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Napo Feedback on DSOU / Accredited Programmes Consultation

Introduction and background

I am grateful for the opportunity to finally present feedback on behalf of Napo for the consultation. It is unfortunate that this opportunity came after publication of the information as a 'fait accompli'. Nevertheless we enter into consultation in the spirit of seeking ever to improve.

Since TR each division (and latterly region) had a Divisional Sex Offender Unit (DSOU) based in the Public Protection team, along with the Polygraph Testers. Why do we work with people convicted of sexual offences? The obvious answer to that is for public protection and to ensure no more victims. The other important part is to support those men (currently we only do groups for men) to make changes and develop skills to manage old me thoughts, feelings and behaviours. This consultation process is not important for the members of the DSOUs but also the public and the Probation Service.

It is the facilitator's role to ensure that they themselves understand each man's individual risk factors to guide them into setting goals and developing skills to enable them to manage these but also to support the men to have hope for their future that they can overcome those old me thoughts and feelings, which isn't as relevant in general offending behaviour programmes (Strengths based). To do this effectively, facilitators need to be fully skilled in the assessment of risk (in collaboration with their Probation Practitioners), the theory which underpins the programme and the theories which apply to the behaviour of those convicted of sexual offending, such as attachment theory, Pathways Model (Ward and Seigert 2002), Behavioural and Social Learning Theories, Dynamic Acute and Stable Risk Factors (Mann, Hanson and Thornton 2010), Motivational Interviewing etc to name just a few key theories and models relevant to this work. Without this underpinning knowledge there may be gaps which could contribute to increasing risk factors not being picked up and reported to the Probation Practitioner. The consequence could be a further offence, and someone being seriously harmed, and a reduction in confidence of the Probation Service by the public etc.

The document suggests facilitators could deliver the general offending behaviour programmes as well to reduce burnout. It would be helpful to see what the figures are in relation to DSOU facilitators experiencing burnout as I would suspect the figures are really low? The reason for this is that, in the main, facilitators choose to go into working with people convicted of sexual offences. Working in this field can be highly rewarding and satisfying, with practitioners reporting that rewards often outweigh challenges (Clarke and Roger 2002). Common motivations for doing this work include that of contributing to reducing the prevalence of sexual harm, working with a challenging group of people, and working in a specialist field. Because of the focus on one area of work, facilitators are able to build up extensive skills and knowledge in this field (a reward), which is then imparted to colleagues, stakeholders etc via training, consultancy, briefings, advice, which are just a few

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examples, and contributing to the professionalism of people within the service. By not being able to continue with this focus and by asking people to deliver other programmes there may well be an increase in burnout and emotional wellbeing issues as the focus of work and span of control will significantly change. Is this what HMPPS want to expose their employees to?

Consultancy work, alongside delivering the programmes, is an important factor for the resilience of the DSOU facilitators. No, it wasn't in the E3 model but nor was any aspect of the work with people convicted of sexual offences. Hence those who were accredited National and Regional Trainers for all of the suite of programmes, the training for case managers and for SARN (Structured Assessment of Risk and Need) and Risk Matrix 2000 were all just dropped with no explanation or notice or consultation, leaving a huge gap in this area of work. The HMIP (2018) Report found that there is a lack of confidence amongst Probation Officers in working with this group of service users. Needless to say, the DSOUs proactively had already started developing things to alleviate this deficit in their areas, Humberside and Lincs Treatment Managers developed the 5 day Stop Gap training, which then rolled out nationally, London developed the Chemsex Briefings. The DSOUs allocated SPOCs for each PDU, gave briefings to the judiciary and magistrates, provided advice to court teams, report writers, MAPPA, Child Protection Meetings, ongoing advice and support re Maps for Change and New Me MOT, ways of working with people who were not eligible for a programme, working with people maintaining their innocence, people with hearing disabilities, working with people with intellectual disabilities, people with autism, mental health or personality assessments, women who have committed sexual offences, working with Circles of Support just to name a few examples. **Do you feel that a series of 7 minute videos is more enabling than having a dedicated worker to go to with any questions?**

Removing this dedicated and easily accessible additional support to both colleagues and stakeholders may well lead to a reduction in confidence of the NPS ability to deliver these services. The SPOC positions enables Probation Practitioners to question but more importantly talk through their assessments and increasing their knowledge and confidence each time they do this. It also provides increased support to Probation Officers (and SPOs) who are currently overwhelmed with work, to enable them to make considered and safe professional judgement. Just look at the fantastic work facilitators undertook in working remotely with the men on a 1:1 basis and the amount of risk information that was shared as a result, and that wouldn't have been disclosed otherwise.

Facilitators who choose to do this specific work may leave, removing that expertise. New facilitators coming in won't have the opportunity to build up that knowledge if delivering several programmes, so there will become another large gap and no one to fill it, and how will that be perceived in any further inspections or SFO investigations? This is especially important at this time when we are moving into transition, hundreds of newly qualified officers, hundreds of PQUIPs, probation practitioners in short supply and huge caseloads surely this will prove to be a huge business risk for the service?

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HMIP Action Plan

I have attached the HMIP Action Plan following the damming HMIP inspection in January 2019. Of Note key actions are

- Promote closer working between CRCs, prison staff and the NPS so that there is continuity of resettlement support, effective public protection and oversight throughout the sentence
- The workforce is equipped to identify, assess and deliver appropriate interventions to manage the risk of harm presented by those convicted of sexual offences
- Ensure that MAPPA level setting is consistent, clearly communicated across the responsible authorities, and underpinned by robust assessment and regular reviews

There is a risk that all of the above may be negatively impacted by any move to have DSOU work delivered by staff without them undergoing the intensive training in risk and risk management that goes with the PO qualification and the theoretical underpinning of all the work. DSOU facilitators often provide vital input at MAPPA and are highly regarded for their insights- this is likely to be lost. Whilst training is now being actioned and implemented in light of the recommendations, it feels as if it is reactive rather than ongoing planned sequential training, where is the long-term plan?

