



HM Inspectorate
of Probation

An inspection of probation services in:
The Probation Service -
Yorkshire and The Humber Region

HM Inspectorate of Probation, February 2025



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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 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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M3 3FX

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Foreword

This was the first inspection of probation services in Yorkshire and the Humber region since the commencement of the Inspectorate's new adult probation inspection programme in October 2023. Across the region, leaders and staff were committed and dedicated to driving forward effective and meaningful probation practice, but this did not translate into adequate protection of the public or sufficient delivery of services often enough. The region will be disappointed to be rated as 'Requires improvement' overall.

We found that cases were not being assessed for management under multi-agency public protection arrangements (MAPPA) in a timely way and reviewing of Level 1 cases was inconsistent. There were significant delays to the delivery of accredited programmes and core risk reduction work was not being prioritised.

The region had secured access to police systems, resulting in timely access to domestic abuse information in most probation delivery units, and this was a significant achievement, as timely and accurate information sharing is vital for the success of probation services. As we see too often, however, this information was not always being used sufficiently to inform risk assessments or management of the individual. Information received from children's services was not always sufficient to inform robust assessments of risk, and operational relationships did not promote the sufficient sharing of information to safeguard children adequately.

However, strategic relationships with partner agencies involved in supporting people on probation to change were a particular strength and senior leaders were engaging with other agencies across the region to improve outcomes for people on probation. There was some promising progress in the quality of work to engage people in their sentences and to understand their offending behaviour, but insufficient work was being completed to keep people safe and deliver orders of the court.

While recruitment has continued across the region, there remain vacancies across several critical delivery functions, including accredited programmes, Offender Management in Custody, unpaid work, and frontline probation officers. These shortages, along with a high proportion of inexperienced staff, and officers carrying workloads above 100 per cent capacity, all impacted on the delivery of high-quality services.

Regional leaders deserved credit for implementing at pace several changes to national policy aimed at relieving pressure on the prison population and ensuring the targeting of probation resources in the initial period of supervision in the community. They were doing so while being understaffed and overstretched, but remained committed to driving improvements to probation service delivery.

Overall, we saw some high-quality work being delivered across Yorkshire and the Humber region; we just did not see this in enough cases. Regional leaders knew and understood the task before them and were putting in place the strategic building blocks to drive improvements. They now require a period of operational stability to apply themselves to achieving this.



Martin Jones CBE
HM Chief Inspector of Probation

Ratings

Yorkshire and The Humber
Fieldwork started July 2024

Score **5/24**

Overall rating

Requires improvement



1. Organisational arrangements and activity

R 1.1 Leadership

Requires improvement



R 1.2 Staffing

Requires improvement



2. Service delivery

R 2.1 Public protection

Inadequate



R 2.2 Desistance

Inadequate



R 2.3 Court work

Inadequate



R 2.4 Unpaid work

Inadequate



R 2.5 Resettlement

Inadequate



R 2.6 Victim work

Outstanding



Executive summary

Introduction

Outside of London, Yorkshire and the Humber is the second largest Probation Service region, in terms of the number of cases managed, and is one of the 12 regions of England and Wales. Along with the North East Probation Service region and several prisons, it is part of the wider North East area of HM Prison and Probation Service (HMPPS). Probation services were delivered across 11 probation delivery units (PDUs) in total across the region. All PDUs within the region were inspected between July and October 2024.

At the time of announcing our inspection of Yorkshire and the Humber region, the regional probation director was new in post, although very experienced and had a well-established regional leadership team. The region had a staffing target level of 2,310 staff, with 2,117 staff employed. There were probation officer (PO) vacancies across all PDUs, along with gaps in administrative resource. On average, POs were holding a caseload of 34 cases, and probation services officers (PSOs) 44 cases.

The national workload management tool, used by the Probation Service to monitor available capacity across the service, indicated that individual POs were working at an average of 120 per cent, and PSOs at 106 per cent capacity, higher than what is considered manageable. At the point of inspection, the region was implementing, at pace, several national policies aimed at reducing prison capacity, including the end of custody supervised licence scheme, 'Probation Reset' (announced at the same time as the inspection), and the release of some prisoners at the 40 per cent point in their sentence (standard determinate sentence 40 (SDS40), announced during the inspection period).

As a region, the Yorkshire and the Humber Probation Service spans four police forces and works closely with both Police and Crime Commissioners and mayoral offices to reduce reoffending. In total, there are 21 local authorities across the region, encompassing several local safeguarding partnerships, 22 clinical commissioning groups, 20 courts, 13 approved premises, and a number of prisons, including two long-term and high security estates.

Methodology

We conducted fieldwork in each PDU across Yorkshire and the Humber between 01 July and 25 October 2024. We reviewed 546 cases, of which 327 were subject to a community sentence and 219 were subject to release on licence. From each of these cases, we collated data for our public protection and desistance ratings. We also conducted 466 interviews with probation practitioners. We also reviewed 299 court reports and 209 cases subject to resettlement provision. We inspected 47 unpaid work cases and 60 statutory victim cases from across the region where community sentences and licences had commenced between 04 Dec 2023 and 07 April 2024.

1 Organisational arrangements and activity

R1.1 Leadership

Regional leadership was rated as 'Requires improvement'. While we saw some encouraging work relating to engaging people on probation and desistance within some PDUs, the overall management of risk and the actions taken to keep people safe was poor across the region. Regional leaders had supported the recruitment and

deployment of a quality development team and there was regular assurance activity, but those activities had not yet driven sufficient improvements to the delivery of services to address and manage risk of harm. While we saw effective casework practice within all PDUs, we did not see this in enough cases and there had been insufficient improvement since our last inspection.

There were a high number of multi-agency public protection arrangements (MAPPA) cases that were yet to have their management level determined, and Level 1 reviews did not take place routinely, which was of concern. Access to structured interventions and accredited programmes was not strategically driven, with long waiting lists and little service delivery. In part, this had been frustrated by national job evaluation processes and had meant that a number of staff had left the interventions team, making delivery more complex. However, more could and should have been done with the resource available, in order to provide core risk reduction work.

Relationships with stakeholders and key partnership agencies were a particular strength across the region. Regional and local delivery plans aligned and there were strong strategic relationships across prison and probation services, with clear priorities for focusing on reducing reoffending and protecting the public. The Regional Rehabilitation Board was an impressive vehicle for developing services across the region, including co-commissioning opportunities and the sharing of best practice. The Probation Service, and its contribution, was highly respected by partners and stakeholders, and had driven forward a number of initiatives to improve outcomes for people on probation.

There was strong strategic management of commissioning processes, and PDUs were supported on a local level by recently appointed commissioning and partnership managers to improve access to services across the region. Contracts were regularly reviewed, and action taken when needed, to ensure that appropriate service levels were reached. Opportunities had been taken to commission services to meet specific diverse needs across the region. However, national procurement processes created some barriers to the swift commissioning of services, which meant that the needs of people on probation remained unmet in some instances. Commissioned rehabilitative service (CRS) interventions were underutilised by probation practitioners.

