not meaningfully involved in the entire planning cycle. Furthermore, their views about what would prevent further offending were not routinely explored. This is disappointing. Diversity needs and personal circumstances were generally considered in order to maximise engagement and compliance.

Both senior case managers and case managers generally had a good understanding of how motivated service users were and what obstacles might affect their engagement and compliance. Encouragingly, many plans included how the requirements of the sentence would be delivered and the level and type of contact necessary to support positive outcomes. We were not, however, confident that service users fully understood the consequences of poor engagement.

Planning commonly revealed the key factors that had contributed to the individual's offending behaviour. However, objectives were not prioritised and the sequencing of work focusing on desistance was limited. Assessed emotional well-being needs were often omitted from plans. While strengths and protective factors were identified and featured in around six out of ten assessments, not all were suitably integrated into plans to support desistance. This limited the level of personalisation and work to build on strengths. The vast majority of plans were timely and set out the services that were most likely to reduce reoffending and support desistance.

Planning did not sufficiently focus on keeping other people safe in just under half of the inspected cases. In these, domestic abuse issues and safeguarding concerns were not considered effectively in planning. Almost half of the plans failed to address risk of harm factors adequately, and there was little evidence that risk of harm issues, when identified, were prioritised. Again, the greater deficiencies lay 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. However, they did not engage effectively with other agencies involved with service users. There was little evidence that they made links between their own plans and those held by other agencies. This was a deficiency in almost half the inspected cases. Contingency arrangements to manage assessed risk were equally lacking.

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

The requirements of the sentence were implemented promptly in the majority of cases. This maximised the service users' motivation, which is commonly stronger at

the start of a sentence. Responsible officers showed a commitment to maintaining effective working relationships with service users. This included the constructive use of information from self-assessment questionnaires, prompt responses to missed appointments (via telephone calls and letters to the service user) and the affirmation of positive achievements.

We found many examples where responsible officers had personalised their interventions to meet assessed needs. Often, vulnerable individuals were seen several times a week, medical needs were appropriately considered, motivational work was carried out and individual circumstances were taken into account so that individuals could complete their sentence.

In post-custody cases, in particular where service users were subject to integrated offender management (IOM) arrangements, we saw evidence of good joint prison visits with the police. In other non-IOM cases, contact either through correspondence or visits was limited.

Responsible officers had mostly explored individuals' past responses to supervision and identified what would help to support compliance. Enforcement decisions were generally taken correctly, but decisions about acceptable absences were not recorded or explained well. Work to re-engage individuals following recall and enforcement was done well.

The delivery of services to support desistance was done well in relation to some areas of need, for example employment, training, education and accommodation. However, a number of key areas, including alcohol and drug misuse and attitudes to offending, did not receive the required attention. This applied to approximately half of the inspected cases.

Responsible officers had correctly 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 encouraging evidence of responsible officers trying to build on the strengths and protective factors of service users. Examples included personalised RAR interventions and links with Rotunda College to support employability interests. Good motivational work was supported by a meaningful focus on sustaining employment and pursuing a non-criminal identity.

The involvement of key people in the life of the service user was limited. We found numerous opportunities that responsible officers had missed. If there had been better engagement with 'significant others', more could have been achieved to reduce reoffending.

Almost one-quarter of those whose cases we inspected were not offered enough supervisory contact. This was partly due to cases not being reallocated when responsible officers were absent because of sickness. This meant that these service users were left unsupervised, some for weeks and months.

The involvement of local services during the course of statutory supervision was encouraging, but practitioners did not always pay sufficient attention to reintegrating individuals into the community once their sentence had been served.

In over half of the inspected cases, we found that responsible officers had not focused enough on supporting the safety of other people when delivering services. The level and nature of contact offered were not sufficient to minimise and manage

risk of harm. There were far too many gaps and delays in contacting those who had been assessed as posing a risk of harm to other people. In these instances, actual and potential victims had been left with limited protection. These deficiencies were greater in cases managed by case managers.

