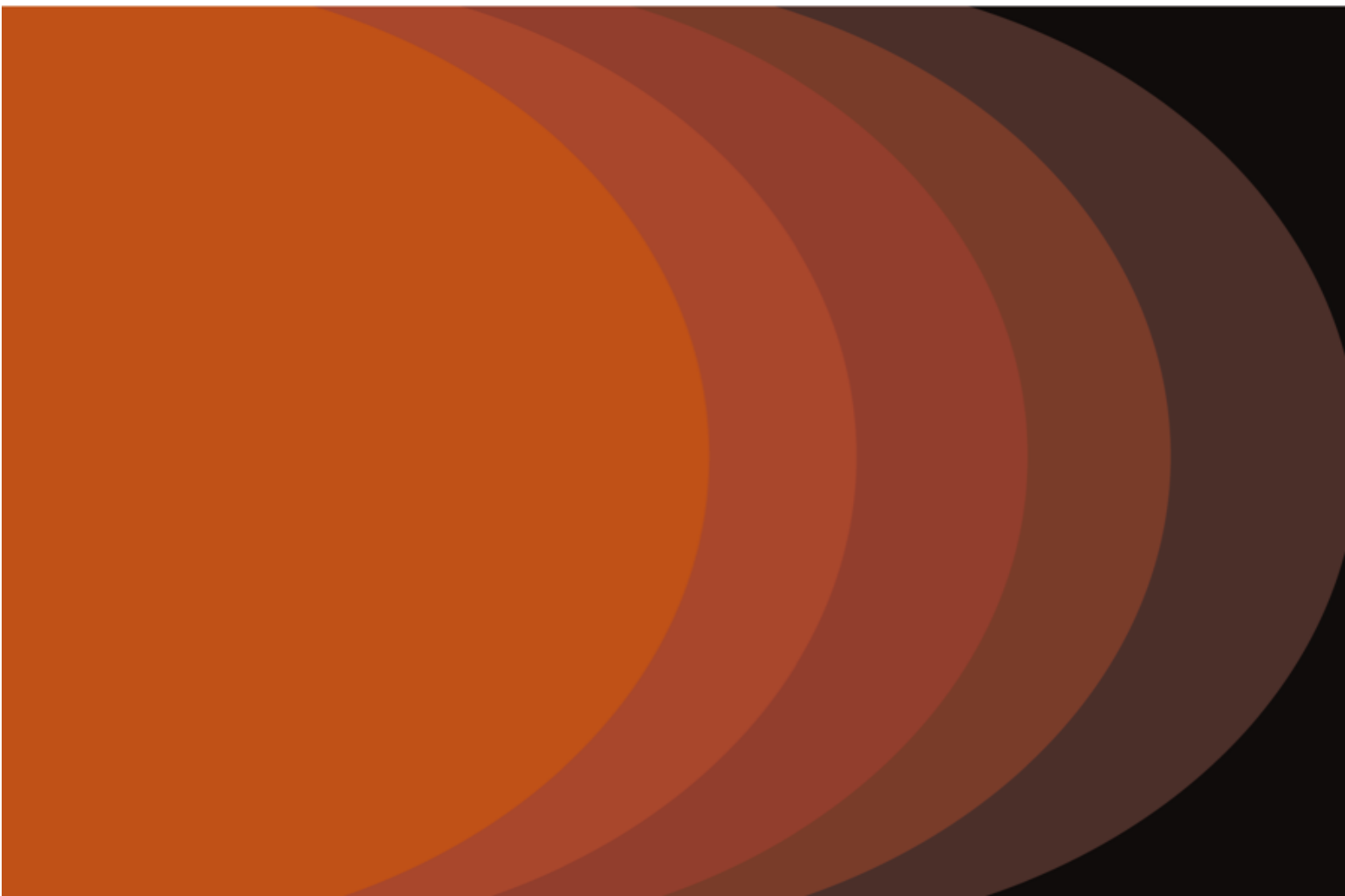
Her Majesty's Inspectorate of Probation

An inspection of youth offending services in

Tower Hamlets and City of London

HM Inspectorate of Probation, July 2022



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Acknowledgements

This inspection was led by HM Inspector Avtar Singh, 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

Her Majesty's 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 offending service (YOS) inspections. We have inspected and rated Tower Hamlets and City of London Youth Justice Service (YJS) across three broad areas: the arrangements for organisational delivery of the service, the quality of work done with children sentenced by the courts, and the quality of out-of-court disposal work. Overall, Tower Hamlets and City of London YJS was rated as 'Requires improvement'. We also inspected the quality of resettlement policy and provision, which was separately rated as 'Requires improvement'. On five of our separate quality standards which contribute to the overall judgement, we rated this service as 'Inadequate'.

In this YJS we found a number of areas that were cause for concern and requiring significant improvement. Leaders need to do much more to achieve better outcomes for children being supervised by the YJS. We found significant failings across the arrangements for organisational service delivery and out-of-court work. Performance is not understood well and there has been a dependence on data and management information that is inaccurate and unreliable. The management board is large, not robustly effective in its role, and not communicating its decisions well to YJS staff. It does not have an active risk register and risks to the service are not fully understood.

There have been too many lengthy gaps and interim arrangements in the appointment of key staff. This has had a negative impact on a service which is responsible for helping extremely vulnerable children. Safety and wellbeing and risk of harm work needs to improve across court and out-of-court work.

Relationships with statutory partners in safeguarding and public protection work are not effective. Several essential policies and procedures are underdeveloped and in draft format. Disappointingly, there is little evidence of an organisation which is continuously learning from lessons when things go wrong. This needs to change and a culture of embracing and applying learning is required.

At a practice level, while staff morale is low and staff do not feel valued, they are nevertheless enthusiastic and highly determined to help children to live more fulfilling lives. They engage well with children and their parents or carers and we saw some positive examples of work with children, particularly in relation to diversity and children's self-identity. The YJS has access to some good health and education provision. Additionally, there are several third-sector services, some of which are providing added value for children from diverse backgrounds.

The YJS has taken some immediate decisions and actions to respond to the failings found in this inspection. This is encouraging and we hope that the necessary improvements will occur at pace. In this report we make seven recommendations to further improve the work of Tower Hamlets and City of London YJS. We trust that they will assist the YJS as it continues its improvement journey.

Justin Russell
HM Chief Inspector of Probation

Ratings

Tower Hamlets and City of London Youth Justice Service

Fieldwork started: April 2022

Score **8/36**

Overall rating		**Requires improvement**	
1.	**Organisational delivery**		
1.1	Governance and leadership	**Inadequate**	
1.2	Staff	**Requires improvement**	
1.3	Partnerships and services	**Requires improvement**	
1.4	Information and facilities	**Inadequate**	
2.	**Court disposals**		
2.1	Assessment	**Good**	
2.2	Planning	**Requires improvement**	
2.3	Implementation and delivery	**Requires improvement**	
2.4	Reviewing	**Requires improvement**	
3.	**Out-of-court disposals**		
3.1	Assessment	**Requires improvement**	
3.2	Planning	**Inadequate**	
3.3	Implementation and delivery	**Inadequate**	
3.4	Out-of-court disposal policy and provision	**Inadequate**	
4.	**Resettlement**		
4.1	Resettlement policy and provision	**Requires improvement**	

Executive summary

Overall, Tower Hamlets and City of London Youth Justice Service (YJS) is rated as: 'Requires improvement'. This rating has been determined by inspecting the YJS in three areas of its work, referred to as 'domains'. We inspect against 12 core 'standards', shared between the domains. The standards are based on established models and frameworks, which are grounded in evidence, learning, and experience. They are designed to drive improvements in the quality of work with children who have offended.[1] Published scoring rules generate the overall YJS rating.[2] We inspected the quality of resettlement policy and provision separately, and rated this work as: 'Requires improvement'. The findings and subsequent ratings in those domains are described below.

Organisational delivery

We interviewed 58 people who were involved in providing strategic leadership, overseeing operational management, supporting the YJS with partnership arrangements, and delivering services directly to children.

The governance and leadership of Tower Hamlets and City of London YJS does not support and promote the delivery of a high-quality, personalised, and responsive service for all children.

Within the partnership arrangements, the collaboration and cooperation between teams are not consistently leading to better outcomes for children and improvements in service delivery. Some staff do not understand how their roles fit within the arrangements, especially following the amalgamation of the youth service and the YJS. There is a lack of clarity about who has the authority to make decisions. Board members largely advocate for the work of the YJS in their broader roles and relevant local strategic partnerships.

Staff do not fully understand their responsibilities within the partnership arrangements, and what they are accountable for. Decisions are consistently not communicated or explained well enough, resulting in a lack of alignment between the issues described by staff and those understood by leaders. Staff do not always feel valued and report that they do not always feel they are treated with respect.

There are ineffective systems for identifying, capturing, and managing issues and risks, through a risk register, for example. Any mitigating actions or improvements that leaders have sought to make have not always resulted in meaningful change. Consequently, leaders are not doing enough to tackle poor outcomes for children. The leadership is not sufficiently focused or sighted on safety and risk of harm, giving serious cause for concern.

Staff within the YJS are insufficiently empowered to deliver a high-quality, personalised, and responsive service for all children. Staff report that morale is poor.

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[1] HM Inspectorate of Probation's standards can be found here: https://www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/

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

There are shortfalls in the strategy for maintaining the quality of delivery during periods of planned and unplanned staff absences. Some cases are allocated to staff who are insufficiently qualified and/or experienced and we found that not all staff feel motivated by the organisation to contribute to the delivery of a quality service.

The staffing of the YJS is largely representative of the diversity of the local population and the use of volunteers in referral order panels is largely effective. There are some weaknesses within the strategy for identifying and developing fully the potential of individual staff to support succession planning. There could be increased use of reward and recognition. Not all staff receive effective supervision, and the induction programme for new staff has limitations.

The appraisal process is not always used effectively to ensure that staff are competent to deliver a quality service. Inconsistent attention is given to identifying and addressing poor performance or recognising and rewarding exceptional work. The YJS has not regularly identified and planned for the learning needs of all staff, and there are some limitations in the access to in-service training. A culture of learning and continuous improvement is not consistently promoted. However, there are plans to integrate YJS staff into the offer provided by the Supporting Families Academy.

Most children report positive relationships with their case managers. These are helping them to better understand their lived experiences and what they need to do to lead more constructive lives. However, opportunities to use analysis to influence service delivery are being missed. While the volume, range, and quality of some services meet the desistance needs and diversity of children, the YJS does not ensure that services build on strengths and enhance protective factors for all children. This was particularly evidenced in our case findings from out-of-court work. The YJS does not consistently review and evaluate the quality of all services and does not always take remedial actions where required. The availability of information does not support a high-quality, personalised, and responsive approach for all children.

