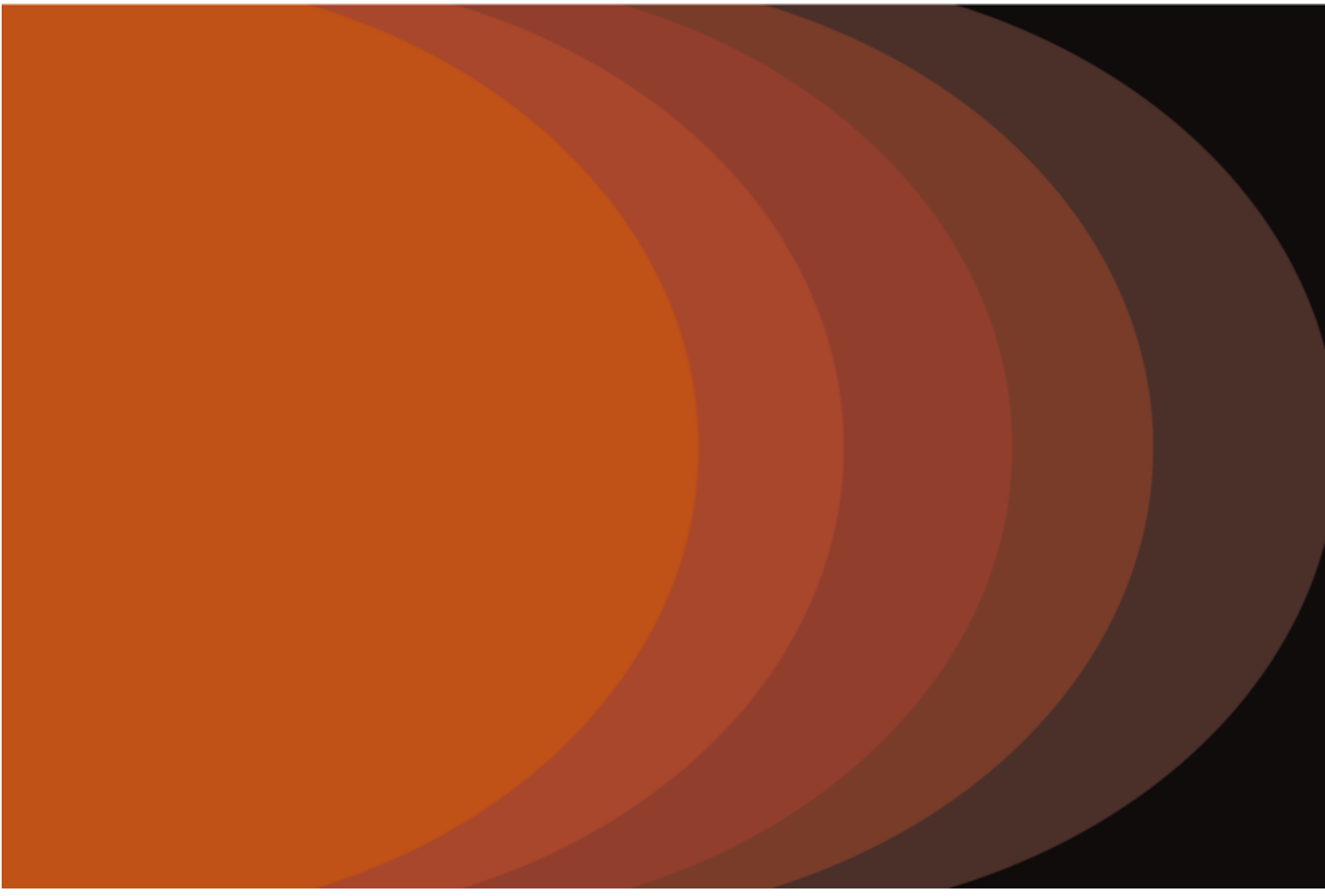
HM Inspectorate of Probation

An inspection of youth offending services in

Birmingham

HM Inspectorate of Probation, March 2023



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Acknowledgements

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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.

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

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Foreword

This reinspection is part of our programme of youth offending service (YOS) inspections. We have inspected and rated Birmingham 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, Birmingham YOS was rated as 'Requires improvement'. We also inspected the quality of resettlement policy and provision, which was separately rated as 'Requires improvement'. This was a reinspection of Birmingham, following our previous visit in 2020. Although the service continues to be rated as 'Requires improvement', we have seen enhanced and improved service delivery.

Birmingham is the largest youth justice service in England and Wales which presents additional challenges to the improvement journey it has been on, and the impact of this should not be underestimated. Birmingham YJS is undergoing significant changes to improve the quality of provision. We found dedication and commitment from the board, senior leaders, and the wider service to achieve this. This includes increases in funding and services from partners, such as an improved education offer, which now provides wraparound support to children.

Considerable work to develop the board has been completed. There is now an independent chair and consistent attendance from partners. Significant work has been undertaken by the senior leaders. However, there remains a disconnect between the board and senior leadership and the wider staff group. Recruitment and retention of staff has been challenging and most staff who contributed to the inspection, reported finding the current workload excessive. For some, they also felt they had not been fully equipped to undertake their roles and expectations were beyond their capabilities.