The region had been successful in working with police partners to agree access to policing systems. This had facilitated swift and timely access to information in almost all PDUs, although the level of resource allocated to checking intelligence logs lacked resilience. Access to safeguarding information from children's services varied across the region and we saw barriers to information sharing which resulted in incomplete and unsafe risk assessments.

Regional staff were generally positive about their experience of working for Yorkshire and the Humber region, and felt that there was a culture of openness. They were able to offer constructive challenge, as well as have their ideas for improving the service heard. The majority of regional staff said that they felt valued for the work they completed.

There were arrangements in place for engaging people on probation, although this was in its infancy across the majority of PDUs. Where that engagement had been achieved, there had been tangible results to the way that services were delivered, with improvements made to increase accessibility and meaningful inclusion.

Governance arrangements at a regional level were over-complex, resulting in insufficient insight into the gaps and barriers to service delivery. Business plans spanning several areas of regionally driven activity created confusion for heads of

service. Plans for realigning regional management oversight and improving accountability were defined but not yet to implemented at the time of our inspection.

R1.2 Staffing

Staffing requirements across the region were well understood, with a comprehensive people plan in place, incorporating five distinct people-related workstreams: workforce planning; health and wellbeing; equality, diversity, inclusion, and belonging; engagement; and learning and development.

Workforce planning was comprehensive, and underpinned by an impressive regional dashboard, locally created and managed, ensuring that senior leaders had a good oversight of current and future recruitment needs, with administrators supporting this activity across some PDUs.

Since our last inspection, regional staffing had increased. Corporate service posts and quality and performance roles were sufficiently resourced. Regional functions, to support frontline delivery and improvements in practice, had also been recruited to, including quality development teams, commissioning and contract managers, and victim liaison officers (VLOs). However, there were vacancies remaining across intervention teams, unpaid work supervisors, Offender Management in Custody (OMiC) teams, and within PO and administrative grades. These were all contributing to the barriers to delivering a high-quality service to people on probation.

There was an impressive regional induction process in place, to support new staff and improve retention of successful applicants while they waited to start their roles. The region proactively reviewed the diversity information of applicants and took action to ensure fair accessibility in the recruitment process. Mentoring support for newly appointed senior managers was delivered but was not offered universally, which left some feeling inadequately supported.

Learning completion rates for mandatory learning were monitored, but little was done to understand how this learning was being embedded or applied in practice. Sharing and embedding of learning from Serious Further Offences (SFOs) were not monitored at a PDU level.

The span of control for the head of public protection was vast, and as a consequence impacted on the strategic oversight of MAPPA processes, with heads of service insufficiently supported to deliver all that was required of them at a local level. Senior and middle managers within PDUs universally had unmanageable workloads, and management oversight was insufficient in the majority of cases.

2 Service delivery

2.1 Public protection

The implementation and delivery of services to keep people safe was consistently the least sufficient area of practice in the cases we inspected across all PDUs. The lack of structured interventions and access to accredited programmes meant that, in a number of cases we inspected, core risk reduction work was not completed. Practitioners had swift and timely access to domestic abuse information at the start of sentences in the majority of cases, although access to child safeguarding information was less consistent. Having timely access to information is an essential building block, but, as we see too often, this information was not always used to inform robust assessments or risk management planning, and follow-up enquiries were not always made where it would have been appropriate to do so.

Consideration of actual and potential victims was insufficient in just under half of the cases inspected, and a failure fully to take into account available sources of information led to insufficient risk management in too many cases. There needed to be higher levels of contact and home visits undertaken to improve the management of risk.

The management of MAPPA cases demonstrated a higher level of sufficiency, in terms of using available sources of information to manage the case, considering the protection of victims, and ensuring that plans to keep people safe were suitable, and that levels of contact and home visits were sufficient, but still required improvement overall. However, not all MAPPA cases inspected were identified as requiring MAPPA management in line with policy guidelines and received infrequent reviews, in line with our wider findings overall.

2.2 Desistance

On a regional basis, quality improvement work had been undertaken regarding the assessment and planning aspects of sentence delivery and desistance, and factors linked to offending were well identified across a number of cases that we inspected. In general, the reasons for, and the steps to address, offending were well understood.

However, addressing these factors did not translate into high-quality work during the delivery of sentences. There was a lack of interventions being delivered in a sequenced or timely way to address offending-related factors. This was particularly seen in cases where contact with people on probation was suspended at short notice under the Probation Reset scheme, as a result of the limited notice given to practitioners when the national policy was implemented at pace.

Probation practitioners often engaged well with people on probation, and offered constructive supervision sessions in some cases. The lack of accredited programmes impacted on addressing offending behaviour in those cases where group work would have been appropriate. While co-location with CRS providers was routine within PDUs, probation practitioners needed to refer more cases into these support services, in order to drive up intervention delivery and improve outcomes for people on probation.

2.3 Court work

Sufficient advice was offered to courts and appropriate proposals were made in the majority of cases we inspected. Individuals were often meaningfully involved in the preparation of their report, and practitioners routinely considered their diversity and personal circumstances.

However, sentencing proposals made by practitioners were not always specific, in terms of targeting requirements that would address risk of further offending and harm, and pre-sentence information and advice was not sufficiently personalised in too many cases. Risk information was not used or analysed sufficiently to support the court's decision-making. A regional approach was taken to drive improvement in service delivery to the courts, with inclusion in a national pilot scheme for targeting effective proposals at court.

2.4 Unpaid work

There were strengths in the delivery of unpaid work across the region. This included clear and comprehensive induction processes, with examples of individuals being able to work on the day of initial induction. Supervisors were generally enthusiastic

and supportive of ensuring the delivery of high-quality services to the community and we saw examples of meaningful and valued placements across all PDUs. Steps had been taken to ensure inclusivity in placements, including specific groups for women and those with neurodiversity needs, and positive feedback was received from both beneficiaries and those completing unpaid work hours.

Arrangements for delivering unpaid work maximised rehabilitative elements and supported desistance in 64 per cent of cases. However, we found that the assessment and planning of personalised unpaid work activity was insufficient. Enforcement did not take place when necessary, in all cases. At the time of the inspection, the region was transitioning to standalone unpaid work teams, to improve the management of these requirements, including automatic enforcement in some PDUs, but this had yet to be embedded.

2.5 Resettlement

The restructuring of resettlement functions within custody, on a regional basis, were incomplete. Along with vacancies across OMiC structures, this was impacting on the quality of services being delivered in preparation for release. However, where handovers to community offender managers (COMs) were required, these took place in a timely way in the majority of cases.

