HM Inspectorate of Probation

An inspection of probation services in:

Leeds PDU

The Probation Service – Yorkshire and the Humber region

HM Inspectorate of Probation, October 2024

Contents

Acknowledgements

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The role of HM Inspectorate of Probation

HM Inspectorate of Probation is the independent inspector of youth justice and probation services in England and Wales. We report on the effectiveness of probation and youth justice 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

While this Probation Delivery Unit (PDU) had some strengths and had made some progress, the overall quality of work undertaken was impacted by ongoing staffing difficulties and a drift in the key relationships with children's social care. This led to an overall rating of 'Inadequate'.

There were some strong partnership arrangements in place, with the head of the PDU chairing the Reducing Reoffending Board. Many partners were well engaged and clear on some of the challenges in Leeds. Work was in place to streamline accommodation referral pathways and ensure that the right services were in place to support people on probation. The operational work with partners to identify and address the risks of domestic abuse in Leeds was comprehensive, with some promising practice seen in the cases we inspected.

As with many PDUs nationally, Leeds PDU has faced challenges with staffing levels at practitioner and administrative grades. The leadership team had taken a proactive approach to this. As a result, the PDU's position was steadily improving, albeit still fragile. Around half of all staff at practitioner grades had been in post for less than three years; however, leaders had a limited understanding of the training needs of staff locally. Regionally mandated professional development days were delivered locally. These had not been personalised to the needs of staff, with the delivery of online events often not conducive to staff learning.

The PDU relied too much on regional feedback about the quality of sentence management work. It was concerning that the existing quality assurance processes had not identified the significant gaps in the work to support desistance and keep other people safe. There were no local mechanisms by which leaders could identify, analyse and address gaps in practice. Inspectors saw examples of insufficient assessments and plans being countersigned by managers.

There were significant gaps in the availability of mental health services. A lack of infrastructure meant that mental health treatment requirements were not being recommended by the PDU or used across Leeds. Vacancies in some regional teams resulted in limited use of accredited programmes. No structured interventions were being offered to people on probation at the time we carried out our fieldwork. While probation practitioners were using some approved toolkits, delivery of interventions to address reoffending and support desistance was insufficient overall.

Leaders need to identify staff's development needs, and to develop local mechanisms that will help them to understand the quality of practice. This should allow the leadership team to identify and make the changes required to improve the quality of work to keep other people safe and ensure that people on probation receive necessary interventions.

Martin Jones CBE
HM Chief Inspector of Probation

Ratings

Leeds PDU Fieldwork started August 2024		Score	**3/21**
Overall rating		**Inadequate**	
1.	**Organisational arrangements and activity**		
P 1.1	Leadership	Requires improvement	
P 1.2	Staffing	Requires improvement	
P 1.3	Services	Requires improvement	
2.	**Service delivery**		
P 2.1	Assessment	Inadequate	
P 2.2	Planning	Inadequate	
P 2.3	Implementation and delivery	Inadequate	
P 2.4	Reviewing	Inadequate	

Recommendations

As a result of our inspection findings, we have made a number of recommendations that we believe, if implemented, will have a positive impact on the quality of probation services.

Leeds PDU should:

1. work is undertaken with other agencies to manage child safeguarding, such as the police and children's social care services, to ensure that actual and potential victims are sufficiently protected
2. improve the quality of work to assess, plan for, manage and review the risk of harm
3. improve the use of interventions and services available for people on probation to support desistance and manage the risk of harm
4. ensure that people on probation (with a protected characteristic) have access to appropriate services and interventions
5. conduct an analysis of skills, knowledge and experience within the practitioner group and implement a system for checking that learning has been consolidated into practice
6. ensure that it has sufficient staffing resources to deliver a high quality, personalised and responsive service for all people on probation
7. ensure middle managers have enough capacity to provide the appropriate level of oversight according to the needs of staff members and level of casework in the team.

Background

We conducted fieldwork in Leeds PDU over a period of two weeks, beginning on 05 August 2024. We inspected 52 community orders and 30 releases on licence from custody where sentences and licences had commenced during two separate weeks, between 01 January 2024 and 07 January 2024 and 29 January 2024 and 04 February 2024. We also conducted 68 interviews with probation practitioners.

The Probation Reset[1] policy was implemented during the time of this inspection. Twelve of the 82 cases we inspected were subject to Probation Reset. This meant that those individuals had their supervision suspended for the final third of their supervision period. This change was delivered at pace and implemented from 01 July 2024.

