HM Inspectorate of Probation

An inspection of youth offending services in

Staffordshire

HM Inspectorate of Probation, December 2023

Contents

Acknowledgements

This inspection was led by HM Inspector Rebecca Howard, 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.

The role of HM Inspectorate of Probation

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

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

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Please note that throughout the report the names in the practice examples have been changed to protect the individual's identity.

Foreword

This inspection is part of our programme of youth justice service (YJS) inspections. We have inspected and rated Staffordshire Youth Offending Service (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, Staffordshire YOS was rated as 'Requires improvement'. We also inspected the quality of resettlement policy and provision, which was separately rated as 'Requires improvement'.

There has been consistent commitment and attendance from most partners at the management board. However, further development is needed to ensure that board members fully understand their roles and responsibilities in advocating and supporting the YOS. This includes offering greater strategic oversight and improved connectivity with the service. Positively, the board has prioritised having a health representative as a core member, and now needs to proactively support the YOS in embedding a geographically equitable health offer that meets the needs of all children.

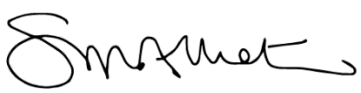
The strategies outlining how the service intends to meet the protected characteristics of children and address disproportionality have not been fully developed. The board and YOS need to work collaboratively to understand children's diversity needs and analyse overrepresented cohorts of children.

Staffing arrangements are a strength; there is a stable and dedicated team who passionately advocate for the children and families they work with. There is good access to training and learning opportunities, including access to formal qualifications such as the youth justice foundation degree. Staff find managers approachable and supportive; they feel valued by the service and that their hard work is acknowledged and rewarded.

The YOS has good links with the third sector, and children have access to a wide range of services to meet desistance needs and build on protective factors. However, the services for victims need reviewing to ensure that they are adequately prioritised, and the provision meets their needs.

Arrangements for keeping the child and other people safe were insufficient; these require an immediate and full review to ensure that risks are appropriately identified and addressed. Arrangements for achieving safety for children need partnership commitment and input, so that there is a shared responsibility and coordinated approach in supporting children.

The YOS has recognised the importance of hearing the child's voice and using this to shape service delivery. It is further developing this approach to ensure that it is accessible, and children have ample opportunities to contribute. There is a positive child-centred approach to delivering out-of-court disposals and dedication to diverting children away from the youth justice system. However, the framework needs reviewing to ensure that all eligible children are consistently offered diversion opportunities.



Sue McAllister
Interim HM Chief Inspector of Probation

Ratings

Staffordshire Youth Offending Service Fieldwork started September 2023		**Score**	**9/36**
Overall rating		**Requires improvement**	
1.	**Organisational delivery**		
1.1	Governance and leadership	**Requires improvement**	
1.2	Staff	**Good**	
1.3	Partnerships and services	**Requires improvement**	
1.4	Information and facilities	**Requires improvement**	
2.	**Court disposals**		
2.1	Assessment	**Inadequate**	
2.2	Planning	**Requires improvement**	
2.3	Implementation and delivery	**Inadequate**	
2.4	Reviewing	**Requires improvement**	
3.	**Out-of-court disposals**		
3.1	Assessment	**Inadequate**	
3.2	Planning	**Inadequate**	
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	**Requires improvement**	

[1] The rating for resettlement does not influence the overall YOS rating.

Recommendations

As a result of our inspection findings, we have made 11 recommendations that we believe, if implemented, will have a positive impact on the quality of youth offending services in Staffordshire. This will improve the lives of the children in contact with youth offending services, and better protect the public.

The Staffordshire Youth Offending Service should:

1. review and improve management oversight and quality assurance arrangements to ensure that standards of sufficiency are understood, and processes add value in improving the quality of practice
2. complete an immediate review of and further develop risk management processes, to ensure there is a coordinated approach and partnership response to keeping children and others safe; this includes supporting practitioners and managers in improving knowledge and analysis of risks to and from children, and measures required to promote safety
3. work with police partners to create joint protocols and policies for out-of-court disposals which clearly articulate processes, expectations, and roles of all services, this includes a review and further development of out-of-court disposal processes to ensure that all eligible children are consistently considered for diversion.
4. review the delivery of restorative justice to ensure that victims are prioritised, and services are available to meet their needs
5. review the volunteer provision, including proactive recruitment to secure volunteers who reflect the YOS cohort, ensure their workload is manageable and develop arrangements which include effective support and oversight processes and training opportunities for volunteers
6. work with partners to further develop resettlement provision to make sure that there is a shared multi-agency responsibility and coordinated approach in supporting children to transition back into the community
7. further develop evaluation processes to provide an in-depth evidence-based understanding of practice and use this to inform service delivery, including utilising learning and examples of effective practice within the sector.

