



Her Majesty's
Inspectorate of
Probation

An inspection of youth offending services in

Bradford

HM Inspectorate of Probation

JANUARY 2020



Her Majesty's
Inspectorate of
Probation



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. HMI Probation was joined by colleague inspectors from police, health, social care and education services. 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.

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Foreword

This inspection is part of our programme of youth offending team (YOT) inspections, and is one of six inspections conducted jointly with Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, and the Care Quality Commission. We have inspected and rated Bradford YOT across three broad areas: the arrangements for organisational delivery, and the quality of court disposals work and out-of-court disposals work. We have rated Bradford YOT as 'Requires improvement'.

We had a number of serious concerns about this YOT, with performance on eight of our twelve quality standards judged to be 'inadequate' and the service only rescued from an overall 'Inadequate' rating by some better-quality work with out-of-court disposal cases.

Bradford YOT has experienced several changes of leadership, including senior managers and a change to the Chair of the Management Board. This has resulted in a lack of both strategic vision and effective operational oversight. Board members did not provide scrutiny to the performance of the YOT.

Staff were working hard in the absence of leadership and structures to deliver effective services. The YOT was not able to adapt and improve its services to meet the needs of the children and young people in Bradford because it lacked the data to inform this.

There were some systemic failings across the partnership in meeting the safety and wellbeing needs of the children and young people, and in adequately protecting others from harm. There were also two distinct and contradictory processes in place, in relation to delivering out-of-court disposals.

Staff lacked the training, oversight and processes to enable them to complete high-quality assessments using Assetplus, although assessments for out-of-court disposals, using their in-house tool, were better. This indicates that, with the right training and support, the staff do have the ability to transfer this to all assessments.

There was good restorative justice practice in place, with a high uptake from victims, but victim safety work was not as strong, and there was a lack of suitable reparation placements, including a near absence of placements at weekends, and those suitable for girls.

There was a new senior management team in place, and they knew the challenges faced by the YOT, and were well placed and committed to address the issues identified. The staff expressed optimism about the new leadership and its ability to make necessary improvements.



Justin Russell

Chief Inspector of Probation

Overall findings

Overall, Bradford Youth Offending Team (YOT) is rated as: **Requires improvement**. This rating has been determined by inspecting the youth offending services in three domains of their work. The findings in those domains are described below.



Organisational delivery

We undertook this inspection over a two-week period. The first week consisted of detailed assessments of 70 cases and interviews with the case managers. During the second week, we were joined by inspectors from Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services, the Care Quality Commission and specialists in social care and education training and employment. We interviewed the YOT service manager and the Chair of the Management Board, and held focus groups with other members of the Board and other key stakeholders. Based on this evidence.

Our key findings about organisational delivery are as follows:

- The allocation principle of case managers retaining the supervision of children or young people's cases is helpful in ensuring that the children maintain meaningful relationships with staff
- Staff work hard to deliver effective services, despite the disruptions to its leadership and structures
- The youth education and health meeting is a good way to screen the needs of children and young people newly being supervised by the YOT
- The co-location of YOT and children's social care staff is starting to improve communication and relationships.

But:

- There has been major instability in the YOT Management Board and the senior leadership team. This has left staff lacking effective leadership and oversight
- The Chair of the Management Board has only recently been appointed and is in an interim position
- Board members do not know their role, and need to be provided with a suitable induction programme and information to enable them to fulfil their responsibilities. They need to be empowered to provide scrutiny
- There is a lack of information available to the YOT and the Board, and the information they do have is not used to drive service delivery or review practices
- Staff are not receiving annual appraisals.

- The West Yorkshire Police disposal policy for young people is in conflict with the Bradford YOT policy. The YOT is not always informed when children and young people receive a disposal from the police.
- Management oversight and countersigning is not consistent.
- There are some systemic failures across the partnership to safeguard children and protect the public from harm.



Court disposals

We reviewed 42 cases managed by the YOT which had received a court disposal six to nine months before we visited. Based on an analysis of these case files and interviews with the relevant case managers

Our key findings are:

- There is a good restorative justice service for victims who wish to participate.
- The Rights, Respect and Responsibilities (RRR) programme is delivered in a manner that meets the needs of the children and young people.
- Staff are responsive to the diversity needs of the children and young people.
- The Back on Track meetings are an effective way of re-engaging children and young people who may potentially breach their orders.
- Speech, language and communication needs assessments are used to shape the delivery of interventions by case managers.

But:

- There are delays in the completion of Assetplus assessments.
- Managers are countersigning assessments that do not meet a sufficient standard.
- The membership of the risk and vulnerability meeting is not comprehensive and the process for referring cases to this meeting is flawed.
- Plans do not adequately address risk to others, or safety and wellbeing concerns.
- There are insufficient suitable reparation placements available at times to suit the young people.
- New information in relation to risk of harm, and safety and wellbeing is not responded to in a way that reduces the risk to the young people and others.



Out-of-court disposals

We reviewed 28 cases managed by the YOT that had received an out-of-court disposal at least three to five months before we visited. Based on an analysis of these case files, interviews with the relevant case managers and, where necessary, others closely involved in the case, our key findings about out-of-court disposals are as follows:

- There is good use of the young person's perspective in the assessment.
- Where appropriate, the victim's perspective is incorporated into the decision-making process and planning for the out-of-court disposal.
- Assessments are completed in a timely manner.
- There is good use of doorstep curfews as a condition of youth conditional cautions.
- The panel process has improved joint decision-making processes, and the membership of the panel is correct.

But:

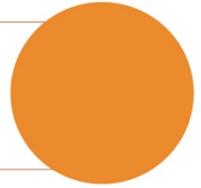
- There is a lack of integration between the planning processes and documentation.
- Copies of signed out-of-court disposals are not available on the YOT case management system.
- There is a conflict between the West Yorkshire Police disposal policy and the Bradford YOT panel process. This has resulted in suitable cases not being referred into the panel.
- There is a lack of evidence that the implications of out-of-court disposals are being fully explained to the child or young person, and their family.

Service: Bradford Youth Offending Team

Fieldwork started: September 2019

Overall rating

Requires improvement



1. Organisational delivery

1.1	Governance and leadership	Inadequate	
1.2	Staff	Requires improvement	
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	Inadequate	
3.3	Implementation and delivery	Good	
3.4	Joint working	Good	

Recommendations

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

The YOT manager should:

1. ensure that all staff are trained to complete comprehensive assessments that identify and plan for the safety and wellbeing, and risk of harm to others, of children and young people supervised by the YOT
2. make use of the information and data available across the partnership and in the YOT, to understand and respond to the needs of the children and young people being supervised
3. review the membership and referral process for the risk and vulnerability meeting, to ensure that it fulfils its role in assisting in the management of risk across the partnership
4. ensure that team managers have a shared understanding of the required quality and timeliness of assessments.

The Director of Children's Services should:

5. ensure that the Management Board is chaired at the appropriate level, and that Board members are fully equipped to fulfil their role.

West Yorkshire Police should:

6. review their youth out-of-court disposal policy, to align it with the out-of-court panel process of the YOT
7. review the role of the seconded police officer, to ensure that they are being used in an effective way to manage risk of harm and align the role to the Youth Justice Board's model.

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, being dealt with out of court. Her Majesty’s Inspectorate of Probation inspects both these aspects of youth offending services.

YOTs are statutory partnerships, and they are multidisciplinary, to deal with the needs of the whole child. They are required to include 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, 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 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.

Bradford is a diverse, multicultural city in the north of England. The latest population figures, produced by the Office for National Statistics on 26 June 2019, show that an estimated 537,173 people live in Bradford District. Bradford District is the fifth largest metropolitan district (in terms of population) in England, after Birmingham, Leeds, Sheffield and Manchester, although the District’s population growth is lower than that of other major cities.

Bradford is the fifth most income-deprived local authority in England. There are wide variations across the district, with 27 per cent of the District’s population living in areas classed in the 10 per cent most deprived areas in England, and 6 per cent of the population living in areas classed in the 10 per cent least deprived areas in England.

According to 2011 census data, 56 per cent of the 10–17-year-old population is white, 37 per cent is Asian/Asian British and 8 per cent is from other backgrounds. As in other areas, however, the Asian youth population in Bradford is under-represented in the local youth justice population. This has had the effect of making the other large ethnic group (white) over-represented in the local youth justice system.²

Bradford YOT performance in the three key performance indicators – reducing reoffending, reducing the number of first-time entrants and reducing the use of custody – has been poor. The most recent performance indicators place them in the bottom third of the country for first-time entrants and custody, and the bottom half for reoffending.

