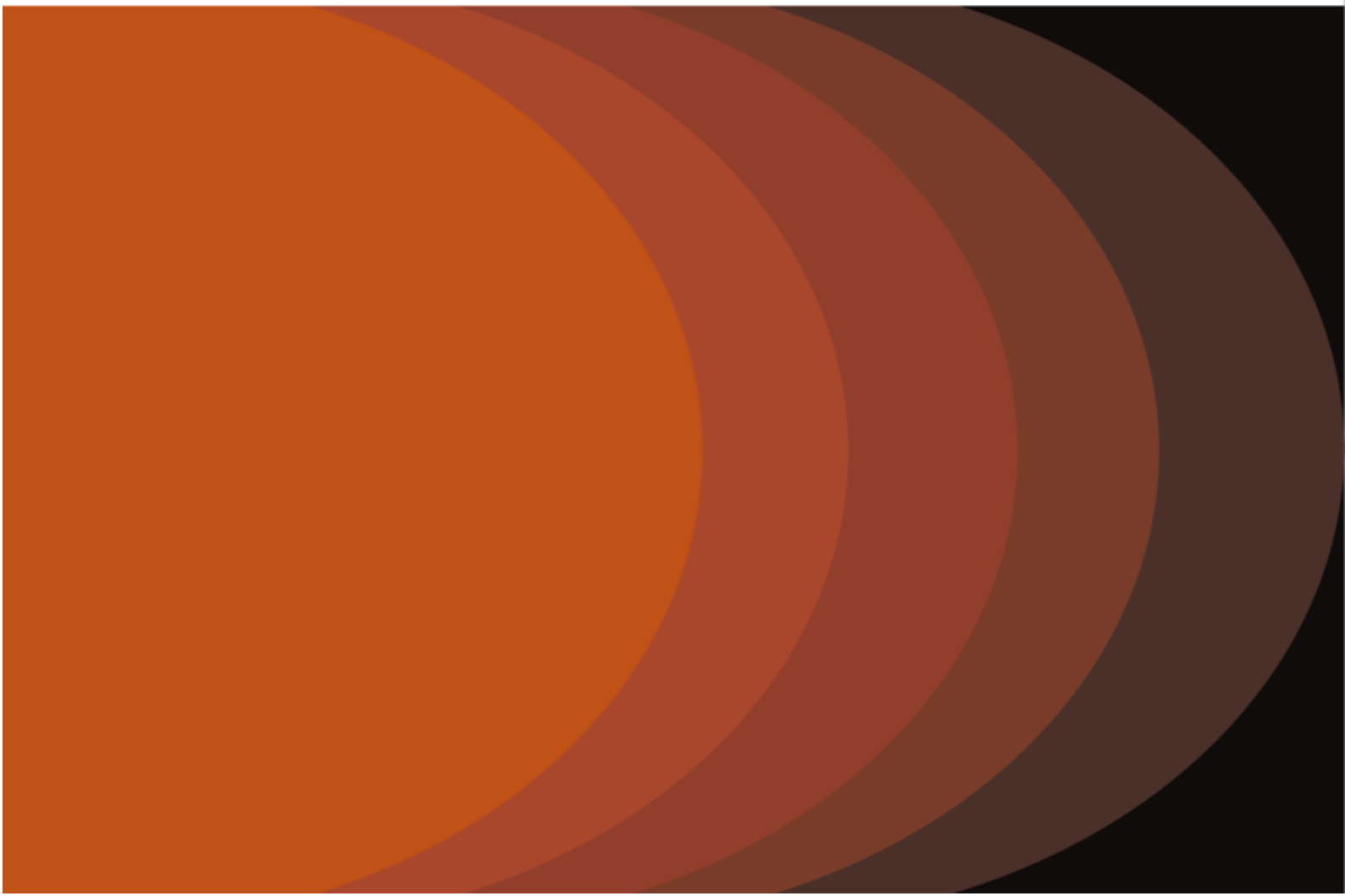
Her Majesty's Inspectorate of Probation

An inspection of youth offending services in

Cheshire Youth Justice Service

HM Inspectorate of Probation, December 2021



Acknowledgements

This inspection was led by HM Inspector Yvonne McGuckian, supported by a team of inspectors and colleagues from across the Inspectorate. HM Inspectorate of Probation was joined by colleague inspectors from police, health, social care and education. 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.

ISBN: 978-1-914478-34-5

This publication is available for download at:

www.justiceinspectorates.gov.uk/hmiprobation

Published by:

Her Majesty's Inspectorate of Probation
1st Floor Civil Justice Centre
1 Bridge Street West
Manchester
M3 3FX

Follow us on Twitter @hmiprobation

Contents

Foreword **4**
Ratings **5**
Executive summary **6**
Recommendations **10**
Background **11**
Contextual facts **13**
1. Organisational delivery **16**
1.1. Governance and leadership 17
1.2. Staff 20
1.3. Partnerships and services 23
1.4. Information and facilities 26
2. Court disposals **28**
2.1. Assessment 29
2.2. Planning 31
2.3. Implementation and delivery 33
2.4. Reviewing 35
3. Out of court disposals **37**
3.1. Assessment 38
3.2. Planning 39
3.3. Implementation and delivery 41
3.4. Joint working 42
Annex 1: Methodology **44**
Annex 2: Inspection results **47**

Foreword

This inspection is part of our four-year programme of youth offending service (YOS) inspections. We have inspected and rated Cheshire Youth Justice Service 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, Cheshire was rated as 'Good'.

This joint inspection, assessing the quality of work by the Youth Justice Service, highlights a clear ambition for children, sustained and effective partnerships, and generally sound operational delivery. Cheshire has achieved the highest score of any of the joint inspections undertaken with colleague inspectors from the police, health, social care and education that we have completed to date.

The board was highly effective in setting out the priorities for the service, which managers and staff have been able to translate into the services delivered to and available for children. Board members were clear in their roles and responsibilities and ensured they took appropriate steps to understand the needs of children who came into contact with the service.

We noted several strengths, including the ability of managers to establish and maintain effective partnerships with four different local authorities. This has been sustained over time and remained consistent during periods of significant change, including the Covid-19 pandemic. The cooperation and shared culture of learning across the partnership were evident, leading to a service that used evidence and research effectively in the development and delivery of services. This had positive benefits for children, including excellent access to health services and support to remain in education, training or employment.

Staff formed good relationships with children, understanding the factors that had led them to offend, and we were pleased to find that the needs of children and victims were both given priority.

There are some areas for the partnership to consider which could enhance the service children receive. These include clarification around the deployment and use of police officers within the service, to ensure that the current provision fits with mandated guidance and is effective in supporting the service to deliver high-quality work with children.

The range and access to suitable buildings which meet children's needs should be reviewed. There are limited places to work with children and victims, and it is our assessment that this is having a detrimental impact on case work. This has been exacerbated by Covid-19 but was also an issue prior to the pandemic.

There is a positive pathfinder programme in place to divert children from the criminal justice system. However, funding for this is not yet part of the mainstream YJS budget. It is important that the partnership proactively considers how to ensure the strong diversionary practice through the programme is sustained.

In this report we make a number of recommendations, which, if implemented, we hope will support Cheshire to continue to deliver a high-quality service for children.

Justin Russell
Chief Inspector of Probation

Ratings

Cheshire Youth Justice Service		Score	26/36
Overall rating		**Good**	
1.	**Organisational delivery**		
1.1	Governance and leadership	**Outstanding**	
1.2	Staff	**Good**	
1.3	Partnerships and services	**Good**	
1.4	Information and facilities	**Good**	
2.	**Court disposals**		
2.1	Assessment	**Good**	
2.2	Planning	**Requires improvement**	
2.3	Implementation and delivery	**Good**	
2.4	Reviewing	**Good**	
3.	**Out-of-court disposals**		
3.1	Assessment	**Good**	
3.2	Planning	**Good**	
3.3	Implementation and delivery	**Outstanding**	
3.4	Joint working	**Outstanding**	

Executive summary

Overall, Cheshire YJS is rated as: 'Good'. This rating has been determined by inspecting it in three areas of its work, referred to as 'domains'. We inspect against 12 'standards', shared between the domains. The standards are based on established models and frameworks, which are grounded in evidence, learning and experience. They are designed to drive improvements in the quality of work with children who have offended.[1] Published scoring rules generate the overall YOS rating.[2] The findings and subsequent ratings in those domains are described below. Our fieldwork was conducted between 12 and 16 July 2021, and 26 and 30 July 2021. We note the case sample and the inspection all occurred during the period of Covid-19, and Cheshire had maintained strong service delivery despite the challenges the pandemic presented.

1. Organisational delivery

Organisational delivery was very strong. Governance and leadership have been rated as 'Outstanding', and staffing, partnerships and services, and information and facilities have all been rated as 'Good'. Cheshire YJS has a complex set of partnership arrangements. The management board and management team have worked consistently well in establishing and maintaining positive professional relationships and partnerships that support them to deliver effective services to children.

Cheshire YJS covers four local authorities: Cheshire East, Cheshire West and Chester, Halton, and Warrington. There are 185 sites that provide education and 79 care homes. Twenty per cent of YJS cases had child in care or care leaver status as at April 2021. The YJS borders 15 other local authorities and is close to Manchester, Liverpool and Birmingham. There is one police force, Cheshire Constabulary, and a wide range of health providers. This picture is not static, and managers, staff, and partners make considerable efforts to ensure any changes cause minimal disruption to service delivery.

A few issues need addressing to enable the YJS to flourish and build on its rating of 'Good', most notably the lack of clarity around the role and tasking processes of police officers and the need to define these more clearly in line with statutory guidance. Accommodation and accessing safe and suitable places to see children are also areas requiring development. While the YJS has developed some workarounds, longer-term solutions are needed. The board will need to consider the implications of these and explore how to rectify them as a priority.

We were impressed with the YJS's use of evidence and academic research to inform and develop practice and services. This is some of the strongest we have seen.

We interviewed the YOT manager and the chair of the management board. We held meetings with other members of the board and key stakeholders. Inspectors from the Care Quality Commission, Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

[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 0–36, which is banded to produce the overall rating, as follows: 0–6 = 'Inadequate', 7–18 = 'Requires improvement', 19–30 = 'Good', 31–36 = 'Outstanding'.

and inspectors with education and social care expertise were part of our inspection team. They interviewed stakeholders and reviewed some of the work in cases we had assessed in the first part of our inspection. They looked in detail at how partners supported the YJS's work.

Key findings about organisational delivery are as follows:

- the board has a clear and agreed vision and strategy for the children that the YJS works with. The vision is shared across the partnership and has been translated effectively into service delivery. This vision recognises that, in the early stages, children's outcomes are better if they are diverted from the justice system. It also recognises the importance of a child-first approach, while ensuring the impact of crime on victims is not minimised
- this positive, child-focused culture is embedded across the many partner organisations working with the YJS. The YJS values its arrangements with partners, providers and agencies, and works hard at all levels to maintain effective relationships and pathways into services. The scale of this task is significant, and some initiatives take shape over a long period of time. The maturity of the partnerships and willingness to challenge each other are strengths
- staff from all agencies demonstrated good knowledge, skills and experience. All staff were passionate about their work and dedicated to delivering a child-focused service. Staff were flexible and innovative in their approach to supporting children, building trust-based and therapeutic relationships
- local, regional and national evidence is used to review and revise services. We found such examples across the partnership, aided by mature and open relationships. We identified numerous examples of the use of learning to improve practice, including learning from inspections and reviews. The YJS uses research effectively to guide service delivery.