There have been significant changes to the out-of-court disposal process since our last inspection, and we have seen improvements in the quality of assessment and planning activities. There was evidence that children and their parents or carers are more actively involved and engaged since our last inspection. However, there has been a decline in the quality of delivery for post-court cases, with practice not sufficiently promoting the safety of children and other people. There needs to be better coordination and a shared response with other partners to risk and safety management.

The YOS produces comprehensive data, which has enabled in-depth knowledge of those accessing the service and a clear understanding of disproportionality. There is a commitment to addressing the over-representation of black and mixed heritage children within the caseload and to meeting the diversity needs of children. The YOS now needs to embed its diversity strategy so that it is understood operationally and drives improvement in casework. Recognising and responding to the diversity needs of staff requires further development, particularly around ensuring consistent consideration across all protected characteristics.

The YOS has been proactive in evaluating some areas of practice, such as work with children in and leaving custody, and changes in delivery have seen a large reduction in custodial sentences and remands. The YOS now needs to focus on developing effective resettlement provision.

Justin Russell

HM Chief Inspector of Probation

Ratings

Birmingham Youth Offending Service Fieldwork started December 2022		**Score**	**11/36**
Overall rating		**Requires improvement**	
1.	**Organisational delivery**		
1.1	Governance and leadership	**Requires improvement**	
1.2	Staff	**Requires improvement**	
1.3	Partnerships and services	**Requires improvement**	
1.4	Information and facilities	**Requires improvement**	
2.	**Court disposals**		
2.1	Assessment	**Requires improvement**	
2.2	Planning	**Requires improvement**	
2.3	Implementation and delivery	**Inadequate**	
2.4	Reviewing	**Inadequate**	
3.	**Out-of-court disposals**		
3.1	Assessment	**Requires improvement**	
3.2	Planning	**Good**	
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 Birmingham. This will improve the lives of the children in contact with youth offending services, and better protect the public.

The Birmingham Youth Offending Service should:

1. continue to work with police partners to improve victim consent rates, information sharing arrangements, and consistency in approaches to diversion
2. implement measures to understand the current capabilities of all staff and, where necessary, complete tailored training to ensure that all are equipped to undertake their roles
3. work with partners to review and further develop risk management processes, ensuring that there is a coordinated approach and shared response to keeping children and others safe
4. improve identification and analysis of risks to and from the child, ensuring that adequate attention is paid to actual and potential victims
5. improve reviewing activity, to ensure that changes in desistance and risks to and from the child are effectively identified, analysed, and appropriately responded to
6. further develop management oversight processes, to make sure that these are consistently providing adequate support and guidance which drives quality
7. work with partners to further develop and embed resettlement guidance and provision to ensure that processes and pathways to effective resettlement are clear and understood.

The Director of Children's Services should:

8. continue to support the YOS and children's social care, to strengthen operational relationships so that thresholds, roles, and responsibilities are understood and adhered to.

The partnership board should:

9. review and implement strategies to improve the connection and collaboration between the board, senior leadership team, and the wider service
10. support the YOS in embedding its diversity strategy. This needs to include processes for recognising and addressing effectively the diversity needs of all staff, children, and victims accessing the service across all protected characteristics.
11. work with the YOS to improve workforce stability, capacity, and contingency arrangements, to promote consistency and high-quality work.

Background

We conducted fieldwork in Birmingham Youth Offending Service (YOS) over a period of a week, beginning 05 December 2022. We inspected cases where the sentence or licence, out-of-court disposals, and resettlement cases were delivered between 06 December 2021 and 30 September 2022. We also conducted 63 interviews with case managers and 22 with a manager.

The YOS is part of Birmingham Children's Trust (BCT) and is managed within the vulnerable young people directorate. Birmingham children's services joined the trust in 2018, following long-standing deficiencies in service provision. BCT is owned by Birmingham City Council and commissioned to provide all child, young person, and family services. Operational delivery is controlled by the Trust executive team, accountable to the trust board.

Birmingham YOS is the largest youth justice service in England and Wales and is covered by West Midlands Police. It employs 141 staff and there are four area-based teams, covering East, West, South, and central locations. The senior leadership team consists of a head of service, who oversees four assistant heads of service; an education, employment, and training strategy and performance manager; a research and information manager; and a business and resource manager. The management structure also includes team managers and deputy team managers. At the time of the inspection, the YOS was managing 148 post-court cases and 72 out-of-court disposal cases. In December 2022, the YOS launched its prevention service, which will increase the number of children they work with. This is supported through the appointment of additional staff, including managers.