The role of Her Majesty’s 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

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

² Information provided by Bradford YOT.

vulnerable. We inspect these services and publish inspection reports. We highlight good and poor practice, and use our data and information to encourage high-quality services. We are independent of government, and speak independently.

Her Majesty's 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 Her Majesty's Inspectorate of Probation's standards are available here:
<https://www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/>

Contextual facts

First-time entrant
(rate per 100,000)

330

Bradford
YOS ⁴

244

Yorkshire

236

England and
Wales

Reoffending rates

42.1%

Bradford
YOS ⁵

39.2%

England and
Wales

**Offences per
offender**

2.36

Bradford
YOS ⁴

1.57

England and
Wales

**Offences per
1,000**

22.5

Bradford
YOS

15.9

Yorkshire

13.1

England and
Wales

Young people cautioned or sentenced by ethnicity ⁶

Ethnicity	Bradford	Yorkshire	England and Wales
White	331 68%	2,240 81%	18,826 71%
BME	151 31%	470 17%	6,828 26%
Not known	2 0%	40 1%	1,027 4%
Total	484	2,750	26,681



⁴ Youth Justice Board. (2019). *First-time entrants, January to December 2018*.

⁵ Ministry of Justice. (2019). *Proven reoffending statistics, July 2016 to June 2017*.

⁶ Youth Justice Board. (2019). *Youth justice annual statistics: 2017-2018*.



1. Organisational delivery

Organisations that are well led and well managed are more likely to achieve their aims. We inspect against four standards: Governance and leadership; Staff; Partnerships and services; and Information and facilities.

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.	

Overall, we have rated Bradford as 'Inadequate' for governance and leadership. This is because there has been an absence of strategic leadership for some time, and this has had an impact on service delivery.

The Board has provided little strategic direction, and has had a number of Chairs in recent years. The Board is provided with reports, and the agenda is set by the YOT. These reports focus predominantly on the main key performance indicators, and there has been little challenge on poor performance, and a passive acceptance of information that has been provided to the Board. There is no tradition of scrutiny or challenge by Board members – for example, the Board was not aware of the proportion of YOT children and young people of statutory school age who received their entitlement to full-time education.

Much of the data and information that would enable the Board both to challenge and advocate for the YOT is available across the partnership, but this is not collated or utilised to improve services or outcomes for the children and young people supervised by Bradford YOT.

Most important community partners are represented at the Board, but for some partners their attendance has been poor, while for others the organisation has been represented, but not at the right level of seniority. This has meant that Board members are not able to make decisions that would have an impact on service delivery. Very few of the Board members are in their posts on a permanent basis, and therefore there is an ongoing lack of stability in the membership of the Board.

Health is a standing agenda item for the meetings, but scrutiny and challenge have been limited as minimal information about health has been requested by the Board over the past 12 months. Where it has been requested, this has mainly focused on physical health and the role of the two nurses in the YOT.

There are gaps in membership from the Clinical Commissioning Group, voluntary sector, community safety lead member, and Police and Crime Commissioner's office, all of which could provide routes to resources and additional services for the YOT. Attendance by the police representative has been poor.

Board members are not provided with an induction or given a clear understanding of their role on the Board and the expectations associated with it. There was evidence of people taking on the Board role 'to help out', with no clear expectation or knowledge of the role, and little capacity to deliver on any follow-up actions.

There is a youth justice plan, which was completed earlier in 2019, and Board members were aware of the content of the plan. It was completed by the previous service manager, with little recourse to Board members, the YOT management team or YOT practitioners. The plan identifies most key elements of delivery that need to be addressed, but none of the 19 priorities within it identify the need to address the unacceptably high proportion of young people who are not in education, employment or training (NEET). The strategy identified in the plan is not fully known, or shared by key partners and staff.

There is a new Chair of the Board, who holds an appropriately senior position. In her first and only Board to date, she was appropriately challenging with the YOT service manager and partners, raising the expectations that the partnership will take shared responsibility for meeting the needs of the children of Bradford. This is still an interim appointment; however, and therefore she could move or be replaced as Chair of the Board.

The YOT is represented at the relevant strategic meetings, including the Community Safety Board, Safeguarding Board, and silver⁴ serious and organised crime meetings. This representation is at the right level, and links the YOT into key partnerships.

The YOT seconds a worker to the West Yorkshire liaison and diversion scheme. This places a worker in custody and provides a link between the scheme and the YOT. This worker delivers the assessment, intervention and referrals for children who receive a community resolution from the police.

The partnership has provided the YOT with appropriate staffing, including two seconded police officers, one and a half full time equivalent probation officers, two safeguarding nurses, a speech and language therapy (SALT) practitioner, and links to child and adolescent mental health services (CAMHS) and substance misuse services. The supervisory arrangements for the seconded police officers were poor, however, with no joint management oversight of the role. There was no overarching health strategy specifically for the YOT, and no manager at the YOT who had overall responsibility for health. There had been no joint meetings across the YOT health providers; a number of health staff were on long-term sick leave; and some managers were in interim posts.

There has not been an education worker in post for over a year, following the retirement of the previous post holder, and this has been recognised as a gap. A new provision, which has just been developed, will provide a new and sharper focus on education within the YOT, but this was not fully in place at the time of the inspection. This will identify a link education lead for each geographical YOT team. The new provision is not yet widely known about among the YOT staff. The need to communicate this is urgent.

There are examples of how Board members have responded to issues identified at the Board within their own organisation. This includes the education member on the Board developing the process outlined above.

There has been an absence of effective leadership due to instability in the YOT over the past two years. There have been three Board Chairs over this period, some of whom have been more active than others. There have been four heads of service for the YOT in the past eight months, and the service manager retired in the month preceding the inspection. During the summer of 2019, two team managers also left

⁴ Silver meetings are police-led meetings at a senior management level.

in a six-week period. Not surprisingly, this has had a destabilising impact on the staff at the YOT.

There has been no effective link between the YOT leadership team, operational managers and the Management Board. Board reports are prepared by the YOT service manager, and the YOT has been setting the agenda. YOT team managers rarely attend the Board, and the Board does not drive the agenda for the meetings. At the time of the inspection, Board members did not know the date of the next Board meeting.

There has been a lack of vision and strategy for the YOT. YOT team managers had a limited understanding of the activities of the Board, and in the staff survey 88 per cent of staff said that they were unaware of the activities of the Board. There has also been a lack of collective understanding of the strategy, with 41 per cent of staff stating that they did not know the vision or strategy of the YOT well.

The now full-time speech and language provision is a good example of managers identifying unmet need and responding accordingly. In a number of the cases reviewed, speech and language assessments provided school staff with helpful strategies to integrate better a child into the class and help them learn.

In the main, schools work well with the YOT. The majority are responsive to admitting and retaining YOT young people. In one instance, however, while working with a child who was excluded, the school was carrying out weekly checks but had not invested in home tutoring, and the child had been out of the education system for too long.

Special educational needs, and behavioural, social, emotional and general educational needs (pre-offending) were not identified at an early enough stage by schools to enable action to be taken. In other instances, cases were not escalated quickly enough. The increasing trend for children from overseas to move to the area renders this particularly challenging.

There has been a lack of clear communication, with key messages being delivered at different times. Fifty per cent of staff reported not being listened to, and 68 per cent said that they had not been asked for their views. Historically, there had been staff forums for the development and discussion of ideas; these had ceased until recently, when a new focus group was developed to create a new young-person-friendly plan.

Strategic leaders and senior officers have recognised the previous gaps in leadership and provision, and have a good understanding of the difficulties this has presented, and the challenges ahead. They are motivated to address these.

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

Overall, we gave a rating of 'Requires improvement' for staff. This is because, despite the staff group being stable and motivated, they had not received appraisals; management supervision was not effective; and there was a lack of effective training.

YOT caseloads are manageable, with 71 per cent of staff reporting that they had a caseload they were comfortable with; however, health staff were, at times, carrying high caseloads. There is little strategic planning for periods of leave or sickness. Staff levels and caseloads are known by individual team managers, but there is no formalised allocation policy.

Some of the health staff reported that their caseloads are high, and many said that these are limiting the amount of work that they can do with each child, as well as being able to carry out additional screening. Case managers, health staff and several Board members all said that there is insufficient health provision, but there was a lack of analysis of data to establish if this is the case. One member of the health team had a caseload of 66 children, with 9 of these being identified as complex. Health staff we met were highly motivated but there was limited data to show if this had resulted in improving outcomes for children.