But:

- a lack of clarity around the deployment and use of police officers within the service has led to confusion around how the current provision fits with mandated guidance, and raised questions regarding the effectiveness of the police role in supporting the service to deliver high-quality work with children
- the YJS uses community venues, including children's centres, youth clubs and libraries, to see children. However, in some areas, it can be hard to find a suitable space and staff have reported challenges in finding appropriate venues and confidential places to work with children. It is noted the Covid-19 pandemic has exacerbated some of these issues. Previously used venues also now have reduced capacity, which is presenting additional pressures.

2. Court disposals

We took a detailed look at 31 community sentences and three custodial sentences managed by the YJS. We also conducted 33 interviews with the relevant case managers. We examined the quality of assessment; planning; implementation and delivery of services; and reviewing. We inspected each of these elements in respect of work done to address desistance. For services to keep the child safe, we assessed the quality of planning and implementation and delivery in the 30 cases where we expected meaningful work to take

place. Similarly, for work to keep others safe, we assessed the quality of planning and implementation and delivery in the 28 cases where meaningful work was required.

In this service, work to support desistance was the strongest area: 74 per cent of cases met all our quality requirements for assessment, 85 per cent for planning and 88 per cent for implementation and delivery. The quality of assessment, planning and review of safety and wellbeing and risk of harm to others was more mixed. Assessment and planning for work to address safety and wellbeing issues met our standards in 68 per cent and 67 per cent of cases respectively; but planning to address the safety of others was only sufficient in 54 per cent of cases, leading to a rating of 'Requires improvement' for that standard. Although reviewing of work to address desistance met our standards in 83 per cent of cases, reviewing of work to manage the safety and wellbeing of the child and the safety of others was sufficient in only 65 and 71 per cent of cases respectively.

Our key findings about court disposals are as follows:

- the delivery of interventions to manage and respond to desistance and safety and wellbeing factors is strong and staff focus on this consistently. We saw some good joint work with social workers, education providers and staff in residential homes
- health interventions are a strength, and all children are offered a health assessment
- assessments are detailed and analytical, and planning to meet children's desistance needs is supported by specialist assessments, including of speech and communication needs; education, training and employment; and mental health
- staff carry out appropriate assessment of the needs and wishes of victims. Victim awareness sessions for children and restorative justice for victims are embedded in practice
- delivery of interventions is well sequenced and tailored to meet individual needs. Children receive support from a range of professionals who build trusting and positive relationships with them
- most children attend school and are supported to maintain their attendance. This is a key desistance factor.

But:

- management oversight of cases classified as medium risk of harm is not fully effective
- planning to manage risk of harm needs to improve so that it is specific to the individual risks posed and contains clear actions that would need to be taken if the child's circumstances were to change
- assessments should consider the needs and experiences of black, Asian and minority ethnic children. Staff need support to speak to children with confidence about any discrimination they have faced and to understand issues of self-identity
- there is limited support for children who are exploited and a lack of work to proactively target perpetrators, to break the cycle of abuse.

3. Out-of-court disposals

We inspected 23 cases managed by the YJS that had received an out-of-court disposal. These consisted of two youth conditional cautions, two youth cautions, and 18 community resolutions. We also reviewed one case where the outcome was no further action, but an assessment had been undertaken, a plan produced, and interventions delivered. We interviewed the case managers in the 23 cases.

We examined the quality of assessment; planning; and implementation and delivery of services. Each of these elements was inspected in respect of work done to address desistance. For the 12 cases where there were factors related to harm, we also inspected work done to keep other people safe. In the 20 cases where safety and wellbeing concerns were identified, we looked at work done to safeguard the child. We also looked at the quality of joint working with local police in the two youth conditional caution cases.

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

- staff undertake insightful, well-evidenced and analytical assessments of the reasons that children offend and the risks they pose to others
- there is good use of out-of-court disposals to prevent children from entering the criminal justice system
- all children can access the same wide range of support services, regardless of the type of contact they have with the YJS
- interventions are proportionate to need and delivered quickly
- plans take the child's views and wishes into account
- staff maintain good contact and engagement with parents throughout the case
- exit planning is proactive and enables children to access services in the community once contact ends.

But:

- staffing on the Divert team is stretched and some cases are allocated to staff who are not sufficiently experienced to manage them
- the out-of-court decision-making process needs to be reviewed, with a consistent police officer involved to resolve delays and ensure effective joint work is undertaken
- contingency planning to manage safety and wellbeing is inconsistent, and sometimes underestimates the issues faced by the child
- support for children who are exploited is underdeveloped; staff rely too much on the child's and parents' ability to manage the risks. There needs to be an effective multi-agency response to reduce the risks of exploitation, which targets and disrupts perpetrators.

Recommendations

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

The Cheshire Youth Justice Service should:

1. work with the police to make sure that there is police representation at all risk management meetings and the role of the police is consistently considered in all appropriate cases, to ensure risks are effectively managed
2. work with the management board to ensure funding for Divert is part of the mainstream YJS budget, to enable its success to be sustained
3. provide effective management oversight that improves the planning to manage risk of harm to others, especially in medium-risk cases.

Cheshire Constabulary should:

4. clarify the roles and tasking priorities of police officers to ensure they effectively support the work of the YJS in line with national guidance, including decision-making for out-of-court disposals
5. ensure that all seconded police staff are skilled, knowledgeable, and trained, particularly with regards to safeguarding and child exploitation, to increase their effectiveness in their role within the YJS.

The chair of the management board should:

6. provide staff with safe, confidential and accessible places to work with children.

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. We use the terms child or children to denote their special legal status and to highlight the obligations of relevant agencies such as social care, education and health to meet their safety and wellbeing needs.

YOTs are statutory partnerships, and they are multi-disciplinary, 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; however, this can vary.

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

Cheshire has a complex set of partnership arrangements, including 185 sites that provide education and 79 children's residential homes. Approximately 750 children from out of the area are placed in Cheshire. Twenty per cent of YJS cases involve children who are in care or have care leaver status (April 2021). The YJS borders 15 other local authorities with proximity to Manchester, Liverpool and Birmingham. Transport links are exceptional, and this drives some of the county lines issues.

The area is predominantly white, with white people making up 96 per cent of the population. The traveller community has a presence in some areas of the county.

The YJS in its current form, covering Cheshire East, Cheshire West and Chester, Halton, and Warrington, has existed since November 2016. Before that, there were several versions of the service (Halton and Warrington, and Halton, Warrington and Cheshire West). The design of a single pan-Cheshire service was constrained to some extent by the existing structures and legacies of human resources/staffing arrangements.

Cheshire has a single police force covering the whole area and the YJS is coterminous with the police, probation services and courts. This has enabled it to achieve some economies of scale and has been beneficial for service delivery and the quality of work in some areas. However, the added complexity of working with four local authorities, four safeguarding partnerships, four community safety partnerships and multiple health providers has not been without its challenges in an area of approximately 1,000 square miles, with a population of 1.1 million and over 250,000 children.

Cheshire YJS covers some urban areas of deprivation (Widnes, Runcorn and parts of Warrington, Chester, Crewe and Macclesfield), as well as large rural areas and a collection of smaller towns, such as Winsford, Northwich and Congleton.

The volume of work and demands on services fluctuate and are not always evenly distributed across the four local authorities. This means the YJS is not simply four 'mini YOTs' and must have a more flexible and nuanced operational delivery model. It is currently

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

organised into several cluster areas (north, south, east and west) so that case managers and colleagues 'only' have to deal routinely with two of the four local authority areas. A small number of specialist workers cover all of Cheshire. This includes workers who supervise harmful sexual behaviour, and the Divert team (out-of-court disposals), which works across Cheshire but links children to the applicable local authority early help or children's social care departments as required.

Delivering a shared service across multiple local authorities is complex and challenging, not least because of the need to access multiple (and different) children's services information management systems. The plethora of systems and access passwords is an ongoing issue, but the YJS's ChildView case management system and all YJS staff laptops and iPhones are supported by Halton Borough Council, which allows for levels of consistency of approach.

Contextual facts

Youth justice information

163	First-time entrant rate per 100,000 in Cheshire YJS[4]
207	First-time entrant rate per 100,000 in England and Wales
40.5%	Reoffending rate for Cheshire YJS[5]
38.5%	Reoffending rate in England and Wales[6]

Population information[7]

1,066,647	Total population in local authority (June 2020)
97,544	Total youth population (10–17 years) in local authority (June 2020)

Caseload information[8]

Age	**10–14**	**15–17**
Cheshire YJS	23%	77%
National average	22%	78%

Race/ethnicity	**White**	**Black and minority ethnic**	**Unknown**
Cheshire YJS	96%	5%	0%
National average	69%	28%	3%

Gender	**Male**	**Female**
Cheshire YJS	86%	14%
National average	85%	15%

[4] Youth Justice Board. (2019). *First time entrants, January 2019 – December 2019.*

[5] Ministry of Justice. (2019). *Proven reoffending statistics, January 2018 – December 2018.*

[6] Youth Justice Board. (2019). *Youth Justice annual statistics: year to year.*

[7] Office for National Statistics. (2019). *UK Population estimates, mid-2018.*

[8] Youth Justice Board. (2019). *Youth Justice annual statistics: year to year.*

Additional caseload data[9]

215	**Total current caseload, of which:**
83	Court disposals
132	Out-of-court disposals

Of the 83 court disposals

81	Total current caseload on community sentences
2	Total current caseload in custody
4	Total current caseload on licence

Of the 132 out-of-court disposals

68	Total current caseload with youth caution
6	Total current caseload with youth conditional caution
68	Total current caseload: community resolution or other out-of-court disposal

Education and child protection status of caseload

14.7%	Current caseload 'Looked After Children' resident in the YOT area
10.4%	Current caseload 'Looked After Children' placed outside the YOT area
5.5%	Current caseload with child protection plan
19%	Current caseload with child in need plan
3%	Current caseload aged 16 and under not in school/pupil referral unit/alternative education
17.8%	Current caseload aged 16 and under in a pupil referral unit or alternative education
41.9%	Current caseload aged 17+ not in education, training or employment

For children in the inspected cases subject to court disposals[10]

Offence types[11]	%
Violence against the person	56%
Burglary	9%
Fraud and forgery	3%
Arson	3%

[9] Information supplied by Cheshire YJS. Figures do not add up to 100 due to rounding.

[10] Figures do not add up to 100 due to rounding.

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

Criminal damage	3%
Drug offences	18%
Summary motoring offences	9%

1. Organisational delivery

We found a strong, clear-sighted board and management team that had translated the shared vision for children into effective service delivery. There were many examples of innovation and understanding, and the evidence base for the YJS's work was a strength. The open and mature relationships at senior level enabled challenge and promoted the needs of this cohort of children.

Strengths:

- Governance and leadership were excellent, with many examples of cooperative work between the four local authorities and numerous partners.
- The partners had a clear and shared vision for the service, which had been effectively translated into practice.
- Board members were appropriately focused on practice and service delivery, as well as maintaining strategic oversight and partnership links.
- Staff were well trained, knowledgeable and committed to working with children and families.
- Partnerships, although complex, worked well together to provide a wide range of services.

