

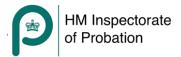
Joint inspection of youth justice services in

Suffolk

HM Inspectorate of Probation, January 2023

Contents

Foreword	
Ratings	4
Recommendations	5
Background	6
Domain one: Organisational delivery	7
1.1. Governance and leadership	7
1.2. Staff	9
1.3. Partnerships and services	10
1.4. Information and facilities	12
Domain two: Court disposals	15
2.1. Assessment	15
2.2. Planning	16
2.3. Implementation and delivery	17
2.4. Reviewing	18
Domain three: Out-of-court disposals	19
3.1. Assessment	19
3.2. Planning	20
3.3. Implementation and delivery	21
3.4. Out-of-court disposal policy and provision	22
4.1. Resettlement	23
4.1. Resettlement policy and provision	23
Fther information	24







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Foreword

This inspection is part of our programme of youth justice service (YJS) inspections. We have inspected and rated Suffolk YJS 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, Suffolk YJS was rated as 'Requires improvement'. This has been particularly impacted by the poor case management practice for court disposals which we rated as 'inadequate' against three of our standards. We also inspected the quality of resettlement policy and provision, which was separately rated as 'Good'.

Governance and leadership need to improve so that the board and its partners are fully sighted on the needs of children who come to this service. Although there is data, the lack of effective analysis of this means there is no clear picture of need or any in-depth understanding regarding the quality of work undertaken with children. This is making it difficult for the board to identify if work is having the intended impact or focus its resources effectively. The rate of children entering the criminal justice system in Suffolk YJS remains higher than the national average. Although identified as a priority, the focus on diversity issues is too narrow, and the needs of girls and children who are black, mixed heritage or from a minority group were not considered well enough in the work we inspected.

We found some evidence of effective work in some cases, with a strong offer of services from health and a proactive response to criminal exploitation. Resettlement was also an area of strength with effective joint work with partners and early commissioning of accommodation, to ensure the necessary support for children being released from custody. However, the quality of service delivered to children on court orders was inconsistent, and in too many cases there was not enough focus on their safety and wellbeing or actions to reduce any harm they posed to other people. Assessments lacked analysis and planning was poor, with inspectors identifying limited effective focus upon children's individual needs.

The out-of-court disposal scheme has been reviewed and there are plans in place to rectify the deficits we identified; including the introduction of an assessment to inform the panel's decision-making, and a review of panel membership and arrangements. The absence of a panel in which health and social care could contribute to decision making has resulted in missed opportunities for effective early multi-agency support to children.

The service has been through some significant changes, including a restructure and the implementation of a new case management system. Staff turnover has been high, and although the vacancy rate has reduced, several staff and managers are new to their roles. These factors have, in part, affected the progress of some planned improvements. The partnership has recognised many of the areas we have identified and is committed to making positive change.

Justin Russell

HM Chief Inspector of Probation

Ratings

Suffolk Youth Justice Service Fieldwork started June 2022 Score		9/36	
Overa	all rating	Requires improvement	
1.	Organisational delivery		
1.1	Governance and leadership	Requires improvement	
1.2	Staff	Requires improvement	
1.3	Partnerships and services	Good	
1.4	Information and facilities	Requires improvement	
2.	Court disposals		
2.1	Assessment	Requires improvement	
2.2	Planning	Inadequate	
2.3	Implementation and delivery	Inadequate	
2.4	Reviewing	Inadequate	
3.	Out-of-court disposals		
3.1	Assessment	Inadequate	
3.2	Planning	Requires improvement	
3.3	Implementation and delivery	Requires improvement	
3.4	Out-of-court disposal policy and provision	Requires improvement	
4.	Resettlement ¹		
4.1	Resettlement policy and provision	Good	

 $^{^{\}rm 1}$ The rating for Resettlement does not influence the overall YJS rating.

Recommendations

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

The Suffolk youth justice service should:

- 1. improve the analysis and quality of assessments, to ensure an accurate understanding of children's desistance, safety and wellbeing needs, and the risk of harm that they pose to others
- 2. develop the quality of planning activity so that it is effective in safeguarding children, protecting victims, and coordinated with other partnership plans
- 3. review the use of YJS police officers as case managers and ensure appropriate training for YJS police staff in relation to safeguarding practice.