Birmingham is a city and metropolitan borough in the county of West Midlands. It is the second largest city in England. The 2021 census recorded the population at 1,144,900, which represents an increase of 6.7 per cent since 2011. There are 123,909 children aged 10 to 17 residing in Birmingham. It is an ethnically and culturally diverse city; the proportion of children aged 10 to 17 from a black, Asian, and minority ethnic heritage sits at 55 per cent. However, 67 per cent of children working with the YOS at the time of the inspection were from this heritage. Like most youth justice services, the number of cared for children is high, sitting at 13 per cent of the caseload at the time of inspection. Children subject to child protection plans made up 6 per cent of the caseload, and children on child in need plans 13 per cent.

The complexities and challenges experienced in Birmingham should not be underestimated; there are high levels of deprivation, serious youth violence, and exploitation. Birmingham is ranked the seventh most deprived local authority in England, and child poverty in Birmingham is worse than the England and core cities average. Many children working with the YOS have multiple needs; at the time of inspection, 67 per cent were experiencing emotional and health difficulties and 61 per cent had substance misuse issues. Children with learning difficulties and disabilities accounted for 55 per cent. The most common offence is violence against the person, which, within our case sample, accounted for 51 per cent of domain two and 61 per cent of domain three cases. The YOS has a strong understanding of the cohort of children, monitoring and analysing this data proactively.

Domain one: Organisational delivery

To inspect organisational delivery, we reviewed written evidence submitted in advance by the youth offending service and conducted 18 meetings, including with children, 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 YOS supports and promotes the delivery of a high-quality, personalised and responsive service for all children.	Requires improvement

Strengths:

- Considerable work has been completed to improve the quality and functioning of the management board. Board members have an induction to the board. There is now an independent chair, and representation from all partners of the appropriate seniority. Board members and senior leaders are invested in the service and understand their role and responsibilities. They have a detailed knowledge of the profile of children and victims accessing the service. Members are sighted on risks to provision. The management board and senior leadership team are committed to achieving the vision and improving the quality of the service. Detailed data analysis is used to inform service delivery and service development sessions have been held. Extensive work within the service has been delivered to address findings from the previous inspection, with a focus upon specifically improving the quality of practice.
- The partnership has recognised that mental health and speech, language, and communication provision has not been sufficiently resourced. Provision has been increased to meet the need.
- The partnership has advocated for the YOS to improve service quality. This includes enhancing the education, training, and employment (ETE) provision. Impact is being seen in the significant reduction of school-aged children not having a placement, and since the last inspection this has reduced from 11 per cent to 2 per cent.
- Partners have increased funding and seconded staff into the YOS. There are also secondment opportunities for YOS practitioners into other services.
- The board and YOS have effective strategic links which assist in driving consistency and quality provision in Birmingham and the West Midlands.

Areas for improvement:

- There is a significant disconnect between the board and leadership team, and the wider service. The vast majority of staff who participated in the inspection report they do not feel heard. It was evident that many key messages on the service transformation were not reaching all staff. Although there have been clear efforts to engage with staff, more work is needed to unify the service and improve transparency, communication, and collaboration.

- The involvement of children, parents or carers, and victims needs to be strengthened, to ensure that their views are captured and their voices influence strategy and operational delivery effectively.
- Further work is required with police partners to improve victim consent rates and information sharing practices, as well as ensure that there are proactive and consistent approaches to diversion.
- The YOS and children's social care services need to develop strategic and operational arrangements further, to ensure that, where required, children and families are receiving adequate support.
- The YOS needs to review their progress and plans in relation to their improvement journey. Not all necessary changes have been embedded successfully or have impacted in the manner intended. This is particularly evidenced by the domain two case ratings, which found considerable work is still required to improve the quality of practice.

1.2. Staff

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

Strengths:

- The YOS has increased the number of managers to lead strategic areas.
- Successful volunteer recruitment means that the YOS now has sufficient numbers to support service delivery. Volunteers are satisfied with the support they receive to undertake their role.
- Learning and development has been prioritised and there has been significant investment in, and rejuvenation of, the training offer. Staff can access a comprehensive range of training relevant to their role.
- A robust training plan, matrix, and tracker have been developed which identify and monitor required training. These support training oversight and understanding the skill base required for each role.
- There are promotion and development opportunities for staff, including moves from practitioner to management posts and secondments.
- The YOS has developed specialist clinical support packages which are available to all staff. It has invested in training and support for grief and loss, serious youth violence, and vicarious trauma.

Areas for improvement:

- Although evidence suggests that caseloads were manageable, most staff who contributed to the inspection, at both practitioner and management level, reported finding the current workload excessive. Many staff also considered it was overwhelming. Some felt they have not been fully equipped for their roles and expectations were beyond their capabilities. Not all staff we spoke to during the inspection feel confident and sufficiently experienced to manage and oversee the work they have been allocated.
- Recruitment and retention of staff has been challenging. Although the YOS has attempted to recruit proactively, not all campaigns have been successful and there have been delays in staff starting posts. The service has high levels of sickness and there are several vacant posts across different levels of the organisation. Contingency arrangements were not sufficiently robust to manage the reduced capacity. In the cases we reviewed, the reduced capacity had impacted on the quality of delivery, which we found to be insufficient in the majority of post court cases.
- Operational management roles require further clarity on their functions, responsibilities, and oversight.
- Supervision and management oversight are not sufficient to support staff and to drive quality casework to keep children and others safe.
- Although there is a robust induction package, we found instances where new staff had not been given the opportunity to fully complete this.

