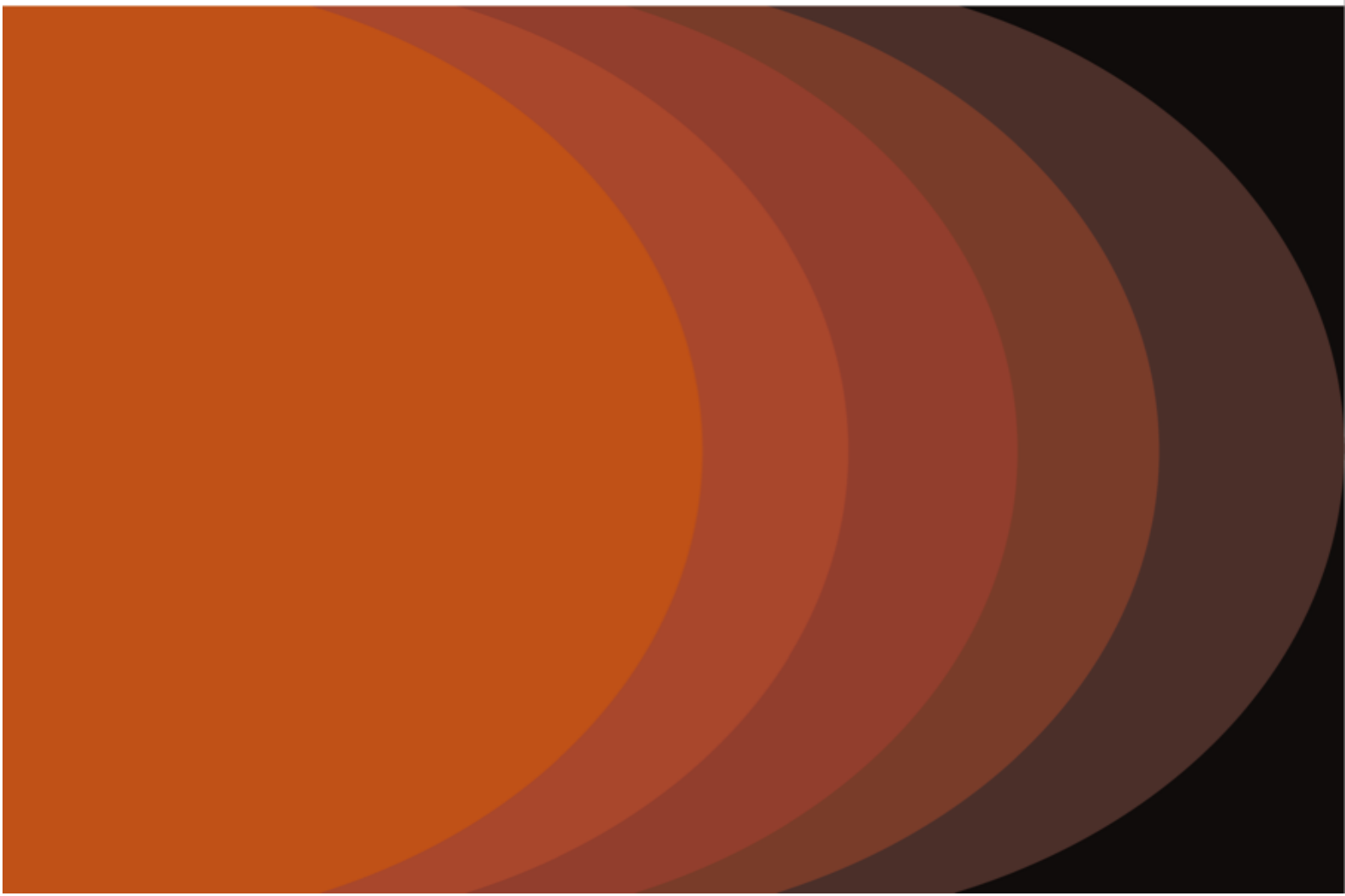
Her Majesty's Inspectorate of Probation

An inspection of youth offending services in

Birmingham

HM Inspectorate of Probation, October 2020



Acknowledgements

This inspection was led by HM Inspector Maria Jerram, supported by a team of inspectors and colleagues from across the Inspectorate. We would like to thank all those who helped plan and took part in the inspection; without their help and cooperation, the inspection would not have been possible.

The role of HM Inspectorate of Probation

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

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

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

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Foreword

This inspection is part of our four-year programme of youth offending service (YOS) inspections. We have inspected and rated Birmingham YOS across three broad areas: the arrangements for organisational delivery of the service; the quality of work done with children sentenced by the courts; and the quality of out-of-court disposal work. Overall, Birmingham YOS was rated as 'Requires improvement'.

Birmingham is the largest youth offending service in England and Wales. It has a caseload of over 370 children, over 140 staff and an annual budget of over £7 million. It works with some of the most challenging but also vulnerable and damaged children in the city and can have a profound impact on their life chances.

It was therefore disappointing to find such inconsistent practice in such a significant proportion of the cases we looked at, and a deterioration in the quality of that practice since our last inspection in 2016.

Rates of reoffending in Birmingham have been more positive than the national picture, and we found areas of good practice in work to support children sentenced by the courts to desist from offending. However, we judged plans and reviews to keep children safe and to manage the risk of harm to others to be inadequate. Out-of-court work was also assessed as Inadequate in three out of four of our standards and requires substantial improvement. Processes do not support effective joint decision-making, best practice or focus sufficiently on the needs of children and the protection of the public. Assessments and plans for safety and wellbeing and risk of harm to others were inadequate.

Funding constraints have led to important posts being left unfilled over the past year, with a direct impact on performance and engagement with victims. Management oversight was inadequate in well over half of the cases we inspected and is not having an impact on the quality of work delivered. There is also a lack of scrutiny and challenge throughout the service.

Due to delays caused by COVID-19 following the first part of the inspection, we provided the YOS with an interim report on the quality of practice. It has used this to create an improvement plan, invest in training and seek external guidance. The local authority has resolved some financial issues which will now enable the YOS to recruit staff into key posts that have been held vacant.

This is a critical time for Birmingham YOS. If it is to secure necessary improvements and avoid becoming an inadequate service, there must be a high level of scrutiny and a relentless focus on making improvements with pace.

Justin Russell
Chief Inspector of Probation

Ratings

Birmingham Youth Offending Service		**Score**	**7/36**
Overall rating		**Requires improvement**	
1.	**Organisational delivery**		
1.1	Governance and leadership	Requires improvement	
1.2	Staff	Requires improvement	
1.3	Partnerships and services	Requires improvement	
1.4	Information and facilities	Requires improvement	
2.	**Court disposals**		
2.1	Assessment	Requires improvement	
2.2	Planning	Inadequate	
2.3	Implementation and delivery	Requires improvement	
2.4	Reviewing	Inadequate	
3.	**Out-of-court disposals**		
3.1	Assessment	Inadequate	
3.2	Planning	Inadequate	
3.3	Implementation and delivery	Requires improvement	
3.4	Joint working	Inadequate	

Executive summary

Overall, Birmingham YOS is rated as: 'Requires improvement'. This rating has been determined by inspecting the YOS in three areas of its work, referred to as 'domains'. We inspect against 12 'standards', shared between the domains. Our fieldwork was conducted over two separate periods, the first from 09 to 13 March 2020 and the second between 20 and 24 July. 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.

The inspection of Birmingham YOS had originally been scheduled to be completed under our joint inspection framework. A joint inspection involves two weeks of fieldwork, the first undertaken by HM Inspectorate of Probation inspectors and a second week which involves partner inspectors from Her Majesty's Inspectorate of Constabulary, Fire & Rescue Services (HMICFRS), Care Quality Commission (CQC), social care and education. The initial week of HM Inspectorate of Probation fieldwork took place between 09 and 13 March 2020 and focused on inspecting the quality of work done with individual children sentenced by the courts, and the quality of out-of-court disposal work. Due to the outbreak of COVID-19, which happened in the middle of the inspection process, we were unable to complete the inspection in March. We then worked closely with Birmingham Children's Trust to conclude the inspection remotely using video conferencing software for interviews and focus groups. As the other inspectorates were unable to join us for the rescheduled dates, this was done under our alternative, HMI Probation-only inspection framework. We completed our second and final week of fieldwork between 20 and 24 July. Birmingham YOS was provided with an interim report on the quality of its practice in March 2020 and has used this during the intervening period to inform a service improvement plan.

We have inspected against 12 'standards', across three domains. The standards are based on established models and frameworks, which are grounded in evidence, learning and experience.

1. Organisational delivery

We interviewed the YOS Manager and the Chair of the Management Board. We held meetings with other members of the Board and key stakeholders

The YOS's arrangements for governance and leadership, staffing, partnership and services, and information and facilities have all been assessed as 'Requires improvement'.

[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'.

The vision and strategy for the YOS is understood by partners and most YOS staff. All statutory partners are represented on the Board, but attendance from some members is inconsistent and there has been limited effective challenge and scrutiny of YOS practice. Systems for identifying, capturing and managing issues and risks are not robust enough, and responses to these are not always timely or effective.

There is variation in management processes across the five YOS area teams and the quality of work delivered is also variable. The YOS's structure has not enabled it to provide a quality service. Frameworks and guidance are not sufficiently developed. There are some gaps in policies and procedures, and an absence of effective management oversight of both risk of harm to others, and safety and wellbeing. As a result of financial constraints caused by rising remand costs, key posts, such as the performance and development manager and strategic lead for restorative justice, had been left vacant for over 12 months. The impact of this on the quality of management supervision across the five teams and poor engagement with victims was clear in the results from our case assessment data. Management oversight was effective in only a third of out-of-court cases we inspected, and victims were properly considered in less than half.