In those cases where other service providers were involved, the coordination of work by responsible officers to manage risk of harm was weak. There was very little evidence on case records to demonstrate that practitioners were exchanging information on risk or emerging risk of harm with service providers. A number of partners we spoke to told us that information on risk of harm was often either incomplete, limited or not included in referrals. They expressed this as a concern and we agreed.

Responsible officers did not take account of significant individuals in the service user's life when managing risk of harm in almost one-third of inspected cases. Practitioners did not routinely carry out home visits where risk of harm had been identified. We were concerned that some of the case managers we interviewed struggled to comprehend how home visits could help them to manage risk of harm. Where individuals were being managed under IOM schemes, joint home visiting did take place as required and these visits were contributing to keeping potential and actual victims safe.

In relation to accredited programmes, tutors reported that the pressure to prepare and deliver sessions was immense. Therefore, it was not common practice to check the contact logs of individual group members before sessions. This led to tutors being unaware of the risk of harm individuals might pose to staff or other group participants.

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

Reviewing was variable and significantly let down by responsible officers failing to focus properly on risk of harm issues. When done well, reviews were making a 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 focus sufficiently on reviewing what was preventing individuals from complying with their sentence. We found very little evidence of adjustments being made following reviews. Reviews provided very brief updates, with little analysis of the changes that had been made. Significant changes in personal circumstances or poor compliance levels did not often trigger a review.

Half of the service users had not been involved in reviewing their sentences in a meaningful way. Reviews were often treated as an administrative process rather than as an opportunity to reflect on progress and make any necessary adjustments. Case managers did not fully understand the purpose of reviews, with most reporting that reviews were an opportunity to summarise the current position. There was

usually a written record of the review but much of this work did not support the delivery of effective services. In a small number of cases, senior case managers were using the local 'enabling plan' well to determine the changes that were needed to maximise compliance. This was encouraging.

Reviews of work that focused on supporting the service user's desistance were better. Although changes in factors linked to offending behaviour were mostly identified, this did not necessarily lead to meaningful adjustments to service users' plans. Again, accounts were too descriptive, comprising an administrative summary of work undertaken. Reviews did, however, provide a reassuring consideration of strengths and work to build on protective factors.

Healthy relationships were assessed as being very important to service users, and we found evidence of responsible officers working hard to best support this goal.

In too many cases, there was very limited recorded information from other agencies. This meant that reviews did not robustly cover all the relevant desistance factors.

In almost one-third of those cases where risk of harm issues had been identified, reviewing failed to address these issues sufficiently. This led to over half of the reviews remaining largely the same in content, despite evidence in case files showing changes in circumstances. Examples included recalls, loss of contact, and new relationships being formed.

There was very little evidence of information from other agencies being included to support the review of risk of harm work. We did, however, see some examples of information being exchanged in emails.

Service users were not themselves sufficiently involved in exploring and addressing the risks that had been identified. This was a worrying gap in practice, as they were not always invited 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 were not done well in far too many cases. Management oversight was not effective in these cases.

4. Unpaid work and Through the Gate

CRC

A new system to manage unpaid work has very recently been implemented. As such, it is too early to make any concrete judgements about the success, or otherwise, of the reorganisation of unpaid work. Assessments generally focus, however, on the critical issues relevant to unpaid work. Individuals' personal circumstances and diversity needs are appropriately considered in the vast majority of cases. Risks related to domestic abuse are not assessed fully in all cases. Case recording is poor. There are delays in individuals starting their unpaid work. There are mixed views on the new arrangements for unpaid work from those involved in overseeing its delivery.

Through the Gate provision shows promise. Resettlement plans are completed and individuals can contribute to their plans. Diversity needs are considered appropriately in most cases. Not all plans adequately build on individual strengths and protective factors. This is a missed opportunity. There are gaps in the delivery of some resettlement services. The coordination of resettlement activity is variable and communication between prison-based staff and responsible officers in the community, before and at the point of release, is erratic.