The Management Board should:

1. work with the YOS to develop an evidence-based diversity strategy and approach to disproportionality; which supports the development of appropriate guidance and is embedded in operational delivery
2. increase knowledge and understanding of how to support and advocate for the YOS, including ensuring the YOS statutory work is prioritised and adequately resourced
3. improve strategic oversight, responsibility, and connectivity to the service to make sure that delivery of key areas such as resettlement, out-of-court disposals, and risk and safety management are sufficient

4. actively work with and support the YOS in securing and embedding a geographically equitable health offer; and review all provision to ensure there is sufficient resource which meets the health needs of all children.

Background

We conducted fieldwork in Staffordshire YOS over a period of a week, beginning 25 September 2023. We inspected cases where the sentence or licence, out-of-court disposal or resettlement provision was delivered between 26 September 2022 and 21 July 2023. We also conducted 46 interviews with case managers.

Staffordshire is a county in the West Midlands of England, bordering Cheshire, Derbyshire, and Shropshire. The county has eight districts and is diverse in terms of its landscape with a mix of rural and urban areas. In December 2022, the Office for National Statistics recorded that there were 77,798 children aged 10-17 years in Staffordshire. Children from black, Asian, and minority heritage make up 10 per cent of this figure. At the time of inspection, seven per cent of the children working with the YOS were from these heritages. While this indicates that children from black, Asian, and minority ethnic heritages are not disproportionately represented, proactive analysis completed by the YOS illustrates that there is incidence of overrepresentation in children referred for out-of-court disposals.

Staffordshire youth offending service (SYOS) is located within 'futures matter', which is part of the children's social care directorate, and sits alongside other services including child exploitation, family group conferencing, and the breathing space project. The strategic management structure compromises the head of future matters and the YOS lead. The YOS lead has oversight of youth justice provision and prevention services. There are two teams for youth justice provision, covering the north and the south of Staffordshire. Each are overseen by an operational manager, with support from a senior practitioner in each team.

At the time of inspection, 45 children were subject to community orders, three children were in custody, and three were on licence. Out-of-court disposals made up the largest proportion of the YOS's workload, with 68 children working with the service in this capacity. The majority of the caseload were boys aged between 15 and 17. The YOS identified that their most common offences were violence against the person, followed by criminal damage and drug-related offences (15 per cent). Within our case samples, violence against the person was the most prevalent offence, making up 35 per cent of all inspected cases, followed by sexual contact offences at 15 per cent. Like many areas, there were high numbers of children within the YOS cohort who experienced emotional wellbeing and mental health difficulties (44 per cent) and/or had a learning disability (51 per cent). Nine per cent of the YOS cohort were cared for by the local authority, three per cent were subject to child protection plans, and 11 per cent were on an open child in need plan. All statutory school-aged children were in some form of education, either mainstream or in alternative provision.

Staffordshire police service covers the YOS area. The YOS has good links with the Office of the Police and Crime Commissioner (OPCC). The OPPC is a regular management board member and has supported the YOS in providing prevention services to children.

Domain one: Organisational delivery

To inspect organisational delivery, we reviewed written evidence submitted in advance by the YOS and conducted 13 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:

- Statutory partners are of appropriate seniority and represented at the board, including consistent attendance from police, probation, and children's social care. Board membership is enhanced through representation from the third sector and the Office of the Police and Crime Commissioner (OPCC).
- There is an induction process in place. Board members must commit to ongoing learning and are required to participate in regular development days.
- Prevention and early intervention are priorities. The YOS and the partnership have developed a coordinated offer to prevent children becoming involved in the criminal justice system.
- Through partnership arrangements, probation, police, and substance misuse practitioners have been seconded to the YOS. The YOS has strong links with the OPCC and third sector, which have enriched the services available to children and families.
- Securing and maintaining education, training, and employment (ETE) is a priority. The YOS and the partnership have developed effective links and pathways to support YOS children into appropriate ETE.
- The vision and strategy are understood by staff. YOS managers and senior leaders are visible, and staff feel that strong support is offered to them.
- The board and YOS have effective links to other strategies and provision within Staffordshire to support service delivery.

Areas for improvement:

- Although the board uses the YOS's quality assurance processes and key performance indicators to understand and measure service delivery, these have not adequately identified areas that are underperforming, such as risk to others and children's safety and wellbeing; this has resulted in the board lacking understanding of the issues within practice.
- Connectivity between the YOS staff and the board needs to be strengthened to ensure there is effective strategic oversight of operational activity, such as resettlement and out-of-court disposals.

