An inspection of youth offending services in

Blackpool

HM Inspectorate of Probation

DECEMBER 2018

This inspection was led by HM Inspector Tracy Green, supported by a team of inspectors, as well as staff from our operations and research teams. The Head of Youth Offending Team 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:

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Published by:

Her Majesty's Inspectorate of Probation
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Foreword

We have given Blackpool YOT an overall rating of 'Inadequate'. The inspection found there were a number of areas where practice is poor. Before the inspection, the YOT had been moved to the Blackpool Young People's Service, an integrated early help service. This move had been difficult and was not managed well. Staff have now reverted to specialist roles, supervised by experienced YOT managers, which they have welcomed.

During this period, the head of service left the YOT, and there has been no permanent replacement. This has had a detrimental effect on staff morale, and on the delivery of services. There is a lack of pride among the staff in the work of the YOT. The Management Board was not sufficiently challenging during this time, and accepted an overly optimistic assurance of the impact of the changes. There was also no challenge to the YOT's poor performance.

A manager from a neighbouring YOT now provides interim support for Blackpool YOT three days a week. Blackpool YOT also has an improvement plan. However, the plan is not robust and does not address all the underlying issues in the YOT.

Overall, the YOT lacks an understanding of the needs and issues of the children and young people it supervises, and there has been a lack of management oversight and scrutiny. The processes for out-of-court disposals are particularly complex, and there is no mechanism for identifying those children and young people who would benefit from earlier intervention.

There are elements of emerging good practice, and some good partnership arrangements in place, in particular in relation to education and probation. The new Board Chair has a good understanding of YOT practice and has begun to restructure the Management Board.

The recommendations in this report have been designed to assist Blackpool YOT to build on its strengths and focus on areas for improvement.

Dame Glenys Stacey
Chief Inspector of Probation

Overall findings

Overall, Blackpool YOT is rated as: **Inadequate.** This rating has been determined by inspecting the youth offending team in three domains of its work. The findings are described below.

Organisational delivery

Our key findings about organisational delivery were as follows:

- Arrangements for good partnership working are in place.
- The YOT is co-located with other children's services in a convenient town centre location.
- The Management Board did not scrutinise and challenge the YOT's work well enough. This has now been identified and addressed.
- The Board is now chaired by the Director of Children's Services, who has a good knowledge of YOT work.
- There have been a number of organisational changes affecting the staff group, which have not been managed well.
- There is no analysis of the needs and profile of children and young people subject to YOT supervision.
- Staff morale is low.

Court disposals

Our key findings about court disposals were as follows:

- Multi-agency risk management meetings are used well.
- Caseloads are manageable.
- Assessments of children and young people's diversity-related needs are good.
- Assessments of risk to others and safety and wellbeing require improvement.
- Assessments are not completed in a timely manner, and managers do not oversee the work well enough or countersign assessments in all cases.
- External controls (such as the use of curfews, exclusion requirements, or links with neighbourhood police teams) are not used well and there is insufficient contingency planning.
- There are not enough resources available for work with children and young people.

Out-of-court disposals

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

- There is a joint decision-making process between the YOT and police.
- The out-of-court disposal processes are complex. There is a lack of clear policies and procedures governing how out-of-court disposals are determined, and the range of police-led disposals is confusing.
- Child Action North West (CANW) is only commissioned to deliver reparation following a triage disposal, and there is a lack of feedback about the interventions provided by this service.
- The YOT does not have sufficient evidence to show that children and young people and their parents/carers understand the implications of receiving an out-of-court disposal.

Service:	Blackpool Youth Offending Team
Fieldwork started:	October 2018

Overall rating	Inadequate

1. Organisational delivery

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

2. Court disposals

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

3. Out-of-court disposals

3.1	Assessment	Inadequate
3.2	Planning	Inadequate
3.3	Implementation and delivery	Inadequate
3.4	Joint working	Inadequate

Recommendations

As a result of our inspection findings we have made nine recommendations that we believe, if implemented, will have a positive impact on the quality of youth offending services in Blackpool. This will improve the lives of the children in contact with youth offending services, and better protect the public.

The Youth Offending Team Manager should:

1. commission training to develop the staff's skills and knowledge in key areas of practice
2. re-establish the staff's sense of pride in the work of the YOT
3. introduce a process to ensure the timeliness and quality of AssetPlus assessments
4. develop a range of suitable interventions for work with children and young people.

The Director of Children's Services should:

5. fully analyse the needs and profile of the children and young people subject to YOT supervision and use this to commission appropriate services
6. ensure Board members are able to challenge each other and the YOT manager and advocate for the YOT in their own organisations
7. together with the Office of the Police and Crime Commissioner, review the out-of-court disposals processes and commissioned services to ensure informed decision-making and good information-sharing for out-of-court cases.