Areas for improvement:

- The lack of identified YJS police officer resource is a gap in staffing.
- There are insufficient suitable, safe and accessible premises for staff to meet children and victims.
- The response to child exploitation is underdeveloped. Parents and children need better targeted support.

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.	Outstanding

Key data[12]

Total projected budget for the current financial year – 2020/2021	£2,801,086 (of which YJB Good Practice Grant £1,003,017)[12]

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

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

The board has set a clear and agreed vision and strategy for children who encounter the YJS. This is predicated on evidence that, in the early stages, children's outcomes are better if they are diverted from the justice system. The vision balances a child-first approach with ensuring that the impact of crime on victims is not minimised. The strategy has been shared across the partnership, with each of the four local authorities and numerous partners implementing the overarching strategy in line with locally set priorities. The vision has been translated effectively into the services delivered. Two examples of strategic innovation are the YJS being awarded pathfinder status due to the success of the Divert programme and the use of academic research.

The board and YJS management team have made considerable efforts to maintain relationships and to embed the YJS's culture across many partners and over a sustained period. This has taken time and commitment. It has resulted in the YJS developing initiatives over time and sustaining its approaches, despite changes within the partnership.

The board is effective, challenging and well run by members. The board chair is well engaged and a strong advocate for the YJS. Challenge is encouraged and recognised as a strength. The board membership includes an academic who focuses and informs its work, so that decisions are in line with the evidence base. Membership is reviewed, and changes made to improve attendance and representation.

The membership of the board is appropriate and representative of the various partners. Members have the right level of authority to make effective strategic decisions, for example on resource allocation. The recent appointment of a new education representative is intended to improve oversight of this important aspect of multi-agency work.

There is a strong emphasis on health care throughout the service. Health care is represented at the board by a person of the correct seniority to make decisions. This board member chairs a health subgroup and a community of interest with health staff working within the YJS. Both provide the board member with excellent information on operational and strategic work.

Education, training and employment (ETE) feature well in the YJS's broader statutory priorities. The board's priorities are aligned with the needs of the service and wider priorities

[12] Information supplied by YOT.

set by partners. The board understands that ETE are key desistance factors and gives them priority. The board has been able to balance competing demands and has taken a proactive approach in leading some areas of practice. One of the examples is the work undertaken by the YJS and the police to reduce the number of children excluded from school for possession of weapons. Most school-age children are in some form of provision: most are in school, and just three per cent are not in any form of education. The situation for those aged over 17 is not as positive, with 42 per cent not in employment or training.[13] This figure has increased as a result of the Covid-19 pandemic.

Managers and the board are self-aware and put in place measures to assess the quality and impact of provision and sharpen their own oversight. We found various examples where the board had used audits well to help them focus on aspects of service delivery. In 2020 the management team completed an ETE audit, which accurately identified strengths and areas for improvement.

The work of the board is visible to staff across the partnership.

Do the partnership arrangements actively support effective service delivery?

We found evidence of some excellent support from partner organisations, which was making a difference to children. Health services provided strong representation on the board. The current representative has developed a number of proactive methods of overseeing the quality of work with, and needs of, this group of children. These included chairing quarterly health meetings with respective trust managers, health practitioners and the YJS health lead. As a result of this meeting, staff have developed their own groups to share best practice and review consistency. The board member had also attended meetings with Child and Adolescent Mental Health Service (CAMHS) staff and meetings to consider children at high risk of harm to familiarise himself with the work of the YJS. This translated into several benefits for the service, including a fully staffed health care team. An increase in the number of speech and language therapists has meant improved access to the service and better outcomes for children. The team is highly experienced, motivated, passionate and flexible. We found an excellent health offer for children across Cheshire, irrespective of postcode, from the point of arrest to after sentencing, including examples of health transition plans for when children were no longer supervised by the YJS.

Although there is a lack of clarity around the police officer roles within the YJS team itself, the police nevertheless provide significant support for youth justice services across Cheshire through the Complex Youth team (pre-criminalisation), Navigate (high-risk children within the YJS), child sexual exploitation and criminal exploitation coordinators, and problem-solving teams in local policing units.

We heard of good initiatives to prevent the unnecessary criminalisation of children, which were not restricted to children in care.

Cheshire has eight identified police officers working in youth justice through the Complex Youth and Navigate teams. There is a lack of clarity around the roles in terms of police officers within the YJS team itself. This needs prioritising to ensure it fits with national guidance from the Youth Justice Board, College of Policing and National Police Chief Council.

When provided, co-located YOT police officers often ensure there is effective police oversight of the full cohort of children within the YOT. They also enable the free flow of intelligence, both hard and soft, that is invaluable in combating youth crime.

[13] Information supplied by the YOT.

Risk management meetings were held for children identified as posing a high risk of harm to themselves or the wider public. Where such a child was managed under Navigate, a member of the Navigate police team would attend to provide an update on intelligence. For all other children, police attendance was left to local officers, many of whom were unable to attend because of other commitments. This could result in the YJS having an incomplete picture of the risks currently posed by and to a child.

Senior managers and the board were proactive in their scrutiny of ETE. They had put in place measures such as quarterly scorecards to assess the quality of provision and sharpen their own oversight. In 2020, the management team completed an audit, which accurately identified strengths and areas for improvement. These included sustaining ETE opportunities for YJS children and managing the impact of Covid-19 restrictions on children's learning.

The proportion of children who remained engaged in education during the period of Covid-19 restrictions was broadly similar to the previous (pre-Covid-19) year. However, more children had been placed on reduced timetables by schools. Managers were not entirely clear about the reasons for this.

Does the leadership of the YOT support effective service delivery?

YJS leaders and managers drive the culture within the service and provide an effective link between the board and the service. 85 per cent of staff who completed the survey said they were sufficiently aware of the board's activities. The board sets aside part of each of its meetings to look at practice issues. Staff have prepared reports for these and have spoken to board members directly.

Leaders and managers have a shared understanding of the risks to the service, and consider the action needed to mitigate these. The management team has taken pragmatic decisions that enable it to reduce the impact of risks. This was most evident in the management of the Covid-19 arrangements. Senior managers understood and managed the impact of Covid-19 for staff and children. This involved retaining services for those in greatest need, protecting staff and promoting mental and emotional wellbeing. Managers ensured that staff were kept up to date with emerging information, and staff appreciated the initial weekly bulletin from the head of service.

The connection between the board and frontline staff was strong and direct, allowing them to share information. The YJS had achieved this in a variety of ways, including through staff attendance at board meetings, and managers' oversight of practice through complex case panels. The health representative on the board chaired a health sub-group.

The leadership team promotes the use of evidence-based approaches, commissioning reviews and research to improve outcomes for all children. The work to reduce the criminalisation of children in care and its extension is a good example of this and is applied to all children in care. This is a significant undertaking, given the numbers in the area.

The leadership team has an open approach to learning and supports staff to suggest ideas for improvement. The member of staff responsible for note-taking at board meetings made a suggestion about data-sharing. This was taken up and has resulted in greater challenge and openness.

1.2. Staff

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

Key staffing data[14]

Total staff headcount (full-time equivalent, FTE)	77.25
Total headcount qualified[15] case managers (FTE)	17.9
Total headcount other case managers (FTE)	37
Vacancy rate (total unfilled posts as percentage of total staff headcount)	1.11%
Vacancy rate: case managers only (total unfilled case manager posts as percentage of total case manager headcount)	4.17%
Average caseload per case manager (FTE)	7
Average annual sickness days (all staff)	4.20
Staff attrition (percentage of all staff leaving in 12-month period)	5.43%

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

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

In general, staffing and workloads support effective service delivery. As the ratings in domains two and three show, YJS workers spend time understanding children's needs, the reality of their lives and the effect of any trauma experienced. Workers prioritise relationship-building, which means that sometimes they will take a step back. This occurs when a child already has, or needs to build, a relationship with another trusted adult. Where we saw this, it was in the child's best interests, and the YJS worker supported the main contact.

Staffing levels for health workers are monitored proactively and reviewed against local health needs. This had resulted in growth in the health team, which meant there was excellent provision across each borough.

Workloads within the YJS are managed and monitored. Caseloads are mainly manageable and there is only one vacancy. The staff team is stable and experienced. The Divert team, which deals with children who receive out-of-court disposals, is stretched. Because of this, work is allocated to case-holding staff and on occasion to staff who do not normally undertake case work.

[14] Information supplied by YOT and reflecting the caseload at the time of the inspection announcement.

[15] Holding a recognised social work or youth justice qualification.

Team managers and senior practitioners actively monitor workloads. Allocation of new work takes account of a range of factors, including complex cases, court work and geography. There are arrangements to cover absences.

Case managers often have cases from more than one local authority. A team of intervention workers provides support in delivering the planned interventions. These workers have a detailed knowledge of services available in the four local authority areas.

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

Staff from all agencies demonstrated good knowledge, skills and experience. All staff were passionate about their work and dedicated to delivering a child-focused service. Staff were also flexible and innovative in their approach to supporting children, building trust-based and therapeutic relationships.

There is a highly skilled, stable and experienced health team, which manages the risks and vulnerabilities of children effectively. Managers trust workers' judgement, which allows staff to do what they think is right for the child.

Probation staff focus on transition cases and continue to work with children after they turn 18. This provides continuity for children, who are then supervised by the probation service. We saw cases where this had been effective, as in the following practice example.

Good practice example

Sean received a 12-month youth rehabilitation order 10 days before his 18th birthday. He continued to be supervised by the YJS until two months after this, when he transferred to the probation service with 10 months of his order still to run. His conviction was for offences of fraud by false representation, primarily to pay off a drug debt he had accrued. He was a looked after child. For the greater part of the YJS's period of management, Sean was living out of the area for his own safety. He returned to his home area, where the risk was, in the last two months of his order. This transition period focused on monitoring his behaviour and risks as well as providing welfare support and advice to assist his move to adult probation.

Most of the initial delivery was undertaken by phone due to the Covid-19 restrictions, with Cheshire YJS workers continuing to manage the case rather than arrange for caretaking. The case manager kept in contact with him and his allocated seconded probation officer, who was co-working the case. Sean's return to his home area prompted a change in the allocated Community Rehabilitation Company office. However, once transition meetings started, the focus was on ensuring that he was fully informed and prepared for the move to adult services.

The service uses the specific skills of staff well. Complex cases are managed by social workers, probation officers, or case managers with other relevant professional qualifications and these staff also offer support to colleagues about safeguarding and child protection processes. ETE workers are tenacious and knowledgeable. They facilitate the exchange of information between educational and training providers and case workers. They also work alongside schools to prepare risk assessments so that children can remain in school.

Some staff reported that they lack the confidence to discuss issues of race and discrimination with children. Data in domains two and three shows that issues of race are

not always given the prominence they should. However, the YJS has undertaken work to identify the specific needs of girls and children from the traveller community.

Cheshire is a predominantly white area, with white people comprising 96 per cent of the total population. The percentage of children from a black, Asian and minority ethnic background who have been sentenced or cautioned, at five per cent, is much lower than we often find. The national average is 26 per cent. Of the staff, 2.2 per cent are from a black, Asian and minority ethnic group.[16]

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

Staff who completed our survey said that supervision was either very good (90 per cent) or good (10 per cent). This was confirmed in our discussions with staff. Case managers value supervision and reflective case management sessions. Line management arrangements are consistently applied and helpful to staff. Staff come well prepared, which is an expectation of the service.