Strengths:
• Unpaid work arrangements for women in Merseyside are good, with placements offered in women's centres that promote effective wrap-around services. • Unpaid work orders are mostly managed appropriately and in line with court expectations. • Resettlement plans identify the key areas of work to support desistance.

Areas for improvement:
• Unpaid work plans are not sufficiently personalised. • Recording of unpaid work placements and associated details are not sufficiently transparent; greater clarity would enable responsible officers to better manage these sentences. • Resettlement planning lacks focus on individuals' strengths and protective factors. • The coordination of resettlement activity and communication between • prison-based staff and community-based responsible officers leaves much room for improvement.

4.1. Unpaid work	Not rated[13]
Unpaid work is delivered safely and effectively, engaging the service user in line with the expectations of the court.	

We found that almost two-thirds of unpaid work assessments included the service user's motivation and willingness to comply with the sentence of the court. These assessments carefully considered the impact of personal circumstances and diversity needs on work requirements. Work to assess and understand motivation to comply with the requirements of the sentence was done less well. Other sources of available information were not routinely referred to in all inspected cases. This weakened the quality of assessments. Health, safety and vulnerability issues were assessed well, however.

In a small number of cases, we found that risk of harm to others was poorly assessed. Of concern were a number of cases where domestic abuse risks had been insufficiently explored. This impacted negatively on the management of risk of harm in these cases.

A new operating model to coordinate unpaid work was introduced in April 2018. This fell just after the period from which our inspection sample was drawn. All the cases we reviewed were managed under the new arrangements. Case records did not immediately show which placements were used and the reasons for using them. Therefore, it was not possible to assess the suitability of the allocation of work placements fairly.

Given the very new and quite complex operating model, we found several teething problems. One of these was inadequate case recording, partly brought about by different teams working on distinct parts of the case management processes. Communication arrangements between responsible officers, service users, staff in the professional services centre, administrators and supervisors on site were not clear. We were advised that service users had made complaints about the new system, arguing that the reduced contact with responsible officers was problematic for them. Often, they did not know who to contact or who they should turn to for advice.

In over three-quarters of cases, the sentence of the court was implemented appropriately. In most cases, unpaid work was offered within a week of the court appearance. However, less than two-thirds of individuals started unpaid work promptly after their court appearance. In most cases, responsible officers used and recorded their professional judgement appropriately when appointments were missed. Enforcement action was taken as required in over two-thirds of cases. Reviews were undertaken, with responsible officers making sure that barriers to successful completion were addressed.

[13] Due to very recent changes in delivery it is not appropriate to rate this area of work.

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

We found examples of emerging promising practice in the delivery of some aspects of Through the Gate services. Resettlement plans were mostly completed on time and plans were well supported with information from a variety of sources. Individuals were consistently 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 meant that opportunities to build on strengths were sometimes missed. Resettlement plans did largely and appropriately consider factors related to risk of harm. We also found some meaningful liaison between responsible officers and those delivering resettlement services in custody.

The planning for resettlement work was good and the critical factors associated with service users' offending behaviour had been identified accurately. However, there were gaps in the delivery of some resettlement services. For example, only one in five received interventions to support their finance, benefits and debt needs. We found some evidence of needs being prioritised but around one-third of individuals did not receive the necessary attention to their urgent 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.

In around one-quarter of the cases the coordination of resettlement activities with other services being delivered in prison was not done well. Disappointingly, communication between prison-based staff and responsible officers in the community, before and at the point of release, was erratic. To the organisation's credit, it has recognised this and has recently taken action to improve communication. In almost half of the inspected cases, either there was no evidence of resettlement services supporting an effective handover to local service providers in the community, or it was not clear from case records that they had done this.