- Board members are clearly committed, but more work is needed to support them to fully understand their role and strategic responsibilities, including stronger advocacy for the YOS in their organisations.
- Police partners have brought data on children released under investigation (RUI) and stop and search, which is positive. Other board members need to be consistent in bringing information and data from their own services that can help inform and assist the YOS.
- The board is not fully sighted on all potential risks to the service, including challenges with commissioning and disparities with service provision. Increased awareness and understanding of these organisational risks will assist it in supporting the service to develop effective contingencies and mitigation.
- There is a lack of clear lines of accountability within the YOS. This is impacting upon the successful operationalisation and delivery of the vision and strategy.
- Operational relationships between children's social care and the YOS need to be strengthened to ensure there is a clear understanding of each other's roles and responsibilities, and improved co-ordination and collaboration.
- Until recently, health attendance at the board has been a consistent gap. Lack of representation has hindered progress in improving the health provision for YOS children. It is essential that representation is maintained to support the YOS to advocate for appropriate health services.
- We found that the health provision across the area is inequitable and not all children's needs are adequately addressed. The board is not well sighted on the impact of these disparities.
- Elements of YOS provision, including restorative justice, have struggled to recover following the pandemic. This is having a detrimental impact on service delivery. The board needs to proactively support the YOS to ensure that victims and the delivery of restorative justice are prioritised.

1.2. Staff

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

Strengths:

- The workforce is stable with adequate staffing levels to meet service needs. Workloads are reasonable and there are effective contingency arrangements which respond appropriately to changes in demand.
- There is a measured approach to allocation which considers staff skills and experience and identifies the most appropriate practitioner to work with the child and family.
- The YOS promotes a culture of learning and development. It has utilised the appraisal process to identify relevant training to develop staff. Induction processes support and prepare new staff to undertake their roles.
- The YOS has invested in its staff and has provided a variety of opportunities for them to gain formal qualifications, including the certificate of effective practice and the youth justice foundation degree.
- Staff and volunteers feel highly valued by the YOS and the wider partnership. They are motivated, passionate, and dedicated to working with children and families. Achievements by staff are recognised and acknowledged.
- Appropriate attention is paid to supporting and improving staff engagement. Staff feel that they are closely aligned with the YOS and are given ample opportunity to link in with their managers and colleagues.
- Practitioners and managers report that their welfare is a priority and appropriate measures have been taken to promote their safety.

Areas for improvement:

- Practitioners describe supervision as frequent and supportive. However, in the cases we reviewed, management oversight was not consistently driving or improving the quality of work. For domain two, we assessed that management oversight was necessary in 18 cases but was only sufficient in seven. In domain three, we assessed that management oversight was sufficient in less than half the cases.
- The YOS needs to further develop the training offer to support manager and practitioner knowledge and understanding of the risks to and from children.
- The support and oversight provided to volunteers needs to be improved. Greater access to training and support will enable volunteers to further develop and feel more connected to the service.
- The workloads of the volunteers are high and demanding; at the time of inspection there were three volunteers to cover the whole of Staffordshire. Recruitment needs to be prioritised and targeted to increase the numbers of active volunteers who are representative of the children and families with whom the YOS works.

1.3. Partnerships and services

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

Strengths:

- Data analysis is comprehensive and impressive. This routinely provides detailed insight into the profile and demographics of children and families who have accessed the YOS.
- Children have access to a wide range of services and interventions to meet their desistance needs, which build on strengths and protective factors.
- The YOS education, training, and employment (ETE) support provision is a strength. There are proactive efforts to support and advocate for children in securing and maintaining appropriate ETE.
- The YOS has a strong relationship with the probation service. There is a considered approach to transition which enables children to move to this service effectively.
- YOS children have quick access to substance misuse intervention and support.
- The YOS has effective relationships with the courts, providing regular updates, training, and observation opportunity to magistrates.
- The partnership has been developing its response for children identified as at risk from exploitation. Existing arrangements are robust and offer children appropriate support.
- In response to increases in children involved in sexually harmful behaviour, the YOS has developed its support and intervention packages, including further training for practitioners and managers.

Areas for improvement:

- Risk and safety management processes need to improve to ensure that they are effective in keeping children and other people safe. There needs to be consistent support and input from partners to ensure risks are identified and understood, and that there is shared responsibility to manage these.
- Victims and the services available for them are not adequately prioritised. A review is needed to ensure that victims receive a consistent high-quality service that meets their needs. Data analysis needs to include consent and uptake rates, the services provided, and feedback from victims. This will assist in evaluating provision to understand effectiveness and inform service delivery.
- In the cases we reviewed, where children had worked with the in-house speech, language, and communication therapist specialist, intervention and support were impressive. However, due to commissioning restrictions this provision is not available for all YOS children.

- The YOS has seconded health practitioners who are able to be effective in supporting the physical and mental health needs of some children. Unfortunately, commissioning restrictions and lengthy waiting lists for specialist services mean that not all needs are adequately addressed. Positively, the YOS are working proactively to resolve this.
- Reparation work is underused and there are limited options available for children. This provision requires a full review to ensure that there are a range of restorative community projects which will provide children with opportunities to build on strengths, learn, and develop.