Too few individuals received a proportionate level of contact with their COM prior to release, and some were being released at earlier points in their sentence because of changes in prison release policies, which was also impacting on that level of contact. In just over half of the cases inspected, there was effective coordination of pre-release activities, but resettlement and desistance needs, as well as key risk of harm issues, were not routinely identified or addressed for all cases.

2.6 Victim work

Victims who were eligible for support via the Victim Contact Scheme, as a consequence of being a victim of a serious sexual or violent offence, received timely contact from VLOs in the majority of cases. Sufficient information was shared to allow victims to make an informed choice about their inclusion in the scheme. VLOs fed into release plans and were proactive in representing the views of victims, including support to make personal impact statements for inclusion in Parole Board processes.

While the overall level of service provided to victims was impressive, MAPPA referrals were unacceptably delayed in three out of the 33 victim cases inspected. In some instances, VLOs did not receive timely information from probation practitioners regarding changes in the circumstances relating to perpetrators. While there was a failure-to-notify process in place across the region, this was not driving forward action to address situations where information had not been shared in a timely way.

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.

Yorkshire and the Humber Probation region should:

1. ensure that MAPPA level setting for custody and community cases is timely, taking into consideration the earliest possible date of release and any temporary releases, and be fully informed by information from all relevant agencies in all cases
2. ensure that all MAPPA Level 1 cases have sufficient management oversight and that there is an appropriate focus on information exchange with other agencies to inform risk assessment and review
3. implement a system for directing and following up action and learning in response to themes from SFO reviews and other sources of information about the quality of practice
4. support heads of PDU to engage with local child safeguarding partnerships, to improve the access to, and sharing of, sufficient child safeguarding information to facilitate the management of risk of harm
5. improve the availability and completion rates of accredited programmes and structured interventions
6. review referral rates and use of CRSs to ensure that they are meeting the needs of people on probation.

HMPPS should:

7. ensure that senior probation officers have sufficient capacity and resource to undertake effective management oversight of casework
8. delegate greater authority to regional probation directors in relation to spending, including on commissioned services and contract management, and streamline commercial processes
9. evaluate the effectiveness of training material delivered to practitioners in relation to keeping people safe, and provide reporting mechanisms for regions to identify concerns about deficits in practitioner skills and knowledge.

Background

Outside of London, Yorkshire and the Humber is the second largest Probation Service region, in terms of the number of cases managed, and is one of the 12 regions of England and Wales. Along with the North East Probation Service and several prisons, it is part of the wider North East area of HMPPS.

Probation services were delivered across 11 PDUs in total. Three of these – Barnsley and Rotherham, Doncaster, and Sheffield – were located in same area as the South Yorkshire Police Force. Wakefield, Leeds, Kirklees, Bradford, and Calderdale were within the boundaries of West Yorkshire Police Force; York and North Yorkshire were covered by the North Yorkshire Police Force; and Hull and East Riding, and North and North East Lincolnshire were within the Humberside Police Force area. All PDUs within the region were inspected between July and October 2024.

At the time of announcing our inspection of Yorkshire and the Humber region, the regional probation director was new in post, although they were very experienced in the role and the regional leadership team was well established. The region employed 2,117 staff, with a target staffing figure of 2,310. The largest number of vacancies was for POs across all PDUs, and there were gaps in administrative resource. On average, POs were holding a caseload of 34 cases, and PSOs 44 cases. The total number of individuals being supervised in the community was 17,222 at the point of inspection, with 10,942 people on probation subject to community orders and 6,280 individuals receiving supervision following release from prison. A further 5,384 cases allocated to the Yorkshire and Humber region were in custody.

The national workload management tool, used by the Probation Service to monitor available capacity across the service, indicated that individual POs were working at an average of 120 per cent, and PSOs at 106 per cent capacity, higher than what is considered manageable. At the point of inspection, the region was implementing, at pace, several national policies aimed at reducing prison capacity including the end of custody supervised licence scheme, 'Probation Reset' (announced at the same time as the inspection), and the release of some prisoners under SDS40 (announced during the inspection period).

As a region, the Yorkshire and the Humber Probation Service spanned four police forces and worked closely with both Police and Crime Commissioners and mayoral offices to reduce reoffending. In total, there were 21 local authorities across the region, encompassing several local safeguarding partnerships, 22 clinical commissioning groups, 13 approved premises, and a number of prisons, including two long-term and high security estates. The region provided a service to 20 courts in total. A Regional Rehabilitation Board facilitated commissioning and service delivery with partner agencies across all PDUs and supported the work of local reducing reoffending boards.

CRSs were available for people on probation and were delivered across the region, with providers including Shelter, St Giles Trust, Ingeus, Growth Company, Change Grow Live, Forward Trust, and Together Women. Regional outcomes innovation fund (ROIF) arrangements were in place for smaller contracted providers, with more bespoke delivery of services, in several PDUs, and the health and justice managers supported the delivery of services as part of the combatting drugs strategy and the offender personality disorder pathway.

1. Organisational arrangements and activity

R 1.1. Leadership



Regional leadership drives the delivery of a high-quality, personalised, and responsive service for all people on probation.

Requires improvement

Strengths:

- The regional business plan aligned with HMPPS North East and Yorkshire and the Humber area priorities, which were focused on the core priorities of protecting the public, reducing reoffending, and improving delivery and performance. This was in concordance with the regional reducing reoffending plan, co-written with the Prison Group Director. The plans focused on reasonable priorities, including access to training, skills, and work, improving access to drug and alcohol treatment, building family and community ties, securing suitable accommodation, and delivering the order of the court. Leaders were taking action against all identified priorities.
- In response to previous inspection findings, PDU heads of service had been included in the draft stages of agreeing regional plans. Each PDU had created individualised objectives within their own business plans, to drive the activity of meeting regional requirements.
- Relationships with key stakeholders were strong and partners were confident in being able to have open and honest conversations with the Probation Service to challenge when needed. They valued Yorkshire and the Humber Probation Service as partners who brought a breadth and depth of knowledge on a regional level, and this was replicated across PDUs.
- Strong partnerships, at both regional and PDU level, had enabled Yorkshire and the Humber to have administrative access to police domestic abuse information across all four police force areas. This meant that, as seen in case inspection, there was timely access to police information to inform court report and assessment processes. There were also strong strategic relationships with children's services, although with varying degrees of maturity across the region. While we saw some examples of problematic access to child safeguarding information, much had been achieved and there was a commitment to improve information sharing further.
- The Regional Rehabilitation Board was used by regional leaders to explore co-commissioning opportunities effectively across Yorkshire and the Humber, and share learning between neighbouring authorities in regard to service provision and extended services, both into and out of custody. An example of this was the commissioning of employment advisers in two PDUs, a model proving to be effective in custody. Through this shared platform, there had been an opportunity to hold agencies to account and bring others around the table who shared the objectives of reducing reoffending and improving lives, including housing and healthcare providers and local authorities.