The director for children and young people should:

4. ensure concerns about children referred from the YJS to the children's social care multi-agency safeguarding hub (MASH) are progressed in line with child protection procedures, in all relevant cases.

Suffolk police:

5. implement an effective flagging system to identify children who are known to and open to the YJS and ensure communication with the YJS is embedded.

The Suffolk YJS board and the office for the police and crime commissioner should:

review the funding arrangements to ensure the YJS can meet statutory responsibilities effectively as well as delivering quality diversionary interventions.

The Suffolk YJS partnership board should:

- 7. prioritise access to relevant partnership data and information to facilitate strategic understanding and analysis at board level, utilise this to complete effective needs assessments, and ensure this is translated into targeted service delivery which meets the needs of children
- 8. improve all children and young people's chances of success in education, training and employment by making better use of shared data, increase the proportion of children who receive their full entitlement to education, significantly reduce the number of children who are not in education, employment or training (NEET), and consider the importance of a dedicated education resource to achieve this
- 9. improve understanding of the needs and outcomes for diverse groups of children, including girls, children in care, and those from black, mixed heritage and minority ethnic groups.

Background

We conducted fieldwork in Suffolk YJS over a period of two weeks, beginning on 27 June 2022 and 11 July 2022. We inspected cases where the sentence or licence began between 28 June 2021 to 22 April 2022; out-of-court disposals that were delivered between Monday 28 June 2021 and Friday 22 April 2022; and resettlement cases that were sentenced or released between Monday 28 June 2021 to Friday 22 April 2022. We also conducted 53 interviews with case managers.

The service is hosted by Suffolk County Council, and delivers targeted prevention and diversion work, as well as court-ordered work. Suffolk YJS is co-located with other parts of children's services.

Suffolk is a large, mainly rural, county, with Ipswich being the principal town. The YJS has three area teams, based in Ipswich, Bury St Edmunds, and Lowestoft. Both the Bury and Lowestoft offices cover large geographical areas. In Bury St Edmunds in particular, because of the large geographical area, work is organised on a patch-based system. Staff in the teams have a mixed caseload to maximise flexibility.

There are three clinical commissioning groups (CCGs) in Suffolk. Norfolk and Suffolk NHS Foundation Trust provides mental health services.

The management board includes representatives from: Suffolk County Council, children's social care and education; Suffolk Constabulary; the National Probation Service; the CCGs and public health; the voluntary sector; and the courts. The board is chaired by the Director of Children and Young People's Services.

The headquarter team includes the Head and Deputy Head of Service, a manager and assistant managers for quality assurance, and a manager and assistant manager for restorative practice. There are also three team managers and assistant managers. The team manager in the north has a split post, with 40 per cent of time devoted to project work. The service also has a harmful sexual behaviour coordinator, who is 50 per cent funded by Suffolk County Council.

Suffolk YJS hosts two small, externally funded, criminal exploitation 'hubs'. They offer an immediate flexible intervention in high-risk locations or with high-risk groups, and work with third-sector organisations and other partners to build community resilience. The YJB-funded regional county lines pathfinder lead for Suffolk was line-managed within Suffolk YJS until 31 March 2022.

We inspected Suffolk at a time when they had experienced some considerable challenges. They had recently changed case recording systems and were operating within a context of considerable staff illness and absence, alongside ensuring an appropriate response to the ongoing impact of Covid-19.

Domain one: Organisational delivery

To inspect organisational delivery, we reviewed written evidence submitted in advance by the YJS and conducted 80 meetings, including with staff, volunteers, managers, board members, and partnership staff and their managers.

Key findings about organisational delivery were as follows.

