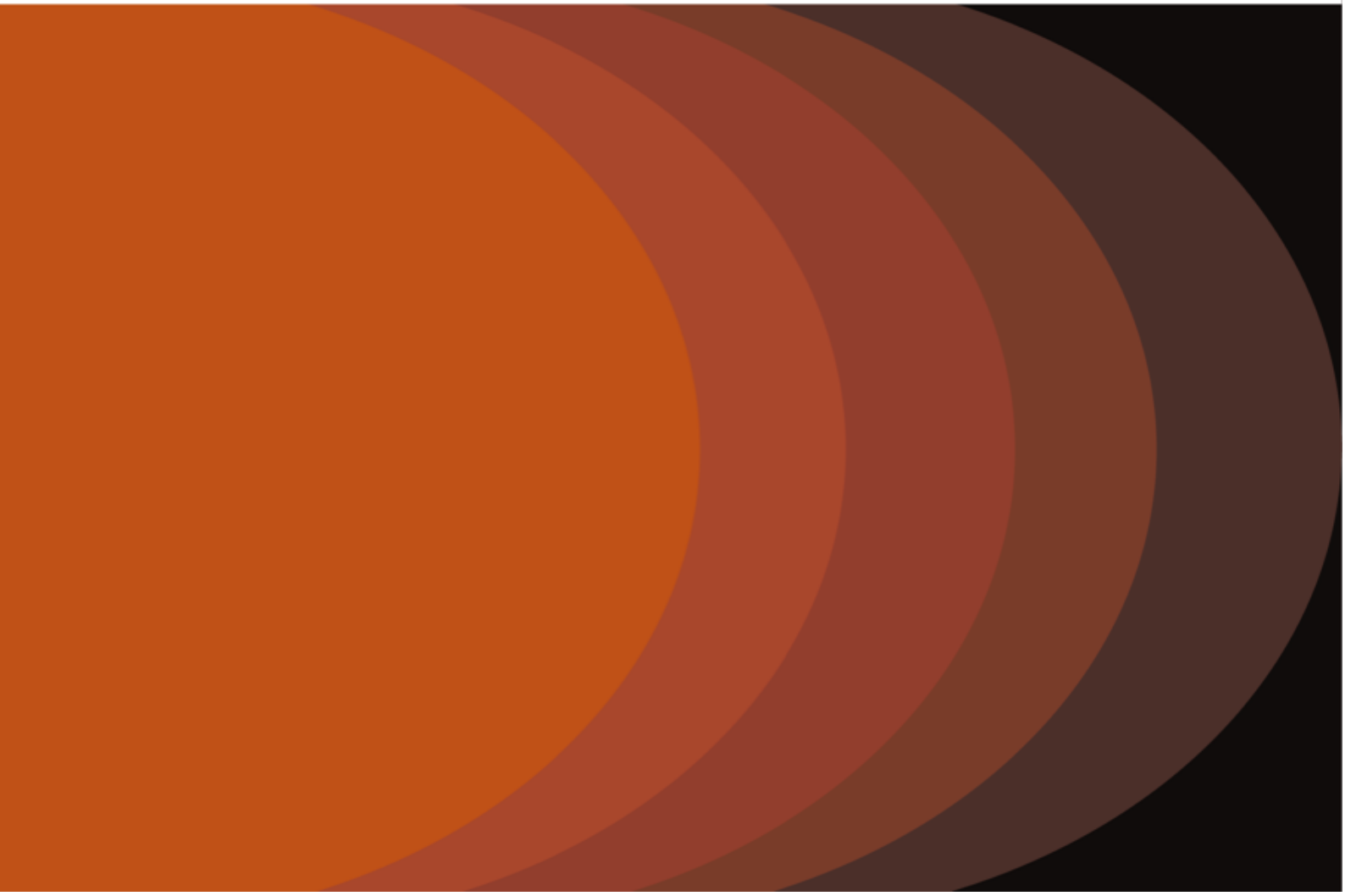
Her Majesty's Inspectorate of Probation

An inspection of youth offending services in

# Cardiff

HM Inspectorate of Probation, July 2020



**Acknowledgements**

This inspection which was undertaken in January 2020 was led by HM Inspector Mike Lane, supported by a team of inspectors and colleagues from across the Inspectorate. HMI Probation was joined by colleague inspectors: Andy Reed (HMICFRS); Bobbie Jones (Care Inspectorate Wales); Alun Connick and Sion Peters-Flynn (Estyn); Tom Stephenson (Healthcare Inspectorate Wales) and Tony Bunday (CQC). 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.

**The role of HM Inspectorate of Probation**

Her Majesty's Inspectorate of Probation is the independent inspector of youth offending and probation services in England and Wales. We report on the effectiveness of probation and youth offending service work with adults and children.

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

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 four-year programme of youth offending service (YOS) inspections. We have inspected and rated Cardiff YOS across three broad areas: the arrangements for organisational delivery of the service, the quality of work done with children sentenced by the courts, and the quality of out-of-court disposal work. Overall, Cardiff YOS was rated as 'Inadequate'.

The YOS's governance and leadership, staffing, partnership and services, and information and facilities all failed to meet an acceptable standard. We, therefore, have serious concerns about the effectiveness of organisational delivery in Cardiff YOS.

The YOS's structure did not enable it to provide a quality service. There was limited understanding of the challenges facing children supervised by the YOS. Children's needs were not being addressed, and children were unable to access some services in a timely way or at all. Board members were not effective in holding the YOS or its partners to account and did not set strategic direction or priorities for the YOS. Mitigating actions or improvements that leaders had sought to make had not shown sufficient impact.

The disappointing results for governance and leadership were mirrored in our ratings for post-court and out-of-court disposal work. Across the board, the quality of assessments and planning, implementation and delivery of services and reviewing the progress of cases was poor.

In part, the poor quality of practice was caused by ineffective management supervision of cases, and there were too few operational managers in the YOS to provide consistent support and direction for case managers and other staff. The YOS needs to build in greater management capacity to ensure that there is regular and rigorous oversight of the work that will lead to improved outcomes for the children it supervises.

The findings from this inspection are very disappointing. However, the actions taken since the inspection by senior managers in Cardiff encourage us to believe that they will act on our recommendations to improve the service, but there is a great deal of work to do. We, and our partner inspectorates, will closely monitor their progress to ensure they implement the recommendations in this report.

**Justin Russell**
Chief Inspector of Probation

## Ratings

| Cardiff Youth Offending Service | | Score | 0/36 |
|---|---|---|---|
| **Overall rating** | | **Inadequate** |  |
| **1.** | **Organisational delivery** | | |
| 1.1 | Governance and leadership | **Inadequate** |  |
| 1.2 | Staff | **Inadequate** |  |
| 1.3 | Partnerships and services | **Inadequate** |  |
| 1.4 | Information and facilities | **Inadequate** |  |
| **2.** | **Court disposals** | | |
| 2.1 | Assessment | **Inadequate** |  |
| 2.2 | Planning | **Inadequate** |  |
| 2.3 | Implementation and delivery | **Inadequate** |  |
| 2.4 | Reviewing | **Inadequate** |  |
| **3.** | **Out-of-court disposals** | | |
| 3.1 | Assessment | **Inadequate** |  |
| 3.2 | Planning | **Inadequate** |  |
| 3.3 | Implementation and delivery | **Inadequate** |  |
| 3.4 | Joint working | **Inadequate** |  |

# Executive summary

Overall, Cardiff YOS is rated as: **Inadequate**. This rating has been determined by inspecting the YOS in three areas of its work, referred to as 'domains'. We inspect against 12 'standards', shared between the domains. The standards are based on established models and frameworks, which are grounded in evidence, learning and experience. They are designed to drive improvements in the quality of work with children who have offended.[1] Published scoring rules generate the overall YOS rating.[2] The findings and subsequent ratings in those domains are described below.

## 1. Organisational delivery

We have rated organisational delivery as 'Inadequate'. At the time this inspection was undertaken in January 2020, the YOS's arrangements for governance and leadership, staffing, partnership and services, and information and facilities all failed to meet our required standards.

The vision and strategy for the YOS were unclear. The YOS Management Board and leadership had commissioned a process review and undertaken a self-effectiveness review in summer 2019, but there was little evidence of the impact of this work. Staff and key stakeholders were not aware of developments or did not understand them. There was no effective system for identifying, capturing and managing issues and risks, and there was minimal evidence that learning and evidence from previous inspections and audits had been used to drive improvement. Mitigating actions or improvements that leaders had sought to make had not shown sufficient impact. Consequently, leaders were not doing enough to address poor delivery of services.

The YOS's structure did not enable it to provide a quality service. Frameworks and guidance were not sufficiently developed. There were outdated policies and procedures; a lack of adequate management capacity; an absence of effective systems and processes for management oversight of both risk of harm to others and safety and wellbeing; poor quality of staff induction and supervision; and gaps in training.

There was limited understanding of the needs of children within the complex YOS cohort. Profiling lacked sophistication and information was not used sufficiently well. Children's needs were not being addressed, and they were unable to access some services in a timely way or at all.

We interviewed the YOS Manager and the Chair of the Management Board. We held meetings with other members of the board, staff and key stakeholders. Inspectors from the police and health, education and social services were part of our inspection team. They followed up issues that had emerged from the case inspections and interviewed senior leaders and staff across the YOS partnership.

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

[2] Each of the 12 standards is scored on a 0–3 scale in which 'Inadequate' = 0; 'Requires improvement' = 1; 'Good' = 2; 'Outstanding' = 3. Adding these scores produces a total score ranging from 0–36, which is banded to produce the overall rating, as follows: 0–6 = 'Inadequate', 7–18 = 'Requires improvement', 19–30 = 'Good', 31–36 = 'Outstanding'.

Our key findings about organisational delivery are as follows:

- Partnership agencies' attendance at YOS Management Board meetings was good.
- The YOS was well served by a dedicated information officer, who can extract various performance and monitoring reports from the case management system.
- Staff were working hard and were motivated to meet the needs of the children they supervise, despite the lack of strategic management, structures and processes to support their work.
- The Chief Executive Officer of the local authority has said he will make resources available to ensure progress is made to meet our recommendations.

But:

- Board members did not understand their role and responsibilities, were not sufficiently senior, and did not advocate effectively for the children in the YOS cohort.
- Although attendance at meetings was good, Board members were not effective in holding the YOS or its partners to account and did not set strategic direction or priorities for the YOS.
- There were some concerns regarding communication between agencies across the partnership in their safeguarding and public protection practice, in relation to three specific cases, which led to HM Inspectorate of Probation issuing an organisational alert.
- The YOS Management Board had failed to act swiftly and sufficiently on recommendations from previous inspection and audits.
- There were serious gaps in service provision, particularly health and education services.
- Policies, procedures and guidance were not up to date, which left staff without an effective framework to understand and deliver good-quality practice.
- Managers' oversight of cases was poor, and senior leaders had no clear line of sight to practice.
- Performance information was not used to drive improvement, evidenced by a lack of communication with staff and stakeholders about the findings of internal and externally commissioned audits.
- There was inadequate workforce planning, insufficient training and no proper induction for new staff.

## 2. Court disposals

We took a detailed look at 16 community sentences and 2 custodial sentences managed by the YOS. We also conducted 18 interviews with the relevant case managers. We examined the quality of assessment; planning; implementation and delivery; and reviewing. Each of these elements was inspected in respect of work done to address desistance, and the safety and wellbeing of the child. For the 18

cases where there were factors related to harm,[3] we also inspected work done to keep other people safe. In the 18 cases where there were factors related to safety and wellbeing, we looked at work done to keep the child safe. The quality of work undertaken in relation to each element of case supervision needs to be above a specific threshold for it to be rated as satisfactory.