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:

- There are a range of policies, procedures, and guidance in place which are regularly reviewed. These are centrally located for staff to access.
- The YOS utilises community venues and home visits to see children and families. This avoids children having to travel lengthy distances. Children are given a choice of locations so that they feel safe and comfortable.
- ICT packages are effective, and staff are able to work remotely from home and at the YOS premises using the childview case management system.
- The ICT systems allow the YOS to easily extract data and run comprehensive performance reports. The reports also consolidate data from children's social care and youth justice systems, allowing real-time, up-to-date access to information.
- Using research and scrutiny of its own data, the YOS developed a bespoke package of intervention to support children with high and complex needs. The approach had such a good impact that this has informed future provision.
- Keele University has completed independent evaluation to review areas of provision and the findings have been used effectively to inform service delivery, including the turnaround programme.

Areas for improvement:

- There is a robust quality assurance framework that provides frequent opportunities for oversight of work, but this is not adequately identifying or addressing deficits in practice. Further work on understanding appropriate levels of sufficiency is needed.
- To further develop an understanding of good and effective practice, the YOS should utilise learning from the sector and local youth justice services.
- Policies need reviewing to ensure that there is clear guidance on all key processes and procedures, which is routinely followed. This will assist managers and practitioners in understanding expectations and minimum practice requirements.
- Although current arrangements allow the YOS to complete detailed checks with other services, including education and children's social care (CSC), practitioners do not have direct access to CSC systems. In our case inspection, we found examples where this had hindered effective information sharing.
- The majority of referral order panels continue to be delivered online. Volunteers have found the ICT challenging and difficult to use; they are keen to return to in-person meetings. The YOS needs to ensure that panels are individualised and delivered in the most appropriate way for children's needs.

Involvement of children and their parents or carers

The YOS and management board have recognised the importance of hearing the child's voice and understanding their lived experience. This is a developing area, and the service is taking a considered and detailed approach to maximise child and parent or carer participation. Work has been completed to ensure that children are involved in the development of an inclusive participation approach. This includes working with children, families, and the wider staff group to explore the best methods to reach and engage children.

The YOS has been proactive in seeking the views of children and parents or carers to inform service delivery. Work is under way to further improve these processes to ensure that feedback opportunities are accessible and routinely undertaken. This includes developing mechanisms that allow the experiences of children, parents and carers to be routinely heard at board level. In addition, quality assurance activity and the evaluation of provision now includes the child's voice and they are able to provide direct feedback on their experiences. This information has been collated, analysed, and used to inform and shape service delivery.

The YOS contacted, on our behalf, children, parents, and carers who had worked with the service to gain their consent for an interview or text survey. We spoke to 22 children, eight parents, and one carer. We also had 25 full and five partial responses to our text survey. This is the highest response rate of children, parents, and carers the inspectorate has received during this core inspection programme. Responses from both our text survey and interviews were overwhelmingly positive. In the text survey, when asked to rate the YOS on a scale of 1 to 10, with 1 being 'poor' and 10 being 'fantastic', 22 of the 29 responses gave a score of nine or above.

All the participants who we spoke to felt that the practitioner with whom they worked was adequately skilled. One parent told us:

> *"I cannot praise the YOS worker enough; always there to support my son and family, I felt she went the extra mile."*

A child informed us:

> *"She [practitioner] answers her phone when I call, she looks for things that might help me, she encouraged me to think about things. She was approachable."*

Most participants believed that they had been given access to the right services to support them. One parent commented:

> *"I cannot fault the service given by the YOS; they have gone above and beyond supporting us as a whole family. For my son they have worked to get him the right education and safety support, and for our family they have helped us protect ourselves from others."*

When asked 'how good are the services you have received?' all participants answered either 'very good' or 'quite good'. One child told us:

> *"I talk to her about my anger, why I got into trouble and how to stay out of trouble. I've also done boxing, which helps with my anger. I've also done a cookery course with the Duke of Edinburgh scheme. My only criticism is the timeline. I needed this service sooner."*

Diversity

- The strategic approach to addressing diversity and protected characteristics of children is underdeveloped. The board needs to support the YOS to identify and understand disproportionality, including developing a clear strategic response. Keys areas such as resettlement and out-of-court disposals need to be considered. This includes specific guidance on how the strategy will be operationalised to deliver systemic change and meet the needs of children.
- Guidance and policies need to provide clear information on how the service intends to meet all the protected characteristics of children and address any areas of disproportionality.
- The YOS recognised that it needed to improve its knowledge and understanding of diversity. Appropriate training was sourced and undertaken. We found evidence that this training had been applied in case work. Within the domain two, three, and resettlement case samples, provision to meet the diversity needs of children was a strength. Practitioners were skilled at recognising diversity and making appropriate adjustments to meet the needs of children. In the resettlement cases, appropriate diversity information was shared to ensure that children's needs were met within the secure estate.
- The workforce and volunteer cohort does not currently reflect the local population or the YOS caseload; future recruitment should encourage males and applicants from Black, Asian, and minority ethnic heritage.
- Most staff and volunteers felt that their individual diversity needs were considered and responded to.
- The YOS collects and analyses data for some protected characteristics. It identified an increase in girls accessing the service and undertook further research and audits to inform its response. As a result of this work bespoke interventions for girls are now available.