Leeds PDU is one of 11 PDUs in the Yorkshire and the Humber probation region. Many of the PDU's core services are managed regionally, including unpaid work, some interventions, and work with victims.

The PDU has two offices. Waterloo House is based in the city centre, and the York Road office is three miles to the east of the city. Leeds has three approved premises, one magistrates' court and a crown court. The women's probation team is based at a local women's centre, and there is an activity hub in the city centre.

Leeds is the largest city in Yorkshire, with a population of 822,483.[2] The proven reoffending rate is 31.1 per cent.[3] Leeds City Council provides local authority governance.

At the point when the inspection was announced, Leeds PDU had a caseload of 2,818 people on probation who were subject to community sentences and post-release supervision. In total, 1,050 individuals were being managed in custody before release.

The head of the PDU had been in post for around eight months when the inspection fieldwork took place. Two deputy heads of PDU had been in post for less than three months. The PDU was fully staffed at senior probation officer (SPO) grade. However, only 72 per cent of probation officers (POs) and 83 per cent of probation services officers (PSOs) were in post when we announced this inspection. There were also vacancies at case administrator and reception grades.

Commissioned Rehabilitative Services (CRS) were provided by Shelter for accommodation support; Ingeus for personal wellbeing; The Growth Company for education, training and employment; and the Together Women project for women's services. The PDU had commissioned additional services from the National Autism Society, and services were provided by Forward Leeds to support those with drug and alcohol needs.

[1] Probation Reset is a nationally mandated operational policy change and has been implemented to alleviate probation workload in response to prison capacity challenges. This mandates that supervision of a person on probation, who is eligible according to certain criteria, will be suspended at the two-thirds point of their sentence. These measures aim to target resources at the start of supervision in the community.

[2] Source: Office for National Statistics (November 2023). UK population estimates, mid-2022.

[3] Source: Ministry of Justice. (July 2024). Proven reoffending statistics: October 2021 to September 2022.

1. Organisational arrangements and activity

P 1.1. Leadership

The leadership of the PDU enables delivery of a high quality, personalised, and responsive service for all people on probation.	Requires improvement

The senior leadership team had all been in post for less than eight months at the point of inspection. The head of PDU, having been promoted from deputy head, brought significant local understanding of the business and continuity to the role. This meant a largely smooth transition for both staff and partners. Work to streamline the PDU business plan was collaborative and sought to drive and track improvements in service delivery. Systems were required to ensure information from quality assurance and oversight of casework was available and understood by leaders, so that they could improve the quality of work to keep other people safe. Leaders were not yet enabling the consistent delivery of high-quality probation services, resulting in an overall rating of 'Requires improvement'.

Strengths

- The Leeds Reducing Reoffending Board was chaired by the head of PDU, who was driving strategic activity around key risks and needs. Partners were engaged and supporting activity, such as the arrangements to provide services for females at a women's centre, and the provision of the Creating Future Opportunities (CFO) activity hub. The partnership was realistic about challenges such as accommodation needs and was streamlining pathways to support service delivery.
- Leaders took a considered and sequenced approach to identifying PDU priorities, and had a clear vision to improve assessment and planning. This was having some impact in improving assessment and planning for desistance. An effective system was in place to share police information. This supported some promising work to assess risk of harm where domestic abuse was a factor.
- An open invitation had led to 30 PDU staff engaging with leaders to formulate the PDU strategy. In the staff survey, 65 per cent of staff said that the vision and strategy drove the delivery of a high-quality service.
- Governance arrangements, including operational and management meetings, were clear, and priorities were set from the PDU delivery plan. These arrangements had effectively managed mandated national changes to practice, including those related to Probation Reset and to SDS40, the government's early release scheme. Staff were clear about these changes, which was reflected in cases. Partners had been engaged in work to plan, mitigate and accommodate changes in practice.
- Leaders had made changes to the delivery model to improve relationships and the specialist knowledge of staff. Key partners had welcomed a combined Integrated Offender Management (IOM) and concentrator model to support the delivery of drug rehabilitation requirements. This had improved the effectiveness of information exchange with Forward Leeds regarding community sentence treatment requirements. Semi-specialist staff supported an effective transfer process for those young people transitioning from youth justice to adult probation services.

