



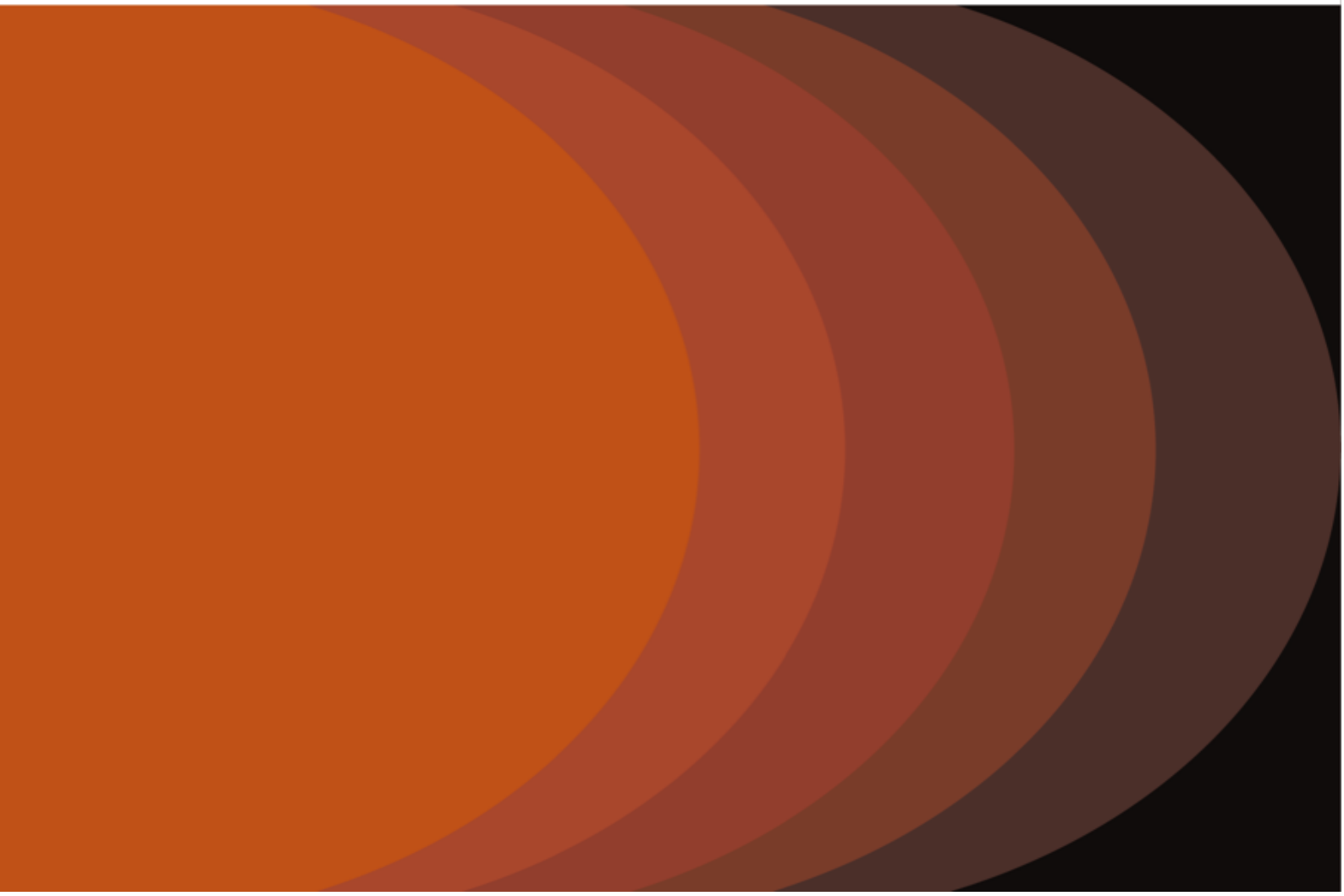
Her Majesty's  
Inspectorate of  
Probation

An inspection of youth offending services in

# Luton

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HM Inspectorate of Probation, May 2020



## **Acknowledgements**

This inspection was led by HM Inspector Maria Jerram, supported by a team of inspectors and colleagues from across the Inspectorate. We would like to thank all those who helped plan and took part in the inspection; without their help and cooperation, the inspection would not have been possible.

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## Foreword

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

The local authority has seen substantial budget reductions since 2014, which has impacted significantly on the allocated YOS budget. To make savings, the YOS has been involved in three restructures since 2016. The impact on staff has been significant, but there is now a stable, motivated team in place.

Staff and managers in Luton YOS work hard to deliver a high-quality service to support the desistance of children from offending. Work delivered to support desistance is outstanding in all areas of practice, and staff are skilled at engaging children. However, some aspects of work to manage the risk of harm to others and to secure the safety and wellbeing of children requires significant improvement. Managers' oversight of work is ineffective in too many cases. This is impacting on the overall quality of work delivered and needs to be improved.

YOS governance arrangements have recently been through a period of transition and new processes are still being embedded. The new Chair of the Board has a good understanding of the YOS's work and the challenges facing the service. The Board must now ensure that partner agencies attend regularly and that systems are in place to measure and monitor delivery against the youth justice plan objectives. Processes need to be established to ensure that partners are advocating for YOS children in their own services.














The work undertaken with out-of-court disposals requires improvement to ensure that the quality of services and interventions delivered to children and families are of a consistent standard. The YOS's work with victims also needs to be developed so that victims' wishes are considered across all interventions.

Our inspection found that the YOS had some areas of strength that it can build on to make swift progress. We have made a small number of recommendations to the YOS which, if implemented, should strengthen its work with children.



**Justin Russell**  
Chief Inspector of Probation

## Ratings

<b>Luton Youth Offending Service</b>	<b>Score</b>	<b>16/36</b>
<b>Overall rating</b>	<b>Requires improvement</b>	
<b>1. Organisational delivery</b>		
1.1 Governance and leadership	<b>Requires improvement</b>	
1.2 Staff	<b>Good</b>	
1.3 Partnerships and services	<b>Good</b>	
1.4 Information and facilities	<b>Outstanding</b>	
<b>2. Court disposals</b>		
2.1 Assessment	<b>Good</b>	
2.2 Planning	<b>Inadequate</b>	
2.3 Implementation and delivery	<b>Requires improvement</b>	
2.4 Reviewing	<b>Good</b>	
<b>3. Out-of-court disposals</b>		
3.1 Assessment	<b>Inadequate</b>	
3.2 Planning	<b>Inadequate</b>	
3.3 Implementation and delivery	<b>Good</b>	
3.4 Joint working	<b>Requires improvement</b>	

## Executive summary

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

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### 1. Organisational delivery



Luton Borough Council has suffered substantial budget reductions in recent years, and this has put pressure on all services, including the YOS. The partnership has responded by working collaboratively to secure the continued delivery of services while, at the same time, making the required financial savings. As a result, the YOS has been involved in three restructures since 2016, and the process of reorganisation and loss of personnel have impacted significantly on staff morale. The YOS Service Manager, who has been in post since 2016, has led the team through these changes. Staff report that they now feel the service is more stable and that they are clear about the priorities and motivated to deliver on them.

In terms of governance, a Bedfordshire-wide scoping exercise was undertaken in 2016/2017 to ascertain whether the leadership and management arrangements of youth offending services in Bedfordshire were sufficiently robust. As a result of this exercise, a Pan-Bedfordshire Strategic Youth Justice Board was established in 2018 with an independent Chair and a remit to operate for one year as a pilot. The pilot ended in June 2019 and a decision was made to revert to single Boards, to focus more specifically on local issues. At the time of the inspection, the new Board arrangements were in the initial stages and still being embedded. There has been some concern about inconsistent attendance of some partners at Board meetings and addressing this is a priority for the new Chair of the Board.

Staff are supported through a workforce development plan and have access to training to support their practice. They have received some training to develop skills in managing risk of harm, but our findings indicate that further training and guidance may help to improve the quality of risk management work for both court work and out-of-court work. Practitioners have access to a range of services to meet the needs of children. The YOS's health provision is especially strong. However, we found that, in some cases, poor coordination of services negatively impacts on the quality of work to support the safety and wellbeing of children and to manage the risk of harm to others. Managers' oversight of work is ineffective in too many cases and processes, such as those for out-of-court disposals and risk management, are not consistently applied. This is impacting on the overall quality of work delivered.

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<sup>1</sup> HM Inspectorate of Probation's standards can be found here:

<https://www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/>

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

We were impressed with the facilities and the focus on gaining the views of children about the services they receive. The YOS Manager is a strong advocate for the service and has been influential in shaping the partnership's understanding of issues such as serious youth violence and child exploitation. The YOS uses high-quality information reports to provide a clear picture of the needs of children. The Board could make better use of these reports to understand the YOS cohort and ensure that their specific needs are met by partner agencies, and to make sure that the quality of YOS work is sufficient.

As part of our inspection, we interviewed the YOS Manager and the Chair of the Management Board. We held meetings with other members of the Board and key stakeholders.

Key findings about organisational delivery are as follows:

- Luton YOS is ambitious for its children. The Chair of the YOS Management Board shares that ambition.
- The YOS is an influential partner in setting wider strategic plans and agendas.
- The YOS takes an innovative approach to the use of information to target and develop services.
- The staff group is stable, and workers are skilled and creative in engaging children. Workloads are manageable.
- There are some positive and creative partnerships in place that benefit children.
- There is a well-resourced health and wellbeing team, which has a clear understanding of the impact of good health services on positive outcomes for children.
- Issues relating to disproportionality are understood, and programmes of intervention have been put in place to meet the specific needs of black, Asian and minority ethnic (BAME) children.

But:

- Board members do not sufficiently understand how their individual agencies are supporting children known to the YOS and there is insufficient evidence of them being held to account in Board meetings.
- Risk management processes are not having the required impact on the quality of work to manage risk of harm and the safety and wellbeing of children.
- The needs of potential and actual victims and opportunities for restorative justice are not considered in every relevant case.
- Out-of-court processes are not consistently applied and there is not always a clear rationale for the decisions made.

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## 2. Court disposals



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We took a detailed look at 19 community sentences and 2 custodial sentences managed by the YOT. We also conducted 18 interviews with the relevant case managers. We examined the quality of assessment; planning; implementation and

delivery; and reviewing. Each of these elements was inspected in respect of work done to address desistance, and the safety and wellbeing of the child.