The YOT practitioner staff force is stable, with 73 per cent of staff having worked at the YOT for more than five years.

Staff are very motivated and committed to delivering services to children. In the case inspection, there were examples of staff going to substantial extra effort to meet the needs of the children they were supervising. Staff are working hard to meet the needs of the children and young people they supervise, despite the lack of strategic management, and structures and processes that support their work.

Case managers have not had an annual appraisal for a number of years. The lack of a meaningful appraisal process limits the opportunities for feedback and development for staff.

Staff are not skilled in completing Assetplus assessments. This is evidenced in the ratings for domain two cases. Only 35 per cent of staff reported that they felt fully skilled to undertake their role. Domain three data for out-of-court cases suggests that staff have the ability to complete good assessments but this is not transferred to the YJB-approved assessment tool. The two team managers that were the trainers for Assetplus have left, and new staff are being trained by shadowing current practitioners. The training that has been delivered has not been effective. Further training has been identified to address this.

The seconded police officers have not been sufficiently trained. They have had no child sexual exploitation training and no specific safeguarding training. There is also limited understanding of the MAPPA process, and training in this area would be beneficial, considering the officers' potential involvement in this process.

YOT workers lack sufficient understanding and knowledge of the education landscape to enable them to engage with schools, parents and young people confidently. They are not sufficiently aware of the specialist resources that exist within the education and learning department. They also lack the training to utilise these education services fully. Despite this, there was good and tenacious work by case managers in relation to education. In the most effective cases, they added value to the work of schools and social workers, and made a distinct contribution. For instance, they prepared children and parents in advance of school-based case meetings, and acted as advocates for the children. They kept the school informed about YOT activity and applied good risk assessments – for example, in relation to the child's sibling. As a result, children's behaviour in school had improved.

In the cases inspected, staff demonstrated a lack of knowledge in managing risk of harm, and safety and wellbeing concerns for children. High risk of harm cases are

mainly allocated to qualified workers, with some cases going to unqualified staff for developmental purposes. This is not always fully supported by a mentoring or co-allocation process.

An area of strength was that case managers retained the case if a child reoffended; this enabled young people to build positive and sustained relationships with their case manager. Feedback from the young people indicated that they valued this.

Team managers had been able to access suitable management training programmes.

Although the YOT workforce is representative of the population of the local community, volunteers have raised concerns about their lack of representativeness and the overall lack of communication they receive.

There is regular management supervision, which is focused on managing cases, but some staff do not feel that this is effective. There has been a quality assurance process but this involved using a variety of tools, which has created a confused understanding. This has been recognised, and a new single standardised tool has been developed and is to be used by all staff.

Line management is mostly ineffective and inconsistent in relation to supervision of court order cases, and some of the work countersigned was not of a sufficient standard. Team managers recognised that there was an inconsistent approach to countersigning, and that this was having a detrimental impact on practitioner learning and development on the completion of the Assetplus tool. Assessments were often completed late, and countersigning was also delayed.

There is a lack of a comprehensive induction process, with staff shadowing current workers, which in some instances increases the risk of poor or weak practice being replicated by new staff.

Health staff receive good support from their employing organisations, including appropriate clinical and managerial supervision. Staff employed by Bradford District Care NHS Foundation Trust also have safeguarding supervision four times a year, and we saw evidence that staff are able to access specialists for safeguarding advice if needed. Health staff also have a link manager from the YOT, and supervision quarterly. There is no joint supervision between the staff employment agency and the YOT. We were informed that health staff are all up to date with mandatory training, including level 3 safeguarding.

Reception staff have not received any safeguarding training.

There has not been an effective appraisal process, with some staff reporting that they had not had an appraisal for over five years, and 62 per cent saying that they had never had an annual appraisal.

The health staff and managers we met during the inspection, as well as the seconded YOT worker to the liaison and diversion scheme, were all highly motivated and dedicated to meeting the needs of the children and young people they work with. Staff were flexible in their approach, such as carrying out home visits or joint visits. The health team reported good working relationships with each other, as well as with case managers. There was evidence of joint working between health staff and the children and young people in their care, but also of developing resources such as a child-friendly intervention plan which would help children and young people understand what was expected of them.

There is not a process of rewarding exceptional work, other than on an ad hoc basis, with occasional emails from the line or service manager.

The training plan is not up to date, and training is requested on an ad hoc basis. Staff can access the Bradford Evolve training platform, which is an online resource covering a range of topics, but some staff lacked awareness on how to do this.

The SALT worker had identified a lack of understanding by case managers of speech and language needs, and had delivered mandatory training. This had been well received and had led to an increase in referrals. We also saw examples in domain two of how case managers had shared SALT assessments with schools, to help them meet the communication needs of the children.

Internal training had been commissioned and provided on completing plans; however, again, evidence from our sample of court order cases indicates that this learning has not been fully embedded.

The service commissioned a peer review in June 2019 which identified a number of areas that needed further development. This had led to a change in the quality assurance process. Other activities from the peer review had not yet been implemented at the time of this inspection.

There was no evidence of learning from serious case reviews or serious incidents.

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.	

Overall, partnerships were inadequate. This was because there were serious gaps in the partnership which negatively affected the outcomes for young people. This included the police decision-making process, lack of education provision, and gaps in children’s social care.

There is a paucity of information within the YOT about the profile and needs of the children and young people. Some of this information is available within partner agencies but this is not utilised by the YOT. There has been no recent evaluation of the health needs of the YOT children, as well as insufficient analysis of the work completed by health staff to identify outcomes achieved, and whether young people’s health needs are being met. Work has been started by some providers to be able to produce detailed information, but this is in its infancy. As a result of these factors, the YOT cannot be sure if it has the correct provision and sufficient resource to meet children and young people’s health needs.

This absence of data, which could be used to commission or guide the delivery of services, also applies to education information. YOT managers lack basic high-level management data to enable them, and the Board, to interrogate the overall patterns of education attainment, attendance and progress of the cohort.

There is an understanding of the crime profile of custody cases, and an awareness about actual or potential disproportionality; however, this information has not yet been used to develop services or review practices. There is a limited understanding of sentencing patterns and offence types.

The core role of the police officers in a YOT is information sharing. This is outlined in YJB guidance. We did find evidence of information being shared by the police but, other than notifications about the arrest of children and young people, this was not systematic or consistent. Insufficient use is made of police data and intelligence.

There are additional benefits of a more systematic approach to the gathering and sharing of information. For example, the YOT police officers could more readily identify cases that have not already been referred by the police to local authority child safeguarding teams, and so take remedial action.

There is good restorative justice provision, with two victim workers in place who contact all relevant victims and offer this service. There is a lack of suitable and appropriate reparation placements, however, with most reparation taking place at 'the largest allotment in Bradford'. We saw many examples of reparation comprising chores in the young person's own family home, citing the family as indirect victims of offending. This is not appropriate. Few reparation activities take place at the weekend, and there is no specialist provision for girls.

There is a good range of input from the health provider, with dedicated nurses, a CAMHS practitioner, a SALT and access to a substance misuse service. A substance misuse practitioner from The Bridge attends the youth education and health meeting. This is a multi-agency health meeting (including nurses, a CAMHS practitioner, a SALT and the substance misuse practitioner) for each case at the start of contact with the YOT. The meeting looks at what is known about the child or young person's health and education needs, identifying cases that need additional support and making electronic referrals through the case managers. There is no routine system for ensuring that actions have been completed by individuals or organisations, which means that needs may not be addressed. One action plan we viewed was limited and did not address all the child's identified health needs. While there had not been an education input to this meeting for 18 months, a new type of education provision had been found to address this gap, although this was very new and not fully understood by staff.

The substance misuse service can offer a number of appointments, depending on the level of risk of the child or young person, and continues working with a child after the YOT order has ended.

The seconded police officers are a key partner in the out-of-court disposal panel meeting. We felt that one of the officers spent far too much time on administrative work to service the out-of-court disposal function, which was not the best use of their time. As a result, there was limited evidence of other relevant activity, such as joint visits to homes and prisons, and other interventions. These activities add real value to reducing reoffending, and were underused. The YOT police officers also had limited contact with the dedicated neighbourhood police officer teams.

Thresholds are not understood or consistently applied. In some cases, there was evidence of drift and delay, and a failure to recognise the need to take timely and decisive action in promoting the welfare and protection of children and young people. In a few cases that we saw, there was a failure by the YOT to make a child protection referral to children's social care services, despite the known and potential risk of harm to the children and young people. In some instances, children's social care services failed to undertake a statutory assessment or hold section 47 enquiries to determine the level of need and risk.

