An inspection of youth offending services in

Western Bay

HM Inspectorate of Probation

March 2019

This inspection was led by HM Inspector Yvonne McGuckian, supported by a team of inspectors, as well as staff from our operations and research teams. HMI Probation was joined by colleague inspectors from HM Inspectorate of Constabulary, Fire and Rescue Service (HMICFRS), Care Inspectorate Wales (CIW), Healthcare Inspectorate Wales (HIW) and Estyn. The Head of Youth Offending Service Inspections, responsible for this inspection programme, is Alan MacDonald. We would like to thank all those who helped plan and took part in the inspection; without their help and cooperation, the inspection would not have been possible.

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

This publication is available for download at:

www.justiceinspectorates.gov.uk/hmiprobation

Published by:
Her Majesty's Inspectorate of Probation
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Foreword

This inspection is part of our programme of joint inspections of youth offending services. As planned, we have inspected and rated Western Bay Youth Justice and Early Intervention Service across three broad areas: the arrangements for organisational delivery, and the quality of both court disposal and out-of-court disposal work. We have rated Western Bay Youth Justice and Early Intervention Service as 'Inadequate' – our lowest rating.

Western Bay Youth Justice and Early Intervention Service was created in 2014, amalgamating the youth offending services of Swansea, Neath Port Talbot and Bridgend. This joint inspection found that this amalgamation has been implemented poorly and that none of the three local authorities has taken full responsibility for the service. This lies at the heart of many of the problems we identify in this report.

The Management Board does not have a good enough understanding of its role and responsibilities. It is not sufficiently in touch with the work. Inconsistent partnership work and inadequate day-to-day management are resulting in poor casework, with staff lacking the support they need to deliver well. We found some pockets of good practice, including the running of the out-of-court disposal scheme, the intervention centre and the building skills programme. Where good practice happens, this tends to be due to individual efforts and to be built on pre-amalgamation schemes.

The Board has failed to set a clear vision and direction for the service. In its absence, operational managers and staff have been left to firefight and respond to the symptoms of significant systemic problems. Work to help children and young people desist from offending is the strongest area of work, but safety and wellbeing needs are often underestimated. In cases were children and young people have court orders, work to identify, plan, reduce and manage risk of serious harm is poor.

Partnership work, needed to safeguard children and young people with complex needs, is inadequate. We found many examples where it was impossible to tell if children and young people were protected. When issues are identified, the service and partners do not always take necessary safeguarding actions.

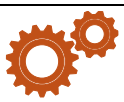
We expect the Management Board to take swift action in response to our recommendations to ensure that the service works together to meet the safeguarding and offending needs of children and young people. Critically, work to meet public protection responsibilities needs to be effective.

Dame Glenys Stacey

Chief Inspector of Probation

Overall findings

Overall Western Bay is rated as: **Inadequate**. This rating has been determined by inspecting the youth justice and early intervention service in three domains of its work. The findings in those domains are described below.



Organisational delivery

Our key findings about organisational delivery are as follows:

- The governance and leadership of the service are ineffective. There is no shared vision, understanding of purpose or suitable strategy to provide a high-quality personalised responsive service to children and young people.
- None of the three local authorities involved in the service has taken appropriate responsibility for the work of the service. This has resulted in confusion in processes and procedures, and inconsistent service delivery.
- The Management Board does not understand the needs of this specific group of children and young people, the staff team or the service.
- There is no challenge or accountability. The recently appointed Chair has a developing understanding of the deficiencies of the Board.
- At a strategic level, partnership arrangements are inadequate and do not facilitate the delivery of effective practice, particularly in prevention and post-court work.
- There are some pockets of good work, but these are often due to personal relationships developed between children and young people and individual staff members, not as a result of joint working arrangements. The police provide good support to the service in delivering the out-of-court disposal scheme.

Court disposals

Our key findings about court disposals are as follows:

- Safety and wellbeing factors faced by children and young people are often underestimated and are not always planned for. The service and partner agencies do not always undertake actions to reduce vulnerability. Some children and young people are not safe.
- Risk of serious harm is also underestimated; planning in this area is poor and there is too little focus on the needs and wishes of victims.
- Reviewing does not always take place or lead to necessary changes.
- Staff training in the use of the AssetPlus assessment system has not equipped them to use the system well. This affects the quality of their assessments.
- Staff develop good relationships with children and young people and are committed to supporting them.

- Assessment and planning designed to help prevent further offending are the strongest areas of practice.
- Some good interventions are delivered, including substance misuse services and some vocational training.
- Children's and young people's access to health services is poor.

Out-of-court disposals

Our key findings about out-of-court disposals are as follows:

- Joint work between the service and the police is good and provides an effective out-of-court disposal scheme. Police monitoring showed that 90 per cent of children and young people who received an out-of-court disposal did not come back into the service.
- Assessment and planning for this group of children and young people are good.
- Risk of serious harm is given sufficient priority.
- Interventions to prevent further offending are delivered as planned.
- Joint work with partners to keep children and young people safe is not good enough and, despite efforts by case managers, leaves some at risk.
- We are concerned that some children as young as eight are being incorrectly referred to the service's prevention from offending scheme. These children have safeguarding needs, which should not be met in a criminal justice service.

Service:	Western Bay Youth Justice and Early Intervention Service
Fieldwork started:	December 2018

Overall rating

Inadequate

1. Organisational delivery

1.1	Governance and leadership	Inadequate
1.2	Staff	Inadequate
1.3	Partnerships and services	Inadequate
1.4	Information and facilities	Inadequate

2. Court disposals

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

3. Out-of-court disposals

3.1	Assessment	Good
3.2	Planning	Requires improvement
3.3	Implementation and delivery	Inadequate[1]
3.4	Joint working	Outstanding

[1] Under 3.3 professional discretion was exercised because of cases close to the grade boundary. Overall performance for implementation and delivery was therefore scored inadequate.

Recommendations

As a result of our inspection findings we have made recommendations that we believe, if implemented, will have a positive impact on the quality of the youth justice and early intervention service in Western Bay. This will improve the lives of the children and young people in contact with the service, and better protect the public.

Western Bay Youth Justice and Early Intervention Service (WBYJEIS) Management Board should:

1. review and clarify its role and function, include all statutory partners and work in an effective way to make sure that the service operates to a sufficient standard
2. make sure that partnership agencies provide appropriate support and services
3. develop effective oversight of the service's work and effective challenge to partners
4. develop a clear plan to manage disaggregation of individual YOTs from the service to limit any detrimental effect on the remaining parts of WBYJEIS
5. provide the resources and support to the management team to manage the service effectively
6. review the role and function of the prevention service.

The WBYJEIS Manager should:

7. make sure that all staff have appropriate supervision and management oversight
8. review the management structure and lines of accountability.