Fewer than 50 per cent of cases met all our requirements in terms of assessment, planning, delivery and implementation, and reviewing. This led to our judgement of 'Inadequate' for those elements of work. Of particular concern was the quality of assessment for both desistance and safety and wellbeing (33 per cent) and the inadequacy of planning for safety and wellbeing and for risk of harm to others (just 11 per cent and 17 per cent respectively). Reviewing of cases was also extremely poor; only 33 per cent of reviews met our standards for desistance and 22 per cent met them for safety and wellbeing. The quality of reviewing of risk of harm was also very poor, with only 14 per cent meeting our requirements for this standard.

In terms of the quality of implementation and delivery of supervision plans, 75 per cent of the cases inspected met our standards for work to address desistance. However, only 44 per cent met the standard for work to address safety and wellbeing, and 39 per cent met the standard to address risk of harm. Because of the shortfalls in the implementation and delivery of safeguarding and public protection work, the ratings panel judged that there were no grounds for exercising professional discretion about the overall rating, which remained as 'Inadequate'.

Our key findings about court disposals are as follows:

- Implementation and delivery of services effectively supported the child's desistance.
- Staff focused on maintaining an effective working relationship with the child and their parents/carers.
- Planning was proportionate to the court outcome, with interventions capable of being delivered within an appropriate timescale.
- When services were delivered, they were those most likely to support desistance. Staff paid sufficient attention to sequencing and the available timescales.

But:

- The quality of assessment in relation to children's desistance, safety and wellbeing and risk of harm to others was inadequate.
- The quality of planning to address safety and wellbeing and risk of harm to others was poor.
- Assessment and planning to address the needs and wishes of victims were inadequate.
- Implementation and delivery of work concerning safeguarding and public protection were insufficient.
- There were serious shortfalls in all aspects of case managers' reviewing practice.

[3] The number of cases quoted here that relate to harm, or safety and well-being, is based on the inspectors' rather than the YOS's judgement.

- Management oversight of post-court cases was extremely poor.
- Assessment and planning to address the needs and wishes of victims were inadequate.

## 3. Out-of-court disposals

We inspected 11 cases managed by the YOS that had received an out-of-court disposal (OOCD). These consisted of three youth conditional cautions, two youth cautions, and six community resolutions. We interviewed the case managers in 10 cases.

We examined the quality of assessment, planning, and implementation and delivery of services. We inspected each of these elements in respect of work done to address desistance. For the seven cases where there were factors related to harm,[4] we also inspected work done to keep other people safe. In the eight cases where there were relevant factors, we looked at work done to ensure the safety and wellbeing of the child. We also looked at the quality of joint working with local police. The quality of work undertaken in relation to each element of case supervision needs to be above a specific threshold for it to be rated as satisfactory.

In this YOS, fewer than 50 per cent of cases met all our requirements in terms of assessment, planning, and implementation and delivery. This led to our judgements of 'Inadequate' for those elements of work. Although assessment and planning for desistance were strong (82 per cent and 73 per cent respectively), this was not the case in relation to both safety and wellbeing and risk of harm to others. Assessment met our standards in just 18 per cent of cases for safety and wellbeing, with only 27 per cent of cases being sufficient for risk of harm. There were serious shortfalls in the quality of planning for safety and wellbeing, with none of the eight relevant cases meeting our required standards. In terms of the quality of implementation and delivery of plans to work with these children, the work to address desistance, safeguarding and public protection was inadequate, meeting our standards in just 45 per cent, 14 per cent and 29 per cent of cases respectively.

For joint working with other agencies, while two-thirds of cases met the standard for joint work with the police, only 45 per cent of the cases met our standards for YOS recommendations to be sufficiently well-informed, analytical and personalised to the child. Evidence across domain one revealed shortfalls in the delivery of the OOCD panel and a lack of a suitable framework, procedures and guidance to support quality work with this type of case. Therefore, our judgement for this aspect of work was 'Inadequate'.

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

- Assessment of desistance in OOCD cases was outstanding.
- Planning for desistance was good.
- Staff focused sufficiently on developing and maintaining an effective working relationship with the child and their parents/carers.
- Assessments were strengths-based in that they considered the child's maturity, capacity to change and diversity, and were proportionate to the disposal type.

[4] See footnote 3.

But:

- There were serious shortfalls in the quality of assessment and planning for a child's safety and wellbeing and risk of harm to others.
- Implementation and delivery of work to address desistance, safety and wellbeing and risk of harm to others were inadequate.
- Management oversight of OOCDs was poor.
- There was no service level agreement between the YOS and Media Academy Cardiff; this meant the YOS did not effectively monitor and evaluate the commissioned arrangements for delivering some OOCDs.
- Their framework for delivery of OOCDs was underdeveloped and there was a lack of protocols and guidance for key stakeholders within the partnership.
- Inspectors observed the panel and found that it reviewed many cases where the OCCD decision had already been made, and for these cases it was therefore more of a case management forum than the decision-making body it should be.
- The rationale for joint decision-making in OOCD cases was not recorded clearly.

# Recommendations

As a result of our inspection findings, we have made 14 recommendations that we believe, if implemented, will have a positive impact on the quality of youth offending services in Cardiff. This will improve the lives of the children in contact with youth offending services, and better protect the public.

**The Cardiff Youth Offending Service Management Board should:**

1. ensure it sets the strategic direction for the YOS by having a clear vision that is communicated to staff and key stakeholders

2. review its membership, role and function to make sure that its representatives have the seniority to make decisions and commit necessary resources to the YOS

3. make sure that all members of the YOS partnership and other partner agencies provide appropriate support and services

4. develop members' knowledge and understanding of their role as Board members and the service's work and provide effective challenge to partners

5. provide the management team with the necessary resources and support to manage the service effectively

6. develop robust plans to drive service improvement in response to findings from audits and inspections and communicate these more effectively to staff.

**The Cardiff YOS Manager should:**

7. ensure that all staff have appropriate induction, training, supervision and management oversight of their work

8. establish a service level agreement, protocols, performance frameworks and guidance in relation to commissioned services for out-of-court disposal work

9. review the management structure, communication and lines of accountability to ensure that the quality of safeguarding and public protection work improves

10. develop and update policies, procedures and guidance that will enable all staff to deliver quality work

11. have oversight of all YOS cases where there are safeguarding and public protection issues, making sure that appropriate referrals are made, and joint work takes place as needed.

**Local authority education services should:**

12. develop effective strategies to encourage children who speak Welsh to access services in their preferred language, and to use, develop and recognise the value of the language as an employment skill.

**Cardiff and Vale Health Board should:**

13. ensure that its statutory duty to provide relevant and timely physical, sexual, emotional and mental health services to YOS children is fulfilled.

**South Wales Police should:**

14. ensure that Public Protection Notice (PPN) forms on YOS children are consistently completed by frontline police officers.

# Background

Youth Offending Teams (YOTs) supervise 10–18-year-olds who have been sentenced by a court, or who have come to the attention of the police because of their offending behaviour but have not been charged – instead, they were dealt with out-of-court. HM Inspectorate of Probation inspects both these aspects of youth offending services.

YOTs are statutory partnerships, and they are multi-disciplinary, to deal with the needs of the whole child. They are required to have staff from local authority social care and education services, the police, the National Probation Service and local health services.[5] Most YOTs are based within local authorities; however, this can vary.

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

Cardiff is the largest local authority in Wales. It has also experienced the largest population growth in Wales over the last decade and is projected to grow far faster than any other Welsh local authority. Over the next 20 years, in absolute numbers, Cardiff's population is projected to grow more than the rest of Wales combined.

Cardiff has a population of over 360,000 of which 30,714 are aged 10 to 17 (8.4 per cent of the total). Between 2006 and 2016, its population grew by 11.6 per cent. This growth trend is set to continue, with projected growth of just over 20 per cent between 2016 and 2036. Cardiff is also by far the most ethnically diverse local authority in Wales: about a fifth of its population is from an ethnic minority, and over 100 languages are spoken in the city. A third of school children are from an ethnic minority. The current unemployment rate (6.1 per cent) is the second highest across Wales and exceeds both the Welsh and British rates.

Cardiff is one of five cities in the UK to be developing, in partnership with UNICEF UK, as a 'child-friendly city'. This means there is an aspiration to place the rights of children at the heart of its policies and strategies, and to involve children in decision-making and commit to addressing barriers that limit their lives.

Cardiff YOS is located within the local authority's Children's Services Directorate. Of the YOS cohort, 88 per cent are male, 78 per cent are aged over 14, and 24 per cent are black and minority ethnic. In 2018/2019, the most prevalent offence type in the Cardiff YOS caseload was violence against the person, followed by theft and handling stolen goods. The YOS partnership noted that offences related to drugs had also increased. First-time entry and re-offending rates for young people in Cardiff are both higher than the England and Wales average.

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

# Contextual facts

| | |
|---|---|
| **241** | First-time entrant rate per 100,000 in Cardiff[6] |
| **197** | First-time entrant rate per 100,000 in Wales |
| **222** | First-time entrant rate per 100,000 in England and Wales |
| **54.4%** | Reoffending rate in Cardiff[7] |
| **38.4%** | Reoffending rate in England and Wales |

**Population information[8]**

| | |
|---|---|
| **364,248** | Total population Cardiff |
| **30,714** | Total youth population (10–17 years) in Cardiff |
| **6,220** | Total black and minority ethnic youth population in Cardiff (Census 2011) |

**Caseload information[9]**

| **Age** | **10–14** | **15–17** |
|---|---|---|
| Cardiff YOS | 22% | 78% |
| National average | 23% | 77% |

| **Race/ethnicity** | **White** | **Black and minority ethnic** | **Unknown** |
|---|---|---|---|
| Cardiff YOS | 69% | 24% | 7% |
| National average | 70% | 26% | 4% |

| **Gender** | **Male** | **Female** |
|---|---|---|
| Cardiff YOS | 88% | 12% |
| National average | 85% | 15% |

[6] Youth Justice Board. (2019). *First Time Entrants, April to March 2019.*

[7] Ministry of Justice. (2019). *Proven reoffending statistics, April 2017 to March 2018.*

[8] Office for National Statistics. (2019). *UK population estimates, mid-2018.*

[9] Youth Justice Board. (2020). *Youth Justice annual statistics: 2018 to 2019.*

**Additional caseload data**[10]

| | |
|---|---|
| **119** | **Total current caseload, of which:** |
| **52 (44%)** | court disposals |
| **67 (56%)** | out-of-court disposals |

**Of the 52 court disposals**

| | |
|---|---|
| **46 (88%)** | Total current caseload on community sentences |
| **4 (8%)** | Total current caseload in custody |
| **2 (4%)** | Total current caseload on licence |

**Of the 67 out-of-court disposals**

| | |
|---|---|
| **5 (7%)** | Total current caseload with youth caution |
| **10 (15%)** | Total current caseload with youth conditional caution |
| **52 (78%)** | Total current caseload: community resolution or other out-of-court disposal |

**Education and child protection status of caseload**

| | |
|---|---|
| **7%** | Current caseload 'Looked After Children' resident in the YOT area |
| **2%** | Current caseload 'Looked After Children' placed outside the YOT area |
| **5%** | Current caseload with child protection plan |
| **19%** | Current caseload with child in need plan |
| **5.35%** | Current caseload aged 16 and under not in school/pupil referral unit/alternative education |
| **21.40%** | Current caseload aged 16 and under in a pupil referral unit or alternative education |
| **17%** | Current caseload aged 17+ not in education, training or employment |

**For children in the YOS cohort subject to court disposals:**

| Offence types[11] | % |
|---|---|
| Violence against the person | 50% |
| Burglary | 11% |
| Robbery | 6% |
| Theft and handling stolen goods | 17% |
| Summary motoring offences | 6% |
| Other summary offences | 11% |

[10] Data supplied by the YOT, reflecting the caseload at the time of the inspection announcement.