The difference in pay bands reflects the additional skills and knowledge brought to a role. This does not devalue the work of PSO's, it is simply a fact. There will be PSOs who do an amazing job in the group room but by virtue of their training pathway lack the wrap around knowledge to manage risk, which suggests further training and assessments need to be in place before delivering Horizon or other programmes. There are also highly experienced PSOs and POs who were also fully accredited facilitators of the legacy community programmes, both will need refresher and or update training in new ways of working, e.g. OSP, the bio-psycho-social model etc before undertaking Horizon training. The argument that it is the OM who ultimately managed the risk is severely flawed. Within a group setting we need staff who can recognise offence paralleling behaviours. We also need staff who can recognise subtle grooming behaviours that may occur between group members or towards facilitators themselves. There are many more examples of issues our qualified staff are equipped to deal with, where others trained on the programme route alone will lack. A further question we would ask is that with the necessary increased training and recognition that it is normally POs who hold these cases, will Band 3 facilitators who deliver Horizon etc be paid at Band 4 rates?

The CRC interventions teams have a high turnover of staff and high levels of attrition in groups. DSOU teams do not face the same issues and a large part of this relates to having staff who are intensely trained, as well as having choice about delivering to this group of people on probation. The decision to have DSOU swallowed up within a larger team of generic interventions has been viewed with significant resistance by DSOU and HOPPs nationally. Whilst it could be argued the former have a vested interest and are perhaps not

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impartial, this certainly cannot be said about our HOPPs. They are highly skilled staff in leadership and their professional view needs to be heard. **What is your view is on the amount of concern being expressed about this new model?**

DSOUs have worked extremely hard to build relationships with OMUs, this was highlighted in previous inspections as being necessary, and being part of public protection has been key to this. We now run the risk of returning to be the poor relative. **What consideration has been given to the public confidence and perception of this?** Should there be an SFO there is the significant possibility it could be flagged up that risk indicators were missed within group or failed to be handled appropriately because facilitators were not robustly trained. Furthermore, it could be that an SFO identified an absence of subject matter expert input at MAPPA.

Running a group for drink drivers or substance users is a world away from the complexities around those who commit sexual offences. That does not mean one role is of any less value- but there is no getting away from the fact that they are different. Co-working around female sexual offending and transgender cases are just a few examples of highly valued practice that is now at risk as well as the ongoing training, advice, support and consultancy, as there will not be the time nor space to continue to do this.

Carole Doherty, Napo Vice Chair, 10 May 2021

Response to the consultation document

This is to be read in the context of how the suite of programmes for men convicted of sexual offences fits in. Each section of the consultation document is addressed in order. This is made up from feedback from staff working in all areas and at all grades in DSOUs.

1. Introduction

The document refers to Accredited Programmes being added onto PSS. Is this a change? If this is the case the PSS lasts for a maximum 12m, so these referrals will need to be carefully managed if they are to complete in the given time scale.

HORIZON and the other programmes for men convicted of sexual offences, according to the manual guidelines and design of programme, dictate a maximum of 10 group members yet the new operating model specifies 12. The quality of the material to be delivered in each session would be jeopardised for a group as large as 12 due to the necessary allowance for feedback from participants and checking their learning. Why has this not been taken into account in drawing up this new model? The point of the programme is rehabilitative, does the model relate to this? How will this relate to men on New Me Strengths as they will require even more time to process their learning due to intellectual disabilities and that they will be drawing and then feeding back a large number of exercises?

2. Design Principles

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The document proposes Staff will be delivering AP and SI's, it also refers to delivery being able to be more flexible given the ADF and suggests 1-1 delivery. I have no issue with this but wonder what calculations have been done with regards to the Staffing levels required in order to deliver all of this, and what facilities will be needed to deliver this? For example

Room space. We are struggling to get rooms for delivery now, and if you open up 1-1 delivery and SI's this will have a significant impact on Staffing and Facilities required. Especially if you are setting a timescale of 8 weeks from referral to starting an intervention.

Interventions staff trained in both APs and Structured Interventions (SIs) delivery to allow flexibility in dealing with demand. Additional support from sessional staff may be used as required. – what are the structured interventions and where is the staff resource/time going be taken from in order to provide this? Will this require further training? Will all staff be delivering all programmes and all structured interventions?

Within the planning for the suite of sexual programmes, a great deal of time is spent ensuring the right mix of men, ensuring no relations, that they aren't victim/perpetrator, been in prison together, abused the same victims, consideration given if risk to staff, personality disorder, mental health problems, personality disorder, learning disabilities, neuro diverse, chaotic substance misuse etc. Doing this impact significantly on the positive group completion rate, in contrast to General offending behaviour programmes which don't have the time for this level of selection. If this time is removed for the benefit of quantity over quality not only could it compromise completions of those convicted of sexual offences, it could also potentially contribute to an increase of risk of reoffending and therefore not only a business risk to the service but also a reduction in the confidence of stakeholders into this work.

The document also refers to a continuation with the alternative delivery format. Whilst the feedback from delivering programmes remotely has been positive it is not anywhere near as good as standard delivery, for the service user, or the facilitator trying to do the work.

The ADF was designed to be used during the pandemic and to be used in very exceptional circumstances, there could be a concern that there may be a drift toward it being used routinely for convenience and to hit targets, rather than to meet an exceptional need.

3. **Process Map and People for Accredited Programmes**

Nothing to comment at this stage

- **Head of Programmes**

Is it a requirement that Head of Programmes should have a Probation Officer qualification and if not, when and why did this change? If the role going forward requires the person to have a probation qualification, why, at a time of significant change and therefore vulnerability, are you opening the Probation Service up to increased vulnerability by potentially appointing people without qualification? How confident can we be in those appointments and their understanding of the risk of harm to the public?

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- **Programme Manager**

It is interesting to hear that this person will be line managing the staff needed to deliver the "volumes" of interventions, is this now quantity and not quality driven?

Why has the Band 6 been replaced by the Programme Manager?

How do you envisage this will impact on the DSOU SPOs who currently do this role?

It is incredibly disappointing the employer has made the decision to remove the Band 6 with no meaningful consultation with the trade unions, and that the plan is to remove this level of knowledge and experience right in a time of huge change and vulnerabilities in the Probation Service

- **Treatment Managers**

Our current managers in the Divisional Units are Senior Probation Officers and have generic SPO JDs. There was a consensus that they did not want to lose their SPO substantive roles and the ability to move between functions as a SPO. They were concerned that a move to specific JDs would limit their options and the movement between functions, impacting the wider resilience of the organisation. Most managers were concerned about the personal impacts for them on job satisfaction if the treatment management side of their work was removed from them. The clinical oversight and development of facilitators was important to them and an area where they have expertise to give.