The directors of children's services should:

9. monitor and review all cases where there are safety and wellbeing issues, making sure that appropriate referrals are made and joint work takes place as needed
10. improve the quality (and awareness from staff) of the referral systems so that children and young people receive the services they need.

The local authority education services should:

11. review the effectiveness of information-sharing protocols to ensure that all schools and workers involved have the information they need to provide support tailored to children and young people's individual needs.
12. develop effective strategies to encourage children and young people who speak Welsh to access services in their preferred language, and to use, develop and recognise the value of the language as an employment skill
13. develop a literacy and numeracy strategy to support children and young people to develop these skills to improve the chances of desistance.

Abertawe Bro Morgannwg University Health Board (ABMUHB) should:

14. provide relevant and timely physical, sexual, emotional and mental health services to meet the needs of children and young people to reduce further harm and promote wellbeing.

Introduction

Youth offending teams (YOTs) supervise 10–18-year-olds who have been sentenced by a court, or who have come to the attention of the police because of their offending behaviour but have not been charged, and instead are dealt with out of court. HMI Probation inspects both these aspects of YOTs.

YOTs are statutory partnerships, and are multi-disciplinary, to deal with the needs of the whole child. They are required to have staff from local authority social care and education, the police, the National Probation Service and local health services.[2] Most YOTs are based within local authorities, although this can vary.

YOT work is governed and shaped by a range of legislation and guidance specific to the youth justice sector (such as the National Standards for Youth Justice) or else applicable across the criminal justice sector – for example, Multi-Agency Public Protection Arrangements (MAPPA) guidance. The Youth Justice Board (YJB) for England and Wales provides some funding to YOTs. It also monitors their performance and issues guidance to them about how things are to be done.

Established in 2014, Western Bay Youth Justice and Early Intervention Service was an amalgamation of Swansea, Neath Port Talbot and Bridgend youth offending services.

The Chair of the Management Board is the Director of Neath Port Talbot's Children's Services. Bridgend is the lead local authority, and the Director of Education provides line management for the service's head of service. The service has four work strands: prevention, out of court, post court and voluntary engagement. At the time of the inspection, the service held around 220 cases.

Following concerns identified in the first fieldwork week, we issued an organisational alert. This was based on four specific cases where we were not assured that safeguarding and vulnerability had been addressed or that risk of serious harm to others was understood and managed. In addition, we found an underestimation of risks in safeguarding and risk of harm assessments. We were not confident that the service knew all of the risks. We asked that a plan be produced to show how cases could be reviewed. No plan was produced nor is one in place, and the response to the organisational alert lacks understanding and urgency.

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 provide assurance on the effectiveness of work with adults and children who have offended to implement orders of the court, reduce reoffending, protect the public and safeguard the vulnerable. We inspect these services and publish inspection reports. We highlight good and poor practice, and use our data and information to encourage good-quality services. We are independent of government, and speak independently.

[2] The *Crime and Disorder Act 1998* set out the arrangements for local YOTs and partnership working.

HM Inspectorate of Probation standards

The standards against which we inspect are based on established models and frameworks, which are grounded in evidence, learning and experience. These standards are designed to drive improvements in the quality of work with people who have offended.[3]

[3] HM Inspectorate of Probation's standards are available here: https://www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/

Key facts

First-time entrant rate[4] per 100,000

120 Western Bay

273 Average for England and Wales

Reoffending rates[5]

47.9% Western Bay

41.6% Average for England and Wales

Caseload information[6]

Age	**10-14**	**15-17**
Western Bay	12%	88%
National average	24%	76%

Race/ethnicity	**White**	**Black and minority ethnic**
Western Bay	96%	2%
National average	73%	24%

Gender	**Male**	**Female**
Western Bay	80%	20%
National average	83%	17%

Population information[7, 8]

	Swansea	**Neath Port Talbot**	**Bridgend**
Total population	245,480	142,090	144,288
Total youth population	8.5%	8.6%	8.9%
Total black and minority ethnic youth population	7.1%	2.7%	2.9%

4 Youth Justice Board. (2018). First-Time Entrants, October 2016 to September 2017.
5 Ministry of Justice. (2018). Proven reoffending statistics, July 2015 to June 2016.
6 Youth Justice Board. (2018). Youth Justice annual statistics: 2016 to 2017.
7 Office for National Statistics. (2018). UK Population estimates, mid-2017.
8 Office for National Statistics. (2012). Census 2011.

1. Organisational delivery

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

1.1 Governance and leadership	Inadequate
The governance and leadership of the YOT supports and promotes the delivery of a high-quality, personalised and responsive service for all children and young people.	

The governance and leadership of the service are ineffective. There is no shared vision, understanding of purpose or the strategy to provide a high-quality personalised responsive service to children and young people. None of the three local authorities have taken appropriate responsibility for the work of the service. We saw examples of how each local authority prioritised its own children and young people, but the local authorities had not considered the difficulties inherent in working to three different social care systems, HR systems and a variety of referral systems. The directors of social care have not analysed whether safeguarding needs are identified and responded to.

The Management Board has no mechanism to assess the quality of service delivered, nor is it sighted on the many issues that are preventing effective work, including the safety and wellbeing of children and young people, and public protection responsibilities. The Board does not understand the needs of this specific group of children and young people, the staff team or the service. There is no challenge or accountability. The recently appointed Chair has a developing understanding of the deficiencies of the Board.

The Board has been reliant on the monitoring of the three key performance indicators (first-time entrants, reoffending rates and use of custody). It has accepted reports provided by the previous head of service without sufficient scrutiny.

The Board knows that part of its role is to respond to issues that have been escalated, but when asked it was unable to give an example of an issue that needed to be resolved. Escalation processes are not effective in reaching the Board and driving systemic change. The Board was unable to say why its dissatisfaction with health provision had not been raised.

The health representative has not attended a Board meeting for 12 months, and has instead carried out YOS business in the Children's Health Board without access to first-hand data or analysis of children's and young people's needs or an appreciation of gaps in service.

Attendance at the Board by other members is variable and subject to frequent change. Careers Wales, who could provide useful assistance, has not yet been invited to attend the Board.

There is no evidence that Board membership assists with service delivery by partner agencies. This is particularly apparent in health, education and social care. The role and responsibility of the YOS is not widely understood, and this has resulted in confusion about information sharing and a lack of specific pathways to help children and young people access the services they need. Roles and responsibilities are unclear, especially between the service and the three children's social care services. This has left some children and young people in unsafe situations.

When we surveyed staff about their experiences of working for the service, only half said they knew about the activities of the Board. A high proportion of staff (85 per cent) said that they were not asked their views.

At a strategic level, partnership arrangements are inadequate and do not facilitate the delivery of effective practice, particularly in prevention and post-court work.

Some agencies do not understand the role of WBYJEIS and make inappropriate referrals to the prevention service. The prevention service aim is to prevent children and young people from offending. However, we found that three children aged eight had been referred to the service, a criminal justice agency, when they had clear safeguarding needs. One child was referred by a school because he was self-harming and threatening to kill himself. We instructed the service to make an immediate child safeguarding referral.