- To ensure that learning needs and underperformance are addressed, appraisals, individual staff development, and performance management need strengthening.
- There is an undoubted commitment to learning and development, but more time needs to be dedicated to ensuring that learning can be processed, embedded, and is then translated into practice.
- A large majority of staff who were involved in the inspection, including new and longer-standing team members, report feeling anxious and disheartened. This was, in part, linked to the pace of change. Staff indicated they recognised the importance of change but considered that this needs to be better paced, managed and delivered.

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 produced routinely. This provides a wealth of information on the profile of the cohort, its demographics, desistance, risk, and safety needs. Analysis is used to inform service delivery.
- Diversion is a priority, and the YOS has launched a prevention team to support children to avoid contact with the criminal justice system.
- The education offer has been enhanced; mechanisms are in place to monitor and identify children requiring support. Wraparound support is available for all children, including in-house provision and clearer pathways for access to other ETE services.
- Children can access a range of community reparation projects. This includes both direct and indirect reparation and allows children to develop skills.
- There is a range of constructive activities available to develop desistance and protective factors further, including boxing and mentoring. The YOS also has access to the music studio project, where children work with professionals to create music and learn about the industry.
- Children involved in harmful sexual behaviour have access to specialist provision, including assessments, support, interventions, and consultations for practitioners.
- There is priority access for children requiring alcohol and substance misuse support, and intervention is tailored to meet their needs.
- There are strong links with the exploitation service and there is evidence of promising work to support children and families.
- Children eligible to work with police offender managers receive an enhanced package of support and work effectively with the YOS.

Areas for improvement:

- There is a strong offer to victims but, because of very low consent rates obtained from the police, the YOS is not able to offer services and reach many victims. Data analysis needs to be expanded to explore the work with victims, to understand consent and uptake rates as well as satisfaction levels.
- There is a good range of partnership services, but we found a lack of understanding of the provision and access routes by practitioners, insufficient coordination between services, and a lack of confidence in some of the provision available.
- Not all children who required a mental health or speech, language, and communication needs intervention were being reached. The health offer has now been enhanced but requires embedding to ensure that the pathways are understood, and children's needs are met.

- Partnership contribution and involvement in keeping children and other people safe are not adequate. More work is needed to ensure that information is shared quickly, and that there is a coordinated, cohesive approach.
- Risk and safety management processes are not fully understood. The framework is not providing adequate support and oversight in keeping children and other people safe.
- Relationships and practice with children's social care services need to be strengthened, to ensure that children are receiving the appropriate support from the right service.
- The service does not currently have its full allocation of probation practitioners. While there are clear and robust transition processes for children moving from youth justice to probation services, the absence of practitioners means that the process is not being followed consistently.

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 YOS has been proactive in developing and reviewing guidance to support the delivery of services. These are on SharePoint, allowing easy access for all staff.
- The YOS is invested in redeveloping locations where children are seen, to ensure that these are child friendly and provide access to a range of facilities. Children, staff, and specialists have been involved in creating the redesign. The girls we spoke to as part of the inspection said that they are given the choice of where to be seen and when.
- Efforts are under way to improve child safety when working with the YOS. This includes a booking system for appointments, identifying dangerous locations and agreeing travel routes with the child.
- The YOS data sharing agreements have improved access to information with some key partners. This allows direct access to some partner systems.
- Robust mechanisms are in place to identify, review, and learn from serious incidents. Analysis and learning are disseminated within the service and partnership.
- The YOS evaluates its provision proactively, to explore and understand service performance. Areas requiring more focus are incorporated in improvement plans.

Areas for improvement:

- Several of the new protocols and guidance documents have needed to be reviewed or re-reviewed quickly. The implementation and embedding of these with staff has not been achieved consistently or effectively and this has impacted upon the quality of practice.
- The current case management system is not meeting service needs fully. The YOS has plans to address this.
- The current facilities do not provide an appropriate base for all staff and specialist workers. For many, there is a feeling of isolation, silo working, and disconnection from colleagues.
- Birmingham has numerous complexities and local knowledge is critical for managing safety. The limited access to community facilities and reduction in teams mean that some staff report they are travelling and working in areas unfamiliar to them. Some staff also indicate the team changes have impacted upon children, with some children travelling across areas within the city. This has resulted in a number of the staff who participated in the inspection reporting concerns around their own and children's safety. Most staff felt that the current facilities for seeing children are not always easily accessible, appropriate for the work they undertake, or child friendly.
- The quality assurance framework identifies areas for development. However, more focus is needed to respond to findings and tailor training to individual need, to then address deficits in practice.