In statutory case work, management oversight is provided on request and for cases where the case manager has assessed that there is a high risk of reoffending, safety and wellbeing concerns or harm. The YJS made this decision to help staff develop skills and competence. We found that there was a lack of management oversight in cases where a medium risk of harm was identified, leading to some deficiencies, particularly in contingency planning to manage the risk of harm and where the risk involved exploitation. These factors led to the only judgment of 'Requires improvement' given for case work.

We found that planning to address the specific needs of victims was sufficient in 47 per cent of the medium-risk cases and in 71 per cent of high-risk cases. While staff felt that management oversight in the cases was always sufficient, we disagreed, judging it sufficient in 86 per cent of the high-risk cases but in only 62 per cent of medium-risk cases. In our view, there is a potential gap in oversight of cases where risks are increasing or changing, and on the cusp of becoming high risk.

Induction processes are in place and used as needed. This includes induction and training for board members and volunteers.

Partnership workers are well supervised and respond well to supervision.

YJS staff were very positive about the way in which managers supported their work. Performance management of staff is both challenging and effective. Poor performance is addressed fairly and thoroughly when the need arises.

Although social workers in Cheshire East do not receive structured supervision from a qualified social worker, which is a requirement of professional standards, the supervision they do receive is of a good standard.

Line managers give verbal praise to recognise good and exceptional practice, but formal arrangements are more limited.

Are arrangements for learning and development comprehensive and responsive?

Good training plans are in place for most staff and volunteers. This includes offers of both formal and informal training. Volunteers and the support staff team spoke positively about the support they received, including training in trauma.

[16] Information supplied by the service.

Learning from serious incidents is underdeveloped. Processes are in place to disseminate learning; however, staff could only describe general feedback, such as 'information-sharing needs to be better', rather than being able to give examples of direct and focused learning.

The collaboration between the local authorities and agencies to learn and share best practice is a strength. This benefits the work with children when they move across borders and with children who are placed by another local authority in one of the four Cheshire areas.

Administrative and support staff felt that their professional development was a high priority. Because of this, staff working on the support service were highly motivated.

1.3. Partnerships and services

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

Caseload characteristics[17]

Percentage of current caseload with mental health issues	46%
Percentage of current caseload with substance misuse issues	54.6%
Percentage of current caseload with an education, health and care plan	35%

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

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

The analysis of children's needs was informed by a wide range of sources, including AssetPlus data, children's experiences, academic learning from the evidence base and data and information from partner agencies.

The health needs assessment is to be refreshed, even though the service has met all the objectives in the current plan. This is an example of a partner striving to future-proof service delivery.

The YJS's understanding of needs relating to child sexual exploitation and child criminal exploitation is developing. At the time of the inspection, the pan-Cheshire partnership was planning further analysis to protect children from these risks. Multi-agency meetings to identify the children at risk are in place. This is a complex picture in the Cheshire area. The partnership has taken its time to understand the profile and nature of the issues, drawing on leading academics to guide and evaluate the work. In case work, we found little evidence of practical support for children who were being exploited.

The YJS was instrumental in the decision of the Office of the Police and Crime Commissioner to carry out a review to ensure that black, Asian and minority ethnic children in Cheshire are not over-represented in the criminal justice system. This was proposed by the YJS head of service at the Criminal Justice Board and taken forward by the Office of the Police and Crime Commissioner. The service's data indicates that over-representation in the YJS caseload is

[17] Data supplied by the service.

not an issue of concern, since the proportion of black, Asian and minority ethnic children is broadly in line with population figures. The review will enable black, Asian and minority ethnic children and traveller families to describe their experiences and perceptions of the criminal justice system. The report will be considered by the Cheshire Criminal Justice Board in late 2021. It was positive to find that this area of work forms part of the current youth justice plan and will remain a priority.

There is ongoing assessment of the effectiveness of the Divert programme. However, further understanding of the use of the police outcome of no further action, when recommended by the YJS, is needed. While it was clear that this outcome was benefiting children, especially those who are looked after, planning of the work to break the cycle of offending was not always robust enough. We found a small number of examples where, in our view, the potential consequences of the child's behaviour were not fully recognised or where discrepancies between the accounts given by the police and by the child were not cross-checked. In one case, the child gave a substantially different account to the victim. The failure to accurately understand what had happened meant that there was not a full understanding of the potential for risk of harm.

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

Children benefit from a wide and comprehensive range of services and interventions, which enable a personalised and responsive service. All children were offered a health screening appointment. Health care staff collaborate with providers in planning to ensure that children's health needs continue to be met when they transition from the service. Although there was no formal primary care pathway, health care professionals were aware of the appropriate services and referred children to them as required.

While delivery models and structures differed across the wide range of ETE providers, partnership managers were confident and positive about how well ETE and YJS workers connected with specialist services such as the Virtual School, special educational needs and disability (SEND) services, ETE, post-16 education, safeguarding and early help. There is a very good focus on the needs of the individual child. It was positive that this approach was mirrored in each local authority area.

ETE are seen as critical to the child's desistance and are part and parcel of the YJS service. They are an influential part of the work. An example is the work carried out to ensure that children are not automatically excluded from school if they are found in possession of a knife or weapon. Very few children attend the pupil referral unit, and when they do plans are in place to move them into provision that can meet their needs.

SEND leads check that all children entitled to education, health and care plans (EHCPs) have them and that the plans are implemented. Unusually, they also sign off all plans. Where needed, EHCPs are also produced for children aged 15 and 16 to support their transition into further education. This is an example of proactive and child-centred service provision.

A very good range of interventions are available through the four local authority social care services, who work well with YJS case managers. Of note is the work and support available to children in care who live out of their local area. The service responds to these children in the same way as it does Cheshire's own looked after children. This is a significant commitment, given the numbers of children in the area. Senior managers in social care hold other local authorities to account if they find that they are not supporting children adequately.

Work done by the police with children who are part of the complex case service, including those on integrated offender management (IOM), focuses on building key relationships so that the child's needs and risks are better understood.

The YJS's range of interventions are often used to support existing work by other agencies. These include services provided for girls that recognise their particular needs, including the need for some girls to be seen in a gender-specific venue.

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

A key strength of the service is the way it has been able to establish and maintain relationships and services across a complex and varied partnership group. It was clear that these relationships were based on trust and a mutual understanding of roles and responsibilities. The relationships were open and mature, enabling effective challenge and the development of services and evidence-based working practices.

The YJS has been influential in driving innovation and keeping the partnership focused on the children who need its services.

The YJS values the arrangements with partners, providers and agencies, and works hard at all levels to maintain effective relationships and pathways into services. The scale of this task is significant, and some initiatives take shape over a long period of time. The maturity of the partnership sets the tone and culture at all levels.

There are well-developed links between the YJS police and local policing teams to address anti-social behaviour and low-level criminality involving children.

Transition arrangements for children moving to probation are good. They are supported by the North West Transitions group, which facilitates a coordinated approach for youth-to-adult transitions across the region.

The outcome of out-of-court disposals is made by recommendation from the YJS to the police officer in charge of the case. The individual officer then has the option to decide whether the recommendation is appropriate to the case. Escalation processes are in place to resolve disagreements. In the cases we assessed in domain three, we found that all the proposals were appropriate and proportionate. Further limited enquiries in week two showed some inconsistencies in decisions made and a limited ability for officers in charge to challenge recommendations.

There are a range of multi-agency panels and meetings to manage desistance, safety and wellbeing and risk of harm. The focus on victims is promoted by dedicated staff who prompt case managers to think about the impact of offending on the family, parents and victims.

Restorative justice is recognised as a powerful element of case work. The team has undertaken 12 restorative justice conferences during the Covid-19 period.

Involvement of children and their parents and carers

Children and their parents and carers have been consulted about the services they have received. The management team has held a series of conversational audits, discussions with individuals based on themes. The outcome of these has been fed back to the board.

The board has ambitions to increase the involvement and influence of children, parents and carers. Plans are taking shape about how this can be achieved.

We received very few survey responses from children. Those who did respond were positive about the workers who had supported them.

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.	Good

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

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

The service has a wide range of relevant, up-to-date policies and procedures in place. These were accessible to staff via an intranet system, and staff were confident in accessing them. Staff have to navigate a range of services and access points, so access to the right information at the right time was critical. We found that managers were helpful in guiding staff to access the right service. Importantly, staff felt able to ask for help if arrangements were not clear or had recently changed.

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

The YJS uses community venues, including libraries, community hubs and youth centres, to see children. The YJS footprint covers a wide geographical area, comprising towns and rural areas. The areas are not equally well served by accessible community venues for staff to undertake face-to-face work with children and for restorative meetings. In some areas, it can be hard to find a suitable space. During the Covid-19 pandemic, staff have contacted children by phone or through socially distanced home visits. As restrictions have eased, some previously used venues now have reduced capacity.

The difficulty in finding suitable venues was a strong theme in the staff survey. Staff were frustrated that they struggled to find suitable venues to see children and victims, in order to undertake work in a confidential space. Although managers knew that this was challenging, the size and scale of the issue was perceived differently by staff and their managers.

While health care staff also found that their working environment was not always conducive to delivering therapeutic interventions, they had access to more suitable rooms. There had been no apparent investigation by the YJS or the management board to see if these rooms could be accessed by non-health staff if no alternative venues could be found.

One member of staff told us:

> *"We cover a large area and have no designated office where we see our young people. A lot of time can be spent/wasted in travelling to different areas/appointments. Time which could be spent better and focused towards our young people".*

Another comment received in the staff survey was:

> *"The partnership should ensure youth justice staff can access safe, suitable, child friendly spaces in which they can do sessions with children close to their own homes. Currently children are mainly seen either in their own home (not always appropriate), in their educational placement (also not always conducive to good engagement), in a municipal office (very 'corporate' and not child friendly) or in a public venue such as a library or coffee*

shop. The YOT itself should not have its own building, as this potentially stigmatises our service users, but we should have designated rooms or spaces where we can see children in the community, children's or family centres in every town across Cheshire".

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

IT systems are in place to allow staff to work remotely. This enabled the swift move to home working at the start of the Covid-19 pandemic, ahead of the government announcement. The performance and information team are skilled and provide a wide range of information quickly in response to the needs of the board, team and service managers.

Specified staff have read-only access to a wide range of partnership systems, including the social care systems and Niche, the police system. This gives only partial access to information and does not give the same level of information a police officer would have access to.

Managers use performance information well to monitor performance at team and individual level. Monthly performance meetings are chaired by the operational manager, who gives staff high-level feedback on themes.

Health care staff have developed robust systems, agreed with the YJS, to ensure relevant information is readily accessible. This is used well to inform assessments and work with children.

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

Local, regional and national evidence is used to review and revise services. We found examples of this across the partnership. For example, we identified numerous examples of learning being used to improve practice, including learning from inspections and reviews. This was aided by mature and open relationships between partner organisations.

Evidence-based data was presented to the board to demonstrate how health needs were met. The YJS was proactive in identifying and addressing gaps to consistently improve service provision.

The YJS has actively sought the views of children and their parents and carers through structured conversational audits. It is using this information to improve services.