Case managers and social workers have insufficient understanding of their respective roles and responsibilities. This hinders effective communication and joint working in meeting young people's needs, including their need for protection.

Case managers reported major challenges in meeting with social workers, and late requests to attend strategy meetings and initial child protection conferences. This resulted in workers not being able to attend meetings owing to competing demands.

Where we saw stronger practice, there were aspects of effective joint work across the YOT and children's social care – for example, in supporting a young person while on remand. Communication about the Looked After Children status of children on remand needs to be clarified, however, to ensure compliance with statutory guidance. In one case, the input of early help⁵ to a case known to the YOT supported intervention for the young person and their family. Case managers routinely undertake joint visits to children looked after in custody and attend statutory Looked After Children reviews.

The YOT links with the West Yorkshire resettlement consortium, which provides an enhanced regional level of support for children released from Wetherby Young Offenders Institute. This includes the opportunity to attend a release on temporary licence clinic, to start early planning for release.

There is a multi-agency approach to addressing the unnecessary criminalisation of children in care.

There are some partnership arrangements to meet the needs of the children. There is a commissioning arrangement with Himmat, which delivers the RRR programme, and Saturday Intensive Support and Supervision contacts. There are commissioned services for substance misuse, with groupwork provision and one-to-one counselling. A new groupwork programme has been piloted by Adept, which provides education on illegal substances to schools and professionals, and there are plans to start this as a rolling programme. Adept staff reported that there have been issues in trying to book a suitable room for this at the YOT, and that this has hindered the delivery of this programme at times.

There are good transition processes in place with probation staff, who try to allocate youth cases to semi-specialist workers in the adult probation services.

There are insufficient education re-engagement activities for 16-year-olds, to enable them to remain in some form of education or training, with a shortage, in particular, of vocational options. Information on existing provision is not sufficiently communicated to YOT workers. Case managers noted an "absolute need" for more alternative provision, pupil referral units or special schools. They also identified a need for a review of the current approach, with a policy shift towards more social, emotional, mental health provision. The impact of these deficits on children supervised by the YOT is that there is insufficient locally accessible education provision as an alternative to mainstream education.

The work of the youth service is not sufficiently aligned with that of the YOT.

There was a service specification in place with the health provider, but this had a review date of January 2016,⁶ with no evidence that this had occurred. There were two nurses at the YOT, whose hours made up 1.6 full-time-equivalent (FTE) posts, and at the time of the inspection there was a vacancy for a 0.6 FTE position. This was being reviewed, to see if support could be offered from other areas that work closely with the YOT which are fully staffed.

Recently, the nurses had started to complete welfare visits with children and young people in custody. As a result, they had developed better links with nurses based in

⁵ Early help, also known as early intervention, is support given as soon as a problem emerges, at any time in a child or young person's life. Early help services can be delivered to parents, children or whole families, but their main focus is outcomes for children. Department for Education, 2018

⁶ Information provided on site to the Care Quality Commission inspector.

young offenders institutions, and there had been examples where these had benefited the child, such as identifying a child who was not receiving their medication. We were not able to meet with the nurses during this inspection, and so we were unable to establish whether a formal health assessment was completed during these visits, or how this information formed part of the sentence planning for children and young people.

There are systemic weaknesses across the partnership in the identification and management of risk to children. This includes a lack of safeguarding referrals from operational police officers, and YOT practitioners. Where these failings exist, they are of the most serious level, and could affect the safety and wellbeing of children.

An out-of-court disposal panel process is in place, to decide on the best outcomes for children and young people who have been investigated by the police, and in cases where the young person has admitted the offence. The panel consists of a YOT manager, a police officer, a YOT caseworker and a victim engagement worker. It was positive that the views of victims were being taken into account, as well as those of the young person and their parent/carer, and evidence of the impact of this could be seen in our assessment of out-of-court disposal cases. The panel process could have been improved by having more direct links to schools, so that any relevant information could be taken into account.

When a decision was made that a community resolution was the most appropriate outcome, a referral was made to a dedicated liaison and diversion worker. This was an effective system to make sure that preventative work could be targeted at children and young people who had committed low-level offences, although the YOT Board had not scrutinised this work, to examine its effectiveness. The West Yorkshire Police policy on out-of-court disposals dictates that decisions about children and young people receiving their first disposal can be made by the police alone. The policy does not explicitly state that it is necessary to tell the YOT about these decisions when they have been made.

We found that, in the three months prior to our inspection, 118 children and young people had been given community resolutions by the police. In 39 cases (33 percent),⁷ the YOT had not been made aware of this. This meant that, in these cases, the liaison and diversion worker would not have been able to work with the child or young person, and therefore to provide intervention to support them to desist from offending.

As West Yorkshire Police can also decide to issue first-time cautions and conditional cautions to children and young people, these cases would also not be subject to the partnership decision-making panel. This procedure is in almost direct contradiction to the aims of the YOT out-of-court disposal process, and may partially explain the high level of first-time entrants in Bradford.

There is no panel to decide whether it is appropriate to charge a child or young person. Considering the serious impact of a charge, and also the impact of the increased workload on the YOT and the wider criminal justice system, this would be a sensible extension to the process of decision-making. Indeed, it was notable that some charged cases had been sent back to the YOT from the youth court to consider whether a caution or conditional caution was a more appropriate outcome.

⁷ Information provided on site to the Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services inspector.

Partnerships with Connexions (Prospects) are good, and advisers knowledgeable. The NEET figure is too high, at 30 per cent,⁸ and tackling it was not expressed as a priority. More positively, however, there were few 'not knowns', which means that NEET young people remain in contact with a Connexions personal adviser. Inspectors accepted that a proportion of these young people are some distance away from sustaining training or work because of their chaotic lifestyles.

There is a risk and vulnerability meeting, but this does not utilise partners' information, and it is mainly attended by YOT staff. It is reliant on case managers requesting that their cases be discussed. This does not make full use of partnership arrangements.

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.	

We have rated information and facilities as 'Inadequate'. This is due to the lack of management information that could have been used to develop and commission resources. In addition, policies needed updating and staff were not fully aware of their content.

Many policies are out of date, or need reviewing. Only 26 per cent of staff reported that they understand the YOT's policies very well.

Most staff know how to access the right services, but this is not monitored or overseen, which means that referrals to services are based on the knowledge and motivation of the member of staff rather than the needs of the young person.

Evidence from the case inspection indicated that staff were not fully aware of their roles and responsibilities in relation to safeguarding children, particularly in relation to wider family members.

Police crime trend data was not presented to the YOT Board, to enable them to understand patterns of offending and emerging trends, and react accordingly. A flag on the police intelligence system to identify information about children and young people on the youth offending team caseload was not used – not even for those who were most vulnerable or most at risk of reoffending. This means that the officers would not necessarily be drawn to important information on the police system. Such a flag would alert the seconded police officer if a young person came to any type of police attention, not just those who are arrested. This would increase the information sharing with case managers, which, in turn, could aid their ability to respond to changes in risk factors for the young person.

An out-of-court scrutiny panel operates for the whole of the West Yorkshire Police area. This examined 16 cases from across the county involving children and young people. While it was possible that only a limited number of the cases examined were from Bradford, we saw no evidence that the YOT Board was using this information to scrutinise how well the process was working in the area.

West Yorkshire Police has set up a youth independent advisory group for the Bradford area. This was a positive initiative to improve communication between

⁸ Information provided on site to the education inspector.

young people and the police. The YOT has not been involved in this group, but there have been opportunities for the YOT Board to use this (or a similar) group to help inform the work of the YOT, and to improve continually.

Staff have been tenacious in getting children into services, particularly re-engaging children with education.

The YOT and children's social care services have been co-located within the same building for over 18 months, although this has not yet resulted in a culture of strong communication or a holistic approach to the joint delivery of services. Workers spoke positively of their relationship with colleagues, and value each other's input on cases that are jointly managed. Staff are on different floors, however, and because of a high turnover of social workers, staff do not always have face-to-face contact with each other. This has resulted in limited contact with colleagues across the partnership, and contributes to silo working practice. The arrangement is now under review.

The new YOT base is suitable for meeting young people, who said that they prefer the building to the previous one. There is a room where children are scanned with a hand-held scanner, to stop any weapons coming onto the premises. The children chose the colour of the paint in the YOT reception area. Children and young people have also been used in an interview process for the new team manager, and have been consulted on the new young-person-friendly plan.

Staff use a mix of home and office visits to see the young people in their care, and use community venues when available. Risk assessments are completed in advance of home visits and there is a lone working policy. In addition, interview rooms are comfortable and well equipped, and televisions, DVDs and web-based interventions are available, although these are sometimes difficult to access.