- The efficacy of their approach with partners was routinely evaluated. Within Hull and East Riding PDU, ROIF had been allocated for securing housing, via partners and with the support of the local authority, for people being released from custody under SDS40. Lessons learnt from this model were being used to inform partnership working with other housing providers across the region.
- The commissioning board was effective and ensured robust governance of contracts with partnership agencies. There was a strong strategic lead in contract management. The recruitment of commissioning and partnership managers at a regional level was supporting PDUs and partners in accessing co-commissioning opportunities. Contracts were regularly reviewed, and referral rates and engagement with services monitored. There were clear lines of escalation if services were not meeting their contracted requirements.
- Data collection and access to management information, including performance information, caseload data, and workforce planning, were a particular strength. The data was presented in easily accessible and user-friendly dashboards and was used to inform regional activity across all workstreams.
- Meaningful information was available to senior leaders to understand the needs of the people on probation, and this had been used to drive commissioning bids and the use of ROIF in meeting diverse need. The largest of these contracts, outside of CRSs, were services for those with neurodiverse needs, delivered via the National Autistic Society. There was evidence of other, smaller, contracted services to meet specific identified needs and there was a responsiveness to locally identified need. This included opting to commission services in response to our findings in the early PDU inspections, before the full regional inspection had been concluded.
- The region encouraged a culture of openness and constructive challenge. There were various avenues for sharing ideas to improve service delivery, with 79 per cent of staff survey respondents agreeing that this was the case. One vehicle for driving forward ideas was via the 'great ideas group', which had seen tangible results following ideas submitted across the region. Senior leaders were invested in this process and actively encouraged participation across all grades of staff.
- In response to our staff survey, 78 per cent of respondents said that they felt valued for the work that they did. Leaders monitored reward and recognition awards to make sure that they were being used sufficiently and equitably. There was a member of staff dedicated to staff engagement and communication.
- Engagement with people on probation was promoted across the region, although some PDUs were in their infancy in terms of delivering against this. St Giles Wise supported delivery of the engaging people on probation strategy, and engaging people on probation forums had commenced in some PDUs. There was a dedicated resource at a regional level for driving forward this work. We saw examples of people on probation being included in service design, with dedicated topics that fed into themes of work at a regional level. This also took place across approved premises, encouraging participants to have their voice heard, and feedback from people subject to unpaid work requirements was continually sought, and used at a regional level to improve service delivery.

Areas for improvement:

- Insufficient action had been taken to improve the quality of risk assessment and management plans since our last inspection. The region had a single priority, to 'deliver quality services'. Some limited improvements to the engagement of people on probation in their sentences, and to assessment and planning to support desistance had been made, but not enough to translate into high-quality services being delivered or keeping people safe.
- Despite our findings during the last inspection, there remained a high number of cases where MAPPA levels were yet to be set or reviews completed. There was an inconsistent approach to level setting and reviewing of MAPPA cases, and there had been insufficient strategic oversight at a regional level to address this. There was a lack of management assurance that these cases were being appropriately managed via multi-agency arrangements in accordance with their level of risk.
- Governance arrangements at a regional level were over-complex, counterproductive, and did not sufficiently drive or support service improvement at an operational level. There were approximately 25 committees, subcommittees, working parties, and steering groups at a regional level. Regional management and reporting structures were not sufficiently streamlined, which meant that senior leaders did not have sufficient insight into gaps and barriers to service delivery. Plans for realigning senior management oversight and improving accountability were in place, but yet to be implemented at the point of inspection.
- Although the regional plan broadly identified activities to achieve objectives, it lacked detail in how these were to be delivered or measured. This, along with over-complicated governance structures spanning a number of areas of the business, resulted in confusion across PDUs about their individual responsibilities against the regional plan and made measuring progress against regional objectives difficult to gauge.
- Business plans and governance arrangements, spanning several areas of regionally driven activity, were confusing for heads of service responsible for operational delivery. This resulted in a lack of clarity about priorities and what they were accountable for delivering.
- While the access to police domestic abuse information, via Probation Service administrative staff, was a significant achievement, the resource allocated to this task lacked resilience, especially given the ever-increasing demands upon it.
- Accredited programme delivery was being held back by a lack of strategic oversight and direction. Delivery rates across all programmes were very low, and significantly lower than would be expected with the resource available. Leaders had devised a method for prioritising programme places, but this focused on those at risk of not completing programmes before the end of their sentence, rather than making the initial period of supervision count. There was an overall lack of assurance that programmes were being planned and delivered in a coherent and logistically efficient way. Core risk reduction work for those convicted of a sexual offence, or requiring the Building Better Relationships programme to address domestic abuse behaviours, were not being prioritised. Recruitment of new facilitator staff and rapid training arrangements were impressive, but leaders had not sufficiently communicated

with those already doing the job, which meant that there was much anxiety and uncertainty among this dedicated staff group.

- We saw gaps in commissioned service provision for people on probation from ethnic minorities in several PDUs where specific services would have been expected. Local services that were accessible to all were being utilised in some PDUs, but there were still gaps to meet the needs of those from an ethnic minority who were subject to probation supervision. In some Yorkshire PDUs almost a third of those subject to probation were from an ethnic minority and yet there were no specific services being offered. Two previous commissioning campaigns had failed to result in the successful engagement of a service, partly due to barriers created via long Ministry of Justice procurement processes. Where it had been possible to do so, smaller contracts had been agreed, and further work had been done to support local agencies prepare for future tendering opportunities. A further campaign was under way, but any secured provision was unlikely to be able to commence prior to April 2025.
- CRSs were being underused in PDUs, despite strong commissioning and contract management arrangements. More could have been done by regional leaders to utilise the referral, start, and successful completion data, to drive improvements.
- Despite this range of activity aimed at driving up quality, learning was not consistently embedded and had not resulted in high-quality service delivery in all cases. Not all practitioners received feedback from regional case audit tool assessments completed on their cases, one-to-one sessions were often underutilised, and embedding quality and learning (EQual) sessions were not always reaching those who most needed to learn. There was an inconsistent approach to how PDUs welcomed and used the quality development officer (QDO) resource.
- Eleven out of 96 survey respondents told us that they had experienced bullying, harassment, or abuse in the last three months. Only two of these felt that sufficient action had been taken at the point of completing the survey. While the people plan was positive about promoting inclusion and belonging, a stronger steer on how unacceptable behaviour would be tackled was required.