The analysis of the cohort of YJS children is not consistently updated and does not capture the full range of desistance needs, safety and wellbeing factors, and risk of harm factors. Some data is not accurate and too much data is unreliable. The accuracy of information provided to the Youth Justice Board is not clear. While monitoring takes place, it is likely that some of the data used to inform decisions is predicated on information which is incorrect.

Not all arrangements with statutory partners and other providers are established, maintained, and used effectively to support desistance, maintain safety and wellbeing, or manage the risk of harm to others. There are significant gaps in policies and processes, impeding the delivery of a quality service. Many that are in place have been poorly communicated, are not current, and not well understood by practitioners. A number require reviewing and approving at management board level. However, the YJS's delivery environment is a strength, offering the necessary levels of safety, security, privacy, and confidentiality.

Access to the ChildView case management system is efficient and supports timely recording of information.

Learning is not fully harnessed and there are no systematic reviews of incidents when things go wrong. There is limited evidence that the YJS uses sources of learning and evidence to consistently drive improvement. Timely actions are often not taken when they are required.

Key findings about organisational delivery are as follows:

- Practitioners were enthusiastic and keen to help make a lasting difference in the lives of children.
- Volunteers were used well in referral order panel work.
- The YJS's delivery environment offered the necessary levels of safety, security, privacy, and confidentiality.
- Access to the ChildView system was efficient and supporting timely recording of information.

But:

- The collaboration of the YJS partnership is not consistently leading to better outcomes for children and improvements in service delivery.
- YJS management board membership is large and ineffective.
- Staff are not clear about how the amalgamation of the Youth Service and Youth Justice Service will help them to achieve better outcomes for children.
- Decisions are not explained or communicated well by senior leaders.
- There is no risk register enabling the YJS to address risks to the service strategically.
- There is poor staff morale and staff do not feel listened to.
- Performance is not understood.
- Data is unreliable and management information is not accurate.
- Planned and unplanned staff absences are not managed well.
- Appraisal processes are not effective in developing staff.
- There are significant gaps in up-to-date and effective policies.
- Management oversight is not consistently effective.
- Learning from serious incidents is not harnessed.

Court disposals

We took a detailed look at 16 community cases managed by the YJS. We also conducted 16 interviews with the relevant case managers. We examined the quality of assessment; planning; implementation and delivery of services; and reviewing. Each of these elements was inspected in respect of work done to address desistance, to keep the child safe, and to keep other people safe.

Our key findings about court disposals are as follows:

- Assessment work to understand children's behaviour was strong.
- Practitioners took account of the child's strengths and protective factors, as well as their level of maturity and willingness to change.
- Planning to support the child's desistance was good.
- Case managers engaged children and their parents or carers meaningfully in planning.

- Case managers focused on developing and maintaining an effective relationship with children and their parent or carers.
- Attention to and response to diversity needs was a strength in casework.

But:

- When assessing a child's safety and wellbeing and risk of harm to others, staff need to be much more disciplined in identifying and analysing the risks to and from the child.
- The concerns and risks relating to actual and potential victims were not consistently considered when planning to address the risk of harm to others; victim work was therefore overlooked.
- Not enough services were delivered to prevent children from causing harm to others.
- Staff did not consistently set out contingency arrangements to manage the child's safety and wellbeing and their risk of harm to others.
- Guidance to support safety and wellbeing work was incomplete.
- There was not enough effective joint working to support risk of harm work.
- Managers' oversight of work was often not effective.

Out-of-court disposals

We inspected nine cases managed by the YJS that had received an out-of-court disposal. These consisted of seven youth conditional cautions, one community resolution, and one other disposal. We interviewed the case managers in nine cases.

We examined the quality of assessment; planning; and implementation and delivery of services. Each of these elements was inspected in respect of work done to address desistance, to keep the child safe, and to keep other people safe. The quality of the work undertaken for each factor needs to be above a specified threshold for each aspect of supervision to be rated as satisfactory.

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 about out-of-court disposals are as follows:

- Assessment activity analysing and supporting desistance was largely done well in the inspected cases.
- Attention to diversity needs and personal circumstances in most aspects of casework was good.

But:

- The current out-of-court disposal policy was produced in March 2022 and needs to be embedded into practice.
- Planning for work to support the safety and wellbeing of the child and keep others safe was poor.
- The quality of work supporting desistance was variable.
- The delivery of work to keep children safe and prevent them from causing harm to others was poor.

- The coordination of work by YJS practitioners, where other agencies are involved, was not effective.
- Contingency planning needs to be evident so that the arrangements for managing a child's risk of harm to others is clear.

Resettlement

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 YJS that had received a custodial sentence.

Our key findings about resettlement work are as follows:

- The YJS has a custody and resettlement procedures and good practice guidance document which includes the Youth Justice Board's seven resettlement pathways.
- There was a good focus on developing a prosocial identity, especially cultural identity.
- Suitable accommodation for children being released from custody was available.
- There were effective relationships between YJS and custodial staff.
- A YJS practitioner has a designated responsibility for overseeing resettlement work.

But:

- Guidance to support effective resettlement work needs to be enhanced, for example, in addressing structural barriers.
- More clarity is needed to enable practitioners to carry out effective safety and wellbeing and risk of harm work.
- The needs of victims were not covered well.
- Escalation procedures were underdeveloped.
- Information exchange between the police and the YJS did not always take place and was not timely.
- Reviewing of resettlement arrangements needs to be better organised and implemented.
- There needs to be wider consultation with children and their parents or carers to understand the impact of resettlement arrangements.
- A strategic plan is needed to ensure that the policy meets the resettlement needs of all children.

Recommendations

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

The Tower Hamlets and City of London Youth Justice Service management board should:

1. review its membership to ensure that the right people, at the right level of seniority, are included to engage actively in achieving better outcomes for YJS children
2. ensure that there are comprehensive quality assurance arrangements to understand performance and respond to the profile and needs of all children supervised by the YJS
3. make sure that all data and management information is accurate, reliable, and enables informed decision-making
4. review its out-of-court provision to ensure that the arrangements are effective and support diversion.

The Tower Hamlets and City of London Youth Justice Service team service head should:

5. improve the quality of assessment, planning, and service delivery work to keep children safe and manage the risk of harm they present to others
6. ensure robust contingency plans are in place for all children that address their safety and wellbeing, and risk of harm to others
7. make sure safeguarding and public protection arrangements are comprehensive and understood by all staff.

Background

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

YOTs are statutory partnerships, and they are multidisciplinary, to deal with the needs of the whole child. They are required to have staff from local authority social care and education services, the police, the Probation Service, and local health services.[3] Most YOTs are based within local authorities, although this can vary.

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

The two local authorities in Tower Hamlets and the City of London have worked in partnership for several years, an arrangement that has been recently extended for a further two years. Due to the small residential population of the City of London, the YJS has not had a City of London child on its caseload for around three years, but the two authorities continue to work closely together.

Tower Hamlets has an estimated population of 310,000. It also has a comparatively young population, the fifth youngest nationally with a median age of 31.9, and around 80,000 children between the ages of 0-19. Tower Hamlets is highly diverse, with 69 per cent of the population belonging to a black, Asian, and minority ethnic community. The two largest groups are Bangladeshi (32 per cent) and white British (31 per cent). One hundred and twenty-three languages are spoken in local schools.

Tower Hamlets has the highest child poverty rates in England, at 32 per cent. Twelve per cent of residents earn below the London living wage. There are 20,073 applications on the housing waiting list, the third highest in London.

There are currently 82 children open to the YJS with three children presently in custody. Over 50 per cent of these children have been involved in drug or violent offences.

In June 2021, the YJS in its current identity was officially launched as the Youth Justice and Young People's Service. Youth services in the borough are valued by the community, and some providers have been established for over 30 years. For the YJS, the merger intends to strengthen its targeted prevention service, allowing it to keep children whose behaviour is of concern allocated to the Break the Cycle team.

[3] The *Crime and Disorder Act 1998* set out the arrangements for local YOTs and partnership working.

Contextual facts

Population information[4]

267	First-time entrant rate per 100,000 in Tower Hamlets and City of London[5]
154	First-time entrant rate per 100,000 in England and Wales
25.5%	Reoffending rate in Tower Hamlets and City of London[6]
33.6%	Reoffending rate in England and Wales

342,907	Total population Tower Hamlets and City of London
30,659	Total youth population (10–17 years) in Tower Hamlets and City of London

Caseload information[7]

Age	10–14 years	15–17 years
Tower Hamlets and City of London YJS	**20%**	**80%**
National average	18%	82%

Race/ethnicity[8]	White	Black and minority ethnic	Unknown
Tower Hamlets and City of London YJS	**17%**	**83%**	**0%**
Youth population (10–17 years) in Tower Hamlets and City of London	18%	82%	0%

Gender	Male	Female
Tower Hamlets and City of London YJS	**90%**	**10%**
National average	86%	13%

[4] Office for National Statistics. (2021). *UK population estimates, mid-2020*.

[5] Youth Justice Board. (2022). *First-time entrants, October to September 2021.*

[6] Ministry of Justice. (2022). *Proven reoffending statistics, July 2019 to June 2020.*

[7] Youth Justice Board. (2022). *Youth justice annual statistics: 2020 to 2021.*

[8] Data supplied by the YJS.

Additional caseload data[9]

83	Total current caseload, of which:
68.5%	Court disposals
31.5%	Out-of-court disposals

Of the 57 court disposals:

54	Total current caseload: community sentences
3	Total current caseload in custody
0	Total current caseload on licence

Of the 26 out-of-court disposals:

2	Total current caseload: youth caution
11	Total current caseload: youth conditional caution
13	Total current caseload: community resolution or other out-of-court disposal

Education and child protection status of caseload:

7%	Proportion of current caseload 'Looked After Children' resident in the YJS area
6%	Proportion of current caseload 'Looked After Children' placed outside the YJS area
4%	Percentage of current caseload with child protection plan
22%	Percentage of current caseload with child in need plan
41.9%	Percentage of current caseload aged 16 and under in full-time school
58.1%	Percentage of children aged 16 and under in a pupil referral unit, alternative education, or attending school part-time
55.3%	Percentage of current caseload aged 17+ not in education, training, or employment

For children subject to court disposals (including resettlement cases):

Offence types[10]	%
Violence against the person	**50%**
Burglary	**11%**
Robbery	**6%**

[9] Data supplied by the YJS but may be inaccurate, reflecting the caseload at the time of the inspection announcement.

[10] Data from the cases assessed during this inspection.

Theft and handling stolen goods	6%
Fraud and forgery	11%
Drug offences	6%
Summary motoring offences	6%
Other indictable offences	6%

1. Organisational delivery

The governance and leadership of Tower Hamlets and City of London YJS does not support and promote the delivery of a high-quality, personalised, and responsive service for all children.