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

Strengths:

- The draft three-year youth justice plan sets out the partnership's priorities. Diversion of children from the criminal justice system is a key aim and work to achieve this is undertaken by the YJS. This is ambitious with the clear intention of supporting children as early as possible.
- Board members of appropriate seniority attend across the partnership, including Police, Children's Social Care, Education and Health. They contribute to strategic decisions and commit resources when required.
- Discussions with senior leaders show that they are aware of local strategic issues as they arise and are responsive to these. The development of the criminal exploitation hub is a positive example, and there are clear processes and pathways to support children at risk of criminal exploitation.
- Staff understand their roles and responsibilities within the partnership, the service is well regarded by partners, and makes a significant contribution to wider partnership strategies; for example, the shared role of the HSB coordinator.
- There is a good health offer for children, which includes access to speech and language therapy (SaLT), primary mental health and substance misuse services. Support from the police, in the form of information-gathering and intelligence-sharing, is also evident. A local trauma informed approach has been developed with psychology support.
- The YJS has invested in the management team and, as part of the restructure, introduced practice development and quality assurance roles.
 These roles are clearly defined, intended to support service delivery.
- The operational management team has communicated the board's strategy well. Over 59 out of 63 staff who completed the survey said they understood the vision and strategy 'very well' or 'quite well'.

Areas for improvement:

 Needs analysis and performance information with a specific focus on the YJS cohort of children are limited. The previous case management system did not support effective data management, and the change to the new system

- meant no data was available for a period of time. The implementation of a new system is intended to help address previous data management issues.
- The strategic aim to improve children's access to suitable ETE is not underpinned by suitable resources, a focus on detail, or sufficient challenge by the board. Progress to improve ETE outcomes for children has been slow.
- The quality-of-service delivery is not being sufficiently improved by the board, particularly for children who are on statutory court orders. Ratings for domain two indicate that the focus on safety and wellbeing and the risk that children present to others is weak or inconsistent in too many cases. The board were not well sighted on this.
- Risks to the service are not fully understood or planned for; the change in the
 makeup of the staff team following the restructure (including the loss of
 experienced staff), the changes to the management structure, and the
 inability of the board to obtain effective data and analysis, had not been
 effectively considered by the board.
- There have been delays in progressing a strategic approach to meeting
 diverse needs; whilst a strategy and action plan is in place in relation to
 women and girls, girls remain overrepresented and specific gender informed
 pathways for them are limited. Work is also only just beginning in terms of
 understanding the experiences of Black, Asian and minority ethnic children
 and identifying why they are disproportionally represented in the YJS.
 Similarly, work around reducing the number of children who become first time
 entrants has been slow to progress.

1.2. Staff



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

Requires improvement

Strengths:

- The staff are passionate and motivated. They are committed to their work and put relationships with children and their families at the heart of what they do.
- The service has worked hard to mitigate difficulties in recruiting staff. Staffing vacancy rates have reduced from 20 per cent to nine per cent.
- At strategic and managerial level, there is a strong emphasis on training and joint working. Training for staff on the locally developed trauma-informed practice model has been well received.
- Management capacity has been supported by the introduction of roles focusing upon quality assurance, practice development and restorative approaches, and these are beginning to embed.
- The service restructure has resulted in some significant improvements for many staff and there are examples of staff being recruited into first-line manager roles as part of succession planning.
- Workloads are actively managed. Case managers co-work cases to provide continuity and contingency.

- High staff turnover and sickness levels have affected staffing for the past year. Staffing levels have impacted upon continuity of delivery of case work.
- It was a concern to find that police staff were managing cases. Additionally, some police staff indicated that they had not been trained effectively to assess children's risks and needs, which is essential for the case manager role.
- The YJS does not sufficiently use the specialist skills of probation staff to support the management of high-risk or transition cases.
- Management oversight of casework was not fully effective. Actions requested by managers were not always followed up, and some work signed off as sufficient by managers lacked basic information and analysis.
- The service redesign had a significant impact on staffing, with a negative effect on some staff. Some staff report that these issues are not fully resolved.
- The levels of training and management oversight are not yet resulting in effective assessments in out-of-court disposal cases or in the effective management of children on statutory orders.
- Although efforts have been made to recruit, the primary mental health worker
 role in north Suffolk has been vacant for a long time, which has reduced direct
 access to health services for children with identified health needs. While a
 workaround has been put in place, the YJS has not tracked or monitored this to
 ensure all children requiring health support have had their needs met.
- The workforce does not fully represent the local population, but the proportion of Black and minority ethnic staff is increasing.