R 1.2. Staffing



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

Requires improvement

Strengths:

- There was a comprehensive people plan in place, with the core objective of 'enabling our people to be their best'. This plan sought to deliver national Probation Service workforce objectives at a regional level, against five distinct people-related workstreams: workforce planning; health and wellbeing; equality, diversity, inclusion, and belonging; engagement; and learning and development. This plan acted as a vehicle for several activities aimed at recruiting and retaining the workforce, engaging staff, and promoting inclusion within the organisation, with clear objectives and measurable outcomes.
- Workforce planning was comprehensive and underpinned by an impressive regional dashboard, MYPDU. Regional senior leaders had a good oversight of current and future recruitment needs. The region was able to track the length of time from agreeing a campaign to commencement in role, and used this data to understand better and unblock barriers to recruitment. Some PDUs had access to workforce planning administrators, and this had a positive impact on recruitment speediness.
- All QDO, contract and partnership managers, and victim liaison officer posts were fully staffed, following a recruitment process which had been carried out since our last inspection. Corporate services and quality and performance functions were sufficiently resourced.
- There was an effective regional induction scheme in place. New recruits were supported as soon as job offers were made, which sustained their engagement while vetting took place. Of 40 staff survey respondents who had changed role within the last two years, 27 considered that they had received an effective induction.
- Close monitoring of protected characteristics and recruitment activity had meant that Yorkshire and the Humber region had been able to identify where candidates had exited recruitment campaigns. Using this information, they now provided a diverse panel member at all points of sifting and interview stages, to improve accessibility.
- Promotions across Yorkshire and the Humber region were tracked by senior leaders and monitored to understand progression routes and ensure equitability.

Areas for improvement:

- Staffing vacancies in unpaid work supervisors, programme facilitators, and offender managers in custody were directly impacting on the delivery of high-quality services due to a lack of access to interventions and pre-release support.

- The head of public protection had strategic oversight of MAPPA processes and direct line management responsibility for resettlement, OMiC, the offender personality disorder pathway, and statutory victim contact. This model resulted in heads of service being insufficiently supported to manage MAPPA processes and there was a lack of regionally driven action to address the high number of cases with MAPPA level setting and reviews outstanding.
- The region monitored mandatory learning completion levels but there had been little further done to understand how this was being applied in practice. There was a suite of interventions available to deliver on protected development day events, but some confusion across PDUs about how much autonomy they had in driving forward the learning requirements of their PDU, against the overall regional learning plan.
- Recruitment to case administrator grades had been particularly problematic, with high attrition rates. The pay at this grade was not attractive for the responsibility and workload demands that these positions required.
- Newly appointed senior managers had been offered mentoring buddies to support their transition into their roles. This was not universally seen for all, and some newly promoted members of staff indicated that they would have benefited from this additional support.
- Following our last inspection of the region, there had been a review of the community integration team model, with a decision to move away from this. Short-sentenced prisoners were now being allocated to generic offender management teams within the community. However, the restructuring of resettlement teams within custody and the model for deliver was still to be agreed. Uncertainty for those staff based in prisons, alongside staff vacancies within OMiC, were impacting on the quality of services delivered for those being released from prison.
- Management oversight by regional senior leaders was insufficient. Governance arrangements for the regional leadership team (RLT) and links into the operational line were over-complicated and did not ensure clear lines of accountability. The strategic management of interventions was lacking and had led to significant deficits in delivery. Restructuring of resettlement functions was incomplete. The combination of these factors impacted on driving improvements to service delivery and ensuring high-quality services.
- Management oversight of casework was insufficient, ineffective, or absent in the majority of cases we inspected in PDUs. Training on skills for effective engagement, development, and supervision was being delivered to managers. However, this was yet to impact on better risk management and support for people on probation.

Feedback from people on probation

User Voice, working with HM Inspectorate of Probation, had contact with 710 people on probation across Yorkshire and the Humber as part of this inspection. Surveys were carried out with 670 people, and 48 people were interviewed by User Voice. Eight people completed a survey and an interview.

Strengths:

- The majority of respondents surveyed (ranging between 86 per cent and 98 per cent at PDU level) said that they understood what was expected of them while on probation. This provided a good foundation for ensuring that individuals were aware of the benefits of engagement with their sentence and the consequences of non-compliance.
- Overall, 80 per cent of respondents stated that they felt that their probation practitioner had taken the time to understand their personal needs during induction. This was reflected in our findings at PDU levels, where we saw some effective practice in the analysis of protected characteristics and personal circumstances, and the impact on the individual's ability to engage and comply. A slightly higher percentage of those subject to community sentences reported being understood than those subject to licence supervision (83 per cent and 78 per cent, respectively). One individual said:
"They asked about me and everything about that was good to help them understand me better. Everything was very well explained to me."
- A reasonable majority, 65 per cent of respondents overall, stated that their appointments were useful in helping them and their rehabilitation. Women reported finding their appointments useful in 78 per cent of cases, in comparison with 65 per cent of men. This was reflective of the positive desistance scores we saw across PDUs relating to practitioners focusing sufficiently on factors linked to offending, and planning focusing sufficiently on reducing reoffending and supporting desistance.

Areas for improvement

- In some PDUs, up to a quarter, or more, of respondents did not feel involved in creating their sentence plan with their probation practitioners. While we saw good examples of engaging the person on probation in both the initial assessment and planning of their sentence in the cases we inspected, more could have been done to promote inclusion in these processes, with 11 per cent of respondents (75 out of 669) stating that they were not aware of having a sentence plan.
- While the number of positive responses was still high, fewer from a minority ethnic background reported being able to contact their probation practitioner when needed (75 per cent, in comparison with 84 per cent of white respondents), and fewer said that they had sufficient contact time with their probation practitioner (79 per cent, in comparison with 84 per cent of white respondents).

Diversity and inclusion

Strengths:

- While the staffing demographic of PDUs was not always representative of the communities they served, there was a proactive approach to engaging with local communities to increase applications from diverse backgrounds. One example of this was in Huddersfield, where there had been active engagement with Local Services 2 You, a group of local community groups meeting diverse needs. This had led to a better understanding of the needs of the local community, improved access to services for people on probation, and promoted recruitment into the Probation Service.
- There was active use of diversity information to inform service planning. Previous commissioning activity to secure services to meet the needs of people on probation from ethnic minorities had stalled, partly due to central procurement processes. More had been done with local providers to improve their viability to re-bid under future tendering opportunities, and those campaigns had been readvertised.
- Where it was able to do so, the region commissioned smaller contracts specific to individual need identified within PDUs. This included debt advice in Barnsley; Humbercare Circles to support those convicted of a sexual offence; evaluation of mental health treatment requirements; targeted housing support, trauma informed, for those who experienced multiple disadvantages; age-specific services for people from ethnic minorities in Sheffield; and access to education, training, and employment in Hull.
- There had been significant investment in supporting people on probation with neurodiverse needs to access appropriate specialist support via a contract with the National Autistic Society. This had included training for practitioners, case formulations, building audits, and direct support to individuals on probation. The contract had been extended, based on the evidence of the positive impact it had had in supporting better outcomes for those with neurodiverse needs.
- In some PDUs, people on probation were regularly asked for feedback on monthly themes, to develop and improve how diversity needs were met.
- Regional leaders encouraged staff to hold cultural competency conversations to increase confidence. Some PDUs scored highly for considering and analysing protected characteristics and personal circumstances, and how these would impact on the person being able to engage in their sentence. An example of this was in Wakefield, where people on probation (Ingeus peer mentors) had been actively engaged in protected development days, in conjunction with the equality, diversity, and inclusion group, to share their lived experience.
- Most PDUs had women-only reporting facilities and many were engaged with local women's services to provide support and interventions away from the main probation office. There were close working links with both CRS providers for women and other local services across most PDUs.