For the 19 cases where there were factors related to harm, we also inspected work done to keep other people safe and ensure the safety and wellbeing of the child. The quality of each element of work needs to be above a specified threshold for that aspect of performance to be rated as satisfactory.

In this YOS, the quality of work in post-court cases varied considerably across the standards. Work to support the children's desistance from offending was rated outstanding across all four standards. Quality of assessment was originally given a rating of 'Requires Improvement'. However, following the ratings panel, and taking overall account of qualitative evidence from all our interviews, we used professional discretion to increase this to 'Good', as it was a more accurate reflection of the practice we observed. Overall, the quality of planning was the weakest area of work and was rated as 'Inadequate'.

Luton YOS works well to support the desistance from crime of the children with whom it engages. The consistency with which practitioners effectively engage children and their families is impressive. Work to keep other people safe is the weakest area of practice across all four areas, being particularly deficient in relation to planning.

There was some variation in the quality of work relating to the safety and wellbeing of the children themselves across the four standards. This was assessed as 'Requires Improvement' in relation to planning, whereas it was 'Good' in terms of assessment and implementation and delivery and 'Outstanding' in relation to reviewing.

Our key findings about court disposals are as follows:

- The quality of work to support desistance is outstanding in assessment, planning, implementation and delivery and in reviewing.
- Staff take account of the views of children and their parents and carers.
- Information held by other agencies is used to inform assessments and consideration is given to diversity and individual needs.
- Practitioners support children to comply with the requirements of their sentence and take appropriate enforcement action when required.

But:

- Restorative justice practice does not always consider the wishes and needs of identified and potential victims.
- Case managers do not consider all potential risk factors when determining a child or young person's risk of harm to others, or their safety and wellbeing.
- Planning to manage risk of harm is inadequate and contingency planning does not reflect the needs of individual cases.
- The involvement of other agencies in managing the risk of harm is not sufficiently well-coordinated.
- Management oversight does not make enough difference to the quality of the work delivered to manage risk of harm or safety and wellbeing.



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### 3. Out-of-court disposals



We inspected 15 cases managed by the YOS that had received an out-of-court disposal (OOCd). All cases we inspected were community resolution interventions, and one was a drug and alcohol disposal. The YOS did not have any youth caution or youth conditional caution cases during the timeframe covered by this inspection. We interviewed the case managers in all cases.

We examined the quality of assessment; planning; and implementation and delivery of services. Each of these elements was inspected in respect of work done to address desistance. For the nine cases where there were factors related to harm, we also inspected work done to keep other people safe. In the 13 cases where safety and wellbeing concerns were identified, we looked at work done to safeguard the child. We also looked at the quality of joint working with local police. We found that less than half of the 15 cases inspected met all our standards relating to assessment. This led to our judgement of 'Inadequate' for this element of work.

Originally, work relating to implementation and delivery was rated as 'Requires Improvement'. However, following a ratings panel meeting, and considering the small number of cases, the narrow score margins and the quality of work delivered overall, we used professional discretion to increase this to 'Good'. The quality of planning fell below our expected standards in over half of cases, leading to an 'Inadequate' judgement for this area of practice. Between half and two-thirds of cases we inspected met all our standards for joint working, hence the judgement of 'Requires Improvement'.

Processes for OOCd cases in Luton involve an initial triage assessment, which is used to inform decision-making at an OOCd decision-making panel. We found that some cases were not presented at the panel and that decisions were made between the practitioner and the police officer in charge of the case. This did not follow the process set out in the YOS triage and diversion policy and meant that there was not always management oversight, or a record of the rationale for the decisions made. Once a decision had been made regarding disposals, a full AssetPlus assessment, which considers risk of harm and safety and wellbeing, is completed on all diversion cases. It is the standard of these assessments and subsequent work that we have inspected and rated.

Diversion disposals in Luton reflect the practice that we are seeing nationally, in that they are increasingly used to divert children from the formal youth justice system. There are positives in taking this course of action. Diversion at the earliest opportunity means that valuable interventions can be delivered without children getting a criminal record that can have lasting consequences. This must, however, be balanced equally with attending to issues of risk of harm to others and the safety and wellbeing of children themselves. In most cases we inspected, OOCds were imposed for offences that involved varying degrees of violence, and while we considered the agreed disposal recommendation to be appropriate in almost all cases, we found that consideration was not routinely given to the risks posed to others, including actual and potential victims. This undermined the overall quality of the work delivered. Equally, we saw high levels of vulnerability and complex needs that were significantly impacting on the lives of children, and these were not always prioritised, particularly in planning.

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

- Staff demonstrate good engagement skills and fully consider any barriers to the child's motivation and engagement.
- Assessment, planning, and implementation and delivery to support desistance are outstanding.
- Assessments focus on the child's strengths and protective factors.
- Service delivery to support the safety of other people is good.

But:

- O OCD processes are not consistently applied and the rationale for decision-making is not always clearly recorded.
- Joint working with other agencies to implement and deliver services requires better coordination.
- Planning to support the safety of other people and the safety and wellbeing of children is inadequate.
- Assessments do not sufficiently analyse how to keep other people safe.
- The YOS recommendations to support joint decision-making are not sufficiently well-informed and analytical.

## Recommendations

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

### **Luton Youth Offending Service should:**

1. accurately assess the risk to a child's safety and wellbeing and risk of harm to others, and make sure that all risks are reviewed and managed via effective processes
2. ensure that management oversight is consistent and effective and makes a difference to the quality of work delivered
3. develop the YOS's victim and restorative justice processes to make certain that the needs of potential and actual victims and opportunities for restorative justice are fully considered and acted upon in every relevant case
4. apply out-of-court processes consistently and ensure that YOS recommendations are sufficiently well-informed, analytical and personalised to the child
5. improve the quality of assessment and planning for out-of-court disposal cases.

### **Luton Youth Offending Service Management Board should:**

6. prioritise Board attendance and ensure each partner understands the role of their individual agencies in relation to the children involved with the YOS.

## Background

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

YOTs are statutory partnerships, and they are multi-disciplinary, to deal with the needs of the whole child or young person. They are required to have staff from local authority social care and education services, the police, the National Probation Service and local health services.<sup>3</sup> Most YOTs are based within local authorities; however, this can vary.

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

Luton is a large town located approximately 30 miles north of central London and is a unitary authority in Bedfordshire. The town is densely populated and ethnically diverse. In recent years, organised crime in Luton and Bedfordshire has increasingly involved children, who have been exploited into criminality and coerced to perform roles in the supply of drugs. Offences of violence remain a major area of concern for communities and services in Luton and the YOS has seen a rise in violent offending and weapons-related offences. Addressing this is a strategic priority.

The local authority has seen substantial budget reductions since 2014, which has impacted significantly on the allocated YOS budget. To make savings, the YOS has been involved in three restructures since 2016.

Early intervention and prevention are a key strategic priority across all services, including the YOS. In August 2017, the Targeted Youth Service (TYS) was transferred to the management structure of the YOS to create an integrated model of youth support services. The YYS is made up of youth workers who carry out detached youth work as well as delivering workshops in schools.

In common with the national picture, Luton has seen a reduction in the numbers of first-time entrants over the past two years. The rates of reoffending are lower than the England and Wales average, having steadily reduced over the past four years. The number of children in custody has decreased but remains slightly higher than the national average. BAME children are over-represented within the YOS cohort and the service is working to understand and address this.

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<sup>3</sup> The *Crime and Disorder Act 1998* set out the arrangements for local YOTs and partnership working.

## Contextual facts

<b>184</b>	First-time entrant rate per 100,000 in Luton YOS <sup>4</sup>
<b>222</b>	First-time entrant rate per 100,000 in England and Wales <sup>4</sup>
<b>32.5%</b>	Reoffending rate for Luton YOS <sup>5</sup>
<b>39.2%</b>	Reoffending rate in England and Wales <sup>5</sup>

### Population information<sup>6</sup>

<b>214,109</b>	Total population Luton
<b>22,776</b>	Total youth population (10–17 years) in Luton
<b>12,076</b>	Total black and minority ethnic youth population Luton

### Caseload information<sup>7</sup>

Age	10–14	15–17
Luton YOS	14%	86%
National average	24%	76%

Race/ethnicity	White	Black and minority ethnic	Unknown
Luton YOS	38%	60%	2%
National average	71%	26%	3%

Gender	Male	Female
Luton YOS	90%	10%
National average	84%	16%

<sup>4</sup> Youth Justice Board. (2019). *First Time Entrants, April to March 2019*.

<sup>5</sup> Ministry of Justice. (2019). *Proven reoffending statistics, October 2016 to September 2017*.

<sup>6</sup> Office for National Statistics. (2012). *Census 2011*.

<sup>7</sup> Youth Justice Board. (2019). *Youth Justice annual statistics: 2017 to 2018*.

### Additional caseload data<sup>8</sup>

28	Total current caseload: community sentences
6 (5 custodial orders, 1 secure remand)	Total current caseload in custody
5	Total current caseload on licence
0	Total current caseload: youth caution
0	Total current caseload: youth conditional caution
60	Total current caseload: community resolution or other out-of-court disposal
40%	Proportion of current caseload subject to court disposal
60%	Proportion of current caseload subject to out-of-court disposal
13%	Proportion of current caseload 'looked after children' resident in the YOS area
9%	Proportion of current caseload 'looked after children' placed outside the YOS area
4%	Proportion of current caseload with child protection plan
7%	Proportion of current caseload with child in need plan
4%	Proportion of current caseload aged 16 and under not in school/pupil referral unit/alternative education
38%	Proportion of children aged 16 and under in a pupil referral unit or alternative education
24%	Proportion of current caseload aged 17+ not in education, training or employment

For children subject to court disposals:

Offence types <sup>9</sup>	%
Violence against the person	62%
Breach of restraining order or breach of non-molestation order	5%
Sexual offence (non-contact)	5%
Burglary	5%
Theft and handling stolen goods	10%
Drug offences	10%
Summary motoring offences	5%

<sup>8</sup> Supplied by YOS and reflecting the caseload at the time of the inspection announcement.

<sup>9</sup> Data from the cases assessed during this inspection.