1.3. Partnerships and services



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

Good

Strengths:

- The partnership provides a wide range of services to benefit children and young people. These include universal, targeted and specialist provision.
- We saw examples of innovation and good practice, including the county lines pathfinder and the development of FLATS (Family Learning and Thinking Skills – a programme designed to support effective parenting and reduce family breakdown).
- The data and performance officers have been instrumental in implementing the new case management system. There are plans in place to develop a data warehouse to improve data collection and analysis across the partnership.
- The views of children and their parents were almost always included in the cases we assessed, which was a strength. This needs to be developed into a comprehensive analysis to inform well-targeted services.
- Work to identify and support children who are vulnerable to or who are criminally exploited is strong.
- There are clear referral pathways into health services, and waiting times were short for services provided for the YJS. The SaLT team adopts a successful 'opt-out' of consultation service, which enables practitioners to discuss speech, language or communication needs with the SALT for the majority of children.
- The police officers and police community support officers are co-located within the YJS building. They are committed, dedicated officers and perform the role of evidence review officer for cases referred to the YJS.
- The psychologist's assessments of children provide the partnership and case managers with a depth of understanding about the effects of trauma that children have experienced. Formulations help all professionals to work in a clear and consistent way with children.

- Data is available from across the partnership, but it is not coordinated and used to provide a comprehensive strategic or operational analysis of the profile of the children who come into contact with the service.
- The use of data and analysis is underdeveloped, the limitations of the
 previous case management system contributed to this and for a period of
 time the service had no data whilst they moved to a new case management
 system.
- There is limited tracking and monitoring of the referral rates and outcomes of services for children.

- There is very little analysis, review or evaluation of the quality of services received by children. While the YJS uses case examples to show the board how work is carried out, this does not enable it to analyse or evaluate sufficiently the quality of the partnership's services for children.
- Too little progress has been made to support children into education, training and employment. Escalation routes are new and are not yet improving this.
- Delays and issues with data have contributed to limited analysis of diversity factors or issues of disproportionality. Too little is understood about the experiences of black, Asian, and minority ethnic children.

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.

Requires improvement

Strengths:

- The co-location of the YJS, children's social care and leaving care teams has improved communication and relationships in the three local area offices.
- The InfoBar reception facilities in Ipswich are good, well located and child friendly. Staff reported that the facilities are similar across all office locations. Children benefit from the use of a large kitchen and comfortable seating.
- A full range of policies and procedures are in place. These are accessible to staff and induction processes ensure staff understand them. Policies are underpinned by service standards that set out timescales and pathways.
- All case managers have access to an intervention portal, an online directory
 with a wide range of interventions and services. This provides staff with the
 pathways to referrals.

- Leaders and managers did not make good enough use of the available data
 to help them plan services effectively, for example to ensure that children and
 young people's ETE needs were met. A lack of analysis meant it was difficult
 to establish what changes were required to better address children's needs.
 In some instances, some key ETE partner organisations had access to
 accurate and very useful data for their own purposes, but the YJS had not
 used this to help inform its own core understanding or analysis.
- Analysis of the available data is underdeveloped and there is no clear shared understanding of the quality of delivery and performance. While there are some examples of where this is done well, these are isolated rather than coordinated.
- Performance and quality assurance systems do not sufficiently drive improvement. The new case management systems and elements of the service redesign should bring about improvements. However, at the time of the inspection, senior leaders did not focus sufficiently on the consistency and quality of frontline service delivery.
- The quality of recording on the case management system varied. In some cases, it provided a clear understanding of the child and the work being undertaken. In others, it was very difficult to understand what was being delivered. This does not support continuity in service delivery to children.
- The service does not routinely use information on diversity to drive improvements at operational or strategic level. Work to address disproportionality has begun, but the service needs to consider other diversity issues, disproportionality and protected characteristics.

Involvement of children and their parents or carers

The YJS has developed a quality assurance development plan which includes exploring how children and parents and carers will be consulted and engaged with the service. Case managers routinely seek children's and their parent or carers views, and recorded these in assessments, which was a strength.