In another case, the child was on a Child Protection Plan due to neglect and physical abuse. Children's services made a referral to the WBYJEIS as the child, on several occasions, had taken a knife from the kitchen. This was perceived to be pre-criminal behaviour, when it was more likely to have been an attempt to keep himself safe or a repeat of behaviours he had seen in the family home. In both cases, children's social care was the appropriate agency to protect these children, not the youth justice service.

The three local authorities in the Western Bay area essentially operate as three separate entities. There is some evidence of cross-authority working but this largely depends on individual initiative, rather than being supported by appropriate management structures and consistent policies and procedures.

Some senior managers know about the impact of adverse childhood experiences, although none of the partner agencies knew how their contribution supports desistance.

The leadership team has faced major difficulties in supporting effective delivery. The operational structure is confusing, and communication to managers is limited. The two managers hold separate responsibilities (pre and post-court work) but teams have generic caseloads and so have to report to both of them. A senior practitioner role has recently been introduced to hold cases and have line management responsibility for several case managers. This has further confused lines of accountability.

There is insufficient operational manager capacity, with only two managers across three teams. The managers have been left in a very difficult position, with no clear direction or support from the Management Board.

Due to the lack of partnership arrangements and direction from the Board, service managers try to address the many barriers to effective work, but they do not have the authority or capacity to resolve the fundamental problems.

When managers raise issues, these have not been resolved at Board level; the reason for this is unclear. Managers are trying to resolve individual issues when a systemic approach is required. The two operational managers have been unsupported and did not have a suitable handover when the previous head of service left in September 2018.

The new head of service, who has not received an induction, started in October 2018, with the brief to take Bridgend out of the Western Bay service, without detriment to any of the local authorities. The proposed timescale for this major piece of work is April 2019. The Board and chief executive officers have undertaken no planning for this work.

There are no mitigations or controls to identify or manage service risks. This includes the failure to amalgamate the three YOSs into one coherent service, and the forthcoming separation of Bridgend.

1.2 Staff	Inadequate
Staff within the YOT are empowered to deliver a high-quality, personalised and responsive service for all children and young people.	

Inadequate supervision, a poor culture that does not support learning and improvement, and a demotivated workforce all need to be addressed before this organisation will start to improve. Although caseloads are at an acceptable level now, they have previously been high.

Staffing levels have been affected by both short and long-term sickness absence. The Board and management team do not know the scale of this as there is no centralised monitoring of staff sickness, which each of the three local authorities tracks separately. One manager has not been trained on these systems.

Cases are often reallocated to cover sickness but this adds to existing workloads. We found that some children and young people had several staff working with them over the period of the order or with voluntary involvement.

The service does not have an effective strategy to ensure that children and young people who speak Welsh receive a service in that language, can develop it or are encouraged to develop an awareness of its value as an employment skill. There are not enough bilingual resources for workers to encourage children and young people's use of Welsh.

The services teams include qualified social workers and support staff. Qualified social workers are supervised by an unqualified manager. In post-court cases, the specialist social worker role has not safeguarded all relevant children and young people.

Services from the drug and alcohol workers are good. The drug and alcohol workers are well motivated and had manageable caseloads of between 10 and 12 children and young people. However, these workers are also used for other duties, such as transportation of children and young people, when other staff are not available.

One speech and language therapist covers the three geographical areas that make up Western Bay. A further member of the team was on maternity leave and had not been replaced, which had significantly reduced the level of service, and both members of the team acknowledged that this was not providing the service with the support that it needed. Advice from the speech and language therapist is valued, but sometimes used in place of information that should have been provided by schools. In practice, the speech and language therapist could only provide children and young people with an assessment but no individual work.

The service is well supported by South Wales Police. Seconded officers are designated to the three borough command areas: one in Bridgend, two in Swansea and one in Neath Port Talbot. The officers are based alongside case managers with good access to IT and systems, and the co-location also promotes intelligence sharing. One officer is due to retire and their replacement is already in place to facilitate mentoring and sharing of experience. The police officers cover other geographical areas when required.

All the officers are well regarded members of the youth justice team. They provide invaluable assistance to the case managers through intelligence sharing, and where appropriate conduct joint home visits.

The police officers have limited contact with neighbourhood policing teams. More effective communication would enhance the wider police knowledge of the work of the youth offending service.

There is a good understanding of the multi-agency public protection arrangements (MAPPA) process, and positive relationships with the police officers and the MAPPA unit.

Although the police officers understand child sexual and criminal exploitation, they have been given no specific training on this and have received limited joint safeguarding training.

Staff are committed and work hard to help children and young people. However, this is often in the absence of effective partnership services. Some staff are demotivated. This seems to have been rooted in ongoing issues following the failure to implement the original amalgamation plan fully, and lack of consistent support. Overall, staff morale is fragile.

Management oversight arrangements are in place but inconsistently applied. Some staff, including managers, had not had supervision for months. The few staff who receive regular supervision appreciate it.

Staff can access training offered by the three local authorities. There has been whole-staff training on trauma-informed practice and the impact of adverse childhood experiences. Most staff feel that they could access and attend the training they require for the role.

Case managers were trained in the AssetPlus assessment system earlier in 2018. However, we found that staff did not know some key functions and their use of the system is rudimentary. There is little evidence of a culture of learning, and where improvements are made these are often due to individual efforts.

1.3 Partnerships and services	Inadequate
A comprehensive range of high-quality services is in place, enabling personalised and responsive provision for all children and young people.	

Except for the police, the partnership has failed to provide a range of services to meet the needs of children and young people.

There is no accurate, recent or comprehensive needs analysis, at either strategic or operational level. The specific needs of children and young people are not well understood. Information contained in the youth justice plan does not give specific detail of unmet needs. The plan does contain the views of staff and some children and young people, but there are no clear actions to address their points.

Decisions by the offending service managers, local authorities and Board members are made on a 'best guess' basis or taken from a single local authority perspective, rather than being evidence-based.

Most schools provide the service with information about children and young people's educational performance in a timely manner. They usually provide information about the child being on roll and, on occasion, levels of attendance. However, the range of information given is not consistent across all the schools. Few schools provide helpful information about children and young people's literacy and numeracy levels. A minority of schools do not inform case managers when children and young people are absent or when their behaviour is impeding their performance; in a few cases, this results in the school excluding children and young people without the case managers' knowledge.

Too many children and young people of school age are not receiving their full entitlement to education; in a few cases they only receive an hour a day, which means that they are unoccupied at times when they are most vulnerable and more likely to reoffend.

Arrangements in pupil referral units (PRUs) for children and young people to access offending behaviour support do not take their needs into account. In one PRU, workers are not able to contact staff if they need access to children and young people as the published telephone number does not work. Another has refused children and young people access to their case manager because they have behaved badly, when this access could be used to help rectify that behaviour.