What is it about the work they were doing which suggests it didn't work well that is needs change?

Combining the Treatment Management/Programme Management tasks has enabled some reduction in the duplication of tasks which is inherent within the split PM/TM roles where the PM retains line management responsibility for the facilitators.

The TM post makes no reference to any delivery and TMs' will need to do some delivery to maintain their accreditation, although this is very minimal and is referred to in Manuals.

The combined SPO/TM post, allows for greater support of facilitators both as TM and line management, given counselling budget has been pared back though still very much needed given the emotional resilience needed in this line of work.

DSOU SPO/Treatment Managers have a wealth of experience/knowledge in relation to the delivery and treatment management of sexual offending programmes. This will be lost if the SPO posts go.

Because of their wealth of experience/knowledge DSOU SPO/Treatment Managers provide a crucial role in supporting OMs in the field to make decisions around assessment and management of risk of men convicted of sexual offences. Again this would be lost if the SPO posts go.

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This also applies in relation to advice and support given to PSR writers in Court teams i.e. providing advice and support round risk assessment and correct proposals.
DSOU/SPOs also help to deliver training packages in relation to working with men who sexually offend i.e. Maps For Change and New Me MOT.

- **Programme Facilitators**

There is little detail on the amount of programme sessions staff will be expected to run per week, and what best practice looks like (i.e. avoiding back-to-back sessions for example). These standards need to be ironed out in the consultation period as staff well-being is inextricably linked to this and therefore the effectiveness of programmes. The policy for programmes related to sexual offending states no more than 4 sessions per week, and for general offending behaviour programmes, it is 5 sessions per week. How will delivery of 121 sessions and structured interventions be incorporated into this?

A decision was made a few years back that programmes for those convicted of sexual offences be facilitated by qualified Probation Officers. The new operating model indicates you have changed this policy yet again. Is that correct? If so, are PSO grades only to be recruited into Interventions Teams in the future?

What will be the pay band for Facilitators?

Should qualified POs be looking to remove themselves from programmes to protect their financial position? How much of a business risk will this be if they do?

Where is the research to say that unqualified and inexperienced people (in working with those convicted of sexual offences) will be able to stand up to the professional accountability argument? This would suggest a need for further training for them?

Previous research, and inspections, would suggest that it should be those most experienced and with a thorough understanding of the research underpinning the work with people convicted of sexual offences should deliver the programmes to them?

Again, were the trade unions involved in these discussions prior to this decision making?

What form of 'suitability' assessment will be carried out for Facilitators who have not previously delivered programmes for those convicted of Sexual offences?

Has there been an assumption that the skills required for other programmes may convert/ apply/transfer easily to pcso?

New skills for this type of work may not lend themselves to learning 'on the job'.

PAM assist and other psychological assistance is required for Facilitators working with people convicted of sexual offences. Some Interventions personnel may have psychological difficulties which may be exacerbated from working with people who have committed these crimes (Facilitators who have been raped, been victims as children of sexual offences etc). Where in the operational model has this been considered?

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Where is the screening for suitability?

Where has equality and diversity (p9) necessitating exclusion from this work, as suggested above, been considered in the operating model?

All facilitators to run all programmes. – 'qualification' and grade issue. *not take account of individuals who may not want to run BBR for personal reasons and CRC not wanting to run Horizon etc for personal reasons.

What will be the future for Probation qualified staff, or those Staff in the DSOUs with significant experience working with people convicted of sexual offences, and what about the impact on public protection by taking those people out of those roles. Surely this would be a significant business risk?

The model doesn't suggest such Training and experience is required, are they at risk of being moved out of Programmes? If so, this has a significant impact on the development of new staff and the experience and knowledge you have in the Teams, and the impact on public protection.

What plans are there for suitability assessment of Horizon facilitators? Previously we have undergone in depth assessment centres to ensure suitability as to reasons why we want to work with this group of people, it also checks out the understanding of potential emotional

impact, and facilitators understanding of why these men commit sexual offences. Who will ensure this happens, and how?

What will happen to the Band 4 DSOU facilitators if all are expected to run other groups?

Also, the structure appears to ignore our structure and separates PM from TM. It seems that the proposed model absorbs the DSOU into general programmes, without recognising the differences.

Were the DSOU consulted prior to this?'

There appears to be a lack of transparency around what they intend to do in relation to the different bands. Whilst senior management may know what they have in mind, the future plan is conspicuous by its absence. This does not reduce anxiety; it just leads to speculation and people coming to their own conclusions about what is going on with their own role.

One of the main concerns raised is an anxiety about an attempt to demote Band 4's? Some people have very recently been through this process in Approved Premises and feel dread at the thought of this happening again… where we could be offered either a transfer, a reduction in pay/debanding or staff competing for jobs at their current grade. There is no mention of a financial impact on staff and obviously, this is something that we desperately need to understand.

DSOU staff knowledge and experience has helped us to forge link roles into PDUs at both SPO and facilitator level.

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In NPS London, the DSOU have also forged links with Challenge (PD programme), Psychosexual clinic, Circles, Hendon Police training college with delivering MoSaVo course etc

Aside from groupwork, facilitators also support PPs in working with females that sexually offend

New Me Strengths requires highly skilled and differently trained facilitators in working with people with intellectual disabilities.

DSOU facilitators are happy delivering the programme and many have moved away from facilitating general offending behaviour groups in order to be able to specialise in this area of work. They may not be interested in delivering other programmes

Many general offending behaviour facilitators are not remotely interested in delivering sexual offending behaviour programmes and as such might lack the requisite skills to work with this cohort of men. In particular they might hold discriminatory attitudes to this cohort and struggle to create a warm environment in which to deliver the work.

What are the plans for assessing the eligibility and selection of staff to deliver the programmes for those convicted of sexual offences? Within the CRCs there will be some people who were accredited community programme facilitators, what plans are there for them to undertake refresher training, should they choose to, and to include updates re OSP etc?