The YJS contacted, on our behalf, children who had open cases at the time of the inspection, to obtain their consent for a text survey. We delivered the survey independently to the 27 children who consented, and seven children replied. We also spoke directly with some children currently working with the YJS and some of their parents or carers.

Children thought that the services they received were good. Four rated them as very good and three as quite good.

All children said that they were seen in places that felt safe. They also said that staff had the right skills to work with them.

When we asked the children if they had been able to access the right services to stay out of trouble, three said yes and four said no.

Four children indicated that they had been able to access the materials and equipment they needed, while three said they had not.

None of the children who replied to our survey could think of any improvements that the YJS could make.

Some children were positive about their contact with the service. They made the following comments:

"Very helpful and easy to talk to."

"They are open minded."

Two children said that watching videos was a useful way of learning.

"Watched a video about carrying weapons and a Monopoly type game where you were asked questions about what you should do. These were good and better than talking about the same thing all the time."

"Watched a video about county lines better than a conversation."

Diversity

There was limited evidence of the management board taking a deliberate or strategically informed approach to meeting children's diverse needs.

Of the children who are cautioned or sentenced 55 per cent identify as white. Black and minority ethnic children make up 34 per cent, and 11 per cent of offences are recorded as unknown.

The experiences or representation of children from black, Asian and minority ethnic backgrounds and the number of children in care, had not been given enough focus and more work was needed to improve outcomes for these children. The service is only just beginning work to understand the experiences of black, Asian and minority ethnic children and identify why they are disproportionally represented in the YJS. Diversity considerations and equality objectives were not clearly articulated in policies or strategic objectives. We found limited evidence that the board considered disproportionality when making decisions on policy.

There was an action plan to reduce the number of children in care, but progress had been slow in implementing it. It was positive to find that some training in restorative justice had been given to care staff in local authority children's homes. The board needs to ensure that all partners commit to making sure progress is made on the action plan.

The board has not taken a strategic approach to meeting the needs of girls, who are overrepresented in the YJS. There remains no specific gender-informed pathway for them. The organisational data showed that girls make up 20 per cent of the caseload Staff we spoke to had not had specific training in working with girls, and assessments did not reflect any specific needs arising from gender.

There was evidence that staff showed some responsivity to individual needs when forming relationships with children.

Children who are cautioned or sentenced in Suffolk tend to be younger than elsewhere in the east of England region or nationally. 31 per cent of children were aged 10 to 14, while the national figure is 18 per cent. We saw little strategic work to make sure that services are tailored to this age group and their levels of maturity.

Domain two: Court disposals

We took a detailed look at 22 community sentences and one custodial sentence managed by the YJS.

2.1. Assessment



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

Requires Improvement

Our rating² for assessment is based on the following key questions:

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	78%
Does assessment sufficiently analyse how to keep the child safe?	52%
Does assessment sufficiently analyse how to keep other people safe?	57%

Assessment of desistance was the strongest area in court disposal work and set out the reasons that led to the child offending. Case managers sought the views of the child and their parent or carer and utilised this well. There was a good level of detail about children's strengths, and we saw that case managers took the time to reinforce the child's skills. Information from other agencies was readily available and incorporated into assessment of desistance. Staff had access to children's social care systems and good relationships with partnership workers.

The analysis of how to keep the child safe was not consistent. Where case managers had used information on adverse childhood experiences to consider desistance, they did not use it to inform and analyse the child's safety effectively. Case managers knew about some risks to the child but underestimated the imminence and impact of these on the child on a day-to-day basis. Risks were listed in the assessments, but not analysed, so it was sometimes difficult to understand whether a risk was current, in the past or ongoing. Case managers did not routinely consider the effects of learning disability and the additional vulnerabilities that this might bring.

It was concerning to find that risks to children of being criminally exploited into drug dealing or drug running were not assessed accurately in a number of cases.

In too many cases the exact nature of the risk was not included in the assessment, and the lack of specific information about who was at risk and in what circumstances meant that planning to anticipate and manage risk of harm became very difficult.