# 1. Organisational delivery



A Bedfordshire-wide scoping exercise was undertaken in 2016/2017 to ascertain whether the leadership and management arrangements of the YOS in Bedfordshire were sufficiently robust. Because of this exercise, a Pan-Bedfordshire Strategic Youth Justice Board was established in 2018 with an independent Chair and a remit to operate for one year as a pilot. The pilot ended in June 2019, and a decision was made to revert to single Boards to focus more specifically on local issues. Pan-Bedfordshire strategic relationships have been maintained.

The partnership has worked collaboratively to support effective service delivery, and services to children have been prioritised. There has been an alignment of resources, systems and staff to meet strategic objectives and priorities, and youth justice is a thread running through the statutory plans of other services in Luton, such as the community safety partnership. The YOS benefits from seconded staff and from financial input from partners.

The first YOS Board meeting under the new arrangements took place in September 2019. At the time of the inspection, the new YOS Board's processes were still in the initial stages and were bedding in. There has been some concern about the inconsistent attendance of some partners at Board meetings, and addressing this is a priority for the new Chair of the Board.

The YOS Service Manager is a strong advocate for the service and has important links to other strategic groups, which means that the YOS agenda is promoted in a number of arenas. This has been helpful in promoting concerns such as serious youth violence and child exploitation across the partnership.

The service embraces improvement and innovation. It draws on the views of stakeholders, including the children with which it works, to inform service developments. The organisational structure that the YOS sits within enables children to access well-coordinated, timely services. Practitioners have workloads that are complex but manageable; they have the capacity to form meaningful relationships with the children they work with.

## Strengths:

- Luton YOS is ambitious for its children. The Chair of the YOS Management Board shares that ambition.
- The YOS is an influential partner in setting wider strategic plans and agendas.
- The YOS takes an innovative and sophisticated approach to the use of information to target and develop services.
- The staff group is stable and workers are skilled and creative in engaging children. Workloads are manageable.
- There are some positive and creative partnerships in place that benefit children.
- There is a well-resourced health and wellbeing team, which has a clear understanding of the impact of good health services on positive outcomes for children.

- Issues relating to disproportionality are understood, and programmes of intervention have been put in place to meet the specific needs of BAME children.

### Areas for improvement:

- Board members do not sufficiently understand how their individual agencies are supporting children known to the YOS, and there is insufficient evidence of them being held to account in Board meetings.
- Risk management processes are not having the required impact on the quality of work to manage risk of harm and the safety and wellbeing of children.
- The needs of potential and actual victims and opportunities for restorative justice are not considered in every relevant case.
- Out-of-court processes are not consistently applied and there is not always a clear rationale for the decisions made.

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

## 1.1. Governance and leadership



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

Requires improvement

### Key data<sup>10</sup>

Total spend in previous financial year – 2018/2019	£1,935,408 (YJB Good Practice Grant £341,351)
Total projected budget for the current financial year – 2020/2021	£2,019,774 (YJB Good Practice Grant £338,137)

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

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

There is a detailed youth justice plan (2019-2022), which has been agreed by the YOS Management Board and presented to the children's social care Overview and Scrutiny Committee. The youth justice plan sets the direction for the service, and most staff who responded to our staff survey felt sufficiently updated on strategic issues and the activities of the Management Board.

<sup>10</sup> The purpose of the Youth Justice Good Practice Grant is to develop good practice and commission research with a view to achieving outcomes in reducing offending, reducing numbers of first-time entrants to the justice system and reducing the use of youth custody.



There have been challenges with inconsistent attendance from some Board members. This needs to improve to provide the required level of scrutiny of YOS practice, partnership arrangements and service delivery.

The Chair of the Board is the Police Superintendent for Bedfordshire Police, and he has strong links to other strategic boards in Luton and across Bedfordshire. The Chair has a good understanding of the work of the YOS and the potential risks to service delivery and is committed to developing the operation of the Board.

The Board needs to ensure that it has systems in place to measure and monitor delivery against the objectives in the youth justice plan that are specific to the work of the YOS, as well as those that relate to wider prevention work. Priorities in the plan, such as improving the quality of management oversight, embedding effective quality assurance processes and protecting victims, require close monitoring.

There is no formal induction in place for Board members, but guidance on their roles and responsibilities has been produced and shared with them. YJB guidance and HM Inspectorate of Probation reports have been used to inform the recently revised terms of reference for the Board.

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

Although Board members advocate for the YOS in a general sense and in different arenas, this tends to be generic. There is limited evidence of prioritisation of YOS children and the specific complex needs that make them different from the wider population. For example, work has been done at a strategic level to reduce numbers of school exclusions in Luton, but it is not clear how this is being monitored in relation to YOS children, particularly given the significant number currently attending a pupil referral unit (PRU) rather than a mainstream school.

The YOS provides detailed information reports that analyse local trends, performance against national key performance indicators and the profiles and needs of children to assist Board members.

The YOS receives funding and/or staffing contributions from the Police and Crime Commissioner's office, the education service, the clinical commissioning group and the National Probation Service. The integration of the TYS and YOS has helped to provide greater support for children and families. It has also created useful links with local third-sector organisations, which supports integration and exit planning.

The YOS hosts and coordinates the MAGPan, a multi-agency panel that has been developed to coordinate interventions for individuals who are involved in, or affected by, serious violence, criminal exploitation and gang-related activity across Luton. YOS cases are discussed at this panel and intelligence is shared to support risk management work. In some cases, however, we found that records of discussions were not always maintained in the case management system. This meant that case managers were not always aware of the details of discussions, and information was not used as effectively as it could have been.

OOCD decision-making processes are not consistently applied. In some instances, cases are presented at the OOC panel, but in others, the decision is made by the YOS worker and the police officer in charge of the case. The rationale for these different approaches is not clear, and this means that decision-making lacks clarity and management oversight in some cases.

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

The Service Manager is an excellent advocate for the YOS and has been instrumental in influencing the partnership agenda, particularly in relation to criminal exploitation and the vulnerability of children affected by it. For example, he is the

theme lead for serious youth violence on behalf of the Community Safety Partnership and the strategic representative for the Bedfordshire Police Vulnerability and Exploitation Unit.

The YOS operational managers write sections of the youth justice plan and understand the role and function of the Board in overseeing the implementation of the plan. Some managers have delivered presentations at Board meetings. Weekly YOS leadership management team meetings provide a forum to discuss strategic priorities and monitor service delivery. In the responses to our staff survey, most staff reported that they understood the current YOS vision, challenges and development plans for the service. Partnership managers are less clear about the vision and how their services contribute to achieving it.

Quality assurance processes are in place, but follow-up action plans have yet to impact on some areas of practice, for example the delivery of OOCs and work to support safety and wellbeing and manage risk of harm.

## 1.2. Staff



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

Good

### Key staffing data<sup>11</sup>

Total staff headcount (full-time equivalent, FTE)	52 (including TYS and Amber unit)
Vacancy rate (total unfilled posts as percentage of total staff headcount)	1.92% = 1 post
Vacancy rate: case managers only (total unfilled case manager posts as percentage of total case manager headcount)	1.92% = 1 post
Average caseload: case managers (FTE)	12
Average annual sickness days (all staff)	2.3
Staff attrition (percentage of all staff leaving in 12-month period)	5.77% = 3 staff

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

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

We met with a committed staff team who are motivated to deliver high-quality, personalised services to children. Following a period of restructuring, the staff team is now stable, with low levels of sickness. The integration of the targeted practitioners in the team allows for a more coordinated response to children who often have multiple, complex needs.

<sup>11</sup> Data supplied by YOS and reflecting the caseload at the time of the inspection announcement.

There are four youth justice assistant posts in the service, and they support the delivery of personalised and responsive services. They deliver group work and focused one-to-one sessions, supervise reparation sessions and work with children who are subject to Intensive Supervision and Surveillance (ISS) requirements.

Data reports on caseloads are monitored by managers and there is an allocation system in place. The allocation of work takes into consideration the risk level of cases and skills and experience of staff. All but one staff member responding to our survey reported their workload to be manageable.

There are processes in place to support the delivery of services during periods of annual leave and unplanned absence. Rotas for office and court duty, as well as weekend cover, are established.

All volunteers responding to our survey feel that they have received sufficient training and that they also benefit from ongoing support and guidance to assist them in their role. They reported that the referral order panel process is organised and well-coordinated, with panel members who sit on initial panel meetings sitting on subsequent panel meetings. This means that they can track and support the progress of the children over the duration of their order.

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

The YOS team includes some staff who have social work and/or youth justice qualifications. A youth justice officer career progression scheme is in place, and we met with staff who have been supported to move into higher grade roles. This promotes staff retention and motivation. The ethnic make-up of the staff group does not fully reflect that of the children the service works with.

Case data from domains two and three shows that staff are skilled at undertaking assessments and delivering interventions in relation to the desistance needs of the child. However, the same data shows that they are less able to demonstrate these skills when assessing and managing risk to others and risk to the safety and wellbeing of children.

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

Staff are positive about the oversight that they receive to support their practice, and found their supervision to be either valuable or very valuable. However, inspectors found that management oversight was inconsistent; it was effective in only half of the cases inspected. There was an absence of challenge, scrutiny and clear direction, which impacted on the quality of work delivered.

In addition to regular supervision, processes such as the Likelihood of Custody Scrutiny Panel (LOCS), risk management meetings and diversion and prevention planning meetings are in place to provide an increased level of oversight of practice. However, we found that these processes are not always having the required impact, and there is potential for lines of accountability to be blurred. For example, the risk management meetings are chaired by an operations manager on a rotating basis, resulting in the inconsistent oversight of cases and actions not always being followed up.

Staff feel valued in their roles. They are encouraged to make suggestions and contribute to service development. Most staff feel that their views are listened to and acted on by the YOS.

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

Staff are supported with a workforce development plan and regular supervision. The YOS identifies and plans for the learning needs of all staff and provides appropriate access to in-service training. Most staff (87 per cent) who responded to our survey felt that their training needs were met and that they had the skills and knowledge needed to undertake their role. Practitioner training has included restorative practice, understanding the impact of adverse childhood experiences and working with harmful sexual behaviour.