Annex 1: Methodology

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 Chief Executive Officer 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 34 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 40 meetings with a range of staff internal and external to the CRC. The evidence explored under this domain was judged against our published ratings characteristics.[14]

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 service users 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, we interviewed other people who were significantly involved in the case.

We examined 119 cases across all service delivery offices: North Liverpool, South Liverpool, The Wirral, Sefton and Prescot. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of 5), and we ensured that the ratios in relation to gender, type of disposal and risk of serious harm level matched those in the eligible population.

[14] HM Inspectorate's domain one ratings characteristics can be found here: https://www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/

Domain three: unpaid work and Through the Gate

We completed case assessments for two further samples: unpaid work and 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 5).

Unpaid work

We examined 35 cases with unpaid work requirements that had begun at least three months previously. The sample included cases where the order was 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 32 custodial cases in which the service user was released on licence or post-sentence supervision from the CRC's resettlement prisons over a two-week period, six weeks previously. The sample included service users entitled to pre-release Through the Gate services from the CRC who were then supervised post-release by the CRC or by the NPS. We used the case management and assessment systems to inspect these cases.

Meetings were also held with the following individuals/groups:

- the senior manager in the CRC responsible for Through the Gate services
- the Head of Resettlement at HM Prison Liverpool
- 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/or meeting identified resettlement needs.

Annex 2: Inspection results: domains two and three[15]

2. Case supervision

Standard/Key question	Rating/% yes
2.1. Assessment Assessment is well-informed, analytical and personalised, actively involving the service user	**Good**
2.1.1. Does assessment focus sufficiently on engaging the service user?	66%
2.1.2. Does assessment focus sufficiently on the factors linked to offending and desistance?	80%
2.1.3. Does assessment focus sufficiently on keeping other people safe?	63%[16]
2.2. Planning Planning is well-informed, holistic and personalised, actively involving the service user.	**Requires improvement**
2.2.1. Does planning focus sufficiently on engaging the service user?	67%
2.2.2. Does planning focus sufficiently on reducing reoffending and supporting the service user's desistance?	78%
2.2.3. Does planning focus sufficiently on keeping other people safe?	54%
2.3. Implementation and delivery High-quality, well-focused, personalised and coordinated services are delivered, engaging the service user	**Requires improvement**
2.3.1. Is the sentence/post-custody period implemented effectively with a focus on engaging the service user?	75%
2.3.2. Does the implementation and delivery of services effectively support the service user's desistance?	61%

[15] Please note: percentages relating to questions 2.2.3, 2.3.3 and 2.4.3 are calculated for the *relevant* sub-sample, i.e. those cases where risk of serious harm issues apply, rather than for the *total* inspected sample.

[16] Limited professional discretion was exercised with key question 2.1.3, resulting in this overall standard being rated as 'good'.

2.3.3.	Does the implementation and delivery of services effectively support the safety of other people?	46%[17]
2.4.	**Reviewing** Reviewing of progress is well-informed, analytical and personalised, actively involving the service user	**Inadequate**
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?	62%
2.4.3.	Does reviewing focus sufficiently on keeping other people safe?	40%

4. CRC-specific work

Standard/Key question		Rating/% yes
4.1.	**Unpaid work** Unpaid work is delivered safely and effectively, engaging the service user in line with the expectations of the court	**No Rating**
4.1.1.	Does assessment focus on the key issues relevant to unpaid work?	-
4.1.2.	Do arrangements for unpaid work focus sufficiently on supporting the service user's engagement and compliance with the sentence?	-
4.1.3.	Do arrangements for unpaid work maximise the opportunity for the service user's personal development?	-
4.1.4.	Is the sentence of the court implemented appropriately?	-
4.2.	**Through the Gate** Through the Gate services are personalised and coordinated, addressing the service user's resettlement needs	**Requires improvement**
4.2.1.	Does resettlement planning focus sufficiently on the service user's resettlement needs and on factors linked to offending and desistance?	84%
4.2.2.	Does resettlement activity focus sufficiently on supporting the service user's resettlement?	74%

[17] Limited professional discretion was exercised with key question 2.3.3, resulting in this overall standard being rated as 'requires improvement'.