² 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. <u>A more detailed explanation is available in the data annexe.</u>

2.2. Planning



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

Inadequate

Our rating³ for planning is based on the following key questions:

	% 'Yes'
Does planning focus sufficiently on supporting the child's desistance?	57%
Does planning focus sufficiently on keeping the child safe?	39%
Does planning focus sufficiently on keeping other people safe?	35%

The lack of detail and quality of analysis in some assessments make it more difficult for case managers to plan effectively. Planning was too generic and did not include the interventions and actions that would best help the child to understand their behaviour and make better-informed decisions. The role and involvement of partner agencies were not clear and, in some cases, missing.

Case managers did not sufficiently consider how to sequence interventions in plans, or how to adapt them to meet the child's learning needs. Planning did not focus enough on supporting children with ETE, despite this being a key desistance factor.

Planning to promote the child's safety was poor. One of the reasons for this was a lack of effective joint planning with other agencies, including children's social care and substance misuse services, particularly where exploitation was a known risk to the child. Agencies produced separate plans, but the YJS's plan did not draw these together so that all organisations knew exactly what actions they would need to take.

Too few cases included contingency planning or considered the use of external controls. Most contingency plans we assessed included identical actions and did not take individual circumstances into account. The actions to be taken were process-driven, for example 'a review of the asset should be completed within 48 hours', rather than specifying who would do what and within what timeframes, tailored to the individual child.

There were similar themes in risk management planning to keep other people safe. Planning to meet the views and wishes of victims was inconsistent. Case managers paid good attention to this in some plans, but not in others, including where there were external controls, such as restraining orders and curfews. Too few interventions to reduce risk were included and the role other agencies played was unclear. Contingency planning was very limited, even in cases where there was an identified risk to known victims or where the next victim could be identified.

³ 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. A more detailed explanation is available in the data annexe.

2.3. Implementation and delivery



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

Inadequate

Our rating⁴ 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?	74%
Does the implementation and delivery of services effectively support the safety of the child?	48%
Does the implementation and delivery of services effectively support the safety of other people?	39%

The delivery of interventions was not balanced, with far less attention given to the safety of the child or other people. The same level of attention is needed for each element across desistance, safety and wellbeing, and safety of other people.

Children were encouraged to comply with their orders, and staff showed flexibility to enable children to meet with them and undertake work. Case managers carried out home visits and involved different workers to provide a range of interventions, including SaLT workers and social workers. They took care not to overwhelm the children. There was frequent contact with children, who were encouraged and supported to engage with specialist workers. There was a strong focus on developing and maintaining a relationship with the child, and we saw this in almost every case. However, whilst positive, other aspects of case management such as safeguarding and public protection need to be given equal attention.

Our assessments found that there was not enough coordination between agencies to support the child's safety. This included where there were mental and emotional health concerns.

Services to manage risk of harm to others were delivered in only half of the cases where they were needed. Victims' needs were not given adequate and ongoing priority. In one case where there was poor delivery to manage risk to others:

"Planned interventions were not started until six months after the contract was agreed, the delays in structured intervention work negatively impacted on reducing his risk to others, and further assaults were committed during this time. It was unclear from records how other agencies, including the current placement, were involved in managing risks, as there was no evidence of risk plans being considered. Children in care reviews were not attended by the YJS."

⁴ 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. <u>A more detailed explanation is available in the data annexe.</u>

2.4. Reviewing



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

Inadequate

Our rating⁵ for reviewing is based on the following key questions:

	% 'Yes'
Does reviewing focus sufficiently on supporting the child's desistance?	70%
Does reviewing focus sufficiently on keeping the child safe?	43%
Does reviewing focus sufficiently on keeping other people safe?	43%

Reviewing of desistance factors was the strongest and most consistently completed element of this standard. Case managers considered the child's levels of motivation and compliance. They identified barriers to engagement quickly and made attempts to overcome them. Case managers identified and responded to changes in factors that affected the child's desistance. They paid attention to supporting the child's strengths and enhancing their protective factors. The FLATS programme is a practical example of how the service has used resources to support parents in their parenting and relationships with their child.

However, reviews led to the necessary adjustments in work in just over half of the cases, and diversity factors were considered in too few cases.