A culture of learning and improvement is promoted, for example through the Practitioner Reflective & Effective Practice (PREP) Groups. The meetings take place fortnightly and are led by one of the service's five operations managers. Staff report that these sessions are valuable in supporting their learning and enabling the sharing of ideas to improve services. Staff appraisals are in place and reviewed regularly. Ninety per cent of staff who responded to our survey found the process valuable or very valuable. Newer staff reported a helpful induction process that had assisted in preparing them for their role.

### 1.3. Partnerships and services



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

Good

Percentage of current caseload with mental health issues <sup>12</sup>	29%
Percentage of current caseload with substance misuse issues	52%
Percentage of current caseload with an education, health and care plan	11%

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

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

There is an in-depth understanding of the characteristics of children in the caseload, based on a wide range of recent and reliable information. Efforts are made to anticipate future demands and to understand complex cases and the diversity of cases. The YOS recognises the need to develop services that meet the specific needs of all children.

Sixty per cent of the children the YOS is working with identify as Black British, Asian or mixed/dual heritage. This is 7 per cent higher than the last national published population data. This indicates that this group of children are over-represented in the youth justice system. An analysis of data undertaken by the YOS also indicates that, when black children enter the youth justice system, they are more likely to remain

<sup>12</sup> Data supplied by YOT.

and escalate within the system than their white counterparts. Addressing this disproportionality is a priority for the YOS. A group work provision that focuses on identity, including heritage and ethnicity, has been commissioned. A local media and training organisation has also been commissioned to deliver a specific programme of intervention to young Asian males.

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

The YOS has access to the volume, range and quality of services, including specialist and mainstream interventions, needed to meet the needs of children. Sufficient attention is given to the ability of the services to build on strengths and enhance protective factors.

The service has a clear understanding of the needs of children, and partners demonstrate a commitment to working together to meet them. Most staff feel they have access to all the services they need to meet the needs of children in terms of desistance, safety and wellbeing and protection of the public. Inspectors agree that the appropriate services are available, but they considered that the services are not always well-coordinated to meet the needs of children.

The YOS has good health provision for children and there is swift access to support and services. All children entering the service meet with the YOS nurse. A health check is undertaken, and follow-up actions are identified. A sizeable proportion of the YOS cohort have been identified as experiencing varying degrees of mental health issues, and a community mental health nurse is available to undertake specialist assessments and deliver interventions. There are no waiting lists, and access to support is swift.

Arrangements are also in place for checks to be undertaken with the YOS when a child is admitted to A&E with concerning injuries. Children have access to substance misuse support, which is provided by a commissioned service. YOS specialist staff are clear about their roles and responsibilities and they are active in seeking referrals.

There are two education workers in post. An education coordinator, seconded from the council's Children & Learning Department, focuses on the needs of school-age children. This post provides a useful link to the wider education system and supports the effective exchange of information with schools and other services. An education, training and employment officer supports children over the age of 16 to access education, training and employment opportunities and liaises with local providers to promote access for YOS children. Staff check whether children have an education, health and care plan (EHCP) so that this can be considered in any interventions delivered by the YOS.

A speech and language therapist post was created in the YOS in 2013. Children involved with the YOS are recognised to have a high level of need in this area, and we saw good examples of work to support them being delivered by the therapist.

There are several reparation projects, including litter picking, hedge cutting and working on allotments. Children can achieve AQA accreditation for the reparation tasks they complete. The YOS has also commissioned local providers such as the No Way Trust and Walk to Freedom to deliver a range of intervention programmes and services relating to the consequences of crime, dealing with life challenges positively, keeping safe and avoiding crime.

The YOS holds the Restorative Justice (RJ) Quality Assurance Mark from the Restorative Justice Council, and most members of staff are trained as RJ facilitators. There is also a specific victim worker post, but we found that insufficient attention

was given to the protection of actual and potential victims in several areas of practice.

Platform 1 is a local initiative, which has been developed by the YOS in collaboration with other council services and private sector organisations to provide career pathways for children. Currently, a cohort of children are completing CSCS card training and can also benefit from job coaching support. This is a promising new initiative and we saw direct evidence from one of the case files of a child having benefited from engaging in the project.

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

The Amber Unit is a team made up of police community support officers and targeted youth workers. The team is co-located with the YOS and aims to reduce serious youth violence and child exploitation. Each Luton high school has a dedicated Amber single point of contact and the team delivers diversionary group work programmes in several high schools.

There has been no seconded probation officer in post for 18 months. As an interim measure, funding has been provided to cover the post with an agency worker, but a more permanent solution is required to ensure a qualified probation officer is in post. The YOS was also without a seconded police officer for a period at the beginning of 2019, and this had an impact on the OOC processes and information-sharing. This has now been resolved and a dedicated police officer is now in post.

We saw some good examples of effective joint work between the YOS and children's social care, but this was not consistent. In some cases, a lack of communication, planning and joint delivery undermined the quality of safeguarding work and led to drift and delay. Social workers are not routinely invited to the YOS risk management meetings or planning meetings, and this was a missed opportunity to ensure that a coordinated joint plan was in place to support the safety of the child.

Sentencers spoke positively about the work of the YOS in court, the information they receive (including through pre-sentence reports) and the quality of work delivered in court. Sentencers provide feedback on the quality of each pre-sentence report and this is collated by the YOS for analysis.

Overall, the YOS has access to a wide range of services, but we found that these were not always well-coordinated. For example, the involvement of other agencies in managing the risk of harm was sufficient in only 53 per cent of statutory cases.

### **Involvement of children and their parents and carers**

Children are invited and encouraged to give feedback to the YOS on their experiences of the services they receive. There is a system where they can post anonymous feedback on cards that are provided in the office where they are seen. This provides them with an opportunity to give ideas on how the service can be improved, and their comments are reviewed by the management team.

The YOS Service Manager has scheduled meetings with children to gain feedback from them on their experiences of the service. Feedback from one child led to arrangements being put in place with Feltham Young Offender Institute (YOI) for a Luton YOS worker to be based there one day a month to offer support to Luton children. This will provide better opportunities to support resettlement planning for children during their sentence and prior to release.

Since November 2019, all children subject to ISS have completed a weekly feedback form detailing the experience of their week on ISS. The feedback from children is given to their case managers each week to address any issues in the following

week's timetable. Operations managers will also begin undertaking monthly reviews of the feedback to identify overall patterns, and findings will be shared at service meetings.

Staff have held consultation sessions with children to gain feedback on their experiences of the YOS, and this has resulted in one child devising and delivering a presentation to the YOS team.

Processes for gaining the views of parents and carers need to be developed and the YOS recognises that it needs to establish processes to make sure that they are receiving this feedback

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#### 1.4. Information and facilities



Timely and relevant information is available and appropriate facilities are in place to support a high-quality, personalised and responsive approach for all children.

Outstanding

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

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

A full suite of up-to-date policies and procedures is in place and regularly reviewed. All staff responding to our survey stated that they understood the policies and procedures that apply to their work either quite well or very well. A multi-agency protocol, which includes the YOS and other agencies such as the local authority and the police, has been produced to guide residential care homes and foster carers on when it is appropriate to involve the police following incidents within the care setting. This has been developed in response to the recognised increasing number of looked after children in the YOS cohort.

Staff know how to access the right services from partners and providers to meet the needs of the children they work with, and they feel that communication within the service is a strength. There are helpful daily morning meetings for the service, which ensures that all staff are aware of any incidents of concern and plans for the day. Managers send out a briefing at the end of each week, updating staff of activities during the week and any other relevant information.

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

The YOS environment is a child-friendly space that has been designed in conjunction with children. The rooms that practitioners use for their meetings with children are comfortable and private. Staff report that they feel safe in the buildings where they work with children. There is a weapon detection arch in the YOS reception area and procedures are in place to promote the safety of staff and children.

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

Staff were positive about the main case management system, ChildView. They have direct access to the children's social care Liquidlogic database, which supports effective joint working and the sharing/integration of each other's plans. To assist

with risk assessments, the YOS seconded police officer provides staff with timely information from police databases. The co-location of health and education workers within the YOS enhances the flow of information between specialists and services, providing for a more coordinated approach to individual cases.

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

The use of IT and data is supported by an effective performance, systems and information manager who understands the work of the YOS. High-quality reports are produced to assist the leadership team and Management Board in understanding the profiles and needs of children, as well as the performance of the service. Managers have been trained to run their own data reports to assist them in managing their individual teams and understanding staff performance.

Data has been used to drive commissioning of services, such as programmes to work with the over-represented BAME children in the service. The YOS's culture of learning and development extends to its strategic commitment to improve services and outcomes for children. Initiatives such as the Amber Unit and the MAGPan have been developed, based in part on data that the YOS has produced that has highlighted concerns relating to serious youth violence. This information has been used to influence the partnership's understanding of the profiles of children affected by these issues.

A live tracker is used so that any trends, themes and/or concerns can be responded to immediately rather than retrospectively. This has led to the development of an Outcome Performance Framework Group, which includes the management team and uses datasets to focus on developing practice, addressing challenges, producing the service delivery plan and escalating concerns to the Board.

The YOS has processes in place to manage serious incidents and complete critical learning reviews (CLR). Three CLRs have recently been completed, and the reports were finalised in November. Plans are in place for workshops to be held with partner agencies to promote learning and improvements across the network.

Local accountability meetings (LAM) provide opportunities for partners to work together to look at key performance indicators and priorities that impact on all services seconded to or commissioned into the YOS. The LAM is newly established and not yet fully embedded.

Senior managers are committed to the development of powerful analytical and predictive tools within the YOS. An analysis of custodial cases identified specific risk factors that increased the chances of a child being sentenced to custody. This analysis was used to create a checklist for case managers and a Likelihood of Custody Panel. The panel looks at all cases where children are identified as having predisposing factors that suggest they may need additional support.





## 2. Court disposals

We took a detailed look at 19 community sentences and 2 custodial sentences managed by the YOT. We also conducted 18 interviews with the relevant case managers. We examined the quality of assessment; planning; implementation and delivery; and reviewing. Each of these elements was inspected in respect of work done to address desistance and the safety and wellbeing of the child.

For the 19 cases where there were factors related to harm, we also inspected work done to keep other people safe and ensure the safety and wellbeing of the child. The quality of each factor needs to be above a specified threshold for that aspect of performance to be rated as satisfactory.