Not all data used to understand the needs of children is reliable. Profiling lacked sophistication and information was not used sufficiently well. Children have access to a range of interventions and services, but the quality of resources available to deliver interventions are poor. Staff do not always have access to suitable facilities to meet with children.

Our key findings about organisational delivery are as follows:

- A current three-year youth justice plan sets out the priorities for the YOS. The wider YOS management team has contributed to the development of the plan.
- The Chair of the Board is a local councillor who holds the social inclusion, community safety and equalities brief. He is committed to using the findings of this inspection to drive improvement.
- Strategic managers in the YOS have been instrumental in the development of the contextual safeguarding hub, where the YOS has a daily presence, resulting in improved information exchange.
- There is a motivated staff team who are committed to supporting the children they work with.
- Children can access a wide range of services to meet a variety of needs.

But:

- There is insufficient attention paid at a strategic level to assessing and mitigating risks to service delivery.
- There has been more focus on improving processes to meet targets rather than assuring that the YOS provides a high-quality, evidence-based service.
- The quality of services delivered to children is not consistent across the five YOS teams.
- Until it was raised by HM Inspectorate of Probation, operational and strategic managers did not have an understanding of some of the weaknesses in practice.

- Managers do not have enough impact on the quality of recording and practice. Actions identified by managers are not always followed up.
- Vacancies in key positions have impacted on the quality of services and there is insufficient resilience in the structure to deal with staff absences.
- A key priority for the Board is addressing the over-representation of black and mixed heritage children in the justice system. Despite a good strategic understanding of the issue, there is too little impetus to address this in YOS practice.
- The YOS has worked with partners to increase the participation of children in mainstream schooling but there has been too little focus on YOS children and measuring improvements among this group.
- The YOS has made very limited progress in addressing the findings of the last inspection, and the results in domains two and three demonstrate a deterioration in the quality of practice since 2016.
- There has not been enough attention paid to the suitability and effectiveness of out-of-court disposal processes.

2. Court disposals

We took a detailed look at 55 community sentences and 7 custodial sentences managed by the YOS. We also conducted 58 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 53 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 48 cases where meaningful work was required.

In Birmingham YOS, just over half of cases met all our requirements in terms of quality of assessment and implementation and delivery, which led to a judgement of 'Requires improvement' in both these areas. We found that the quality of assessment of the factors affecting desistance and the interventions delivered to support desistance were good. However, assessments of safety and wellbeing and risk of harm to others were weaker, which brought our overall judgement down to 'Requires improvement'.

Planning and reviewing were done sufficiently well in less than half of cases we inspected, hence our judgement of 'Inadequate' for those elements of work. Planning and reviewing to support desistance were done well enough in over 70 per cent of cases, which meant that these elements of work were rated as good. However, the overall rating for planning of 'Inadequate' was determined by the scores in relation to safety and wellbeing and risk of harm to others, as this was done well enough in only 42 per cent and 48 per cent of cases respectively. The 'Inadequate' rating for reviewing was determined by the score for work to manage the risk of harm to others, which was satisfactory in less than 50 per cent of the cases inspected.

Work to support children to desist from crime was the strongest area of practice in post-court work. The consistency with which practitioners effectively engage children and their families is good. However, work to keep other people safe is weak across

all four standards in this domain, and particularly deficient in relation to planning and reviewing. There is a lack of consistency in the quality of work on the safety and wellbeing of the child themselves across the areas. This was assessed as 'Requires improvement' for assessment, implementation and delivery, and reviewing, whereas it was 'Inadequate' in planning.

While the overall ratings for the YOS reflect the average scores across all teams, in practice we found some significant variation between them. For example, when looking at post-court work across the five teams that make up Birmingham YOS the best performing team was rated outstanding in six elements of practice in contrast to the team with the lowest rating, which was assessed as 'Inadequate' in eight elements of practice.

The findings across the teams indicate an inconsistent approach to practice. They also suggest that there are opportunities for learning between the teams, and a need for a shared understanding of best practice and a unified management approach. Overall, we assessed the management oversight to be adequate in 43 per cent of cases we inspected, varying between 11 per cent and 67 per cent across the teams. In the two teams where we considered management oversight to be the most effective, there was an association between this and the quality of practice that the teams delivered.

Our key findings about court disposals are as follows:

- Assessments consider the diversity and wider familial and social context of the child.
- The quality of work to support desistance is good in relation to assessment, implementation and delivery, and in reviewing.
- Service delivery involves parents/carers or significant others and takes their views into consideration.
- The reviewing of cases focuses on building upon the child's strengths and protective factors.
- Staff develop and maintain an effective working relationship with children and their parents/carers.

But:

- Practice across the area teams is not consistent and varies in quality and effectiveness.
- Assessment, planning and case reviewing for children in custody are of insufficient quality in the majority of cases.
- The wishes and needs of identified and potential victims are not prioritised, and risk of harm to others is underestimated.
- Planning for risk of harm and safety and wellbeing is inadequate and contingency planning does not reflect the needs of the case.
- Planning, implementation and delivery, and reviewing of court cases do not focus sufficiently on keeping other people safe.
- Management oversight does not impact on the quality of the work delivered to manage risk of harm or safety and wellbeing.
- Reviewing does not consistently lead to the necessary adjustments in the ongoing plan of work to promote the safety and wellbeing of the child.

- The involvement of other organisations in keeping children safe and addressing risk of harm to others is not always well coordinated.

3. Out-of-court disposals

We inspected 37 cases managed by the YOS that had received an out-of-court disposal. These consisted of 27 youth conditional cautions, 4 youth cautions and 6 community resolutions. We interviewed the case managers in 27 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 24 cases where there were factors related to harm, we also inspected work done to keep other people safe. In the 28 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.

Implementation and delivery of out-of-court disposal work was rated as 'Requires improvement' as we found it to be sufficient in just over half of cases. The quality of planning fell below our expected standards in over half of cases, leading to an 'Inadequate' judgment for this area of practice. Less than a quarter of cases we inspected met all our standards for joint working, hence the judgement of 'Inadequate' for this inspection standard. In almost half of the cases we inspected there was no evidence that the YOS had made any recommendations for the most appropriate out-of-court disposal, and even where they did, we found that only half of these were appropriate and proportionate.

Processes for out-of-court disposal cases in Birmingham involve the completion of an initial screening prior to decision-making. The screening is based on information collated by the police from various agencies. However, the child and their parent/carer are not interviewed at this stage, which means that their specific circumstances, motivation and attitude towards the offence are not fully understood at the point that disposal decisions are made. It also means that, despite the YOS being present at the decision-making panel, it is not able to make a meaningful recommendation based on a detailed knowledge of the child. We found that the rationale for decision-making was recorded in very few cases, so it was difficult to know why a disposal had been agreed. Once a decision regarding disposals has been made, a full AssetPlus assessment, which considers desistance, risk of harm and safety and wellbeing, is completed on all diversion cases. It is the standard of these assessments and subsequent work that we have inspected and rated.

In just over half of cases we inspected, out-of-court disposals were imposed for offences that involved varying degrees of violence. Despite this, we found that consideration was not routinely given to the risks posed to others, including actual and potential victims. Equally, we saw high levels of vulnerability and complex needs. In just under half of the cases we inspected, the child was aged 14 or under. In almost a third of cases it was noted that the child had a disability, mainly related to mental health, cognitive or learning disabilities, and in most cases, we assessed the impact on the individual as significant. In 30 of the 37 cases, there had been no prior out-of-court disposal imposed, and in some cases, we felt that a less onerous disposal than the one determined would have been sufficient.

For out-of-court disposals, across the five teams there was less variation in practice than that in post-court work. We found that the quality of the recommendations

made by the YOS to inform decision-making was consistently inadequate. On management oversight, there were some differences across the teams, and we assessed its effectiveness to be between 17 per cent and 56 per cent, demonstrating a need for significant improvement across the service.

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

- YOS staff develop and maintain effective relationships with children and their parents/carers.
- Sufficient attention is given to encouraging and enabling the child's compliance with the work of the YOS.
- Children and their parents/carers are meaningfully involved in their assessment process, and their views are considered.
- The quality of work to support desistance is good in planning, and implementation and delivery.
- In most cases, planning takes enough account of opportunities for integration into community and mainstream services following completion of out-of-court disposals.

But:

- In only a minority of cases did the YOS make a positive contribution to determining the disposal, and the rationale for joint disposal decisions is not clearly recorded. The YOS recommendations to support joint decision-making are not sufficiently well informed, analytical and personalised to the child.
- Assessments of, and planning for, safety and wellbeing and risk of harm to others are inadequate.
- Not enough attention is given to the protection of actual and potential victims in the work delivered.
- There is little evidence that the YOS informs the police of progress on out-of-court disposals.

Recommendations

As a result of our inspection findings we have made 12 recommendations that we believe, if implemented, will have a positive impact on the quality of youth offending services in Birmingham. This will improve the lives of the children in contact with youth offending services, and better protect the public.

Birmingham Youth Offending Service should:

1. develop a consistent approach to practice across the five area teams, ensuring that staff receive the training and support they need, and that management oversight is effective and makes a difference to the quality of all work delivered

2. accurately assess the risk to a child's safety and wellbeing and risk of harm to others, including in out-of-court disposal cases, and make sure that all risks are planned for, reviewed and managed via effective processes

3. consider and address the specific needs of children sentenced to custody, making sure that risks are identified and addressed in all areas of practice and service delivery

4. develop, implement and monitor the impact of an action plan to improve outcomes for black and mixed heritage boys, who are over-represented in the youth justice system

5. develop victim and restorative justice processes to make certain that the needs of potential and actual victims, and opportunities for restorative justice, are fully considered and acted upon in every relevant case

6. review out-of-court disposal work with the police to ensure that there is a consistent and transparent process, and that children are appropriately considered for community resolutions

7. make well-informed, analytical out-of-court disposal recommendations that support joint decision-making and are personalised to the specific needs of the child

8. work with other agencies to make sure that children's needs are understood, joint plans are in place and that implementation of services are well coordinated

The Director of Children's Services should:

9. make sure the YOS structure has enough management capacity to fully enact its three-year plan and drive the delivery of high-quality services to children

10. consider the high numbers of YOS children attending the pupil referral unit, alternative education or without a school placement, assess their needs, and address any barriers that might be impacting on their reintegration with mainstream education.