DSOU facilitators are primarily PO qualified and as such bring a wealth of experience and knowledge and theoretical background to delivering groupwork programmes to men who sexually offend. If it's true that the plan is for all facilitators to be Band 3, this wealth of knowledge and experience would be lost to the DSOUs and potentially have significant consequences for public protection

- **Partner Link Workers**

Nothing to comment at this stage

- **Programme Administrators**

Repeated below as well:

There is reference to a scheduling tool which sounds unbelievable. Has anyone seen what this looks like? I am very sceptical about this as any such tool would need to be extremity sophisticated to do what they are suggesting. I wasn't sure if it was a standalone tool, or something in IM either, as the document refers to IM being used by TMs/PMs to monitor the waiting list. IM is not fit for this purpose, so it concerns me that this document suggests it is.

The reference to Admin in this document is quite limited but it infers they are quite a removed from the day-to-day local delivery. The fact the SAO reports to Head of Interventions and not Head of Programmes is interesting. Previous experience would suggest that systems, processes and Teams work better when people work together locally. Whilst having an overarching process is useful, having Admin at a local input level is crucial

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One other point is that the way the role of the administrator is referred to in the TOM is very limited, namely letters and IM, and we would want to see that broadened out considerably.

Our administrators are firmly embedded in the team and own the work of the individual team/programme. They do many more tasks to support delivery, such as processing referrals, updating databases, helping with management of waiting lists, preparing programme materials, supporting use of Media Manager, providing performance data, managing asset lists and other information security issues, on occasions contacting service users (e.g. re Covid or the feedback questionnaires), etc.

There would be concern about administrators moving to a 'hub' model where they just did general tasks for programmes rather than the more specialised ones we require.

Programmes Admin feel that they have been missed a lot from the narrative and thinking relating to changes to Programme delivery and anticipated operating models (+reunification). It feels very much that they are instructed rather than involved in any decision making, despite these changes having a significant impact on the roles of Programme Admin.

There is continued reference around delivering a 'mixed economy' of Programmes (Thinking Skills, Building Better Relationships and Sexual Offending Programmes) and yet, no mention of the impact upon Programme Admin. Admin are seeking clarity and acknowledgment on how a change in the suite of programmes delivered by a Programmes Team, will impact upon the roles and remit of Programme Admin.

There is a lack of training and development for Programme Admin – this is a wider issue, but highlighted in the attached document. There is a clear expectation for Admin to deliver more and be involved in a wider suite of programmes and yet no mention of a training package to support admin in this expanded role.

The staff structure clearly moves Programme Admin out of Programmes Teams – this raises many concerns and is a huge change to how Admin currently operate (embedded within Programmes Teams). The staff structure indicates some sort of 'admin hub'. Admin are not in favour of this set up. Again, has this been discussed with the trade unions before decisions have been made?

Admin currently manage Ndelius, Pathways (media Manager), Interventions Manager and local waiting lists – this presents much duplication of activities and there is a wider argument about the need to streamline the number of applications required to manage programmes. The Operating Model references a further 'scheduling tool' – we require clarification of what this is? Will it replace localised waiting lists and/or IM?? There are significant issues with managing multiple applications that do not link with one another.

There is a need to clarify what the expected referral process is. At the moment, the referral process we operate does not match what is stated within the Operating Model. Does this desired referral process match what is done nationally? This is of relevance as there is an associated 'waiting time' target, which will be compared to other regions – we must,

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therefore, ensure that the referral processes mimic across all regions and that the measure is replicated, if we are to produce any type of performance measure that is comparable nationally (i.e. the dashboard dataset which clearly does this).

The Operating Model increases the expectation of Admin to be involved in a number of additional tasks i.e. Programme suitability checks, Reporting from IM and 'scheduling tool', 'timeline checks' and performance evaluation etc. I believe the risk needs to be managed and led by PM/TMs not Grade 2 Admin. If we are to take on these additional tasks, can we have training i.e. we have been unable to present a business case for Admin to get on Intermediate Excel training and yet we are expected to feed into performance type data collection (links to point 3).

4. **Operating Model**

- **Courts and Sentencing**

Nothing to add at this moment

- **Eligibility and Suitability**

…. A second eligibility and suitability assessment must be completed by the Interventions team within ten working days of sentence. Small point here – the Interventions team is to provide

a 'second *assessment*' having previously provided pre-sentence *advice*. Who owns the first assessment? Bigger point – the second assessment must be completed by the Interventions team *within ten working days of sentence*. TBH at that stage I'd rather the SU was developing a relationship with the OM, not with a facilitator; and the short deadline has resource implications.'

10 working days to check suitability and eligibility is not enough, particularly for cases requiring NMS. Is there to be a defined process for doing this this or is this just about checking OSP etc?

The PPs must be informed of an ineligible or unsuitable SUs within 15 working days from sentence – when will this be agreed as there will need to be new processes in place to support this?

Opportunity for planning ahead for Programmes Team reduced if need to wait for PP referral and then have someone on a programme within 8 weeks. Takes away careful group selection and likely to be an impact on attrition. Significant impact on scheduling.

What support is to be given to PPs to help them make informed decisions about when to refer? No Case Manager training now.

Prefer model we use (pre Covid) where we pre group quickly, share goals with OM to begin work upon, and then revisit and refresh pre group goals before group start.

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Does not allow for cases to be prioritised by risk/need for group starts if there becomes a target for 8 weeks starts for all.

If referral is not submitted until PP feels is appropriate, and interventions team don't check again until 6 months before termination, this would not leave time for programme such as Horizon to be completed at a rate of once weekly (e.g. typical eve group)

- **Referral**

The new model states that upon the PP making a referral, having done all necessary pre and readiness work, the Interventions Team then have monthly contact with the SU to 'prepare' him. Surely this is a duplication of the preparation the PP has just completed? SUs can be 'over treated' – has this been considered? Furthermore not all SUs are reluctant to complete a programme, some actually want to and do not need regular encouragement.

8 weeks from referral to starting an intervention seems very unrealistic

Referral to the Interventions team can be made and a start date for a suitable group to be offered within eight weeks – what process will be put in place to support this? I guess this will be reflected in IIF and will take some time with current waiting lists and staff resource to achieve this. If we are underperforming in these areas – what will be the impact on staff?