Involvement of children and their parents or carers

The YOS recognises that the involvement of children, their parents or carers and victims needs strengthening. This has been identified as a priority, and a participation working group, which includes board members and practitioners, has been established. The working group is reviewing its existing practice and exploring how to enhance this area. The initial work is showing promise. For instance, children are now involved in the recruitment of staff and a participation forum was used to hear children's experiences and views of police custody. Based on this feedback, 'distraction packs' have been created and are now used for children in police custody. However, mechanisms which proactively seek and routinely gather feedback to inform evaluation of provision and influence service delivery require further development.

During the inspection, we met six children and completed two further telephone interviews, one with a child and one with a parent. We also had five responses to our text survey, including both children and parents.

All children we met and spoke to felt that the YOS had supported and helped them to avoid further offending and build on their strengths. One child stated:

> *"When you don't get love and support at home, they give you it here, they listen to me. They taught me that what I was doing wasn't helping me and now I know right from wrong".*

Most of the children we spoke to said that the YOS had been flexible and accommodating to assist them in attending sessions. They felt that their views on how and when intervention and support were to be delivered had been considered. One child commented:

> *"I had to complete reparation, but they gave me a choice on the project. I worked in a charity shop and they let me pick my hours so that I could spread these over a few weeks to keep out of trouble".*

Children valued the time that their practitioner had spent with them and the relationship that they had developed. They reported feeling listened to and that their practitioner was responsive to their needs, ensuring that they were supported. One child stated:

> *"I don't like meeting new people and talking but with my worker, we just clicked, the conversation is natural, funny and flows. They let me talk about things that I am worried about and just normal stuff".*

The parent who completed the telephone interview advised that communication had been frequent, but that this could be challenging because English was not their first language. They said that they were reliant on an English-speaking family member to translate, and that if they were not home, they did not understand the full content of the discussions. They advised that all written communication was in English and difficult to understand.

In the text survey, participants were asked to rate the YOS on a scale of 1 to 10, with 1 being poor and 10 fantastic. Three of the respondents rated the service from 7 to 10. However, two participants who were parents gave a score of 2, saying that they were disappointed with the service they received from the YOS. One parent felt that communication had been poor, and that they were not informed when the case was closed. The other parent described that planned intervention to support their child was not always completed.

Diversity

- The management board has a strong understanding of the diversity needs and disproportionality experienced by children and families accessing the service. The YOS produces data on children's diversity proactively and has a detailed knowledge of disproportionality and over-representation. However, the YOS and its partners need to embed their strategy and approach to addressing disproportionality. This will provide clarity on direction and expectations for operational practice.
- Meeting the diversity needs of children and addressing disproportionality are a priority of the service. However, much of the current guidance does not state explicitly how the service intends to meet all protected characteristics for children. This lack of operational clarity is impacting on practice.
- The diversity of the overall workforce is reflective of the local population aged 10 to 17. There are lower numbers of male practitioners. Future recruitment could consider targeted recruitment campaigns to increase the numbers of male practitioners.
- Many of the staff who participated in the inspection felt that their individual diversity needs were not recognised, understood, or responded to effectively. This was across protected characteristics and is an area that requires review.
- There is a dedicated team for girls accessing the service. Girls are offered a bespoke and holistic intervention to meet their needs, delivered by female practitioners.
- Although this area has improved since the last inspection, further work is needed to ensure the needs of black and mixed heritage children, who are currently over-represented in the service, are being fully met.
- Delivery to meet diversity needs in the domain three sample was a strength; there were good examples of children's needs being identified and responded to effectively. However, sufficiency of delivery declined in the domain two sample. To support consistency and drive quality, further work is required to strengthen assessment and analysis of diversity and planning to meet the needs of all children.
- In most resettlement cases, children's diversity needs are recognised and catered for within custody and following release into the community. Necessary information is shared with the secure estate, reasonable adjustments are considered and efforts to assess diversity needs are undertaken. There are good processes in place for children with special educational needs and disabilities (SEND), and relevant information is shared between the establishments, the YOS, and the SEND teams.

Domain two: Court disposals

We took a detailed look at 33 community sentences and six custodial sentences managed by the YOS.

2.1. Assessment

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

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

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	69%
Does assessment sufficiently analyse how to keep the child safe?	59%
Does assessment sufficiently analyse how to keep other people safe?	**51%**

Assessment of desistance was of sufficient quality in the majority of cases. Practitioners were skilled at drawing out and analysing strengths and protective factors, providing a balanced assessment. The voices of children and their parents or carers formed an integral part of the assessment, giving insight into the child's experiences. Analysis was comprehensive and illustrated a strong understanding of desistance. Recognition and analysis of diversity needed to be strengthened. However, in the instances where this was sufficient, we found evidence practitioners had taken time to explore culture, religion, ethnicity, and neurodiversity, to understand their impact on the lived experience of the child.

We found some thorough assessments of risks to the child, and some detailed understanding of potential outcomes. However, this quality was not consistent across the sample and we found many instances where risks, including exploitation and emotional harm had not been identified or analysed adequately. Assessment to keep others safe was the weakest area of practice. Not all risks from the child were recognised and analysed effectively. There was not enough attention paid to identifying actual and potential victims, or the imminency of potential harm. Exploration of controls and interventions needed improving, to assist practitioners in analysing mechanisms to keep the child and others safe.