The Youth Justice Board should:

8. provide further guidance and advice on completing the integrated planning and pathways document in AssetPlus
9. review the national policy for caretaking arrangements for children placed out of their own local authority area.

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 – instead, they were dealt with out of court. HMI Probation inspects both these aspects of youth offending services.

YOTs are statutory partnerships, and they 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.[1] Most YOTs are based within local authorities; however, 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 guidance). The Youth Justice Board for England and Wales (YJB) provides some funding to YOTs. It also monitors their performance and issues guidance to them about how things are to be done.

Blackpool is a small unitary authority containing three of the most deprived wards in the country. The average household income is one-third of the national income. Blackpool is seven miles long and three miles wide. It has 13 privately run children's homes, which is a disproportionately large number for an authority of its size. It is estimated that caretaking cases from neighbouring authorities make up 20 per cent of Blackpool's cases.

Blackpool has a large amount of affordable private rented accommodation, which means it also has a transient population of children and young people living with their families. These two factors combined make it difficult to gather information from other areas and ensure that these children have access to mainstream services, often only for short periods of time, before they move again.

Before the inspection, Blackpool YOT had merged with a number of other children's services in Blackpool, including leaving care, substance misuse and Connexions. Case managers had become generic workers for a period of time. The YOT recognised that this model was not working, and recently moved back into its specialist YOT teams, known as 'pods', to deliver youth justice services. The cases that were inspected were from the period of generic working. Blackpool has been identified by the YJB as an authority in need of additional support because of its poor performance in the three national indicators.

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

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

good and poor practice, and use our data and information to encourage good-quality services. We are independent of government, and speak independently.

HM Inspectorate of Probation standards

Organisations that are well led and well managed are more likely to achieve their aims. We inspect organisational delivery against four standards. These standards are based on established models and frameworks, which are grounded in evidence, learning and experience. They are designed to drive improvements in the quality of work with people who have offended.[2]

[2] HMI Probation (March 2018). *Standards for inspecting probation services.* https://www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/

Key facts

First time entrant rate[2] per 100,000	436	Blackpool YOT	301	Average for England and Wales
Reoffending[3]				
Rate	50.7%	Blackpool YOT	41.9%	Average for England and Wales
Frequency per offender	2.39	Blackpool YOT	1.63	Average for England and Wales
Offences per 1,000 10-17 year olds	27.7	Blackpool YOT	13.8	Average for England and Wales

Caseload information[4]

Age	**10-14**	**15-17**
Blackpool	22%	78%
National average	24%	76%

Race/ethnicity	**White**	**Black and minority ethnic**
Blackpool	93%	7%
National average	73%	24%

Gender	**Male**	**Female**
Blackpool	81%	19%
National average	83%	17%

Young people cautioned or sentenced

Cautioned	
Youth caution	59
Youth conditional caution	22
Sentenced	
Referral order	28
Youth rehabilitation order	56
Detention and training order	2
Section 90-91 detention	1

Population information[5]

Total population Blackpool (2017)	**139,870**	
Total youth population (2017)	12,079	(8.6%)
Total black and minority ethnic youth population (2011 census)	583	(4.4%)

2 *First-time entrants, October 2016 to September 2017,* Youth Justice Board (YJB).
3 *Proven reoffending statistics, July 2015 to June 2016,* Ministry of Justice, (April 2018).
4 *Youth Justice annual statistics: 2016 to 2017,* YJB, (January 2018).
5 *Population estimates for UK: Mid 2017,* Office for National Statistics.

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 Chair of the Board has recently changed from the Chief Executive to the Director of Children's Services. The new Chair identified that the Board had not sufficiently scrutinised or challenged the service, and has reconfigured members' responsibilities. Board members have now taken on the role of champions of key areas of practice.

Board members did not receive an induction when they took up their role and did not understand what was expected of them as members of the Management Board. There were too many Board members. The Board had been distracted from its primary role of overseeing and supporting the YOT by the other services provided by Blackpool Young People's Service (BYPS). Previous Board reports had contained comprehensive information about care leavers and substance misuse services, and considerably less about the YOT's performance. This has now been identified and redressed.

Board members recognise that they had not been sufficiently engaged in the work of the YOT and are keen to fulfil their responsibilities more fully. The Chair of the Board has a good understanding of YOT business and is committed to improving the lives of the children and young people who are subject to YOT supervision. A full day's workshop for Board members is planned for November to begin to address these deficiencies. The Board is well attended by all relevant partner agencies and some non-statutory members, such as courts and the lead member.