In this YOS, the quality of work in post-court cases varied considerably across the standards. Work to support the child's desistance from offending was rated outstanding across all four standards. Quality of assessment was originally given a rating of 'Requires Improvement'. However, following the ratings panel, and taking overall account of qualitative evidence from all our interviews, we used professional discretion to increase this to 'Good', as it was a more accurate reflection of the practice we observed. Overall, the quality of planning was the weakest area of work and was rated as 'Inadequate'.

Luton YOS works well to support the desistance from crime of the children with whom it engages. The consistency with which practitioners effectively engage children and their families is impressive. Work to keep other people safe is the weakest area of practice across all four areas and was particularly deficient in relation to planning.

There was some variation in the quality of work relating to the safety and wellbeing of the children themselves across the four standards. This was assessed as 'Requires Improvement' in relation to planning, whereas it was 'Good' in terms of assessment and implementation and delivery, and 'Outstanding' in relation to reviewing.

### Strengths:

- The quality of work to support desistance is outstanding in assessment, planning, implementation and delivery and in reviewing.
- Staff take account of the views of children and their parents and carers.
- Information held by other agencies is used to inform assessments and consideration is given to diversity and individual needs.
- Practitioners support children to comply with the requirements of their sentence and take appropriate enforcement action when required.

### Areas for improvement:

- Restorative justice practice does not always consider the wishes and needs of identified and potential victims.
- Case managers do not consider all potential risk factors when determining a child's risk of harm to others, or their safety and wellbeing.

- Planning to manage risk of harm is inadequate and contingency planning does not reflect the needs of individual cases.
- The involvement of other agencies in managing the risk of harm is not sufficiently well-coordinated.
- Management oversight does not make enough difference to the quality of the work delivered to manage risk of harm or safety and wellbeing.

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

## 2.1. Assessment



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

**Good**

Our rating<sup>13</sup> for assessment is based on the following key questions:

	% yes
Does assessment sufficiently analyse how to support the child's desistance?	95%
Does assessment sufficiently analyse how to keep the child safe?	71%
Does assessment sufficiently analyse how to keep other people safe?	<b>62%</b>

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

Assessments routinely analysed how to support the child's desistance. In every case there was a clear, written record of the assessment of the child's desistance. Assessments were mostly completed within an appropriate period following the start of the sentence or release on licence.

There was sufficient analysis of offending behaviour, including the child's attitudes towards and motivation for their offending, in 18 of 21 cases. Most assessments considered the diversity needs and wider familial and social context of the child, utilising information held by other agencies. In all but one case, assessments focused on the child's strengths and protective factors, and in every case, there was an analysis of any structural barriers facing the child.

Sufficient attention was given to understanding the child's levels of maturity, ability and motivation to change, and their likelihood of engaging with the court disposal, in 18 of 21 cases. In three-quarters of cases, the child and their parents/carers were meaningfully involved in their assessment, and their views were considered.

<sup>13</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation. Although the lowest score (62 per cent) came within the 'Requires improvement' band, this was within five percentage points of the threshold for 'Good' (65 per cent) and professional discretion was used by the ratings panel to raise the overall rating to assessment to 'Good', considering the other scores and other qualitative evidence from interviews

Assessments gave sufficient attention to the needs and wishes of the victim/s and opportunities for restorative justice in only two-thirds of the cases inspected.

Overall, assessment of desistance factors was outstanding.

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

There was a sufficient assessment of the child's safety and wellbeing within an appropriate period following the start of the sentence or release on licence in 18 of 21 cases.

The cases we inspected indicated a high level of vulnerability concern. Two children had a learning disability and five had been subject to a child protection plan or section 47 enquiries at some point during the sentence being inspected. In 6 of the 21 cases inspected, we did not agree with the safety and wellbeing classification level because we thought that concerns had been underestimated.

In every case there was a clear, written record of the assessment of the child's safety and wellbeing. However, we found that assessments clearly identified and analysed risks to safety and wellbeing in 15 of 21 cases. Assessments analysed controls and interventions to promote the safety and wellbeing of the child in two-thirds of cases.

Overall, assessment of safety and wellbeing was good.

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

There was a sufficient assessment to keep other people safe within an appropriate period following the start of the sentence or release on licence in just under two-thirds of cases. There was a clear, written record of the assessment to keep other people safe in all but one case, but there was sufficient analysis of how to keep other people safe in just 13 of 21 cases. Inspectors judged the case manager's classification of risk of serious harm to be correct in 15 of 21 cases. Three cases were eligible for Multi-Agency Public Protection Arrangements (MAPPA) and the correct processes were applied.

Assessments drew sufficiently on available sources of information, including past behaviour and convictions, and involved other agencies in 15 of 20 cases. There was an adequate analysis of risk of harm to others posed by the child, including identifying who is at risk and the nature of that risk, in 11 cases. There was a sufficient analysis of controls and interventions to manage and minimise the risk of harm presented by the child in just over half of cases inspected.

An example of practice noted by an inspector:

*“A risk management meeting took place, but there are some discrepancies with information shared at the meeting, and some key details were omitted. The offences that had been committed were two assaults occasioning grievous bodily harm (GBH) and the case manager was vague about the details. Given the seriousness of the behaviour, the failure to explore it undermines the assessment of risk. This is compounded by the fact that previous disruptive behaviour has not been explored to assess whether there is a pattern of aggression that staff need to be aware of. Given that the index offences involved the possession of knives, this history is particularly relevant to the assessment of risk of harm to others”.*

Overall, assessments of risk of harm to others required improvement.

## 2.2. Planning



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

Inadequate

Our rating<sup>14</sup> for planning is based on the following key questions:

	% yes
Does planning focus sufficiently on supporting the child's desistance?	86%
Does planning focus sufficiently on keeping the child safe?	63%
Does planning focus sufficiently on keeping other people safe?	42%

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

Planning focused sufficiently on supporting the child's desistance in 18 of 21 cases. In most cases, planning set out the services most likely to support desistance, paying attention to the available timescales and the need for sequencing of interventions. Sufficient account of the diversity and wider familial and social context of the child was taken in 15 of 21 cases. Planning focused on developing the child's strengths and protective factors and sought to reinforce or develop these as necessary in most cases.

Attention was given to the child's levels of maturity, ability and motivation to change in all but one case. The child and their parents/carers were meaningfully involved in the planning process, and their views considered, in 15 of 21 cases. Planning was proportionate to the court outcome, with interventions capable of being delivered within an appropriate timescale in the majority of cases.

Planning gave enough attention to the needs and wishes of the victim/s in just under two-thirds of relevant cases.

Overall, planning to support desistance was outstanding.

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

Planning focused sufficiently on keeping the child safe in 12 of 19 cases. Planning sufficiently addressed risks to the safety and wellbeing of the child in 15 of the 19 cases where concerns were identified. Other agencies were appropriately involved in 13 of 16 cases. This provided opportunities to align with other plans, for example child protection or care plans, where this was required. Planning set out the necessary controls and interventions to promote the safety and wellbeing of the child in just over two-thirds of cases.

Contingency planning to manage the safety and wellbeing of children was weak. Arrangements to manage and respond to increasing concerns were made effectively in just over half of the cases inspected.

<sup>14</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annex 2 for a more detailed explanation.

An example of practice noted by an inspector:

*“Whilst there is specific planning around gang association and self-identity, there is no specific safeguarding planning and there is no alignment with the ‘Looked after child plan’. Contingency planning is inadequate for a child who should have been assessed as high risk but, regardless, is identified as involved in gang activity and county lines. The child was known to have had missing episodes and whilst the case manager queried how this would be managed by carers, there was no planning activity and contingency planning to manage any presenting or escalating risks as planning was not specific or personalised”.*

Overall, planning to promote the safety and wellbeing of the child required improvement.

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

Planning promoted the safety of other people and sufficiently addressed risk of harm factors in less than half of inspected cases. Other agencies were involved, where appropriate, in 11 of the 18 cases where this was required. Planning set out the necessary controls and interventions to promote the safety of other people in 7 of 19 cases. Contingency arrangements to manage those risks that had been identified were good enough in just 7 of the 19 relevant cases.

Planning to address any specific concerns and risks related to actual and potential victims was adequate in less than half of relevant cases.

An example of practice noted by an inspector:

*“No attention is paid to potential ongoing risk towards the identifiable victim, and concerns raised by the RJ worker about the victim’s close home locality and fear of further assault were neither acknowledged nor addressed. There was no contact with the child’s college to assess reported tensions and a suggestion that the victim may attend the same college”.*

Overall, planning to keep other people safe was inadequate.

## 2.3. Implementation and delivery



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

Requires improvement

Our rating<sup>15</sup> for implementation and delivery is based on the following key questions:

	% yes
Does the implementation and delivery of services effectively support the child’s desistance?	85%
Does the implementation and delivery of services effectively support the safety of the child safe?	67%
Does the implementation and delivery of services effectively support the safety of other people?	<b>61%</b>

<sup>15</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

### **Does the implementation and delivery of services effectively support the child or young person's desistance?**

There was sufficient focus on developing and maintaining an effective working relationship with the child and their parents/carers in 18 of 20 cases. It was evident that staff encourage and enable children to comply with their court order and that they take appropriate enforcement action where required.

The YOS delivered the services most likely to support desistance, paying attention to sequencing interventions and the available timescales, in all but one case. Service delivery reflected the diversity and wider familial and social context of the child, involving parents/carers or significant others in all but two cases. Service delivery routinely built on the child's strengths, and enhanced protective factors to promote opportunities for community integration, in all but three cases.

An example of practice noted by an inspector:

*"The case manager coordinated a bespoke package of intervention, which was carefully delivered in sequence by specialised staff. The offer in terms of speech and language therapy, education and substance misuse provision is well utilised, providing the child with a high-quality service. The other partnership services at her school, and the Child and Adolescent Mental Health Service (CAMHS), are well-coordinated so that there is alignment without overlap, and ongoing communication with all professionals".*

Overall, delivery of work to support the child's desistance was outstanding.

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

The implementation and delivery of services effectively supported the safety of the child in 12 of 18 cases. The involvement of other organisations in keeping the child safe was sufficiently well-coordinated in 13 of 18 relevant cases.

An example of practice noted by an inspector:

*"The practitioner ensured that the measures already in place continued, and repeatedly responded to new safeguarding concerns in an appropriate manner. There was excellent joint working with social care in this case to ensure that everything was done to safeguard the child. The safety and wellbeing issues were overseen well by the risk management panel".*

Overall, work to support the safety and wellbeing of the child was good.