The Chair of the Board should:

11. make sure that robust quality assurance systems are in place to enable the Board to have a clear overview of practice and service delivery

12. hold each partner agency to account within, and between, YOS Board meetings.

Background

Youth offending teams (YOTs) supervise 10–18-year-olds 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. HMI Probation inspects both these aspects of youth offending services.

YOTs are statutory partnerships, and they are multidisciplinary, to deal with the needs of the whole child. They are required to have staff from local authority social care and education services, the police, the National 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.

Birmingham is a richly diverse city with a population of over a million people and has one of the youngest populations of any European city. It is one of the most deprived areas in England with 41 per cent of neighbourhoods among the 10 per cent most deprived in the country. Families face significant challenges in terms of unemployment, low income, educational attainment, housing and crime. As a result, many children will struggle to achieve their full potential and remain safe.

Levels of youth violence across the city increased by 10 per cent in 2018/19 compared to figures for 2017/18. A key priority of the community safety partnership is to reduce violence across communities and to tackle exploitation, 'county lines', urban street gangs and child sexual exploitation.

The YOS sits within the Birmingham Children's Trust. Birmingham children's services was taken into the trust in April 2018 due to long-term inadequacies in service delivery. In December 2018, Ofsted deemed that children's services were no longer 'Inadequate', and they were assessed as 'Requires improvement'.

Birmingham YOS is the largest in the country. It is made up of five multi-agency area teams based across the city. In addition, it operates a city-wide alternative to custody, intensive supervision and surveillance (ISS) team, a court, bail and remand team, and a harmful sexual behaviour team targeted at children aged 6 to 17. In addition to statutory partners based in the service (probation, social care, health and police), there are co-located specialist staff supporting service delivery, including: restorative practice workers supporting victims of crime; parenting workers offering individual and group work support; an accommodation officer; a specialist autism worker; a speech and language therapist; substance misuse staff; and training and employment mentors.

In common with the national picture, Birmingham has seen a reduction in the numbers of first-time entrants into the criminal justice system over the past two years. Based on the most recent published data, since April 2015, the rates of reoffending have been consistently lower than the England and Wales average.

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

Asian and white children are under-represented within the YOS cohort and children who are black or mixed heritage are significantly over-represented. Despite making up 19 per cent of the Birmingham youth population, black or mixed heritage children make up 37 per cent of the YOS statutory cohort. This has been an ongoing issue, and addressing it is a priority in the youth justice plan.

Contextual facts

Youth justice information

351	First-time entrant rate per 100,000 in Birmingham[4]
214	First-time entrant rate per 100,000 in England and Wales[4]
32.7%	Reoffending rate for Birmingham[5]
38.4%	Reoffending rate in England and Wales [6]

Population information

1,141,374	Total population Birmingham[7]
121,498	Total youth population (10–17 years) in Birmingham[7]
64,832	Total black and minority ethnic youth population Birmingham [8]

Caseload information[9]

Age	10–14	15–17
Birmingham YOS	20%	80%
National average	23%	77%

Race/ethnicity	White	Black and minority ethnic	Unknown
Birmingham YOS[10]	37%	59%	5%[11]
National average	70%	26%	4%

Gender	Male	Female
Birmingham YOS	85%	15%
National average	85%	15%

[4] Youth Justice Board. (2020). *First-time entrants, October 2018 to September 2019.*

[5] Ministry of Justice. (2020). *Proven reoffending statistics, April 2017 to March 2018.*

[6] Ministry of Justice. (2020). *Proven reoffending statistics, April 2017 to March 2018.*

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

[8] Office for National Statistics. (2012). *Census 2011.*

[9] Youth Justice Board. (2020). *Youth Justice annual statistics: 2018 to 2019.*

[10] Ethnic breakdown of children in Birmingham who receive a criminal justice sanction.

[11] In some cases, figures may not total, or may exceed, 100 due to rounding.

Additional caseload data[12]

373	**Total current caseload, of which:**
305 (82%)	Court disposals
68 (18%)	Out-of-court disposals

Of the 305 court disposals

254 (83%)	Total current caseload on community sentences
35 (11%)	Total current caseload in custody
16 (5%)	Total current caseload on licence

Of the 68 out-of-court disposals

2 (3%)	Total current caseload with youth caution
41 (60%)	Total current caseload with youth conditional caution
25 (37%)	Total current caseload: community resolution or another out-of-court disposal

Education and child protection status of caseload

2%	Proportion of current caseload 'Looked After Children' resident in the YOT area
2%	Proportion of current caseload 'Looked After Children' placed outside the YOT area
1%	Proportion of current caseload with child protection plan
7%	Proportion of current caseload with child in need plan
11%	Proportion of current caseload aged 16 and under not in school/pupil referral unit/alternative education
51%	Proportion of current caseload aged 16 and under in a pupil referral unit or alternative education
34%	Proportion of current caseload aged 17+ not in education, training or employment

For children in the inspected cases subject to court disposals:

Offence types[13]	%
Violence against the person	40%
Burglary	3%
Robbery	10%

[12] Information supplied by the YOS.

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

Theft and handling stolen goods	8%
Fraud and forgery	2%
Arson	3%
Criminal damage	2%
Drug offences	5%
Summary motoring offences	10%
Indictable motoring offences	5%
Other summary offences	6%
Other indictable offences	6%

1. Organisational delivery

We interviewed the YOS Manager and the Chair of the Management Board. We held meetings with other members of the Board and key stakeholders.

The YOS's arrangements for governance and leadership, staffing, partnership and services, and information and facilities have all been assessed as 'Requires improvement'.

The vision and strategy for the YOS is understood by partners and most YOS staff. All statutory partners are represented on the Board, but attendance from some members is inconsistent, and there has been limited effective challenge and scrutiny of YOS practice. Systems for identifying, capturing and managing issues and risks are not robust enough, and responses are not always timely or effective.

There is variation in management processes across the five YOS teams and the quality of work delivered is also variable. The YOS's structure has not enabled it to provide a quality service. Frameworks and guidance are not sufficiently developed. There are some gaps in policies and procedures, and an absence of effective management oversight of both risk of harm to others and safety and wellbeing.

Not all data used to understand the needs of children is reliable. Profiling lacked sophistication and information was not used sufficiently well. Children have access to a range of interventions and services, but the quality of resources available to case managers in their one-to-one work with children are poor. Staff do not always have access to suitable facilities to meet with children.

Strengths:

- A current three-year youth justice plan sets out the priorities for the YOS. The wider YOS management team has contributed to the development of the plan.
- The Chair of the Board is a local councillor who holds the social inclusion, community safety and equalities brief. He is committed to using the findings of this inspection to drive improvement.
- Strategic managers in the YOS have been instrumental in the development of the contextual safeguarding hub, where the YOS has a daily presence, resulting in improved information exchange.
- There is a motivated staff team who are committed to supporting the children they work with.
- Children can access a wide range of services to meet a variety of needs.

Areas for improvement:

- There is insufficient attention paid at a strategic level to assessing and mitigating risks to service delivery.
- There has been more focus on improving processes to meet targets rather than assuring that the YOS provides a high-quality, evidence-based service.
- The quality of services delivered to children is not consistent across the five YOS teams.
- Until it was raised by HM Inspectorate of Probation, operational and strategic managers did not understand some of the weaknesses in practice.
- Managers do not have enough impact on the quality of recording and practice. Actions identified by managers are not always followed up.
- Vacancies in key positions have impacted on the quality of services and there is insufficient resilience in the structure to deal with staff absences.
- A key priority for the Board is addressing the over-representation of black and mixed heritage children in the justice system. Despite a good strategic understanding of the issue, there is too little impetus to address this in YOS practice.
- The YOS has worked with partners to increase the participation of children in mainstream schooling but there has been too little focus on YOS children and measuring improvements among this group.
- The YOS has made very limited progress in addressing the findings of the last inspection, and the results in domains two and three demonstrate a deterioration in the quality of practice since 2016.
- Not enough attention has been paid to the suitability and effectiveness of out-of-court disposal processes.

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.	Requires improvement

Key data[14]

Total spend in previous financial year – 2018/2019	No information provided by the YOS
Total projected budget for the current financial year – 2020/2021	£7,356,298 (of which £1,915,731 is YJB Good Practice Grant)[15]

In making a judgement about governance and leadership, we take into account 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?

A current three-year youth justice plan sets out the priorities for the YOS. The wider YOS management team has contributed to the development of the plan. Partners and most YOS staff are aware of the plan and the strategic ambitions for the service. The Chair of the Board is a local councillor who holds the social inclusion, community safety and equalities brief. He has been chairing the Board for the last 12 months and his knowledge of the service is developing but not yet sufficiently detailed. He is committed to using the findings of this inspection to drive improvement.

The YOS Board includes key statutory partners who are the right seniority and most members are well-established. However, there has been poor attendance from the Clinical Commissioning Group (CCG) and no consistent local authority education representative. This is significant when considering the numbers of school-age children attending the pupil referral unit or not in education. At strategic and operational levels there has been more focus on improving processes to meet targets and key performance indicators rather than assuring that the YOS provides a high-quality, evidence-based service.

The Birmingham Children's Trust Director for practice, and the Board Chair, have recognised that swift action is required to improve the level of scrutiny provided by the Board and will be revising the YOS Management Board processes. At Board meetings, the YOS provides updates on YOS performance, practice and projects that are being developed. However, there has been a lack of scrutiny and challenge, and Board members have not sufficiently held the YOS and each other to account for improving outcomes for children. The Board needs to have mechanisms that enable it to assess whether it is delivering on its strategic priorities, and address any barriers to improvement.