Within the partnership arrangements, the collaboration and cooperation between teams is not consistently leading to better outcomes for children and improvements in service delivery. Some staff do not understand how their roles fit within the arrangements, especially following the amalgamation of the youth service and the YJS. There is a lack of clarity about who has the authority to make decisions. Board members largely advocate for the work of the YJS in their broader roles and relevant local strategic partnerships.

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There are ineffective systems for identifying, capturing, and managing issues and risks, through a risk register, for example. Any mitigating actions or improvements that leaders have sought to make have not always resulted in meaningful change. Consequently, leaders are not doing enough to tackle poor outcomes for children, particularly those being considered for out-of-court disposals. The leadership is not sufficiently focused or sighted on safety and risk of harm, giving serious cause for concern.

Staff within the YJS are insufficiently empowered to deliver a high-quality, personalised, and responsive service for all children. Staff report that morale is poor.

There are shortfalls in the strategy for maintaining the quality of delivery during periods of planned and unplanned staff absences. Some cases are allocated to staff who are insufficiently qualified and/or experienced and we found that not all staff feel motivated by the organisation to contribute to the delivery of a quality service.

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Not all arrangements with statutory partners and other providers are established, maintained, and used effectively to support desistance, maintain safety and wellbeing, or manage the risk of harm to others. There are significant gaps in policies and processes, impeding the delivery of a quality service. Many that are in place have been poorly communicated, are not current, and not well understood by practitioners. A number require reviewing and approving at management board level. However, the YJS's delivery environment is a strength, offering the necessary levels of safety, security, privacy, and confidentiality.

Access to the ChildView case management system is efficient and supports timely recording of information.

Learning is not fully harnessed and there are no systematic reviews of incidents when things go wrong. There is limited evidence that the YJS uses sources of learning and evidence to consistently drive improvement. Timely actions are often not taken when they are required.

Strengths

- Practitioners are enthusiastic and keen to help make a lasting difference in the lives of children.
- Volunteers are used well in referral order panel work.
- The YJS's delivery environment offers the necessary levels of safety, security, privacy, and confidentiality.
- Access to the ChildView system is efficient and supporting timely recording of information.

Areas for improvement

- The collaboration of the YJS partnership is not consistently leading to better outcomes for children and improvements in service delivery.
- YJS management board membership is large and ineffective.
- Staff are not clear about how the amalgamation of the Youth Service and Youth Justice Service will help them to achieve better outcomes for children.
- Decisions are not explained or communicated well by senior leaders.

- There is no risk register enabling the YJS to address risks to the service strategically.
- There is poor staff morale and staff do not feel listened to.
- Performance is not understood.
- Data is unreliable and management information is not accurate.
- Planned and unplanned staff absences are not managed well.
- Appraisal processes are not effective in developing staff.
- There are significant gaps in up-to-date and effective policies.
- Management oversight is not consistently effective.
- Learning from serious incidents is not harnessed.

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

1.1. Governance and leadership

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

Key data

Total spend in previous financial year (2021-2022)	£1,401,749
Total projected budget current for financial year (2022-2023)	YJB grant not confirmed at point of report preparation

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

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

Tower Hamlets and City of London Youth Justice Service (YJS) has a youth justice plan (2021-2022) which is supported by a strategic plan (2021-2023). Its ambition for children who come into contact with the YJS is to provide 'safety, hope, and opportunity'. The partnership's vision for each child is 'the best possible future, the best possible support and challenge'. While these plans exist, it is unclear how delivery against targets and objectives is being measured given the unreliable data issues identified in this inspection. The youth justice plan and the strategic plan are aligned to the children's and families strategy 2019-2024 and the community safety partnership plan 2021-2024.

Disproportionality is a feature in both plans. Additionally, the YJS has produced a disproportionality plan 2022-2023 to inform and drive its objectives. In July 2021, a disproportionality deep-dive analysis was commissioned and, while this was a good initiative, learning is unclear, given the potential unreliability of data used.

The Youth Justice Management Board contains all statutory partners. They attend regularly, but membership is large and does not consistently support effective decision-making. It is not clear how all partners add value to the work of the board, for example, reporting on education is generally strong, but challenges faced by YJS staff in the relationships with children's social care, the exploitation team, and out-of-court disposal work were not understood well enough. There is no systematic reporting into the board by all partners. This was recognised in the self-assessment completed on 08 February 2022 and while board meetings reflect some healthy discussions, it is not clear how these consistently lead to positive outcomes for children.

Board members recognise the role they and their agencies must play to enable YJS children to flourish. The chair of the board is committed, well-engaged with the challenges faced by the YJS, and has a good understanding of the work of the YJS. He has been a board member for five years and chair for two. Induction arrangements for board members are comprehensive, supported by written material and a range of meetings with staff working within the partnership. However, decision-making is not always timely and change management has not always been processed well. The absence of a consistent probation resource in the YJS for some four years is unacceptable. Additionally, six different individuals had been in post as interim head of service over a period of five years, with poor management at a senior level. This has led to significant holes in effective service delivery. We note that there is now a permanent head of service.

It is positive that operational information is communicated to the board by YJS staff, ensuring that there is a connection between operational and strategic aspects of the service. In addition to the board's quarterly meetings, there are also quarterly spotlight and training sessions. At most board meetings, children's voices are heard through video recordings. These provide powerful testimonies of the lived experiences of children.

Governance arrangements supported by delivery plans are not comprehensive. Some key documents, for example the safety and wellbeing policy, are still in draft format and a number of other policies and arrangements are out of date.

Given the unreliability of data we found, for example on the first-time entrants, it is not possible to be confident that performance against the strategy is meaningful or leading to positive outcomes for children. This is a significant failing, with the board leading an organisation that is without accurate data and management information.

Do the partnership arrangements actively support effective service delivery?

The purpose of the restructure in 2021 sought to provide greater connectivity and alignment with wider provision in the Youth Service and the YJS. While there is now some level of advocacy across the new arrangements, this is currently minimal. Amalgamation of the Youth Service and YJS may bring added value, but the service is in its infancy. Staff report very mixed views about how service delivery will improve as a result of this structural reorganisation. For them, all they have seen at the moment is a change in name.

Work to maximise positive education outcomes is a strength. Supporting data demonstrates how and what work has been carried out to minimise exclusions and support children in colleges. We were also impressed by the London East Alternative Provision (LEAP) delivery plan supporting education and the Breaking the Cycle project.

Most staff (nine out of 14 in our survey) reported that they understood the roles and responsibilities they had within 'internal' partnership working.

Board meeting notes from the past 12 months indicate an active interest and engagement with diversity and disproportionality issues. However, given the inaccuracy of management information, it is not clear what impact any activity is having. The investment in the Ether programme[11] (supporting black and minority ethnic young men involved in the youth justice system through personal development) is encouraging and being received well.

The Children Living in Care Council delivered an innovative programme to support desistance and prevent harm. This supported integration with wider services for children. Activities included music, creating podcasts, and education. The evaluation showed that it had added value to helping children recognise their potential.

Does the leadership of the YOT support effective service delivery?

The YJS head of service and deputy attend board meetings. Team managers have recently been advised that they are no longer required to attend; for them, this feels like a gap given the context of an organisation that is redefining and redesigning itself. Some staff have attended board meetings, and most (11 out of 14 in our survey) were aware of board activities.

Meetings held with staff and stakeholders showed that some had a very good idea of the vision, strategy, and priorities of the YJS. However, this clarity was not shared by all.

Staff are encouraged by their managers to be open about their experiences and provide challenge. However, they report often feeling unsafe to speak about their concerns and anxieties openly. Some report not being listened to by their leadership and management, resulting in them feeling undervalued at times. They believe there is a culture in the YJS where trust is lacking. Additionally, the service is constantly 'firefighting' and not putting in place infrastructures that result in meaningful change. This is most worrying and needs to be addressed urgently.

The board does not have a risk register and is not monitoring and addressing risks in any strategic way. There are concerns about high numbers of FTEs, the leadership of the YJS, lack of data, and gaps in staffing. However, these issues have not been meaningfully addressed, leaving staff confused and anxious.

[11] https://www.wipers.org.uk/the-ether-programme

1.2. Staff

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

Key staffing data[12]

Total staff headcount (full-time equivalent (FTE))	18
Total headcount qualified case managers (FTE)[13]	10
Vacancy rate (total unfilled posts as percentage of total staff headcount)	11%
Vacancy rate case managers only (total unfilled case manager posts as percentage of total case manager headcount)	5%
Average caseload case managers (FTE)[14]	9
Average annual working days sickness (all staff)	7
Staff attrition (percentage of all staff leaving in 12-month period)	16.6%

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

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

Staffing has been a challenge for the YJS and a number of vacancies in the partnership have remained unfilled for varying amounts of time. Interim and temporary arrangements have been unsettling for staff and this has led to variable practice, especially in the area of safety and wellbeing and risk of harm to others.

Staff report a changing picture relating to their caseloads as colleagues leave and are not immediately replaced or are off work due to illness. Staff sickness rates have been high, placing demands on staff who remain at work. While caseloads are not excessive, changes in case managers have impacted the continuity of care some children receive. Some planned departures are not managed well and there are often lengthy gaps before appointments are made.

Eleven out of 13 operational YJS staff who completed our survey reported that their workloads were reasonable. Nine out of 11 volunteers reported that they were allocated manageable workloads. YJS managers reported that they were "busy", but the volume of work allocated to them was generally acceptable.

[12] Data supplied by YJS and reflecting staffing at the time of the inspection announcement.

[13] Qualified case managers are those with a relevant social work, youth justice or probation qualification.

[14] Data supplied by YJS, based on staffing and workload at the time of the inspection announcement. This may be inaccurate.

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

Youth justice operational staff reflect the diversity of the local population; the profile of volunteers is currently diverse in terms of age and ethnicity. There are fewer black, Asian, and minority ethnic managers and senior leaders.

The allocation of work was not considered to be managed in a way that brought out the best in staff. Allocations were largely made on the basis of the number of cases a case manager held rather than the skills and/or experience they brought to the role. This method carries risk and needs to be reviewed.

Operational staff reported that they were not always given access to learning and development opportunities to progress their careers. Some had accessed short-term learning outside of their organisation, but this had been driven by them. A workforce development strategy would support effective workforce development and succession planning.

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

The YJS provides generic introduction booklets, including Welcome to Tower Hamlets and Practice Standards, for example, but it is not clear how directly relevant these are to youth justice practitioners.

Regular monthly supervision with team managers for paid operational staff is scheduled into the working timetable. Almost a quarter of staff who completed our survey said that their supervision and support were not so good. There are opportunities for clinical group supervision with a psychologist, with support provided for the management of more complex cases. Managers report that the quality of their own supervision varies but is largely regular. Given the variable findings from our case reviews, we do not believe that supervisory support is providing consistent guidance and advice, especially in safety and wellbeing and risk of harm work. This is supported by our conclusions from case reviews where we found that in six out of 16 domain 2 cases and four out of eight domain 3 cases management oversight was not effective.