[11] Data from the cases assessed during this inspection.

# 1. Organisational delivery

The vision and strategy for the YOS were unclear. The YOS Management Board and leadership had commissioned a process review and undertaken a self-effectiveness review in summer 2019, but there was little evidence of the impact of this work. Staff and key stakeholders were not aware of developments or did not understand them. There was no effective system for identifying, capturing and managing issues and risks. Mitigating actions or improvements that leaders had sought to make had not shown sufficient impact. Consequently, leaders were not doing enough to address poor delivery of services.

There was no clear escalation policy or processes to remove barriers to effective joint working at operational and senior levels. Lessons to be learned and good practice were rarely identified through feedback from other stakeholders, and there were limited discussions about performance with partners and other providers. There is minimal evidence of learning and evidence being used to drive improvement, and action to improve services is not taken when it is required.

The YOS Management Board included all statutory and non-statutory partners, but the Board has too many members, and the majority lacked the seniority or authority to make decisions or commit resources. The participation and contribution of all partners was inconsistent and insufficiently focused on YOS business. Partners did not understand or recognise their own agency's statutory responsibilities and the contribution they should make to the YOS.

The YOS's structure does not enable it to provide a quality service. Frameworks and guidance were not sufficiently developed. There were outdated policies and procedures; a lack of adequate management capacity; and an absence of effective systems and processes for management oversight of both risk of harm to others and safety and wellbeing. Arrangements for staff induction and training were poor, as was the quality of supervision.

The workforce lacked the range of skills, knowledge and expertise required to deliver a high-quality service, and this was not being addressed. There were low levels of staff satisfaction and morale, alongside high levels of anxiety and uncertainty. The culture is one in which staff are not equipped to fulfil their responsibilities or held accountable for their work. Meetings with staff were irregular and there was a lack of quality supervision, guidance and support.

There was limited understanding of the needs of the children supervised by the YOS. Profiling lacked sophistication and information was not used sufficiently well. Children's needs were not being addressed, and they were unable to access some services in a timely way or at all. There was minimal quality assurance or evaluation of the services delivered. Consequently, leaders and managers did not adequately monitor the quality of provision and address shortfalls or deteriorations in services or outcomes achieved by children known to the YOS.

**Strengths:**

- Partnership agencies' attendance at YOS Management Board meetings was good.
- The YOS was well served by a dedicated information officer, who can extract various performance and monitoring reports from the case management system.
- Staff were working hard and were motivated to meet the needs of the children they supervise, despite the lack of strategic management, structures and processes to support their work.
- The Chief Executive Officer of the local authority has said he will make resources available to ensure progress is made to meet our recommendations.

**Areas for improvement:**

- Board members did not understand their role and responsibilities, were not sufficiently senior, and did not advocate effectively for the children in the YOS cohort.
- Although attendance at meetings was good, Board members were not effective in holding the YOS or its partners to account and did not set strategic direction or priorities for the YOS.
- There were some concerns regarding communication between agencies across the partnership in their safeguarding and public protection practice, in relation to three specific cases, which led to HMI Probation issuing an organisational alert.
- The YOS Management Board had failed to act swiftly and sufficiently on recommendations from the previous inspection and audits.
- There were serious gaps in service provision, particularly health and education services.
- Policies, procedures and guidance were not up to date, which left staff without an effective framework to understand and deliver good-quality practice.
- Managers' oversight of cases was poor, and senior leaders had no clear line of sight to practice.
- Performance information was not used to drive improvement, evidenced by a lack of communication with staff and stakeholders about the findings of internal and externally commissioned audits.
- There was inadequate workforce planning, insufficient training and no proper induction for new staff.

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

### 1.1. Governance and leadership

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

**Key data**[12]

| | |
|---|---|
| Total spend in previous financial year (2018/2019) | £1,957,105 |
| Total projected budget for the current financial year (2019/2020) | £1,932,140 |

In making a judgement about governance and leadership, we take into account the answers to the following three questions:

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

Inspectors found no clear strategy to set the direction of the YOS. The evidence base used to monitor the quality of the services delivered was inadequate. Strategic leaders and senior officers had recognised that links between the YOS and wider children's services were ineffective. In response, they stated their intention to improve outcomes for children by establishing an adolescent service, which would incorporate both the YOS and wider care and support services for children. They intended to achieve this through delivery of the children's services strategy.

To date, delivery of the children's services strategy has focused primarily on building resilience within the newly established operational management tier and restructuring the main body of children's services into locality teams. Work to establish the adolescent service had not yet progressed beyond appointing an operational manager in September 2019 to replace the interim post-holder who had held this position since July 2018. Arrangements to further implement this service were underdeveloped, leaving YOS staff feeling marginalised. Although leaders recognise the potential long-term benefits of locating the YOS within a broader adolescent service, they are unlikely to realise these benefits without a clear timescale, strategy and implementation plan.

We were not confident that the YOS had accurate assessments or sufficiently robust plans to address and manage the safety and wellbeing and risk of harm issues of the children in the YOS caseload. There were some concerns regarding communication between agencies across the partnership in their safeguarding and public protection practice, in relation to three specific cases, which led to HMI Probation issuing an organisational alert during week one of fieldwork. The immediate response from the Board assured the Inspectorate that all appropriate safeguarding and public protection processes were in place. However, there had been a failure to interrogate

[12] Data supplied by YOS, based on finances at the time of the inspection announcement.

the different IT systems or share case information between relevant partners. This had an adverse effect on the quality of decision-making.

The YOS Management Board includes all statutory and non-statutory partners, such as the Police and Crime Commissioner, Careers Wales, lead member and courts. However, the Board membership is too large, and many Board members lack the seniority or authority to make decisions or commit resources. Agendas are too full, and this distracts from the specific focus needed for the YOS.

There are no clear processes and actions in place for induction or ongoing training of Board members. The draft induction document is from a neighbouring YOS and still refers to that YOS and its Board members, rather than Cardiff. The existing Board membership terms of reference had not been refreshed or revised since 2016 (despite numerous discussions at Board level since March 2019). In June 2019, the YOS Management Board received an input from YJB Cymru on effective governance. This led to a self-assessment exercise with Board members, which demonstrated the knowledge gap of the Board. However, there had been insufficient progress to address the shortfalls at the time of our inspection.

Although the attendance of Board members is good, meetings lack structure and partners' participation and contributions are inconsistent and do not focus sufficiently on YOS business. Partners do not understand or recognise their own agency's statutory responsibilities and contribution to the YOS. The Chair of the YOS Board was appointed in June 2019, and, although engaged, she is still learning about youth justice, the function of the Board, the quality of provision, and statutory partners' responsibilities, and gaining a full understanding of the YOS's work.

The YOS Management Board said that the partnership was 'on a journey', but the inspection team judged that some members were too optimistic about the progress that had been made in recent months, particularly given the findings of the independent audit by the Silver Bullet consultancy (commissioned in July 2019) and the current inspection ratings. Inspectors found that strategic leaders within the YOS partnership had not taken sufficient action in response to the findings of the Silver Bullet audit, which highlighted serious shortfalls in safeguarding and public protection work within the YOS. The local authority CEO accepted that they should have produced a coordinated response and plan more swiftly, given the findings on poor case management practice. Inspectors noted that this report was not shared with staff, and that the action plan was not robust and lacked detail about who 'owned' and was responsible for actions.

**Do the partnership arrangements actively support effective service delivery?**

There is no consistent advocacy by YOS Board members within their broader roles. Board members should also do more to commit the full range of resources to enable effective service delivery to YOS children**.** This has led to gaps in service provision and a lack of understanding of the specific needs of the children within the YOS caseload. There is an absence of clear structures, frameworks, policies and pathways to address the risks and needs of children, together with an inability to remove key barriers to the YOS cohort accessing some services.

The YOS has gaps in statutory provision in health and education. Their healthcare post has been vacant for over 18 months, and necessary action to fill the vacancy had been delayed. The YOS and Cardiff and Vale University Health Board (the body responsible for health provision to the service) both acknowledged this and were reviewing the provision to identify what will meet the needs of the YOS. The YOS education, training and employment (ETE) worker had been on maternity leave for around six months before the inspection. The service had failed to provide cover for this post. This has resulted in a lack of communication between the YOS and

education providers and has reduced the service's ability to ensure that learners receive the assessment they need to best plan their future. Overall, inspectors found the YOS's joint working with wider social care was poor.

The YOS partnership did not utilise sufficiently the National Referral Mechanism for protecting children being groomed by adults to take part in 'county lines' drug supply activity. This led to a need to grow knowledge and expertise from the ground up in the absence of robust guidance and management oversight. The consequence of this was that some children were not receiving the right support to keep themselves safe, meet their wellbeing needs or lessen risk to others.

It was further evident from the cases inspected that there was a limited shared understanding of the prevalence and seriousness of criminal exploitation. YOS staff were particularly frustrated by the failure of children's services managers, staff and other partners to fully recognise the extent of child criminal exploitation and its impact on many of those they worked with. Senior managers acknowledged this deficit. However, a partnership approach to improving the quality of work in this area was still some way off, given that the draft child exploitation strategy was not due to be ratified by the partnership until April 2020.

YOS staff broadly welcomed the introduction of the adolescent service and expressed confidence in their newly appointed operational manager. However, they felt that insufficient attention had been paid to addressing 'silo' working and, in particular, poor information-sharing between the YOS and the children's services multi-agency safeguarding hub.

YOS staff reported that they did not feel valued and that other agencies perceived them to be a separate 'stand-alone' service. While staff and managers from wider children's services clearly valued the specialist expertise held by YOS workers, they also reported a widespread separation in terms of service delivery between the YOS and the remainder of children's services.

Although there was a long-standing commissioned arrangement with Media Academy Cardiff (MAC) to deliver some OOCD interventions, there was no service level agreement to effectively measure performance or outcomes against the service specification.

The Junior Attendance Centre (JAC) has been suspended since September 2019, following issues with staff conduct and health and safety. There were no policies and protocols in place in relation to the JAC and, before the suspension, there was a lack of governance of those arrangements.

Lines of accountability to other strategic boards are confusing and require urgent review. The Deputy Chair of the YOS Board has directed YOS business to the Community Safety Board and views this as the preferred escalation route. However, this doesn't enable the direct access needed to the local authority CEO and the CEOs of the statutory partners (especially considering the serious communication failures in relation to safeguarding and public protection within the YOS cohort).

Inspectors saw no adequate plans or clear accountability for progress against recommendations made after the previous HMIP inspection, in 2016. This inspection highlighted the need for improvement in the governance of the YOS, and in planning and review of work to manage both risk of harm to others and vulnerability (now known as 'safety and wellbeing') and management oversight of practice around public protection and safeguarding.

**Does the leadership of the YOT support effective service delivery?**

The YOS leadership team did not provide an effective link to the Management Board. There have been changes to the governance arrangements for the Board since 2016, which have led to a lack of communication between the YOS leadership team and senior leaders across the partnership. Within this period, the YOS operational manager post has been held by three people. These changes have largely been reactive, driven by wider issues within children's services and the local authority. As a result, the knowledge of youth justice at this management level has been limited.

The Management Board does not have a sufficient line of sight to practice. However, it has recently established a pattern of themed staff presentations to Board meetings, as one element of engaging with practice. Where audits have revealed areas of concern, the Board has not responded quickly enough to address the issues identified. There is a lack of strategic and operational assessment of business risk.