- Unpaid work delivery to women only and neurodivergent groups was available in some PDUs.
- There was a commitment to seconding qualified staff into all youth offending services and we heard positive reports from youth justice leaders about the impact they had on understanding the risk that individuals presented, and supporting transitions into adult services.

Areas for improvement:

- Within a number of PDUs, we saw significant numbers of people on probation from an ethnic minority background, but limited, if any, services commissioned by the Probation Service to meet their specific needs.
- Disparity information was collated and disseminated on a regular basis for all PDUs, but this was not then being used consistently to drive service delivery locally.
- Additional support from contract and partnership teams to analyse caseload data and support commissioning on a local level would have been of benefit, specifically for heads of PDUs who were new in post.
- Equality, diversity, and inclusion groups within PDUs varied in their maturity. Although we saw some examples of proactive inclusion activities, such as culture clubs, this required further development.

2. Service delivery

R 2.1. Public protection



High-quality, personalised, and responsive services are delivered to protect the public.

Inadequate

Our rating¹ for public protection is based on the percentage of cases we inspected being judged satisfactory against four key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Does assessment focus sufficiently on keeping other people safe?	31%
Does planning focus sufficiently on keeping other people safe?	41%
Does the implementation and delivery of services effectively support the safety of other people?	26%
Does reviewing focus sufficiently on keeping other people safe?	34%

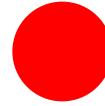
- Direct access to police systems across Yorkshire and the Humber facilitated timely intelligence about domestic abuse history, to inform assessments in almost all PDUs. Progress towards better information sharing was encouraging as this was a key building block for public protection. While sufficient information about domestic abuse was available in 80 per cent of cases at the initial assessment stage, this was not then always fully utilised by practitioners to make informed judgements about levels of risk and appropriate risk management measures.
- Access to child safeguarding information was evident in almost three-quarters of relevant cases inspected at the initial assessment stage, but was not always fully utilised to inform how a case would be managed, taking into account risk to children. However, in almost a quarter of cases where information was received from children's services, the level of detail in the information provided was insufficient to inform a comprehensive assessment of risk. Across all PDUs, we saw barriers to information sharing between probation and local services on an operational basis.
- In too many cases, there was an insufficient analysis of risk related to actual and potential victims within initial assessments. This, along with a failure fully

¹ The rating for the standard is driven by the aggregate scores from PDUs for the key questions, 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.](#)

to take into account available sources of information, meant that we saw insufficient assessment or planning to keep people safe far too often.

- The implementation and delivery of services effectively to support the protection of the public and keep people safe was consistently the least sufficient area of practice in the cases we inspected across all PDUs. In part, this was due to practitioner workloads, but also a lack of access to core risk reduction work via accredited programmes and structured interventions.
- While we saw some examples of effective risk management at all stages of sentences, we did not see this in enough cases. The level and nature of contact were insufficient in two-fifths of cases overall, and home visits were conducted in less than half of the cases where we would have expected to have seen them.
- The quality of work carried out by practitioners on cases subject to MAPPA was slightly better than for all other cases we inspected, but was still not good enough overall. Planning to keep people safe, and also the level of contact and home visits, was sufficient in a higher number of MAPPA cases than for those managed without MAPPA involvement. Practitioners drew sufficiently on available sources of information and analysed specific concerns to actual and potential victims in a higher number of those MAPPA cases than for others. We identified a number of MAPPA cases within the inspected cohort where level setting had been delayed and reviews with middle managers sometimes took place infrequently.

R 2.2. Desistance



High-quality, personalised, and responsive services are delivered to promote desistance.

Inadequate

Our rating² for desistance is based on the percentage of cases we inspected being judged satisfactory against four key questions and is driven by the lowest score:

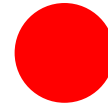
Key question	Percentage 'Yes'
Does assessment focus sufficiently on the factors linked to offending and desistance?	68%
Does planning focus sufficiently on reducing reoffending and supporting desistance?	65%
Does the implementation and delivery of services effectively support desistance?	42%
Does reviewing focus sufficiently on supporting desistance?	47%

- Assessments generally focused on analysing factors related to offending, and identified strengths and protective factors in most cases. Subsequent sentence planning mostly prioritised factors linked to offending that were most critical, and set out services most likely to reduce reoffending and support desistance. Regional leaders had decided to prioritise assessment and planning following our previous inspection and findings from their internal audit work. Quality improvement plans and sessions had been running with quality development officers to drive up sufficiency in this area of practice, and some progress was evident. Assessment of desistance was generally the most sufficient area of delivery within casework.
- However, this did not follow through into the implementation and delivery of sentences. While the delivery of services built upon the individual's strengths and enhanced protective factors in 58 per cent of cases, there was insufficient delivery of services specifically to reduce the likelihood of offending in over half of the cases we inspected. Insufficient attention was paid to delivering interventions in a sequenced or timely way, and the level and nature of contact were not sufficient in too many cases. This had particularly impacted on Probation Reset cases who had had their supervision suspended at an earlier point in their sentence than had been envisaged at the start of their order or licence. In some cases, practitioners and their managers had very little time to prepare for the suspension of contact with people on probation because of the way in which the national policy was expected to be implemented at short notice.

² The rating for the standard is driven by the aggregate scores from PDUs for 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.](#)

- There were good links locally with CRS providers, with many co-located in Probation Service offices. However, their services were not being utilised to their full potential, with 181 out of 450 cases not accessing services, where it would have been suitable for them to do so. Accredited programmes were being delivered in only eight out of 39 cases where there was a requirement to do so. There had been an increase in drug rehabilitation requirements and alcohol treatment requirements, and in some PDUs services had stepped up to meet these demands; however, there was an inconsistency to the quality of services received across the region. There were positive experiences of the delivery of mental health treatment requirements across South Yorkshire, but other areas had struggled to recruit to key positions and had been unable to offer the same level of service. While we saw some good examples of probation practitioners engaging and delivering interventions on a one-to-one basis during supervision, this was not seen in enough cases to make up for the gaps in service delivery overall.