Domain two: Court disposals

We took a detailed look at 18 community sentences managed by the YOS.

2.1. Assessment

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

Our rating[2] for assessment is based on the following key questions:

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	94%
Does assessment sufficiently analyse how to keep the child safe?	50%
Does assessment sufficiently analyse how to keep other people safe?	**33%**

Assessment of desistance was comprehensive; practitioners were able to identify and analyse factors affecting children's desistance, including education and peer relationships. Areas of concern were appropriately explored, and there was a strong focus on understanding and analysing protective factors, the child's interests, and aspirations. Practitioners were skilled at recognising diversity and individual needs, including any structural barriers and whether adjustments were required to promote engagement. This included identifying potential learning and communication needs and what was required by the professional network to support the child's understanding. There was a good recognition of children who were cared for by the local authority and how they may have been affected by these personal circumstances. The impact of early experiences on presenting behaviour was carefully and sensitively explored with children, who in most cases were meaningfully involved.

Assessments of risks to and from the child were not consistently and proactively using information held by other services, resulting in gaps in knowledge and understanding of potential harm. This included not following up police intelligence or liaising effectively with other agencies working with the family, such as education. In some of the cases we reviewed, there appeared to be difficulties in obtaining necessary information from children's social care.

Not all potential risks to the child had been adequately identified, explored, and understood, including physical and emotional harm. In several cases, there were indicators of exploitation, but these were not sufficiently analysed and did not trigger an appropriate response to promote the child's safety. In most cases, analysis needed to be more in-depth and detailed, exploring the nature and context in which concerns may occur.

[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. A more detailed explanation is available on our website.

While there were some effective and detailed assessment of risks from the child, most did not contain comprehensive analysis of the nature, context, and imminency of potential harm. Assessment of risks from the child tended to focus on the index offence and did not adequately consider other known behaviours. This had limited the understanding and assessment of risks, with not all actual and potential victims being identified. More professional curiosity and direct liaison with services was needed to support analysis of controls and interventions.

In several cases, we found an underestimation of potential risks to and from the child, leading to unreasonable risk classifications. Management oversight processes were not identifying gaps in assessment and understanding of risk. It is, therefore, essential that these processes are reviewed to ensure that assessment activity is of sufficient quality.

2.2. Planning

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

Our rating[3] for planning is based on the following key questions:

	% 'Yes'
Does planning focus sufficiently on supporting the child's desistance?	89%
Does planning focus sufficiently on keeping the child safe?	**56%**
Does planning focus sufficiently on keeping other people safe?	**56%**

Plans were completed collaboratively with children and captured their views and aspirations. They were produced in an accessible and child-friendly format, clearly articulating achievable goals. Key areas of desistance were planned for and there was a strong emphasis on building on strengths and community integration. For instance, supporting the ETE needs of children was a priority, as well as identifying constructive activities that children were interested in. Planning had considered the personal circumstances and diversity needs of children. We saw examples of how neurodiversity had been recognised and appropriate adjustments made to support engagement. In other cases, practitioners had utilised the speech and language therapist to ensure plans had considered and catered for the needs of the child. Plans were bespoke, with appropriate interventions and services identified to build on desistance, including conflict resolution and developing healthy relationships.

The quality of planning to keep the child and others safe was impacted by deficits in assessment, where not all risks had been sufficiently acknowledged. For instance, critical areas of intervention were missing, such as the need for emotional wellbeing and support to prevent or reduce concerns in relation to exploitation. Not all potential and actual victims had been effectively identified and planning activity was not adequately robust. This included not making appropriate referrals to safeguard victims or utilising external controls.

The involvement of and coordination with other services to promote safety was not sufficient in a large number of cases. There needed to be better liaison with services already working with the child and their family to ensure that plans were aligned, and the professional network understood their roles and responsibilities. Contingency arrangements were not consistently setting out necessary actions to mitigate against increases in concerns. Contingency plans were not always tailored to the risks and needs of the child and required more detail on appropriate responses, including those of other services to support safety. In some of the cases we reviewed, contingency planning had not been completed due to an underestimation of potential risks.

[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 on our website.