The YJS uses research effectively to guide service delivery. It has established working groups to consider how to work in a trauma-informed way, which has given staff and volunteers the opportunity to change practice. The development of child-appropriate language in referral panel reports is one example.

Divert cases are subject to routine external scrutiny by a multi-agency criminal justice panel. There is a high level of agreement between the YJS and the panel.

2. Court disposals

We took a detailed look at 31 community sentences and three custodial sentences managed by the YJS. We also conducted 32 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. For services to keep the child safe, we only assessed the quality of planning, and implementation and delivery in the 30 cases where we expected meaningful work to take place. Similarly, for work to keep others safe, we assessed the quality of planning, and implementation and delivery in the 28 cases where meaningful work was required.

In this service, work to support desistance was the strongest area. For desistance, 74 per cent of cases met all our quality requirements for assessment, 85 per cent for planning and 88 per cent for implementation and delivery. The quality of assessment planning and review of safety and wellbeing and risk of harm to others was mixed. Assessment and planning for work to address safety and wellbeing issues met our standards in 68 per cent and 67 per cent of cases respectively; but planning to address safety of others was only sufficient in 54 per cent of cases, leading to a rating of 'Requires improvement' for that standard. Reviewing of work to address desistance met our standards in 83 per cent of cases; however, reviewing of work to manage safety and wellbeing of the child and safety of others was sufficient in only 65 and 71 per cent of cases respectively.

Strengths:

- Assessments are detailed and analytical, and planning to meet children's desistance needs is supported by specialist assessments, including of speech and communication needs, ETE and mental health.
- Staff carry out appropriate assessment of the needs and wishes of victims. Victim awareness sessions for children and restorative justice for victims are embedded in practice.
- Delivery of interventions is well sequenced and tailored to meet individual needs. Children receive support from a range of professionals who build trusting and positive relationships with them.
- Most children attend school and are supported to maintain their placement. This is a priority for the partnership, as it recognises the importance of this as a key desistance factor.

Areas for improvement:

- Planning to manage risk of harm needs to improve so that it is specific to the individual risks posed and contains clear actions that would need to be taken if the child's circumstances were to change.
- Assessments should consider the needs and experiences of black, Asian and minority ethnic children. Staff need support to speak to children with confidence about any discrimination they have faced and to understand issues of self-identity.

- There is limited support for children who are exploited and a lack of work to proactively target perpetrators, to break the cycle of abuse.

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

2.1. Assessment

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

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

	% yes
Does assessment sufficiently analyse how to support the child's desistance?	74%
Does assessment sufficiently analyse how to keep the child safe?	**68%**
Does assessment sufficiently analyse how to keep other people safe?	71%

In over 70 per cent of cases, assessments sufficiently analysed the child's desistance and risk of harm to others. Assessments of children's safety and wellbeing were almost as good. As a result, we rated this area of the YJS's work as 'Good'.

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

Assessments were sound, drew on all of the available information and drew appropriate conclusions. There was a particularly strong focus on the child's strengths and protective factors in 32 of the 34 cases. The child's motivation and ability to comply with the court order were also considered, based on the child's reactions and any previous experience of supervision. Information on the child's social and familial context included the parents' or carers' perspective, any social care history and views expressed by the child. This enabled workers to identify not only factors related to offending, but also where the child was vulnerable to specific offending, such as exploitation by local drug dealers and county lines.

The needs and wishes of victims were properly assessed in 17 of the relevant 25 cases. This was consistent across both the medium and high risk of harm cases.

Attention to children's experience of racial discrimination and self-identity was not as strong as attention to social context. In one case, the inspector noted:

> *'The child is recorded as a black male (unspecified ethnicity) yet there is no reference to or acknowledgement of any relevant cultural considerations or significance of the young person's racial identity'.*

Does assessment sufficiently analyse how to keep the child safe?

Where a child had experienced trauma, any known or suspected effects were recorded. This was helpful to all professionals who came into contact with the child, often providing

[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 1 for a more detailed explanation.

explanations for why the child struggled to build relationships and specific triggers to emotional harm.

At the assessment stage, staff had access to a wide range of information, which they added to the assessment. Of note was the information gained from speech, language and communication assessments, which outlined any difficulties in the child's ability to understand and communicate. From an early stage, this information was used to help staff understand how best to speak to the child.

Assessments analysed existing controls and interventions to promote the safety and wellbeing of the child. However, in our view these were then used to reduce the assessed level of safeguarding needs, rather than provide a realistic assessment of need. This served to underestimate the actual safety and wellbeing issues faced by children. As a result of this, the assessments were not always sufficiently analytical.

Assessments clearly identified and analysed any risks to the safety and wellbeing of the child in 22 of the 34 cases. Where we judged this aspect of work to be insufficient, the assessment often underestimated the impact of the child's behaviour on their safety and wellbeing, although it was often seen as an issue for desistance. In one example, the inspector recorded that:

> *'The child received a 10-month referral order for possession with intent to supply cannabis. They reported that they were smoking £70 worth of cannabis daily so had taken to dealing to support the 'habit' and to stop them from getting into debt. The risks involved in this lifestyle were not considered to put the child at risk, nor was the health impact of the relatively high daily usage. Consequently, neither were analysed with regards to keeping the child safe'.*

Does assessment sufficiently analyse how to keep other people safe?

Of the 34 cases we assessed, there were identifiable risk factors in 30. These were sufficiently assessed in 21 cases.

The assessments drew on a wide range of information, which was then used to understand the context of the child's offending. Both convictions and negative behaviours were analysed to understand the circumstances and nature of any actual or potential harm to the child.

Conclusions and classifications were justified and well evidenced. In discussions with inspectors, case managers demonstrated that they had detailed knowledge of the harm caused to victims and effect that the incident had on them.

Assessments clearly identified how and when the risks would present.

The following comment from an inspector is an example of what we found:

> *'The assessment of risk is thorough and makes a clear distinction between the risk in the community and custody and the differences between the two. It focuses on potential risks from all non-offending and non-convicted behaviour and not just on the risks associated with the index offence. There is also a recognition of the increasing gravity of behaviour being undertaken by the young person'.*

Where we judged assessments to be insufficient, this was because the YJS worker had not considered any existing controls and interventions to manage and minimise the risk of harm presented by the child. In particular, they relied too much on safety plans put in place by children's social care to protect vulnerable family members and siblings. We found that the assessments stated that plans were in place, but the worker had not considered whether these were adequate to manage identified risk of harm to others from the YJS's perspective.

This was most evident where a child in need plan had been put in place, but the family was unlikely to be able to manage the risks without significant support. Examples included where the risk came from the community, such as drug dealers turning up at the family home to retrieve drugs or money.

2.2. Planning

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

Our rating[19] for planning is based on the following key questions:

	% yes
Does planning focus sufficiently on supporting the child's desistance?	85%
Does planning focus sufficiently on keeping the child safe?	67%
Does planning focus sufficiently on keeping other people safe?	**54%**

Planning to promote desistance factors was strong, and this was the main focus of planning. However, we found omissions in planning to keep victims safe and a lack of effective contingency planning to manage and reduce predictable behaviours. Planning to keep other people safe was the weakest area of work and resulted in the only rating of 'Requires improvement' that the YJS received. It should be noted that the score of 54 per cent is very close to the rating boundary for 'Inadequate', which is set at under 50 per cent of the work.

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

Planning to support the child's desistance was very strong, in part because children, parents and carers were involved in developing the plans. We saw this in the work of referral order panels, which had worked hard to produce meaningful and clear objectives. This was supported using the 'my ideas for a contract' consultation document that was given to children before panel meetings. We saw this used consistently, and panel members often incorporated the child's ideas for work.

Case managers worked hard to discuss desistance plans with parents. We found meaningful engagement in 31 of the 34 cases.

Plans were strengths-based, often reinforcing the things that children were good at and supporting them to become involved in positive and age-appropriate behaviours.

There was clear identification of work that was statutory and therefore enforceable and those activities that were voluntary.

In all but one case, planning was proportionate to the court outcome. Interventions were well sequenced and planned for quickly.

Services and interventions to address offending-related factors were identified in plans, and we saw good identification of relevant interventions from partner agencies. Supporting the child's education, employment or training was a common feature of planning.

[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 1 for a more detailed explanation.

The expressed views and wishes of victims were incorporated into planned work in 21 of the relevant 27 cases.

We found clear links to the plans of other agencies, and reference was made to existing planning by social care, health and education providers. Desistance factors were relevant and appropriate, for example consolidation of actions contained in EHCPs or mental health planning.

Does planning focus sufficiently on keeping the child safe?

The safety and wellbeing of the child was supported through effective planning in 24 of 30 cases where it was required. As we found with desistance, the necessary controls and interventions were identified in 22 of the 30 cases.

Again, we saw links to plans produced by other agencies, or via other forums. However, for safety and wellbeing there was sufficient alignment in just 19 of 28 cases. Although a range of actions may have been identified, there was a lack of clarity about which specific actions needed to be taken to reduce risks. An example was interventions to disrupt criminal exploitation. These tended to consist of work with the child so that they recognised the risk to themselves of the exploiters; however, some planning relied on the child or parent to manage the risks or to remove themselves from the dangers. This was unrealistic.

The main factor that affected the quality of planning in this area was a lack of contingency planning. This was sufficient in just 13 of the 30 cases. One inspector noted this in a case:

> *'Planning provides interventions to address all the factors identified linked to safety and wellbeing. There are separate 'targets' for engaging with child in need arrangements and addressing the risk of the child being exploited. But there is no contingency planning to deal with a breakdown or non-engagement in child in need arrangements or an increase in criminal exploitation concerns. While the likely action to deal with the change may have been the same as the actions to manage other risks, the actual circumstances that would give rise to the concerns were not clearly recorded so could easily have been missed if they happened, which would not have kept the child safe.'*

Does planning focus sufficiently on keeping other people safe?

This was the weakest area of work we found. Planning to promote the safety of other people sufficiently addressed risk of harm in just over half of the relevant cases.

More often than not, planning involved other agencies and included the right interventions and controls (19 of 28 cases). However, plans failed to address the specific concerns of victims in less than half of the situations where this was needed. It was better in the cases classified as high risk.

Contingency planning was sufficient in just 12 of the 28 cases we assessed. This was often due to a lack of clarity and coordination of actions when there were multiple plans in place. We also noted that actions were spread across the agencies when, in our view, the YJS should have taken a more focused role in managing the risks to others.

The following comments from an inspector about one case were typical of what we found.

> *'Stephen's risk of harm spanned both the home, and the community amongst peer groups. Insufficient attention was given to the role that parents would play in monitoring his behaviour. Information was shared by the police, and the plan was for Stephen be open to the complex team and allocated a police officer. However, there was insufficient understanding around what role that police officer would take to mitigate risk. External*

controls that may have been used, including parental boundaries, and access to knives at home, were not referenced as this appeared to be the role of social care child in need planning, but social care did not specifically reference some pertinent issues related to harm to others within their plan'.

We saw a lack of effective contingency planning for both medium-risk cases (eight of 21) and high-risk cases (four out of seven). Contingency planning was too generic. There were similar actions on most plans, such as sharing information and holding meetings. Very few direct and clear actions were listed. Contingency planning relied on the knowledge of the case manager and other workers, rather than being well recorded and accessible to all professionals.