The Children Trust's Assistant Director responsible for the YOS is also the strategic lead for the early help strategy and is joint Chair of the Birmingham Early Help Partnership, co-ordinating early help services across the partnership, Family Support and the 'Think Family' programme (Birmingham's response to the national 'Troubled Families' programme). A substantial amount of Think Family money is invested in the YOS to support service delivery, and makes up 8 per cent of the overall YOS budget. This funding is guaranteed until March 2021, and if it ends then, this would pose a significant risk to service delivery. Inspectors were concerned to find that there was

[14] Information supplied by YOT.

[15] The purpose of the Youth Justice Good Practice Grant is to develop Good practice and commission research with a view to achieving outcomes in reducing offending, the numbers of first-time entrants to the youth justice system and the use of youth custody.

a lack of clarity at senior management level regarding the contingency plans to mitigate this risk.

The *Legal Aid, Sentencing and Punishment of Offenders Act 2012* set out a single remand framework which transferred the costs of keeping a child in custody on remand to local authorities. In Birmingham, this cost has remained with the YOS and the increasing number of remands and related costs have created a financial strain on the service. Over the past year the YOS has responded by holding six posts vacant to cover the remand costs. This was raised at the Board as a risk in July 2019 and then escalated to the city council, but no further action was taken. This issue has been resolved since this inspection began, and the YOS has had £330,000 returned to its budget. This money will be used to recruit into the posts that had been held vacant and to fund improvement work post-inspection.

A key priority for the Board is addressing the over-representation of black and mixed heritage children in the youth justice system in Birmingham. Despite a good strategic understanding of the issue, there is too little impetus to address this in YOS practice.

Do the partnership arrangements actively support effective service delivery?

The YOS is represented at relevant strategic meetings, which include the community safety Board, safeguarding Board, Birmingham Guns, Gangs and Organised Criminality Strategic Partnership and the 0-18 Mental Health Transformation Board. Strategic managers in the YOS have been instrumental in the development of the contextual safeguarding hub, where the YOS has a daily presence, resulting in improved information exchange.

The partnership has provided the YOS with seconded staff, including police officers, mental health nurses and probation officers. The CCG has recently funded a part-time clinical psychologist post and an autism worker to promote trauma-informed practice within the team. Funding has been secured from the Office of the Police and Crime Commissioner (OPCC) to commission tailored mentoring support for children and at risk of, or involved in, gangs/criminal exploitation, and some YOS children have benefited from this support.

Partners have a good understanding of the needs of children using their own individual services, but the partnership does not consistently analyse data to understand the specific needs of children supervised by the YOS. For example, half of the YOS school-age cohort are attending a pupil referral unit or other alternative education provision. A further 11 per cent have no school placement at all. The YOS has worked with partners to increase the participation of children in mainstream schooling generally, but there has been too little focus on YOS children and measuring improvements for them as a specific group.

Does the leadership of the YOT support effective service delivery?

The YOS has 143 full-time staff, with a senior leadership team made up of a Head of Service (HOS) and two deputy Heads of Service. There are five locality YOS teams, and a further team delivering interventions across the city. There has been a lack of senior management capacity to ensure that the necessary service improvements identified in the HM Inspectorate of Probation 2016 inspection are delivered. Sickness and special leave have reduced team management capacity over the last 12 months. This has meant that one deputy HOS was covering practice manager vacancies, affecting their ability to focus on their own operational tasks, which are critical given the size of the service. The HOS meets the management team regularly

to review performance against Board priorities. Managers feel these meetings provide an opportunity for concerns to be escalated to the Board.

There has not been a unified approach to practice and processes across the service, which has resulted in varied performance between the five locality YOS teams. The best performing team is outstanding in one area of post-court practice, good in another and requires improvement in two. Three teams are inadequate in all areas. This means that services to children are inconsistent in quality across the city and not all teams are delivering on the strategy.

Staff understand the policies and procedures that apply to their role and the significance of their work in achieving the strategic priorities of the YOS. Some staff feel that communication is not as good as it could be, with just under a third who responded to our survey telling us that they do not feel sufficiently updated on strategic issues such as budget, legislation or staffing.

YOS cases can be kept open when an intervention ends if the case workers feels that more support is needed on a voluntary basis. These cases then become what is now locally referred to as 'Think Family' (Troubled Families) cases. While there may be benefits to this approach, we found that not all staff understood what was expected of them in any ongoing work with children and families after YOS interventions ended.

The quality assurance processes in place have not been used to steer the direction of the service or to sufficiently ensure improvements in practice. The performance and development manager post has been held vacant for the past 12 months, and this has further hindered quality assurance and improvement work. We judged management oversight as ineffective in over 50 per cent of the cases we inspected. There was a lack of challenge, direction and follow-up, with assessments countersigned when they were not of a sufficient standard. Performance meetings with staff focus on meeting national standards and the completion of tasks, with little attention paid to the quality of work.

Not all risks to the service are sufficiently understood by the leadership team. Until it was raised by HM Inspectorate of Probation, operational and strategic managers did not have a full understanding of some of the weaknesses in practice. Leaders have responded quickly to our inspection findings and have developed an improvement plan. It is positive that they have committed resources to secure external support and invest in recruitment and staff training.

1.2. Staff

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

Key staffing data[16]

Total staff headcount (full-time equivalent, FTE)	143
Total headcount qualified case managers (FTE)[17]	22
Total headcount other case managers (FTE)	12.5
Vacancy rate (total unfilled posts as percentage of total staff headcount)	9%
Vacancy rate: case managers only (total unfilled case manager posts as percentage of total case manager headcount)	4%
Average caseload per case manager (FTE)	12
Average annual sickness days (all staff)	9.4
Staff attrition (percentage of all staff leaving in 12-month period)	6%

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?

Due to financial pressure, the YOS has held some key posts, such as that for the performance and development manager, vacant for the past 12 months. The strategic lead for restorative justice left the service over 12 months ago and this post has also not been filled. There were no structured plans to mitigate the risks this created, and the impact of these gaps may have contributed to the poor domain two and three results. In addition, sickness rates are higher than the national average, creating additional pressure. There are no plans to cover management and key leadership roles. For example, although it has been agreed for one deputy HOS to take a secondment from October 2020, there were no clear cover arrangements in place at the time of inspection.

Most staff feel that their workload is manageable and that they are allocated work matched to their level of skill and experience. However, there are some inconsistencies in the allocation of work across the service. For example, 'Think Family' cases are considered in the allocation of YOS work for some teams but are additional to their YOS workload for others.

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

[17] Qualified case managers refer to those with a social work or probation professional qualification.

The service is well-served by a panel of volunteers who undertake work on referral order panels and as appropriate adults. We did not receive any feedback to our volunteer survey but all those volunteers we spoke to said they had received suitable training.

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

Almost all staff responding to our survey reported that they feel motivated to deliver high-quality services and are committed to achieving positive outcomes for children. Staff have a good understanding of the children they work with, and the issues and challenges they face. They are flexible in their approach to promote and support children's engagement. At all levels of the organisation, the ethnic make-up of the workforce reflects the communities the YOS serves.

The service has two tiers of case managers, qualified and unqualified, and cases are allocated to them accordingly. Case data from domains two and three shows that staff are good at undertaking assessments and delivering interventions in relation to desistance needs. The same data also shows, however, that they are less skilled in assessing and managing risk to others, and risk to the safety and wellbeing of children.

The service does not have a strategy to identify and develop the potential of individual staff to support succession planning. Communication can be challenging in a large service, but it is important if senior managers are to ensure staff feel listened to and able to contribute to service improvements. Less than half of the staff responding to our survey said they were asked for their views about working for the YOS, through an internal survey or staff committee for example. Just under a quarter felt that their views were listened to and acted upon by managers.

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

The appraisal process is not always used effectively to ensure that staff are competent to deliver a quality service, and not all staff feel that their training needs are sufficiently met. Our inspection found the quality of management oversight to be ineffective, and there is too little staffing resilience.

Most staff responding to our survey reported their supervision as quite good or very good. They said their line managers were supportive and approachable. However, we found management oversight lacked scrutiny and challenge. There was not enough focus on the quality of work, with assessments being countersigned when they were insufficient. We found management oversight to be effective in only 43 per cent of domain 2 cases and 34 per cent of domain 3 cases. Arrangements are in place for partnership staff to receive supervision from the home agencies, and both managers and staff report that this works well.

There were no staff subject to performance measures at the time of the inspection. Managers told us that they tend to deal with capability through informal processes. The YOS needs an approach that is rigorous and robust, ensuring that staff progress and work improves to reach the required standards.

One staff member has recently been nominated for a council award for outstanding work, and in general staff feel that good work is recognised and appreciated by the management team.

Are arrangements for learning and development comprehensive and responsive?

Staff we met reported that they have a range of training opportunities, but over a quarter of those responding to our survey felt that their needs are not adequately met. The YOS has not undertaken a recent skills audit; the Head of Service told us that there are now plans to do this.

Staff can access training through the Children's Trust, but this does not have a specific youth justice focus. There is no workforce development plan that includes whole-service training to support improvements and create a shared approach to practice across teams. In response to our inspection findings, targeted youth justice training has been commissioned from an external provider and will be delivered to all case managing staff. The delivery of this training has already commenced.

Some members of the management team have received systemic supervision training, which they have found useful. Most managers have only recently completed this training and the benefits are not yet evident in the management oversight of casework.

There are no effective systems and processes to support learning across teams, such as regular service meetings or practice forums. This needs to be addressed if the YOS is to create a unified approach to practice that means that services delivered to children are consistent.