Several of the cases deemed to be insufficient across all areas had been affected by staff sickness, absence, and practitioners leaving the service. This impacted on the quality and timeliness of assessments.

[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.

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?	69%
Does planning focus sufficiently on keeping the child safe?	**59%**
Does planning focus sufficiently on keeping other people safe?	**59%**

Planning had improved since the last inspection, moving from a rating of 'Inadequate' to 'Requires improvement'. Planning for desistance was the strongest area of practice. Assessed needs had been translated into clear targets. Appropriate intervention to address areas of concerns were identified and there was a strengths-based approach which sought to build on desistance and support integration with mainstream provision. Planning to meet diversity needed to be improved, to ensure that children's needs are acknowledged, and appropriate adjustments considered. There was a lack of presence of victims' wishes and needs in planning. Although we saw some strong examples of child and family involvement in planning, this was not being routinely completed in all cases.

Deficits in initial assessments where risks to and from the child had not been identified had impacted on the quality of planning. This included not addressing all key concerns, including exploitation and mental health needs. We did see some cases where risk concerns had been addressed adequately in planning, including identifying appropriate intervention, such as healthy relationships, conflict management, and peer relationships. However, this was not always the case and there were critical gaps in planned work such as gang intervention and support.

Other agencies were not consulted or involved effectively to promote safety, coordination, and joined-up working. In many cases, services such as children's social care and schools, should have been involved actively in planning, but they were either not contacted or not challenged when an unsatisfactory response was received. Contingency arrangements require further development so that actions and responses when risks increase are clear, include other services and fully meet the needs of the case. Where other services were already working with the child, plans were not always aligned and there was a lack of clarity on which agency was the lead.

[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?	44%
Does the implementation and delivery of services effectively support the safety of the child?	44%
Does the implementation and delivery of services effectively support the safety of other people?	**41%**

Delivery had declined since the last inspection, with the rating moving from 'Requires Improvement' to 'Inadequate'. Delivery had been significantly affected by staff absence, changing case managers, and insufficient management oversight when a practitioner was away from work. In some cases, there had been multiple practitioners and in others, periods when it was not clear who held responsibility for overseeing the child. This impacted on developing effective relationships with children, families, and the professional network. The continuity of work was disrupted, with critical intervention not being completed. Increases in risks to and from the child were frequently missed or not explored effectively to identify an appropriate response to promote safety.

Although there were efforts to engage and work with children and families, intervention was not always meaningful, appearing to be more of a welfare check than impactful sessions. In many cases, planned work to address desistance was not undertaken and referrals to other specialist services did not take place quickly enough.

There was a lack of presence and effective input from other services to support the YOS in managing risks to and from the child. The current risk management oversight arrangements were not holding other services to account or encouraging a shared responsibility for addressing concerns. There was not a strong understanding of wider risk management processes, such as multi-agency public protection arrangements (MAPPA), with eligible cases not always being referred. Intelligence requests were not routinely completed and information from the police was not always easy to access. Similarly, where there was an unsatisfactory response from children's social care services, these concerns were not escalated routinely. Multi-agency work was disjointed and communication between services was poor. Referrals to specialist provision were not being followed up routinely and information about work that other agencies were completing with the child was not always requested and received.

Interventions to address risk and safety concerns were not always completed. More attention to actual and potential victims was needed to promote safety.

There were some examples of effective delivery and work with other services, but this was present in too few cases. We saw tenacious efforts to engage children and families, and creative approaches to delivering interventions. Many of the practitioners and managers we interviewed were aware of some deficits in their casework. There was clear dedication to, and care for, children.

[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.	Inadequate

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

	% 'Yes'
Does reviewing focus sufficiently on supporting the child's desistance?	**44%**
Does reviewing focus sufficiently on keeping the child safe?	**44%**
Does reviewing focus sufficiently on keeping other people safe?	**44%**

A formal written review of desistance was completed in just under two-thirds of cases, but the reviewing activity was sufficient in only a minority. We saw some good reviewing activity with other services, reflecting progress and analysing changes, but this was present in too few cases. In most, significant changes to desistance were not analysed adequately to understand impact and progress. For instance, where there had been further offences or incidents of repeat behaviour, these were not always recorded or analysed. The revisiting of diversity needs had also declined and was sufficient in too few cases. More attention was needed to explore if current provision was meeting the children's diversity needs and if changes were required. There needed to be more involvement of children and parents or carers in reviewing and seeking their views on progress.

Reviewing to keep the child and others safe was not sufficient. Further work with practitioners, managers, and partners was needed to improve processes and develop collaborative approaches to reviewing. In many cases, communication between services was ineffective, gaps in information were not consistently followed up, and there was not a proactive approach to verifying if risks had changed. Often, it was the responsibility of the practitioner to pursue other services repeatedly rather than having clear information sharing arrangements in place. Multi-agency meetings were held to review risks but, in many cases, this was not triggering a sufficient response to mitigate concerns. There needed to be a more coordinated and aligned response from the partnership, whereby the review of risks to and from the child was a shared responsibility.