A new youth justice plan has been developed to address the specific issues that face Blackpool YOT. It has been set at one year in recognition of the amount of work that needs to be undertaken to address the previous shortfalls. This is aligned to an operational development plan; however, nearly two-thirds of staff were not aware of this strategic vision.

The operational development plan is comprehensive, but is not robust. No timescales are included, which means everything is 'on track' and there is no process for identifying when targets are not met. It also focuses primarily on achieving performance targets and does not address the cultural issues that are preventing the development of Blackpool YOT, such as low staff morale and poor communication. Nearly half of the staff reported that they do not understand the improvement plan well.

The YOT's management structures changed considerably when it moved to BYPS. As part of the move, the YOT's staff were managed by a range of people, not all of whom had a YOT background. The structure has very recently changed back to a YOT 'pod', a specialist team within BYPS with YOT operational managers. This is welcomed by staff. At the time of the inspection, there was no service manager, but there were plans to recruit to this post. There is an interim arrangement with a

neighbouring authority for a manager to attend three days a week as the YOT implements its improvement plan.

Staff felt there was a lack of information and communication from senior leaders.

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.	

Staff report that caseloads are currently manageable; however, there has been a significant turnover of staff due to sickness and staff leaving. This has not been well planned for, and had affected the services provided to children and young people. There were frequent changes of case manager and gaps in the services provided. The high turnover has meant that staff are less able to deliver relationship-based practice to support desistance. Two young people who responded to our survey said that frequent changes of case manager had a negative impact on their experience of YOT supervision. The YOT has relied too much on sessional workers to deliver work with young people.

At the time of the inspection, the victim worker post had not been covered for 18 months. While there had been efforts to recruit to this post, these had been unsuccessful. This had left a significant gap in services for victims and there was no information on victims available for assessments. This is reflected in the victim work in domains two and three.

Only 41 per cent of staff felt they had the skills and knowledge to deliver high-quality services to young people. Staff seemed unaware of some of the issues that can affect a child or young person's capacity to engage in interventions, such as adverse childhood experiences, attachment issues or vulnerability to county lines.

Staff reported a poor experience of supervision, with 43 per cent of staff rating their supervision as poor or very poor. This was because supervision was infrequent or did not meet the needs of the member of staff. Staff reported that they had no feedback on their performance, and there was little opportunity for reflective practice or sharing good practice. Only 6 per cent of staff found their last appraisal to be very valuable.

There was not enough management oversight of the cases involving court disposals and out-of-court disposals, and only the high-risk AssetPlus assessments were routinely countersigned by managers. This meant that most assessments were not sufficiently scrutinised or quality-assured.

Staff training was provided by Blackpool Council and BeSafe, and some workshops on data-recording on Childview had been delivered. Managers reported an occasion when Assessment, Intervention, Moving on (AIM) training had been provided but not all staff had attended as required. Staff have been given training on speech, language and communication needs and provided with information and support on young people's rights to education. Staff demonstrated a good understanding of safeguarding and understood how to make safeguarding referrals.

There was a small team of volunteers who undertook referral order panels. They reported that they had received good training and support and understood their role well.

Overall, morale among some staff was low. Practitioners did not feel enabled to effect changes. Staff struggled to identify anything about their work or their workplace that they were proud of. When pushed, one member of staff said 'surviving'.

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

The YOT has access to a range of partnership services. These include access to 'Family Hubs', where there is a range of services on offer, and early help support for siblings of young people known to the YOT. There is access to good education support for children and young people, and a full-time education worker who has good links with the special educational needs and disability (SEND) department and access to an educational psychologist.

There is a health practitioner who undertakes initial health screening for all new cases and can signpost to appropriate health services. There are good transition arrangements in place for 18-year-old young people, with the YOT probation officer preparing cases for transfer, and then holding the cases if they become NPS cases.

The CRC has also resourced a worker who attends the YOT offices on a weekly basis to link in with the care leavers who are supervised by the CRC. Relationships with children's services are good. Staff have access to the relevant social care database, and there is evidence of good communication. Cases are escalated appropriately if required.

There is good information-sharing about high-risk cases through the multi-agency risk management meetings, which are attended by all relevant partner agencies.

However, there is no up-to-date analysis of the needs of the children and young people subject to YOT supervision and therefore it is not known if these arrangements meet the needs of the YOT young people.

The arrangements for out-of-court disposals are poor. The YOT does not have comprehensive policies and procedures in relation to out-of-court disposals. Key partner organisations are confused about the processes for out-of-court disposals. The YOT has access to CANW for triage cases. However, CANW does not give feedback on the outcomes of interventions to the YOT, and without an analysis of the profile of first-time entrants, the commissioners of the service cannot know if CANW is providing the right interventions to the right young people at the right time.