Will we need to deliver more than 8 sessions per week to achieve this?

What is the anticipated number of sessions for delivery each week per f/t facilitator, bearing in mind it is 4 for programmes for men convicted of sexual offences and 5 for general offending behaviour programmes?

- **Sentence Management**

No Comments at this time

- **Pre Programme Engagement with Service Users**

Does not allow for cases to be prioritised by risk/need for group starts if there becomes a target for 8 weeks starts for all.

Does not allow for the amount of pre group work for those undertaking New Me strengths

'Early engagement' is already serviced by the '2nd (p5 of operating model handout) eligibility and suitability assessment carried out within 10 working days of sentence'. See p6 'Pre-Programme Engagement with Service Users'

Since the operating model dictates the man should commence group within 8 weeks/2 months of sentence - p5 of handout, why is there a need for Interventions Team single point of contact for every SU, to provide him with updates on start date? The 'early engagement with SUs' is serviced by the 8 week start deadline and the '2nd eligibility and suitability' assessment

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Peer Mentor Involvement

What will this look like for the programmes for those convicted of sexual offences?

Administration Support During Delivery

'Administration Support During Delivery' p7. Both Facilitators and admin. staff need to know when a PP has deemed that a failure to attend group is unacceptable. This information is often late, or very late, in being returned to Interventions Team. It creates difficulty in knowing whether a SU should remain on group.

Repeated from above:

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There would be concern about administrators moving to a 'hub' model where they just did general tasks for programmes rather than the more specialised ones we require.

Programmes Admin feel that they have been missed a lot from the narrative and thinking relating to changes to Programme delivery and anticipated operating models (+reunification). It feels very much that they are instructed rather than involved in any decision making, despite these changes having a significant impact on the roles of Programme Admin.

There is continued reference around delivering a 'mixed economy' of Programmes (Thinking Skills, Building Better Relationships and Sexual Offending Programmes) and yet, no mention of the impact upon Programme Admin. Admin are seeking clarity and acknowledgment on how a change in the suite of programmes delivered by a Programmes Team, will impact upon the roles and remit of Programme Admin.

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There is a lack of training and development for Programme Admin – this is a wider issue, but highlighted in the attached document. There is a clear expectation for Admin to deliver more and be involved in a wider suite of programmes and yet no mention of a training package to support admin in this expanded role.

The staff structure clearly moves Programme Admin out of Programmes Teams – this raises many concerns and is a huge change to how Admin currently operate (embedded within Programmes Teams). The staff structure indicates some sort of 'admin hub'. Admin are not in favour of this set up. Again, has this been discussed with the trade unions before decisions have been made?

Admin currently manage Ndelius, Pathways (media Manager), Interventions Manager and local waiting lists – this presents much duplication of activities and there is a wider argument about the need to streamline the number of applications required to manage programmes. The Operating Model references a further 'scheduling tool' – we require clarification of what this is? Will it replace localised waiting lists and/or IM?? There are significant issues with managing multiple applications that do not link with one another.

There is a need to clarify what the expected referral process is. At the moment, the referral process we operate does not match what is stated within the Operating Model. Does this desired referral process match what is done nationally? This is of relevance as there is an associated 'waiting time' target, which will be compared to other regions – we must, therefore, ensure that the referral processes mimic across all regions and that the measure is replicated, if we are to produce any type of performance measure that is comparable nationally (i.e. the dashboard dataset which clearly does this).

The Operating Model increases the expectation of Admin to be involved in a number of additional tasks i.e. Programme suitability checks, Reporting from IM and 'scheduling tool', 'timeline checks' and performance evaluation etc. I believe the risk needs to be managed and led by PM/TMs not Grade 2 Admin. If we are to take on these additional tasks, can we have training i.e. we have been unable to present a business case for Admin to get on Intermediate Excel training and yet we are expected to feed into performance type data collection.

- **Accredited Programme Delivery**

A review of all cases to be undertaken by the Interventions team at six and three months before end of sentence to flag any issues with completion and notification sent to the PPs to take appropriate action. – impact on admin staff? Admin resources and These timeliness checks could be completed by administration staff using a scheduling tool and waiting lists or via monthly TMs and PMs meetings to look at forecasts of demand

Accredited Programme Delivery. 'A review of all cases to be undertaken by the Interventions Team at 6 and 3 months before the end of sentence'. If a SU has a 3 year CO and commences and finishes his programme within the first year, there will have been no contact with

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Interventions Team for the rest of his CO. Why then is there the need for the case to be kept open to Interventions Team?

What is the thinking, that seemingly out of the blue, a Facilitator contacts the SU 6 months and 3 months before the end of that 3 years? Does this not represent a cross over by Facilitators into the PP's remit? If the PP thinks this man needs further intervention, should not the PP be approaching Interventions Team post programme? What sort of work, other than M4C or New Me Mot carried out by the PP, does the model envisage the Interventions Team should do?

- **Post Programme**

No comments at this stage

- **Programmes for Those Convicted of Sexual Offences**

How will 'burnout' be assessed?

How many people have had 'burnout' in SOTP in the past few years?

What if SOTP staff do not wish to deliver other programmes as this was a specific area of work they have applied for?

How will staff suitability for each programme be assessed e.g. where individual staff may have had experience of domestic violence/sexual abuse/ attitudes towards sexual offending?

Has there been an assumption that Facilitators delivering programmes to Sex Offenders suffer 'burn out'? Has it been considered that 'burn out' is more likely arises from over work due to poor organisation and lack of staff and lack of choice in their work?

Burnout is more likely to occur when people do not feel in control of their work or that they have no or little say in it. Currently facilitators in DSOU teams are delivering training (In the N.E it was Stop Gap training – then adopted nationally), London it has been the chemsex briefing, and other such training events are put on, they also deliver specialist reports to courts when requested, reports for case conference, MAPPA input ,co working difficult cases, briefings for magistrates and Mosovos, involvement with circles of support, advice to courts re appropriate sentencing, bespoke pieces of work for individual Probation Officers, pieces of work for those with intellectual disabilities, this helps the resilience of the DSOU facilitators, to not include this in their roles and responsibilities could have an adverse effect on their mental health and wellbeing. Being in the DSOU (which is by choice) enables people to focus on one subject and to develop their skill and knowledge in that subject. This in turn gives that extra support to PPs holding those cases, who, because of a diverse and challenging workload, does not always afford the opportunity to specialise in a subject, and no amount of training will give it due to conflicting tensions with others in their caseloads.