2.3. Implementation and delivery

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

Our rating[4] 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?	94%
Does the implementation and delivery of services effectively support the safety of the child?	61%
Does the implementation and delivery of services effectively support the safety of other people?	**44%**

Planning to address desistance had translated effectively into practice, with key areas to build on strengths and protective characteristics appropriately prioritised. In most cases, delivery had sought to support and improve the child's education, training, and employment (ETE) experiences and options. Constructive activities which encouraged integration with the community were identified and matched to the child's interests. Practitioners were skilled at developing and maintaining positive working relationships with children, parents, and carers. Proactive efforts were made to support engagement, including seeing the child in locations that they had agreed to and felt comfortable and safe in. Practitioners knew their children well and used interactive resources and methods which catered to the child's learning style. In almost all cases, we saw personalised approach where the child's diversity was considered, and appropriate adjustments made.

Delivery to keep the child safe was stronger, and inspectors found some effective communication and a coordinated approach to addressing areas of concern. However, this was not consistent in all cases; in several, information sharing was not prompt or frequent, and there were challenges in receiving information from children's social care. In cases deemed to be insufficient, not all necessary pieces of work to promote safety were completed. This included intervention and support to improve emotional wellbeing, and proactive work to increase the child's understanding of potential risks to them.

There needed to be more focus on potential and actual victims, and a coordinated partnership response to managing these. Existing mechanisms were not adequately monitoring the child's access and proximity to victims, considering imminency of potential harm, or identifying strategies to mitigate concerns. Intervention was not adequately tailored or undertaken to fully address all identified risks. For instance, intervention focused only the offence and not considering of other concerning behaviour, such as reported violence within schools or the community.

[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. A more detailed explanation is available on our website.

2.4. Reviewing

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

Our rating[5] for reviewing is based on the following key questions:

	% 'Yes'
Does reviewing focus sufficiently on supporting the child's desistance?	94%
Does reviewing focus sufficiently on keeping the child safe?	56%
Does reviewing focus sufficiently on keeping other people safe?	**50%**

Reviewing of desistance was impressive. Children, parents, and carers were meaningfully involved and their views on progress and potential barriers were effectively considered. In all cases, the diversity needs of children had been reviewed and explored to ensure that these were being met. This included practitioners altering their approach and delivery style to improve engagement with children. Other factors, including motivation, maturity, and personal circumstances, were considered and used to inform reviewing. Practitioners had taken a balanced approach, exploring areas of concern, strengths, and protective factors to understand changes to desistance. Achievements of children were acknowledged and praised; in one case, the court order was referred back to court appropriately for early revocation. In almost all cases, formal written reviews had been completed and provided detailed analysis of changes to desistance. Where required, adjustments to delivery, including realigning targets to reflect changes and progress, were undertaken.

Reviewing activity was not consistently identifying and responding to changes in risks to and from the child. Positively, information from other services was sought, but this was not adequately used. This included not analysing new information or recent incidents effectively, for instance, further offences.

Necessary responses and adjustments to promote the safety of other people were insufficient in the majority of cases; services working with the child were not always convening to explore concerns and coordinate risk management plans. Stronger contingency plans that outline the roles of other services and identify appropriate actions to be taken would support practitioners and managers in knowing how to respond when risks change.

Reviewing activity to keep the child safe was stronger, and in some cases had triggered an appropriate multi-agency response, including referrals to exploitation forums. However, this was not consistent in all cases, and inspectors found that the plan of work was not always updated to address new concerns.

[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. A more detailed explanation is available on our website.

Domain three: Out-of-court disposals

We inspected 27 cases managed by the YOS that had received an out-of-court disposal.

3.1. Assessment

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

Our rating[6] for assessment is based on the following key questions:

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	63%
Does assessment sufficiently analyse how to keep the child safe?	30%
Does assessment sufficiently analyse how to keep other people safe?	**26%**

The service used a locally agreed assessment tool for out-of-court disposals; at the time of inspection, this had been in place for approximately 18 months. Should a child receive a second youth caution or a conditional caution, an Assetplus assessment is completed. The locally agreed tool actively encouraged a co-produced assessment with the child and family. In the majority of assessments, children and parents or carers were meaningfully involved; it was evident that their views were central, with their perspectives being fully captured. However, inspectors found that practitioners differed in their approach to how the tool was completed, which affected analysis of desistance and risks to and from the child. Some considered that the assessment must be an agreement with the child and recorded as such, even if the practitioner disagreed with the judgements. Other practitioners recorded the child's perspective, but also noted their professional judgements on desistance and risks.

Inspectors found some comprehensive analysis of desistance which recognised areas of concern and strengths, but this was present in too few cases. In a number of assessments, there needed to be more in-depth analysis and professional judgement of desistance, including exploring the impact of early experiences on the child's presenting behaviour. Inspectors found that not all key areas of desistance had been effectively identified, including potential structural barriers that children may be experiencing.

Information held by other services was mostly requested, but this was not being effectively used and analysed to understand desistance, the child's safety, and risks to others. This included practitioners proactively following up and making direct, ongoing contact with services working with the child.