1.3. Partnerships and services

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

Caseload characteristics[18]

Percentage of current caseload with mental health issues	15%
Percentage of current caseload with substance misuse issues	9%
Percentage of current caseload with an education, health and care plan	10%

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?

At a strategic level, the YOS uses information from self-assessments completed by the children to understand their needs, and this approach is welcomed. However, this only provides a partial understanding. There are no checks and balances to test the reliability of self-reported needs, which means the data is insufficient. For example, 9 per cent of children reported having substance misuse issues but YOS staff and the inspection team identified the need as significantly higher. Fifteen per cent of children are identified through self-assessment as having mental health

[18] Data supplied by YOT based on children's self-reports.

needs but the high caseloads of the 'Forward Thinking' Birmingham practitioners indicate this figure is an underestimate.

The reports that Board members receive from the YOS provide an overview of the offending profiles of children, and performance against national key performance indicators. Issues of ethnic disproportionality are identified but not enough work has been done to understand the needs of this group of children in order to address them.

We found that analysis is not consistently used to shape service delivery. For example, intensive supervision and surveillance (ISS) and knife crime programmes have not been evaluated. As such, the YOS cannot assure itself that its interventions are effective and of good quality. We received no response to our sentencer survey so cannot comment on court satisfaction.

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

Children can quickly access a wide range of targeted and specialist services, via referral to partner agencies or through staff embedded within the YOS. There is a local analysis of disproportionality issues but there are no specific interventions to address any distinct needs of black and mixed heritage children, who are over-represented in the services. Consideration has been given to children from the Roma community with specialist interventions available, and we saw positive evidence of this work in some of the cases we inspected.

Workers across all roles are effective in facilitating engagement and fostering positive relationships with children. Staff know the pathways for children to access services (both internally and externally). Partnership staff (such as education, training and employment, nurses and probation) are co-located within the YOS, and the timeframe for access to services, such as mental health and substance misuse services, is timely, taking about two weeks for an initial assessment. The mental health provision available through 'Forward Thinking Birmingham' includes non-medical prescribing, informed cognitive behaviour therapy (CBT), family therapy, brief solution-focused therapy, along with neurodevelopmental assessments.[19] The Forward-Thinking Birmingham nurses currently have high caseloads, and this has not been sufficiently reviewed.

Transitions of children to adult probation were well-managed, with a clear process for handover meetings and a rationale for decisions on which children would transition and which would remain within the YOS. Once the cases are transferred, the probation service allocates youth cases to semi-specialist probation officers who are better placed to meet their needs.

The YOS has five co-located police officers who focus on out-of-court disposal work. There are also links with police station-based officers who assist with the management of children discussed at the 'one day one conversation' (ODOC) multiagency high-risk panel. It was unclear to inspectors how information relating to

[19] Non-medical prescribing (NMP) is the term used to describe any prescribing completed by a healthcare professional other than a doctor or dentist. Cognitive behavioural therapy (CBT) is a talking therapy that can help you manage your problems by changing the way you think and behave. Brief solution-focused brief therapy places focus on a person's present and future circumstances and goals rather than past experiences. Neurodevelopmental assessments include: Autistic Spectrum Conditions, ADHD and learning difficulties/ disability.

children not in these groups is routinely shared with practitioners promptly to support effective risk management work.

Joint working for out-of-court disposals is Inadequate. The YOS does not make enough contribution to the decision-making process, and disposal decisions are based on cross checks by the police before an assessment is completed and the child is seen by a practitioner. There is no strategic approach to the issuing and monitoring of community resolutions. Processes are inconsistent and lack transparency. The findings of this inspection have prompted the service to undertake a thorough review of all out-of-court disposal processes, and it is currently revising its procedures.

The YOS runs a music programme for children who have offended or who are at risk of offending. The project has been evaluated, and feedback from children who have participated reflects a high-level of satisfaction. In terms of education, Change, Grow, Live (CGL) is a commissioned service providing support to help children to manage in educational settings and sustain their placements. Support is also provided to assist post-16 children to find suitable education, training and employment.

The YOS benefits from a gender-specific programme with specialist staff delivering interventions to girls in a safe female-only space. This programme developed out of the ISS provision when it was recognised that girls were struggling to engage in the predominantly male groups.

There has been no strategic lead for restorative justice and victim work for over a year, and this has resulted in an inconsistent approach to work with victims. A priority of the youth justice plan is to improve services to victims, but this gap has hindered progress, and this is evident in our casework findings. In post-court work, victims were properly considered in less than half of the cases we inspected.

Only 64 per cent of staff responding to our survey felt they had enough access to the services, interventions and partnership resources they needed to work with children. The quality and suitability of resources to support one-to-one offending behaviour work with children was highlighted as a specific gap.

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

The ODOC multi-agency risk panel meeting reviews high-risk cases and provides opportunities for information sharing and joint planning.

The YOS mental health team has effective links to the liaison and diversion team in the police station. This means that concerns about children in custody can be shared and responded to promptly. The case management-plus process involves input from a clinical psychologist to assist staff in their work with complex cases. This is a relatively new provision and staff reported that they value the guidance and support it provides.

Work with children's social care can be challenging. Staff report that referrals are not always accepted by social care when the YOS is working with a child. This means that they are often left managing the welfare concerns of children and families as well as delivering YOS interventions. At a strategic level, the YOS has put arrangements in place to strengthen the profile of the YOS within the Child Advice and Support Service (CASS), with a daily presence at manager level to promote more

effective multi-agency practice to safeguard children, particularly those vulnerable to criminal exploitation.

Half of the YOS school-age cohort are attending a pupil referral unit or other alternative education provision. But a further 11 per cent have no school placement at all. The YOS has worked with partners to increase the participation of children in mainstream schooling, but there has been too little focus on YOS children and measuring improvements among this group. There has not been enough analysis to understand the reasons for school exclusions and to assess if the alternative provision children have been provided is suitable.

Involvement of children and their parents/carers

Children have been consulted on some YOS matters, such as how to decorate the female-only space, but this does not happen routinely. The HOS had considered setting up a youth council but this has not yet gone ahead due to resource limitations. We received only three responses to the text survey that we sent to YOS children, so we do not have enough data to comment on their overall level of satisfaction with the services they receive.

1.4. Information and facilities

Timely and relevant information is available and appropriate facilities are in place to support a high-quality, personalised and responsive approach for all children.	Requires improvement

In making a judgement about staffing, we take into account 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?

Most staff responding to our survey said they understand the existing policies and procedures that apply to their role. There are some gaps – for example, there is no allocation policy which would promote consistency across teams. The Think Family processes and expectations for these cases are not understood by staff and managers. There is a lack of consistency across YOS teams in recording, policy and practice for restorative justice and victim work.

Processes and systems for of out-of-court disposals have not been consistent or transparent, and this has affected decision-making and the monitoring of community resolutions. The YOS is currently undertaking a thorough review of its out-of-court disposal procedures to ensure they are effective; this includes revising all documentation.

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

The YOS operates a locality model. Teams were originally based in separate local offices to provide easy access to children and families in those areas, but with the closure of some sites three teams are now based together in one office. This means that two teams must factor in much longer travel time to see children at home or

alternative community venues. Otherwise, children face lengthy journeys to the office in an area where they may not feel safe, and where they may have conflict with other children. The YOS has taken some action to mitigate the impact of this, for example by trying to secure more venues, but some staff reported that it can still be challenging to find suitable places to meet with children, and suitable premises are not always available in all areas.

One YOS site was previously a secure children's home, and the high fences do not present as a child-friendly or neutral community setting.

The ongoing investment in a female-only unit offers a variety of resources, including a cookery area and arts and crafts. This approach is designed to develop trust and relationship-building, critical to effective work with girls.

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

Staff describe ICT systems as reliable and able to facilitate quality work and exchange of information with partners where required. YOS staff have access to social care and Early Help systems, while partnership staff within the YOS have access to both the Caredirector YOS system and their own agency system (such as N-Delius or Niche). Management information reports can be extracted from the Caredirector system, and managers use these to monitor the completion of work.

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

Regular performance meetings are held to look at the timeliness of the completion of casework and progress against national key performance indicators. These are held by individual teams, and each team has a separate improvement plan to address its own challenges. This means that not all staff are working to the same aims and objectives to support service-wide improvement and development.

The YOS has no culture of ongoing learning from mistakes. Findings from serious incidents and critical learning reports are only shared with those who were involved in the case and are not used to promote learning across the whole service. A lack of challenge in management oversight means that workers are missing out on situational learning from their own practice.

The service has made very limited progress in addressing the findings of the last inspection, and the results in domains two and three demonstrate a deterioration in the quality of practice since 2016. There is no evidence from its practice that the YOS has referred to the HM Inspectorate of Probation thematic report on out-of-court disposals to assess the suitability and effectiveness of its out-of-court disposal processes.

The data held by the police on numbers of community resolutions does not match that held by the YOS, and there is no system to record and check how many community resolutions a child has had. Staff stated that checks have improved, but some children could have had up to five community resolutions without receiving any support from the YOS. It is up to the arresting officer to undertake checks, and this does not always happen.

In terms of driving improvement, there has been limited evaluation of the impact of interventions such as the knife crime programmes and services to victims.

2. Court disposals

We took a detailed look at 55 community sentences and 7 custodial sentences managed by the YOS. We also conducted 58 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 53 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 48 cases where meaningful work was required.

In Birmingham YOS, just over half of cases met all our requirements in terms of assessment and implementation and delivery, which led to a judgement of 'Requires improvement' in both these areas. We found that the quality of assessment of the factors affecting desistance and the interventions delivered to support desistance were good. However, assessments of safety and wellbeing and risk of harm to others were weaker and led to our overall judgement of 'Requires improvement'.