There is a joint decision-making panel for cases involving youth conditional cautions.

Information about daily arrests and voluntary interviews is shared regularly. However, police intelligence is not routinely shared to assist with risk assessments of home visits. Where intelligence is shared, this is because individual case managers have requested it rather than because it is part of an established process. The YOT

shares information with the police about the children and young people it supervises through the police 101 phone service.

Access to Child and Adolescent Mental Health Services (CAMHS) can be particularly difficult for children and young people, with a third of cases having to wait three months for the start of treatment.

Feedback from the court was not positive. The court identified the process for out-of-court disposals as weak. It said children were charged to court unnecessarily, which led to delays in appropriate outcomes for children. The court also raised concerns about staff turnover and a lack of experienced YOT court staff, and said that this resulted in poor-quality information being provided. This applied particularly to verbal information provided to the court on progress on an intervention or previous engagement with the YOT. This led to the court making a large number of requests for pre-sentence reports, which are time-consuming for the YOT and sometimes unnecessary. The court commented that communication with the YOT had been poor, due to the high turnover of staff. The YOT has now recognised this, and established a small court team.

1.4 Information and facilities	Requires improvement
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.	

The YOT does not have sufficient up-to-date policies and procedures. Those that are in place are not well understood by the majority of staff. There is no clear information for police staff and YOT practitioners on the range of out-of-court disposals available, and no policy on how to use them. This causes confusion and creates a risk that young people will not receive the correct out-of-court disposal. Opportunities for targeted intervention at the most appropriate time could be missed.

Staff have access to suitable IT equipment, including laptops and mobile phones. All information on cases is available on the case management system. Staff also have access to social care systems.

The YOT changed location last year and is now located in the town centre, close to local transport services. The premises are accessible and largely suitable for young people. They are shared with other services for young people, creating a 'one-stop shop' for young people in Blackpool. Staff can also access a range of other suitable venues across the Blackpool area, including 'Family Hub' centres and drop-in centres for looked after children.

The meeting room where referral order panels are held is in the YOT office. Reaching it involves walking through a staff area where confidential information might be seen. This does not follow national guidance on holding panels in community venues. Panel members are keen to use different venues. The room is also not suitable for people with limited mobility.

The core opening hours for the YOT office are 11am to 3pm. Appointments can be made outside of these times, but the front door will not be open. Staff believe this creates a risk that young people could say they have attended but could not get in.

Staff reported that the meeting rooms are not confidential, and conversations can be overheard in neighbouring rooms. They feel that this prevents them from carrying out some work with young people, especially work to address harmful sexual behaviour. There is no mechanism for getting feedback from children and young people, parents, or victims.

The YOT does not have a comprehensive range of resources to meet the needs of the children and young people it supervises, and the resources it has are not sufficiently accessible.

It has been identified by the YOT senior management team that the YOT lacks performance and management information. A member of the council will now enable the YOT to obtain this information. Managers and practitioners have welcomed this. Information from serious case reviews is shared across the Blackpool workforce.

Summary

Strengths:

- The Management Board Chair has recently changed to the Director of Children's Services, who has restructured the board members' roles.
- The Board members recognise that they have not focused on the quality of services the YOT is delivering or the YOT's performance, and are keen to address this by assigning champions to key areas.
- There are some good partnership arrangements in place, particularly with education and probation services.
- The YOT is co-located with other children's services and in a central location in Blackpool.

Areas for improvement:

- The process for out-of-court disposals is unclear. Decision-making is inconsistent and not routinely shared between agencies.
- The YOT does not fully analyse the needs and profile of the children and young people it supervises. This analysis could be used to commission and engage partnership services.
- Staff do not feel proud of their work with children and young people, or of Blackpool YOT.
- There is a general Blackpool council training programme, but nothing specifically designed for the YOT staff. Such a programme should include a mixture of skills and knowledge, including understanding the impact of adverse childhood experiences on young people's ability to engage in interventions.
- There is a lack of appropriate interventions available for staff to use with young people.

- The YOT does not have a communications strategy for keeping staff informed of its improvement plan, the work of the Board and the work of senior managers, and for providing positive feedback to staff.
- There is an absence of management oversight of cases.

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

Overall, assessments required improvement. There were some areas where the assessments were good, but they were often completed too late or did not include important information. Case managers were good at identifying the diversity needs and reflecting these in assessments. Assessments also contained good-quality information on the child or young person's maturity, ability and motivation to change. There was also good analysis of offending behaviour.

Inspectors found pre-sentence reports to be of good quality.