What consideration has been given to the appropriate work to do with someone who is assessed as high or very high risk? In the community they have Horizon or nothing. If they have been to prison and refused to do a programme they are then released into the community and all we have to offer is Horizon, originally devised for medium risk men. Are

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we not letting the community down by not having the right intensity programme to deliver to these men? Should it be purely about cost?

I was just thinking through some of the implications around the reduction in consultative work. Although it hasn't had such a great focus in our team, colleagues in Manchester have been involved in "co-work" arrangements with OMs. They would usually work with service users who don't fit the criteria for SOTP, such as females, learning disability IQ <60, transgender service users who can't access groups, non-English speakers etc so there will be a clear impact in the team's ability to address the diverse needs of our service users.

It might be useful to ask the operational teams affected what the impact will be. We have been seen as experts and points of contact. Colleagues deliver training and support SOSO's. Post Crasstti Report this has been given extra focus to increase practitioners knowledge and confidence working with men who have committed sexual offences. Strengthening the link between interventions and POs has always been seen as a positive for all involved

We are a "resource" team and provide an important service in supporting the work of our colleagues in offender management with people with sexual convictions. In addition to the Craissati report of 2017, there was a thematic inspection in 2019 of work with men convicted of sexual offences, which found that not enough was being done to protect the public from sex offending, noting that many staff are unsure how best to work with people with sexual convictions in supervision. In response to this the NPS agreed to commit resource and training to this area. We are part of that by helping to deliver training (for example, New Me MOT and Newly Qualified Officer training), as well as fielding queries from OMs and supporting SOSOs. Removing capacity to do this under the proposed new model would, in my view, undermine the work that is being done to promote the most effective practice and protect the public.

I agree with the concerns raised from our consultation meeting in the email below, in particular that the quality and expertise that have been developed in our team over many years would be diluted with everyone delivering all the programmes. Whilst this may appear cost-effective to some in the short term, I think the costs of this change would significantly outweigh any benefits. I hope the model will be re-thought in light of the feedback being given from staff.

To what extent will staff have a say over which Accredited Programmes they deliver? There are lots of reasons (personal and professional) why someone may not want or feel able to deliver particular content, and while we can respect that there can be an organisational need for greater flexibility, what reassurance will we have that there will be an equal respect for our personal needs?

The document describes the only identified benefit of the DSOU as "a developmental opportunity for tutors of other programmes" – given this, is the plan to no longer have any Band 4 PO Staff working within Interventions and what is the incentive for them to remain?

What will happen to the Band 4 PO staff within DSOU?

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Will the employment rights of Band 4 PO staff within the DSOU be protected and will they be able to transfer into other vacant positions?

What is the timescale for these changes to take effect?

Has application been made to CSAAP to remove the requirement for sexual offending behaviour programmes in the community to be delivered by Band 4 qualified staff?

Is there a plan to make changes to the delivery requirements of Horizon and NMS and iHorizon so that Band 3 staff can deliver these programmes as suggested in the document?

How will the professional development of Band 4 staff in DSOU be maintained if there are no qualified Band 5 staff working within the new accredited progs unit?

What specifically does the role of Band 4 staff in the DSOU look like under the new model?

To what extent will the expertise and training of band 4 facilitators within the DSOU be an important aspect of the new model?

What aspect of the role of a facilitator within the DSOU has changed to make it suited to the profile of a band 3 unqualified member of staff?

Will Band 4 staff be expected to deliver all Programmes? What is the timescale of this, if so?

There are over 200 years of experience of delivering interventions to men who have committed sexual offences within the East Midlands DSOU – what is being done to value and retain that essential knowledge and experience?

Why have we been given assurances so far the DSOU will remain as a separate team within Interventions when the published plan is completely different?

If Band 4 staff are TM trained will they be expected to TM all Programmes?

Appalled to read about the changes in a newsletter when direct questions have been avoided. The word deceitful was mentioned.

If someone chose not to train in other programmes, would they have to leave?

Other programmes aren't in our job description so might need a contractual change via HR and TUs.

What's the future for POs in AcPrs in the long-term?

If all AcPRs are to be PSO-led and POs had to leave, what re-training would there be for their new OM job (most people in my team have been here for years)? Would positions be ring-fenced?

Are additional evenings and weekend working being considered? Although the person raising this recognised that it was a second-or-third-hand rumour (which is what happens when we are told nothing), they were still a bit unsettled. If so, it would again have to be a contractual change and likely lead to staff loss.

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Will the expectation of our maximum travel to a delivery site change?

Will we be expected to deliver at non-PS sites? Other agencies' offices could be OK re staff safety etc.

This section talks about DSOU staff running other programmes and goes on to talk about development opportunities for other tutors. It doesn't say other staff will run Horizon, so I wonder if the 'development' referred to is us sharing our expertise? If so, it's a potential relief for our teams but a bit patronising for facilitators of other programmes. I wonder how they will view the way that's worded?

Will Band 4 POs and Band 5 SPOs have to ask to be moved out of DSOU prior to reunification in June 2021 in order to protect their substantive roles as Probation Officers and Senior Probation Officers?

Currently in DSOU the Treatment Manager Role is undertaken by Band 5 SPO staff recruited to a generic Band 5 JD. Many of these staff have previous experience of other generic OM Band 5 SPO roles and were transferred into role in DSOU following E3. Going forward will these staff have their employment rights as Band 5 SPO's protected – will they be able to continue to transfer into and undertake other band 5 jobs as part of general rotation?

Will the Band 5 SPO staff in DSOU be moved into Programme Manager roles following transition?

If any Band 5 SPO staff in DSOU are displaced following transition will they be moved into other Band 5 SPO posts?