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

The implementation and delivery of services effectively supported the safety of other people in 11 of 18 cases. The services delivered were sufficient to manage and minimise the risk of harm in just over half of the cases inspected. Limited priority was given to the protection of actual and potential victims; this was done well enough in only half of the cases inspected. Similarly, there was limited involvement of other agencies in managing the risk of harm and a lack of effective coordination where agencies had been included.

An example of practice noted by an inspector:

*“The risk management meeting failed to identify that the assessed risk level was incorrect and did not explore outstanding risk-related matters (despite records indicating that the child would be charged with possession of an offensive weapon). No enquiries were made regarding an outstanding robbery matter. There was no evidence of the monitoring of the relationships in the child’s life and he was subsequently arrested for assault of his pregnant partner (whilst still assessed as posing a low risk of harm to other people)”.*

Overall, work to support the safety of other people requires improvement.

## 2.4. Reviewing



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

Good

Our rating<sup>16</sup> for reviewing is based on the following key questions:

	% yes
Does reviewing focus sufficiently on supporting the child’s desistance?	90%
Does reviewing focus sufficiently on keeping the child safe?	88%
Does reviewing focus sufficiently on keeping other people safe?	<b>69%</b>

### Does reviewing focus sufficiently on supporting the child’s desistance?

A written review was completed in every relevant case and there was an appropriate focus on supporting the child’s desistance in 19 of the 21 cases. Practitioners identified and responded to changes in factors linked to desistance in almost every case, and they routinely considered how well interventions were building upon the child’s strengths and enhancing protective factors. In all but one case, barriers to engagement and progress were considered. There was a greater level of involvement of the child and their parents/carers in reviewing than there was in planning, and in most cases, it was evident that their views had been considered. Reviewing led to the necessary adjustments in the ongoing plan of work to support desistance in 17 of 21 cases.

An example of practice noted by an inspector:

*“During his sentence, Jason completed victim awareness sessions, produced a letter of explanation and had engaged in a BAME self-identity programme. It was evident that this supported his desistance, his safety and the safety of others. During his sentence, he disclosed thoughts of self-harm and the case manager acted to ensure that he was seen by a CAMHS worker to discuss any risks. At the end of the sentence, he had progressed in his education and was accessing Luton’s YouthScope, which*

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



*offered universal provision to support his ongoing desistance. There was continuous reviewing of his progress throughout the order”.*

Overall, reviewing to support desistance was outstanding.

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

Reviewing identified and responded to changes in factors related to safety and wellbeing in 14 of 16 cases where circumstances had changed, and a review was required. In these cases, reviewing was informed by the necessary input from other agencies involved in promoting the safety and wellbeing of the child. Reviewing led to the necessary adjustments in the ongoing plan of work to promote the safety and wellbeing of the child in 13 of the 16 cases. A written review of safety and wellbeing was completed in all but one case.

Overall, reviewing to support the safety and wellbeing of the child was outstanding.

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

A written review of risk of harm was completed in every case. In 8 cases, there were no changes to the risk of harm factors. Of the 13 cases where changes had occurred, 9 were reviewed appropriately, identifying and responding to changes in factors related to risk of harm to others. Of the 12 cases where other agencies were involved, in most cases those agencies were appropriately involved in reviewing. The child and their parents/carers were meaningfully involved in reviewing their risk of harm in just over two-thirds of cases. Reviewing led to the necessary adjustments in the ongoing plan of work to manage and minimise the risk of harm in 5 of the 9 relevant cases.

Overall, reviewing to support the safety of other people was good.



### 3. Out-of-court disposals

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We inspected 15 cases managed by the YOS that had received an out-of-court disposal (OOCd). All cases we inspected were community resolution interventions, and one was a drug and alcohol disposal. The YOS did not have any youth caution or youth conditional caution cases during the timeframe covered by this inspection. We interviewed the case managers in all cases.

We examined the quality of assessment; planning; and implementation and delivery of services. Each of these elements was inspected in respect of work done to address desistance. For the nine cases where there were factors related to harm, we also inspected work done to keep other people safe. In the 13 cases where safety and wellbeing concerns were identified, we looked at work done to safeguard the child. We also looked at the quality of joint working with local police. We found that less than half of the 15 cases inspected met all our standards relating to assessment. This led to our judgement of 'Inadequate' for this element of work.

Originally, work relating to implementation and delivery was rated as 'Requires improvement'. However, following a ratings panel meeting, and considering the small number of cases, the narrow score margins and the quality of work delivered overall, we used professional discretion to increase this to 'Good'. The quality of planning fell below our expected standards in over half of cases, leading to an 'Inadequate' judgement for this area of practice. Between half and two-thirds of cases we inspected met all our standards for joint working, hence the judgement of 'Requires Improvement'.

Processes for OOCd cases in Luton involve an initial triage assessment, which is discussed at an out-of-court disposal panel and used to inform decision-making. We found that some cases were not presented at the panel and that decisions were made between the practitioner and the police officer in charge of the case. This did not follow the YOS joint decision-making processes and meant that there was not always management oversight, or a record of the rationale for the decisions made. Once a decision had been made regarding disposals, a full AssetPlus assessment, which considers risk of harm and safety and wellbeing, is completed on all diversion cases. It is the standard of these assessments and subsequent work that we have inspected and rated.

Diversion disposals in Luton reflect the practice that we are seeing nationally, in that they are increasingly used to divert children from the formal youth justice system. There are positives in taking this course of action. Diversion at the earliest opportunity means that valuable interventions can be delivered without children having a recorded criminal record that can have lasting consequences. This must, however, be balanced equally with attending to issues of risk of harm to others and the safety and wellbeing of children themselves. In most cases we inspected, OOCds were imposed for offences that involved varying degrees of violence, and while we considered the YOS disposal recommendations to be appropriate in almost all cases, we found that consideration was not routinely given to the risks posed to others, including actual and potential victims. This undermined the overall quality of the work delivered. Equally, we saw high levels of vulnerability and complex needs that were significantly impacting on the lives of children and these were not always prioritised, particularly in planning.

### Strengths:

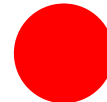
- Staff demonstrate good engagement skills and fully consider any barriers to the child's motivation and engagement.
- Assessment, planning, and implementation and delivery to support desistance are outstanding.
- Assessments focus on the child's strengths and protective factors.
- Service delivery to support the safety of other people is good.

### Areas for improvement:

- OOC processes are not consistently applied and the rationale for decision-making is not clearly recorded.
- Joint working with other agencies to implement and deliver services requires better coordination.
- Planning to support the safety of other people and the safety and wellbeing of children is inadequate.
- Assessments do not sufficiently analyse how to keep other people safe.
- The YOS recommendations to support joint decision-making are not sufficiently well-informed and analytical.

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

### 3.1. Assessment



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

**Inadequate**

Our rating<sup>17</sup> for assessment is based on the following key questions:

	% yes
Does assessment sufficiently analyse how to support the child's desistance?	87%
Does assessment sufficiently analyse how to keep the child safe?	67%
Does assessment sufficiently analyse how to keep other people safe?	<b>40%</b>

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

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

Assessments were based on a sufficient analysis of offending behaviour, including the child's acknowledgement of responsibility, and attitudes towards and motivation for their offending, in 12 of the 15 cases inspected. Practitioners paid attention to the individual and diversity needs of the children in 13 cases and gave due regard to their strengths and protective factors in every case. Most assessments also considered levels of maturity, ability and motivation to change and barriers that may impact on engagement and progress.

It was evident that the children and their parents/carers had been engaged in the assessment process in all but one case. Assessments did not always give attention to the needs and wishes of the victim/s; this was done well enough in 8 of the 12 relevant cases inspected. As a result, opportunities for restorative justice were missed in some cases, and victims and potential victims were not always protected.

Overall, assessment of desistance factors was outstanding.

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

Practitioners gathered all the information available about a child's safety and wellbeing, and liaised with partner agencies where appropriate, in 11 of the 15 cases inspected. In the majority, there was a clear record of the analysis of safety and wellbeing factors, and in all but two cases, we agreed with the YOS risk classification level.

There was a sufficient assessment, completed within an appropriate time of the delivery of the disposal, in 13 cases. Practitioners drew all the information together to analyse any risks to safety and wellbeing in the majority of cases. There was a clear written record of their assessment in the relevant 13 cases.

Overall, assessment of safety and wellbeing was good.

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

There was a clear, written assessment of how to keep other people safe in every inspected case, but in one-third of cases, assessments were completed late.

There was no evidence that there were issues relating to risk of harm in one of the 15 cases inspected. Of the remaining 14, assessments identified and analysed risk of harm to others, including who was at risk and the nature of that risk, in only four cases. Available sources of information, including other assessments that had been completed and other evidence of any concerning behaviour by the child were used to inform assessments in 6 of the 14 cases. This meant that the wider circumstances that might impact on risk of harm were overlooked at the assessment stage. We did not agree with the practitioner's classification of risk of harm to others in 7 of the 15 cases inspected. This was due to risk issues being underestimated.

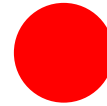
An example noted by an inspector:

*"The risks are underestimated despite the practitioner having correctly identified the nature and pattern of offending. The practitioner was uncertain as to how much weight to give to offences that resulted in the child 'remaining under investigation', which meant that some risk concerns were overlooked. There was a lack of attention to detail in respect of the index offence, giving rise to uncertainty about how much harm had been caused to the victim. Too much emphasis was placed on intentional harm, with indirect or unintended harm being minimised. All of this resulted in a*

*weak risk assessment that failed to identify the need for robust risk management planning, despite the panel process that was designed to oversee this”.*

Overall, assessment of risk of harm was inadequate.

### 3.2. Planning



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

Inadequate

Our rating<sup>18</sup> for planning is based on the following key questions:

	% yes
Does planning focus on supporting the child’s desistance?	80%
Does planning focus sufficiently on keeping the child safe?	46%
Does planning focus sufficiently on keeping other people safe?	<b>44%</b>

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

Planning to support desistance was an area of strength. Practitioners took account of the diversity and wider familial and social context of the child in 12 of the 15 cases inspected. In all but one, objectives to develop and reinforce strengths and protective factors were incorporated into the planning process. In most cases, the desistance factors identified at the assessment stage were addressed. In most cases, planning took account of the child’s levels of maturity, ability and motivation to change, as well as their specific needs and circumstances.