- The leadership team was seen as broadly visible by staff; for example, there were regular question and answer forums with the PDU head. Staff had an open invitation to attend the Leeds managers meeting. When asked in the staff survey, 66 per cent of respondents said that the PDU had a culture of openness, constructive challenge and ideas.
- Leaders understood the risks to service delivery. They reviewed these regularly and put appropriate mitigations in place. This meant targeted and ongoing recruitment campaigns, leading to steadily increasing staffing numbers across all grades. The courts had recognised deficits in the quality of work. As a result, the PDU had increased the number of managers in court, with a part time quality assurance role and a second regional quality development officer in post. The PDU worked closely with regional unpaid work staff to ensure that backlogs and waiting lists were reducing.
- Leaders used segmentation and dashboard data on the profile of staff and people on probation to inform discussions about recruitment and to identify commissioning opportunities. These included contracts to support people on probation with neurodiverse conditions.
- Systems were in place to share learning from serious further offences. As a result, PDU staff were given direct access to police and child safeguarding systems. While further work was required to ensure that information on child safeguarding was shared effectively, in 84 per cent of the assessments inspected, the practitioner had obtained sufficient information on domestic abuse from the police.
- The PDU had developed strong working practices to engage people on probation. Evaluation under the Engagement Maturity Model had significantly improved since 2022, and practice was now firmly embedded. Feedback pathways, including focus groups, had led to some changes within interview rooms and waiting areas. Promising links were found to the feedback of people on probation and staff reward and recognition

Areas for improvement:

- The quality improvement plan was not sufficiently improving the quality of service delivery. The 'strong start' initiative was driving limited improvement in engagement and risk of harm work in the cases inspected.
- The head of PDU was committed to improving quality. However, across the leadership team, priority was given to performance metrics without sufficient focus on the quality of service delivery.
- Aside from the Regional Case Assessment Tool (RCAT), the PDU had no mechanisms for developing local intelligence on the quality of work being delivered. It relied too much on RCAT data for this. It was a cause for concern that regional quality assurance indicators had not identified the extent in the deficits in risk management and sentence delivery work that we found in the cases we inspected.
- There was a lack of proactive management oversight at case allocation stages and a process-driven system for obtaining child safeguarding information. This meant that risks to actual or potential victims were not analysed in 29 out of 78 relevant cases we inspected. As a result, assessment and planning were rated 'Inadequate'.

- There were some barriers to accessing the Regional Outcomes and Innovation Fund. Despite 20 per cent of the caseload identifying as being from a Black, Asian or minority ethnic background, pathways into local specialist services were unclear, with no planned commissioning activity to support these cohorts.
- Oversight of the work to safeguard children was insufficient. Following the departure of a middle manager with a lead role for child safeguarding, both strategic and operational relationships had drifted. The PDU had direct access to the children's services database, with a dedicated member of staff to support information exchange. In reality, information returned was far too basic to form a sufficient assessment of risk, and there was little evidence of further follow-up enquiries by staff in the cases we inspected.
- Results from the people survey in 2022 and 2023 suggested that only 40 per cent of staff consider change to be managed sufficiently by the organisation. The new senior leadership team were aware of the challenges around the change fatigue of staff. They had tried to streamline communications, and had adopted a number of plans on a page to ensure messages were easily digestible for staff. This was not yet having sufficient impact. Only 43 per cent of staff in our survey believed that leaders assessed the impact that any changes to systems or processes would have, including on equality.

P 1.2. Staffing

Staff are enabled to deliver a high-quality, personalised, and responsive service for all people on probation.	Requires improvement

Staffing levels were steadily increasing. The PDU had a full staffing complement across the leadership team, although management roles were broad, with spans of control that were too wide. While practitioner staffing levels were increasing, pressures remained while new staff were training and getting the valuable experience they needed. This was especially evident in the PSO grade. Staff induction and training were not consistently meeting the needs of staff and the oversight of work focused on performance metrics rather than improving the quality of service delivery. Overall, this has resulted in a rating of 'Requires improvement'.