The office is overcrowded, and is, at times, a noisy working environment for staff, 46 per cent of whom reported that their office environment is unsuitable.

Staff are able to use the case management system and have use of laptop computers to enable them to work remotely, but the court laptop computer is not WiFi enabled. This means that staff still have to take physical paper records into the courtroom when undertaking court duty. YOT staff do not have smartphones, and the mobile phones that they have are of poor quality. There is a business case currently under review to address this. Only 18 per cent of staff reported that the information technology available to them helps them to do their job.

Staff use a number of databases. This results in a mixed picture of recording contacts for specialist staff. Positively, YOT staff have access to the children's social care database, but this is not a reciprocal arrangement, with the multi-agency safeguarding hub not having access to the YOT case management system. In addition, the YOT has stopped flagging open YOT cases on the social care system, which means that social workers would not know when a case is open to the YOT. YOT staff do not have access to the community safety database for information about antisocial behaviour.

Crown Prosecution Service (CPS) documents are not provided automatically, and staff are required to request them after sentence; this results in delays, or missing CPS information.

The YOT does not have a data analyst, relying on a link member of staff from the council for providing key performance data to the Board. This has resulted in a lack of useful data both to manage the performance of the staff team – for example, the

timeliness of AssetPlus' – and statistical information to develop and respond to crime and demographic profiles in Bradford, such as emerging crime themes and case profiles. Not all team managers know how to produce reports from the case management system that will assist them with the management information they require.

The YOT strategic management team is self-aware, and recognises its gaps and weaknesses.

Summary

Strengths:

- The allocation principle of case managers retaining the supervision of a child or young person's case is strong, ensuring that the children maintain meaningful relationships with staff.
- Staff work hard to deliver services, despite the absence of leadership and structures.
- The youth education and health meeting is a good mechanism for screening children's needs in new cases.
- Overall, the health provision is good, with two nurses, a SALT practitioner and access to a CAMHS nurse.
- The co-location of YOT staff with children's social care services is starting to aid communication and relationships.

Areas for improvement:

- The Chair of the Management Board needs to be a permanent position, and a person who has the right level of seniority.
- Board members need to know their role, and be provided with a suitable induction, and information to enable them to fulfil their responsibilities. Board members should be empowered to provide scrutiny.
- The YOT and the Board need to make better use of the information that is available to them, and increase the quality of the data they have access to.
- Staff should receive annual appraisals.
- Training should be provided to improve assessments and risk management.
- The West Yorkshire Police out-of-court disposal policy for young people needs to be reviewed, to bring it in line with the YOT out-of-court policy.
- Better use should be made of the police database, to flag known young people and share information about risk.
- Management oversight and countersigning needs to be consistent and rigorous, so that only acceptable work is signed off.
- The new education processes need to be shared with the staff and then monitored for their effectiveness.



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 inspection, we looked at 42 cases which had received a court disposal six to nine months previously. In each of those cases, we examined the case file and interviewed the relevant case manager. We inspect against four standards – assessment, planning, implementation and review.

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

Overall, assessments were inadequate, with the most important shortfall being related to assessments on how to keep other people safe. These were not completed to a sufficient standard in over half of the cases. In these cases, the assessment did not fully identify all the relevant factors associated with the risk of harm to others, and did not fully draw on all available information, which included past behaviours and convictions, or using all other agency information as required.

Case managers were often aware of information from children's social care services and the police, but this was not clearly evidenced in the assessment. In many examples, the case manager was aware of information about historical convictions or outstanding investigations, but this was not included in the assessment of the risks to others presented by the young person, with the assessment wholly concentrating on the index offence for which they had been sentenced. This does not give a complete picture, and therefore does not lead to good planning to help to manage those risks.

Inspectors disagreed with the assessment in relation to risk of harm to others in nearly one-quarter of cases.

Assessments of risk of harm to others were completed late in nearly half of the cases. This was not a matter of being just a few days late; in some cases, the assessments were not completed and countersigned for several months after the original assessment was due.

Assessments on analysing how to keep the child or young person safe were better, and these were done well in nearly two-thirds of cases. Assessments identified the factors in relation to the safety and wellbeing of the child or young person in just over two-thirds of cases. Inspectors agreed with the safety and wellbeing assessment in over 80 per cent of the cases.

The assessment did not fully draw on all the information available and involve other agency information in nearly half of the cases. This included information provided by parents not being incorporated in assessments, and not following up information about siblings and cousins that could have affected the safety and wellbeing assessments.

Line managers countersigned assessments in which there were a number of deficiencies.

Below is a case example of how an assessment did not include all relevant information about risk to others; safety and wellbeing; and the potential consequence of this to the young person:

“Kyle was sentenced to a youth rehabilitation order. He was involved in criminal activity, possibly gang related, but the extent of this [was] not recorded on the assessment. There was a significant incident at his home, where a car was crashed through a garden fence and four masked men assaulted the young person and his father. This resulted in the police armed response unit being called to the house. There were two children under five at the address who witnessed the offence. The assessment was not reviewed following this incident, and no further enquiries were made with either children’s social care or the police for more information in relation to the event”.

Assessment of desistance factors for children and young people was good in over two-thirds of cases. The assessment considered diversity factors, and the wider familial and social context, in three-quarters of cases, and focused on the child or young person’s strengths and protective factors in over two-thirds of cases.

The most frequently occurring factors relating to desistance for the children and young people were lifestyle and education.

In most of the cases, the children and young people were involved in the assessment, and there was a recognition of the young person’s level of maturity. In nearly half of the cases inspected, however, there was not sufficient attention paid to the needs and wishes of the victims.

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

Overall, planning was inadequate. Planning to keep other people safe was one of the weakest areas of practice, with a lack of coordination of information from other sources and little use made of external controls and contingency planning.

The YOT had recognised that planning was an area for development, and had established a focus group of staff to develop a more young-person-friendly plan. This had been shared with a group of young people, and their feedback had been incorporated into the new plan. The cases that we inspected had used the older planning documentation, which is embedded in the Assetplus assessment tool. When looking at planning, we also considered other documents and processes, including references to the high-risk and vulnerability meeting and relevant children’s services plans.

It was found that planning did not focus on keeping other people safe in nearly two-thirds of cases. There was insufficient use of other agencies in the development and

delivery of plans to keep others safe in over half the cases, and this included a wide range of agencies such as children's social care, education and the police.

Planning to address specific concerns to actual or potential victims was only sufficient in less than two-fifths of cases. While there was evidence of work to achieve restorative justice outcomes in a number of cases, there was little work on actually keeping specific or future victims safe. For example, in one case, where the offence had been a targeted arson offence, there had been no planning in relation to checking for lighters, or managing any potential contact with the particular victim. In another case, where the mother of the young person being supervised had been the victim, there had been no planning to keep her safe.

Planning did not make enough use of external controls in most cases. This would have assisted in reducing the risks of harm to others, and there was insufficient use made of contingency planning when risks had been identified.

Planning to keep the child or young person safe was done well in only half the cases, and involved other agencies in only under half of the cases. There were a number of cases where the child or young person was also open to children's social care services, either as a child in need or subject to child protection, and the YOT planning did not address or reference these plans. The result of this could have been a child subject to more than one plan, which did not reference or complement each other. Planning was stronger for young people in custody, however, where there were good links with the overall sentence plan, and planning for safety and wellbeing.

Contingency planning for safety and wellbeing were completed well in over half the cases; however, this was often focused on the case manager completing processes, rather than specific actions to keep the young person safe. Examples of this included contingency planning comprising reviewing the Assetplus assessment or having a discussion with the line manager.

There was a lack of recognition of the risks associated with criminal and sexual exploitation in a number of cases, and, while staff reported that they had received some training in the risk factors and indicators of these behaviours, there was little evidence of this in the cases inspected.

Planning for both risk of harm to others, and safety and wellbeing were overseen by the risk and vulnerability management and planning meeting. Cases were referred to this meeting by case managers, and the meeting was chaired by the service manager. Information was shared by partner agencies at this meeting, and actions identified. Unfortunately, there were several flaws in the processes of this meeting. Referral of a case to the meeting was dependent on the case manager identifying and requesting that the case went to this meeting, and there were a number of cases where this opportunity had been missed. Membership of the meeting was also limited to mostly YOT staff, restricting the scope and range of both the information going into the meeting, and the actions coming from it. Case managers reported that there was little added value from this meeting, and that they would often come away from it just with actions for themselves.