The child and their parents/carers were meaningfully involved in planning, and their views considered, in only 9 of the 15 cases. The YOS has recognised that this is an area of work that needs to improve and has developed ‘My plan’, which promotes and supports the involvement of children and their parents/carers. We did not see evidence of the new plan being used, as the timeframe of the inspected cases pre-dated its implementation.

In 12 of the inspected cases, planning was proportionate to the disposal type, with interventions capable of being completed within appropriate timescales. In most cases, planning set out the services most likely to support desistance, paying sufficient attention to the need for sequencing.

An example of practice noted by an inspector:

*“The case manager identified potential speech, language and communication concerns during the assessment and considered this in planning by outlining how related needs could be addressed. They ensured that sessions were not based heavily on reading; they were to be interactive and varied to maintain attention. Appointments were arranged around the child’s school timetable and the plan outlined how his parents could support attendance. Planning also incorporated a speech and language assessment to help support his engagement at school”.*

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

Overall, planning to support desistance was outstanding.

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

We inspected planning to keep children safe in 13 relevant cases; it was done sufficiently well in six. Of these, planning appropriately involved other agencies and sufficiently aligned with other plans, for example child protection or care plans concerning the child, in just six cases. Contingency planning was poor in almost half of inspected cases. There was a lack of clarity as to what action would be taken should concerns escalate and who would be responsible for responding.

Overall, planning to promote the safety and wellbeing of the child was inadequate.

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

Planning to protect actual or potential victims was done well enough in only four of the nine cases where it was required. In four of seven relevant cases, planning appropriately included other agencies who were involved with the child. This meant the opportunities to coordinate and align intervention plans were missed. Contingency planning lacked the necessary detail to help address specific issues or increasing concerns should they arise.

We assessed planning to keep other people safe in the nine cases that we judged to present a 'medium' or 'high' risk of harm to other people. We found this to be a particularly weak area of practice, with too little attention being paid to promoting the safety of other people or sufficiently addressing risk of harm factors.

An example of practice noted by an inspector:

*“There should have been better planning about the risks posed to other children within the accommodation placement, as well as to female children. Given the nature of the risks (sexual harm), this is too big an oversight to overlook, despite some other pieces of good risk planning via the Diversion and Prevention Panel”.*

Overall, planning to keep other people safe was inadequate.

## 3.3. Implementation and delivery



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

Good

Our rating<sup>19</sup> for implementation and delivery is based on the following key questions:

	% yes
Does service delivery effectively support the child's desistance?	80%

<sup>19</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation. Although the lowest score (62 per cent) came within the 'Requires improvement' band, this was within five percentage points of the threshold for 'Good' (65 per cent) and professional discretion was used by the ratings panel to raise the overall rating to assessment to 'Good', taking into account the other scores and other qualitative evidence from interviews.

Does service delivery effectively support the safety of the child?	81%
Does service delivery effectively support the safety of other people?	77%

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

Practitioners demonstrated that they were skilled at engaging with children and that they routinely delivered services that were most likely to support their desistance. Workers encouraged and enabled engagement and considered the sequencing of interventions to ensure that they were realistic and deliverable within the relevant timeframes. In almost every case, interventions reflected the diversity of the child and considered their personal circumstances. In most cases, staff formed meaningful relationships with children and involved parents and carers in supporting their child. Service delivery promoted opportunities for community integration, including access to mainstream services.

#### Good practice example:

Jamie is a 15-year-old boy of dual heritage (white and Black Caribbean). He was given a diversion programme for an offence of actual bodily harm. He has no previous convictions but had been subject to two previous out-of-court disposals. He has a severe learning disability. He has experienced abuse and neglect and continues to be at risk from both of these, and from criminal exploitation. He poses risks associated with harmful sexual behaviour and anti-social behaviour. There is also a concern relating to potential drug dealing. The practitioner's assessment is thorough, pulling together all the various pieces of information on him and analysing it well. The engagement recognises his diversity needs. There is excellent liaison with education and children's social care. Planning between agencies is well-coordinated and there is good reviewing activity when additional information comes to light.

The delivery of services was proportionate to the type of OOD, and interventions were completed within the required timescales in 13 of 15 cases.

Overall, delivery of work to support the child's desistance was outstanding.

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

In 8 out of 13 relevant cases, service delivery promoted the safety and wellbeing of the child. In two-thirds we found that YOS practitioners worked well with their partners to share information and coordinate the delivery of interventions. We saw examples where YOS practitioners were positively advocating for children to ensure that they received the support and services they needed.

An example of good practice noted by an inspector:

*"During the diversion programme, intensive work aimed at addressing harmful sexual behaviour, peer influence, aggression and impulsivity was delivered. In addition to the case manager, specialist staff are involved in working with the child. Some helpful drug education is delivered, and efforts are made to secure an appropriate education placement. Throughout the programme there is excellent coordination of all the activity by the case manager, who responds quickly to change, exchanges information well, and advocates on behalf of the child to ensure the appropriate services are delivered".*



Overall, work to support the safety and wellbeing of the child was good.

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

In six of the nine cases where a medium or high risk of harm to others had been identified, the services delivered were sufficient to manage or minimise the risk of harm. Attention was given to the protection of actual and potential victims in five of eight relevant cases.

An example of practice noted by an inspector:

*“The practitioner used interactive and age-appropriate work with Daniel to discuss how to support him in understanding the effects of his actions and to become more resilient in difficult situations. Daniel completed sessions on understanding why it was a danger to carry knives, the law and weapons and how to deal with conflict and bullying in a more positive way. Alongside this, the case manager worked with education providers to support him being taken back into mainstream school. They fed back to the school placement panel on the good progress Daniel was making and how he was gaining a better understanding of his actions. This resulted in reassuring his new school that his risk to others had reduced and that it was appropriate for him to return to mainstream education”.*

Overall, work to support the safety of other people was good.

### 3.4. Joint working



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

Requires improvement

Our rating<sup>20</sup> for joint working is based on the following key question:

	% yes
Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child, supporting joint decision making?	53%

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

The process for OOCd decision-making in Luton involves an initial triage assessment being completed when the YOS becomes aware that a child has come to the attention of the police. The assessment is undertaken by a triage duty worker, either at the police station or at the home of the child, depending on the circumstances of the case. Positively, in cases where the police decide that no further action will be taken, the child can be offered a voluntary prevention intervention, which is delivered by the YOS.

Once the triage assessment has been completed, it is expected that the case will be discussed at the weekly OOCd panel before any further discussion with the officer in

<sup>20</sup> The rating for the standard is driven by the lowest score on this key question, which comes within the 'Requires improvement' band of 50 per cent to 65 per cent.

charge of the case. In many cases we found that this process was not followed. Practitioners were making decisions with the officer in charge of the case outside the panel process and with no management oversight of the decisions being made.

Where we saw evidence that discussions had taken place with the police, including outside of the panel process, we considered the quality of the information that had been shared to inform discussions and decision-making. The YOS made recommendations in all but one of the 15 cases inspected. In the majority, the recommendations made were appropriate and proportionate. Of the 14 cases where recommendations were made, 10 considered the degree of the child's understanding of the offence and their acknowledgement of responsibility. We were disappointed to find that the YOS's recommendations were sufficiently well-informed, analytical and personalised to the child or child in just eight cases.

Sufficient attention was given to the child's understanding, and their parents'/carers' understanding, of the implications of receiving an OOC in 11 out of 15 cases. We found that the information provided to inform decision-making was timely enough to meet the needs of the case in just under half of the cases. In five cases, the child had received a previous OOC and in three cases they had received more than two. We found that the rationale for joint decision-making was clearly recorded in only 5 of 14 cases, making it difficult to understand why a certain course of action had been taken.

An example of practice noted by an inspector:

*“The disposal decision was made following a triage assessment which was completed by a triage worker. There was no evidence that an OOC panel had taken place to discuss the decision but there was plenty of liaison between the triage worker and the police officer. The assessment tool scored the case as medium on risk of harm to others and safety and wellbeing. This was despite a lengthy pattern of violence, with the index offence being one of assault occasioning actual bodily harm on a young child. There had been numerous threats of serious violence against other people which was not fully considered in the assessment. This was within the context of the young person having a diagnosis of autism and a learning disability which impacted significantly on his functioning”.*

Overall, the YOS's contribution to the OOC decision-making process required improvement.



## Annexe 1: Methodology

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### HM Inspectorate of Probation standards

The standards against which we inspect youth offending services are based on established models and frameworks, which are grounded in evidence, learning and experience. These standards are designed to drive improvements in the quality of work with children and young people who have offended.<sup>21</sup>

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

#### Domain one: organisational delivery

The youth offending service submitted evidence in advance and the Chair of the Youth Justice Partnership Board delivered a presentation covering the following areas:

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

During the main fieldwork phase, we conducted 32 interviews with case managers, asking them about their experiences of training, development, management supervision and leadership. We held various meetings, which allowed us to triangulate evidence and information. In total, we conducted 12 meetings, including with managers, partner organisations and staff. The evidence collected under this domain was judged against our published ratings characteristics.

#### Domain two: court disposals

We completed case assessments over a one-week period, examining case files and interviewing case managers. Sixty per cent of the cases selected were those of children and young people who had received court disposals six to twelve months earlier, enabling us to examine work in relation to assessing, planning, implementing and reviewing. Where necessary, interviews with other people significantly involved in the case also took place.

We examined 21 court disposals. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of 5), and we ensured that the ratios in relation to gender, sentence or disposal type, risk of serious harm, and risk to safety and wellbeing classifications matched those in the eligible population.

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

We completed case assessments over a one-week period, examining case files and interviewing case managers. Forty per cent of cases selected were those of children who had received out-of-court disposals three to five months earlier. This enabled us to examine work in relation to assessing, planning, implementing and joint working.

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<sup>21</sup> HM Inspectorate's standards are available here:

<https://www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/>

Where necessary, interviews with other people significantly involved in the case also took place.

We examined 15 out-of-court disposals. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of 5), and we ensured that the ratios in relation to gender, sentence or disposal type, risk of serious harm, and risk to safety and wellbeing classifications matched those in the eligible population.