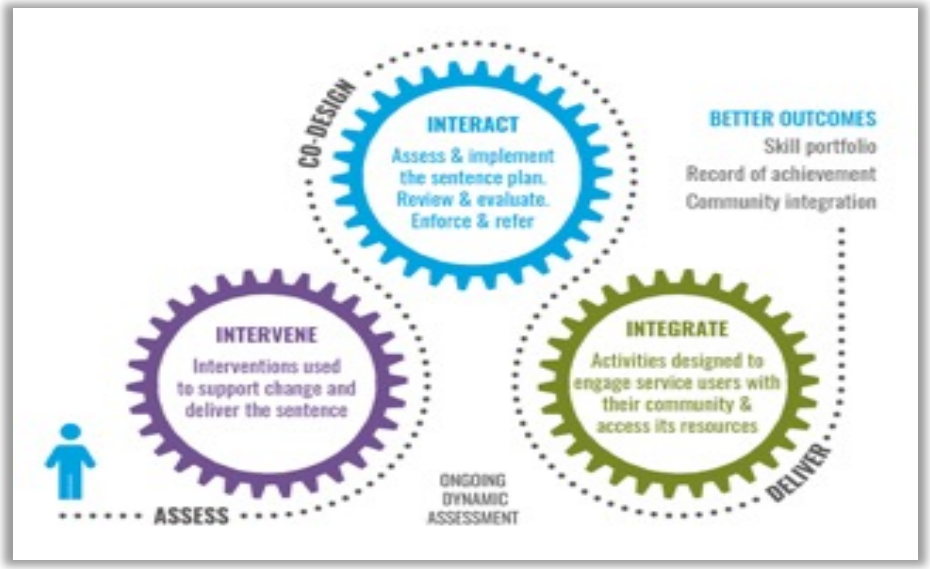
Standard/Key question	Rating/% yes
4.2.3. Is there effective coordination of resettlement activity?	55%

Annex 3: Operating model and map

Operating model

The operating model in practice – as described by Merseyside CRC

Interchange, our model of service delivery, provides us with a strengths-based desistance approach to working with service users to achieve positive rehabilitative outcomes. Seeing every interaction with our service users as an opportunity to help, motivate and support them in achieving their goals is fundamental to the model.