Too many changes to a child's safety and wellbeing were not recognised, and reviews were not sufficiently informed by other agencies. Even when there were some serious safeguarding issues, such as a child's mental health declining significantly, repeated examples of exploitation, or where parents' behaviour was recognised as abusive, we found examples where case managers did not respond to planned actions or complete timely reviews.

The response to changes in risk of harm to others was the similar. The service was slow to recognise the significance of some new information. Sometimes increased risk to others was discussed within the YJS, but not through a formal review. This resulted in other agencies not having the opportunity to contribute to or inform risk management.

⁵ The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. <u>A more detailed explanation is available in the data annexe.</u>

Domain three: Out-of-court disposals

We inspected 35 cases managed by the YJS that had received an out-of-court disposal. These consisted of three youth conditional cautions, six youth cautions and 26 diversion code cases. We interviewed the case managers in 31 cases.

3.1. Assessment



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

Inadequate

Our rating⁶ for assessment is based on the following key questions:

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	57%
Does assessment sufficiently analyse how to keep the child safe?	29%
Does assessment sufficiently analyse how to keep other people safe?	43%

The majority of out-of-court disposal cases we assessed involved violence towards another person or possession of drugs. Assessments tended to be completed on a locally devised form, with more complex cases being assessed using AssetPlus. The quality of assessments was affected by a number of issues; they lacked analysis and underestimated risks to safety and wellbeing. Just over half of the assessments included the child's attitude to and motivation for their behaviour. Screenings contained lists of factors for and against desistance, but case managers did not consider the triggers and influences that had led to offending. Diversity factors were not assessed well enough in a number of cases.

Case managers underestimated risks to children's safety and wellbeing in almost a third of cases. They did not give factors the significance they should or use information from other agencies effectively. There was little analysis of what the risk factors meant for that child and their ongoing safety and wellbeing.

The assessment of risk of harm identified what the risks were and who was at risk in eight out of 27 cases. Again, case managers did not effectively use information held by others and sometimes underestimated risk. We found examples of information held by social care about violence within families or held by schools, both of which could provide critical context and background information, not being effectively considered or informing assessments.

⁶ The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. <u>A more detailed explanation is available in the data annexe.</u>

3.2. Planning



Planning is well-informed, analytical and personalised, actively involving the child and their parents or carers.	Requires improvement
involving the child and their parents or carers.	improvement

Our rating⁷ for planning is based on the following key guestions:

	% 'Yes'
Does planning focus on supporting the child's desistance?	74%
Does planning focus sufficiently on keeping the child safe?	60%
Does planning focus sufficiently on keeping other people safe?	60%

Planning for desistance was generally proportionate to the outcome, setting out the interventions to be delivered and the aim of these.

Children were asked what they thought might help, and their views were considered. Case managers often wrote plans in a way that made sense to the child and described what success would look like and what they wanted the child to learn.

A good range of interventions were available and included in planning to meet different needs, including managing emotions and anger, substance misuse, education and training and the consequences of further contact with the police. Victims' views were not always included and some opportunities for restorative justice were missed.

Case managers worked hard to engage children on voluntary disposals and were creative in their approach. In one case a girl was asked to identify one time a week when she would do something to care for herself. This was a creative way of helping her with anxiety caused by overwork, as she was at college, working two jobs and learning to drive.

Planning promoted safety and wellbeing but didn't sufficiently involve other agencies. This included children who were known to social care and children in care. Contingency planning was a critical factor, with action not being identified for known issues in almost two-thirds of cases.

In just over half of the relevant cases, planning promoted the safety of other people. The lack of joint planning with other agencies was a concern, and case managers did not plan how to meet the needs of victims. Schools should have been involved in planning more often than they were.

Where planning was effective, it was clear what the priority of the work was. There there was appropriate signposting and referral to other agencies and consideration given to completing work within the time available.