Giving sufficient attention to the needs of the victim requires improvement in assessments. Some case officers had not done this because there was no victim worker available at the time. A number of assessments contained a mix of old and current information, and it was difficult to see which information was still relevant and correct. Many assessments were also completed too late, on some occasions by several weeks.

Assessments of the child or young person's safety and wellbeing required improvement. While some assessments did reference life experiences, such as experience of neglect, they did not then analyse the impact of these on the risks to safety and wellbeing. Only half of the assessments drew sufficiently on all available information.

The main gaps in the information related to mental health concerns. There was also a case where the self-assessment identified concerns about suicide, which were not adequately addressed in the assessment. Inspectors agreed with the safety and wellbeing classification in nearly 80 per cent of cases. Where they disagreed, it was because the assessment was too low. There were also examples where contradictory levels of safety and wellbeing were present in the same assessment.

There were some examples of good practice. An inspector noted:

> *"Good assessment of safety and wellbeing. This recognised her experience of the court case and the potential impact, especially around peer response. There was a good recognition of the mother's mental health and how that affected the young person, and an understanding of her peer relationship and past experience of a traumatic life experience. In addition, the young person's past experience of being bullied was recognised".*

Self-assessments completed by the child or family were not integrated into the main assessment. This meant that the voice of the child was lost.

Risk of harm to others was assessed accurately in nearly 80 per cent of cases. Where inspectors disagreed with the assessment, it was because the classification was too low. This was mainly because risks within the family had not been accurately assessed, especially when the parent or carer was the direct, or indirect, victim.

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

Staff used the AssetPlus planning module and referral order contract for planning. Multi-agency risk management meetings were held for higher-risk cases. Planning was stronger in cases where there was a multi-agency response and clearer plans were in place. However, planning was inadequate overall, with just over 50 per cent of plans sufficiently focused on supporting the child or young person's desistance. The main reasons for this were that the plans lacked evidence that the child or young person had been meaningfully engaged, and did not identify their strengths. Planning was stronger in terms of recognising maturity and motivation to change.

Inspectors found that planning was proportionate to the court outcome in nearly two-thirds of cases. Where it was not proportionate, this was often because too many interventions had been planned and it was not always feasible to provide these within the timescales available. Inspectors also found planning in intensive supervision and support cases to be weaker, with the plans lacking focus and desired outcomes.

Planning did not focus on keeping the child or young person safe in the large majority of cases. There was a lack of contingency planning and insufficient use of external controls. Staff also missed opportunities to coordinate with other services that were involved with the young person in planning relating to safety and wellbeing. An inspector noted:

> *"There are a number of gaps in the planning process and there is a lack of contingency as to how to respond to a change in circumstances. This happened on a number of occasions where the young person's circumstances would change significantly. The response to this was reactive rather than part of a proactive planning process".*

Planning to keep other people safe was also weak. There were insufficient contingency arrangements or external controls to protect other people. Where there were examples of good planning, this involved the multi-agency risk management processes. One case was referred to MAPPA as a result of the multi-agency risk management meeting.

One significant gap in planning to keep other people safe related to the safety of the actual or potential victim. Over two-thirds of plans did not address this. At the time of the inspection, the YOT did not have a victim worker. However, it is possible and appropriate for case managers to plan for the safety of victims without the specific input of the victim, although it is clearly preferable to consider the victim's voice.

Planning did not make good use of external controls for either the safety and wellbeing of the child or young person, or to keep other people safe.

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

Implementation and delivery of services were severely hampered by the high levels of sickness and staff turnover. This meant that a number of the cases had several case managers, with little handover between them. Cases were seen on a duty basis, and one case was not seen for over three months. This had a negative impact on the overall delivery of services, with services to support desistance being delivered in less than a third of cases. This was also identified as an issue in the young person's survey.

Staff made good use of the 'football project' as a means of seeing young people, but this was sometimes at the cost of targeted work on offending behaviour. Little reparation work was delivered.

Where delivery of services was better, there had been a consistent case manager for the duration of the order. This was also noted by a young person in their response to the survey. An inspector noted:

> *"The young person and case manager's working relationship was a particular strength in this case, in which it could be seen that he initially did not make eye contact or say much. Within a few weeks, it was obvious he was engaging with several professionals and trusted the YOT worker".*

Enforcement action was not taken in over 40 per cent of cases where the case manager identified that it was needed. When breach action was taken, there was little evidence that the case manager had attempted to try alternative approaches, or that a compliance panel had considered the case, to try and re-engage the young person first. In one case, a custodial sentence had been recommended for the breach.

Implementation of services to keep the child or young person safe was also poor. Services were delivered well in less than a third of cases. There was a lack of coordination with mental health services. Case managers did not offer enough support to help young people who had lived, or still lived, in difficult home circumstances.