Strengths:

- The senior leadership team was actively involved in workforce planning. This was leading to steadily increasing numbers of staff in all grades. The PDU had a full complement of staff in leadership and middle manager posts. When the inspection was announced, 83 per cent of PSOs were in post, with a further 17 staff waiting either to start or for their induction.
- Attrition rates were lower than the regional average, with eight per cent of all staff recorded as leaving the organisation compared with 10 per cent regionally.
- Active case management had been suspended for the final third of the supervision of people on probation (Probation Reset), and this was starting to have some impact on the workload of some practitioners. When the inspection was announced, only 42 per cent of PDU staff considered their workloads to be manageable. When asked in their case inspection interviews, 58 per cent of probation practitioners said that their workloads were either very or quite manageable. Further work was required to ensure that workloads were equitable.
- The senior leadership team had begun work to tackle the culture of 'fire-fighting' in their practice, and change it to a more planned, proactive and reflective approach. Staff were generally benefiting from Embedding Quality and Learning (EQUal) sessions to review and explore the quality of assessments and plans. Staff who attended the sessions considered that they promoted elements of reflective practice.
- Poor performance was being addressed, with some staff subject to performance improvement plans. Further work was required to ensure that staff were consistently meeting sufficient quality standards and to strengthen the link between these and performance improvement plans.
- Staff were generally receiving supervision. They described managers as broadly visible, supportive and approachable. Where this was not the case, it was because of changes across the middle manager grade, with some staff receiving more remote support from other team managers while new managers assumed their positions. Of those responding to the staff survey, 73 per cent said they received supervision sufficiently and frequently, and 67 per cent stated that they received supervision that enhanced the quality of their work.
- There were a number of recent examples of staff progression and promotion across all grades, including senior leadership roles in the PDU.

Areas for improvement:

- Only 72 per cent of POs were in post when the inspection was announced. At that time, no decision had been made regionally on where the 25 PQiP learners would be placed after qualification. Were Leeds PDU not to retain sufficient numbers of newly qualified staff, this would impact negatively on workloads in the future.
- The workloads of PSO staff remained high, with insufficient staff to support effective allocations. This meant that some PSO work was carried out by qualified POs. Examples of staffing pressures included the PDU head and business manager covering evening reception duties in one office until sufficient reception staff had been recruited and trained.
- Cases were allocated following sentence by court administrators. This relied on practitioners providing an arbitrary number of induction slots per month. PDU managers held an allocation meeting to address disparities in workloads across individuals and within teams. This considered staff workload and any reasonable adjustments. Where multiple cases had been allocated to practitioners, managers had to adopt reactive approaches to redistribute cases based on grade and workload. Of the cases we inspected, 54 per cent had received at least two allocations. The PDU is due to implement a new allocation system that will provide additional and more proactive oversight.
- Approaches to improving quality assurance were having little impact on the management oversight of cases. Management oversight was insufficient, ineffective or absent in 61 out of 79 relevant cases we inspected. Levels of oversight were not commensurate with the assessed risk of harm, with assessments that were insufficient regularly countersigned.
- SPOs had broad roles, with large spans of control. This meant that they had insufficient capacity to provide a level of oversight of cases that was commensurate with risk and tailored to the practitioner's individual needs.
- Managers were not always able to engage in reflective discussions with less experienced staff who had not accessed the necessary training on professional curiosity. They had little capacity to provide the foundational learning required themselves.
- There was a lack of staff buy-in to the regionally mandated professional development days. These had not been sequenced according to a local PDU training needs analysis and the method of online delivery was not conducive to staff engagement.
- RCAT feedback to practitioners was patchy at best and was not consistently incorporated into quality development targets in staff personal development plans. Plans had not been personalised and had not improved attendance levels within the required training suites (classroom based). When asked in the staff survey, only 32 out of 79 respondents felt that staff potential had been identified and developed.
- Only 21 out of 45 relevant PDU staff who had changed roles within the last two years felt that they had received an effective induction into their roles. New PSO staff were required to undertake the Gateway to Practice, overseen by the regional learning and development team. This provision alone had not effectively provided the necessary skills, knowledge and experience to prepare staff for their roles.

P 1.3. Services

A comprehensive range of high-quality services is in place, supporting a tailored and responsive service for all people on probation.	Requires improvement

Services were generally in place to meet the needs and manage the risks of people on probation, with some positive partnership work to address domestic abuse and adult safeguarding within the city. Regional accredited programmes teams were understaffed. This reduced the number of available programmes, with no structured interventions offered for people on probation. This meant that practitioners already under pressure could not deliver rehabilitation requirements sufficiently. Services have therefore been rated as 'Requires improvement'.