Since 2016, the removal of three management posts within the YOS team, without sufficient thought to the consequences of this, has resulted in two team managers being given responsibilities and duties far beyond their grade and job descriptions. Most notably, the escalation process for concerns about education, health or other provision has been ineffective, resulting in health and education partners failing to fulfil their statutory duty to the YOS. There has also been a failure to respond to escalations and long-standing concerns (about staffing levels, workload, barriers to partnership working, gaps in services and risks to the service) that have been raised repeatedly by team managers.

The Management Board had not seen, or signed off, key policy documents about safeguarding and risk management of the YOS cohort. The Board had also not had sight of internal individual management reviews (IMRs) on three recent YOS cases where there had been serious incidents in the last 12 months. The Board accepted this as a failing. Despite requests from inspectors, these IMR documents were not provided to us during the inspection.

Although staff are motivated and committed to working and engaging with children on a day-to-day basis, their morale is low, due to the poor communication from leaders. Staff report that they do feel not listened to (93 per cent of respondents to the staff survey said that their views about working for the YOS are not sought). Although in recent months the Board has received topic-based presentations from some practitioners, the staff survey indicated that 79 per cent of YOS staff were unaware of the activities of the YOS Management Board. There were high levels of staff sickness (810 days in total at the point of inspection – up from 630 days in the financial year 2018/2019). There was also a lack of resilience at all levels of the organisation in relation to cover arrangements for work and duties, which is a risk to service delivery.

The current YOS operational manager only took over responsibility for the YOS in September 2019. Her YOS responsibilities are part of her much wider portfolio within children's services, which includes Edge of Care, the Adolescent Resource Centre and Integrated Family Support Teams. The breadth of this portfolio is challenging, given the time needed to focus on the deficiencies of the YOS partnership at a strategic and operational level. This said, the YOS staff are positive about her vision for the future direction of the service, albeit a detailed plan is needed to achieve this. The YOS operational manager is also still learning about youth justice, the function of the Board, and statutory partners' responsibilities, and needs to gain a full understanding of the specialist nature of criminal justice work.

### 1.2. Staff

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

**Key staffing data**[13]

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| Total staff headcount (full-time equivalent, FTE) | 47 |
| Vacancy rate (total unfilled posts as percentage of total staff headcount) | 6.4% |
| Vacancy rate: case managers only (total unfilled case manager posts as percentage of total case manager headcount) | 3.2% |
| Average caseload: case managers (FTE) | 11[14] |
| Total annual sickness days (all staff) | 810 |
| Staff attrition (percentage of all staff leaving in 12-month period) | 15% |

In making a judgement about staffing, we take into account the answers to the following four questions:

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

There was no case allocation policy or process, which led to poorly thought out allocation of cases and no clear mechanisms for reviewing changing demands or case profiles. The workloads of different members of staff vary, and there was no workload management strategy. Managers did not have the capacity to prioritise work effectively, specifically in relation to safeguarding, public protection, staff supervision and quality assurance. The YOS lacked a robust quality assurance framework.

Team managers' spans of control were too wide, and their numbers of direct reports too high. The impact of this was evident in the poor management oversight of practice. In the domain two cases we inspected, we judged 94 per cent of management oversight insufficient, and in the domain three cases, 78 per cent of management oversight was insufficient.

The YOS held some staff vacancies, including a victim officer post, a YOT case manager post, anti-social behaviour case manager posts and an administration post. It was unclear whether and when these posts were to be filled.

[13] Data is supplied by YOS and reflects staffing at the time of the inspection announcement (December 2019)

[14] Data supplied by YOS, based on staffing and workload at the time of the inspection announcement.

**Do the skills of YOT staff support the delivery of a high-quality, personalised and responsive service for all children?**

There was a lack of ethnic diversity among the staff, which did not reflect the characteristics of the children supervised by the YOS. The staff survey indicated that seven per cent of respondents were BAME, compared with the YOS caseload of 24 per cent BAME.

There is a pool of staff within the YOS who are suitably qualified and experienced. However, the majority of staff have not had specific youth justice training in aspects of practice such as assessing and managing risk of harm and promoting desistance. We were concerned to find that some staff had not received adequate AssetPlus training and did not understand how to use this key assessment tool. These issues were highlighted in the Silver Bullet consultancy report dated July 2019, and no action had been taken (nor had the report been shared with staff).

The lack of clarity around expectations, guidance and direction of the service has impacted on staff morale. Many staff reported feeling anxious and uncertain about the future direction of the service. Inspectors found minimal processes in place for eliciting staff feedback via surveys or regular structured team meetings. Although staff were cautiously optimistic about the new YOS operational manager, many were candid about the resourcing and partnership challenges (internally and externally) that they faced daily. Despite this, staff showed they were motivated to work with and engage with this difficult and complex group of children. We interviewed a small sample of five children, in a focus group. All were complimentary about how their case managers had engaged with them and strived to meet their needs and provide support.

The YOS police officers had not received formal training on their role, merely a hand-over from their predecessor. There was little guidance available to them other than the YJB guidance in relation to the role of a seconded officer. The officers lacked detailed knowledge of safeguarding, child sexual exploitation and Multi-Agency Public Protection Arrangements (MAPPA). They had only received limited training in these areas, although they had all undertaken adverse childhood experience training, delivered by the police force. This knowledge and skill base is essential to enable the officers to offer the appropriate guidance to case managers, contribute effectively to risk panel meetings, and provide the YOS with specialist support around safeguarding, for both the child and the public. They had not undertaken any joint training with the other YOS staff.

The service had employed several bilingual staff since the last inspection in 2016. There was a Welsh-speaking post within the administration team, specifically for reception and telephone duties. However, overall service arrangements to respond to the needs of Welsh speakers are not good enough. Where children could speak Welsh, the service did not link them systematically to a Welsh-speaking case worker. The availability of bilingual pro forma letters or learning/activity resources in Welsh was poor. Most signage or wall displays are only in English.

The YOS contains a committed group of volunteer staff. These are from various backgrounds, a mix of gender, age, ethnic origin and experience. Volunteers spoke positively about the training and support from the YOS. The range of activities volunteers were engaged in included referral order panel membership, providing appropriate adult support and neighbourhood resolution projects. The referral panel members understood their role and how they linked with case managers and other members of staff in the YOS.

The YOS had no strategy to identify staff potential and support succession planning. There was no evidence that staff are given 'acting up' opportunities or mentoring within the organisation.

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

Inspectors judged the quality of management oversight to be poor. Some staff lacked the skills to effectively assess and plan how to manage safety and wellbeing and risk of harm to others. However, these shortfalls were not adequately addressed or remedied through effective supervision by line managers. HMI Probation raised individual alerts on three cases during week one of fieldwork because of significant concerns about safeguarding practice in these cases.

Many staff said they had not received a proper induction or regular supervision. The supervision they did receive was not of sufficient quality and the records of such meetings were limited or not present. In the cases inspected during week one of fieldwork, 59 per cent of staff said management oversight was ineffective. HMIP inspectors judged management oversight to be ineffective in 94 per cent of post-court cases and 78 per cent of OOCD cases.

Until recently, YOS team managers had not received regular supervision. At one stage, they stated they had gone two months without any contact from the previous YOS operational manager. There is no policy for escalating concerns about the quality of case management or removing barriers to effective working, meaning that all the risk was held at team manager level within the YOS.

Staff from the two substance misuse partner organisations said that they received supervision from their partnership managers, but those managers said that they get limited or no information from YOS managers about the performance of their individual staff members.

In the staff survey, 44 per cent of staff said that their last appraisal was either overdue or had not been valuable. Team managers had not received an updated appraisal and objectives were simply cut and pasted from corporate objectives from the previous year. Staff reported that there are no mechanisms in place to recognise and reward achievement. Positive feedback is sporadic and not meaningful.

There was some response to staffing issues (such as the suspension of the Junior Attendance Centre, the replacing of the previous police officer and suspension of a YOS case manager), but these were when a crisis had emerged rather than a result of any forward planning or analysis of the needs of YOS children.

**Are arrangements for learning and development comprehensive and responsive?**

We found no workforce development analysis (skills audit) and subsequent training plan, other than a spreadsheet of attendance at training events. These events take place mainly online, through the council systems. Staff reported that they had received minimal AssetPlus training and inspectors found a clear need for basic assessment skills to be delivered to many staff. There is a lack of MAPPA training and only some staff are AIM2 trained. Further training in relation to criminal exploitation and risk of harm is also necessary.

Inspectors found (and staff reported) a lack of team meetings and poor communication within and across the organisation and partnership. There had been a failure to share findings from individual management reviews, the Silver Bullet consultancy audit and previous inspections, and there was no clear plan to review

different aspects of work. There is minimal evidence of a quality assurance framework and insufficient evidence of management feedback within case records.

### 1.3. Partnerships and services

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

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| Percentage of current caseload with mental health issues[15] | 34% |
| Percentage of current caseload with substance misuse issues | 62% |
| Percentage of current caseload with an education, health and care plan | 14% |

In making a judgement about partnerships and services, we take into account the answers to the following three questions:

**Is there a sufficiently comprehensive and up-to-date analysis of the profile of children, to ensure that the YOT can deliver well-targeted services?**

The YOS has not carried out a clear analysis of the profile of the YOS cohort, which is complex and includes children with multiple risks and needs. As a result, there are gaps in service provision and this impacts negatively on children in terms of their safeguarding, risk of harm to others and likelihood of reoffending.

The healthcare post had been vacant for over 18 months, and necessary action to fill the vacancy had been delayed. The YOS and Cardiff and Vale University Health Board (the body responsible for health provision to the service) both acknowledged this and were reviewing the provision to identify what will meet the needs of the YOS cohort.

YOS staff did not focus sufficiently on the important relationship between improving children's poor basic skills and reducing offending behaviour. There was no analysis of the literacy and numeracy skills of the children who are engaged with the service. Staff were not always clear to whom they could refer young people to help them improve their skills.

**Does the YOT partnership have access to the volume, range and quality of services and interventions to meet the needs of all children?**

The YOS is well supported by South Wales Police, with two full-time seconded police officers, and a third temporarily attached to the department. The officers are co-located in the YOS building but not in the general office, which hinders the free flow of soft intelligence and information. The officers were supervised by a police sergeant, who is also responsible for the integrated offender management (IOM) unit. In addition, there was support from the detective sergeant in the Management of Sexual and Violent Offenders (MOSOVO) team, who regularly attends the YOS to provide support and advice on safeguarding matters. Links were developing between the seconded police staff and the local policing team, encouraged by the YOS

[15] Data supplied by YOS, based on caseload issues at the time of the inspection announcement.

sergeant. Officers from within the unit were working closer with the organised crime unit and problem-solving teams around children at risk of county lines.

The YOS had no established referral pathway to speech and language therapy via a YOS health professional. Speech and language therapy could be accessed through the YOS education worker, but this post had not been covered since July 2019 due to maternity leave, which had left a gap in service provision.

Addressing harmful sexual behaviour can be a part of a sentence plan. Sexual health promotion was available via a referral to a specialist worker based at YOS, but this resource appeared limited and basic. This YOS staff member also promoted sexual health in schools through a healthy living initiative.

The lack of healthcare professionals among YOS staff has reduced the opportunity for YOS staff to be up-skilled in areas such as mental and emotional wellbeing. The lack of healthcare staff has also resulted in YOS staff becoming reliant on referring children to external services. In some cases, these children would not meet thresholds for more intensive and specialist services, but they still have an identified health need to be addressed.

The YOS ETE worker had been on maternity leave for around six months before the inspection. The service had failed to provide cover for this post, which had resulted in a gap in the YOS's communication with education providers and reduced the service's ability to ensure that learners receive the assessment they need to best plan their future. Information about the educational background and needs of children new to the YOS caseload and the educational progress of existing YOS children was not being gathered effectively to inform case workers' interventions.