Source: Merseyside CRC

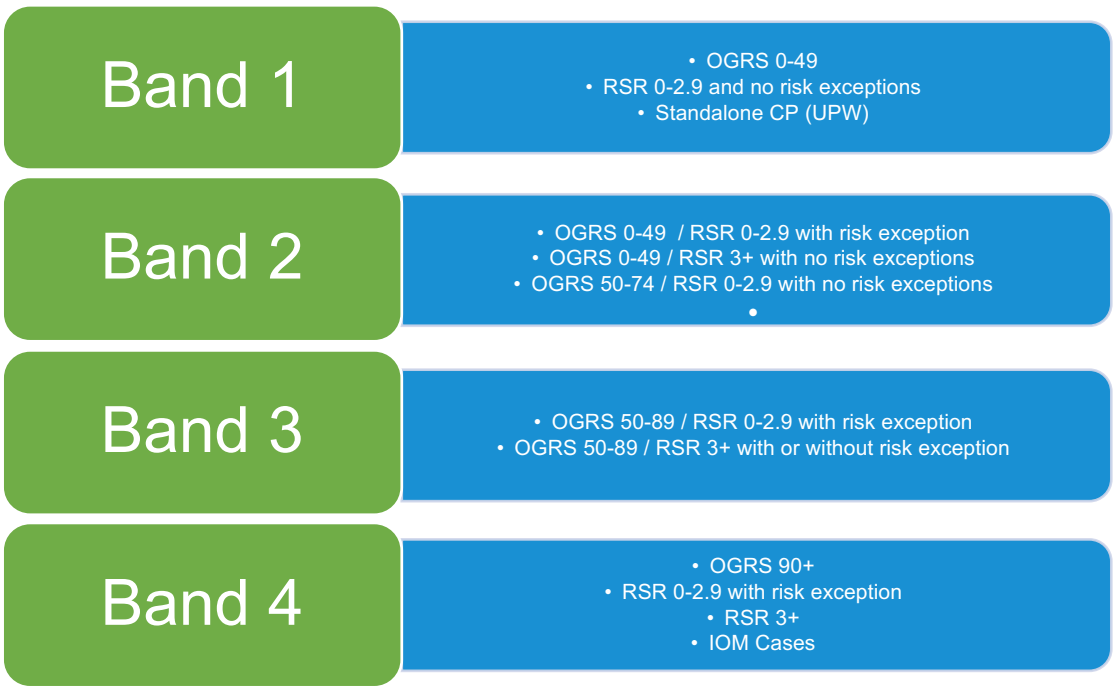
Source: Merseyside CRC

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 Professional Services Centre (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 Local Delivery Unit (LDU) such as women's, intensive community orders, resettlement specialist.



Source: Merseyside CRC

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 Interserve Banding and Assessment Tool (**IBAT**) directs that any cases with the following exceptions will be allocated to a senior case manager:

- 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

Source: Merseyside CRC

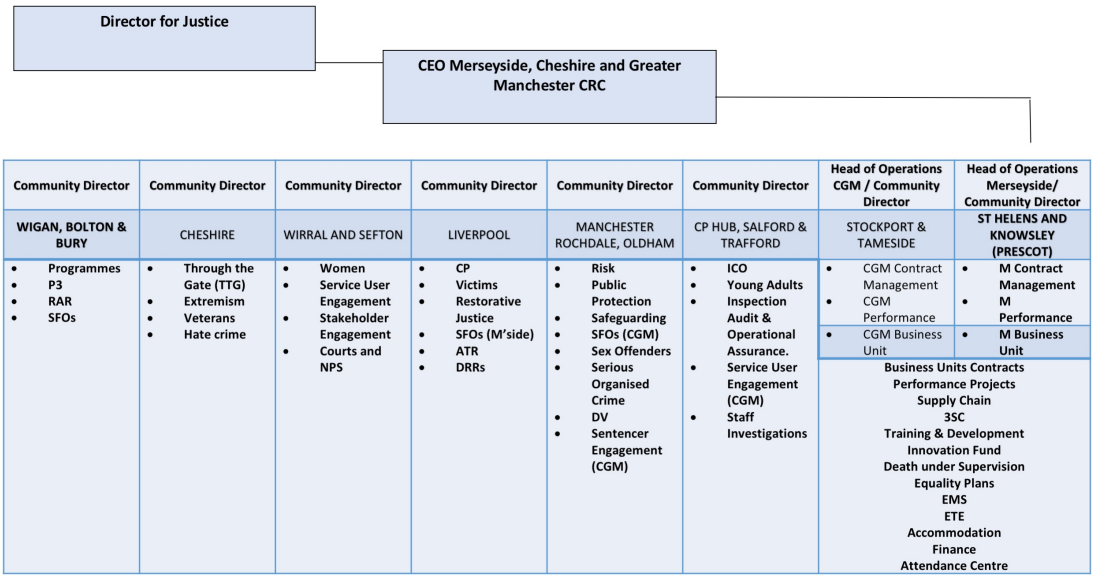
Community payback (unpaid work)

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 Early Management Oversight (EMO 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.