Strengths:

- Multi-agency approaches to addressing domestic abuse were comprehensive and supported positive approaches. Information was shared following multi-agency triage and regular attendance at multi-agency risk assessment conferences (MARAC), which supported Claire's Law disclosures. Staff have access to police domestic abuse information, which was detailed and swift.
- A domestic abuse cohort had been identified to improve multi-agency information-sharing and management approaches. In the cases we inspected, 69 out of 82 cases had sufficient information about domestic abuse. In total, multi-agency work on domestic abuse was sufficient in 36 out of 57 relevant cases.
- Positive multi-agency work to support IOM was evident in the relevant cases we inspected. This had been strengthened by the introduction of a concentrator model. We also saw evidence of management oversight in case conferences.
- The PDU had arranged engagement events to improve relationships with some CRS providers and increase referral numbers. Some CRS providers had been involved in the Leeds PDU managers meetings. This had some positive impact on referral and completion levels for the personal wellbeing services.
- Positive relationships with the Leeds Youth Justice Service (YJS) at a strategic and operational level meant that there was an effective and timely system for identifying children, providing them with transition interventions and transferring them to adult probation services. This was supported by an SPO lead, seconded YJS staff and semi-specialist probation practitioners based in sentence management teams.
- Representatives from the CFO hub were well engaged within the Reducing Reoffending Board, supported by effective operational SPO links. This was used to provide effective engagement opportunities for people on probation in the cases we inspected.
- Pathways were in place for neurodiversity services. These were provided by the National Autism Society and commissioned using the Regional Outcomes and Innovation Fund. The provider supported PDU staff with case formulation to support holistic assessments to take into account the neurodiversity of people on probation, as well as carrying out direct work, where appropriate, with people on probation. Training had been delivered for staff, which had improved the quality of referrals. This had resulted in positive and responsive relationships with the provider.

- Proactive screening into the Offender Personality Disorder pathway had led to appropriate numbers of referrals. Staff were offered support from a clinical psychologist when managing relevant cases. Staff were positive about this support.
- Drug rehabilitation requirements were being recommended in appropriate numbers, with a view to increasing these by 30 per cent between 2023 and 2025. The PDU was meeting current target figures.
- When asked about their experiences in the User Voice survey, people on probation generally said that appointments were set at a mutually agreeable time, the distance required to travel to appointments was reasonable and they felt safe accessing probation offices.
- The PDU leadership team has worked closely with regional unpaid work managers, which has led to a reduction in the backlog of cases waiting for a start date. This had been supported by new initiatives such as automatic enforcement. Work has focused on increasing compliance rates.
- Where managers had lead responsibility roles, this provided tangible benefits in supporting the PDU's relationships with partners and service providers. Benefits were evident in the adult safeguarding partnership, in youth justice transitions and in strengthening accommodation pathways by supporting relationships with the local authority, resettlement services and accommodation providers.

Areas for improvement:

- The deficits in the work to safeguard children were concerning. Strategic and operational relationships had drifted. This led to a significant impact on the quality of child safeguarding practice in the cases we inspected. Despite having dedicated PDU staff with direct access to information from children's social care, information was not requested in 24 out of 80 relevant cases we inspected when it should have been. A further 46 out of 79 relevant cases contained insufficient information on which to base an assessment of risk. Multi-agency working arrangements to manage the risk to children were insufficient in 49 out of 63 relevant cases we inspected.
- Resources across all partners for multi-agency public protection arrangements were insufficient for the demand in Leeds. For new cases, the average waiting time between screening and convening a level 2 panel was five months. While the number of panels could be increased locally, the finite resources of key partners meant that many were unable to commit staff for additional panels. The impact that this will have on the ability to coordinate services to manage critical risk cases in Leeds was concerning.
- There are staff vacancies in the regional interventions team; as a result, insufficient accredited programmes have been delivered to meet assessed need. People on probation have had to wait up to 18 months for a start date. No structured interventions are being offered. This has contributed to insufficient delivery of services to support risk and ensure the safety of others.
- Mental health treatment requirements were not being offered in Leeds. A delay in recruiting for the senior practitioner role in the commissioned provider meant that there was no infrastructure in place to deliver these services. Regional commissioning teams were not identifying wider mental health pathways as a priority, despite clear gaps in provision across Leeds.
- There was a lack of available and suitable housing services for women on probation, especially within the CAS3 provision and onward resettlement.

Feedback from people on probation

User Voice, working with HM Inspectorate of Probation, had contact with 80 people on probation as part of this inspection. They completed 17 online surveys, 58 face-to face interviews and five in-depth interviews. Women were under-represented in the survey, compared with the proportion in the PDU caseload. The proportion of individuals who identified as being from a Black, Asian and minority ethnic background was representative of the caseload.