Adjustments to the plan or interventions were not sufficiently robust to address changes in desistance, child safety, and risks to others. Clearer and more comprehensive contingency plans, co-produced with partners, would assist in knowing how to respond when desistance factors and risks change.

[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 38 cases managed by the YOS that had received an out-of-court disposal. These consisted of 13 youth conditional cautions, four youth cautions, 12 community resolutions, and nine outcome 22 disposals. We interviewed the case managers in 27 cases.

3.1. Assessment

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

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

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	74%
Does assessment sufficiently analyse how to keep the child safe?	**58%**
Does assessment sufficiently analyse how to keep other people safe?	**58%**

Assessment in out-of-court disposals had improved since the last inspection, with the rating moving from 'Inadequate' to 'Requires improvement'. Assessment of desistance was the strongest area; we found children and parents and carers meaningfully involved, and their voice captured and analysed. In most assessments, information from other agencies had been used effectively to understand the child and their previous experiences. There was a clear focus on identifying and exploring strengths and protective factors. Analysis of the child's motivation and maturity was strong, and practitioners also demonstrated a clear understanding of personal circumstances, including the wider familial and social context. We saw several good examples of exploring culture, religion, and learning needs, but this was not consistent.

Although information from other agencies had been sought, this had not been analysed sufficiently to understand risks to and from the child, and the nature and context of potential behaviour. We found an over-reliance on the child's account and a lack of professional curiosity to verify information. Practitioners did not explore previous experiences consistently, to understand the impact of trauma on presenting behaviours. Consequently, many risks to and from the child were not identified. Rationales and evidence of how judgements were reached lacked detail and analysis for both safety and wellbeing, and risk of serious harm. More attention to actual and potential victims was needed to support future safety.

[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.

3.2. Planning

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

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

	% 'Yes'
Does planning focus on supporting the child's desistance?	87%
Does planning focus sufficiently on keeping the child safe?	**74%**
Does planning focus sufficiently on keeping other people safe?	82%

Planning for out-of-court disposals had significantly improved since the last inspection, moving from a rating of 'Inadequate' to 'Good'. It was strong across desistance, child safety and wellbeing, and risks to others. It was enhanced by the multi-agency decision-making panel and discussion about appropriate interventions, and clear guidance was provided to the practitioner.

Planning was proportionate and coordinated, involving children and families meaningfully. Targets were clear, realistic, and sequenced. There was a balanced approach, where areas of concern were addressed, but also a clear focus on further developing protective factors and strengths. Practitioners recognised the importance of supporting children to access mainstream provision, including constructive activities. Planning was holistic and considered exit strategies early, with referrals to specialist services for the child and family. Diversity needs and personal circumstances had been considered in most cases. Plans had incorporated specialist information about learning needs and, where required, adjustments to enhance engagement were made.

Planning to keep the child safe was sufficient in the majority of cases. There was a focus on the child, with safety planning arrangements being communicated to the child and family effectively. Appropriate intervention to promote safety was identified, and, where needed, referrals made to specialist services, including substance misuse and Empower U, the exploitation service. Planning to keep others safe was of good quality. Potential and actual victims had been considered, and measures put in place to promote safety. Intervention to address risk concerns was tailored and appropriate interventions, such as healthy relationships and managing conflict, identified.

We found strong examples of contingency planning to support keeping the child safe and managing risks to others. However, this was not consistent for all cases, and more work was needed to identify appropriate actions and responses when and if risks changed.

[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?	68%
Does service delivery effectively support the safety of the child?	**50%**
Does service delivery effectively support the safety of other people?	63%

Practitioners were skilled at developing effective relationships with children and families. There was a clear focus on engagement, with practitioners being creative and flexible to encourage participation. However, in several cases we found drift and gaps in provision following reallocation because of case managers leaving or sickness. This included long periods when children had not been contacted. There were strong examples of children's diversity needs being recognised and responded to. This included being culturally aware and tailoring delivery of support to acknowledge religious needs and promote engagement. However, this was not consistent and there were cases where learning needs had not been understood, or necessary adjustments made. Although there was a girl's empowerment team, in some of the cases we reviewed, reduced capacity meant that access to this provision was not always possible. Developing strengths and increasing community integration were a priority. Children were referred to, and received, good-quality services, including boxing, mentoring, and ETE support.

Delivery to keep the child safe was the weakest area. There was poor communication and a lack of coordination and joined-up working between services to promote safety. This included making and following up necessary referrals to specialist services, such as mental health providers. In many cases, inspectors assessed that, because of the complex needs and risks to the child, children's social care services should have been more involved. The YOS needed to be more proactive in escalating concerns when responses from children's social care services were not satisfactory. Increases in risks to the child were not always recognised and responded to appropriately, adjustments to ongoing work to keep the child safe.

Delivery to keep others safe was stronger. We found that intervention targeted areas of concern and were impactful, particularly virtual reality sessions. In many cases, home visits were undertaken frequently, to monitor risk concerns. However, police intelligence was not routinely requested or easily obtained to support ongoing oversight. In some cases, there were gaps in critical information which would have assisted the partnership in managing risks to others.