The Abertawe Bro Morgannwg University Health Board is responsible for health provision to the service. We did not find any vision or strategy document, or long or short-terms goals for children and young people's healthcare needs. There is little evidence of partnership working between the health board and the service.

A physical health screening has been developed, by a senior education manager. The screening has no practical use and does not lead to service provision. Staff have, in the main, stopped using it.

Child and Adolescent Mental Health Services (CAMHS) are provided directly to the service with a monthly half-day session, which gives case advice for staff rather than see children or young people. The CAMHS support does not meet the needs of the children and young people; this was confirmed within the case notes and by many members of staff. We found a significant level of need in cases yet, despite evidence of ongoing distressed behaviour, children do not receive services unless their condition is acute.

> *In one case a 14-year-old girl had a history of offences of theft of alcohol. She self-harmed and was known to be vulnerable. She had asked for help on many occasions and this was not provided as she "did not meet the threshold for services". It was only when she went into a supermarket, stole and drank vodka, and self-harmed in the store that she got the help she desperately needed.*

One member of staff described the CAHMS service as *"non-existent; two strikes and you're out they will write out twice, then remove you from their list if no response".*

The Health Board is not providing any physical or psychological healthcare to the service (apart from the very limited CAMHS); it was evident that some children and young people had mental health issues that did not meet the threshold for CAMHS to get involved. Some sexual healthcare is available for children and young people.

There is a significant level of disengagement by the Health Board in several key areas, including at the Management Board and day-to-day direct input into the work of the service.

Child sexual exploitation (CSE) services are inconsistent. Case managers do not understand the assessment documents, and planning and response to cases are unclear, not shared or non-existent. We asked for further information on two boys whose cases were closed, despite clear evidence of ongoing vulnerability. In both these cases, once the boys were removed from the imminent danger, they received no support to manage their emotional needs, and there was little planning to manage the effects and increased vulnerability when they had suffered from sexual abuse.

Access and joint work with the three children's social care services are mixed. Thresholds for services are unclear, and case managers do not understand why referrals have not been accepted. Feedback on referrals is rare.

During our discussions with staff and partnership workers, it was clear that staff were very child-focused, and spoke warmly of the children and young people with whom they interacted. They clearly had their individual interests at heart, and were striving to achieve the best outcomes. This was set against a wider service and management structure that does not always support or facilitate this.

There are no systems to review or evaluate the suitability, use or effectiveness of services, and an over-reliance on anecdotal information.

There are a few examples of how safeguarding and risk of harm issues are managed, but these are the exception. Risk of harm issues are underestimated, planning is poor and agencies, other than the police, often have separate and uncoordinated risk management measures.

The service's ability to meet desistance needs, safeguard children and young people, and protect victims is compromised by an absence of clear direction, poor strategic partnership response and highly variable partnership working at an operational level.

Offence types and patterns of sentencing are not monitored. The Board has not considered the implications of the reduction of children and young people receiving custody and having community sentences instead.

1.4 Information and facilities	Inadequate
Timely and relevant information is available and appropriate facilities are in place to support a high-quality, personalised and responsive approach for all children and young people.	

There are a range of policies in place, but these do not adequately reflect the different approaches in the three local authorities. There is little connection between policy and practice. Staff are confused by these differences, by unclear and changing thresholds, and a lack of effective challenge about the quality and availability of services provided by the partner agencies. As a result, children and young people do not always receive the help they need.

The service is delivered from a range of places, most of which are suitable. Children and young people who attend the Bridgend office have to report to an open reception desk. Staff in this office are co-located with trading standards and environmental health services. We share their concerns that confidentiality is difficult to achieve. The Board members we spoke to had not visited the delivery sites to satisfy themselves of their suitability.

The Board has not assessed the safety of staff when working remotely, although staff themselves have developed some systems.

The intervention centre is a child-centred facility based in Swansea; it is accessible to all children and young people. The centre delivers a range of services, including education and training, offending behaviour work and a space where relationships between staff and children can develop.

At the time of the amalgamation, one case management system was introduced. However, staff still have to use three separate and very different social care systems to access information. These systems cannot be used remotely so managers and staff need to drive to the office located in that area to access information, which delays information sharing.

Information-sharing protocols are in place but are not always fully understood. There is confusion across the partnership about what information can be shared; this is symptomatic of the failure to work together. The result of this is seen in our assessments of work under domains two and three. It is difficult for case managers to gain a full understanding of all risk of harm or safeguarding factors.

Managers have difficulty accessing information, including on sickness absence. Three different annual appraisal systems are used.

There is limited evidence that analysis or learning is used systematically to drive improvements at any level. Improvement work has been delegated by the Board to a task group of operational staff and the Performance and Audit Group (PAG). The work of this group has value, but it does not have authority to make the wide-scale changes needed by the service and its partners. The Board takes little responsibility for service improvement.

Summary

Strengths:

- There are committed staff and management teams, who want to provide an effective service to children and young people.
- There is effective partnership work between the police and service.

Areas for improvement:

- The safety and wellbeing of children and young people and victims should be assured through partnership work.
- The Management Board needs to understand its roles and responsibilities, and the needs of children and young people.
- The roles and responsibilities of the service should be clear to staff and partners.
- Partners need to be held to account for service provision to meet the needs of children and young people known to the service.
- Lines of accountability and management should be clear and effective.
- Management capacity is too limited to provide effective oversight of work, manage the service, and manage the disaggregation of Bridgend from WBYJEIS.
- There should be effective communication between the three local authorities and health boards about the quality of service provision, including joint wok with children's social care, health provision and education services.

2. Court disposals

Work with children and young people sentenced by the courts will be more effective if it is well targeted, planned and implemented. In our inspections, we look at a sample of cases. In each of those cases, we inspect against four standards.

2.1 Assessment	Inadequate
Assessment is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.	

Overall the quality of assessments was inadequate. Assessment of desistance factors were the strongest, being sufficient in 65 per cent of cases. The views of the child or young person and their parents/carers were usually incorporated into assessments, along with identified strengths and protective factors.

Staff we interviewed often had a better understanding of the child or young person than was recorded on the AssetPlus assessment. Despite training in the use of AssetPlus eight months previously, staff had only a basic understanding of this assessment tool.

Many of the staff could not access the definitions of risk of serious harm or safety and wellbeing, which could have contributed to widespread underestimation of these factors. In 20 of the 31 cases assessed, the safety and wellbeing of children and young people were underestimated and inaccurate. The impact of all types of abuse, long-term parental emotional abuse and highly risky behaviours were not given sufficient weight. We found cases where we assessed that children and young people were still unsafe.