Merseyside CRC organogram



Source: Merseyside CRC

Third Sector

Available services and involvement of the third sector – as described by Merseyside CRC

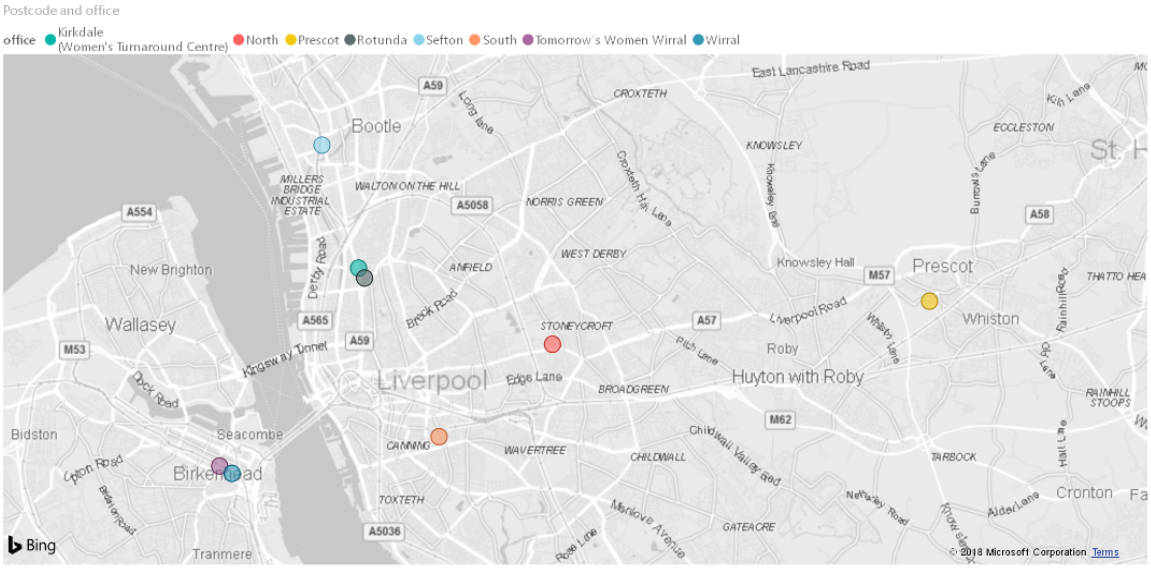
3SC (Third Sector Consortium) are a key partner and they enable the third sector to build partnerships so that they can bid for work. 3SC work closely with our other key partners, Shelter and P3. Shelter provide resettlement services for men and women in custody and P3 provide a highly successful intensive intervention for men and women in the community who have multiple needs.

Merseyside CRC (MCRC) works with three providers who deliver women's services, Person Shaped Support (PSS), Tomorrow's Women Wirral (TWW) and Adelaide House. MCRC are proud to have an established partnership with User Voice, which is key to our Service User Engagement Strategy.

Additional services have been commissioned by MCRC to support service users to change, including Rotunda College, Riverside Housing Association and Intuitive Thinking.

We need to discern how well practitioners are cognisant of these interventions and services. Also, how do they monitor how their service users are doing, i.e. what is the information exchange like with those who are delivering these services?

Map and website



office	address	Postcode	Purpose	Flex
Kirkdale (Women's Turnaround Centre)	142-148 Stanley Road, Kirkdale, Liverpool	L5 7QQ	PF site	13
Light for Life	The Housing Centre, 68 Eastbank Street, Southport	PR8 1ES	Partnership site	
North	Cheadle Avenue, Old Swan, Liverpool	L13 3AE	CRC, NPS, UPW	6,7,
Prescot	Sinclair Way, Prescot	L34 1PB	PF site	1,2,
Rotunda	107-115 Great Mersey St, Kirkdale, Liverpool	L5 2PL	Partnership site	
Sefton	Stella Nova, Unit 4, Washington Parade, Bootle	L20 4TZ	PF site	9,1(
South	180 Falkner Street, Liverpool	L8 7SX	CRC, NPS, UPW	11,