Staff who had joined the YJS more recently spoke about a mixed learning induction experience. Their introduction to other colleagues was good but they did not feel fully integrated into the reorganised service. Induction for volunteers was described as informative and relevant. Issues of disproportionality and diversity were largely covered well.

None of the staff or managers we spoke to said they had an up-to-date appraisal. For those who had had previous appraisals, only one out of 12 in our survey reported that the process had been valuable.

There is a Tower Hamlets performance management accountability framework, which was last updated on 15 March 2022. Managers reported that they received good support from their human resources colleagues and understood what was expected of them when managing performance. Our conversations with a range of staff, however, reflected concerns that poor performance was not being dealt with appropriately.

Are arrangements for learning and development comprehensive and responsive?

Currently, most case managers in the YJS are qualified probation officers. A training needs analysis was undertaken, but this was completed by staff and not their line managers. It is not clear what the analysis identified and what training has been put in place as a result.

Some bespoke training has been provided to support the resettlement needs of black and Asian minority ethnic children in the youth justice system. This training is currently being used to inform the development of the resettlement policy. This is a good example of learning being used well to support improvement. All staff can access the Supporting Families Division learning offer (2022-2023) which has been designed to strengthen knowledge and skills of working with children and families across the division. All 11 volunteers who completed our survey praised the training opportunities they had received. However, many staff considered that the borough's in-house training that they could access was far too generic.

Disappointingly, the YJS has not been proactive in carrying out learning reviews from all four serious further incidents that had occurred in the past 12 months. Following the appointment of a head of service, the most recent incident was reviewed, and this is encouraging. However, we would expect all serious incidents to be reviewed and learning integrated into practice.

Employment opportunities are advertised openly in the borough and all staff can apply for vacancies.

Do managers pay sufficient attention to staff engagement?

Only six out of 11 staff who completed our staff survey believed that the YJS strongly motivated them to contribute to the delivery of a high-quality service. In contrast, all 11 volunteers who completed the survey reported that the YJS motivated them to fulfil their roles as volunteers.

There is a council-wide annual staff survey to which staff contribute. Views are sought in a dynamic way but some staff (five out of 12 in our survey) report that they are not always listened to and there is little point in them investing their time to give their views. Nine out of 13 staff who completed our survey reported that their views about working for the YJS were not regularly sought.

The recognition of good practice is mostly through informal means, such as affirmation at team meetings and good news stories. Staff can be nominated for council awards (including a social work academy award), but this method is not often used. In 2020, the YJS court team received the best team of the year award from the director in children's social care. We were only able to identify one other example of a YJS staff member being nominated for an award.

There are a range of policies to ensure the safety and wellbeing of staff. Resources include direct line management support, reflective supervision, and access to the council's staff support scheme. Most staff report that their resilience comes from peer support and not from what is provided by the YJS.

During the pandemic, the YJS was responsive in providing laptops and mobile phones to all staff. Most staff had risk, health and safety assessments completed and this ensured that their particular needs were met. A small number of staff, however, reported that they waited for some time before adjustments were made, with some still waiting 12 months later.

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

Caseload characteristics[15]

Percentage of current caseload with mental health issues	25.4%
Percentage of current caseload with substance misuse issues	54.2%
Percentage of current caseload with an education, health and care plan	18.6%

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

Is there a sufficiently comprehensive and up-to-date analysis of the profile of children, used by the YOT to deliver well-targeted services?

The YJS has access to a range of management information, but its reliability is questionable, as shown in the evidence across a range of characteristics we were provided with in advance. This leads us to question the accuracy of other management information used and held by the YJS, such as analysis linked to desistance needs, safety and wellbeing, diversity, and patterns of sentencing. It is disappointing that these obvious errors had not been picked up by the YJS when submitting its evidence in advance to us. Senior leaders and managers have been made aware of our findings and we are encouraged to learn that a strategic decision has now been taken to employ a dedicated data analyst who will be directly attached to the YJS, rather than the current corporate analyst role in the council.

Some data has been produced on disproportionality, but the YJS does not use the YJB disproportionality toolkit. Access to under-18 stop-and-search data from the police is now available and this can be used to analyse disparities. Meetings to explore any issues in policing have not yet been embedded. Furthermore, out-of-court disposal disproportionality data has not been consistently broken down by ethnicity to consider any differences in outcome for different groups of children.

The YJS has developed its own self-assessment tool to better understand the voice of children. This is a positive initiative and will support the child-first approach to enable children to flourish.

Does the YOT partnership provide the volume, range and quality of services and interventions required to meet the needs of all children?

There is good access to specialist and mainstream services and interventions, in particular health and education, to meet the desistance needs of children. Each child subject to a YJS intervention, both statutory and non-statutory, is on the roll at a school and has an education officer, who tracks all YJS children (pre- and post-16) to ensure their education and training needs are met. Advocacy for children at risk of exclusion or reduced timetables is good.

[15] Data supplied by YJS but may be inaccurate.

The YJS is part of a wider London resettlement pathway development initiative and is involved in the pilot for the London accommodation resettlement pathway supporting children leaving custody. This work will enhance the resettlement needs of children.

The Compass Safe East drugs service is valued by staff, and children are referred appropriately. We found evidence of this work in our case reviews. The Safe East worker is present in the Mulberry YJS town hall office every Monday. This visibility has increased referrals to the service and provided staff with active support.

The Step Forward counselling service is used well. The counsellor is able to see children in custody and the community. This provides continuity of care to address safety and wellbeing needs. The speech and language therapy (SaLT) and children and adolescent mental health services (CAMHS) provisions within the YJS are both accessible and strong.

The Ether programme, supporting black and minority ethnic young men, and the Streets of Growth[16] initiative provide meaningful and targeted interventions for children. These programmes are evaluated to measure impact.

The Breaking the Cycle of Youth Violence project, which uses the whole-family model, adds value and is a promising initiative with a strong evidence base. Given the worrying pattern of youth violence in the localities covered by Tower Hamlets and City of London YJS, this is a timely initiative.

There is a lack of evidence of consistent meaningful victim work, and reparation projects are limited. The review and evaluation of service provision across the YJS is underdeveloped, but children are asked to provide feedback on the services they have received. For example, when they begin a health intervention, their needs are rated and then reviewed regularly to see what change has occurred. This helps children to appreciate the progress they are making so that they can build on their strengths and protective factors.

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

The YJS is part of a national task force pilot, in collaboration with the Department for Education, in which a dedicated multidisciplinary team works with children attending the pupil referral unit (PRU) – London East Alternative Provision (LEAP). The team consists of a YJS case manager, SaLT, CAMHS, social worker, family worker, and other service providers. The aim of the project is to provide a robust support network to work directly with children at LEAP. Here, partnership arrangements are well established and work well.

The YJS police officers provide daily briefings, but inspectors noted little evidence of their footprint in the casework we reviewed. This gap needs to be examined.

The information-sharing agreement document relating to Multi Agency Public Protection Arrangements (MAPPA) requires updating. This needs to be reviewed urgently to ensure that information-sharing arrangements are fit for purpose.

The education worker and health staff are actively involved in working with and supporting children. Case managers appreciate the input they provide. Relationships with children's social care are described as not always positive, although they are improving. There is a sense that thresholds are too high when considering YJS

[16] http://www.streetsofgrowth.org

children whose vulnerability is not always recognised. Some YJS staff report that they are not consistently invited to strategy meetings, which makes the management of risk difficult.

The YJS does not have its own risk management panel or process to address safeguarding and public protection concerns. This impacts negatively on risk management planning and YJS oversight of the management of risk. While there are procedures to engage YJS operational staff with meetings where safety and wellbeing (children's social care) and risk of harm (exploitation team) are addressed, these have not been communicated or understood well by staff. This means that not all staff know what they are required to do. It is the responsibility of managers to communicate expectations effectively and monitor how well actions are being applied. Given the number of serious further incidents in the past 12 months, it is essential that learning is captured and applied.

The YJS is part of the court users' group. There have been opportunities for YJS staff to deliver presentations to group members on a range of topics affecting the children they are working with.

Involvement of children and their parents or carers

The YJS uses a range of formal and informal processes to collect and analyse the views of children and their parents or carers. Notably, the self-assessment tool that has been internally developed provides dynamic information and enables staff to respond to the needs of children in 'live' time. Practitioners are enthusiastic about using feedback to inform their interventions.

As part of the inspection process, children are invited to participate in a text survey, and those whose cases are inspected are offered the opportunity to speak to an inspector to give their feedback. Inspectors spoke to nine children. They all knew what the YJS was trying to do to help them and felt that their workers had the right skills to do the work. Our findings showed that, while most of the children were happy with their workers and the services they were receiving, there were areas of development for the YJS.

- Young people who were working would prefer late evening reporting.
- Children would like their workers to be punctual.
- Children would like better consistency in their scheduling of appointments and venues.

More positively, children reported that their workers were respectful, kind, knowledgeable, and spent time talking with them and understanding them. Additionally, staff were polite, flexible, and helpful.

One child said:

> *"She says positives to help me think positively."*

And another child said:

> *"She done awesome. She done a good job. I was previously incarcerated and she referred me to intensive supervision. It really helped me and I worked at Amazon for a bit and got other jobs. I'm really pleased."*

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.	Inadequate

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

Do the policies and guidance in place enable staff to deliver a high-quality service, meeting the needs of all children?

The YJS does not have comprehensive up-to-date policies to support staff to deliver effective services to children, and the policies it does have, have not always been communicated well. Just under half of the staff (five out of 11) who completed our survey expressed a lack of robust clarity in their understanding of some policies and, in particular, what was expected of them.

The YJS does not have a policy register to record all policies available and their required review dates. This has contributed to some policies being out of date.

The safety and wellbeing and risk of harm policies are in draft and do not, in their current design, set out effective processes for managing safety and wellbeing and risk of harm. These policies were produced very recently, in March 2022. Some staff do not understand their role in relation to the exploitation team, even though a high number of YJS children will be experiencing or at risk of exploitation. Staff were unclear about thresholds and criteria for referral to the exploitation team and the Multi Agency Risk Panel (MARP).

The policy on lone working and personal safety is clear but again it is not current, dating from 2019. A management oversight guide was produced in March 2022, but this is not comprehensive and needs to be reviewed.

Staff are mostly able to access the right services from partners and providers where there are good historic relationships. Many, however, were unsure about access to the exploitation team. Additionally, although the director of education reported that staff could access the services of an educational psychologist, staff were unaware of this pathway.

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

Staff meet and see children in a variety of settings and raised no concerns about these arrangements. The amalgamation of the Youth Service and the YJS has made more venues available, and this is appreciated by staff, children, and their parents or carers alike. Referral order panels are always held in the town hall.

The YJS uses a document 'Safe areas vs dangerous areas' to determine the best and safest places to see children. In our case reviews, we found several examples of children being seen in different venues given their vulnerabilities and anxieties about safety.