Planning to support desistance was stronger, being done well in over 60 per cent of cases. Planning took account of services most likely to support desistance in nearly 70 per cent of cases, and took account of diversity and wider familial context in most cases. Many of the plans had an appropriate focus on re-engaging the young person back into education, which would support desistance. Planning did not pay sufficient attention to the needs and wishes of the victims in over half of the cases, however,

and in only just over half the cases did planning consider the maturity and motivation of the child or young person.

There were examples where the plan had not been changed from a previous assessment and outcome, with no updating or reviewing of the plan for the young person.

Planning was proportionate to the court outcome in three-quarters of cases, and involved the child or young person and their family in just over 60 per cent of cases.

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 implementation and delivery of services was inadequate. The main reasons for this were a lack both of interventions to support the safety of other people, and also of coordination between services. The implementation and delivery of services to support the safety of other people was not done well in nearly 60 per cent of cases. The main reason for this not being done was a lack of attention given to actual and potential victims. The delivery of services to manage and minimise the risk of harm was done well in only half the cases.

Involvement with other agencies in the management of risk was not well coordinated in over 50 per cent of cases. This included instances of a lack of information sharing and coordinated planning with agencies such as the police, antisocial behaviour team, early help services and children’s social care services. An example of this is presented below:

“Adam was a 14-year-old male, released on licence following a short detention and training order for an offence of arson. While on licence, he was further arrested for an offence of robbery and possession of [a] knife. The case manager had little information about this offence, and had not requested further information from the police. Adam lived with his two younger siblings, both of whom were subject to child-in-need support, but the information about the knife was not shared with the siblings’ social worker. This lack of systematic information sharing could have resulted in increased, but unmanaged risk to the siblings”.

Inspectors also found three cases where young people had been found in possession of a knife, but there was a lack of response in the intervention, or external controls, to keep other people safe.

The implementation and delivery of services to support the young person was done well in nearly two-thirds of cases, with services being delivered to support safety and wellbeing delivered in the majority of cases, and coordination of agencies being carried out well in 60 per cent of cases. The implementation and delivery of services to young people in custody was a particular strength, with case managers actively supporting the young people who were in their care; playing an active role in coordinating services in custody; and visiting on an increased level in response to a deterioration in the young person’s behaviour.

Implementation to support the young person’s desistance was done well in 70 per cent of cases. In nearly two-thirds of cases, services built on children and young people’s strengths and protective factors. We saw many examples of case managers working hard to re-engage children back into education, some of whom had missed education for up to a year.

Cases were referred to the in-house SALT worker, who completed assessments and provided information on how to pitch their intervention to ensure that the young person understood the work. This information was also shared with schools, to help the children achieve their potential in the school environment.

Children and young people who had an order over three months were expected to complete the RRR programme. This was delivered by Himmat, a commissioned service, which had a worker embedded in the YOT. This six-session course can be delivered on a one-to-one or groupwork basis, and is a certificated programme. The content covers a range of topics and is a “personal development programme that aims to instil a sense of belonging among young people and encourages tolerance, mutual respect and community cohesion”. While not all eligible young people completed this programme, when they did there was very positive feedback.

Service delivery reflected the diversity and wider familial context of the child or young person in over three-quarter of cases, with staff demonstrating cultural and religious sensitivity with the young people with whom they worked.

There were examples of case managers giving attention to encouraging and enabling children and young people’s compliance. There was a good mix of home, community and office visits, with engagement with family and appointments offered at times to facilitate college timetables or positive leisure activities. This was done well in 90 per cent of cases. When young people failed to attend their YOT appointments, this was responded to appropriately, with warning letters being issued and a Back on Track meeting with the case manager, team manager, young person and family member.

There was also evidence of restorative work being completed with children and young people, with examples of letters of explanation and shuttle mediation. Reparation was also completed, although there was a lack of placements, with most young people being placed at the YOT allotment or in the bike project. This lack of range of placements limited the opportunities for reparation, and in one case the child completed work in their family home. Case managers also reported that there is very little reparation available at weekends.

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

Reviewing was judged to be inadequate. It did not pay due attention to new information from other agencies, or the young person, that had an impact on the levels of risk or the intervention required. When reviewing cases, a number of sources of information are used, including the review Assetplus, case records and sentence planning information.

Reviewing did not focus on keeping other people safe in over 50 per cent of cases; did not respond to changes in risk of harm to others in over 50 per cent of cases;

and did not lead to amendments in the ongoing work to manage the changes in risk of harm to others in over 60 per cent of cases. Inspectors saw cases where important information that would have affected the risk assessment, such as an ongoing serious police investigation, had not been included in reviews, and plans had not been adjusted in the light of this information.

Reviewing to keep the child or young person safe was not done well in over 50 per cent of cases; it did not respond to all relevant changes in factors relating to safety and wellbeing, and was not always informed by the necessary information from other agencies. In one example, the police had issued a threat-to-life notification, but a review had not been completed and there had been no follow-up for further information from the police that would have assisted in adjusting plans to safeguard the young person.

A further case example demonstrates the problems in relation to reviewing:

"The young person had disclosed significant and persistent concerns regarding risk to physical safety. He initially disclosed a 'bounty on his head'. He was shortly thereafter assaulted, evidencing a very real threat. The young person had recently attended to see the new case manager and disclosed having a machete upon his person. This is a significant risk issue to self and others, which requires intervention.

"He had also disclosed ongoing and evidenced self-harming behaviour. The intensive support and supervision worker has given verbal advice and [a] crisis contact number but, overall, there has been no coordinated and formal multi-agency review of the high-level risk issues present in this case, both in terms of the risk to self ([he]has now been diagnosed with ADHD [attention deficit hyperactivity disorder], conduct disorder and psychosis) and risk from peers and home environment, or of this YP's [young person's] risk to others, including [a] recent rape arrest."

Reviewing to respond to changes in desistance was slightly better, with this being done as required in 60 per cent of cases. The reviewing mostly built on the child or young person's strengths, and considered their motivation. In over 50 per cent of the cases, this led to adjustments in the ongoing work. An inspector noted:

"There is evidence that the reviewing process was ongoing and that the young person was involved in this. Potential barriers to compliance were discussed, and an appropriate way of working [was] established that did not involve further punishment of the young person".

Where possible, most reviewing also took account of the views of the child or young person and their family.

Summary

Strengths:

- There is a good restorative justice service for victims who wish to participate.
- The Rights, Respect and Responsibilities programme is delivered in a responsive way, to meet the needs of the children and young people.
- Staff are receptive to the diversity needs of the children and young people.
- The Back on Track meetings are an effective way of re-engaging children and young people who may potentially breach their orders.
- Speech, language and communication needs assessments are used to shape the delivery of interventions by case managers.

Areas for improvement:

- There are delays in the completion of Assetplus assessments.
- Managers are countersigning assessments that do not meet a sufficient standard.
- The membership of the risk and vulnerability meeting is not comprehensive, and the process for referring cases to this meeting is flawed.
- Plans do not adequately address risk of harm to others, and safety and wellbeing concerns.
- There are insufficient suitable reparation placements available at times to suit the young people.
- New information in relation to risk of harm, and safety and wellbeing is not responded to in a way that reduces the risk to the young people and others.

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 inspection, we looked at 28 cases that had received out-of-court disposals three to five months earlier. Of these cases, 23 were youth conditional cautions, four were youth cautions and there was one community resolution. In each of these cases, we inspected against four standards – assessment, planning, implementation and joint working.

In Bradford YOT, community resolution cases were managed by the liaison and diversion scheme, and these did not form part of the inspection.

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

Assessment was judged to be good overall. The tool that had been developed was completed well in most cases, and using this tool, case managers were able to record and analyse the information that was relevant to the child or young person.

The YOT has developed its own assessment tool, which is used in most cases. This tool uses a signs of safety model, and assesses likelihood of reoffending, safety and wellbeing concerns, and risk of serious harm. It also uses a self-assessment alcohol screening, and speech and language screening. Staff are expected to complete a full AssetPlus assessment for Looked After Children and high-risk offences. In the sample inspected, all the assessments had been completed using the in-house tool.

When this tool is used well, staff are able to analyse all the relevant factors and make an appropriate assessment.

There was sufficient analysis of desistance factors in most of the cases, which also considered the diversity and wider familial context for the young person. Good use was made of information held on the children’s social care database, which all staff are able to access. Staff are provided with information from the police about the index offence, but this is not uploaded onto the YOT case management system, and so is not readily available. There were occasional gaps in education information being available, and staff relied on the families of the young people for this information.