Source: Merseyside CRC

http://www.merseysidecrc.co.uk

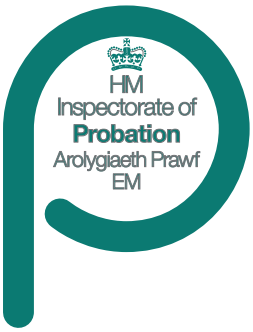
Annex 4: Glossary

Accredited programme	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
Allocation	The process by which a decision is made about whether an offender will be supervised by a CRC or the NPS
Approach	The overall way in which something is made to happen; an approach comprises processes and structured actions within a framework of principles and policies
Assessment	The process by which a decision is made about the things an individual needs to do to reduce the likelihood of them reoffending and/or causing further harm
Barriers	The things that make it difficult for an individual to change
Case manager	The term used by some CRCs, including Purple Futures' CRCs, for the probation services officer grade who holds lead responsibility for managing a case
Child safeguarding	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
Cluster	A grouping of adjacent local delivery units, organised to assist in administration and monitoring
CRC	Community Rehabilitation Company: 21 CRCs were set up in June 2014, to manage most offenders who present a low or medium risk of serious harm
Criminal justice system	Involves any or all of the agencies involved in upholding and implementing the law – police, courts, youth offending teams, probation and prisons
Desistance	The cessation of offending or other antisocial behaviour
Diversity	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
Enforcement	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
HM Prison	Her Majesty's Prison

IOM	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
Interchange manager	A member of staff within Purple Futures' CRCs equivalent to a senior probation officer in the NPS
Interchange model	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
Intervention	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 programme; a restrictive intervention (to minimise their risk of harm) 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
IQAM	Interchange Quality Assurance Model: this provides an operating system for quality assurance of service delivery. IQAM is based on a continuous improvement cycle, which commences with internal audit and observations. Results from quarterly audits are fed into the local Operations and Quality Group where improvements and areas of good practice are identified. Areas for improvement form actions on the Quality Improvement Plan, which are then reviewed via subsequent audits
Licence	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
MAPPA	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
NPS	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
OASys	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

Offender management	A core principle of offender management is that a single practitioner takes responsibility for managing an offender through the period they are serving their sentence, whether in custody or the community
Partners	Partners include statutory and non-statutory organisations, working with the participant/offender through a partnership agreement with a CRC or the NPS
Post-sentence supervision	Post-sentence supervision: brought in via the *Offender Rehabilitation Act 2014*, the PSS is a period of supervision following the end of a licence. Breaches are enforced by the magistrates' court
Pre-sentence report	This refers to any report prepared for a court, whether delivered orally or in a written format
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
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 the writing of pre-sentence reports
Professional services centre	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. The centre servicing Merseyside CRC is in Liverpool
Providers	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
RAR	Rehabilitation activity requirement: from February 2015, when the *Offender Rehabilitation Act 2014* 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
Responsible officer	The term used for the officer (previously entitled 'offender manager') who holds lead responsibility for managing a case
Senior case manager	The term used by some CRCs, including Purple Futures' CRCs, for the probation officer grade who holds lead responsibility for managing a case
Stakeholder	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.

	Example of internal stakeholders are people or groups of people within the organisation
Suspended sentence order	A custodial sentence that is suspended and carried out in the community
Through the Gate	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
Transforming Rehabilitation	The government's programme for how offenders are managed in England and Wales from June 2014
Unpaid work	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
Women's Alliance	The Merseyside Women's Services Alliance (Women's Alliance) is a sub-group of the Merseyside Reducing Reoffending Board. Both are overseen by the PCC-led Merseyside Criminal Justice Board. The Women's Alliance is a multi-agency group that works to improve services to local women in the criminal justice system. Its priorities include building the alliance, and developing resettlement and accommodation services



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