Planning and reviewing were done sufficiently well in less than half of cases we inspected, hence our judgement of 'Inadequate' for those elements of work. Planning and reviewing to support desistance were done well enough in over 70 per cent of cases, which meant that these elements of work were rated as good. However, the overall rating for planning of 'Inadequate' was determined by the scores in relation to safety and wellbeing and risk of harm to others, as this was done well enough in only 42 per cent and 48 per cent of cases respectively. The 'Inadequate' rating for reviewing was determined by the score for work to manage the risk of harm to others, where we judged that less than 50 per cent of the cases, we inspected were satisfactory.

Work to support children to desist from crime was the strongest area of practice in post-court work. The consistency with which practitioners effectively engage children and their families is good. Work to keep other people safe is weak across all four standards in this domain, and particularly deficient in relation to planning and reviewing. There is a lack of consistency in the quality of work on the safety and wellbeing of the child themselves across the areas. This was assessed as 'Requires improvement' for assessment, implementation and delivery, and reviewing, whereas it was 'Inadequate' in planning.

While the overall ratings for the YOS reflect the average scores across all teams, in practice we found some significant variation between them. For example, when looking at post-court work across the five teams that make up Birmingham YOS, the best performing team was rated outstanding in six elements of practice in contrast to the team with the lowest rating, which was assessed to be 'Inadequate' in eight elements of practice.

The findings across the teams indicate an inconsistent approach to practice. They also suggest that there are opportunities for learning between the teams, and a need for a shared understanding of best practice and a unified management approach. Overall, we assessed the management oversight to be adequate in 43 per cent of cases we inspected, varying between 11 per cent and 67 per cent across the teams. In the two teams where we considered management oversight to be the most

effective, there was an association between this and the quality of practice that the teams delivered.

Strengths:

- Assessments consider the diversity and wider familial and social context of the child.
- The quality of work to support desistance is good in relation to assessment, implementation and delivery, and in reviewing.
- Service delivery involves parents/carers or significant others and takes their views into consideration.
- The reviewing of cases focuses on building upon the child's strengths and protective factors.
- Staff develop and maintain an effective working relationship with children and their parents/carers.

Areas for improvement:

- Practice across the area teams is not consistent and varies in quality and effectiveness.
- Assessment, planning and case reviewing for children in custody are of insufficient quality in the majority of cases.
- The wishes and needs of identified and potential victims are not prioritised and risk of harm to others is underestimated.
- Planning for risk of harm and safety and wellbeing is inadequate and contingency planning does not reflect the needs of the case.
- Planning, implementation and delivery, and reviewing of court cases do not focus sufficiently on keeping other people safe.
- Management oversight does not impact on the quality of the work delivered to manage risk of harm or safety and wellbeing.
- Reviewing does not consistently lead to the necessary adjustments in the ongoing plan of work to promote the safety and wellbeing of the child
- The involvement of other organisations in keeping children safe and addressing risk of harm to others is not always well coordinated.

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.	Requires improvement

Our rating[20] for assessment is based on the following key questions:

	% yes
Does assessment sufficiently analyse how to support the child's desistance?	77%
Does assessment sufficiently analyse how to keep the child safe?	**55%**
Does assessment sufficiently analyse how to keep other people safe?	**55%**

We found that assessments consistently considered the factors that impact on future offending, paying attention to the strengths of children and the challenges they face in changing their thinking and behaviour. However, the quality of assessment of factors linked to safety and wellbeing was variable and, in some cases, focused too little on the life experiences and individual circumstances of the child. We found that insufficient attention was given to the experiences, needs and wishes of victims. Assessments did not consider the breadth of issues that impact on risk of harm or set out how risks would be managed and reduced. For children in custody, the quality of assessments of safety and wellbeing fell below expected standards in just under half of cases. We were concerned to find that the particularly complex needs and vulnerabilities of this group of children were not fully recognised.

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

In all but 5 of 62 cases inspected, there was a clear written record of the assessment of the factors likely to promote or inhibit the child's desistance from crime and, in most cases, assessments were completed on time. The main issues identified as likely to impact on desistance were lifestyle, education, training and employment (ETE), self-identity and resilience. Significant numbers of children on the YOS caseload were in pupil referral unit (PRU) placements or did not have suitable ETE provision. In several cases, inspectors noted the challenges that YOS staff faced when children were out of education and where this was assessed as a significant factor in addressing and reducing future offending. We found that where children had an education and health care plan (EHCP), these were not always obtained by the case manager and this affected the ability to asses all their needs.

In most cases there was a sufficient analysis of offending behaviour, including the child's attitudes towards and motivation for their offending. In 51 out of 62 cases, adequate consideration was given to the diversity and wider familial and social context of the child. In the same number of cases, there was enough focus on the child's strengths and protective factors. Attention was given to understanding a child's ability and motivation to change in 46 cases. We assessed key structural

[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.

barriers impacting on the child in 39 cases. The YOS assessments analysed the impact of these barriers well enough in most cases.

The child and their parents/carers were meaningfully involved in their assessment, and their views are considered in just over three-quarters of cases.

Overall, assessment of desistance was good.

Does assessment sufficiently analyse how to keep the child safe?

Inspectors assessed that in 53 of 62 cases there was a medium or high level of concern about safety and wellbeing. Most children were facing significant challenges and deprivation, and adverse childhood experiences were common among the cohort. A significant number of children had been involved with children's social care at some point during the sentence being inspected. In 9 cases the child had been subject to a child protection plan or section 47 enquiry.

In almost a third of cases (20) we did not agree with the YOS-assessed classification of risk as we considered that the level of concern had been underestimated. In just under half of cases, assessments did not clearly identify and analyse all the risks to the safety and wellbeing of the child or consider the controls and interventions required to keep them safe. The assessment and analysis of risk is critical to effective planning to mitigate and manage the identified risk. Our findings indicate an association between the poor quality of assessments for safety and wellbeing and deficits in planning.

Assessments were timely but did not draw sufficiently on available sources of information, including other assessments, nor did they always involve other agencies when it would have been appropriate to do so. This meant that there were gaps in information, and the needs of children were not always fully understood. YOS staff paid attention to some wider risk factors, such as the impact of witnessing domestic violence on children, but not all long-term factors were considered. The damaging and cumulative impact of long-term neglect and emotional abuse, for example, was not routinely recognised as a factor affecting safety and wellbeing and offending.

Growing up neglected: a multi-agency response to older children,[21] a joint report from Ofsted, Care Quality Commission, HM Inspectorate of Constabulary and Fire & Rescue Services, and HMI Probation, highlights the importance of considering neglect in the context of offending:

> *"When older children who have experienced neglect come to the attention of agencies, the most obvious risks of, for example, exploitation or offending behaviour may elicit an appropriate response from professionals initially. But, without understanding and addressing the underlying impact of neglect, the effectiveness of any work to support these children will be limited."*

[21] Ofsted. (2018). *Growing up neglected: a multi-agency response to older children.*

Poor practice example
Ivan's assessment identifies a low level of concern in relation to safety and wellbeing. However, he has ADHD and autism and has been excluded from education in the past. His father died because of an overdose; his mother is alcohol-dependent and has mental health issues which have impacted on her parenting capacity. As a result, Ivan lives with his sibling in overcrowded accommodation. He has been convicted for a second knife offence but the risk to him from carrying knives is not considered. His friend was recently murdered, and he uses cannabis, but this is not mentioned in the assessment. He struggles with night-time enuresis, which is further evidence of trauma. His circumstances and experiences do not reflect a low level of risk to his safety and wellbeing.

Overall, assessment of safety and wellbeing requires improvement.

Does assessment sufficiently analyse how to keep other people safe?

There was no evidence of any risk of harm factors in eight of the inspected cases. Of the remaining 54 cases where risk factors were identified, assessments drew sufficiently on available sources of information, including past behaviour and convictions, and involved other agencies in just 33 of 54 cases. In some cases, the YOS worker had not had access to Crown Prosecution Service papers when they were completing the initial assessment. This made it difficult to triangulate and verify information provided by the child, which undermined some aspects of the assessment. In only 24 of 54 cases was there an analysis of controls and interventions to manage and minimise the risk of harm presented by the child. As with safety and wellbeing, this can be linked with the inadequate findings for planning to manage the risk of harm to others. In just over two-thirds of cases, inspectors agreed with the assessed risk level; we judged the level of risk to be under-assessed in 18 cases and not assessed at all in one case.

Assessments did not pay enough attention to victims, and this impacted on the overall quality of work done to manage risk of harm and keep other people safe.

Overall, assessment of risk of harm to others requires improvement.

2.2. Planning

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

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

	% yes
Does planning focus sufficiently on supporting the child's desistance?	71%
Does planning focus sufficiently on keeping the child safe?	**42%**
Does planning focus sufficiently on keeping other people safe?	48%

[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.

Inspectors saw examples of good planning for work in the community, in particular there was a consistent focus on desistance. However, the rating for this standard was driven by the lack of sufficient planning to address specific risks to the children, themselves, and to victims. Planning for children in custody was inadequate in relation to desistance, safety and wellbeing, and risk of harm to others. Typically, children in custody have high levels of need and require support from multiple services.

An inspector did note one case where work with a child in custody had been done well:

> *"Jason was 15 when he was made subject to a detention and training order for robbery and possession of a knife. The YOS worker completed a good quality assessment which was thoughtful, holistic and balanced. The child was placed in a local authority secure children's home due to his assessed vulnerability. He received strong support from the YOS health team. Risks were understood and responded to, and the professional network communicated and worked well together to support the child who had been assessed as having complex needs. Risks to other people, such as family and other children, were managed well and there was a good exit plan for when he left custody."*

The coordination of services in custody and in the community is essential if interventions are to be effective, and planning is critical to achieving this. Children themselves, especially those in custody who will be going through transition procedures, should be included in the planning process to promote and support their engagement, but we saw evidence of this in only two of the seven custodial cases we inspected.