Where there were weaknesses in the assessment, this was due to the case manager wholly relying on the young person’s version of events, with no challenge from other sources of information, and a lack of professional curiosity.

The most important factors identified in relation to desistance were education, training and employment; lifestyle; and substance use.

Assessments were strong in identifying key barriers facing the young person, and in focusing on the child or young person’s strengths and protective factors. Staff were able to articulate the positive influence of factors such as sport, education and family when assessing desistance.

This is demonstrated in the following example:

“The offence analysis highlights that it is likely [that] the young person is being pressured by older people to steal items from the store. It explores wider family issues, including the fact that the young person is being supported by children’s social care on a child-in-need plan. Key information from children’s social care and child and adolescent mental health services is included throughout the assessment. A good range of positives are identified within the assessment. Good information is included around education, and barriers here are explored. Due to the number of factors against desistance identified, he is correctly identified as being at a high risk of reoffending”.

A particular strength is how well staff were able to engage with children and young people, and their parents, and this was done in all the cases that inspectors saw. Case managers also cross-referenced information from the self-assessment in the assessment tool. The young person’s voice was also very clear in the assessments, with regular use of direct quotes from the children and young people and their families.

A further strength was the attention given to the wishes and needs of the victim, which was evident in the vast majority of the assessments. This was much better than in the post-court cases, and the attendance of the victim workers at the decision-making panel probably contributed to this difference. These assessments were also completed in a timely manner.

In nearly all of the cases, there was good identification of the safety and wellbeing concerns of the child within the assessment, and good use was made of information from other agencies.

This is demonstrated below:

“Concerns around the young person’s safety and wellbeing are clearly identified within the assessment, including the fact [that] he is at risk of criminal exploitation from older peers. It was good to note that the emotional impact of having a strained relationship with his mother, whom he sees intermittently, is recognised, alongside the trauma of witnessing and experiencing previous violence from his father to [his] mother”.

Inspectors agreed with the safety and wellbeing classification in over 90 per cent of the assessments.

Assessments were also good at identifying and analysing the risks posed by the child or young person in most of the cases, although there was less evidence of use of information from other agencies in this section. The main gaps were not fully utilising historical information, and a lack of information from education establishments. Inspectors agreed with the classification of risk to others in the vast majority of assessments.

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

Planning to address the child or young person’s safety and wellbeing was inadequate. Planning was not specific to meet the needs of the case, and there was a lack of sequencing of the work required to be completed. To help formulate the plans, a number of resources were used, including the plan which was contained in the in-house assessment tool and the out-of-court disposal decision-making panel notes. Usually, the inspection process would also consider the disposal, signed by the young person and parent, which is administered by the police. This specifies any conditions or requirements of the out-of-court disposal. Unfortunately, these are not available on the YOT case management system, as they are not currently shared by the police, although a case entry is put onto this system, confirming that the disposal has been administered.

Overall, planning to support desistance was less strong than assessment, and there are clear areas for development in the planning process. There was less evidence that children and young people were involved, and planning also did not take account of the child or young person’s strengths in over 50 per cent of the cases.

The main gap in planning that inspectors identified was a lack of sequencing. It was sometimes vague and unspecific; for example, plans simply stated, “offending behaviour” or “drugs awareness”, without saying who would do this work, how or where it would be done, or how the young person would know that they had completed their conditions.

An inspector noted:

“Beyond the identified interventions in the diversion assessment, and verbal notes at [the] panel, of what is likely to be done, there is no actual planning activity. No formal document/no plan shared or signed by the young person, and while the diversion assessment states that offending behaviour/victim awareness and restorative justice is to be undertaken, there is no subsequent discussion with the young person about the outcome of the panel or any capturing of their views as to what type of intervention would be beneficial. The only dialogue with the young person about the conditions is when the caution is given by the police officer”.

This description highlights a gap in the process in relation to planning. The plan is created from the assessment document, which is discussed at the panel. When the caution is delivered by the police, however, this is a separate activity, which does not comprehensively reference the earlier activities, and the lack of the signed document on the YOT system compounds this.

Planning to support the needs and wishes of the victim was very good, however, with this done well in most of the cases. Planning was also found to be proportionate to the disposal type in nearly all the cases.

Planning did not focus sufficiently on keeping the child or young person safe in over half the cases. The main concerns identified in this area were a lack of contingency

planning, and a lack of YOT planning linking up appropriately with plans from other departments – for example, child-in-need plans, or Looked After Child plans.

Planning to keep other people safe was completed well in less than half the cases; again, the main concern in this area was a lack of contingency planning, which was absent in most cases where it was identified as being required. Planning to keep specific victims safe, however, was done well in most of the cases.

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

Implementation and delivery was good overall. There was good use made of conditions on the caution, and of community resources to meet the children’s ongoing needs.

Services were delivered to support desistance in most of the cases, and took into account the diversity and wider familial and social context of the child or young person. Examples of this included evening appointments to facilitate college attendance, telephone support between appointments, and appointments arranged to facilitate religious commitments. There was also a strong focus on enabling the child or young person’s compliance, and maintaining an effective relationship with them.

There were a number of clear examples of how the case manager was promoting opportunities for community reintegration after the intervention had ended. This included referrals to the community drugs team, introduction to the local youth club and ongoing parenting support. This was absent, however, in one-third of the cases where this was deemed to be necessary.

A number of children were required to complete community reparation as a condition of the youth conditional caution, but there was a major gap in community reparation placements. There were examples of appropriate reparation, such as at a homeless charity and, where the victim was a police officer, cleaning police cars, but in most cases this was absent, with reparation being limited to the community allotment and a bike project. Inspectors also saw a number of examples of the reparation being to undertake chores in the young person’s own family home, when no one in the family was a victim. This weakens the role of community reparation, and could heighten family tensions if the young person does not complete the reparation. There was also one case where the mother was the victim, and although she explicitly requested community reparation, the reparation eventually took place in the family home.

There was good use made of alternative conditions on the caution, however, including a doorstep curfew, which was overseen by the neighbourhood policing team.

Implementation to promote the safety and wellbeing of the child or young person was done well in most cases, with very good involvement of other agencies. An example of this was noted by an inspector:

“There is clear evidence that the concerns around the young person's safety are returned to repeatedly, to ensure [that] there have been no further incidents of concern, which is good. Work is completed to ensure [that] the young person understands the risks of exploitation and [of] getting involved in further offending. Towards the end of the intervention, there is a clear discussion between the YOS and school, to share concerns”.

The delivery of services to support the safety of other people was done well in just under three-quarters of cases. There was evidence of staff delivering weapons awareness work, but there was no agreed intervention programme, with case managers left to find their own materials on the internet, or sharing with colleagues. One area of strength was the service offered to victims, with sufficient attention paid to their protection in most cases, and there were examples of good restorative activity taking place with victims. This included full restorative conferences, as well as letters of apology and one case of direct reparation.

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

Joint working was good. This was a consequence of the new decision-making panel that had recently been introduced. The YOT had changed its processes for managing their out-of-court disposals in March 2019, and introduced a decision-making panel at that time. The panel consists of police, a YOT team manager and the YOT victim worker.

Case managers complete the in-house assessment tool, and these findings and recommendations are presented to the panel. When this took place, the decision-making was clear, and the disposal was appropriate to the needs of the case in over 90 per cent of cases. The recommendations were appropriate and proportionate, and considered the degree to which the child or young person understood the offence and acknowledged responsibility. There were occasions, however, when police still administered youth conditional cautions, without any prior consultation with the YOT. This had occurred in four cases in our sample, all of which had been after the implementation of the panel process.

More concerning is the West Yorkshire Police disposal policy, which allows for police to make a disposal decision unilaterally. This is in contradiction to the Bradford YOT policy of all suitable cases being referred to the decision-making panel. This conflict in policies allows for cases to be decided by the police, with the YOT not being involved or, potentially, not knowing about the outcome.

In nearly a quarter of the cases, there was no evidence of sufficient attention being given to the child or young person's understanding of the implications of the out-of-court disposal. This is partially due both to the lack of signed police paperwork on the YOT case management system, with the administration of the out-of-court disposal limited to a police diary entry, and also the out-of-court disposal not being jointly delivered with the case manager. If these things were to happen, it would ensure a greater integration of the out-of-court disposal plan, and a shared understanding, from all parties, of the implications of an out-of-court disposal.

The YOT worked effectively with the police in implementing the out-of-court disposal in the majority of cases, and there was excellent attention given to compliance and enforcement of the conditions of the youth conditional caution.