The YOS has a full-time seconded probation officer, who is supervised by an NPS senior probation officer. There are quarterly three-way probation and YOS meetings with the YOS link team manager where cases due to transition to adult probation are discussed. The seconded YOS probation officer also attends probation team meetings to ensure that knowledge and information are shared. At the time of the inspection the YOS probation officer's workload was manageable and they received training from their home and host organisation.

**Are arrangements with statutory partners, providers and other agencies established, maintained and used effectively to deliver high-quality services?**

Partnership arrangements did not actively support effective service delivery or integration with wider services for children. YOS staff broadly welcomed the introduction of the adolescent service and expressed confidence in their newly appointed operational manager. However, they felt that insufficient attention had been paid to addressing 'silo' working and, in particular, poor information-sharing between the YOS and the children's services multi-agency safeguarding hub.

YOS staff reported that they did not feel valued and that other agencies perceived them to be a separate 'stand-alone' service. Similarly, while staff and managers from wider children's services clearly valued the specialist expertise held by YOS workers, they also reported a widespread separation in terms of service delivery between the YOS and the remainder of children's services.

YOS workers and other children's services teams did not understand each other's roles and responsibilities well enough. Some positive examples of working together were evident in respect of homelessness and preventive services. However, eligibility criteria for care and support were not understood or consistently applied, leading to a conflict in expectations between workers. This hindered effective communication and joint work to meet young people's needs, including their safeguarding needs.

Case planning forums (where children deemed the highest risk are discussed) were often ineffective in managing cases where there was a high risk of harm and safety and wellbeing needs. In many of the inspected cases, the right actions were not taken, barriers to effective partnership working were not removed and there was insufficient representation of key stakeholders (aside from YOS and the police) at the required decision-making level. Inspectors observed the planning forum meeting for a child who was due to be released from custody and noted that insufficient plans were made to effectively manage risk of harm to others and safety and wellbeing issues.

There are two substance misuse workers dedicated to the YOS from two partner agencies (Adferiad and CGL – Change Grow Live). One partner agency is funded by the local authority and one is funded by the health board. Both substance misuse workers are committed and enthusiastic about their roles, despite the significant leadership and management issues of the YOS. Both spoke positively about the support from their respective partnership manager, and both partnership managers praised the work of each individual substance misuse worker. However, neither of the YOS team managers could evidence that there was regular communication between the YOS and the partner agencies.

Inspectors judged that a range of appropriate substance misuse interventions, based on young people's individual needs, were provided through the partnership's input to the YOS. Indeed, it was evident that staff acted to address urgent health needs. However, there was a lack of resources at the YOS to help children access support for less acute health needs. The YOS did not have the capacity to fully assess children's health needs beyond the basic AssetPlus health screening tool, and there was a lack of established pathways to meet assessed needs.

The YOS has a strong partnership with Careers Wales. A Careers Wales manager attended YOS Board meetings regularly and supported the careers advisers employed within the YOS appropriately. Careers Wales ensured that its staff who were seconded to the YOS had good access to training opportunities.

The YOS worked with a wide range of partners to enable children to access learning opportunities. Partners included schools, key work-based learning providers, colleges, specialist learning providers and employers. The partnership also worke**d** with MAC (Media Academy Cardiff) to deliver some OOCDs. This enabled children to access further ETE courses, support or interventions – both during and beyond their YOS supervision. Staff liaised well with these providers to help children make effective transitions into ETE. Staff used opportunities well for children to have taster sessions before committing to further learning. The local authority's extension of Education Other Than At School (EOTAS) and flexible education provision has improved the range of options available to meet individual learners' needs within the YOS. However, case workers did not always understand the full range of provision available to YOS children.

There was no clear working protocol or agreed processes for the OOCD panel. Inspectors observed the panel and found that it reviewed many cases where the OCCD decision had already been made, and where the panel was therefore more of a case management forum. In some cases, there was evidence of a delay in the case being assessed and interventions being delivered.

### Involvement of children and their parents and carers

Senior leaders acknowledged that they need to undertake more work to ensure they are systematically engaging children and their parents or carers. Inspectors interviewed a small group of five children and, overall, these children felt that the YOS had been helpful. All of the children said that knife crime was a serious issue in Cardiff and getting worse, and that they knew people who had been stabbed. All the

group felt that the expectations of their interventions had been explained to them, and that staff treated them with respect. They all said that they could talk to their case managers and they felt listened to. One child said that it would be helpful if there were more locations to meet YOS staff, as they sometimes had to travel quite far.

Feedback from the children's text survey was more mixed. Some children were complimentary about the work undertaken by their case managers, while others highlighted travelling distance to the YOS and lack of resources as issues. In total, 16 surveys were sent before the inspection fieldwork began, and 6 completed responses were received.

### 1.4. Information and facilities

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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. | Inadequate |

In making a judgement about staffing, we take into account the answers to the following four questions:

**Are the necessary policies and guidance in place to enable staff to deliver a quality service, meeting the needs of all children?**

Numerous key policies and guidance were out of date and required review, especially those relating to the management of safety and wellbeing and risk of harm to others.

Many protocols were out of date and referred to legislation that is now obsolete (such as final warnings and reprimands). The court protocol had not been reviewed since 2016. The joint children's social care/YOS policy was dated 2011; the disciplinary policy was dated April 2016; and the capability policy was dated March 2014. None of these documents have been revisited or revised to reflect current YOS working practices and arrangements.

There were no clear protocols or frameworks and guidance to inform the delivery of OOCDs by key stakeholders within the partnership. There was no service level agreement between the YOS and Media Academy Cardiff. This means that the commissioned arrangements for delivering some OOCDs are not monitored and evaluated effectively.

**Does the YOT's delivery environment(s) meet the needs of all children and enable staff to deliver a quality service?**

The YOS is based solely at the John Kane Centre and staff from partner agencies are co-located within the building. The YOS encourages agile working; however, staff reported that space is often at a premium, and this hampers their ability to work effectively. Court staff are based separately within the youth court in Cardiff.

Staff raised concerns about several aspects of the YOS building. These included no separate entrance for staff and children, a lack of space to undertake effective work, and occasions when there had been confrontation or conflict between children on the premises.

**Do the information and communication technology (ICT) systems enable staff to deliver a quality service, meeting the needs of all children?**

All staff (including seconded staff from the police, probation and MAC) accessed Childview as the main YOS case management system. The police officers have full access to the YOS and police IT systems, including the Police National Computer, and had a good working knowledge of them. The records management system had an effective flagging system that was used to good effect by the YOS police officers. This enables a child who is managed by the YOS to be brought to the attention of the YOS police officers quickly.

Frontline police officers are required to submit a Public Protection Notice (PPN) whenever they encounter a child where they have concerns around safeguarding or vulnerability. These forms are submitted to the multi-agency safeguarding hub (MASH), which in turn disseminates the information to relevant partner agencies where required. The HMICFRS inspector found that there was inconsistency in the completion of these forms by frontline staff, with a number not having been submitted for children managed by the YOS. As a consequence, the YOS police officers were required to complete a PPN retrospectively and submit to the MASH. However, the quality of these submissions is sometimes poor, with much of the information not being available to the YOS officer.

Within children's services, there is no systematic process for social workers to undertake checks on YOS referrals. Checks on the children's services Carefirst system, and subsequent flagging on Childview, depend solely on YOS case managers. Inspectors found that the MASH does not have access to the YOS case management system. Consequently, there is no reliable system in place to ensure all shared work is identified in a timely manner. Positively, YOS staff have access to Carefirst. However, they were concerned about their lack of familiarity with this system and their inability to search for up-to-date, relevant information. Children's services social workers shared their frustration with the inefficiencies in the Carefirst system. For example, they were unable to record significant information chronologically, leading them to request formal notifications from the YOS, which created duplication of work on both sides. The limitations of Carefirst are recognised by senior leaders and plans are in place to replace it.

The local authority has rolled out a management information system for EOTAS providers, which enables them to record pupil attendance and performance. However, the YOS does not have access to this system and so is not able to monitor whether pupils are attending education hubs in the community.

**Is analysis, evidence and learning used effectively to drive improvement?**

In June 2019, the YOS Management Board received an input from YJB Cymru on effective governance. This led to a self-assessment exercise with Board members, which demonstrated their knowledge gap. However, there had been insufficient progress to address these gaps by the time of our inspection.

The YOS is well served by a dedicated information officer, who can extract various performance and monitoring reports from the case management system – both at an individual officer and a wider organisational level. However, there is limited evidence of this data being used sufficiently well to drive sustained improvement. Since August 2019, reports for the Management Board have been streamlined and revised to include a section on organisational health, which includes issues such as challenges, sickness and vacancies.

There was little evidence of a YOS partnership response to various previous inspections and audits. These include the previous HM Inspectorate of Probation

inspection in 2016, the YOS Management Board self-assessment audit by YJB Cymru in June 2019; the Silver Bullet consultancy case audit in July 2019; learning from three serious incidents over the last 12 months involving YOS cases; and findings from benchmarking exercises against previous HM Inspectorate of Probation reports in Western Bay and Wrexham.

There had also been minimal analysis of the impact of the absence of health and education professionals within the YOS. The Healthcare Inspectorate Wales inspector found that the physical and mental health screening on AssetPlus was not completed in a third of the case sample, leaving a large number of young people unassessed for health needs. Even when full AssetPlus assessments were completed, there were no clear pathways for children to receive specialist physical or mental health services. Education inspectors found that there was no systematic evaluation of whether children's ETE skills improved during their involvement with the YOS.

Since July 2019, there has been a reducing reoffending panel to monitor cases of concern. However, this appears to be held at team manager level, with no clear escalation process where issues need to be addressed at a more senior level.

## 2. Court disposals

We took a detailed look at 16 community sentences and 2 custodial sentences managed by the YOS. We also conducted 18 interviews with the relevant case managers. We examined the quality of assessment; planning; implementation and delivery; and reviewing. Each of these elements was inspected in respect of work done to address desistance and the safety and wellbeing of the child. For the 18 cases where there were factors related to harm, we also inspected work done to keep other people safe. In the 18 cases where there were relevant factors, we looked at work done to ensure the safety and wellbeing of the child. The quality of work undertaken in relation to each element of case supervision needs to be above a specific threshold for it to be rated as satisfactory.

When children are sentenced to a court disposal, we expect to see the YOS maximising the likelihood of successful outcomes by addressing desistance factors, effectively engaging with children and their parents/carers and responding to relevant diversity factors. We also expect to see that children are kept safe and their safety and wellbeing needs are addressed. Finally, we expect that everything reasonable is done to manage the risk of harm posed by children who have offended. This should be through good-quality assessment and planning, with the delivery of appropriate interventions, effective leadership and management and good partnership working across all statutory and voluntary agencies.

In this YOS, the fact that fewer than 50 per cent of cases met all our requirements in terms of assessment, planning, delivery and implementation, and reviewing led to our judgements of 'Inadequate' for those elements of work. Of particular concern was the quality of assessment in relation to both desistance and safety and wellbeing (only a third of cases were satisfactory for each of these) and the inadequacy of planning for safety and wellbeing and risk of harm to others (just 11 per cent and 17 per cent respectively were satisfactory). Reviewing was also extremely poor, as only 33 per cent met our standards in relation to desistance, 22 per cent in connection with safety and wellbeing and just 14 per cent for the quality of reviewing of risk of harm.