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

Access to the ChildView 5.1.0 case management system is quick and staff can find case material easily. This enables them to make timely entries, plan and use information to deliver services. They also have access to MOSAIC, the case management system used by children's social care. However, management information about individual casework delivery and performance has not been available for the past four months following the departure of the data analyst. Staff had been advised that this information was critical in monitoring their work and they had to use it. They are now puzzled that this information is no longer available, and it is not clear when it will be. Any gaps could mean risk of harm work not receiving effective oversight and thus potentially leaving children and victims at risk.

Youth justice case managers have access to the Microsoft Office suite (Teams, Outlook, Word, Excel etc). All 11 YJS staff in our survey believed the ICT they were provided with was helping them to deliver quality services to children. Partners within the YJS can access each other's case management systems and where this is not possible alternative arrangements, for example emails, are used well.

Are analysis, evidence and learning used effectively to drive improvement?

Performance is not understood well given the unreliability of data and the absence of live performance information. It is disappointing that this business area had not been identified as a high priority until after this inspection.

With the exception of the countersigning of work and pre-sentence report (PSR) assurance, there are very few robust quality assurance and auditing processes to support service improvement. Until February 2022, and most worryingly, there was no process or framework for responding to serious incidents or further serious offences.

No audits had been undertaken until March 2022, when Wardell Associates reviewed out-of-court disposal work. It is too early to assess any impact from the findings of this review, but there is demonstrable commitment to using the findings from our inspection to create a baseline for improvement with, for example, immediate reviews of the street community resolution offer, the effectiveness of the scrutiny panel, data on FTEs, communications with staff, and consolidating safety and risk policies and procedures.

Diversity

Throughout our standards, we expect a personalised and responsive approach for all children, which includes taking account of their diversity and protected characteristics. Those factors may influence our judgements in specific standards. Here, we present an overall summary of the approach to diversity that we found in this YJS.

The YJS has introduced a new written PSR format for courts. This focuses on giving the background and personal circumstances of the child at the beginning of the report before introducing their offending behaviour. This promotes better attention to their individual circumstances, lived experience, and diversity needs.

The annual Ronke Martins-Taylor Memorial Award, set up after the death of the council's divisional director of children's services in 2021, recognises young people working with the YJS who have achieved change through their strength of character and support offered to them. The YJS submits nominations to celebrate achievements.

The YJS has a disproportionality action plan and practice guide. It has made the tackling of disproportionality a strategic priority and has agreed to focus on a range of topics, including the language used in court reports, prevention, links to Early Help, and building stronger connections with community organisations.

YJS staff have completed an ethnicity disproportionality deep-dive analysis to better understand the structural barriers experienced by the children they are supervising. The review found variable treatment in the receipt of free school meals and exclusion, for example.

Given the unreliability of data that we found during this inspection, it is not possible to be fully confident about the YJS's disproportionality data and progress made at a strategic level.

The translation and interpreting services are impressive and used appropriately to support engagement with children and their parents or carers. The YJS has access to several information leaflets that have been translated into different languages.

An improved self-assessment tool, which is completed by children, has been introduced. This includes more targeted questions on diversity and has given practitioners new information to respond better to the diversity needs of children.

Trauma-informed practice (linked to experiences of prejudice) and cultural awareness training modules are now more aligned with the specific needs of children from different backgrounds.

We found several examples in our case reviews where practitioners had held sensitive conversations about racism and the impact prejudice had had on the children they were supervising. These conversations had resulted in better engagement and had been valued by children.

The Ether programme for black and minority ethnic young men is being used well and there has been some evaluation (in June and December 2021) to consider its impact.

The Tower Hamlets Inequality Commission was set up in 2020 following the death of George Floyd in the USA to help improve the life experiences of black, Asian, and minority ethnic residents. It has generated an increase in conversations about inequality and experiences of children from different backgrounds. Staff have used self-disclosure appropriately to speak with children about their own experiences of trauma and the impact on them following the death of George Floyd. This has empowered children to talk about their own lived experiences of racism.

2. Court disposals

We took a detailed look at 16 community sentences managed by the YJS. We also conducted 16 interviews with the relevant case managers. We examined the quality of assessment; planning; implementation and delivery of services; and reviewing. Each of these elements was inspected in respect of work done to address desistance, keeping the child safe and keeping other people safe.

Our key findings about court disposals are as follows.

Strengths

- Assessment work to understand why children had offended was strong.
- Practitioners took account of the child's strengths and protective factors, as well as their level of maturity and willingness to change.
- Planning to support the child's desistance was good.
- Case managers engaged children and their parents or carers meaningfully in planning.
- Case managers focused on developing and maintaining an effective relationship with children and their parents or carers.
- Attention to and response to diversity needs was a strength in casework.

Areas for improvement

- When assessing a child's safety and wellbeing and risk of harm to others, staff need to be much more disciplined in identifying and analysing the risks to and from the child.
- The concerns and risks relating to actual and potential victims were not consistently considered when planning to address the risk of harm to others, leading to victim work being overlooked.
- Not enough services were delivered to prevent children from causing harm to others.
- Staff did not consistently set out contingency arrangements to manage the child's safety and wellbeing and their risk of harm to others.
- Guidance to support safety and wellbeing work was incomplete.
- There was not enough effective joint working to support risk of harm work.
- Managers' oversight of work was often not effective.

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

2.1. Assessment

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

Our rating[17] for assessment is based on the following key questions:

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	88%
Does assessment sufficiently analyse how to keep the child safe?	**75%**
Does assessment sufficiently analyse how to keep other people safe?	81%

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

Assessment work to support children in desisting from further offending was well embedded. Practitioners took a forensic approach, and this gave them good access to current and historical information. Diversity needs and personal circumstances were understood well. Notably, we found that practitioners had made positive use of information held by other agencies in 15 out of the 16 cases we inspected. The accessing of information from partners within the YJS was particularly good. Additionally, practitioners had properly reviewed the child's level of maturity.

Practitioners included the voice of children and their parents or carers to inform what they believed were the reasons behind the child's offending and other behaviours.

One inspector noted:

> *"The assessment details the index offence of the theft of bicycles as part of a wider pattern of acquisitive offending. This is useful in terms of the context. The case manager outlines a previous triage for theft (again stealing a bicycle) as well as pending offences for further thefts. There is good analysis of offending around the child's attitude to money. The assessment of desistance includes all of the areas I would expect to see, including his disengagement from school, with a preference for seeking employment to earn money."*

Does assessment sufficiently analyse how to keep the child safe?

Assessment activity sought to identify the child's safety and wellbeing needs in 11 out of the 16 inspected cases. Practitioners gathered relevant assessment information held by other agencies appropriately in 14 out of the 16 reviewed cases. Inspectors did not agree with three out of 16 classifications by practitioners of safety and wellbeing. Furthermore, not all assessments included an analysis of controls and interventions to promote the safety and wellbeing of the child. Attention to vulnerability was often overlooked.

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

Does assessment sufficiently analyse how to keep other people safe?

Assessments to identify all relevant factors linked to keeping other people safe were stronger. We found that in 12 out of 15 cases, practitioners had explained the nature of the risk and who was at risk of harm to others. This helped children to recognise the potential harm they could cause to others. Assessment work did not always draw on information held by other agencies, especially external partners. This meant that critical information was often missed. We agreed with all the risk classifications in the 16 reviewed cases, which was reassuring.

2.2. Planning

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

Our rating[18] for planning is based on the following key questions:

	% 'Yes'
Does planning focus sufficiently on supporting the child's desistance?	88%
Does planning focus sufficiently on keeping the child safe?	**56%**
Does planning focus sufficiently on keeping other people safe?	63%

Does planning focus on supporting the child's desistance?

Planning to support children to not commit further offences was positive. In 14 out of the 16 cases reviewed, there were timely plans that robustly identified what work needed to be delivered. In 15 out of the 16 cases, planning had taken account of the child's personal circumstances, including their broader familial environment. More account should have been taken of the child's strengths and level of maturity to engage with the services identified.

Does planning focus sufficiently on keeping the child safe?

Planning to keep children safe was variable and weak. Too often case managers did not understand what was expected of them. This confusion meant that not all children received the most suitable plans to keep them safe. In seven out of 15 cases, planning did not sufficiently promote or address safety and wellbeing risks to children. Additionally, much more liaison was needed with other agencies to ensure that planning activity was aligned with clear areas of responsibility identified. It was disappointing to find that the necessary controls and interventions to support safety and wellbeing were absent in five out of the 15 inspected cases. Furthermore, contingency planning was poor in too many cases. Children's circumstances can change very rapidly, and it is essential that this is understood when determining the work that will be delivered.

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

Does planning focus sufficiently on keeping other people safe?

Planning to keep other people safe was marginally better but, again, practice was not consistent. In five out of 15 cases, not enough attention had been given to promoting the safety of other people and addressing risk of harm factors. Equally, the needs of victims did not feature as a high enough priority in far too many cases. This omission runs the risk that important work is not carried out. Additionally, there was an absence of controls to manage risk of harm in five out 15 cases, and contingency planning was similarly poor.

One inspector noted:

> *"The plan involves work around conflict resolution, use of weapons and risk of violence. However, it does not include any controls to protect the victim and refers to previous bail conditions which had expired on sentence. Furthermore, the contingency arrangements are too generic and overlook measures to address any arising conflict situations."*

2.3. Implementation and delivery

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

Our rating[19] 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?	88%
Does the implementation and delivery of services effectively support the safety of the child?	69%
Does the implementation and delivery of services effectively support the safety of other people?	**63%**

Does the implementation and delivery of services effectively support the child's desistance?

The implementation and delivery of work to help children not reoffend was an area of strength. We found that in 14 out of the 16 inspected cases, the delivered services were the most appropriate ones to support desistance. Pleasingly, case managers had considered the diversity needs of children, which we do not always find across our inspections. Attention paid by practitioners enabled greater participation and ensured that services were tailored to meet the specific needs of children. There was good involvement with parents or carers, and this enabled the wider familial context to be better understood. Interventions were delivered from a position of building on strengths, and opportunities for community integration were maximised.

[19] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

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

Work in this area was not consistent. Inspectors found that in four out of 15 reviewed cases, services delivered were not always contributing to keeping children safe. This was in part due to practitioners often being unclear about what was expected of them, especially in working with statutory partners. Leaders and managers need to do much more to help practitioners recognise their responsibilities.

One inspector noted:

> *"It is unclear how well supported the child was regarding exploitation and this appears to have been an oversight. Gaps in this area at an earlier stage meant that concerns around the child's continued exploitation were not responded to and this may have contributed to the further offence. The child's family were very open to parenting support, but this was not offered. There was a missed opportunity to involve parents."*

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

The delivery of services to support the safety of others was again not consistent. Too often, the practitioner had not paid adequate attention to protecting the needs of victims. This failure is a worry and needs to be rectified urgently. In six out of 15 cases, the involvement of other agencies to manage the risk of harm to others was not coordinated well. This was in part due to some information-sharing and joint working protocols being out of date.