In one case, an inspector noted:

> *"The child and their family had relocated in Wales due to links to gangs and criminal exploitation. The child regularly smokes cannabis and has been reported missing from home on one occasion – he was found back in his original area over 100 miles away. He threatened dad with a knife within the family home. Despite concerns regarding lifestyle, associates, boundaries in the family home, substance misuse and feelings of safety, the case manager identifies low safety and wellbeing concerns and does not open the AssetPlus matrix to explore, analyse and justify this rating."*

Information on some assessments was inaccurate. In one case the child was recorded as having no involvement with children's social care, although he was in fact a Looked After Child.

External controls – actions that adults can take to protect the child or young person – were included in the assessment in just a quarter of cases. Actions that could have been taken by children's social care, schools and the child sexual exploitation service were often missing.

Assessments of risk of serious harm to others were also inadequate, with only 37 per cent judged to be accurate. Again, we found widespread underestimation of risk factors, and previous risky behaviour – including criminal behaviour – was not used to understand actual and potential risk to victims.

In two cases, children who had downloaded indecent images of child sexual abuse were assessed as low risk of serious harm; we disagreed with both assessments. In one case, the child's ability to access the 'dark web' was not assessed or understood. The assessment was

too ready to accept the child's explanation when, in reality, it is virtually impossible to come across materials of this nature accidently.

Although assessments were often countersigned, deficits were not identified through this process and staff were unclear about management oversight arrangements.

2.2 Planning	Inadequate
Planning is well-informed, holistic and personalised, actively involving the child or young person and their parents/carers.	

Planning to reduce offending was good in three-quarters of cases. Interventions and services most likely to reduce further offending were identified, as were the child or young person's strengths. The views of parents/carers and the child or young person were used to inform planning, which was often tailored to meet individual needs. Careful consideration was given to the sequencing of interventions, which were proportionate to the court order and offence.

Planning to protect actual and potential victims was sufficient in 18 of the 25 cases where it was needed, despite case managers having access to the victims' needs and wishes.

Safety and wellbeing needs were planned for in 41 per cent of cases. In 26 cases there should have been joint planning with another agency but this happened in only half of the cases. We found some good examples of coordinated planning, but these were the exception and based on an individual staff member's approach rather than as an expected aspect of planning.

Effective planning to include contingency arrangements, so that the services can respond to predictable changes, occurred in just under a third of cases where it was needed. This was due to case managers not knowing how to access the contingency section of AssetPlus.

Interventions to manage and reduce vulnerability were included in planning in 12 of the 27 cases where it was required. Staff told us that they did not always know what other agencies could provide. For example, case managers did not have the confidence that social care would work in cooperation to safeguard children, and in some cases legitimate requests for help and support for children and young people had not been accepted.

The absence of emotional and mental health services was a key barrier to effective planning; case managers had learned that, over time, the referrals would be futile.

> *In one case a young person was looked after and his offending was linked to the breakdown of his adoption and subsequent emotional trauma. The views of the social worker were not considered or obtained, and there was no joint planning. Access to the drug and alcohol worker was good. There was no planning focused on addressing his significant emotional health needs.*

Planning to manage and reduce risk of serious harm was the weakest, being sufficient in only a quarter of cases. Referrals were routinely made to the substance misuse service, and work was undertaken as a result. As case managers underestimated risk of serious harm to others, subsequent planning lacked specific actions, including those to protect actual victims or contingency arrangements.

Joint planning was undertaken in a quarter of relevant cases. Information sharing was problematic and, in some cases, gave false reassurance to partner agencies.

In one case the child's school was notified by the police when he was arrested for downloading indecent images of children. The school rang the service five months later – three months after the referral order was made – to find out the outcome of the court case. As he had been, incorrectly, assessed as low risk to children, there was no joint planning about his use of the internet at the school or college he attended. The college had implemented a range of safeguarding measures based on its own policies, none of which was informed by the Youth Justice Service.

Victim awareness work was often planned for, but the specific wishes and concerns of victims remained, in the main, unaddressed.

Inspectors observed a risk management panel. This was well chaired and appropriate actions were identified, but we were not assured that the panel was considering the right cases, due to the underestimation of risks.

2.3 Implementation and delivery	Inadequate
High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child or young person.	

The building skills programme and the music engagement DJ course (see below) were good interventions that led to qualifications and work. These had been developed in response to a long-term deficit in access to mainstream services.

A range of relevant offending behaviour programmes were available but there were problems in delivering these, sometimes due to staffing levels. Interventions to reduce risk of serious harm were delivered in just over a third of cases.

Case managers had a strong focus on building on children and young people's existing strengths, forming appropriate and meaningful relationships and on ensuring compliance. These are areas where the staff have a high degree of control. Where children and young people needed interventions and support from partner agencies, objectives became difficult to achieve.

Partnership working with health was very patchy and limited to speech and language advice (a very limited service). Sexual health and a monthly CAMHS session for consultation and advice for staff were not enough to meet the needs we identified in the cases.

We identified 12 children and young people who needed mental health support; only three received this, and that was when their needs were acute and sectioning under the Mental Health Act was considered.

Twenty-one children and young people needed substance misuse services, and sixteen received this help. Substance misuse staff were dedicated and committed to engaging children and young people.

Eleven children and young people had education, training or employment needs; seven received services, with all but one provided by the WBYJEIS intervention workers.

Youth offending workers undertake helpfully targeted work (such as knife crime awareness) with children and young people to develop their resilience, self-esteem and appropriate behaviour. However, the outcomes of these activities are not analysed effectively to inform an evaluation of their impact or to promote quality improvement planning at a strategic level. What children and young people learn from these programmes is not recorded in a way that can help the service to evaluate their progress.

There are no effective systems to monitor easily the proportion of children and young people who are not receiving their entitlement to education, training and employment (NEET), or to clearly monitor the number of those who are NEET. There is insufficient analysis of the length of time individuals spend as NEET. This information is not reported to the Management Board to help identify the priorities of this group; this impedes strategic planning.

The service's intervention centre offers children and young people a broad range of accredited activities to help develop vocational and life skills. Engagement activities are effective in encouraging these children and young people to pursue accreditation, and fill an important gap where pupil referral units are failing to fully occupy children and young people.

The centre's music engagement programme has enabled four young people to work as DJs in Ibiza. Several children and young people attend the centre to pursue Duke of Edinburgh's Awards – very few schools support children and young people involved with the service to progress from the bronze awards to higher levels.

A construction skills programme is highly effective in developing partnerships with community schools, enabling children and young people to become involved in building innovative and imaginative facilities for pupils, such as castles and mud gardens. Schools appreciate the children and young people's efforts and fund these projects from their own budgets.

Several young people on the construction skills project have undertaken the Welsh awarding body Agored Cymru awards in health and safety and progressed to obtain construction skills certification scheme cards, which improve their employment prospects.

The services' staff attend team-around-the-school meetings in a few Bridgend secondary schools to provide timely support and intervention to children at risk of disengaging from education. These meetings are too new to evaluate their impact. There is no clear plan for rolling out these meetings to other schools.