- The PDU allocation process was supporting a largely positive induction experience for people on probation. When asked, 70 out of 75 respondents to the User Voice survey understood what was expected of them while on probation.
- Despite the workload pressures described by staff, people on probation were positive about the practitioners who facilitated their induction. In total, 62 out of 69 relevant respondents indicated that the practitioner took the time to understand their personal needs. It was disappointing, however, that practitioners did not consistently use this information in assessments and plans to understand the person on probation and promote their engagement.
- The people on probation surveyed generally indicated that they were offered appointments at a time that suited them. This reflected some of the effective and flexible practices we saw in the cases we inspected. The distance people were required to travel to appointments was reasonable and they felt safe accessing the probation office.
- Practitioners were developing some effective relationships with people on probation, with 63 out of 75 respondents to the User Voice survey indicating that they had a good relationship with their practitioner. Practitioners were accessible and responsive to individuals, with 65 out of 75 respondents to the survey stating that they had been able to contact their probation practitioner when they needed to.

  > *"My probation officer, he was really understanding and empathetic. I could actually talk to him, and he helped me and tried to understand me.*

- The PDU had developed some strong working practices to engage people on probation. This had led to some improvements, such as to interview spaces in the PDU. When asked in the User Voice survey, 51 out of 75 respondents indicated that they had been asked their views and felt listened to.

  Of those who indicated that they required support services, 40 out of 51 respondents stated that the probation service has helped them to access services relevant to their personal needs, strengths and circumstances. This was not always evident in the cases we inspected. Sufficient services were delivered to support desistance and the safety of others in only a minority of cases.

Diversity and inclusion

Strengths:

- The Equality and Diversity Group was led by a committed SPO. It had access to data on staff's protected characteristics, links to staff reference groups and mental health allies, and the results from the People Survey. Staff were largely engaged, with around 45 representatives from across the PDU. The work of this group had contributed to the wellbeing and People Survey plans.
- The PDU culture club gave staff access to resources and learning on a range of protected characteristics. This activity was driven by the Equality and Diversity Group.
- The IOM provision had developed a female-specific cohort. In relevant cases, there were close working relationships between the police, probation and third-sector organisations in order to engage women and support their desistance.
- There were services in place to meet a broad range of diversity needs. The National Autistic Society provided pathways for people who were neurodiverse. Semi-specialist practitioners supported transition from youth justice services and work with young adults. The co-location of the Together Women project meant that women could access a further range of services through the women's centre.

Areas for improvement:

- Assessments of women did not sufficiently take into account the impact of their protected characteristics or personal circumstances on their ability to engage with supervision.
- Despite staff input to develop cultural competence, this had not had sufficient impact. Assessments were not sufficiently exploring the impact of individuals' ethnic diversity in their engagement with services.
- In total, 20 per cent of the PDU caseload were from a Black, Asian or minority ethnic background, and there were insufficient pathways for them into specialist services. PDU leaders had identified gaps in specialist provision to regional staff; however, tackling these was not prioritised in regional commissioning plans. These gaps were evident in the cases we inspected: delivery of services to support desistance and ensure the safety of others was less effective than for individuals from a white background.

2. Service delivery

P 2.1. Assessment

Assessment is well-informed, analytical and personalised, involving actively the person on probation.	Inadequate

Our rating[4] for assessment is based on the percentage of cases we inspected being judged satisfactory against three key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Does assessment focus sufficiently on engaging the person on probation?	51%
Does assessment focus sufficiently on the factors linked to offending and desistance?	62%
Does assessment focus sufficiently on keeping other people safe?	**23%**

- Assessment activity did not focus sufficiently on keeping other people safe. This meant that the overall rating for assessment was 'Inadequate'. The PDU had direct access to information on safeguarding from children's services, and information on domestic abuse from the police. The systems for accessing information from the police were robust, with sufficient resources in place. However, this was not the case for child safeguarding enquiries. In 48 out of 81 relevant cases, the practitioner had not identified or clearly analysed the risk of harm to others.
- Deficits in information-gathering and analysis led to 20 out of 77 relevant cases we inspected having an inaccurate risk classification. This was concerning given that it is this risk classification that guides the practitioner to identify the level of multi-agency resource required to manage risk and to identify the frequency of contact.
- Strong and detailed information-sharing with the police supported the assessment of domestic abuse, with 69 out of 82 cases having sufficient information on file. In total, in 51 out of 79 relevant cases the practitioner had sufficiently used the available information to complete their assessments.
- Only two members of staff were trained to support information-sharing with children's social care. Contingency arrangements were weak to mitigate staff absence and connectivity problems with information systems. Information returned from enquiries relied on the practitioner following this up with children's services teams to seek more detailed information on risk. This was not happening enough. Overall, the practitioner sufficiently considered harm related to child safeguarding