In terms of the quality of implementation and delivery of supervision plans, 75 per cent of our cases met our standards for work to address desistance. However, only 44 per cent met the standard for work to address safety and wellbeing, while 39 per cent met the standard to address risk of harm. Because of the shortfalls in the implementation and delivery of safeguarding and public protection work, the ratings panel judged that there were no grounds for exercising professional discretion about the overall rating, which remained as 'Inadequate'.

**Strengths**:

- Implementation and delivery of services effectively supported the child's desistance.
- Staff focused on maintaining an effective working relationship with the child and their parents/carers.
- Planning was proportionate to the court outcome, with interventions capable of being delivered within an appropriate timescale.
- When services were delivered, they were those most likely to support desistance. Staff paid sufficient attention to sequencing and the available timescales.

**Areas for improvement:**

- The quality of assessment in relation to a child's desistance, safety and wellbeing and risk of harm to others was inadequate.
- The quality of planning to address safety and wellbeing and risk of harm to others was poor.
- Assessment and planning to address the needs and wishes of victims were inadequate.
- Implementation and delivery of work concerning safeguarding and public protection were insufficient.
- There were serious shortfalls in all aspects of case managers' reviewing practice.
- Management oversight of post-court cases was extremely poor

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

## 2.1. Assessment

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|---|---|
| Assessment is well-informed, analytical and personalised, actively involving the child and their parents/carers. | Inadequate |

Our rating[16] for assessment is based on the following key questions:

| | % yes |
|---|---|
| Does assessment sufficiently analyse how to support the child's desistance? | **33%** |
| Does assessment sufficiently analyse how to keep the child safe? | **33%** |
| Does assessment sufficiently analyse how to keep other people safe? | 44% |

### Does assessment sufficiently analyse how to support the child's desistance?

Inspectors found the quality of assessment to be inadequate across desistance, safety and wellbeing and risk of harm to others. Assessments consistently lacked analysis and did not draw key information from other sources and agencies to inform judgements or risk classification. Previous and current behaviour was not considered systematically, and there was a lack of an investigative approach in many of the inspected cases. Management oversight was very poor and did not address or remedy the shortfalls in practice.

[16] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

In only 7 out of 18 cases inspected, did the assessment have a sufficient analysis of offending behaviour, including the child's attitudes towards, and motivation for, their offending. In just half of the cases, staff considered the diversity and wider social context of the child, while in two-thirds of cases, the assessment focused on the child's strengths and their protective factors. Assessment of structural barriers to desistance was inadequate, especially given some of the gaps in wider partnership provision for the YOS cohort around health and education, with just one third of cases meeting our required standard. The needs and wishes of the victim were taken into account in just one-fifth of the relevant cases, therefore limiting opportunities for restorative justice.

**Does assessment sufficiently analyse how to keep the child safe?**

Assessments of safety and wellbeing consistently underestimated factors and issues in the cases inspected, and therefore we judged practice as inadequate. In just 6 out of 17 relevant cases, staff sufficiently identified and analysed the risks to a child's safety and wellbeing. In 7 cases, assessments drew appropriately on assessments or information held by other agencies. Just 4 out of 17 relevant cases saw staff giving enough attention to analysing the controls or interventions that best promoted the child's safety and wellbeing.

An inspector noted:

> *"The child was in constant isolation at school but it is not known why. He left school 18 months early and there is also no exploration of the reason for this within the assessment. There are indicators of criminal exploitation and parental concern around the child's lifestyle and associates. He is not engaging with professionals and presents as vulnerable and younger than his age. The child has an EHCP [education, health and care plan] but this has not been seen by the case manager. He has ADHD and Tourette's and has previously been CIN [a child in need]. All of these factors have not been pulled together and analysed to accurately assess the level of safety and wellbeing".*

**Does assessment sufficiently analyse how to keep other people safe?**

Assessment of a child's risk of harm to others was poor. In just 5 out of 16 relevant cases, assessments identified and analysed any risk of harm to others posed by the child, including identifying who was at risk, and the nature of that risk. Case managers used available sources of information and involved other agencies, where appropriate, in only a quarter of cases. They considered controls and interventions to manage and minimise the risk of harm to others posed by the child in just a quarter of cases. Although inspectors agreed with the actual level of classification of risk of harm to others in 14 out of 18 cases, there was a lack of reasoned analysis, and case managers did not use available sources of information to support their classification decision.

## 2.2. Planning

| | |
|---|---|
| Planning is well-informed, holistic and personalised, actively involving the child and their parents/carers. | Inadequate |

Our rating[17] for planning is based on the following key questions:

| | % yes |
|---|---|
| Does planning focus sufficiently on supporting the child's desistance? | 44% |
| Does planning focus sufficiently on keeping the child safe? | **11%** |
| Does planning focus sufficiently on keeping other people safe? | 17% |

### Does planning focus sufficiently on supporting the child's desistance?

Inspectors found the quality of planning for desistance, safety and wellbeing and risk of harm to others to be inadequate. Within the cases inspected, plans were often too brief and general, with no clear link to the plans of other agencies where relevant. In particular, the quality of contingency planning was poor and, as with assessment, management oversight was lacking and did not address deficits in practice.

Case managers set out the services most likely to support desistance in 8 out of 18 cases. In 8 out of 18 relevant cases, planning did not take account of the diversity and social context of the child. In the more than half of 18 cases, the planning did not recognise the child's strengths and protective factors, and in just 7 out of 18 of cases, staff thought about their level of maturity and how that affected their motivation. In 11 out of 17 cases, there was insufficient evidence that the child, or their parents/carers, had been involved in the planning and their views taken into account. The needs and wishes of victims were only considered in 3 of the relevant 15 cases.

### Does planning focus sufficiently on keeping the child safe?

The risks to a child's safety and wellbeing were addressed in just 3 out of 18 relevant cases. Only 3 out of 18 cases saw planning adequately involve other agencies. There were serious shortfalls in contingency arrangements to manage issues relating to safety and wellbeing, which were not identified in 16 of the 18 relevant cases. Overall, planning focused on keeping the child safe in just 2 of the 18 cases inspected.

An inspector noted:

> *"In this case, contingency planning for safety and wellbeing was poor and was far too brief and minimal/unspecific. There was no join-up or reference to either the existing LAC [looked after children] plan, no copy or reference to the ECHP and no link to the CAMHS [child and adolescent mental health service] in-reach plan".*

### Does planning focus sufficiently on keeping other people safe?

The quality of planning to keep other people safe was inadequate. There was sufficient planning to promote the safety of others in only 4 out of 18 cases inspected,

[17] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

and just 3 out of 18 of cases involved other agencies, where appropriate. Planning to address any specific concerns and risks related to actual and potential victims was evident in only 3 of the 18 cases inspected.

Planning set out the necessary controls and interventions to promote the safety of other people in 4 of the 18 cases. Effective contingency arrangements to manage those risks that had been identified, however, were not evident in 16 out of the 18 cases inspected.

One inspector highlighted:

> *"Planning for ROH [risk of harm] was insufficient. The YOS multi-agency case planning forum was ineffective and drifted, whilst there was minimal evidence of joint planning, intelligence sharing and feedback with and from the police. Contingency planning was poor and far too brief and unspecific. It was pulled through into review plans that were inadequately updated with contemporaneous information".*

### 2.3. Implementation and delivery

| | |
|---|---|
| High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child. | Inadequate |

Our rating[18] for implementation and delivery is based on the following key questions:

| | % yes |
|---|---|
| Does the implementation and delivery of services effectively support the child's desistance? | 75% |
| Does the implementation and delivery of services effectively support the safety of the child safe? | 44% |
| Does the implementation and delivery of services effectively support the safety of other people? | **39%** |

**Does the implementation and delivery of services effectively support the child's desistance?**

In three-quarters of cases we inspected, the services delivered were those most likely to support desistance, and the child's strengths and protective factors were acknowledged and built on in 12 out of 17 relevant cases. In 13 of 17 relevant cases, it was clear that staff focused on maintaining an effective working relationship with the child and their parents/carers. Just over three-quarters of inspected cases evidenced that sufficient attention was given to encouraging and enabling the child's compliance with the work of the YOS.

**Does the implementation and delivery of services effectively support the safety of the child?**

[18] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

Inspectors rated work to promote the safety and wellbeing of the child as inadequate. The delivery of services to promote the child's safety and wellbeing was evident in just 7 out of 18 cases, and the case manager had coordinated the involvement of other organisations in just over half of all relevant cases. Overall, the implementation and delivery of services effectively supported the safety of the child in only 8 out of 18 of the cases inspected.

An inspector noted:

> *"There were significant gaps in access to services from social care, who deemed that the child did not meet the threshold, despite numerous issues such as homelessness, NEET [not in education, employment or training], substance misuse and family breakdown. This was escalated to YOS team managers and discussed with a social care team manager but did not change the decision and this was not escalated further nor followed up. There were gaps in accessing services for mental health need, again with YOS staff undertaking crisis management and support work. The child admitted he needed bereavement counselling via CAMHS, but was rejected and told he needed to be in full-time employment before he was ready for therapeutic work".*

**Does the implementation and delivery of services effectively support the safety of other people?**

Services delivered to keep other people safe, by managing and minimising the risk of harm, were evident in just 7 of the 18 cases inspected. Only 6 of the relevant 16 cases saw staff coordinate the involvement of other agencies. The protection of actual and potential victims had been considered in just under half of the cases and, overall, the safety of other people was supported effectively in only 7 of the 18 inspected cases.

### 2.4. Reviewing

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

Our rating[19] for reviewing is based on the following key questions:

| | % yes |
|---|---|
| Does reviewing focus sufficiently on supporting the child's desistance? | 33% |
| Does reviewing focus sufficiently on keeping the child safe? | 22% |
| Does reviewing focus sufficiently on keeping other people safe? | **14%** |

**Does reviewing focus sufficiently on supporting the child's desistance?**

[19] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

Children's circumstances can change rapidly, and this can result in an increase, or sometimes decrease, in the likelihood of reoffending, risk of harm to others or risks to their safety and wellbeing. Within the post-court cases inspected, we found that reviews were often late, not undertaken after a significant change, or otherwise minimally updated or cloned from the initial assessments. They were therefore not contemporaneous and did not accurately reflect the current circumstances and issues of the child, nor the work that may have been undertaken to address such issues. Shortfalls in reviewing were not remedied or addressed by adequate management oversight, and there was ineffective joint reviewing and coordination with other agencies.

Reviews resulted in the identification of, and a subsequent response to, changes in the factors linked to desistance in just 7 out of 18 cases inspected. They did not build on the child's strengths and did not adequately consider their motivation and engagement levels in well over half of the cases. The child, and their parents/carers, had been meaningfully involved in the process, and their views had been taken into account, in just 7 out of 18 cases.

**Does reviewing focus sufficiently on keeping the child safe?**

The quality of reviews of children's safety and wellbeing was inadequate. Case managers identified and responded to changes in safety and wellbeing in just a third of relevant cases. Information from other agencies was gathered or considered in only 4 out of 18 cases, and the reviewing process had led to the necessary changes in the ongoing plan in just under a quarter of cases. Overall, reviewing focused sufficiently on keeping the child safe, again in just a quarter of cases we inspected.

An inspector noted:

> *"There was a seven-month delay between the initial assessment and the review assessment. Review was not undertaken after significant changes and events within that period (which included a National Referral Mechanism form submitted, Section 47 investigation, self-reported disclosures of criminal exploitation, new offences committed, self-disclosed substance misuse). When the review was completed, it was minimally updated and did not sufficiently detail the work undertaken or attempted, nor any changes in situation".*

**Does reviewing focus sufficiently on keeping other people safe?**

Reviews of risk of harm to others were also poor. In 10 out of 14 relevant cases, the case manager had not identified, or responded to, changes in risk, and only 2 of the 14 relevant cases had taken account of information from other agencies. The child and their parents/carers had not been meaningfully involved in reviewing the risk of harm to others, or had their views considered, in 11 of the relevant 14 cases. In only two out of 14 relevant cases did the reviewing process lead to necessary adjustments to the ongoing plan of work to manage and minimise these risks. Overall, reviewing focused on keeping other people safe in just 2 out of 14 relevant cases.