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

Plans set out the services most likely to support desistance, paying sufficient attention to the available timescales and the need for sequencing interventions in just over three-quarters of cases. Sufficient account was taken of the diversity and wider familial and social context of the child in just over two-thirds of cases. In most cases, planning focused on developing the child's strengths and protective factors, and sought to reinforce or develop these as necessary.

In 43 of 62 cases, enough attention was paid to the child's levels of maturity, ability and motivation to change. The child and their parents/carers were meaningfully involved in the planning process, and their views considered, in just over two-thirds of cases. In most cases, planning was proportionate to the court outcome, with interventions capable of being delivered within the relevant timeframes. Planning for custodial cases requires significant improvement, particularly in relation to release planning. We found planning to be sufficient for desistance in three of the seven custody cases inspected, but less effective for safety and wellbeing, and managing risk of harm to others.

Good practice example

The referral order contract has been completed identifying targets to complete reparation, to engage with a 'Change, Grow, Live' (CGL) mentor for educational support and with 'Forward Thinking Birmingham' for mental health intervention. Wider planning included support with ADHD and autism, and multi-systemic therapy for the child and his mother to help build their relationship.

Overall, planning to support desistance was good.

Does planning focus sufficiently on keeping the child safe?

Planning promoted the safety and wellbeing of the child, sufficiently addressing risks, in just 24 of 53 of the relevant cases. Other agencies were not always involved when they should have been, and there was alignment with other plans (e.g. child protection or care plans) in only 26 of the 47 cases where we would have expected this to have been done. This meant that YOS plans were not always known to other relevant agencies and services, and in some cases resulted in a lack of coordination among key professionals in promoting and supporting the safety and wellbeing of children. In the cases where safety and wellbeing concerns had been identified, planning did not always set out the necessary controls and interventions to promote the safety and wellbeing of the child. We assessed that this had been done sufficiently well in only 27 of 53 cases. The lives of children, especially those involved in the youth justice system, are often complex and challenging, and circumstances can change quickly. Risk is dynamic and contingency planning is important to avoid reactive responses. We found the contingency planning for safety and wellbeing was weak and was done well enough in 22 of 53 cases.

Overall, planning for safety and wellbeing was inadequate.

Does planning focus sufficiently on keeping other people safe?

Planning promoted the safety of other people, sufficiently addressing risk of harm factors, in only just under half of cases. We were disappointed to find that sufficient attention was given to the needs and wishes of the victim(s) in only 16 of 36 relevant cases. It was not clear how actual and potential victims would be kept safe and how any risk posed to them would be monitored.

Other agencies were involved, where appropriate, in only 21 of 41 relevant cases. This meant that plans were not as robust as we would expect to see, and it was not clear how agencies would coordinate their approach to managing and reducing any risk of harm issues. While individual cases were discussed at several panels and forums (some multiagency) this did not always result in a clear joint plan for the management and monitoring of risk. Planning set out the necessary controls and interventions to promote the safety of other people in just 23 of 48 relevant cases. In many cases, it was not clear what the response would be to escalating risk concerns, and what actions would be taken or by whom.

Poor practice example
It is not clear how potential risks to others will be addressed or managed in this case. For example, there are concerns regarding Fabian's gang association, possession of weapons and sexually harmful behaviour, and he has an outstanding offence of robbery, but appropriate interventions are not clearly identified. External controls have not been considered and there is no effective contingency plan to identify appropriate actions should circumstances change and the risk increase.

Overall, planning for risk of harm to others was inadequate.

2.3. Implementation and delivery

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

Our rating[23] 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?	67%
Does the implementation and delivery of services effectively support the safety of the child?	61%
Does the implementation and delivery of services effectively support the safety of other people?	**52%**

The YOS's approach to desistance focused effectively on engagement and compliance in most cases. However, there was less consistency in the quality of work to keep the child and others safe, especially concerning effectiveness of work with partners, and this has resulted in the overall 'Requires improvement' rating. The delivery of services to children who had received custodial sentences was 'Good' for desistance, safety and wellbeing and risk of harm to others. Despite the deficits in assessment and planning, we found that in most cases the interventions delivered met the needs of the children and considered the risk of harm to others.

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

In just under three-quarters of cases, services delivered were those most likely to support desistance. In these cases, sufficient attention was given to the sequencing of interventions within the available timescales. In most cases, service delivery built upon the child's strengths and enhanced protective factors. In all but 9 out of 60 cases, was enough focus given to developing and maintaining an effective working relationship with the child and their parents/carers.

Service delivery reflected the diversity and wider familial and social context of the child, involving parents/carers or significant others, in three-quarters of cases. In

[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.

most cases, interventions promoted opportunities for community integration, including access to services post-supervision. YOS staff routinely encouraged and enabled the child's compliance with the work of the YOS. In most cases, where it was required, enforcement action was taken appropriately.

Implementation and delivery of services did not always address the desistance factors identified in the assessment. For example, in 43 cases, ETE was identified as impacting on desistance and we found this to be suitably addressed in only just over two-thirds of these cases. Lifestyle was assessed as a challenge for 52 children, but we saw interventions delivered to address this in only 28 cases.

Good practice example

The child was somewhat reserved and difficult to engage at the start of the order; his mistrust of professionals was evident. The case manager worked hard to break down some of the barriers, using humour and her personal experiences in a professional and appropriate way. Several knife-crime-focused sessions took place and the child's early years in a war-torn country were considered, with a referral to 'Forward Thinking Birmingham' made to address his experiences of trauma. The case manager also involved the psychologist to ensure her understanding of the best way to work with the child. Speech and language assessments were undertaken, and the specialist updated the school on the findings.

Overall, implementation and delivery to support desistance was good.

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

Service delivery promoted the safety and wellbeing of the child in 32 of 51 relevant cases. In the cases where we would have expected to see the involvement of other organisations in keeping the child safe, we found an inconsistent approach. Other services were appropriately involved and interventions sufficiently well-coordinated in just over half the relevant cases. We saw some good examples of joint working with children's social care, but this was variable. YOS staff advocated well for the children they worked with, but we saw examples where cases should have been escalated due to barriers affecting access to much-needed services and support.

Overall, implementation and delivery of services to support safety and wellbeing requires improvement.

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 25 of 46 cases. Other agencies were sufficiently well coordinated in managing the risk of harm in 20 of 33 relevant cases.

There was enough attention given to the protection of actual and potential victims in only 15 of the 35 cases where this was required, and this impacted on the quality of the overall work delivered to manage risk of harm to others. In respect of victim protection, an inspector noted the following:

"There has been little focus on the victim. The restorative justice worker became involved three months after sentence and at this stage it was realised that that they did not have the victim's contact details. There has been little focus on interventions targeted at risk of harm and little monitoring of the child's lifestyle and associates."

Overall, implementation and delivery of services to support the safety of other people requires improvement.

2.4. Reviewing

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

Our rating[24] for reviewing is based on the following key questions:

	% yes
Does reviewing focus sufficiently on supporting the child's desistance?	77%
Does reviewing focus sufficiently on keeping the child safe?	62%
Does reviewing focus sufficiently on keeping other people safe?	**44%**

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

In most cases there was a written review of interventions and their impact on desistance. Reviewing identified and responded to changes in factors linked to desistance in 49 of 62 cases. Reviewing focused sufficiently on building upon the child's strengths and enhancing protective factors in 51 cases. In just over three-quarters of cases, attention was given to motivation and any barriers affecting the child's motivation and ability to engage.

In just under three-quarters of cases, the child and their parents/carers were meaningfully involved in reviewing their progress and engagement, and their views were considered

Reviewing led to the necessary adjustments in the ongoing plan of work to support desistance in just over three-quarters of cases.

Overall, reviewing to support desistance was good.

Does reviewing focus sufficiently on keeping the child safe?

In most cases, there was a written review of safety and wellbeing. In 44 cases, there had been a change in circumstances relating to the safety and wellbeing of the child. We found that reviewing identified and responded to these changes in only 28 of these cases. In 41 of these cases we would have expected to see other agencies

[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.

involved in the reviewing process; we saw evidence of this done effectively in just 28 cases. In 41 cases, adjustments in the ongoing plan of work to promote the safety and wellbeing of the child were required to reflect the changes in circumstances; this was done well enough in 24 cases.

Overall, reviewing to keep the child safe requires improvement.

Does reviewing focus sufficiently on keeping other people safe?

Reviewing of the impact of delivered interventions on reducing and managing the risk of harm to others was poor. While a written review was completed in most cases, the majority were not of a sufficient quality. In over half the cases we inspected, reviewing did not identify and respond to changes in factors related to risk of harm. Input from other agencies was sought in just over half the cases where we would have expected to see this from the police and other services. There was limited involvement of the child and their parents/carers in reviewing risk of harm; their views were considered in just 13 of 34 applicable cases. Reviewing led to the necessary adjustments in the ongoing plan of work to manage and minimise the risk of harm in only a third of relevant cases.

Poor practice example

During the order, it becomes known that an allegation of sexual assault has been made against Frank. This triggered the case to be discussed at the local risk panel and the risk level increased to medium. However, there is a lack of appropriate reviewing and response to how this increased risk will be addressed. For example, Frank is referred to the harmful sexual behaviour (HSB) team but acceptance of the case is delayed (due to his not being charged), and this is not followed up by the case manager. A decision about potential risks to female staff working alone with him is not made until near the end of the order, despite concerns being known for several months. At the end of the order, the HSB team are still not actively working with the child and no work was completed by the YOS in the meantime to address this – for example, interventions on healthy relationships.

Overall, reviewing to keep other people safe was Inadequate.

3. Out-of-court disposals

We inspected 37 cases managed by the YOS that had received an out-of-court disposal. These consisted of 27 youth conditional cautions (YCCs), 4 youth cautions, and 6 community resolutions. We interviewed the case managers in 27 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 24 cases where there were factors related to harm, we also inspected work done to keep other people safe. In the 28 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.