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[20] 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?	**56%**

Does reviewing focus sufficiently on supporting the child's desistance?

The reviewing of work to judge the impact of interventions on reducing reoffending was comprehensive. Practitioners carried out both formal and informal reviews.

[20] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

Consideration of protective factors and diversity needs, as well as a robust examination of personal and familial circumstances, were all evident in casework.

In 13 out of 14 inspected cases, children's motivation was consistently reviewed and the barriers that were identified were addressed appropriately. Discussion with children and their parents or carers was generally facilitated well. This helped practitioners to better understand the children's wider experiences and empowered parents or carers to become involved in their children's supervision.

One inspector noted:

> *"The plan was reviewed and has been condensed from seven objectives to four. The language used is more child friendly and is clear in terms of what is expected of the child, using 'I will' sentences. The case manager informed me that the child had picked most of the objectives and that she encouraged him to include the ETE [education, training, and employment] objective. He is portrayed as motivated to attend his impending college course, but feedback was given in interview to think about what additional support he might need to make college a success."*

Does reviewing focus sufficiently on keeping the child safe?

The quality of reviewing activity in keeping children safe was inconsistent in the cases reviewed. Where necessary, reviewing did not routinely respond to changes linked to safety and wellbeing, information was not gathered from other agencies that were involved, and plans were not adjusted to support the continuity of work. This meant that case managers had limited understanding of the changing wellbeing needs of the children.

Does reviewing focus sufficiently on keeping other people safe?

Reviewing did not consistently respond appropriately to changes in the personal and wider circumstances of children, which did not support informed changes in plans to protect others from harm. Of particular concern was the absence of effective information gathering and sharing, particularly with the police.

3. Out-of-court disposals

We inspected nine cases managed by the YJS that had received an out-of-court disposal. These consisted of seven youth conditional cautions, one community resolution and one other disposal. We interviewed the case managers in nine cases.

We examined the quality of assessment; planning; and implementation and delivery of services. Each of these elements was inspected in respect of work done to address desistance, work to keep the child safe and work to keep other people safe. The quality of the work undertaken for each factor needs to be above a specified threshold for each aspect of supervision to be rated as satisfactory.

We also inspected the quality of policy and provision in place for out-of-court disposals, using evidence from documents, meetings, and interviews.

Strengths

- Assessment activity analysing and supporting desistance was largely done well in the inspected cases.
- Attention to diversity needs and personal circumstances in most aspects of casework was good.
- Work carried out built on the strengths and protective factors of children.

Areas for improvement

- The current out-of-court disposal policy was produced in March 2022 and needs to be embedded into practice.
- Planning for work to support the safety and wellbeing of the child and keep others safe was poor.
- The quality of work that supports desistance was variable.
- The delivery of work to keep children safe and prevent them from causing harm to others was poor.
- The coordination of work by YJS practitioners where other agencies were involved was not effective.
- Contingency planning needs to be evident so that the arrangements for managing a child's risk of harm to others is clear.

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

3.1. Assessment

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

Our rating[21] for assessment is based on the following key questions:

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	78%
Does assessment sufficiently analyse how to keep the child safe?	**56%**
Does assessment sufficiently analyse how to keep other people safe?	**56%**

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

Overall, assessment work analysing why children had offended was variable. In three out of the nine inspected cases, practitioners had not fully assessed the child's acknowledgment of responsibility, attitudes towards, and reasons behind their offending behaviour. This meant that practitioners did not always understand how adverse childhood experiences and experiences of trauma may have contributed to children's offending.

The level of attention practitioners paid to the role that diversity had played in the children's offending was encouraging. They had invested time in building a clearer picture of the child's lived experience and cultural background. The pace of interaction was good, and children were made to feel comfortable in disclosing personal information. This was evidenced in our interviews with children.

Case managers did not actively seek information from external agencies, which we found in three out of the nine inspected cases. In these instances, vital information was overlooked, and this led to practitioners having only a partial picture of the child. They missed information relating to patterns in previous behaviour, links to significant life events, and responses to services received.

Assessment activity to understand levels of maturity, capacity, and motivation to change was primarily done well (seven out of nine inspected cases). Here, self-assessment questionnaires, information from parents or carers, and education records were used to identify the likelihood that a child would and could respond to different interventions. Motivation to change was an area that was particularly well explored. Not only did practitioners ask children and their parents or carers questions, but we also found evidence that their views had been included in the assessment process. This was illustrated in all nine inspected cases.

[21] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

Does assessment sufficiently analyse how to keep the child safe?

Assessment work that clearly identifies and analyses risks to the child's safety and wellbeing was weak and needs to improve. We found that in four out of nine inspected cases, this area of work had failed to take accurate account of risks to the safety and wellbeing of the child. This may have been due to some staff having variable knowledge and skills, but we expect managers to provide effective oversight to highlight these gaps. While practitioners generally commented that they had the right skills, we found that this was not the case in safety and wellbeing work.

Not all assessment activity involved gathering, analysing, and integrating information held by other sources, particularly from statutory partners. We found this to be the case in five out of the nine inspected cases. This area of work needs to be improved, because if critical information is missed, this is likely to lead to a child experiencing further harm.

One inspector noted:

> *"Information within the safety and wellbeing plan provided by children's social care is not fully incorporated by the case manager. While issues around potential exploitation are mentioned, the full impact of these risks is not fully analysed or understood. Safety and wellbeing concerns are underestimated and therefore assessing to keep the child safe is insufficient."*

Encouragingly, we agreed with eight out of nine decisions that case managers made about their risk classification of safety and wellbeing. However, the gaps in information led to 'non-comprehensive' safety and wellbeing assessments.

Does assessment sufficiently analyse how to keep other people safe?

In four out of seven inspected cases, assessments did not clearly identify and analyse the risk of harm to others posed by the child. This included a failure to identify who was at risk and the nature of that risk. This is concerning, and attention is needed to ensure that others are protected from harm. Too often assessments lacked depth and breadth. Once again, information from other sources, including plans held by children's social care, had not been accessed in four of the nine inspected cases. This meant that information remained too descriptive and not sufficiently analytical to support the protection of actual and potential victims from harm properly.

One inspector noted:

> *"Assessment identifies most offending behaviours but fails to analyse who is at risk, the nature of the risk and circumstances around when harm could occur. Assessment mainly focuses on the child's needs around substance misuse and driving under the influence of alcohol, rather than the risk of serious harm that could be inflicted on others, for example, using a weapon to make threats, this being the reason for the making of a youth conditional caution (YCC)."*

3.2. Planning

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

Our rating[22] for planning is based on the following key questions:

	% 'Yes'
Does planning focus on supporting the child's desistance?	67%
Does planning focus sufficiently on keeping the child safe?	**33%**
Does planning focus sufficiently on keeping other people safe?	56%

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

Planning to support the child's desistance was variable. Not all plans included the key interventions, who would deliver these services, and the expected timescale for completion. We found these gaps in four out of the nine inspected cases. The sequencing of services was often chaotic. However, a range of interventions had been identified and these had been modified and personalised during the pandemic. For example, some activity was completed independently, and some casework was delivered through 'walking and talking'.

Again, planning that incorporated information on diversity and personal circumstances was good. This ensured that plans were meaningful and directly relevant to meeting the children's needs.

In eight out of the nine inspected cases, practitioners had explained clearly how the interventions would build on the child's strengths and achievements and support personal growth. This was mostly determined jointly with children and their parents or carers.

Practitioners had spent meaningful time with most of the children they were supervising, which gave them access to considerable amounts of information. This helped them to assess how likely children were to comply with interventions and how willing they were to engage with specific services. While this practice was not evident in all the inspected cases, it showed that most practitioners' engagement skills were well developed.

The identification of mainstream services in the community was encouraging. In all nine inspected cases, this work had been done well. While the pandemic presented difficult challenges to all practitioners, they nevertheless worked creatively to ensure that children and their parents or carers knew what was available.

Does planning focus sufficiently on keeping the child safe?

Planning for work to support the safety and wellbeing of children was insufficient. It did not promote and address safety and wellbeing risks adequately in four out of the nine inspected cases. In these cases, there was not enough evidence to satisfy inspectors that all staff fully understood the need for comprehensive plans that would support keeping children safe. The information in plans often lacked detail. Additionally, practitioners had not always accessed information held by other

[22] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

agencies. This was poor practice and again created gaps in critical knowledge to keep children safe. This needs to be addressed urgently.

Contingency planning is essential in keeping up with the quickly changing circumstances of children. We were disappointed to find that contingency arrangements were limited. More attention is needed to ensure that all plans include measures that can be quickly introduced when circumstances change.

Does planning focus sufficiently on keeping other people safe?

Planning for work to keep other people safe was not consistently done well. We found that in three out of eight cases inspected, not enough priority was given to addressing the risk of harm to others. This inconsistency needs to be overcome to ensure that others are kept safe from potential harm. The involvement of other public protection agencies in planning, for example the police and the exploitation team, needs to be much better coordinated.

Contingency planning in four out of eight inspected cases was poor and too often the absence of arrangements led to the potential for further harm to be caused to others. Given the earlier deficits in the assessment of safety and wellbeing and risk of harm to others, it is unsurprising that similar deficits were repeated in this area. More comprehensive assessments are likely to support better planning to manage harm to actual and potential victims.

3.3. Implementation and delivery

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

Our rating[23] for implementation and delivery is based on the following key questions:

	% 'Yes'
Does service delivery effectively support the child's desistance?	56%
Does service delivery effectively support the safety of the child?	**44%**
Does service delivery effectively support the safety of other people?	67%

Does service delivery focus sufficiently on supporting the child's desistance?

Services delivered to support desistance were not consistent. In four of the nine inspected cases, interventions were not addressing the desistance needs of children. Much of the contact involved reviewing and updating information on personal circumstances. There was some evidence that worksheets were completed, and examination of offending behaviour took place, but the range of interventions used was limited. Understanding behaviour work needs to be more central to supervision, and broader familial and social context considerations need to be acknowledged. Not enough attention was paid to exploring the impact that other services were having, for example, drugs and alcohol services.

[23] The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. See Annexe 2 for a more detailed explanation.

Does service delivery focus sufficiently on keeping the child safe?

Service delivery failed to support keeping the child safe in four out of the nine inspected cases. Work with partners to keep children safe was limited and coordination of this work was done well in only three out of nine cases. This is a worrying finding and needs urgent attention. Earlier shortfalls in assessment and planning for this work were having a negative impact on service delivery. The YJS does not have a comprehensive range of assurance and gatekeeping systems. Managers did not always use the countersigning process effectively to alert practitioners to gaps in this area of work. This needs to be improved.

Does service delivery focus sufficiently on keeping other people safe?