Delivery of services to support the safety of other people was also poor. Case managers did not do enough work to protect actual or potential victims, and services were not well coordinated overall. This was most evident where the victim or potential victim was a family member and the young person was still living in the family home.

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

Young people's circumstances can change rapidly, resulting in an increased or decreased likelihood of reoffending, risk of harm to others or risks to their safety and wellbeing. Case managers should review their plans when there is a change in the young person's circumstances that could affect their behaviour. Young people subject to referral orders had to attend a review panel every three months, often resulting in a higher frequency of reviews in those cases.

In a number of cases, the initial assessment was so late that it effectively acted as a review. Overall, in nearly two-thirds of cases, reviews did not identify and respond to changes in factors linked to offending. Reviews were not completed where there was a significant change in circumstances, such as a period of homelessness or further offending. In over half of the cases, other agencies did not contribute enough to reviews to keep the young person safe.

In a third of cases, reviews did not identify and respond to changes related to risk of harm. In half of the cases, reviews were not informed by information from other agencies. An inspector noted:

> *"As the reviews did not take place in a timely manner, they were not responding to changes to the risk that F may pose to others. Furthermore, it is detailed on Childview records that he was arrested regarding an attempted murder in February 2018 and this information was not detailed in any reviews".*

Reviews did not always lead to an updated intervention plan, and in some cases a review was completed but no information was updated and none of the plans were changed.

Summary

Strengths:

- Pre-sentence reports are of a good quality.
- Case managers are good at understanding the diversity needs of children and young people and reflecting these in assessments.
- Case managers make good use of multi-agency risk meetings where appropriate.
- Where there has been a consistent case manager, there is a positive working relationship with the young person.
- Caseloads are manageable.

Areas for improvement:

- Assessments are not completed and countersigned in a timely manner.
- Case managers do not understand and plan for the safety of the victim or consult the victim.
- Case managers do not demonstrate an understanding of the child or young person's lived experience and the impact this has had on their offending and ability to engage in interventions.
- External controls and contingency planning are not used well in the pathways and planning documentation.
- Breach action is taken without fully considering a change in approach or the use of compliance panels.
- The YOT does not have a comprehensive range of resources and interventions to meet the offending needs of the children and young people of Blackpool.

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 case we inspect against four standards.

In Blackpool, there is a complex range of out-of-court disposals for children and young people who are not first-time entrants to the justice system. These are delivered by the police. They are: RJ-Instant, RJ-Formal, Police Resolution and Triage. The evidential standard for these is that of reasonable suspicion. This contrasts with the more formal youth caution and youth conditional caution, where there has to be a realistic prospect of conviction. There was no requirement to consult with the YOT about these disposals, and no expectation that details of the disposals would be shared with the YOT. There was also no clear policy as to when each disposal should be used and how many times a young person could receive each one.

The police guidance was that triage should be used for all young people who enter police custody or attend a voluntary interview. However, it was not clear how many triage disposals a young person could receive. Anecdotally, more children and young people are being arrested in Blackpool than in similar areas.

Children and young people who received a triage disposal were referred by the police to CANW. This is a pan-Lancashire service that offers intervention for triage cases. This intervention is primarily a three-hour reparation placement. The YOT has a service level agreement in place with CANW, but this does not include a requirement for CANW to provide feedback on the individual cases it is working with.

Cases that were deemed suitable for a youth caution or youth conditional caution were referred to the weekly joint panel meeting, attended by the police and YOT. At the time the cases we inspected had gone to this panel, it was attended by a rota of BYPS managers. This has since been changed, and a YOT manager now attends on a regular basis. The cases in the inspection pre-date this change. The panel can make the full range of decisions with regard to disposal, including no further action or charge. Youth cautions and youth conditional cautions are administered by the seconded YOT police officer.

The number of out-of-court disposals was low, which meant that the cases we inspected went back as far as January 2018, and up to August 2018. This is a longer time span than would normally be the case.

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

We inspected a range of cases, including triage, youth caution and youth conditional caution. At the time of the inspection, BYPS had a mixed caseload.

No formal assessments were completed on the triage cases, and AssetPlus assessments were completed on the other cases. Some assessments were completed by non-YOT staff, who reported that they had little or no training in completing a formal assessment. This was reflected in our findings: in a number of assessments, significant information was missing, such as the offence analysis, or the assessment had been opened but not completed. There was also insufficient management oversight of the out-of-court disposals, with no assessments being countersigned and a lack of quality assurance.

Overall, there was a sufficient assessment of the child or young person's desistance in just over a third of cases. The main reason for insufficient assessments were that the assessments were late or incomplete. Case managers were better at identifying the diversity needs of the children and young people and reflecting these in assessments. However, there was a lack of evidence that the child or young person, and their parents/carers, had been involved in the assessment. When a self-assessment had been completed by the family, their views were not integrated into the assessment.