[4] The rating for the standard is driven by the score for the key question, which is placed in a rating band. Full data and further information about inspection methodology is available in the data workbook for this inspection on our website.

in only 21 out of 79 relevant cases. Concerningly, insufficient or no information was available in 46 of these cases.

- Practitioners were clear on their priorities to ensure that their initial assessments were timely, and the User Voice survey provided positive feedback from people on probation about their experiences of induction. These discussions focused on desistance and broadly helped practitioners to identify and analyse the right factors in 70 per cent of all cases inspected.
- Practitioners often took into account the personal circumstances of people on probation in assessments. But further work was required to ensure that practitioners had the confidence to analyse the protected characteristics of people on probation. The PDU should examine further the deficits we found in the work to explore the protected characteristics of women on probation. This was despite having a dedicated and co-located team to work with women on probation.

P 2.2. Planning

Planning is well-informed, holistic and personalised, involving actively the person on probation.	Inadequate

Our rating[5] for planning is based on the percentage of cases we inspected being judged satisfactory against three key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Does planning focus sufficiently on engaging the person on probation?	51%
Does planning focus sufficiently on reducing reoffending and supporting desistance?	68%
Does planning focus sufficiently on keeping other people safe?	**34%**

- Risk assessments often lacked critical information on risk, and, in some, the classification of risk was inaccurate. This meant that risk management plans did not focus sufficiently on keeping other people safe. This resulted in the overall rating for planning being 'Inadequate'.
- Overall, there was an absence of professional curiosity in many of the cases we inspected. In 47 out of 80 of the relevant cases we inspected, plans had not sufficiently addressed or prioritised the critical risk of harm factors where they should have. Many of these related to necessary actions required to safeguard children. Where constructive and/or restrictive interventions were required, these were not referenced in plans in 44 out of the 79 cases that required them.
- As evidenced in the User Voice survey, people on probation were clear about the expectations of their sentences, including frequency and type of contact. Practitioners were capitalising on some promising assessments of desistance to identify the services most likely to reduce offending and support desistance in 70 per cent of all cases inspected.
- Practitioners broadly understood the importance of engaging people on probation in their sentence planning. When asked, 43 out of 66 people on probation indicated that they were involved in creating their sentence plan. In the cases inspected, 57 per cent considered the views of people on probation. There was insufficient management oversight at the point of allocation. This meant that, sometimes, multiple allocations were made to one practitioner, or reactive reallocations were deemed necessary. In addition, the leadership priority to meet national targets for the timeliness of sentence plans meant that, in some cases, they were not sufficiently collaborative.

[5] 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. Full data and further information about inspection methodology is available in the data workbook for this inspection on our website.

P 2.3. Implementation and delivery

High-quality well-focused, personalised, and coordinated services are delivered, engaging the person on probation.	Inadequate

Our rating[6] for implementation and delivery is based on the percentage of cases we inspected being judged satisfactory against three key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Is the sentence or post-custody period implemented effectively with a focus on engaging the person on probation?	67%
Does the implementation and delivery of services effectively support desistance?	39%
Does the implementation and delivery of services effectively support the safety of other people?	**23%**

- Insufficient attention was given to protecting actual or potential victims in 58 out of 76 relevant cases inspected. The very basic information provided from child safeguarding enquiries was generally not followed up, meaning that there was ineffective multi-agency working, including information-sharing to safeguard children (49 out of 63 relevant cases).

Poor practice example

Steven was subject to a community order for a domestic abuse assault and possession of class A drugs. Child safeguarding enquiries had been initiated at the start of Steven's supervision in relation to his two children. The response indicated that there had been previous involvement with children's services. However, no clarification had been sought to identify the extent of children's services' involvement. The children now live 10 minutes from Steven. The practitioner was encouraging contact on the basis that children's services were not currently involved, without a wider understanding of the actual or potential ongoing risks to the children.