In four out of eight inspected cases, not enough services were delivered to keep other people safe. The attention paid to the needs of potential and actual victims was worryingly weak.

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.	Inadequate

In making a judgement about out-of-court disposal policy and provision, we take into account the answers to the following questions:

Is there a policy in place for out-of-court provision that promotes appropriate diversion and supports sustainable desistance?

There is a locally agreed out-of-court disposal policy with the police, supported by operational procedures. The policy was revised in March 2022 and now needs to be embedded into practice. While there is a commitment to joint decision-making, some staff believe that the process has been driven by the police historically, and this is seen as a concern moving forward. Panel members have been able to provide information they hold about children, but it is not clear how much this has influenced decision-making.

The out-of-court disposal eligibility criteria in the revised arrangements are clearly defined, but historical evidence shows that the YJS has primarily used youth conditional cautions (YCCs). It is not clear why this has occurred and what motivated this. Far too many children (first-time entrants) enter statutory supervision directly when diversion may have been more suitable.

There is no recorded escalation process in the out-of-court disposal policy, although we were advised what happens operationally when there is disagreement. No staff could recall that an issue had been escalated in the past 12 months. A formal escalation process is needed to ensure fair outcomes for all children.

The policy distinguishes between community resolutions (triage) and formal out-of-court disposals, but the application of the former to date is not fully understood or implemented well.

The principles and reasons behind diverting children into the most appropriate care and support services are contained in the policy, although more detail on fairness would be helpful. Attention to diversity is good, but more guidance is needed to

ensure that the right information is gathered to support the most appropriate personalised interventions.

Arrangements to ensure safety and wellbeing and safety of others are now explicit. However, the findings from our case reviews showed that this area of work was at present by far the weakest and most concerning.

Does out-of-court disposal provision promote diversion and support sustainable desistance?

The YJS has an out-of-court disposal panel consisting of the police, YJS managers, case prevention officers, and staff from education, the youth service, early help, and health. This arrangement has been in place for some time.

Given the absence of accurate reporting data, it is not possible to conclude with confidence whether decisions are made in a timely manner and leading to effective diversion supporting a child-first approach.

While there are arrangements at a strategic level to ensure that out-of-court disposals are applied consistently, there are significant gaps in the implementation of triage disposals. For example, we were advised that all children stopped for being in possession of cannabis were referred to Safe East for an intervention. Safe East told us that they had not received a single referral from the police since they were commissioned to provide this service in August 2021. This has meant that children have not been receiving the interventions they need to support their desistance and safety and wellbeing.

All the interventions available to children on statutory orders are available to those receiving out-of-court disposals. Interventions are mostly strengths-based and there is a screening process to ensure children receive services that build on their strengths and protective factors.

Provision does not pay enough attention to keeping children and other people safe. This is a serious concern and practice needs to improve immediately.

Are the out-of-court disposal policy and provision regularly assessed and updated to ensure effectiveness and maintain alignment with the evidence base?

The out-of-court disposal provision has not been assessed or evaluated for effectiveness in a timely manner. Given the unreliability of data, with some exceptions (such as education), it is not possible to conclude with confidence what difference out-of-court work is making for all children.

Partners can provide casework information on the progress children are making with their agencies.

Outcomes linked to ethnicity are not evaluated systematically. This means that there is a gap in management information, and it is not always known what disproportionality issues may be present.

The first out-of-court disposal panel under the new arrangements was due to meet in May 2022.

There is an urgent need to review the work of the scrutiny panel and we are pleased that this was due to take place in May 2022. Currently, its effectiveness is unclear. The guidance notes for the process of managing scrutiny panels date from November 2020.

4. 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 YJS that had received a custodial sentence. Our key findings were as follows.

Strengths

- The YJS has a 'custody and resettlement procedures and good practice' guidance document which includes the Youth Justice Board's seven resettlement pathways.
- There was a positive focus on developing a prosocial identity, especially cultural identity.
- Suitable accommodation for children being released from custody was available.
- There are effective relationships between YJS and custodial staff.
- A YJS practitioner has a designated responsibility for overseeing resettlement work.

Areas for improvement

- Guidance to support effective resettlement work needs to be enhanced. For example, in addressing structural barriers.
- More clarity was needed to enable practitioners to carry out effective safety and wellbeing and risk of harm work.
- The needs of victims were not covered well.
- Escalation procedures were underdeveloped.
- Information exchange between the police and the YJS did not always take place and was not timely.
- Reviewing of resettlement arrangements needs to be better organised and implemented.
- There needs to be wider consultation with children and their parents or carers to understand the impact of resettlement arrangements.
- A strategic plan is needed to ensure that the policy meets the resettlement needs of all children.

We gathered evidence for this standard from documents and meetings and inspected two cases to allow us to illustrate the qualitative standards. We do not provide a separate rating for the quality of work in resettlement cases inspected under this standard. In making a judgement about resettlement policy and provision, we take into account the answers to the following three questions:

Is there a resettlement policy in place that promotes a high-quality, constructive and personalised resettlement service for all children?

The YJS has a 'custody and resettlement procedures and good practice' guidance document, which was reviewed in March 2022. The resettlement policy sets out the YJB's seven pathways, which include accommodation, education, training, and employment, healthcare and other services. The YJS has access to the London accommodation pathway finder manual (March 2022), but most staff were largely unaware of this.

There was reference to structural barriers a child may have or is experiencing, but there is limited guidance on how these should or could be overcome. There is a good focus on prosocial identity, especially the need to promote and consolidate cultural identity. Attention to raising and acknowledging diversity needs is good but there is not enough guidance on what actions should or could be taken to support children from diverse backgrounds.

Resettlement work promotes an individualised approach, is strengths-based and future-oriented. Arrangements for effective information exchange with partners and stakeholders are integrated into the policy and we found some evidence of this in the casework we reviewed.

Safeguarding and public protection concerns are identified in the policy, but the language and guidance notes need to be more tailored to the needs of children, specifically their safety and wellbeing. The needs of victims are not covered well in the policy. This is a concerning omission and was evident in the cases we reviewed.

There is no escalation guidance to support staff achieve positive outcomes for all children when partners fail to respond as they should.

Does resettlement provision promote a high-quality, constructive and personalised resettlement service for all children?

In the casework reviewed, we found that suitable accommodation was in place for those children who were about to leave custody. There had been good liaison with parents or carers throughout the custodial period. This ensured that housing needs were given a high priority.

The continuity of education provision from custody to community was encouraging. In one case, the education worker had met and liaised with the child in custody to secure a college interview on release. There had been good advocacy, and this led to a placement being secured. Similarly, in the same case, counselling that had taken place in custody was continued by the same practitioner on release.

Staff involved in resettlement work maximised continuity of work started in custody. For example, working on goals identified by the child through completing interventions, such as the A-Z goal-setting programme.

Resettlement panel meetings add value to the needs of children. There is good representation and actions are agreed and generally implemented well. This helps children to progress through their sentence.

In the past 12 months, staff have received specific resettlement training. This has included inputs into examining the resettlement policy, seven pathways to resettlement, and victim needs. More work is needed in the latter area, as we found little evidence of priority to victim needs.

There needs to be more timely information exchange between the YJS and the police regrading all children to ensure that public protection issues are consistently managed appropriately.

Are resettlement policy and provision regularly assessed and updated to ensure effectiveness and maintain alignment with the evidence base?

The YJS has assigned a case manager to lead on resettlement work. The policy has recently been produced but with very little consideration given to the evaluation of the current provision. Additionally, children and their parents or carers need to be consulted about the impact that the provision has had on them. This will lead to informed change.

Annexe 1: Methodology

HM Inspectorate of Probation standards

The standards against which we inspect youth offending services are based on established models and frameworks, which are grounded in evidence, learning, and experience. These standards are designed to drive improvements in the quality of work with children who have offended.[24]

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

Domain one: organisational delivery

The youth offending service submitted evidence in advance and the Chief Executive delivered a presentation covering the following areas:

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

During the main fieldwork phase, we conducted 25 interviews with case managers, asking them about their experiences of training, development, management supervision, and leadership. We held various meetings, which allowed us to triangulate evidence and information. In total, we conducted 14 meetings, including with managers, partner organisations, and staff. The evidence collected under this domain was judged against our published ratings characteristics.[25]

Domain two: court disposals

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

We examined 16 court disposals. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of five), and we ensured that the ratios in relation to gender, sentence or disposal type, risk of serious harm, and risk to safety and wellbeing classifications matched those in the eligible population.

Domain three: out-of-court disposals

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

[24] HM Inspectorate's standards are available here: https://www.justiceinspectorates.gov.uk/hmiprobation/about-our-work/our-standards-and-ratings/

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

We examined nine out-of-court disposals. The sample size was set based on the proportion of out-of-court disposal cases in the YJS.

Resettlement

We completed case assessments over a one-week period, examining two case files and interviewing case managers, in cases where children had received custodial sentences or been released from custodial sentences four to 12 months earlier. This enabled us to gather information to illustrate the impact of resettlement policy and provision on service delivery. Where necessary, interviews with other people significantly involved in the case also took place.

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

Annexe 2: Inspection data

In this inspection, we conducted a detailed examination of a sample of 16 court disposals and nine out-of-court disposals. In each of those cases, we inspect against standards regarding assessment, planning and implementation/delivery. For court disposals, we also look at reviewing. For each standard, inspectors answer a number of key questions about different aspects of quality, including whether there was sufficient analysis of the factors related to offending; the extent to which young offenders were involved in assessment and planning; and whether enough was done to assess the level of risk of harm posed, and to manage that risk. We reviewed a further two cases to obtain data to illustrate our findings about resettlement policy and provision.

To score an 'Outstanding' rating for the sections on court disposals or out-of-court disposals, 80 per cent or more of the cases we analyse have to be assessed as sufficient. If between 65 per cent and 79 per cent are judged to be sufficient, then the rating is 'Good' and if between 50 per cent and 64 per cent are judged to be sufficient, then a rating of 'Requires improvement' is applied. Finally, if less than 50 per cent are sufficient, then we rate this as 'Inadequate'. Resettlement cases are not separately rated; the data is for illustrative purposes only.

The rating for each standard is aligned to the banding at the key question level where the lowest proportion of cases were judged to be sufficient, as we believe that each key question is an integral part of the standard. Therefore, if we rate three key questions as 'Good' and one as 'Inadequate', the overall rating for that standard is 'Inadequate'.

Lowest banding (proportion of cases judged to be sufficient key question level)	**Rating (standard)**
Minority: <50%	Inadequate
Too few: 50-64%	Requires improvement
Reasonable majority: 65-79%	Good
Large majority: 80%+	Outstanding ☆

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

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

Domain one standards, the qualitative standard in domain three (standard 3.4) and the resettlement standard (standard 4.1) are judged using predominantly qualitative evidence.