[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. A more detailed explanation is available on our website..

The locally agreed tool moved away from traditional risk classifications and used a scoring system to identify risks to and from children. Inspectors found differing perspectives and understanding of this approach, with some practitioners believing that the score must be agreed with the child, regardless of their professional opinion. There was also confusion on what the different scores meant and how this translated into levels and imminence of risks. For both risks to and from children, inspectors assessed that practitioner's assessment of risk was unclear, and for many there was an underestimation of concerns.

Assessment of safety of the child was not routinely identifying all risks to the child, including emotional harm and exploitation. Where concerns had been recognised, analysis was not adequately detailed to clearly articulate the nature of concerns, the impact, and likelihood of adverse outcomes.

In almost all relevant cases, risks from the child had not been effectively identified, analysed or understood. Key areas of concern, including possible physical and emotional harm, were missed, as well as the identification of potential and actual victims. Risk assessments had not adequately explored the nature, context, and imminency of concerns. This impacted on identifying the likelihood of potential future behaviour and measures needed to mitigate risks.

Quality assurance and management oversight processes were not identifying the different approaches to the locally agreed tool or gaps in assessments. Further development is needed to ensure there is a clear understanding of sufficiency, and that the oversight framework supports practitioners in completing quality assessments.

3.2. Planning

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

Our rating[7] for planning is based on the following key questions:

	% 'Yes'
Does planning focus on supporting the child's desistance?	85%
Does planning focus sufficiently on keeping the child safe?	41%
Does planning focus sufficiently on keeping other people safe?	**33%**

There is a balanced approach to planning for desistance; areas of concerns are appropriately identified and there is a clear focus on developing protective factors. Plans were bespoke to the child and diversity had been effectively considered in most cases. For instance, practitioners had used education, health, and care plans (EHCPs) to inform plans for delivery and record reasonable adjustments. The views of children and parents or carers had been valued and incorporated into plans, including their goals and aspirations, such as securing ETE. Plans were produced in a child-friendly format, clearly detailing proportionate and achievable targets. In some cases where services were working with the child, the practitioner had considered what was already in place and tailored their plans to accommodate this. This avoided the child being overwhelmed and professionals duplicating work.

Planning to promote the safety of the child and others was impacted by gaps in assessment where risks were not sufficiently identified and analysed. Therefore, in a large number of cases, plans were not clearly articulating and identifying measures to adequately manage risks. This included failing to identify specific safety plans, external controls, or arrangements to protect potential and actual victims. Planning to promote safety required stronger alignment, coordination, and input from other agencies. Risk management was not seen as a multi-agency responsibility, and the roles of other services and how they contributed to safety were not clearly articulated. Inspectors found that communication between the professional network could be stilted, and that critical information was not always shared or received. It is essential that services working with the child commit to and actively support the YOS in managing risk.

Planning had not adequately identified necessary responses should the risks to and from the child change. Where children were assessed as posing a risk to others, no contingencies had been considered. Though this planning was slightly better for keeping the child safe, the existing framework and arrangements were not producing robust multi-agency plans. Management oversight processes and expectations need to be reviewed to ensure that plans are future-focused and provide sufficient responses to changes in risks.

[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. A more detailed explanation is available on our website.

3.3. Implementation and delivery

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

Our rating[8] for implementation and delivery is based on the following key questions:

	% 'Yes'
Does service delivery effectively support the child's desistance?	81%
Does service delivery effectively support the safety of the child?	**59%**
Does service delivery effectively support the safety of other people?	67%

There was a strong focus on building positive working relationships with the child, family, and carers. This approach had facilitated effective engagement, particularly in the cases where intervention was voluntary. Practitioners were innovative, and they delivered interactive interventions which were paced appropriately to support the child's understanding. Inspectors found numerous examples of adjustments being made to ensure that the child's needs were met. This included utilising EHCPs to inform and adapt delivery styles. The importance of securing and maintaining appropriate ETE was recognised, and in several cases, we found proactive efforts in supporting children to achieve this. Intervention was proportionate and balanced, focusing on both areas of concern and strengths. In several cases, practitioners assisted children in accessing constructive activities and funding gym membership. In one case, the practitioner had ensured that appointments did not affect or compromise the child's attendance at religious celebrations.

Inspectors found several cases where work to keep the child and others safe was sufficient, services had worked well together, and appropriate intervention was delivered. However, this was present in too few cases and there needed to be a stronger multi-agency approach to promoting safety. In several cases, there was a lack of coordination and joined-up working between the professional networks. It was not always clear which agency would be leading on specific pieces of work, and whether this had been undertaken. Appropriate referrals to and requests for further information from other services were not routinely completed. This included checks with the police and the probation service to explore and verify potential risks from adults.