⁷ The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. <u>A more detailed explanation is available in the data annexe.</u>

3.3. Implementation and delivery



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

Requires improvement

Our rating⁸ for implementation and delivery is based on the following key questions:

	% 'Yes'
Does service delivery effectively support the child's desistance?	77%
Does service delivery effectively support the safety of the child?	60%
Does service delivery effectively support the safety of other people?	69%

Effective service delivery provided good support for children's desistance. Case managers developed relationships with children and parents quickly and maintained these. They considered carefully where to see the child and involved the family in work. Engagement was encouraged with voluntary contact.

Case managers worked with persistence and skill to adapt to children's learning styles, meet their individual needs, and overcome barriers. For example, working in a flexible way, a case manager identified when a child's mental health started to deteriorate and providing effective support then became the priority.

We saw some other effective work. For example, children were asked to write letters of explanation for the victims. This followed a six-point format, encouraging the child to see the effects of their behaviour on other people.

Service delivery to support the child's safety and wellbeing was the area that prevented this standard from being rated as good. Although this was done well in some cases, it was not consistent for all children. A key factor was the YJS working in isolation and not involving other agencies in half of the cases where their input would have been valuable. Health partners were used frequently. However, utilising more effective work with schools and children's social care would have supported the child's safety and wellbeing.

In supporting the safety of others, we saw a range of interventions were delivered to address knife crime, racism and violence. Here we did see evidence of some positive joint work with schools and care homes, and there was a focus on providing children with practical support to behave, react differently in the future and reduce the risks they presented. These included helping a child to create and maintain a no-contact arrangement with another child at school, work on healthy relationships, and the use of street doctors.

⁸ 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. <u>A more detailed explanation is available in the data annexe.</u>

3.4. Out-of-court disposal policy and provision



There is a high-quality, evidence-based out-of-court disposal service in place that promotes diversion and supports sustainable desistance.

Requires improvement

We also inspected the quality of policy and provision in place for out-of-court disposals, using evidence from documents, meetings and interviews. Our key findings were as follows:

Strengths:

- A new out-of-court disposal scheme has been agreed. This is based on current research and evidence. A working group is in place to implement the new scheme, which will involve introducing joint decision-making panels, widening the representation of the partnership, and ensuring assessments are carried out before decisions are made.
- Children benefit from access to a wide range of interventions to support desistance.

- The scheme in operation at the time of the inspection was not meeting the needs of all children and young people. Decisions were made before assessments had been carried out, which meant that the child's full situation could not be taken into account to determine the appropriate outcome or interventions. The children's safety and wellbeing needs were consistently underestimated.
- The board is driving the work of early intervention and diversion. However, it
 needs to ensure sufficient resources are available to complete all work to a
 good standard and that statutory casework is given the focus and attention it
 requires.
- Decision-making consisted of discussions between the YJS and the police, but, in the main, the police officers' recommendations are accepted.
 Recommendations are inconsistent and not informed by a multi-agency decision-making panel.

4.1. Resettlement

4.1. Resettlement policy and provision



There is a high-quality, evidence-based resettlement service for children leaving custody.

Good

We inspected the quality of policy and provision in place for resettlement work, using evidence from documents, meetings and interviews. To illustrate that work, we inspected three cases managed by the YJS that had received a custodial sentence. Our key findings were as follows.

Strengths:

- Resettlement work is seen as priority across the partnership, and case
 managers undertake collaborative work to identify the child's needs quickly.
 Strenuous efforts are made to keep children in the home area, and a range of
 support is provided to parents to help children return home. There are
 effective links with accommodation providers to retain placements for
 children.
- Planning to meet children's needs is underpinned by frequent contact with the custodial estate and with children, and existing practice is being consolidated with the development of a new resettlement policy.
- There are good levels of management oversight and support to ensure effective planning and service provision for children on release from custody.
- Management oversight of resettlement is supportive and effective in escalating issues that need to be resolved. The prior experience of managers who have worked in youth custody has improved the service's understanding of how to work effectively with the secure estate.

- Training has not yet been delivered to staff who are involved in resettlement cases, although staff we spoke to were knowledgeable about this area of work.
- The views of children, parents and carers could be further utilised to inform to inform resettlement policy and provision.

Further information

The following can be found on our website:

- inspection data, including methodology and contextual facts about the YJS
- a glossary of terms used in this report.