The resettlement standard is rated separately and does not influence the overall YOT rating. We apply a limiting judgement, whereby any YOT that receives an 'Inadequate' rating for the resettlement standard is unable to receive an overall 'Outstanding' rating, regardless of how they are rated against the core standards. Where there are no relevant resettlement cases, we do not apply a rating to resettlement work.

Data from inspected cases:[26]

2.1. Assessment (court disposals)	
Does assessment sufficiently analyse how to support the child's desistance?	
a) Is there sufficient analysis of offending behaviour, including the child's attitudes towards and motivations for their offending?	**88%**
b) Does assessment sufficiently analyse diversity issues?	**75%**
c) Does assessment consider personal circumstances, including the wider familial and social context of the child?	**88%**
d) Does assessment utilise information held by other agencies?	**94%**
e) Does assessment focus on the child's strengths and protective factors?	**88%**
f) Does assessment analyse the key structural barriers facing the child?	**56%**
g) Is enough attention given to understanding the child's levels of maturity, ability and motivation to change, and their likelihood of engaging with the court disposal?	**81%**
h) Does assessment give sufficient attention to the needs and wishes of victims, and opportunities for restorative justice?	**69%**
i) Are the child and their parents or carers meaningfully involved in their assessment, and are their views taken into account?	**81%**
Does assessment sufficiently analyse how to keep the child safe?	
a) Does assessment clearly identify and analyse any risks to the safety and wellbeing of the child?	**69%**
b) Does assessment draw sufficiently on available sources of information, including other assessments, and involve other agencies where appropriate?	**88%**
c) Does assessment analyse controls and interventions to promote the safety and wellbeing of the child?	**69%**
Does assessment sufficiently analyse how to keep other people safe?	

[26] Some questions do not apply in all cases.

a) Does assessment clearly identify and analyse any risk of harm to others posed by the child, including identifying who is at risk and the nature of that risk?	**75%**
b) Does assessment draw sufficiently on available sources of information, including past behaviour and convictions, and involve other agencies where appropriate?	**81%**
c) Does assessment analyse controls and interventions to manage and minimise the risk of harm presented by the child?	**69%**

2.2. Planning (court disposals)	
Does planning focus sufficiently on supporting the child's desistance?	
a) Does planning set out the services most likely to support desistance, paying sufficient attention to the available timescales and the need for sequencing?	**88%**
b) Does planning sufficiently address diversity issues?	**63%**
c) Does planning take sufficient account of the child's personal circumstances, including the wider familial and social context of the child?	**94%**
d) Does planning take sufficient account of the child's strengths and protective factors, and seek to reinforce or develop these as necessary?	**88%**
e) Does planning take sufficient account of the child's levels of maturity, ability and motivation to change, and seek to develop these as necessary?	**75%**
f) Does planning give sufficient attention to the needs and wishes of victims?	**50%**
g) Are the child and their parents or carers meaningfully involved in planning, and are their views taken into account?	**88%**

Does planning focus sufficiently on keeping the child safe?	
a) Does planning promote the safety and wellbeing of the child, sufficiently addressing risks?	**50%**
b) Does planning involve other agencies where appropriate, and is there sufficient alignment with other plans (e.g. child protection or care plans) concerning the child?	**63%**
c) Does planning set out the necessary controls and interventions to promote the safety and wellbeing of the child?	**63%**
d) Does planning set out necessary and effective contingency arrangements to manage those risks that have been identified?	**69%**

Does planning focus sufficiently on keeping other people safe?	
a) Does planning promote the safety of other people, sufficiently addressing risk of harm factors?	**63%**
b) Does planning involve other agencies where appropriate?	**75%**
c) Does planning address any specific concerns and risks related to actual and potential victims?	**44%**
d) Does planning set out the necessary controls and interventions to promote the safety of other people?	**63%**
e) Does planning set out necessary and effective contingency arrangements to manage those risks that have been identified?	**63%**

2.3. Implementation and delivery (court disposals)	
Does the implementation and delivery of services effectively support the child's desistance?	
a) Are the delivered services those most likely to support desistance, with sufficient attention given to sequencing and the available timescales?	**88%**
b) Does service delivery account for the diversity issues of the child?	**88%**
c) Does service delivery reflect the wider familial and social context of the child, involving parents or carers, or significant others?	**100%**
d) Does service delivery build upon the child's strengths and enhance protective factors?	**94%**
e) Is sufficient focus given to developing and maintaining an effective working relationship with the child and their parents or carers?	**100%**
f) Does service delivery promote opportunities for community integration, including access to services post-supervision?	**94%**
g) Is sufficient attention given to encouraging and enabling the child's compliance with the work of the YOT?	**88%**
h) Are enforcement actions taken when appropriate?	**69%**
Does the implementation and delivery of services effectively support the safety of the child?	
a) Does service delivery promote the safety and wellbeing of the child?	**69%**
b) Is the involvement of other organisations in keeping the child safe sufficiently well-coordinated?	**63%**

Does the implementation and delivery of services effectively support the safety of other people?	
a) Are the delivered services sufficient to manage and minimise the risk of harm?	**56%**
b) Is sufficient attention given to the protection of actual and potential victims?	**50%**
c) Is the involvement of other agencies in managing the risk of harm sufficiently well-coordinated?	**56%**

2. 4. Reviewing (court disposals)	
Does reviewing focus sufficiently on supporting the child's desistance?	
a) Does reviewing identify and respond to changes in factors linked to desistance?	**88%**
b) Does reviewing focus sufficiently on building upon the child's strengths and enhancing protective factors?	**81%**
c) Does reviewing include analysis of, and respond to, diversity factors?	**63%**
d) Does reviewing consider the personal circumstances, including the wider familial and social context of the child?	**88%**
d) Does reviewing consider motivation and engagement levels and any relevant barriers?	**81%**
e) Are the child and their parents or carers meaningfully involved in reviewing their progress and engagement, and are their views taken into account?	**81%**
f) Does reviewing lead to the necessary adjustments in the ongoing plan of work to support desistance?	**75%**
Does reviewing focus sufficiently on keeping the child safe?	
a) Does reviewing identify and respond to changes in factors related to safety and wellbeing?	**56%**
b) Is reviewing informed by the necessary input from other agencies involved in promoting the safety and wellbeing of the child?	**63%**
c) Does reviewing lead to the necessary adjustments in the ongoing plan of work to promote the safety and wellbeing of the child?	**50%**
Does reviewing focus sufficiently on keeping other people safe?	
a) Does reviewing identify and respond to changes in factors related to risk of harm?	**63%**

b) Is reviewing informed by the necessary input from other agencies involved in managing the risk of harm?	**44%**
c) Does reviewing lead to the necessary adjustments in the ongoing plan all of work to manage and minimise the risk of harm?	**44%**

3.1. Assessment (out-of-court disposals)	
Does assessment sufficiently analyse how to support the child's desistance?	
a) Is there sufficient analysis of offending behaviour, including the child's acknowledgement of responsibility for, attitudes towards and motivations for their offending?	**67%**
b) Does assessment sufficiently analyse diversity issues?	**89%**
c) Does assessment consider personal circumstances, including the wider familial and social context of the child?	**78%**
d) Does assessment utilise information held by other agencies?	**67%**
e) Does assessment focus on the child's strengths and protective factors?	**89%**
f) Does assessment analyse the key structural barriers facing the child?	**56%**
g) Is sufficient attention given to understanding the child's levels of maturity, ability and motivation to change?	**78%**
h) Does assessment give sufficient attention to the needs and wishes of victims, and opportunities for restorative justice?	**33%**
i) Are the child and their parents or carers meaningfully involved in their assessment, and are their views taken into account?	**100%**
Does assessment sufficiently analyse how to keep the child safe?	
a) Does assessment clearly identify and analyse any risks to the safety and wellbeing of the child?	**56%**
b) Does assessment draw sufficiently on available sources of information, including other assessments, and involve other agencies where appropriate?	**44%**
Does assessment sufficiently analyse how to keep other people safe?	
a) Does assessment clearly identify and analyse any risk of harm to others posed by the child, including identifying who is at risk and the nature of that risk?	**33%**
b) Does assessment draw sufficiently on available sources of information, including any other assessments that have been completed, and other evidence of behaviour by the child?	**56%**

3.2. Planning (out-of-court disposals)	
Does planning focus on supporting the child's desistance?	
a) Does planning set out the services most likely to support desistance, paying sufficient attention to the available timescales and the need for sequencing?	**56%**
b) Does planning sufficiently address diversity issues?	**89%**
c) Does planning take sufficient account of the child's personal circumstances, including the wider familial and social context of the child?	**89%**
d) Does planning take sufficient account of the child's strengths and protective factors, and seek to reinforce or develop these as necessary?	**89%**
e) Does planning take sufficient account of the child's levels of maturity, ability and motivation to change, and seek to develop these as necessary?	**67%**
f) Does planning take sufficient account of opportunities for community integration, including access to mainstream services following completion of out-of-court disposal work?	**100%**
g) Does planning give sufficient attention to the needs and wishes of the victims?	**22%**
h) Are the child and their parents or carers meaningfully involved in planning, and are their views taken into account?	**88%**
Does planning focus sufficiently on keeping the child safe?	
a) Does planning promote the safety and wellbeing of the child, sufficiently addressing risks?	**56%**
b) Does planning involve other agencies where appropriate, and is there sufficient alignment with other plans (e.g. child protection or care plans) concerning the child?	**33%**
c) Does planning include necessary contingency arrangements for those risks that have been identified?	**67%**

Does planning focus sufficiently on keeping other people safe?	
a) Does planning promote the safety of other people, sufficiently addressing risk of harm factors?	**56%**
b) Does planning involve other agencies where appropriate?	**56%**
c) Does planning address any specific concerns and risks related to actual and potential victims?	**22%**

d) Does planning include necessary contingency arrangements for those risks that have been identified?	**44%**

3.3. Implementation and delivery (out-of-court disposals)	
Does service delivery effectively support the child's desistance?	
a) Are the delivered services those most likely to support desistance, with sufficient attention given to sequencing and the available timescales?	**56%**
b) Does service delivery account for the diversity issues of the child?	**67%**
c) Does service delivery reflect the wider familial and social context of the child, involving parents or carers, or significant others?	**78%**
d) Is sufficient focus given to developing and maintaining an effective working relationship with the child and their parents or carers?	**78%**
e) Is sufficient attention given to encouraging and enabling the child's compliance with the work of the YOT?	**78%**
f) Does service delivery promote opportunities for community integration, including access to mainstream services?	**89%**
Does service delivery effectively support the safety of the child?	
a) Does service delivery promote the safety and wellbeing of the child?	**56%**
b) Is the involvement of other agencies in keeping the child safe sufficiently well utilised and coordinated?	**33%**

Does service delivery effectively support the safety of other people?	
a) Are the delivered services sufficient to manage and minimise the risk of harm?	**44%**
b) Is sufficient attention given to the protection of actual and potential victims?	**22%**