The safety and wellbeing of the child or young person were not fully analysed in nearly 80 per cent of cases. In one case, significant safety and wellbeing concerns had been documented on Mosaic, but these were not identified in the assessment. In another, there were obvious safety concerns, such as going missing and using drugs, but these were not identified in the assessment.

Assessments to keep other people safe were of sufficient quality in just over 20 per cent of the cases. This was because information about risk had not been included in the assessment, for example information about a young person having a knife, challenging behaviour at school, or the potential impact of driving offences.

As in assessment for post-court cases, the needs of the victims were not given sufficient attention.

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

The majority of planning was insufficient, and there were a number of different reasons for this. In some cases, planning and delivery were carried out by CANW, and there was no process for CANW to provide the YOT with information about this work. Therefore, when a case was referred to CANW, the YOT did not see the planning that was undertaken.

In other cases, where the YOT was responsible for planning, we found there were an excessive number of interventions in some plans, or plans were not sequenced or structured. For example, in one plan, 12 sessions on offence interventions were to be given for a three-month youth conditional caution. This is considered disproportionate for this type of disposal.

Planning did not promote the safety and wellbeing of the child or young person. The main reasons for this were a lack of engagement with other agencies and a lack of contingency planning. An inspector noted:

> *"There is no plan in this case. The young person has an allocated social worker; however, there are no contact records at all in this case, and no evidence of discussion having taken place with them (the young person) to inform and plan activity. The young person has been adopted and is now in a private fostering placement after his adoptive mother was unable to cope with his behaviour. He is associating with negative peers. There are concerns about substance use; however, there is no evidence of planning in relation to any of these relevant factors".*

Planning was better with regard to promoting the safety of other people, but this still required improvement. There was a lack of engagement with other agencies and a lack of contingency planning. However, planning to keep other people safe was good in youth conditional caution cases.

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

The delivery and implementation of services were inadequate. We saw evidence that some interventions were allowed to drift because of staff sickness and leave. Cases were not re-allocated, which resulted in young people either not being seen for periods of weeks or being seen by duty case managers, with few constructive interventions being delivered.

There is no feedback on the cases where CANW provided the intervention.

The required interventions were completed in only a third of cases. Some cases were closed without the work being completed, and in others the case manager did not actively engage with the young person to deliver the interventions.

There was no evidence of any work being delivered to promote the safety and wellbeing of the child or young person.

Services to support the safety of other people were better. Some interventions were delivered in relation to knife crime and drug awareness, but no work was carried out to protect actual or potential victims.

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

The decision-making process for out-of-court disposals was complex. As previously mentioned, the police have a total of four disposals that they can administer without consulting the YOT. A possible, and likely, consequence of this is that police disposals are being administered without the YOT knowing about them. Information on out-of-court disposals is useful to the YOT, both for open cases and as background information on other cases when they formally come to the YOT.

When a youth caution or youth conditional caution is being considered, the case is referred to the decision-making panel. This panel has the right level of authority and can make a full range of decisions. The court had also noted a high number of cases coming through to it where an out-of-court disposal was more appropriate. These were referred to the panel from court.

There was evidence that the YOT's recommendations to the panel were well informed and appropriate to the child or young person. However, this still required improvement. There was a lack of evidence of the YOT working with the police to implement the out-of-court disposal. This was particularly the case with youth conditional cautions. The rationale for decisions and the outcome of the decision were poorly recorded on the case management system.

There was little evidence that the child or young person understood the implications of receiving an out-of-court disposal. In some cases, it was not clear on the case management system, or to the case manager, what the disposal actually was.

Summary

Strengths:

- There is a decision-making panel with the appropriate authority to make decisions on out-of-court disposals.
- The panel has access to the relevant databases to provide information for decision-making.

Areas for improvement:

- A complex range of out-of-court disposals are available, and there are no clear policies or procedures on how to use them.
- CANW's work focuses only on reparation and is not targeted at factors related to reducing offending by the child or young person.
- CANW does not provide feedback on the outcomes of the cases it deals with.
- Case records do not clearly set out the panel's decision, when the disposal was delivered, or what the disposal was.
- Not enough attention is given to ensuring that the child or young person, and their parents/carers, understand the implications of receiving an out-of-court disposal.

Annex 1 – Methodology

The inspection methodology is summarised below, linked to the three domains within our standards framework. Our focus was upon 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 Director of Children's Services delivered a presentation covering the following areas:

- How do organisational delivery arrangements in this area make sure that the work of your YOT 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 25 individual case managers, asking them about their experiences of training, development, management supervision and leadership. Various meetings and focus groups were then held, allowing us to triangulate evidence and information. In total, we conducted 12 meetings.