R 2.3. Court work



The pre-sentence information and advice provided to court supports its decision-making. **Inadequate**

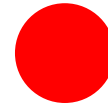
Our rating³ for court work is based on the percentage of cases we inspected being judged satisfactory against one key question:

Key question	Percentage 'Yes'
Is the pre-sentence information and advice provided to court sufficiently analytical and personalised to the individual, supporting the court's decision-making?	35%

- Sufficient records of the advice given to courts, and an appropriate proposal was made, in most cases inspected where a pre-sentence report had been prepared. This included consideration of factors relating to the likelihood of reoffending in most cases, and the individual was meaningfully involved in the preparation of the report, with consideration given to their views, in 83 per cent of cases. Diversity and personal circumstances were considered in around two-thirds of cases, and the individual's motivation and readiness to change was considered in 64 per cent of cases.
- Where advice to courts was prepared well, this included a full analysis of the offences, including previous patterns of behaviour, completion of safeguarding checks relating to both domestic abuse and child safeguarding, with this information used to inform the analysis of ongoing risk of harm to others. Personal circumstances and specific needs were considered and an individualised proposal that both managed risk of harm and supported desistance was made.
- The quality of reports and advice provided to court varied across PDUs. The region had committed resource at a senior manager level to drive forward improvements and was embedding effective targeting of proposals made to courts, as part of a national pilot scheme.
- We found that available information, including that pertaining to domestic abuse and child safeguarding, was used in too few cases, and that consideration had been given to victims and factors relating to risk of harm in only just over half of the cases inspected. As a consequence of these significant gaps, the pre-sentence information and advice provided to the courts were assessed as sufficient in supporting the court's decision-making in only 35 per cent of cases.

³ The rating for the standard is driven by the aggregate score from PDU and unpaid work case inspections, 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.](#)

R 2.4. Unpaid work



Unpaid work is delivered safely and effectively, engaging the person on probation in line with the expectations of the court. **Inadequate**

Our rating⁴ for unpaid work is based on the percentage of cases we inspected being judged satisfactory against four key questions and is driven by the lowest score:

Key question	Percentage 'Yes'
Is the assessment and planning of unpaid work personalised?	23%
Do arrangements for unpaid work maximise rehabilitative elements and support desistance?	64%
Is unpaid work delivered safely?	49%
Is the sentence of the court implemented appropriately?	57%

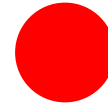
- Practitioners asked people on probation about their personal characteristics at the start of orders in the vast majority of cases, but this had not translated into personal needs or protected characteristics being considered in the context of unpaid work placements (UPW) in just over half of the cases inspected. We saw several examples where there were health or personal needs that had not been fully considered in planning UPW activity, and this had acted as a barrier to engagement and compliance. Risk information pertaining to domestic abuse or safeguarding was not always sufficiently explored and had led to deficits in the management of cases.
- There were comprehensive induction processes, with consistent messaging about expectations and requirements and clear instructions for when and how to attend for placements. In Sheffield, individuals were encouraged to engage in work activities on their first reporting day, a model recognised as good practice. This included having an induction and meeting supervisors, as well as completing UPW hours all in one day, rather than requiring an individual to report separately for an induction and then work activities. This promoted engagement and inclusion. Where possible, difficulties with travel were taken into consideration, with suitable placements being offered in local areas, although there remained some difficulties for those in more rural areas of the region and led to long travel times for some.

⁴ The rating for the standard is driven by the lowest score on each of the key questions, from unpaid work cases inspected during regional fieldwork, 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.](#)

- The placements offered were of good quality, with real opportunities to pay back local communities. This included placements with suitably experienced supervisors, promoting practical skills such as painting and decorating, building maintenance, and gardening. The region had taken full advantage of access to local authority and county council contracts, as well as inviting work placement suggestions from the local community. The region was working with partners across West Yorkshire to deliver immediate justice as part of a national contract, as well as having rapid response agreements with Hull and East Riding County Council. We saw examples of work being completed in local community buildings, lunch clubs being provided to community groups, and donations of handmade clothing to children’s hospitals for prematurely born babies.
- There were suitable options for group and individual placements, and some PDUs were also able to offer women-only groups and were engaging people with neurodiverse needs in an alternative and suitable environment. There was a comprehensive quality assurance process in place to drive forward the quality of UPW delivery, and this included actively seeking feedback from people on probation and beneficiaries. Overwhelmingly, this feedback tended to be positive, with both those completing UPW and those receiving UPW services stating that they had benefited. In a large number of instances, employers stated that they were more likely to employ someone with convictions, given their experience of the delivery of UPW, and 286 out of 287 respondents⁵ indicated that they would use UPW services again.
- Stand-down rates, whereby UPW participants were sent home from a planned session, remained very low. The percentage of orders where UPW requirements had hours outstanding beyond 12 months had improved, from 37 per cent to 23 per cent in the last year. However, this meant that just under a quarter of individuals were still taking longer than 12 months to complete their UPW requirements. In cases inspected on a regional level, enforcement action had been undertaken in just under half of the cases where it would have been suitable to do so (15 out of 33 cases). The region was transitioning to standalone UPW teams, to drive forward improvement in the management of these orders, and some PDUs were adopting automatic enforcement for UPW requirements, although this was yet to be embedded.

⁵ Yorkshire and the Humber Probation Service community payback beneficiary survey, November 2024.

R 2.5. Resettlement



Resettlement work is timely, personalised, and coordinated, addressing the individual's resettlement needs and supporting their integration into the community. **Inadequate**

Our rating⁶ for resettlement is based on the percentage of cases we inspected being judged satisfactory against one key question:

Key question	Percentage 'Yes'
Is resettlement timely, personalised, and coordinated, and does it address key resettlement needs and support the individual's integration into the community?	44%

- In the majority of cases (39 out of 54 cases) where a handover was required from a prison offender manager to a COM, this was completed at an appropriate point before release. However, overall, we found that the quality of work to prepare people for release and put into place risk management plans was insufficient.
- Action had been taken since our previous inspection to disband community integration teams, based on an evaluation which found that they were not supporting people on probation effectively. However, at the time of the inspection there was a lack of strategic clarity about how the needs of people being released from short-term prison sentences were to be met.
- Resettlement and desistance needs, as well as key risk of harm issues, were not routinely identified or addressed prior to release for all cases. We found that there was sufficient information sharing between custody and community cases in 60 per cent of cases, with too few individuals receiving a proportionate level of contact with their COM prior to release. Again, workload pressures were one reason given for insufficient contact, but it was also of note that some cases would have been released under changes to the end of custody supervised licence scheme which meant that release would have taken place earlier than initially anticipated, with less time available to complete pre-release work.
- As with court work, there was a disparity in the sufficiency of delivery by individual PDUs. Overall, in just over half of the resettlement cases inspected, there was effective coordination of resettlement activity delivered pre-release, with resettlement services supporting the handover for delivery in the community in just over half the cases inspected.

⁶ The rating for the standard is driven by the aggregate data from resettlement cases in PDU inspections, giving a score for the key question, 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.](#)

R 2.6. Statutory victim work



Relevant and timely information is provided to victims of a serious offence, and they are given the opportunity to contribute their views at key points in the sentence. **Outstanding**

Our rating⁷ for victim work 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 initial contact with victims encourage engagement with the victim contact scheme and provide information about sources of support?	85%
Is there effective information and communication exchange to support the safety of victims?	82%
Does pre-release contact with victims allow them to make appropriate contributions to the conditions of release?	97%

Statutory victim work relates to the activity by the region in relation to the victim contact scheme. This ensures that victims who have been subject to a violent or sexual offence that has resulted in the perpetrator being sentenced to 12 months or more in prison have the opportunity to engage in support from VLOs throughout the duration of the sentence.