In several cases, inspectors found that there were difficulties in obtaining and sharing information from children's social care and early help. In one case, the YOS was not invited to a child protection conference, despite being involved in the case. Difficulties with multi-agency working were not consistently escalated to managers or directly with the services.

There needed to be more proactive efforts to monitor risks from the child, particularly where potential and actual victims were identified. Where there had been changes to risks from the child, responses from the YOS were not always sufficient

[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. A more detailed explanation is available on our website.

and did not trigger necessary changes to delivery or monitoring. For instance, in several cases the YOS had received information of further worrying behaviour placing others at risk, but this had not triggered a multi-agency meeting or adequate efforts to explore this further.

Oversight arrangements need to be strengthened to ensure that there is a partnership approach to addressing and managing risks. This will support understanding of each service's roles and responsibilities to promote safety.

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:

- There is a decision-making panel which is consistently attended by the YOS, police, health, YOS education worker, and victim liaison officer. All members have input, with decisions agreed jointly between the YOS and police.
- The police do not issue any out-of-court disposals as a single agency, which allows the YOS and police to have joint oversight of all cases involving children.
- The YOS and police are committed to a child-centred approach which considers the individual needs of the child and circumstances of the offence. The gravity matrix is utilised, and mitigating circumstances are considered appropriately in determining the most appropriate outcomes.
- Children and families are meaningfully involved in the out-of-court disposal process. Prior to the panel, the YOS meets the child and family and includes their views in the assessment. Robust checks are undertaken with other services, and information is shared appropriately to inform decision-making.
- There is a robust escalation process which is used effectively when the YOS and police have not agreed on an outcome. This supports appropriate decision-making.
- Review panels are held in every case to support effective exit strategies. These also ensure that disposals are closed appropriately, and ongoing voluntary support is offered when suitable.
- A review of out-of-court disposals has been undertaken, and learning from this has been positively implemented.

Areas for improvement:

- Guidance needs to be further developed with police partners to provide more detail on the processes for out-of-court disposals, including greater clarity on eligibility criteria, parameters of use, and the roles of each service. This will assist in driving quality and consistency in service delivery.
- Risk and safety management processes and provision require a fundamental review to ensure that all potential risks to and from children are identified, understood, and input to address them implemented.
- Not all eligible children are being consistently considered for out-of-court disposals. Within our domain two case sample, we found three children who could have been eligible for the opportunity for diversion.

- The police and YOS need to expand the options available to the out-of-court disposal panel to include, where appropriate, 'no further action'. This will avoid unnecessary contact with the youth justice system in suitable cases.
- Consistent and active representation from children's social care on the panel is needed. This will support decision-making, particularly where there are concerns regarding children's safety and wellbeing.
- The YOS produces routine and comprehensive analysis of out-of-court disposals, providing insight into their delivery. However, the YOS needs to proactively utilise this information to fully understand and shape provision. Further evaluation is needed to provide more in-depth understanding of successes, challenges, and overrepresentation within out-of-court disposals. Any learning should inform future strategies and be routinely shared with the decision-making panel. To enhance this further, examples of effective practice and research should also be considered.

4.1. Resettlement

4.1. Resettlement policy and provision

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

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 two cases managed by the YOS that had received a custodial sentence. Our key findings were as follows.

Strengths:

- There is a policy in place which advocates for a personalised, child-first, and strengths-based approach to resettlement.
- Practitioners who undertake resettlement work have received appropriate training. They felt that this had prepared them adequately for working with custodial cases.
- The importance of maintaining contact with children and families in custody was understood. Contact from the YOS was frequent and meaningful, which enabled ongoing support from the service.
- Securing accommodation for children leaving custody can be challenging. However, in the two cases we reviewed, planning for this had started early on.
- There was appropriate planning to address and support the education, training, employment, and healthcare needs of children.
- In the cases we reviewed, the needs of victims were considered, and measures had been taken to promote safety and mitigate against risks.
- The diversity needs of children had been fully considered. Where required, appropriate information was shared to ensure that their needs were met within the secure estate.
- Transition to adult services, including probation, and leaving care was sufficiently managed.

Areas for improvement:

- There needs to be greater strategic ownership and oversight of resettlement by the partnership. Resettlement is a shared partnership responsibility and requires strategic leads from each service to proactively support the YOS in delivering provision.
- The policy needs more input from the partnership to clearly identify its roles and responsibilities, and the pathways for constructive resettlement.
- The YOS and partnership must ensure that there are adequate opportunities for agencies to come together to plan and discuss the resettlement needs of individual cases, outside of the custodial planning meetings. This will support shared ownership and responsibility for these children.

- The YOS produces comprehensive data analysis of resettlement. However, further evaluation and review of provision is needed to explore and understand if the partnership response to children in custody is meeting their needs. Findings from evaluation should be used to inform a resettlement strategy, with input from the wider partnership.

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.