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.

We examined 24 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. 40 per cent of cases selected were those of children and young people who had received out-of-court disposals two to seven months earlier. The time span of cases inspected was longer than usual due to the smaller numbers of out-of-court disposals. 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.

We examined 13 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

Standards and key questions	Rating
1.1. Governance and leadership 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.	**Inadequate**
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 YOT support effective service delivery?	
1.2. Staff Staff within the YOT are empowered to deliver a high-quality, personalised and responsive service for all children and young people.	**Inadequate**
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 YOT 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 A comprehensive range of high-quality services is in place, enabling personalised and responsive provision for all children and young people.	**Requires improvement**

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 YOT can deliver well-targeted services?	
1.3.2. Does the YOT 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 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.	**Requires improvement**
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 YOT'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 Assessment is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.	**Requires improvement**
2.1.1. Does assessment sufficiently analyse how to support the child or young person's desistance?	58%
2.1.2. Does assessment sufficiently analyse how to keep the child or young person safe?	58%

2.1.3.	Does assessment sufficiently analyse how to keep other people safe?	58%
2.2.	**Planning** Planning is well-informed, holistic and personalised, actively involving the child or young person and their parents/carers.	**Inadequate**
2.2.1.	Does planning focus sufficiently on supporting the child or young person's desistance?	54%
2.2.2.	Does planning focus sufficiently on keeping the child or young person safe?	30%
2.2.3.	Does planning focus sufficiently on keeping other people safe?	39%
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?	33%
2.3.2.	Does the implementation and delivery of services effectively support the safety of the child or young person?	30%
2.3.3.	Does the implementation and delivery of services effectively support the safety of other people?	22%
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?	38%
2.4.2.	Does reviewing focus sufficiently on keeping the child or young person safe?	40%
2.4.3.	Does reviewing focus sufficiently on keeping other people safe?	38%

3. Out-of-court disposals

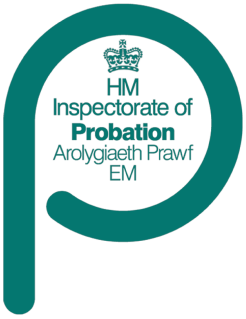
Standards and key questions	Rating and % yes
3.1. Assessment Assessment is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.	**Inadequate**
3.1.1. Does assessment sufficiently analyse how to support the child or young person's desistance?	36%
3.1.2. Does assessment sufficiently analyse how to keep the child or young person safe?	21%
3.1.3. Does assessment sufficiently analyse how to keep other people safe?	21%
3.2. Planning Planning is well-informed, holistic and personalised, actively involving the child or young person and their parents/carers.	**Inadequate**
3.2.1. Does planning focus sufficiently on supporting the child or young person's desistance?	29%
3.2.2. Does planning focus sufficiently on keeping the child or young person safe?	0%
3.2.3. Does planning focus sufficiently on keeping other people safe?	29%
3.3. Implementation and delivery High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child or young person.	**Inadequate**
3.3.1. Does the implementation and delivery of services effectively support the child or young person's desistance?	7%
3.3.2. Does the implementation and delivery of services effectively support the safety of the child or young person?	0%
3.3.3. Does the implementation and delivery of services effectively support the safety of other people?	29%

3.4. Joint working	Inadequate
Joint working with the police supports the delivery of high-quality, personalised and coordinated services.	
3.4.1. Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child or young person, supporting joint decision-making?	50%
3.4.2. Does the YOT work effectively with the police in implementing the out-of-court disposal?	21%

Annex 3 – Glossary

AssetPlus	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.
AIM	Assessment, Intervention, Moving On: specialist training and intervention for children and young people displaying harmful sexual behaviour.
County lines	A term used to describe a form of criminal exploitation of children and young people. Used to describe the way in which gangs and organised crime networks force children and young people into selling and transporting drugs, across counties, often using dedicated mobile phone lines.
Court disposals	The sentence imposed by the court. Examples of youth court disposals are referral orders, youth rehabilitation orders and detention and training orders.
Curfew	Restrictive intervention requiring a service user to remain at an agreed address during a pre-determined period. The curfew may be monitored electronically (electronic tag) or by the police (doorstep curfew).
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.
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. Level 1 is single agency management where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. Levels 2 and 3 require active multi-agency management.
Mosaic	The Children's social care case recording data base used by Blackpool council.
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 harmful behaviour is probable.
Safeguarding	A wider term than child protection that 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).
YOT	Youth Offending Team is 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.
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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ISBN: 978-1-84099-838-2