The issue of poor-quality safeguarding reviews was highlighted by the following case:

> *"There was no clear direction and reviewing for this case to consider Ryan's increased risk and safety concerns. After six weeks of his ISS, Ryan had disengaged with the YOT, had been arrested for new offences and had refused to attend court for new charges. At that time, the YOT supervised Ryan on a post-release licence but did not consider whether a recall would manage his risk and support keeping others safe".*

# 3. Out-of-court disposals

We inspected 11 cases that had received an out-of-court disposal (OOCD) and were managed by the YOS. These consisted of three youth conditional cautions, two youth cautions, and six community resolutions. We interviewed the case managers in 10 cases; the other was a file read.

We examined the quality of assessment; planning; and implementation and delivery of services. Each of these elements was inspected in respect of work done to address desistance. For the seven cases where there were factors related to risk of harm, we also inspected work done to keep other people safe. In the eight cases where there were relevant factors, we looked at work to ensure the safety and wellbeing of the child. We also looked at the quality of joint working with the local police. The quality of work undertaken in relation to each element of case supervision needs to be above a specific threshold for it to be rated as satisfactory.

When children receive an OOCD, we expect to see the YOS maximising the likelihood of successful outcomes by addressing desistance factors, effectively engaging with children and their parents/carers and responding to relevant diversity factors. We also expect to see children being kept safe and their safety and wellbeing needs being addressed. Finally, we expect everything reasonable to be done to manage the risk of harm posed by children who have offended. This should be through good-quality assessment and planning with the delivery of appropriate interventions, effective leadership and management, and good joint decision-making and partnership working across all statutory and voluntary agencies.

Cardiff YOS operates a model such that some of the OOCD work (specifically community resolutions) are delivered by a third-sector organisation – Media Academy Cardiff (MAC). This is done via a commissioned arrangement, and MAC staff undertaking this work have access to YOS, social care and police case management systems. Although a service specification document was developed before MAC was commissioned, the responsible YOS link managers (and indeed the MAC team manager) confirmed that there was no service level agreement in place to measure and evaluate performance effectively. Decision-making on individual cases took place at a weekly panel, attended by YOS workers, victim workers, MAC staff and seconded police officers. Inspectors observed this panel and found (in some instances) that there was evidence of delay in cases being assessed and interventions being delivered. There was no clear working protocol and guidance for the OOCD panel. Inspectors found that the panel reviewed many cases where the OCCD decision had already been made and for these cases it was therefore more of a case management forum than a decision-making body.

In this YOS, fewer than half of the OOCD cases met all our requirements in terms of assessment, planning, and implementation and delivery; this led to our judgements of ‘Inadequate’ for those elements of work. Although assessment and planning for desistance were strong (82 per cent and 73 per cent respectively), this was not the case in relation to both safety and wellbeing and risk of harm to others. Assessment met our standards in just 18 per cent of cases in relation to safety and wellbeing. Only 27 per cent of assessments were sufficient for risk of harm. There were serious deficits regarding the quality of planning for safety and wellbeing, with none of the eight cases with identified needs meeting our required standards. In terms of the quality of implementation and delivery of OOCD plans, the work to address desistance, safeguarding and public protection was inadequate, meeting our standards in just 45 per cent, 14 per cent and 29 per cent of cases respectively.

In relation to joint working with other agencies, 45 per cent of cases met our standards for YOS recommendations being sufficiently well-informed, analytical and personalised to the child, while 67 per cent of cases met the standard for joint work with the police. However, the latter figure was based on a small sub-sample of just three cases. Looking at evidence across domain one, inspectors found shortfalls in the delivery of the OOCD panel and a lack of a suitable framework, procedures and guidance to support quality work. Therefore, our judgement of this joint working standard remained 'Inadequate'.

**Strengths**:

- Assessment of desistance in OOCD cases was outstanding.
- Planning for desistance was good.
- Staff focused sufficiently on developing and maintaining an effective working relationship with the child and their parents/carers.
- Assessments were strengths-based and considered the child's maturity, capacity to change and diversity, and were proportionate to the disposal type.

**Areas for improvement:**

- There were serious shortfalls in the quality of assessment and planning for a child's safety and wellbeing and risk of harm to others in out-of-court cases.
- Implementation and delivery of work to address desistance, safety and wellbeing and risk of harm to others were inadequate.
- Management oversight of OOCDs was poor.
- There was no service level agreement between the YOS and Media Academy Cardiff; this meant the YOS did not effectively monitor and evaluate the commissioned arrangements for delivering some OOCDs.
- The framework for delivering OOCDs was not underdeveloped and there was a lack of protocols and guidance for key stakeholders within the partnership.
- Inspectors observed the panel and found that it reviewed many cases where the OCCD decision had already been made, and for these cases it was therefore more of a case management forum than the decision-making body it should be.
- In some OOCD cases considered by the panel, that inspectors observed, there was evidence of delay in the case being assessed and interventions being delivered.
- The rationale for joint decision-making in OOCD cases was not recorded clearly.

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

### 3.1. Assessment

| | |
|---|---|
| Assessment is well-informed, analytical and personalised, actively involving the child and their parents/carers. | Inadequate |

Our rating[20] for assessment is based on the following key questions:

| | % yes |
|---|---|
| Does assessment sufficiently analyse how to support the child's desistance? | 82% |
| Does assessment sufficiently analyse how to keep the child safe? | **18%** |
| Does assessment sufficiently analyse how to keep other people safe? | 27% |

**Does assessment sufficiently analyse how to support the child's desistance?**

Assessments of desistance and offending-related factors were of sufficient quality in 9 out of the 11 cases we inspected. We found that assessments were strengths-based and considered diversity, maturity and capacity to change. They involved the child and their parents/carers in 10 out of 11 cases.

An inspector noted:

> *"Brandon was subject to YCC [youth conditional caution] for possession of an offensive weapon, where he took a knife to the park and showed his friends. Brandon had strong family support and this was conveyed in the assessment. His parents had taken a positive approach in working with YOS and police, and assessment had shown that Brandon had demonstrated remorse for his actions and that he had no other criminal associates that would lead him to further offending".*

**Does assessment sufficiently analyse how to keep the child safe?**

Assessment of a child's safety and wellbeing was inadequate, being found to be sufficient in less than a fifth of cases. The main shortfalls of assessment practice were a failure to draw on other sources of information and a lack of analysis of past and current issues and behaviours, which led to underestimations of risks to safety and wellbeing. Inspectors agreed with the safety and wellbeing risk classification in just over a third of relevant cases. Many OOCD assessments did not contain a reasoned judgement or classification of the child's safety and wellbeing.

In one case, an inspector found:

> *"The assessment did not offer a classification on safety and wellbeing and did not draw together key historical information from social care records. The child had been previously subject to a CP [child protection] plan, but the case manager admitted that he hadn't checked social care records nor spoken to the previous social worker".*

[20] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

### Does assessment sufficiently analyse how to keep other people safe?

As with safety and wellbeing, assessments of children's risk of harm to others were found to be inadequate. In less than one-third of the cases inspected had the case manager used available sources of information, including other assessments or documents, to inform their own judgement. Inspectors agreed with the level of risk of harm to others in only 5 out of 11 cases, with YOS case managers consistently underestimating the risks posed by the child. We found a similar pattern of practice to that of safety and wellbeing, whereby assessments failed to draw on other sources of information, lacked a reasoned analysis of past and present behaviours, and, in more than half of cases inspected, lacked an evidenced summary and classification of the risk of harm to others. Overall, assessment of risk of harm to others was sufficient in only 3 out of 11 relevant cases.

An inspector highlighted the following case:

> *"Freddie had made threats towards his teacher of rape and violence and had been seen outside the staff member's address. The assessment did not give any detailed context or timescales of these incidents but did consider Freddie's current behaviour with weapons. However, the assessment posed too many unanswered questions about Freddie's behaviour and did not give an adequate and full understanding of his propensity for violence".*

## 3.2. Planning

| | |
|---|---|
| Assessment is well-informed, analytical and personalised, actively involving the child and their parents/carers. | Inadequate |

Our rating[21] for planning is based on the following key questions:

| | % yes |
|---|---|
| Does planning focus on supporting the child's desistance? | 73% |
| Does planning focus sufficiently on keeping the child safe? | **0%** |
| Does planning focus sufficiently on keeping other people safe? | 44% |

### Does planning focus on supporting the child's desistance?

Planning for services to support desistance was sufficient in 9 out of 11 of the OOCD cases inspected. Although planning to take account of diversity issues and social context was lower, at 6 out 11 cases, it was focused on the strengths of the child in nearly three-quarters of cases. Of those five relevant cases where there was a direct victim, planning was sufficient in all of them, while planning took sufficient account of opportunities for community integration, including access to mainstream services following completion of an OOCD, in 10 out of 11 cases.

[21] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

An inspector found in one case:

> *"Planning for desistance was consistent with issues identified within the assessment, specifically in relation to alcohol, emotional wellbeing and positive activity/ETE. Exit planning for desistance was also evident, with the child having been linked with relevant agencies and counselling beyond the scope of the OOCD".*

**Does planning focus sufficiently on keeping the child safe?**

In none of the eight relevant cases inspected did planning sufficiently promote the safety and wellbeing of the child. In just one of those eight cases did we see involvement or alignment with other agencies' plans (such as with social care). Contingency arrangements for any changes to the level of safety and wellbeing were only evident in one case.

One inspector noted:

> *"Despite the child having high safety and wellbeing needs, the plan does not dovetail with the child protection plan and the child protection plan is not being fully implemented. Information from the police and education is not forthcoming and this is impacting on the planning process. The YOS plan is restricted to the conditions of the YCC, which are limited".*

Another inspector judged a case as follows:

> *"Planning for safety and wellbeing was poor and minimal, with no link to the LAC plan. Contingency planning was poor and far too brief, with no specific actions stated, should concerns regarding safety and wellbeing increase further".*

**Does planning focus sufficiently on keeping other people safe?**

Planning to address the factors related to the risk of harm to others was evident in three out of seven relevant cases and involved other agencies in four out of seven cases. Evidence of contingency planning to manage those risks was identified in only two of these seven cases, and planning to address concerns related to actual and potential victims was evident in less than half of the relevant cases. Overall, planning that focused on keeping people safe was evident in just three out of seven cases.

### 3.3. Implementation and delivery

| | |
|---|---|
| High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child. | Inadequate |

Our rating[22] for implementation and delivery is based on the following key questions:

| | % yes |
|---|---|
| Does service delivery effectively support the child's desistance? | 45% |
| Does service delivery effectively support the safety of the child? | **14%** |
| Does service delivery effectively support the safety of other people? | 29% |

**Does service delivery effectively support the child's desistance?**

There was sufficient analysis of offending behaviour in almost two-thirds of the cases. The assessment considered the diversity and social context of the child in just over half of the cases inspected. The child's strengths and protective factors, alongside motivation to change, were considered in just under two-thirds of cases, and in the same proportion of cases practitioners had involved the child and their parents/carers in the assessment and taken their views into account. However, some cases demonstrated where gaps in wider service provision had impacted on the work delivered.