- **Improved Outcome for People with Protected Characteristics**

Please correct this section to reflect that ethnicity and LDC are Protect**ED** characteristics, not protect**IVE** characteristics? The two words have opposing meanings in this context.

5. Logistics and Infrastructure

The consultation document states that teams will be adequately resourced, however we currently have a vacancy in our team and have consistently found it difficult to recruit staff to this job role. With the increase in workload (introduction of SIs) it seems that there will be an even greater need to recruit. How are job roles going to be made more attractive so that we can recruit the right people to these positions? And what will the implications be for those of us currently in post?

The Interventions team will be sufficiently resourced to ensure provision to meet demand and enable starts within eight weeks from programme ready referral, a maximum travel of 60 minutes and available at times to suit working or caring commitments. If travel time is likely to be in excess of 60 minutes, then the Intervention team must utilise 1:1 delivery closer to the SUs address or facilitate a combination of in-person and remote access delivery. – this may increase the workload for facilitators as they will be working combination of 1:1 and group – is this taken into account with new staff resources/additional staff?

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If travel time cannot exceed 60 minutes, we need more delivery sites. Our public transport system, particularly in more rural areas would mean we would struggle with the 60 minute rule.

The consultation document states that now service users will need to travel more that 60mins to get to a programme session. How will this be calculated – i.e. minimum journey time, maximum in traffic, maximum if using public transport etc? In an area like Surrey, travel times can vary hugely depending on the time of day and mode of transport. How are the implications of this going to be managed?

Restricting travel time for service users to 60 minutes is not realistic for sexual offending programmes, particularly when viable group sizes should be retained, and throughput/volume needs to be considered

Starting in 8 weeks is also not realistic for the same reasons and does not allow for sequencing within sentence planning to be driven by the needs of the service user

Currently, some service users, especially those reliant on public transport, have journey times over 60mins and some it's in excess of 2 hours each way to attend group sessions. How will these individuals be catered for?

Is the expectation that groups will be delivered in locations that are closer to them? There are logistical reasons why this is not currently done, particularly impact on waiting lists, having enough people to form a suitable group at each location, and staff travel.

How are these logistical issues going to be addressed?

Are facilitators going to be expected to travel significant distances on top of their current commutes in order to deliver groups in new locations?

What consideration has been given to staff safety when travelling late at night after group delivery, staff wellbeing if the working day is to be extended by increased travel, and recompense for the time and cost of any additional travel?

On a brief read of the document, it is unclear about aspects of group provision: On the one hand it says (p4) *When the* [OM] *assesses the SUs as programme ready (completed motivational work, removed any barriers to attendance and completed any pre-group work as defined in the programme manuals), a referral to the Interventions team can be made and* ***a start date for a suitable group to be offered within eight weeks.*** Which seems to mean that the start date is to be offered within eight weeks, not that the start date must be within eight weeks of the 'programme ready' assessment.

But the document also says that *The Interventions team will be sufficiently resourced to ensure provision to meet demand and enable* ***starts within eight weeks from programme ready referral…*** [Emphases mine.] That can only mean that programme start date is to be within

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eight weeks. If this becomes a target/KPI/audit thing, then I can foresee us asking OMs not to declare the SU to be programme-ready until a time that suits us.

2.2 (p7) *The Interventions team will be sufficiently resourced to ensure provision to meet demand and enable starts within eight weeks from programme ready referral, a maximum travel of 60 minutes and available at times to suit working or caring commitments.* There are three requirements there – how soon, where, and time of day. I simply don't believe that all three can be met in all cases. Midlands TMs have years of experience of it not being possible. If a man in Leamington needs an evening group because he works, then even if we start running them in Coventry which for him is 45 minutes' travel time, what are the chances that a new group will happen to start within eight weeks of him being assessed as programme-ready? The document states that these three requirements will be met because the team will be *sufficiently resourced*. That indicates a failure to understand groupwork – if there are only three men waiting for an evening group in Coventry, no amount of resources can provide another man to make up the quorum for a session (still four in the primary delivery format), let alone a reasonable starting number of seven.

2.3.1 (p7) *If travel time is likely to be in excess of 60 minutes, then the Intervention team must utilise 1:1 delivery closer to the SUs address or facilitate a combination of in-person and remote access delivery.* Which is to say that if a man in rural Warwickshire or Worcestershire would have travel time of more than 60 minutes, then he will do the whole programme with each session delivered by one facilitator. Whether that is in person or remotely, it is big commitment of resources. I don't believe the author of this document has made any attempt to quantify what's needed to fulfil this; I wonder if anybody has. We could have a man who needs 1:1 sessions in (say) Kidderminster; and we have no more than eight weeks to get this started. And then oops, three weeks later we get another 1:1 commitment, in Telford, also to start within eight weeks. Even if both these men get remote sessions, not face-to-face, big chunks of facilitator time are tied up. This proposed commitment to 1:1 is simply reckless unless the likely scale of need has been researched. And I'm not aware of anybody having surveyed our men's' travel times.

2.3.2 Why is this provision of 1:1 delivery restricted to people with likely travel time of over 60 minutes? If we have a man who lives 5 minutes from Selly Oak or Wolverhampton but who works six weeks nights, six weeks days, then there won't be a group to *suit working or caring commitments.* But he doesn't qualify for 1:1 provision.

As an addition to the above, in terms of 60 minute travel times for men and 1:1 working, Horizon is not accredited to be run 1:1 and ADF is only to be used in extreme circumstances (such as the Pandemic) it has not been written to 'catch more men' so in theory the document is saying that if they live more than 60 minutes away from a viable group then we can't take them (unless our number of delivery sites expands).

8 Weeks from referral to commencement (I note referral should not take place until after individual is programme ready). Currently referral forms are sent out immediately people are sentenced or leave custody. Will people get missed, who is going to chase up referrals as readiness could take longer with some than others.

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Where are the trained staff coming from?

How will the backlog from Covid be managed? (I appreciate that some cases have gone back to OM's already)

What about those coming out of prison who should have completed Kaizen as they are assessed as high/very high risk, and haven't been able to do so due to pause on programmes, will there be an expectation for them to complete Horizon in the community? If this is the case and they are not doing the programme intensity they should be doing and there is an SFO, who will be responsible? Is this a risk?