2.3. Implementation and delivery

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

Our rating[20] 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 safe?	80%
Does the implementation and delivery of services effectively support the safety of other people?	**68%**

The YJS evidenced some highly effective work undertaken by its own and partnership staff. Actions were routinely and consistently taken to support desistance and to keep the child safe. Had the same levels been achieved for keeping other people safe and managing risk to others, this standard would have been 'Outstanding'; instead, it was rated 'Good'.

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

Work to build a trusting relationship with the child was given priority and was achieved successfully in almost all cases. Staff were skilful and demonstrated persistence in working with children. They balanced the use of encouragement and enforcement well to set boundaries and help children understand what was expected of them.

Interventions and support to build on the child's strengths and protective factors were evident in the work. These included support for children to undertake positive activities such as sport and art, and to maintain education. Work to keep children in school if they were found in possession of a weapon was very strong. The YJS had worked well with the police to make sure that, if a school called out the police, they could ask pertinent questions about the child and incident to assist the school's decisions to exclude the child or not and to make a risk-based response. This included helping the school to understand the context of the

[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 1 for a more detailed explanation.

incident and supporting it to manage risk. We saw numerous examples of children being reintegrated into school with support.

Care was taken to ensure that children could access suitable support from universal services, once they had finished contact with the YJS. Children were able to keep in contact with the YJS workers on a voluntary basis at the end of their orders if they wished.

Staff demonstrated flexibility in working with children during the Covid-19 arrangements and as these changed.

Good practice example

We assessed the case of a vulnerable girl. In an interview with inspectors, the intervention worker explained how delivery of interventions started slowly, as the child was not very motivated to engage. They also identified that the Covid-19 restrictions, which had limited contact to telephone calls, had hampered her engagement. Once face-to-face meetings resumed, the child's engagement improved. Some interventions were prioritised, but the case manager explained that delivery was 'young person and crisis led' because of the dynamic nature of the child's lifestyle. Nevertheless, at just over the halfway point of the order, structured interventions were delivered to address substance misuse, perspective taking, empathy and healthy relationships. There was evidence of good partnership working and coordination by the case manager. Although the child (now 18) is alleged to have committed a further offence, the case manager felt significant progress had been made so far, evidenced by her improved engagement with the support offered. This would be an important factor as the girl transitioned to adult services.

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

Effective work was undertaken to keep children safe in the majority of cases. Due to children's complex needs, this was often multi-agency work. We saw some very good joint work with staff in residential homes and work to support parents in managing their child's wellbeing, and some excellent support from health workers and the police.

Children were able to access mental health provision quickly for assessment and support. There were no waiting lists.

Where the police were involved in cases, they undertook home visits and offered support to children.

Contact and joint work between YJS and social workers were often good and well-coordinated. One of the features of the work was the consideration of the roles each would take. We found examples where the YJS worker delayed their interventions to allow social workers to reconnect with children and joint work aimed at stabilising children in crisis.

Work with other youth offending teams was good. The YJS often retained case management to provide continuity and until an effective caretaking arrangement could be established. In one case the inspector found that:

> *'Delivery of interventions and support from CAMHS and the speech and language therapist for the child contributed towards keeping him safe. Regular multi-agency meetings were held between CAMHS, education and health, with a focus on keeping the child safe. Additionally, the CAMHS worker completed sessions directly with the child's mother, to*

develop skills to better manage her son's behaviour at home, enabling her to help keep her son safe.

During periods of remote working, the case manager reported that they arranged regular Skype meetings between all professionals working with the child to share updates on his progress/their progress in working with him'.

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

The services delivered were sufficient to manage and minimise the risk of harm in 19 of the 28 relevant cases. In some cases, planned interventions had not taken place. In others, the nature of interventions did not focus on the distinct risks that the child posed to others.

There was sufficient involvement of other agencies in managing the risk of harm in 17 of the 23 cases where this was needed.

It was positive to see that interventions to keep victims safe and help them recover were completed in three-quarters of the relevant cases. Restorative justice approaches were used, helping children to understand the impact of their actions. Victim awareness work was undertaken with the majority of children and, where possible, reparation was undertaken.

We spoke to the manager of a shop that had been broken into by two boys. She told us that having the opportunity to speak to both boys had helped her explain the fear and distress her staff team had felt. She was also able to tell the boys that they could come back into the shop, which one of them has done. She was really pleased to see the progress he has made.

2.4. Reviewing

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

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

	% yes
Does reviewing focus sufficiently on supporting the child's desistance?	83%
Does reviewing focus sufficiently on keeping the child safe?	**65%**
Does reviewing focus sufficiently on keeping other people safe?	71%

Reviewing was an active and ongoing activity. Case managers and partner workers, in the main, exchanged information well and frequently. Systems were in place for staff to seek support and advice when reviewing the changes to the child, their situation and any progress made. Again, work to support desistance was the strongest area of practice. For this standard, the reviewing of safety and wellbeing was rated 'Good'.

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

[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 1 for a more detailed explanation.

Reviews were held in response to significant events and changes. They were carried out quickly and work was adapted as necessary. The reviews around desistance needs were robust. Any changes remained focused on what the child was doing well. Progress was actively identified, and feedback given to children.

Work to keep children motivated was excellent. Staff took time to help children see that they could make the necessary changes and that they were not on their own. It was evident to the inspection team that, for many children, the belief that staff had in them was critically important.

When things changed, or there were setbacks, parents and children were able to talk about what had happened. They were kept fully informed and engaged well with staff. Staff gave us many examples of how they were able to have open and direct discussions with children and parents. These led to agreed and owned changes to plans for future work.

When other professionals were involved, collaborative working focused on what additional support could be given and on assessing how the team around the child might need to change their approach.

A wide range of events triggered reviews, including children finishing interventions and formal review panel meetings. Children were praised when they did well, including being taken back to court for early revocation.

Does reviewing focus sufficiently on keeping the child safe?

There was good exchange of information to alert agencies to changes in safety and wellbeing. This included self-reporting and disclosures made by the child, parents and carers.

Staff actively sought information about children's time in custody and were proactive in asking the youth custody estate to take action to ensure the child's safety. Examples included a child moving from one establishment to another, and a change of unit. We also saw classifications of safety and wellbeing being changed, and the children's social care team increasing children from 'child in need' to 'child protection' status.

In a few cases, nine of 23, not enough action was taken to respond to changes.

Does reviewing focus sufficiently on keeping other people safe?

As with safety and wellbeing, effective information-sharing was key to identifying trigger events that led to reviews being undertaken. This usually worked well. However, there were some notable gaps.

Information on some incidents, such as arrests, was notified to the YJS but because there was no specified YOT police officer, the staff didn't have a direct way of finding out the details.

Arrangements for police attendance at high-risk panels were inconsistent. There was good attendance for children on IOM and Navigate caseloads, but attendance by the arresting officer in most cases was poor. This left gaps in intelligence and information-sharing.

Reviewing of risk of harm led to the necessary adjustments in the ongoing plan of work in 12 of the 19 cases where this was needed. This was particularly evident in the medium-risk cases where there was no routine management oversight. There were points where interventions could have been considered to identify and respond when risks are increasing or changing.

The formal Multi-Agency Public Protection Arrangements work well and were used when required.

3. Out-of-court disposals

We inspected 23 cases managed by the YJS that had received an out-of-court disposal. These consisted of two youth conditional cautions, two youth cautions, and 19 community resolutions. We interviewed the case managers in all of the 23 cases.

We examined the quality of assessment; planning; and implementation and delivery of services. Each of these elements was inspected in respect of work done to address desistance. For the 19 cases where there were factors related to harm, we also inspected work done to keep other people safe. In the 14 cases where safety and wellbeing concerns were identified, we looked at work done to safeguard the child. We also looked at the quality of joint working with local police.

Diverting children from the criminal justice system to improve their outcomes is a key objective of this service. The Divert programme is a pathfinder, which other YOTs are looking at. While this approach generally works well for Cheshire, there are some areas for consideration.

Divert is focused on the point of arrest, to divert the child from ending up in the criminal justice system. On arrest, where the offence allows for the possibility of an out-of-court disposal, the police contact the YJS, which conducts a comprehensive assessment and prepares an action plan, overseen by the service, involving a package of services to address the person's needs and help divert them from future offending. The police, Crown Prosecution Service, courts, Police and Crime Commissioner, local authorities, and Clinical Commissioning Groups are fully engaged with the scheme, which has the strap line 'Diversion is better than Court'. It has pathfinder status with the YJB and refers children into appropriate services, including education, health and early help.

Strengths:

- There is good use of out-of-court disposals to prevent children from entering the criminal justice system.
- Staff undertake insightful, well-evidenced and analytical assessments of the reasons that children offend and the risks they pose to others.
- All children can access the same wide range of support services, regardless of the type of contact with the YJS.
- Interventions are proportionate to need and delivered quickly.
- Plans take the child's views and wishes into account.
- Staff maintain good contact and engagement with parents throughout the case.
- Exit planning is proactive and enables children to access services in the community once contact ends.

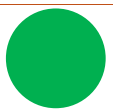
Areas for improvement:

- The decision-making process for out-of-court disposals needs to be reviewed. A consistent police officer should be involved to resolve delays and ensure that the police are satisfied with decisions that are made.

- Contingency planning to manage safety and wellbeing is inconsistent, and sometimes underestimates the issues faced by the child.
- Support for children who are exploited is underdeveloped; staff rely too much on the child's and parents' ability to manage the risks.

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

3.1. Assessment



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

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

	% yes
Does assessment sufficiently analyse how to support the child's desistance?	87%
Does assessment sufficiently analyse how to keep the child safe?	**70%**
Does assessment sufficiently analyse how to keep other people safe?	96%

Assessments of desistance and risk of harm to others were excellent. They were undertaken with rigour and skill and consistently done very well. The assessment of safety and wellbeing was also done well but not as often, resulting in a rating of 'Good' for this standard.

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

The YJS uses both AssetPlus and a locally produced assessment tool. Staff understand the principles of assessment and analysis and apply them equally well to both formats.

Assessments are undertaken before decisions are made on disposals and are used to inform the police of the YJS's recommended outcome. The child's understanding of the incident, their behaviour and their acceptance are analysed alongside their attitudes and motivation. These strengths-based assessments use information and assessments from other sources. In one case the inspector recorded:

> *'The assessment of the child is well triangulated and involved him and his parent. An early help assessment was already in place and a Team around the Family already working diligently with the family. In this sense, the case manager's role was straightforward, as she was able to incorporate the assessments already in place into her own offence analysis to provide a comprehensive overview of the child and his needs'.*

Parents and carers were routinely involved in the assessment. Their views and perceptions were clearly acknowledged. Staff were able to skilfully balance and analyse situations where the carer was also the victim. The assessment outlined any tension and conflict.

[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 1 for a more detailed explanation.

The views and wishes of victims were always included in assessments and used well to inform the potential outcome and decisions.

All assessments are countersigned by managers, who not only check the quality of the assessment but also look to provide some continuity of recommendations.

Does assessment sufficiently analyse how to keep the child safe?

In 17 of the relevant 23 cases, the assessments clearly identified and analysed any risks to the safety and wellbeing of the child. Classifications were appropriate and reasonable.