- In the vast majority of cases we inspected, initial contact with the victim was made at an appropriate time, soon after initial sentencing. In most cases, this included providing sufficient information about the support available to enable the victim to make an informed choice about whether to participate in the contact scheme.
- VLOs interviewed during this inspection were committed and passionate about their roles. In all cases, they shared relevant information about the victim with the probation practitioner and were in a position to share appropriate requests for licence conditions to support risk management early within the sentence. Views expressed by victims were treated appropriately in all cases and, where required, all were supported to provide a victim personal statement to inform Parole Board applications.
- In all but two cases, appropriate consideration had been given to the concerns of the victim, and sufficient attention paid to the victim's safety, when planning for release. No-contact licence conditions had been used in 91

⁷ The rating for the standard is driven by the lowest score on each of the key questions, from eligible cases inspected as part of regional fieldwork, 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.](#)

per cent of cases, and all victims had been informed when these conditions were in place.

- VLOs had not received timely information about the management of the person on probation in eight out of 33 cases. There was a 'failure to notify' process in place across the region which tracked when information should have been shared by practitioners and was not. This process was reliant on VLOs recording this failure. While this data was collated, and despite showing an upward trajectory, there was limited action thereafter to address the issues identified.
- In three out of the 33 victim cases inspected, referral into MAPPA had not been completed until post-release, and this reflected the concerns raised during this inspection about the high number of cases yet to have their MAPPA level agreed across the region.

Learning from Serious Further Offences

SFOs in the region were dealt with by an SFO team within the performance and quality business unit. Led by an SPO team leader, there were six reviewing managers, with support from an administrative officer. A total of 40 SFO reviews were completed during May 2023 and May 2024, with 33 of these having been quality assured, 22 by HMPPS and 11 by HM Inspectorate of Probation.

- The quality of SFO reviews from 2023/2024 was varied. While 14 out of 33 reviews were sufficient (with one being outstanding), a larger number required improvement (18 out of 33), and one was inadequate.
- There was a degree of frustration among leaders and the SFO team that expectations about quality thresholds for SFO reports, and what was good enough, were not being applied consistently. These frustrations were acting as a barrier to improving the quality of review reports overall.
- The workload was high across the SFO team. We were told that national training received by SFO reviewers had not equipped them to produce high-quality reports. There was a constant demand on the team, above what was deliverable, leading to backlogs of reviews. Consideration had been given to a change in some other functions across the performance and quality team to improve the resourcing levels within the SFO team, but this had not been achieved at the time of the inspection.
- Findings were shared across the RLT and operational leadership group. However, we saw little evidence of these themes then being cascaded into teams at PDU level in any type of structured or improvement-driven way, and regional leaders were not ensuring that this learning was embedded.
- The dissemination of findings sat with either heads of PDUs or middle managers for discussion in team meetings, although team meetings did not take place on a regular basis across all PDUs. This limited how effectively the learning was being shared. PDUs concentrated on learning only from their own SFO cases, rather than embedding wider regional and national learning.
- The deficits identified from SFOs over the last 12 months were similar to those found in this inspection, including insufficient offender assessment system (OASys) assessments, insufficient management oversight, deficits in enforcement practice, insufficient reporting frequency and case recording, insufficient management of cases at MAPPA Level 1, and insufficient multi-agency working and completion of relevant safeguarding enquiries.
- The quality improvement plan for the region focused on improving the quality of assessments and planning, as well as management oversight. However, it did not address all identified themes and there remained too many gaps in the risk management of people on probation.

Progress on previous recommendations

Previous recommendation	Action taken and impact	Categorisation	Improvement still required?
<i>From previous Probation Service</i>	<i>Briefly describe action taken and impact</i>	<i>Sufficient progress/ Some progress/ No progress</i>	<i>Yes/no If yes, consider repeating the recommendation</i>
Ensure senior probation officers (SPOs) have sufficient capacity and resource to undertake effective management oversight of casework.	Despite senior case administration and management hub support, SPO workloads remain unmanageable.	Some progress	Yes
Implement an analysis of outcome data against protected characteristics of people on probation and implement any necessary work to reduce disproportionality.	A disparities report is now being run and regularly shared among all heads of service and the RLT. There remains work to be done to reduce disproportionality.	Some progress	No
Improve the availability of accredited programmes and structured interventions.	Staffing levels for programme facilitators have declined since the last inspection and programme delivery rates are insufficient to meet the demand.	No progress	Yes
Support planning at PDU level to enable staff to undertake the necessary sentence management tasks as staffing levels increase.	Staffing levels across PDUs have improved, although there remain gaps in administrative and PO grades. Workload measurement	Some progress	No

	figures have improved since the point of Probation Reset but the impact on quality of service has still to be evidenced.		
Improve the pathways and referrals to commissioned rehabilitative services (CRS).	Referral pathways are clear and the co-location of services has improved. However, referral rates and successful completion rates are still too low.	Some progress	Yes
Review the commissioned rehabilitative services (CRS) contract for accommodation support services to provide an effective service which meets the needs of people on probation.	The region has engaged centrally with commissioning design for future contracts.	Some progress	Yes
Improve the offer and access to support services in relation to mental health.	Available services are available in South Yorkshire, but other areas are struggling to recruit suitably qualified staff. However, work has been completed by health and justice managers to improve access across the region as a whole.	Some progress	No
Improve vetting timeframes, to start newly recruited staff promptly.	There is tracking of timeliness, and turnaround times from the point of offering employment to commencement in post are much improved.	Sufficient progress	No

Ensure that all practicable options have been implemented to provide Sheffield PDU with sufficient practitioners and administrative staff.	Staffing levels across PDUs have improved, although gaps remain in administrative and PO grades. This is supported via an urgent strategic response mechanism and Sheffield PDU is now in an equitable position compared with other PDUs across the region.	Sufficient progress	No
Improve completion rates for accredited programmes and unpaid work.	Unpaid work completion rates have improved. However, there are significant barriers to accredited programme completions.	Some progress	Yes
Improve access to domestic abuse intelligence held by South Yorkshire Police.	A dedicated administrative resource, with access to police systems, is in place.	Significant progress	No
Conduct a review into the implementation of the community integration team (CIT) model in Sheffield to ensure it is meeting the needs of people on probation.	CIT teams have now disbanded. The resettlement in custody model is not yet agreed.	Some progress	No

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 using the following link: [Glossary \(justiceinspectorates.gov.uk\)](https://justiceinspectorates.gov.uk/glossary)