- In 54 out of 78 relevant cases, the practitioner did not carry out a home visit where this was necessary to manage risk of harm effectively. This was a missed opportunity to gather and verify information, engage with key individuals in the person on probation's life and manage critical risks.
- Comprehensive partnership arrangements, including access to detailed police intelligence on domestic abuse, meant that there were more promising approaches to effective multi-agency working in respect of domestic abuse (36 out of 57 relevant cases).

[6] 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. Full data and further information about inspection methodology is available in the data workbook for this inspection on our website.

- Practitioners were taking flexible approaches to delivering services. The requirements of the sentence generally started promptly. Dedicated practitioners were making sufficient efforts to enable individuals to complete their sentence, including taking their personal circumstances into account in 87 per cent of the cases we inspected. Some examples included the practitioner incorporating childcare commitments and employment arrangements when offering appointments. Licence variations were used where appropriate.
- Delivery of the work to address the factors related to offending and support desistance was disappointing. While there was some use of available CRS, the involvement of other organisations in delivering interventions was insufficiently coordinated in half of the relevant cases we inspected.
- Vacancies in the regional intervention team meant that there was no delivery of structured interventions to people on probation in Leeds, and only limited delivery of accredited programmes. Practitioners were attempting to provide interventions, with some delivery of toolkits and practitioner-led interventions. But this was not having sufficient impact. In over half of all cases inspected, the person on probation had not received sufficient services that were most likely to reduce reoffending and support desistance.

P 2.4. Reviewing

Reviewing of progress is well-informed, analytical and personalised, involving actively the person on probation.	Inadequate

Our rating[7] for reviewing is based on the percentage of cases we inspected being judged satisfactory against three key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Does reviewing focus sufficiently on supporting the compliance and engagement of the person on probation?	57%
Does reviewing focus sufficiently on supporting desistance?	44%
Does reviewing focus sufficiently on keeping other people safe?	**24%**

- While formal reviews are not always necessary, where they were needed, they were not consistently prioritised. This was compounded by key messages from the leadership team to prioritise initial sentence planning work. Of the 71 cases where formal reviews should have been completed in response to changes to the factors related to risk of harm, only 28 were completed.
- Where reviews to keep other people safe were taking place, some staff lacked confidence in their skills and knowledge when applying professional curiosity. Other, more experienced members of staff identified workload pressures as a barrier to verifying information with relevant agencies. This meant that reviewing activity was not sufficiently based on the necessary input from other agencies involved in managing the risk of harm in 46 out of 74 relevant cases we inspected. This resulted in the overall rating for reviewing being 'Inadequate'.
- We saw similar deficits in the reviews to support desistance. Reviews were not consistently identifying and addressing changes in the factors linked to offending behaviour. Necessary adjustments were made to the ongoing plan of work in just 39 out of 68 relevant cases. The practitioner asked for input from other agencies on the progress of the person on probation in just over half of all relevant cases inspected.
- There were more consistent approaches to engaging people on probation. In total, 56 per cent of reviews of progress and engagement meaningfully involved the person on probation. However, in 34 out of 75 relevant cases, this did not always result in necessary adjustments being made to ongoing plans.

[7] 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.

Outcomes

- While it may be difficult to draw any direct causal relationship between the quality of the interventions delivered by the PDU and reoffending rates, only 21 out of the cohort of 82 people on probation had been convicted of any further offences. This is below the Leeds proven reoffending rate of 31.1 per cent.[8]
- Significant gaps existed in the involvement of other agencies to manage and minimise the risk of harm. Only 10 per cent of the cases inspected demonstrated an improvement in the individual factors identified as related to risk of harm.
- Overall, sufficient improvements in those factors most closely linked to offending, both in developing strengths and addressing needs, were evidenced in only 18 per cent of the cases we inspected. This reflected inconsistencies in the engagement of services to support and sustain desistance during the sentence and beyond.
- The significant focus on ensuring that practitioners focused on a 'strong start' meant that practitioners often focused on assessment and planning activity. At times, this was to the detriment of service delivery. In the cases inspected, there was sufficient compliance with the order in only half of the cases we inspected.

[8] Source: Ministry of Justice. (July 2024). Proven reoffending statistics: October 2021 to September 2022.

Annexe one – Web links

- Full data from this inspection and further information about the methodology used to conduct this inspection is available on our website.
- A glossary of terms used in this report is available on our website.