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

## Annexe 2: Inspection results

In this inspection, we conducted a detailed examination of a sample of 21 court disposals and 15 out-of-court disposals. In each of those cases, we inspect against four standards: assessment, planning, and implementation/delivery; for court disposals, we also look at reviewing; and in out-of-court disposals, we look at joint working with the police. For each standard, inspectors answer a number of key questions about the quality of different aspects of the service, including whether there was sufficient analysis of the factors related to offending; the extent to which young offenders were involved in assessment and planning; and whether enough was done to assess the level of risk of harm posed, and to manage that risk.

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

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

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

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

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

# 1. Organisational delivery

Standards and key questions	Rating
<p><b>1.1. Governance and leadership</b></p> <p>The governance and leadership of the YOT supports and promotes the delivery of a high-quality, personalised and responsive service for all children.</p> <p>1.1.1. Is there a clear local vision and strategy for the delivery of a high-quality, personalised and responsive service for all children?</p> <p>1.1.2. Do the partnership arrangements actively support effective service delivery?</p> <p>1.1.3. Does the leadership of the YOT support effective service delivery?</p>	<b>Requires improvement</b>
<p><b>1.2. Staff</b></p> <p>Staff within the YOT are empowered to deliver a high-quality, personalised and responsive service for all children.</p> <p>1.2.1. Do staffing and workload levels support the delivery of a high-quality, personalised and responsive service for all children?</p> <p>1.2.2. Do the skills of YOT staff support the delivery of a high-quality, personalised and responsive service for all children?</p> <p>1.2.3. Does the oversight of work support high-quality delivery and professional development?</p> <p>1.2.4. Are arrangements for learning and development comprehensive and responsive?</p>	<b>Good</b>
<p><b>1.3. Partnerships and services</b></p> <p>A comprehensive range of high-quality services is in place, enabling personalised and responsive provision for all children.</p> <p>1.3.1. Is there a sufficiently comprehensive and up-to-date analysis of the profile of children, to ensure that the YOT can deliver well-targeted services?</p> <p>1.3.2. Does the YOT partnership have access to the volume, range and quality of services and interventions to meet the needs of all children?</p> <p>1.3.3. Are arrangements with statutory partners, providers and other agencies established, maintained and used effectively to deliver high-quality services?</p>	<b>Good</b>

<b>1.4. Information and facilities</b>	<b>Outstanding</b>
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Timely and relevant information is available and appropriate facilities are in place to support a high-quality, personalised and responsive approach for all children.

- 1.4.1. Are the necessary policies and guidance in place to enable staff to deliver a quality service, meeting the needs of all children?
- 1.4.2. Does the YOT's delivery environment(s) meet the needs of all children and enable staff to deliver a quality service?
- 1.4.3. Do the Information and Communication Technology (ICT) systems enable staff to deliver a quality service, meeting the needs of all children?
- 1.4.4. Is analysis, evidence and learning used effectively to drive improvement?

## 2. Court disposals

<b>Standards and key questions</b>	<b>Rating and % yes</b>
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<b>2.1. Assessment</b>	<b>Good</b>
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Assessment is well-informed, analytical and personalised, actively involving the child and their parents/carers.

- |  |     |
|--|-----|
| 2.1.1. Does assessment sufficiently analyse how to support the child's desistance? | 95% |
| 2.1.2. Does assessment sufficiently analyse how to keep the child safe?            | 71% |
| 2.1.3. Does assessment sufficiently analyse how to keep other people safe?         | 62% |

<b>2.2. Planning</b>	<b>Inadequate</b>
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Planning is well-informed, holistic and personalised, actively involving the child and their parents/carers.

- |   |     |
|---|-----|
| 2.2.1. Does planning focus sufficiently on supporting the child's desistance? | 86% |
| 2.2.2. Does planning focus sufficiently on keeping the child safe?            | 63% |
| 2.2.3. Does planning focus sufficiently on keeping other people safe?         | 42% |

<b>2.3. Implementation and delivery</b>	<b>Requires improvement</b>
High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child.	
2.3.1. Does the implementation and delivery of services effectively support the child's desistance?	85%
2.3.2. Does the implementation and delivery of services effectively support the safety of the child?	67%
2.3.3. Does the implementation and delivery of services effectively support the safety of other people?	61%
<b>2.4. Reviewing</b>	<b>Good<sup>22</sup></b>
Reviewing of progress is well-informed, analytical and personalised, actively involving the child and their parents/carers.	
2.4.1. Does reviewing focus sufficiently on supporting the child's desistance?	90%
2.4.2. Does reviewing focus sufficiently on keeping the child safe?	88%
2.4.3. Does reviewing focus sufficiently on keeping other people safe?	69%

### 3. Out-of-court disposals

Standards and key questions	Rating and % yes
<b>3.1. Assessment</b>	<b>Inadequate</b>
Assessment is well-informed, analytical and personalised, actively involving the child and their parents/carers.	
3.1.1. Does assessment sufficiently analyse how to support the child's desistance?	87%
3.1.2. Does assessment sufficiently analyse how to keep the child safe?	67%
3.1.3. Does assessment sufficiently analyse how to keep other people safe?	40%

<sup>22</sup> Assessment was originally given a rating of 'Requires improvement'. However, following the ratings panel we used professional discretion to increase this to 'Good'.

<b>3.2. Planning</b>	<b>Inadequate</b>
Planning is well-informed, holistic and personalised, actively involving the child and their parents/carers.	
3.2.1. Does planning focus sufficiently on supporting the child's desistance?	80%
3.2.2. Does planning focus sufficiently on keeping the child safe?	46%
3.2.3. Does planning focus sufficiently on keeping other people safe?	44%
<b>3.3. Implementation and delivery</b>	<b>Good<sup>23</sup></b>
High-quality, well-focused, personalised and coordinated services are delivered, engaging and assisting the child.	
3.3.1. Does service delivery support the child's desistance?	80%
3.3.2. Does service delivery effectively support the safety of the child?	62%
3.3.3. Does service delivery effectively support the safety of other people?	67%
<b>3.4. Joint working</b>	<b>Requires improvement</b>
Joint working with the police supports the delivery of high-quality, personalised and coordinated services.	
3.4.1. Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child, supporting joint decision-making?	53%
3.4.2. Does the YOT work effectively with the police in implementing the out-of-court disposal?	Not applicable for the cases inspected.

<sup>23</sup> Implementation and delivery was originally given a rating of 'Requires Improvement'. However, following the ratings panel, we used professional discretion to increase this to 'Good'.

## Annexe 3: Glossary

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<b>AssetPlus</b>	Assessment and planning framework tool developed by the Youth Justice Board for work with children who have offended, or are at risk of offending, that reflects current research and understanding of what works with children.
<b>Community resolution</b>	Used in low-level, often first-time, offences where there is informal agreement, often also involving the victim, about how the offence should be resolved. Community resolution is a generic term; in practice, many different local terms are used to mean the same thing.
<b>Court disposals</b>	The sentence imposed by the court. Examples of youth court disposals are referral orders, youth rehabilitation orders and detention and training orders.
<b>Child protection</b>	Work to make sure that all reasonable action has been taken to keep to a minimum the risk of a child experiencing significant harm.
<b>Enforcement</b>	Action taken by a case manager in response to a child's failure to comply with the actions specified as part of a community sentence or licence. Enforcement can be punitive or motivational.
<b>Intensive Supervision and Surveillance (ISS)</b>	ISS is a rigorous alternative to custody. It is a mixture of punishment and positive opportunities, which provides the courts with an alternative to custody. ISS targets the most active repeat young offenders and those who commit the most serious crimes. This can include those who have committed a serious single offence.
<b>Local authority</b>	YOTs are often a team within a specific local authority.
<b>Out-of-court disposal</b>	The resolution of a normally low-level offence, where it is not in the public interest to prosecute, through a community resolution, youth caution or youth conditional caution.
<b>Personalised</b>	A personalised approach is one in which services are tailored to meet the needs of individuals, giving people as much choice and control as possible over the support they receive. We use this term to include diversity factors.
<b>Risk of Serious Harm</b>	Risk of Serious Harm (ROSH) is a term used in AssetPlus. All cases are classified as presenting a low, medium, high or very high risk of serious harm to others. HMI Probation uses this term when referring to the classification system, but uses the broader term 'risk of harm' when referring to the analysis which should take place to determine the classification level. This helps to clarify the distinction between the probability of an event occurring and the impact/severity of the event. The term



	Risk of Serious Harm only incorporates 'serious' impact, whereas using 'risk of harm' enables the necessary attention to be given to those young offenders for whom lower impact/severity harmful behaviour is probable.
<b>Referral order</b>	A restorative court order which can be imposed when the child appearing before the court pleads guilty, and the threshold for a youth rehabilitation order is not met.
<b>Safeguarding</b>	Safeguarding is a wider term than child protection and involves promoting a child's health and development and ensuring that their overall welfare needs are met.
<b>Safety and wellbeing</b>	AssetPlus replaced the assessment of vulnerability with a holistic outlook on a child's safety and wellbeing concerns. It is defined as "...those outcomes where the young person's safety and well-being may be compromised through their own behaviour, personal circumstances or because of the acts/omissions of others" (AssetPlus Guidance, 2016).
<b>Youth caution</b>	A caution accepted by a child following admission to an offence where it is not considered to be in the public interest to prosecute the offender.
<b>Youth conditional caution</b>	As for a youth caution, but with conditions attached that the child is required to comply with for up to the next three months. Non-compliance may result in the child being prosecuted for the original offence.
<b>YOT/YOS</b>	Youth Offending Team is the term used in the <i>Crime and Disorder Act 1998</i> to describe a multi-agency team that aims to reduce youth offending. YOTs are known locally by many titles, such as youth justice service (YJS), youth offending service (YOS), and other generic titles that may illustrate their wider role in the local area in delivering services for children.
<b>YOT/YOS Management Board</b>	The YOT Management Board holds the YOT to account to ensure it achieves the primary aim of preventing offending by children.
<b>Youth rehabilitation order</b>	Overarching community sentence to which the court applies requirements (e.g. supervision requirement or unpaid work).
<b>Youth Justice Board</b>	A government body responsible for monitoring and advising ministers on the effectiveness of the youth justice system. The YJB provides grants and guidance to the youth offending teams.



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