Summary

Strengths:

- There was good use of the child or young person's perspective in assessment.
- Where appropriate, the victim's perspective was incorporated into the decision-making process and planning for the out-of-court disposal.
- Assessments were completed in a timely manner.
- There was good use made of doorstep curfews as a condition of a youth conditional caution.
- The panel process improved joint decision-making processes, and the membership of the panel was correct.

Areas for improvement:

- There was a lack of integration between all the planning processes and documentation.
- Copies of signed out-of-court disposals were not available on the YOT case management system.
- There was a conflict between the West Yorkshire Police out-of-court disposal policy and the Bradford YOT panel process. This resulted in suitable cases not being referred.
- There was a lack of evidence of the implications of out-of-court disposals being fully explained to the child or young person and their family.

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 Assistant Director, accompanied by 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 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 24 staff, asking them about their experiences of training, development, management supervision and leadership. We also surveyed 10 volunteers and 10 children and young people. We also held a young person's focus group. The second fieldwork week is the joint element of the inspection. Her Majesty's Inspectorate of 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. In total, we conducted 26 meetings with staff and partners.

Domain two: court disposals

We completed case assessments over a two-week period, examining case files and interviewing case managers. This was due to one inspector being unavailable during the first week. 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 closely 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 42 post-court cases. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of 5), and we ensured that the ratios in relation to gender, 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 two-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 closely 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 28 out-of-court disposals. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of 5), and we ensured that the ratios in relation to gender, 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

In this inspection, we conducted a detailed examination of a sample of 42 post-court cases and 28 out-of-court disposals. In each of those cases, we inspected against four standards: assessment, planning, implementation and delivery, and joint working. For each standard, inspectors answered a number of key questions about different aspects of quality, including whether there was sufficient analysis of the factors related to offending; the extent to which young offenders were involved in assessment and planning; and whether enough was done to assess the level of risk of harm posed – and to manage that risk.

To score an 'Outstanding' rating for the sections on court disposals or out-of-court disposals, 80 per cent or more of the cases we analyse have to be assessed as sufficient. If between 65 per cent and 79 per cent are judged to be sufficient, then the rating is 'Good' and if between 50 per cent and 64 per cent are judged to be sufficient, then a rating of 'Requires improvement' is applied. Finally, if less than 50 per cent are sufficient, then we rate this as 'Inadequate'.

The rating at the standard level is aligned to the lowest banding at the key question level, recognising that each key question is an integral part of the standard. Therefore, if we rate three key questions as 'Good' and one as 'Inadequate', the overall rating for that standard is 'Inadequate'.

Lowest banding (key question level)	Rating (standard)
Minority: <50%	Inadequate
Too few: 50-64%	Requires improvement
Reasonable majority: 65-79%	Good
Large majority: 80%+	Outstanding

Additional scoring rules are used to generate the overall YOT rating. Each of the 12 standards are scored on a 0–3 scale, in which 'Inadequate' = 0; 'Requires improvement' = 1; 'Good' = 2; and 'Outstanding' = 3. Adding these scores produces a total score ranging from 0 to 36, which is banded to produce the overall rating, as follows:

- 0–6 = Inadequate
- 7–18 = Requires improvement
- 19–30 = Good
- 31–36 = Outstanding.

1. Organisational delivery

Standards and key questions	Rating
<p>1.1. Governance and leadership</p> <p>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.</p> <p>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?</p> <p>1.1.2. Do the partnership arrangements actively support effective service delivery?</p> <p>1.1.3. Does the leadership of the YOS support effective service delivery?</p>	Inadequate
<p>1.2. Staff</p> <p>Staff within the YOS are empowered to deliver a high-quality, personalised and responsive service for all children and young people.</p> <p>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?</p> <p>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?</p> <p>1.2.3. Does the oversight of work support high-quality delivery and professional development?</p> <p>1.2.4. Are arrangements for learning and development comprehensive and responsive?</p>	Requires improvement
<p>1.3. Partnerships and services</p> <p>A comprehensive range of high-quality services is in place, enabling personalised and responsive provision for all children and young people.</p> <p>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?</p>	Inadequate

- 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
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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?	67%
2.1.2. Does assessment sufficiently analyse how to keep the child or young person safe?	64%
2.1.3. Does assessment sufficiently analyse how to keep other people safe?	43%

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?	61%
2.2.2. Does planning focus sufficiently on keeping the child or young person safe?	50%
2.2.3. Does planning focus sufficiently on keeping other people safe?	37%
2.3. Implementation and delivery	Inadequate
High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child or young person.	
2.3.1. Does the implementation and delivery of services effectively support the child or young person's desistance?	70%
2.3.2. Does the implementation and delivery of services effectively support the safety of the child or young person?	66%
2.3.3. Does the implementation and delivery of services effectively support the safety of other people?	41%
2.4. Reviewing	Inadequate
Reviewing of progress is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.	
2.4.1. Does reviewing focus sufficiently on supporting the child or young person's desistance?	60%
2.4.2. Does reviewing focus sufficiently on keeping the child or young person safe?	44%
2.4.3. Does reviewing focus sufficiently on keeping other people safe?	44%

3. Out-of-court disposals

Standards and key questions	Rating and % yes
<p>3.1. Assessment</p> <p>Assessment is well-informed, analytical and personalised, actively involving the child or young person and their parents/carers.</p>	Good
3.1.1. Does assessment sufficiently analyse how to support the child or young person's desistance?	86%
3.1.2. Does assessment sufficiently analyse how to keep the child or young person safe?	79%
3.1.3. Does assessment sufficiently analyse how to keep other people safe?	82%
<p>3.2. Planning</p> <p>Planning is well-informed, holistic and personalised, actively involving the child or young person and their parents/carers.</p>	Inadequate
3.2.1. Does planning focus sufficiently on supporting the child or young person's desistance?	68%
3.2.2. Does planning focus sufficiently on keeping the child or young person safe?	47%
3.2.3. Does planning focus sufficiently on keeping other people safe?	45%
<p>3.3. Implementation and delivery</p> <p>High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child or young person.</p>	Good
3.3.1. Does service delivery support the child or young person's desistance?	79%
3.3.2. Does service delivery effectively support the safety of the child or young person?	87%
3.3.3. Does service delivery effectively support the safety of other people?	67%
<p>3.4. Joint working</p> <p>Joint working with the police supports the delivery of high-quality, personalised and coordinated services.</p>	Good

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| 3.4.1. Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child or young person, supporting joint decision-making? | 78% |
| 3.4.2. Does the YOT work effectively with the police in implementing the out-of-court disposal? | 78% |

Annex 3 – Glossary

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
Child criminal exploitation	Occurs when children and young people are exploited, forced or coerced into committing crimes
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 serious harm
Child sexual exploitation	A type of child abuse, occurring when a child or young person is encouraged, forced or manipulated to take part in sexual activity for something in return – for example, presents, drugs, alcohol or emotional attention
Community resolution	Used in low-level, often first-time, offences where there is informal agreement, often also involving the victim, about how the offence should be resolved. Community resolution is a generic term; in practice, many different local terms are used to mean the same thing
Court disposals	The sentence imposed by the court. Examples of youth court disposals are referral orders, youth rehabilitation orders, and detention and training orders
CPS	Crown Prosecution Service
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
Detention and training order	Prison sentence for a child or young person. The length is specified by the court. The child or young person is placed in either a secure children's home, secure training centre or YOT. The placement is dependent upon age and vulnerability. The detention and training order will have both custodial

	and community elements, when the child or young person will be released on licence
Education, training and employment	Work to improve learning, and to increase future employment prospects
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
First-time entrant	A child or young person who receives a statutory criminal justice outcome (youth caution, youth conditional caution or conviction) for the first time
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. 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
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 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. Her Majesty's Inspectorate of 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' incorporates only '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
RRR	Rights, Respect and Responsibilities. A six-week course delivered by Himmat, a commissioned service, which focuses on identify and society
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)
SALT	Speech and language therapy
YJB	Youth Justice Board: Government body responsible for monitoring and advising ministers on the effectiveness of the youth justice system. Provider of grants and guidance to the YOTs
YOT/YOS	Youth offending team/youth offending service. YOT 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), 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 that it achieves the primary aim of preventing offending by children and young people
Youth caution	A caution accepted by a child following admission to an offence where it is not considered to be in the public interest to prosecute the offender
Youth conditional caution	As for a youth caution, but with conditions attached that the child is required to comply with for up to the next three months. Non-compliance may result in the child being prosecuted for the original offence
Youth rehabilitation order	Overarching community sentence to which the court applies requirements (e.g. supervision requirement, unpaid work)



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