Delivery and implementation of safety and wellbeing and risk of serious harm interventions were inadequate. Service delivery promoted safety and wellbeing in 10 of the 27 cases where it was needed, and joint services were delivered in only a third of relevant cases. The effect of a lack of joint work can be seen in the following example:

John was 17 and his safety and wellbeing risks were increasing. The case manager arranged a professionals' meeting to discuss escalating risks and vulnerabilities. They invited staff from his temporary accommodation and his social worker. The case manager received a telephone call from the accommodation provider, voicing concerns that the social worker had arranged a risk meeting for the same afternoon and invited the accommodation provider and a substance misuse service not linked to the youth offending service.

The accommodation provider wanted to ensure that only one meeting involving all practitioners went ahead. The social worker had commissioned a substance misuse service to undertake a drug management plan, following John's accidental overdose. This was not discussed with the case manager or their substance misuse workers, who were already working with him to address his substance misuse. Following this, a Looked After Child review meeting was arranged where the service attended but the social worker did not.

Interventions targeted at reducing risk of harm were delivered in a third of cases; these included access to specialist sexually harmful behaviour interventions.

There was not enough attention to the protection of actual and potential victims. We found several cases where referrals should have been made to social care about siblings, peers and, in one case, a vulnerable woman who had been sexually assaulted.

The needs of children and young people who speak Welsh were not considered. Some Welsh speakers think in Welsh and then translate their thoughts into English, which poses difficulties when children and young people are trying to explain complex issues, including their emotions, and describe the sequence of offences.

The service and its partners have very limited systems to identify the interventions being delivered and their effectiveness.

2.4 Reviewing	Inadequate
Reviewing of progress is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.	

Case managers were aware that children and young people's circumstances can change rapidly, and that this can result in an increase, or sometimes decrease, in the likelihood of reoffending, risk of harm to others or risks to their safety and wellbeing. Reviews of cases resulted in the identification and subsequent response to changes in the factors linked to desistance in 92 per cent of cases, and built on the child or young person's strengths in 91 per cent of cases.

It is particularly important to reassess if there is new information that indicates a change in offending, vulnerability or risk of harm to others. Managers can often provide challenge, to make sure that progress is being made and that risks are managed. Reviewing was not used as an opportunity to reflect on the progress of the case or to amend work. Reviewing desistance was effective in just over half of cases, and under a third provided effective review of safety and wellbeing and risk of serious harm.

Some staff reported that they were thinking about the case on a continual basis, but this rarely translated into a recorded review. Changes to plans were not routinely made in response to new information, including new offences or deteriorating behaviours.

Referral order panels were held to review some cases, and this provided a good opportunity to consider progress. One inspector noted:

> *"In considering general reviewing, there is a sufficient review of promoting desistance factors. Reviewing is completed via referral panel review reports; however, it is interesting to note that this is not informed by a review of AssetPlus."*

We observed an enhanced case management review – this is a new national initiative designed to manage the more complex cases. Bringing together key professionals to give insights into the best methods of intervening and giving a psychological perspective to offending behaviours. Case managers have also benefited from training in Adverse Childhood Experiences (ACEs), and how these affect thinking and behaviour in children and young people. This approach to working is most effective when the understanding is shared across agencies. These are positive initiatives which, when imbedded, should prove beneficial in understanding and working with children and young people, who find it difficult to desist from offending.

Summary

Strengths:

- There is a strong focus on desistance from offending and building on children and young people's existing strengths.
- A wide range of interventions is available to support desistance.
- The building skills programme and music workshops provide opportunities into employment.

Areas for improvement:

- The assessment, planning and delivery of services to address safety and wellbeing and risk of serious harm are inadequate.
- The needs and protection of victims are not given sufficient focus.
- There is widespread underestimation of safety and wellbeing and risk of serious harm.
- There is a lack of joint work with children and young people's social care.
- There are very limited health services to meet the physical, sexual, emotional and mental health needs of children and young people.

3. Out-of-court disposals

Work with children and young people receiving out-of-court disposals will be more effective if it is well targeted, planned and implemented. In our inspections, we look at a sample of cases. In each of these cases, we inspect against four standards.

3.1 Assessment	Good
Assessment is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.	

The out-of-court disposal scheme, known as 'the bureau', is very well established. It has been in operation for around 10 years, and aspects of it have been used to inform national guidance. It is well managed and has made a significant contribution to reducing first-time entrants into the criminal justice system.

We looked at the out-of-court disposal processes. Cases are referred to the bureau, a panel consisting of representatives from the early intervention section of the service, the police and an approved independent volunteer. The full range of outcomes are available to the panel, ranging from no further action through to charge. The panel representatives are consistent, and the process facilitates bespoke interventions and wider safeguarding, enhancing the potential to reduce first-time entrants within Western Bay.

Victim engagement is good, with victims' officers establishing individual needs and wishes. Appropriate proposals, such as restorative justice, are made to meet the needs and wishes of victims, but these are not always followed by case managers.

Assessments of desistance and risk of serious harm are very good. These are completed on either a screening tool or AssetPlus, if the child or young person has been to the bureau in the previous 12 months. This system works well to identify offending and risk factors.

Case managers work hard to include parents/carers and children and young people in the assessment. Their views are discussed and given appropriate priority alongside the professional assessments.

There is careful consideration of the child's or young person's acceptance of the offence, based on detailed discussions with them and their parents. The child's or young person's strengths and protective factors and motivation are well assessed, and form the basis of advice to the bureau panel and the panel report.

In one case an inspector made the following observation:

> *"The assessment identifies that the young person is bored and frustrated as he hasn't been able to join the army as he failed his maths test. He does attend an army training centre on a voluntary basis. Assessment identifies need to support him to obtain maths qualifications."*

Assessment of safety and wellbeing is less well assessed, and is affected by the same issues we found in post-court cases. One in five of the assessments underestimated the child or young person's vulnerability.

3.2 Planning	Requires improvement
Planning is well-informed, holistic and personalised, actively involving the child or young person and their parents/carers.	

Planning for desistance is very good. The bureau process includes parents/carers, children and young people, victims and professionals in an inclusive and wide-ranging conversation. This process identifies and then plans for relevant interventions. Children and young people are encouraged to comply with the interventions, setting up a solid basis for their voluntary engagement. Interventions are well planned and could be completed in appropriate timescales.

Planning involves other agencies when needed, but not all plans have appropriate actions to protect victims.

Planning for safety and wellbeing requires some improvement, as it does not cover all identified factors, and almost never includes contingency planning to account for predictable changes. We found that case managers had some difficulties as they were not always supported by children's social care, as the inspector's comments in one case demonstrate.

> *"He is at ongoing risk of neglect from his mum. Children's services have undertaken an assessment; however, as mum has chosen not to engage with services the case has been closed. No planning about the potential for child sexual exploitation."*

In this case, the service and police were left to try and deal with issues that should have been addressed by social care.