As the service is trying to avoid criminalisation of children who are being exploited, there are some structural difficulties that the partnership has not yet overcome. In particular, there are difficulties in addressing the risks to safety and wellbeing when they come from outside the family home. The systems in place for child protection are based on the risk coming from within the family. Children who are being exploited do not fit easily into this system.

As the approach to contextual safeguarding is being developed, this has the potential to leave children, families and workers in difficult situations. The assessments we saw correctly identified exploitation and vulnerability to this risk.

The children who received out-of-court disposals were just as vulnerable as those who got court orders. In our view, this applied in 20 of the 23 cases. They presented with a range of factors, and not all were apparent at the first contact with the YJS. Some factors only became evident over time, when children got to know and trust case managers.

Does assessment sufficiently analyse how to keep other people safe?

Assessment of risk to others was done very well. Staff used all available information and identified all key harmful behaviours. The nature of risks was clear, as were the situations where the risks might be imminent. Behaviours and intentions were analysed to form a clear picture of risk as it emerged. Assessments for out-of-court disposals were supplemented by specialist assessments, including speech and communication, emotional and mental health screening, and good information from schools about attendance and behaviour.

Information from the police was of variable quality. Staff often had to rely on the information provided by the arresting officer. There were occasions where further information was required to complete the assessment, and staff struggled to contact the individual officer due to shifts and operational duties. Escalation processes were used when needed to try and avoid delay.

3.2. Planning

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

Our rating[23] for planning is based on the following key questions:

	% yes
Does planning focus on supporting the child's desistance?	91%
Does planning focus sufficiently on keeping the child safe?	**75%**

[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 1 for a more detailed explanation.

Does planning focus sufficiently on keeping other people safe?	83%

The quality and consistency of planning followed the same pattern as assessments. Planning was very good for desistance and risk and good for safety and wellbeing. This resulted in a rating of 'Good'.

Does planning focus on supporting the child's desistance?

All of the plans we assessed were proportionate to the incident and the outcome that was subsequently recommended.

Staff set out the services most likely to support desistance and tailored these to the child's individual needs and preferences. Planning was holistic. Children were offered support in a range of areas to support desistance from offending, often in support of plans already in place by social care.

Aims and objectives were realistic and included referrals to specialists. Children were encouraged to accept help and support. Parents, carers and children were involved in planning in all cases. Case workers made sure that they understood that interventions were voluntary but would be beneficial.

In all but one case, the needs and wishes of victims were incorporated and there was a strong emphasis on victim awareness and repairing any harm caused.

Does planning focus sufficiently on keeping the child safe?

Planning promoted the safety and wellbeing of the child in 16 of the 20 cases. Contingency planning was effective in 13 cases.

In all of the cases where we judged planning to be insufficient, this was due to a lack of robust planning for criminal exploitation. Actions in early help, child in need and child protection plans did not provide for any clear disruption activity.

Does planning focus sufficiently on keeping other people safe?

In all but one of the relevant plans, there were actions designed to keep other people safe. These included work on consequential thinking and referrals for parenting support to repair relationships with families and to make sure that other services were effective. In one case, a boy had assaulted his teacher at school. His EHCP recommended that he be given more support in school, including one-to-one support, to help him manage his work and reduce his anxiety and frustrations, which had led to him assaulting teaching staff. This had not been provided by his placing authority. As a result of the YJS intervention, this was funded by the placing authority. This was an effective way to reduce risk of harm to others.

The area of planning to manage risks to others was not as positive as contingency planning. This was sufficient in seven of the 12 cases.

3.3. Implementation and delivery

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

Our rating[24] for implementation and delivery is based on the following key questions:

	% yes
Does service delivery effectively support the child's desistance?	87%
Does service delivery effectively support the safety of the child?	90%
Does service delivery effectively support the safety of other people?	**83%**

This standard has been rated as 'Outstanding'.

Does service delivery effectively support the child's desistance?

The services delivered met the desistance needs of children in 18 of the 22 cases and were well targeted and sequenced.

The methods of delivery were affected by Covid-19, and some had to be delivered by video or telephone. It was clear that, despite this, staff adapted the way they worked to fit in with the children's preferred communication method and any learning difficulties, and they involved parents.

We found numerous examples of effective service delivery. The following example captures the support provided to many children:

Good practice example

The child was on work experience, so appointments were fitted around this. Referrals were made to Journey First to support his transition from school to college. Although no concerns were raised within the screening tool, one professional identified that he may have some communication difficulties in particular circumstances. This was swiftly followed up by the case manager. A speech and language therapy assessment was undertaken and a copy provided for the boy to take to college. The YJS officer delivered emotional resilience work, substance misuse and peer pressure work that was appropriate to the assessment and the plan. Exit planning was excellent, with the boy being able to access support from Journey First for up to 12 months following completion of the out-of-court disposal.

Does service delivery effectively support the safety of the child?

Services to promote safety and wellbeing were used well in 18 of the 20 relevant cases. We found good joint work, especially around speech, language and communication needs and CAHMS. Where children were part of the complex cases cohort, this was used effectively to manage risks of exploitation.

[24] 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 1 for a more detailed explanation.

Again, we found good joint work with social workers, who were able to take actions to support existing plans. The YJS staff made effective decisions about when to and when not to deliver work directly, especially when the child was already involved with social care.

The views of parents and other professionals were taken seriously, as the following example showed.

Good practice example

Towards the end of the diversion, the case manager re-assessed the safety risk of the child and increased the classification to medium risk. This was prompted by the school's and parents' concerns relating to drug use.

The case manager took action to try and re-engage the child with the community drugs teams. They liaised with the police education officer to form a plan for the child's exit from the YJS, and to discuss the child's associated risks at a contextual safeguarding meeting.

Does service delivery effectively support the safety of other people?

There were 10 cases where services were needed to reduce and manage risk of harm. In eight of these, we found a good focus on protecting the victims. YJS staff had used interventions around knife crime and conflict resolution. In the two cases we assessed in which insufficient work had taken place, both relied on the mother's ability to manage risks. In both cases this was over-optimistic.

3.4. Joint working

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

Our rating[25] for joint working is based on the following key questions, based on two cases where a youth conditional caution was issued:

	% yes
Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child, supporting joint decision making?	**100%**
Does the YOT work effectively with the police in implementing the out-of-court disposal?[26]	**100%**

We looked at two cases where a youth conditional caution had been given and assessed them against our standards. In both, we found effective work, which resulted in a rating of 'Outstanding'. The comments that follow apply to the whole of the out-of-court disposal scheme, not just these two cases.

[25] 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 1 for a more detailed explanation.

[26] This question is only relevant in youth conditional caution cases.

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

The current out-of-court disposal process needs reviewing. In Cheshire Constabulary, community resolutions can be issued by an investigating officer. These community resolutions can have interventions attached to them, including restorative justice or a referral to the Divert team.

All referrals to Divert and cautions are sent to a YJS manager. All cases, except for serious offences referred to the Crown Prosecution Service, are referred by the officer in the case (OIC) to the YJS for a decision. There is no out-of-court disposal panel. Given that the YJS covers four local authorities, it has taken the reasonable view that it would be impractical and overly time-consuming to run four panels.

Once a referral is received, research on previous police interaction with the child is undertaken. A victims' officer obtains the view of the victim, and a case worker conducts an assessment of the child (either in person or over the phone).

The Divert manager then quality-assures the assessment where the case worker has recommended a particular outcome. This is sent back to the OIC. Except in exceptional cases, this recommendation is the final decision (there is an escalation process where the OIC does not agree with the recommendation).

Cautions/conditional cautions are administered by local police sergeants. The full range of outcomes are available, ranging from no further action through to a charge to court. Most outcomes are complemented by an intervention.

In Cheshire, no further action is used purely as a recorded outcome for the police system, meaning that there is no trace of offending behaviour on police systems. These can adversely affect the child in later life. This is a good outcome for the child. This outcome does not mean that the YJS takes no action. In order to recommend no further action, an assessment is always undertaken, and support and interventions are usually offered to support the child's desistance.

In a number of the cases reviewed, there were delays in the submission of cases from the police, delays in assessments and delays in implementing the recommendation from the YJS.

80 out-of-court disposal cases are reviewed by a scrutiny committee every year. There is a high level of agreement between the YJS and the committee.

Does the YOT work effectively with the police in implementing the out-of-court disposal?

In the two cases where a youth conditional caution had been issued, the police were notified when the child had completed the requirements of the caution. We saw an update to the OIC in one case and in the other the update was given to the complex case police officer who has some oversight and responsibility for the child in relation to exploitation.

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.[27]

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

Domain one: organisational delivery

The youth offending service submitted evidence in advance and the chair of the YJS management board and Head of Service 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 56 interviews with case managers, asking them about their experiences of training, development, management supervision and leadership. The second fieldwork week is the joint element of the inspection. HM Inspectorate of Probation was joined by colleague inspectors from police, health, social care and education. We followed up issues which had emerged from the case inspections. We held various meetings, which allowed us to triangulate evidence and information. In total, we conducted 52 meetings, which included meetings with managers, partner organisations, and staff. The evidence collected under this domain was judged against our published ratings characteristics.[28]

Domain two: court disposals

We completed case assessments over a one-week period, examining case files and interviewing case managers. 60 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. In some individual cases, further enquiries were made during the second fieldwork week by colleague inspectors from police, health, social care or education.

We examined 34 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.

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

Domain three: out-of-court disposals

We completed case assessments over a one-week period, examining case files and interviewing case managers. 40 per cent of cases selected were those of children who had received out-of-court disposals three to five months earlier. This enabled us to examine work in relation to assessing, planning, implementing and joint working. Where necessary, interviews with other people significantly involved in the case also took place. In some individual cases, further enquiries were made during the second fieldwork week by colleague inspectors from the police, health, social care or education.

We examined 23 out-of-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.

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.

Ratings explained

Domain one ratings are proposed by the lead inspector for each standard. They will be a single judgement, using all the relevant sources of evidence. More detailed information can be found in the probation inspection domain one rules and guidance on the website.

In this inspection, we conducted a detailed examination of a sample of 34 court disposals and 23 out-of-court disposals. In each of those cases, we inspect against four standards: assessment, planning, and implementation/delivery. For court disposals, we look at reviewing; and in out-of-court disposals, we look at joint working with the police. For each standard, inspectors answer a number of key questions about different aspects of quality, including whether there was sufficient analysis of the factors related to offending; the extent to which children were involved in assessment and planning; and whether enough was done to assess and manage the safety and wellbeing of the child, and any risk of harm posed to others.

For each standard, the rating is aligned to the key question with the smallest percentage of inspected cases judged to be satisfactory against that question. recognising that each key question is an integral part of the standard.

Lowest banding (key question level)	Rating (standard)
Minority: less than 50% of inspected cases judged sufficient on the key question	Inadequate
Too few: only 50-64% of inspected cases judged to be sufficient	Requires improvement
Reasonable majority: 65-79% of cases	Good
Large majority: 80% or more of cases	Outstanding ☆

We use case sub-samples for some of the key questions in domains two and three. For example, when judging whether planning focused sufficiently on keeping other people safe, we exclude those cases where the inspector deemed the risk of serious harm to be low. This approach is justified on the basis that we focus on those cases where we expect meaningful work to take place.