[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.

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 centralised approach and review of protocols has improved consistency. The guidance provided fundamental details, including timeframes, definitions, and distinctions between the disposals.
- There is an effective escalation process in place if the YOS and police cannot agree on an outcome.
- A weekly multi-agency panel supports the YOS and police joint decision-making for out-of-court disposals. An assessment is completed prior to the panel, capturing the voice of the child and family. We found that the decision-making process and the application of the disposals were timely in most cases.
- Although work is needed to develop assessment activity further, the quality of this and planning has improved since the last inspection. This supported the panel to make an informed decision and identify the appropriate interventions to address need.
- The individual needs of the children, and mitigating factors, are considered alongside the police gravity matrix, to assist in determining appropriate outcomes for children.
- There are a range of diversion options available to the panel, including outcome 22. This disposal provides diversion without the child receiving a formal criminal sanction.
- Intervention is offered for all disposals where a need was identified. Children can access the same services and provision as post-court cases. This included children for whom the police had issued an out-of-court disposal as a single agency.
- The number of first-time entrants has decreased significantly. Partners are committed to reducing this further and embedding a child-first approach.
- The YOS understand where improvements are needed and are working proactively with partners to address these. Provision had been reviewed and adjustments made to enhance the quality of out-of-court disposals.

Areas for improvement:

- The services' position on meeting the diversity needs of all children, and how they intended to address disproportionality, is not fully understood at an operational level.
- Guidance needs to be developed further, to ensure consistency in the eligibility criteria and enforcement processes, and equitable access to disposals. The YOS is already working with police partners to ensure that future protocols reflect national guidance and will promote and embed diversion further.

- Although there are restorative practice workers who attend the panel, there are barriers to consistently obtaining victim consent or information. This reduces the opportunity for victim's voices to be heard. These blockages need to be successfully addressed to ensure victim's views and voices have a stronger presence in panels.
- Diversion is a priority but further work with partners is required to ensure that children are diverted from the criminal justice system consistently and effectively.
- Some evaluation work is being undertaken. However, to fully understand the current use of out-of-court disposals and support a consistency of practice, the service needs to ensure that up-to-date analysis and evaluation is completed and shared routinely with those involved in out-of-court disposals. This should include exploring the impact of disposals, and monitoring of the decision-making and reoffending patterns.
- Several of the changes to the out-of-court disposal process were new and their impact is not yet known. The YOS needs to continue to work with partners and staff, to support embedding the changes and quality assure work to promote consistency.

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 nine cases managed by the YOT that had received a custodial sentence; six detention and training orders; and three section 91/250 custodial sentences. Our key findings were as follows.

Strengths:

- In the reviewed cases the YOS was proactive in communicating with the child, family, and secure estate. Contact was meaningful and positive relationships with the child and family were established.
- Work to develop pathways for wraparound support prior to and upon release are showing promise. This includes mentoring support, ETE support for pre- and post-16-year-olds, and specialist intervention from the police, who work closely with the YOS.
- The YOS recognised that resettlement provision required development. At the time of our inspection, work was underway to review current provision and create additional guidance
- Following reviews of remand and custodial sentences, the YOS had amended the pre-sentence report template and enhanced community disposals and bails packages to provide courts with robust alternatives to custody. This has supported a significant reduction in custodial sentences and remands.
- Routine analysis of custody and remand cases is now undertaken. This provides detailed information on children subject to these disposals and allows the service to track and monitor outcome.

Areas for improvement:

- There was no specific resettlement guidance in place. Staff were not clear on procedures or practice expectations to meet adequately the needs of children requiring resettlement services. Guidance is needed to outline the basics of resettlement provision, including contact arrangements, timeframes, addressing structural barriers, roles of other services, and escalation routes. It is essential that documentation provides fundamental detail in how to address and manage risk and safety concern
- The partnership arrangements were not meeting the needs of all children requiring resettlement provision effectively. The roles and responsibilities of the partnerships in supporting resettlement needs further development. In the cases we reviewed there was an inconsistent and uncoordinated approach.
- Risk management arrangements for release were not fully understood or adequately comprehensive to promote keeping others safe. Victim safety

needed to be prioritised, with a more cohesive response from partners to address all risks.

- Work to keep children safe needed to be stronger. Information sharing with the secure estate was sufficient in most cases. However, the professional network required robust arrangements to ensure a coordinated approach.
- The YOS needed to work in a more collaborative manner with the secure estate, to ensure that intervention to address worrying behaviour was completed prior to release and was followed through into the community.
- Pathways to support constructive resettlement need further embedding, to ensure effective in-reach from community-based services such as health and ETE. Greater links will assist planning in custody and support transition back into the community.
- Not all practitioners and managers who worked with custody cases had received appropriate training to undertake resettlement work.
- Once the resettlement provision has been fully embedded and implemented, the YOS need to develop robust evaluation systems, including scrutiny of its own practice, services provided by partners, and the views of children and families.

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.