3.3 Implementation and delivery	Inadequate
High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child or young person.	

Delivery of services to support distance from offending is strong. Work focuses on building self-esteem, developing coping skills and in making better decisions.

However, work to keep children and young people safe is inadequate. Despite efforts by the service staff, poor partnership work with health and social care means that some children and young people are left without the protection and support they need. The correct support was provided in just half of the cases where it was needed.

In one case, a child alleged that he had been assaulted at school by a member of staff; he was immediately protected as he was told not to go back to the school. It took children's social care a month to visit the school and speak to other pupils to determine if they were safe.

In another case, the case manager made three referrals to social care but the case was only picked up when she escalated it to the consultant social worker; however, most of the work was completed by the service.

Across all of the cases we assessed pre and post-court, the work of the service was hindered by a lack of effective partnership working with all agencies, except for the police.

3.4 Joint working	Outstanding
Joint working with the police supports the delivery of high-quality, personalised and coordinated services.	

There is a well-established out-of-court disposal scheme. Over time, the professional relationships between the police and the service have matured. The police and service are able to challenge views and decisions. Data provided by the scheme managers shows that the success rate of the bureau is 90 per cent.

Recommendations agreed between the police and service were appropriate and proportionate to the case in all cases we assessed.

Intelligence held on local police systems is checked daily and provided directly to the early intervention service. This includes overnight arrests, voluntary interviews, intelligence and other incidents of relevance. Regular team briefings are undertaken. Intelligence and information are also researched and provided to case managers when requested.

However, there is no effective flagging system identifying when a child or young person being managed by the service had come to the attention of the police; this is dependent on the knowledge of the seconded police officers. There is the potential for key intelligence to be missed. The result is that case managers might not always have up-to-date police information when making decisions regarding children and young people.

Summary

Strengths:

- There is a well-established scheme, leading to appropriate decision-making.
- Excellent engagement of parents and children informs decision making at the bureau.
- A wide range of interventions are available to prevent further offending.

Areas for improvement:

- Work to address safety and wellbeing issues is not as strong as desistance and risk of harm work.
- Lack of joint work and support from children's social care and health results in the Youth Justice Service trying to cover the gaps in service delivery.

Annex 1 – Methodology

The inspection methodology is summarised below, linked to the three domains within our standards framework. Our focus was on obtaining evidence against the standards, key questions and prompts within the framework.

Domain one: organisational delivery
The youth offending service submitted evidence in advance and the Chair of the YOS Management Board delivered a presentation covering the following areas:

- How do organisational delivery arrangements in this area make sure that the work of your YOS is as effective as it can be, and that the life chances of children and young people who have offended are improved?
- What are your priorities for further improving these arrangements?

During the main fieldwork phase, we surveyed 12 individual case managers, asking them about their experiences of training, development, management supervision and leadership. The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We explored the lines of enquiry which emerged from the case inspections. Various meetings and focus groups were then held, allowing us to triangulate evidence and information. These included meeting with the YOS Management Board and its Chair, interviews with a wide range of staff and managers, partnership workers and managers. We visited two of the three office bases used by the YOS. We interviewed two of the three directors of children's social care and two of the three local authority chief executive officers.

Domain two: court disposals
We completed case assessments over a one-week period, examining case files and interviewing case managers. Sixty per cent of the cases selected were those of children and young people who had received court disposals six to nine months earlier, enabling us to examine work in relation to assessing, planning, implementing and reviewing. Where necessary, interviews with other people significantly involved in the case also took place. In some individual cases, further enquiries were made during the second fieldwork week by colleague inspectors from police, health, social care or education.

We examined 31 post-court cases. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of five), and we ensured that the ratios in relation to gender, sentence or disposal type, risk of serious harm, and risk to safety and wellbeing classifications matched those in the eligible population.

Domain three: out-of-court disposals
We completed case assessments over a one-week period, examining case files and interviewing case managers. Forty per cent of cases selected were those of children and young people who had received out-of-court disposals three to five months earlier. This enabled us to examine work in relation to assessing, planning, implementing and joint working. Where necessary, interviews with other people significantly involved in the case also took place. In some individual cases, further enquiries were made during the second fieldwork week by colleague inspectors from police, health, social care or education.

We examined 20 out-of-court disposals. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of five), and we ensured that the ratios in relation to gender, sentence or disposal type, risk of serious harm, and risk to safety and wellbeing classifications matched those in the eligible population.

Annex 2 – Inspection results

1. Organisational delivery

1.1. Governance and leadership	Inadequate
The governance and leadership of the YOS supports and promotes the delivery of a high-quality, personalised and responsive service for all children and young people.	

1.1.1. Is there a clear local vision and strategy for the delivery of a high-quality, personalised and responsive service for all children and young people?

1.1.2. Do the partnership arrangements actively support effective service delivery?

1.1.3. Does the leadership of the YOS support effective service delivery?

1.2. Staff	Inadequate
Staff within the YOS are empowered to deliver a high-quality, personalised and responsive service for all children and young people.	

1.2.1. Do staffing and workload levels support the delivery of a high-quality, personalised and responsive service for all children and young people?

1.2.2. Do the skills of YOS staff support the delivery of a high-quality, personalised and responsive service for all children and young people?

1.2.3. Does the oversight of work support high-quality delivery and professional development?

1.2.4. Are arrangements for learning and development comprehensive and responsive?

1.3. Partnerships and services	Inadequate
A comprehensive range of high-quality services is in place, enabling personalised and responsive provision for all children and young people.	

1.3.1. Is there a sufficiently comprehensive and up-to-date analysis of the profile of children and young people, to ensure that the YOS can deliver well-targeted services?

1.3.2. Does the YOS partnership have access to the volume, range and quality of services and interventions to meet the needs of all children and young people?

1.3.3. Are arrangements with statutory partners, providers and other agencies established, maintained and used effectively to deliver high-quality services?	
1.4. Information and facilities	**Inadequate**
Timely and relevant information is available and appropriate facilities are in place to support a high-quality, personalised and responsive approach for all children and young people.	
1.4.1. Are the necessary policies and guidance in place to enable staff to deliver a quality service, meeting the needs of all children and young people?	
1.4.2. Does the YOS's delivery environment(s) meet the needs of all children and young people and enable staff to deliver a quality service?	
1.4.3. Do the information and communication technology (ICT) systems enable staff to deliver a quality service, meeting the needs of all children and young people?	
1.4.4. Is analysis, evidence and learning used effectively to drive improvement?	