The document also refers to a continuation with the alternative delivery format. In my experience, delivering programmes remotely, whilst better than not delivering them at all, is not anywhere near as good as standard delivery, for the service user or the facilitator trying to do the work.

Whilst the ADF might be used in very exceptional circumstances, my concern would be there is a drift toward it being used routinely for convenience and to hit targets, rather than to meet an exceptional need.

- **Training, Professional Development and Continuous Improvement**

All Facilitators to complete the minimum training requirements set out below before they are able to deliver an APs:

- Core programme skills
- Cognitive Behavioural Skills
- Questioning styles
- Theory underpinning each programme (HMIP identified it as needing improvement)
- Programme specific training delivered via Intervention Services
- Safeguarding
- Extremism
- Risk awareness assessment and management to ensure informed feedback re risk is fed back to PP
- Dealing with challenging behaviour
- Diversity
- Denial - as Horizon can take up to 2 men who maintain their innocence
- MAPPA
- Arms training to understand how it all fits together for mcso
- Desistance training
- Sara training
- Skills Practice training
- AIMS training to ensure understanding of those young people who transfer from YOTS to Probation Service

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Training, Professional Development and Continuous Improvement - Is every Facilitator going to be re-interviewed for a post?

The Training outlined for Staff seems minimal and very basic (e.g. Risk Awareness). There is no reference to any Staff needing to demonstrate they have significant years of experience in working with High risk service users, or a Probation qualification as criteria for delivery of any of the Programmes.

There seems no suggestion that they will get any training in relation to assessing and managing high risk cases. This is a significant concern for Staff working with DV cohort and Sexual offending cohort.

In order to deliver what is stated I envisage requiring significantly more Staff and there doesn't appear to be Staff available in OMU's that could be brought to Interventions without leaving OMU's further understaffed. This would suggest they would be externally recruited and could therefore be appointed, quickly complete the Training outlined and deliver a Horizon, NMS or BBR programme within a few months of joining the Service, and Therefore having little training or experience.

It is mentioned that 'appropriately trained staff (outlined in appendix A)' should run the programmes- this I feel is not specific enough.

To manage high risk sex offenders to a high standard that protects the public you need qualified staff, experienced in risk awareness and management to carry out this very important work hence why at the time of the split, sex offender work was given to band 4 facilitators. The model does not specify how it will adhere to the high standards the public expect when treating men who pose high level of harm. Practitioners who have experience of offender management, so that they are qualified to assist PPU and OM in their risk assessments such as arms is crucial. This intricate work should be recognised and paid accordingly.

The overall risk management knowledge a PO has, I feel, is vital to the overall management of high risk cases on AP's (managing the risk they pose to themselves, each other, current partners and future victims). Post programme reports that emphasise how the SU can strengthen their protective factors and therefore manage their risk, I feel, is more justifiable if done by a qualified member of staff, especially in the case of an SFO.

- **Support and Supervision of Staff**

Support and Supervision – minimum requirement of 2 sessions per year of structured professional support. Is it mandatory that this be offered to a Facilitator or mandatory that the Facilitator attends?

In addition to Structured Professional Support, PMs supervision including session monitoring will take place to support facilitators' quality of delivery, this must include following the

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minimum guidelines set out in the programme manual. In addition, TMs have the flexibility to hold thematic training sessions or workshops on common areas for improvement, support with delivery techniques or how to effectively use equipment and IT- will this be part of Band 4 or Band 5 role? How will quality of thematic training sessions be audited?.

Will contracts be re-written to include weekend working for Facilitators?

What protective conditions are being put in place for Facilitators walking from programme rooms to their cars after finishing delivery of BBR or Sex Offender programmes, often finishing at 9 pm or later, for leaving of building?

Have there been discussions with trade unions before any of these decisions were made?

- **IT to Support Coordination and Delivery of Accredited Programmes**

No Comments to add at this moment

- **Group Rooms and Travel**

Group Rooms and Travel – how is a judgement arrived at that a room used to facilitate a group is both providing a 'rehabilitative enabling environment' and 'has space for up to 12 SUs'?

Very few group rooms have facilities to safely store the paperwork for groups, and with moves to new offices where there isn't any money left for adequate storage what provisions are being made for the increase in space needed for the increase in number of groups and SI being delivered?

HORIZON and possibly other sex offender programmes, according to the manual guidelines and design of programme, dictate a maximum of 10 (which is too many) yet the new operating model specifies 12. The quality of the material to be delivered in each session would be jeopardised for a group as large as 12 due to the necessary allowance for feedback

from participants. Why has this not been taken into account in drawing up this new model? The point of the programme is rehabilitative, does the model relate to this?

The consultation document states that all group rooms will be large enough to accommodate 12 group members and 2 facilitators. None of our current group rooms are of a size where this would be in any way comfortable. In addition we do not currently have break out rooms. Are new group rooms going to be constructed? If so, where?

There is already pressure on group room space, how is this going to be managed/prioritised when the two teams come together?

The report states:-'These rooms must *provide a rehabilitative enabling environment, provide enough space for up to 12 SUs* and two facilitators, have a place to securely store SUs' work,

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video recording facilities, *have break out rooms for 1:1 confidential discussion* and be accessible for all SUs including those with mobility issues.

The new building plan places the group rooms in the very open plan reception areas, with blinds at the windows for privacy. How can we ensure the safety of both the men and the facilitators in these very public environments? '

I have concerns about not enough rooms for the confidential discussions. Also the rooms we do have are not providing an enabling, rehabilitative environment – they need renovation. Some have been the same for 20 years!

Room Size, up to 14 people, rehab environment and break out private room. Even size for 12 is very tight in many rooms, and won't be conducive to checking out learning etc, especially for those with any kind of learning disability or difficulty, e.g. no literacy.

Minibus from UPW to aid attendance. Sounds good but difficult to resource and organise.

The figure of 12 men, I believe, should be challenged as this in my professional opinion does not fit with good practice. Men's voices get lost and treatment diluted as it is more difficult to target treatment needs the more men you have in a room, i.e. resulting in less effective treatment. The optimum number for a group is 8.

- **Quality Assurance and Performance Management**

Isn't this what the treatment managers do, or are there plans for a further level of quality control?