An element of professional discretion may be applied to the standards ratings in domains two and three. Exceptionally, the ratings panel considers whether professional discretion should be exercised where the lowest percentage at the key question level is close to the

rating boundary, for example between 'Requires improvement' and 'Good' (specifically, within five percentage points of the boundary; or where a differing judgement in one case would result in a change in rating; or where the rating is based upon a sample or sub-sample of five cases or fewer). The panel considers the sizes of any sub-samples used and the percentages for the other key questions within that standard, such as whether they fall within different bandings and the level of divergence, to make this decision.

Overall provider rating

Straightforward scoring rules are used to generate the overall provider rating. Each of the ten standards will be scored on a 0-3 scale as listed in the following table.

Score	**Rating (standard)**
0	Inadequate
1	Requires improvement
2	Good
3	Outstanding ☆

Adding the scores for each standard together produces the overall rating on a 0-30 scale as listed in the following table.

Score	Rating (overall)
0-6	Inadequate
7-18	Requires improvement
19-30	Good
31-36	Outstanding ☆

We do not include any weightings in the scoring rules. The rationale for this is that all parts of the standards framework are strongly linked to effective service delivery and positive outcomes, and we have restricted ourselves to those that are most essential. Our view is that providers need to focus across all the standards, and we do not want to distort behaviours in any undesirable ways. Furthermore, the underpinning evidence supports including all standards/key questions in the rating, rather than weighting individual elements.

Annexe 2: Inspection data

The answers to the key questions that determine the ratings for each standard are underpinned by answers to more detailed 'prompts. These tables illustrate the proportions of the case sample with a satisfactory 'yes' response to the prompt questions. It should be noted that there is no mechanistic connection between the proportion of prompt questions answered positively, and the overall score at the key question level. The 'total' does not necessarily equal the 'sum of the parts'. The summary judgement is the overall finding made by the inspector, having taken consideration of the answers to all the prompts, weighing up the relative impact of the strengths and weaknesses.

Domain two: court disposals

2.1. Assessment	
Does assessment sufficiently analyse how to support the child's desistance?	% Yes
Is there sufficient analysis of offending behaviour, including the child's attitudes towards and motivations for their offending?	79%
Does assessment consider the diversity and wider familial and social context of the child, utilising information held by other agencies?	71%
Does assessment focus on the child's strengths and protective factors?	94%
Does assessment analyse the key structural barriers facing the child?	59%
Is sufficient attention given to understanding the child's levels of maturity, ability and motivation to change, and their likelihood of engaging with the court disposal?	82%
Does assessment give sufficient attention to the needs and wishes of the victim/s, and opportunities for restorative justice?	68%
Is the child and their parents/carers meaningfully involved in their assessment, and are their views taken into account?	81%
Does assessment sufficiently analyse how to keep the child safe?	
Does assessment clearly identify and analyse any risks to the safety and wellbeing of the child?	65%
Does assessment draw sufficiently on available sources of information, including other assessments, and involve other agencies where appropriate?	82%
Does assessment analyse controls and interventions to promote the safety and wellbeing of the child?	84%

Does assessment sufficiently analyse how to keep other people safe?	
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?	70%
Does assessment draw sufficiently on available sources of information, including past behaviour and convictions, and involve other agencies where appropriate?	90%
Does assessment analyse controls and interventions to manage and minimise the risk of harm presented by the child?	63%

2.2. Planning	
Does planning focus sufficiently on supporting the child's desistance?	% Yes
Does planning set out the services most likely to support desistance, paying sufficient attention to the available timescales and the need for sequencing?	74%
Does planning take sufficient account of the diversity and wider familial and social context of the child?	76%
Does planning take sufficient account of the child's strengths and protective factors, and seek to reinforce or develop these as necessary?	94%
Does planning take sufficient account of the child's levels of maturity, ability and motivation to change, and seek to develop these as necessary?	79%
Does planning give sufficient attention to the needs and wishes of the victim/s?	78%
Is the child and their parents/carers meaningfully involved in planning, and are their views taken into account?	91%
Does planning focus sufficiently on keeping the child safe?	
Does planning promote the safety and wellbeing of the child, sufficiently addressing risks?	80%
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?	68%
Does planning set out the necessary controls and interventions to promote the safety and wellbeing of the child?	73%

Does planning set out necessary and effective contingency arrangements to manage those risks that have been identified?	43%
Does planning focus sufficiently on keeping other people safe?	
Does planning promote the safety of other people, sufficiently addressing risk of harm factors?	54%
Does planning involve other agencies where appropriate?	73%
Does planning address any specific concerns and risks related to actual and potential victims?	54%
Does planning set out the necessary controls and interventions to promote the safety of other people?	68%
Does planning set out necessary and effective contingency arrangements to manage those risks that have been identified?	43%

2.3. Implementation and delivery	
Does the implementation and delivery of services effectively support the child's desistance?	% Yes
Are the delivered services those most likely to support desistance, with sufficient attention given to sequencing and the available timescales?	85%
Does service delivery reflect the diversity and wider familial and social context of the child, involving parents/carers or significant others?	71%
Does service delivery build upon the child's strengths and enhance protective factors?	94%
Is sufficient focus given to developing and maintaining an effective working relationship with the child and their parents/carers?	94%
Does service delivery promote opportunities for community integration including access to services post-supervision?	94%
Is sufficient attention given to encouraging and enabling the child's compliance with the work of the YOT?	100%
Are enforcement actions taken when appropriate?	89%
Does the implementation and delivery of services effectively support the safety of the child?	
Does service delivery promote the safety and wellbeing of the child?	83%
Is the involvement of other organisations in keeping the child safe sufficiently well-coordinated?	80%

Does the implementation and delivery of services effectively support the safety of other people?	
Are the delivered services sufficient to manage and minimise the risk of harm?	68%
Is sufficient attention given to the protection of actual and potential victims?	71%
Is the involvement of other agencies in managing the risk of harm sufficiently well-coordinated?	74%

2.4. Reviewing	
Does reviewing focus sufficiently on supporting the child's desistance?	% Yes
Does reviewing identify and respond to changes in factors linked to desistance?	90%
Does reviewing focus sufficiently on building upon the child's strengths and enhancing protective factors?	87%
Does reviewing consider motivation and engagement levels and any relevant barriers?	90%
Is the child and their parents/carers meaningfully involved in reviewing their progress and engagement, and are their views taken into account?	83%
Does reviewing lead to the necessary adjustments in the ongoing plan of work to support desistance?	77%
Does reviewing focus sufficiently on keeping the child safe?	
Does reviewing identify and respond to changes in factors related to safety and wellbeing?	69%
Is reviewing informed by the necessary input from other agencies involved in promoting the safety and wellbeing of the child?	81%
Does reviewing lead to the necessary adjustments in the ongoing plan of work to promote the safety and wellbeing of the child?	63%
Does reviewing focus sufficiently on keeping other people safe?	
Does reviewing identify and respond to changes in factors related to risk of harm?	71%
Is reviewing informed by the necessary input from other agencies involved in managing the risk of harm?	86%

Is the child and their parents/carers meaningfully involved in reviewing their risk of harm, and are their views taken into account?	71%
Does reviewing lead to the necessary adjustments in the ongoing plan of work to manage and minimise the risk of harm?	63%

Domain three: out-of-court disposals

3.1. Assessment	
Does assessment sufficiently analyse how to support the child's desistance?	% Yes
Is there sufficient analysis of offending behaviour, including the child's acknowledgement of responsibility, attitudes towards and motivations for their offending?	91%
Does assessment consider the diversity and wider familial and social context of the child, utilising information held by other agencies?	91%
Does assessment focus on the child's strengths and protective factors?	96%
Does assessment analyse the key structural barriers facing the child?	81%
Is sufficient attention given to understanding the child's levels of maturity, ability and motivation to change?	96%
Does assessment give sufficient attention to the needs and wishes of the victim/s, and opportunities for restorative justice?	100%
Is the child and their parents/carers meaningfully involved in their assessment, and are their views taken into account?	95%
Does assessment sufficiently analyse how to keep the child safe?	
Does assessment clearly identify and analyse any risks to the safety and wellbeing of the child?	77%
Does assessment draw sufficiently on available sources of information, including other assessments, and involve other agencies where appropriate?	82%
Does assessment sufficiently analyse how to keep other people safe?	
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?	95%

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?	100%

3.2. Planning	
Does planning focus on supporting the child's desistance?	% Yes
Does planning set out the services most likely to support desistance, paying sufficient attention to the available timescales and the need for sequencing?	91%
Does planning take sufficient account of the diversity and wider familial and social context of the child?	96%
Does planning take sufficient account of the child's strengths and protective factors, and seek to reinforce or develop these as necessary?	96%
Does planning take sufficient account of the child's levels of maturity, ability and motivation to change, and seek to develop these as necessary?	95%
Does planning take sufficient account of opportunities for community integration, including access to mainstream services following completion of out-of-court disposal work?	100%
Does planning give sufficient attention to the needs and wishes of the victim/s?	95%
Is the child and their parents/carers meaningfully involved in planning, and are their views taken into account?	91%
Does planning focus sufficiently on keeping the child safe?	
Does planning promote the safety and wellbeing of the child, sufficiently addressing risks?	80%
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?	85%
Does planning include necessary contingency arrangements for those risks that have been identified?	68%
Does planning focus sufficiently on keeping other people safe?	
Does planning promote the safety of other people, sufficiently addressing risk of harm factors?	92%

Does planning involve other agencies where appropriate?	83%
Does planning address any specific concerns and risks related to actual and potential victims?	89%
Does planning include necessary contingency arrangements for those risks that have been identified?	58%

3.3. Implementation and delivery	
Does service delivery support the child's desistance?	% Yes
Are the delivered services those most likely to support desistance, with sufficient attention given to sequencing and the available timescales?	82%
Does service delivery reflect the diversity and wider familial and social context of the child, involving parents/carers or significant others?	91%
Is sufficient focus given to developing and maintaining an effective working relationship with the child and their parents/carers?	100%
Is sufficient attention given to encouraging and enabling the child's compliance with the work of the YOT?	95%
Does service delivery promote opportunities for community integration, including access to mainstream services?	91%
Does service delivery effectively support the safety of the child?	
Does service delivery promote the safety and wellbeing of the child?	90%
Is the involvement of other agencies in keeping the child safe sufficiently well utilised and coordinated?	85%
Does service delivery effectively support the safety of other people?	
Is sufficient attention given to the protection of actual and potential victims?	85%
Are the delivered services sufficient to manage and minimise the risk of harm?	83%

3.4. Joint working	
Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child, supporting joint decision making?	% Yes

Are the recommendations by the YOT for out-of-court disposal outcomes, conditions and interventions appropriate and proportionate?	100%
Do the recommendations consider the degree of the child's understanding of the offence and their acknowledgement of responsibility?	100%
Is a positive contribution made by the YOT to determining the disposal?	100%
Is sufficient attention given to the child's understanding, and their parents/carers' understanding, of the implications of receiving an out-of-court disposal?	96%
Is the information provided to inform decision making timely to meet the needs of the case, legislation and guidance?	95%
Is the rationale for joint disposal decisions appropriate and clearly recorded?	90%
3.2.1 Does the YOT work effectively with the police in implementing the out-of-court disposal?[29]	
Does the YOT inform the police of progress and outcomes in a sufficient and timely manner?	100%
Is sufficient attention given to compliance with and enforcement of the conditions?	100%

[29] This question is only asked in youth conditional caution cases.