2. Court disposals

Standards and key questions	Rating and % yes
2.1. Assessment	**Inadequate**
Assessment is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.	
2.1.1. Does assessment sufficiently analyse how to support the child or young person's desistance?	65%
2.1.2. Does assessment sufficiently analyse how to keep the child or young person safe?	42%
2.1.3. Does assessment sufficiently analyse how to keep other people safe?	37%
2.2. Planning	**Inadequate**
Planning is well-informed, holistic and personalised, actively involving the child or young person and their parents/carers.	
2.2.1. Does planning focus sufficiently on supporting the child or young person's desistance?	74%

2.2.2. Does planning focus sufficiently on keeping the child or young person safe?	41%
2.2.3. Does planning focus sufficiently on keeping other people safe?	25%
2.3. Implementation and delivery High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child or young person.	**Inadequate**
2.3.1. Does the implementation and delivery of services effectively support the child or young person's desistance?	55%
2.3.2. Does the implementation and delivery of services effectively support the safety of the child or young person?	41%
2.3.3. Does the implementation and delivery of services effectively support the safety of other people?	38%
2.4. Reviewing Reviewing of progress is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.	**Inadequate**
2.4.1. Does reviewing focus sufficiently on supporting the child or young person's desistance?	52%
2.4.2. Does reviewing focus sufficiently on keeping the child or young person safe?	29%
2.4.3. Does reviewing focus sufficiently on keeping other people safe?	32%

3. Out-of-court disposals

Standards and key questions	Rating and % yes
3.1. Assessment Assessment is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.	**Good**
3.1.1. Does assessment sufficiently analyse how to support the child or young person's desistance?	85%
3.1.2. Does assessment sufficiently analyse how to keep the child or young person safe?	65%
3.1.3. Does assessment sufficiently analyse how to keep other people safe?	80%

3.2. Planning Planning is well-informed, holistic and personalised, actively involving the child or young person and their parents/carers.	**Requires improvement**
3.2.1. Does planning focus sufficiently on supporting the child or young person's desistance?	89%
3.2.2. Does planning focus sufficiently on keeping the child or young person safe?	64%
3.2.3. Does planning focus sufficiently on keeping other people safe?	71%

3.3. Implementation and delivery High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child or young person.	**Inadequate**[9]
3.3.1. Does the implementation and delivery of services effectively support the child or young person's desistance?	81%
3.3.2. Does the implementation and delivery of services effectively support the safety of the child or young person?	50%
3.3.3. Does the implementation and delivery of services effectively support the safety of other people?	67%

3.4. Joint working Joint working with the police supports the delivery of high-quality, personalised and coordinated services.	**Outstanding**
3.4.1. Are the YOS's recommendations sufficiently well-informed, analytical and personalised to the child or young person, supporting joint decision-making?	95%
3.4.2. Does the YOS work effectively with the police in implementing the out-of-court disposal?	80%

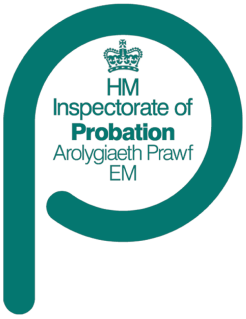
[9] Under 3.3 professional discretion was exercised because of cases close to the grade boundary. Overall performance for implementation and delivery was therefore scored as inadequate.

Annex 3 – Glossary

Adverse childhood experiences	Adverse childhood experiences (ACEs) are traumatic events that affect children while growing up, such as suffering child maltreatment or living in a household affected by domestic violence, substance misuse or mental illness
AssetPlus **Asset+**	Assessment and planning framework tool developed by the Youth Justice Board for work with children and young people who have offended, or are at risk of offending, that reflects current research and understanding of what works with children
CAMHS	Child and Adolescent Mental Health Services
Court disposals	The sentence imposed by the court. Examples of youth court disposals are referral orders, youth rehabilitation orders and detention and training orders
Child Protection	Work to make sure that that all reasonable action has been taken to keep to a minimum the risk of a child experiencing significant harm
CSE and criminal exploitation	Child sexual exploitation, is a type of child abuse, occurring when a child or young person is encouraged, forced and manipulated to take part in sexual activity for something in return, for example presents, drugs, alcohol or emotional attention. Criminal exploitation: occurs with children and young people when they are exploited, forced or coerced into committing crimes
Desistance	The cessation of offending or other antisocial behaviour
Enforcement	Action taken by a case manager in response to a child or young person's failure to comply with the actions specified as part of a community sentence or licence. Enforcement can be punitive or motivational
ETE	Education, training and employment: work to improve learning, and to increase future employment prospects
First-time entrants	A child or young person who receives a statutory criminal justice outcome (youth caution, youth conditional caution or conviction) for the first time
HMIP	Her Majesty's Inspectorate of Probation
HMPPS	Her Majesty's Prison and Probation Service: a government department responsible for carrying

	out sentences given by the courts, in custody and the community
Local Authority	YOTs are often a team within a specific local authority
MAPPA	Multi-agency public protection arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose the highest risk of harm to others
NEET	Children or young people not in any form of full or part-time education, training or employment
Out-of-court disposal	The resolution of a normally low-level offence, where it is not in the public interest to prosecute, through a community resolution, youth caution or youth conditional caution
Personalised	A personalised approach is one in which services are tailored to meet the needs of individuals, giving people as much choice and control as possible over the support they receive. We use this term to include diversity factors
Risk of Serious Harm	Risk of Serious Harm (ROSH) is a term used in AssetPlus. All cases are classified as presenting either a low/ medium/ high/ very high risk of serious harm to others. HMI Probation uses this term when referring to the classification system, but uses the broader term risk of harm when referring to the analysis which should take place in order to determine the classification level. This helps to clarify the distinction between the probability of an event occurring and the impact/severity of the event. The term Risk of Serious Harm only incorporates 'serious' impact, whereas using 'risk of harm' enables the necessary attention to be given to those young offenders for whom lower impact/severity of harmful behaviour is probable
Referral order	A restorative court order which can be imposed when the child or young person appearing before the court pleads guilty, and whereby the threshold does not meet a youth rehabilitation order
Safeguarding	A wider term than Child Protection and involves promoting a child or young person's health and development and ensuring that their overall welfare needs are met
Safety and wellbeing	AssetPlus replaced the assessment of vulnerability with a holistic outlook of a child or young person's safety and wellbeing concerns. It is defined as: "those outcomes where the young person's safety

	and wellbeing may be compromised through their own behaviour, personal circumstances or because of the acts/omissions of others" (*AssetPlus Guidance*, 2016)
Youth caution	A caution accepted by a child or young person following admission to an offence where it is not considered to be in the public interest to prosecute the offender
YOT/YOS	Youth offending team: the term used in the *Crime and Disorder Act 1998* to describe a multi-agency team that aims to reduce youth offending. YOTs are known locally by many titles, such as youth justice service (YJS), youth offending service (YOS) and other generic titles that may illustrate their wider role in the local area in delivering services for children
YOT Management Board	The YOT Management Board holds the YOT to account to ensure it achieves the primary aim of preventing offending by children and young people
YJB	Youth Justice Board: government body responsible for monitoring and advising ministers on the effectiveness of the youth justice system. Providers of grants and guidance to the youth offending teams



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978-1-84099-853-5