In one such case, an inspector found:

> *"There were concerns that the child has speech, language and communication (and possible SEN) needs but this has not been addressed due to gaps in service provision. The YOS had no speech and language therapist and the education worker was on maternity leave with no cover in place. There has been an obstacle with getting the child into a full-time school placement and he is in an unsuitable part-time provision. The child is resistant to engaging but the case worker has been tenacious and persistent in developing a relationship with him".*

**Does service delivery effectively support the safety of the child?**

Evidence that the safety and wellbeing of the child was promoted through service delivery was found for just one of the seven relevant cases, and only one case saw YOS case managers involve and coordinate other agencies in keeping children safe.

This was highlighted by one inspector:

> *"At the end of the intervention there was no better understanding of whether Sonny was at risk of criminal exploitation. Delivery did not include addressing the influence of his peers as linked to risk of harm".*

[22] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

**Does service delivery effectively support the safety of other people?**

As for keeping other people safe, attention had been given to the protection of actual and potential victims in only two of the six relevant cases. The interventions sufficiently managed and minimised the risk of harm in only a third of relevant cases and, overall, the safety of other people was supported effectively in only two out seven relevant cases.

An inspector noted:

> *"There was a lack of contact for a two-month period on the OOCD. Indeed, the child then ended up reoffending via an alleged theft and assault and there was a lack of checking/information-sharing with police. Case manager had discovered this via checking Carefirst social care system and had not been informed via YOT police officer".*

## 3.4. Joint working

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

Our rating[23] for joint working is based on the following key questions:

| | % yes |
|---|---|
| Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child, supporting joint decision making? | **45%** |
| Does the YOT work effectively with the police in implementing the out-of-court disposal? | 67% |

**Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child, supporting joint decision-making?**

The recommendations made by the YOS were appropriate and proportionate in 9 out of 11 cases. In nearly two-thirds of them, the child's understanding of the offence and their acknowledgement of responsibility were considered, and in nearly two-thirds of cases the YOS made a positive contribution to determining the OOCD.

It is positive that, in 8 out of 11 cases, case managers had ensured that the child and their parents/carers understood the implications of receiving an OOCD.

However, there were serious shortfalls in recording the appropriateness and rationale for disposal decisions, with just 2 out of 11 cases meeting our required standards. Overall, only 5 out of 11 cases showed that the YOS's recommendations had been well informed, analytical and personalised to the child, and therefore supported joint decision-making.

[23] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

**Does the YOT work effectively with the police in implementing the out-of-court disposal?**

Of the three cases that required case managers to report on progress to the police, two had been completed in a timely manner. In all three cases, staff had given sufficient attention to compliance with, and enforcement of, the conditions. Overall, in two of the three relevant cases, the YOS worked effectively with the police in implementing the OOCD.

# Annexe 1: Methodology

### HM Inspectorate of Probation standards

The standards against which we inspect youth offending services 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 children who have offended.[24]

The inspection methodology is summarised below, linked to the three domains in our standards framework. We focused on obtaining evidence against the standards, key questions and prompts in our inspection framework.

### Domain one: organisational delivery

The YOS submitted evidence in advance, and the Assistant Director of Children's Services (Chair of Cardiff YOS Management Board) and the Police and Crime Commissioner for South Wales (Deputy Chair of the YOS Management Board) delivered a presentation covering the following areas:

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

During the main fieldwork phase, we conducted 28 interviews with case managers, asking them about their experiences of training, development, management supervision and leadership. The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We followed up issues which had emerged from the case inspections. We held various meetings, which allowed us to triangulate evidence and information. In total, we conducted 46 meetings, which included meetings with managers, partner organisations and staff. The evidence collected under this domain was judged against our published ratings characteristics.[25]

### Domain two: court disposals

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

We examined 18 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.

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

### Domain three: out-of-court disposals

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

We examined 11 OOCDs. 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.

In some areas of this report, data may have been split into smaller sub-samples, for example male/female cases. Where this is the case, the margin of error for the sub-sample findings may be higher than five.

# Annexe 2: Inspection results

In this inspection, we conducted a detailed examination of a sample of 18 court disposals and 11 out-of-court disposals. In each of those cases, we inspect against four standards: assessment, planning, and implementation/delivery. For court disposals, we look at reviewing; and in out-of-court disposals, we look at joint working with the police. For each standard, inspectors answer 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 children 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 0–36, 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 |
|---|---|
| **1.1. Governance and leadership**<br>The governance and leadership of the YOT supports and promotes the delivery of a high-quality, personalised and responsive service for all children. | **Inadequate** |
| 1.1.1. Is there a clear local vision and strategy for the delivery of a high-quality, personalised and responsive service for all children? | |
| 1.1.2. Do the partnership arrangements actively support effective service delivery? | |
| 1.1.3. Does the leadership of the YOT support effective service delivery? | |
| **1.2. Staff**<br>Staff within the YOT are empowered to deliver a high-quality, personalised and responsive service for all children. | **Inadequate** |
| 1.2.1. Do staffing and workload levels support the delivery of a high-quality, personalised and responsive service for all children? | |
| 1.2.2. Do the skills of YOT staff support the delivery of a high-quality, personalised and responsive service for all children? | |
| 1.2.3. Does the oversight of work support high-quality delivery and professional development? | |
| 1.2.4. Are arrangements for learning and development comprehensive and responsive? | |
| **1.3. Partnerships and services**<br>A comprehensive range of high-quality services is in place, enabling personalised and responsive provision for all children. | **Inadequate** |
| 1.3.1. Is there a sufficiently comprehensive and up-to-date analysis of the profile of children, to ensure that the YOT can deliver well-targeted services? | |
| 1.3.2. Does the YOT partnership have access to the volume, range and quality of services and interventions to meet the needs of all children? | |
| 1.3.3. Are arrangements with statutory partners, providers and other agencies established, maintained and used effectively to deliver high-quality services? | |

| 1.4. Information and facilities | Inadequate |
|---|---|
| Timely and relevant information is available and appropriate facilities are in place to support a high-quality, personalised and responsive approach for all children. | |
| 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? | |
| 1.4.2. Does the YOT's delivery environment(s) meet the needs of all children 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? | |
| 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 and their parents/carers. | |
| 2.1.1. Does assessment sufficiently analyse how to support the child's desistance? | 33% |
| 2.1.2. Does assessment sufficiently analyse how to keep the child safe? | 33% |
| 2.1.3. Does assessment sufficiently analyse how to keep other people safe? | 44% |
| **2.2. Planning** | **Inadequate** |
| Planning is well-informed, holistic and personalised, actively involving the child and their parents/carers. | |
| 2.2.1. Does planning focus sufficiently on supporting the child's desistance? | 44% |
| 2.2.2. Does planning focus sufficiently on keeping the child safe? | 11% |
| 2.2.3. Does planning focus sufficiently on keeping other people safe? | 17% |

| | |
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| **2.3. Implementation and delivery**<br>High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child. | **Inadequate** |
| 2.3.1. Does the implementation and delivery of services effectively support the child's desistance? | 75% |
| 2.3.2. Does the implementation and delivery of services effectively support the safety of the child? | 44% |
| 2.3.3. Does the implementation and delivery of services effectively support the safety of other people? | 39% |
| **2.4. Reviewing**<br>Reviewing of progress is well-informed, analytical and personalised, actively involving the child and their parents/carers. | **Inadequate** |
| 2.4.1. Does reviewing focus sufficiently on supporting the child's desistance? | 33% |
| 2.4.2. Does reviewing focus sufficiently on keeping the child safe? | 22% |
| 2.4.3. Does reviewing focus sufficiently on keeping other people safe? | 14% |

## 3. Out-of-court disposals

| Standards and key questions | Rating and % yes |
|---|---|
| **3.1. Assessment**<br>Assessment is well-informed, analytical and personalised, actively involving the child and their parents/carers. | **Inadequate** |
| 3.1.1. Does assessment sufficiently analyse how to support the child's desistance? | 82% |
| 3.1.2. Does assessment sufficiently analyse how to keep the child safe? | 18% |
| 3.1.3. Does assessment sufficiently analyse how to keep other people safe? | 27% |

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| **3.2.** | **Planning**<br>Planning is well-informed, holistic and personalised, actively involving the child and their parents/carers. | **Inadequate** |
| 3.2.1. | Does planning focus sufficiently on supporting the child's desistance? | 73% |
| 3.2.2. | Does planning focus sufficiently on keeping the child safe? | 0% |
| 3.2.3. | Does planning focus sufficiently on keeping other people safe? | 43% |
| **3.3.** | **Implementation and delivery**<br>High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child. | **Inadequate** |
| 3.3.1. | Does service delivery support the child's desistance? | 45% |
| 3.3.2. | Does service delivery effectively support the safety of the child? | 14% |
| 3.3.3. | Does service delivery effectively support the safety of other people? | 29% |
| **3.4.** | **Joint working**<br>Joint working with the police supports the delivery of high-quality, personalised and coordinated services. | **Inadequate** |
| 3.4.1. | Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child, supporting joint decision-making? | 45% |
| 3.4.2. | Does the YOT work effectively with the police in implementing the out-of-court disposal? | 67% |

# Annexe 3: Glossary

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|---|---|
| **AssetPlus** | Assessment and planning framework tool developed by the Youth Justice Board for work with children who have offended, or are at risk of offending, that reflects current research and understanding of what works with children. |
| **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. |
| **Child protection** | Work to make sure that all reasonable action has been taken to keep to a minimum the risk of a child experiencing significant harm. |
| **EOTAS** | Education Other Than At School: includes all forms of education that takes place outside of the formal school environment. |
| **Enforcement** | Action taken by a case manager in response to a child's failure to comply with the actions specified as part of a community sentence or licence. Enforcement can be punitive or motivational. |
| **ETE** | Education, training and employment: work to improve learning, and to increase future employment prospects. |
| **FTE** | First-time entrants: a child 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. |
| **MOSOVO** | Management Of Sexual Offenders and Violent Offenders via a coordinated specialist police team. |
| **NEET** | Children 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. |

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| **Risk of Serious Harm** | Risk of Serious Harm (ROSH) is a term used in AssetPlus. All cases are classified as presenting a low, medium, high or very high risk of serious harm to others. HMI Probation uses this term when referring to the classification system, but uses the broader term 'risk of harm' when referring to the analysis which should take place to determine the classification level. This helps to clarify the distinction between the probability of an event occurring and the impact/severity of the event. The term Risk of Serious Harm only incorporates 'serious' impact, whereas using 'risk of harm' enables the necessary attention to be given to those young offenders for whom lower impact/severity harmful behaviour is probable. |
| **Referral order** | A restorative court order which can be imposed when the child appearing before the court pleads guilty, and the threshold for a youth rehabilitation order is not met. |
| **Safeguarding** | Safeguarding is a wider term than child protection and involves promoting a child'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 on a child's safety and wellbeing concerns. It is defined as "…those outcomes where the young person's safety and well-being may be compromised through their own behaviour, personal circumstances or because of the acts/omissions of others" (AssetPlus Guidance, 2016). |
| **Youth caution** | A caution accepted by a child 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. |
| **YOT/YOS** | Youth Offending Team is the term used in the *Crime and Disorder Act 1998* to describe a multi-agency team that aims to reduce youth offending. YOTs are known locally by many titles, such as youth justice service (YJS), youth offending service (YOS), and other generic titles that may illustrate their wider role in the local area in delivering services for children. |
| **YOT/YOS Management Board** | The YOT Management Board holds the YOT to account to ensure it achieves the primary aim of preventing offending by children. |
| **Youth rehabilitation order** | Overarching community sentence to which the court applies requirements (e.g. supervision requirement or unpaid work). |
| **Youth Justice Board** | A government body responsible for monitoring and advising ministers on the effectiveness of the youth |

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|---|---|
| | justice system. The YJB provider grants and guidance to the youth offending teams. |

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