Implementation and delivery of out-of-court disposal work was rated as 'Requires improvement' as we found it to be sufficient in just over half of cases. The quality of planning fell below our expected standards in over half of cases, leading to an 'Inadequate' judgment for this area of practice. Less than a quarter of cases we inspected met all our standards for joint working, hence the judgement of 'Inadequate' for this inspection standard. In almost half of the cases we inspected, there was no evidence that the YOS had made any recommendations for the most appropriate out-of-court disposal and even where they did, we found that only half of these were appropriate and proportionate.

Processes for out-of-court disposal cases in Birmingham involve the completion of an initial screening prior to decision-making. The screening is based on information collated by the police from various agencies. However, the child and their parent/carer are not interviewed at this stage, which means that their specific circumstances, motivation and attitude towards the offence are not fully understood at the point that disposal decisions are made. It also means that, despite the YOS being present at the decision-making panel, it is not able to make a meaningful recommendation based on a detailed knowledge of the child. We found that the rationale for decision-making was recorded in very few cases, so it was difficult to know why a disposal had been agreed. Once a decision regarding disposals has been made, a full AssetPlus assessment, which considers desistance, risk of harm and safety and wellbeing, is completed on all diversion cases. It is the standard of these assessments and subsequent work that we have inspected and rated.

In just over half of cases we inspected, out-of-court disposals were imposed for offences that involved varying degrees of violence. Despite this, we found that consideration was not routinely given to the risks posed to others, including actual and potential victims. Equally, we saw high levels of vulnerability and complex needs. In just under half of the cases we inspected, the child was aged 14 or under. In 12 cases it was noted that the child had a disability, mainly related to mental health, cognitive or learning disabilities, and in most cases, we assessed the impact on the individual as significant. In 30 of the 37 cases, there had been no prior out-of-court disposal imposed, and in some cases, we felt that a less onerous disposal than the one determined would have been sufficient.

For out-of-court disposals, there was less variation in practice across the five teams than that in post-court work. We found that the quality of the recommendations made by the YOS to inform decision-making was consistently Inadequate. On management oversight, there were some differences across the teams, and we

assessed its effectiveness to be between 17 per cent and 56 per cent, demonstrating a need for significant improvement across the service.

Strengths:

- YOS staff develop and maintain effective relationships with children and their parents/carers.
- Sufficient attention is given to encouraging and enabling the child's compliance with the work of the YOS.
- Children and their parents/carers are meaningfully involved in their assessment process, and their views are considered.
- The quality of work to support desistance is good in planning, and implementation and delivery.
- In most cases, planning takes enough account of opportunities for integration into community and mainstream services following completion of out-of-court disposals.

Areas for improvement:

- In only a minority of cases did the YOS make a positive contribution to determining the disposal, and the rationale for joint disposal decisions is not clearly recorded.
- The YOS recommendations to support joint decision-making are not sufficiently well-informed, analytical and personalised to the child.
- Assessments of, and planning for, safety and wellbeing and risk of harm to others are Inadequate.
- Not enough attention is given to the protection of actual and potential victims in the work delivered.
- There is little evidence that the YOS informs the police of progress on out-of-court disposals.

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.	Inadequate

Our rating[25] for assessment is based on the following key questions:

	% yes
Does assessment sufficiently analyse how to support the child's desistance?	59%
Does assessment sufficiently analyse how to keep the child safe?	**43%**
Does assessment sufficiently analyse how to keep other people safe?	**43%**

Inspectors found that assessments of the factors likely to promote or inhibit the child's desistance from crime required improvement. Assessments did not pay enough attention to the level of maturity of children and their ability and capacity to engage with the support they needed to make changes in their lives. We considered that risks to the safety and wellbeing to the child themselves and to others was routinely underestimated. Case managers did not take enough account of information from relevant people and partners involved in a case. This impacted on their ability to analyse and identify all the factors linked to desistance, safety and wellbeing and risk of harm, and led to our overall rating of 'Inadequate' for assessment.

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

Assessment of factors relating to desistance in out-of-court work was not as strong as that in post-court work. We found that analysis of offending behaviour, including the child's acknowledgement of responsibility, attitudes towards and motivation for their offending, was sufficient in 22 of 37 cases. In most cases, the child and their parents/carers were meaningfully involved in their assessment, and their views were considered.

Enough attention was given to understanding the child's levels of maturity, ability and motivation to change in under half of the cases. The specific needs and capability of the child, and any challenges or barriers that might impact on their engagement with the YOS and other services, were often not fully considered. As a result, not enough thought was given to any additional support that they might need to help them engage, and benefit from interventions. In just over two-thirds of cases, assessments focused on the child's strengths and protective factors. For some children this meant that opportunities for community integration and development were missed.

Overall, assessment to support desistance was rated as requires improvement.

[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.

Does assessment sufficiently analyse how to keep the child safe?

There was not a clear written record of the assessment of the child's safety and wellbeing in every case where we would have expected to see one. Where they were completed, we did not always consider them to be sufficient.

In most of the cases, inspectors considered there to be concern about safety and wellbeing. We found that this was not always recognised by the YOS, and assessments identified a medium or high level of risk in only 10 cases. The quality of assessments was compromised by the limited input of other agencies and other available sources of information, including other assessments. This information was included in only 21 of 37 cases. We saw some good examples of joint work with children's social care, but this was not consistent, and roles and responsibilities were not always clearly defined. In some cases, poor communication between agencies seriously hampered the quality of service the child received; the case example below illustrates this point.

Poor practice example

The child has autism, obsessive compulsive disorder and a physical health problem. The impact of these conditions on his functioning are not explored or understood. There is no discussion with health professionals or the autism resource team to establish what these conditions might mean. The child's mother is concerned about his safety as he is fascinated by gang culture and easily influenced, but his vulnerability to exploitation is not considered. He has an EHCP but this has not been checked to fully understand and respond to his needs. The offence is not considered in the context of his safety and wellbeing, and there a lack of proper analysis of what needs to be done to keep the child safe.

Overall, assessment of safety and wellbeing was rated as inadequate.

Does assessment sufficiently analyse how to keep other people safe?

As with post-court work, we found victim issues were not prioritised in out-of-court work. Assessments gave enough attention to the needs and wishes of the victim(s) in just over a quarter of cases. This impacted on the overall quality of work to manage and minimise the risk for harm to others, and meant that opportunities for restorative justice were missed.

In 20 out of 37 cases, there was a clear written record of the assessment to keep other people safe. In half of the cases where risk was identified, the assessments included information from other agencies and services who were, or had been, involved with the child. This meant that all behaviours and concerns that might contribute to risk of harm to others were not known or analysed in the context of offending behaviour.

In six cases there was no recorded classification of risk of harm. In the 31 cases where risk of harm was classified, inspectors agreed with the assessed level in only 17 cases, and we judged the risk to be largely underestimated in the remaining 14. In some cases, not enough attention was paid to concerns such as knife-carrying for personal protection, and contextual factors that were relevant to the offence and risk of harm to others.

3.2. Planning

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

Our rating[26] for planning is based on the following key questions:

	% yes
Does planning focus on supporting the child's desistance?	65%
Does planning focus sufficiently on keeping the child safe?	**46%**
Does planning focus sufficiently on keeping other people safe?	50%

Planning to support desistance was the most consistent element of this standard. However, the YOS needed to take a more effective approach to joint planning with partner agencies, to keep children safe and protect victims. Planning for safety and wellbeing was Inadequate and this drove the overall rating.

Does planning focus on supporting the child's desistance?

Planning set out the services most likely to support desistance, paying sufficient attention to the available timescales and the need for sequencing in 25 of 37 cases. In just over two-thirds of cases, planning for desistance was personalised to the needs of the child, taking account of their diversity and wider familial and social context. The child's strengths and protective factors were not always considered in planning interventions – we saw this done well enough in just under two-thirds of cases. Sufficient attention was paid to opportunities for community integration, including access to mainstream services following completion of out-of-court disposal work, in 26 of the 37 cases. The child and their parents/carers were meaningfully involved in planning, and their views considered, in only 22 of 37 cases.

In just over two-thirds of cases, planning was proportionate to the disposal type, with necessary interventions capable of being completed within appropriate timeframes.

Good practice example

The parent and the child have contributed to the plan, which is written in a child-friendly way and includes achievable objectives. Planning is not just focused on offending behaviour but on several other factors for desistance, and how these can be built upon, such as the child's interest in music. Consideration is given to his health needs and how this might impact on his ability to engage in interventions.

Overall, planning for desistance was good.

Does planning focus sufficiently on keeping the child safe?

Planning did not consistently promote the safety and wellbeing of the child, only sufficiently addressing risks in 13 of the 28 cases where concerns were identified. In one case no other agencies were involved, but of the 27 cases where they were, we

[26] 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.

found that these agencies were involved in planning in less than half of them. There was an absence of multi-agency planning, and opportunities for joint working were not taken at the earliest opportunity. Out-of-court disposals are relatively brief interventions, which means that effective plans need to be put in place swiftly and consideration given to any exit plan at the earliest opportunity. We were disappointed to find this was not done consistently well enough, especially given the complex circumstances of many of the children whose cases we inspected. We found that contingency planning for safety and wellbeing was poor and done well enough in only just over one-third of cases where concerns had been identified.

An example of poor planning noted by an inspector was as follows:

> *"There is a lack of understanding of potential risks to the child, for example, exploitation, emotional and physical harm. Therefore, this has not been planned for. There are no clear external controls or contingency should risk increase, and the role of other services is not clear".*

Overall, planning to keep the child safe was inadequate.

Does planning focus sufficiently on keeping other people safe?

Planning did not adequately promote the safety of other people; it sufficiently addressed risk of harm factors in just 11 out of 24 cases where concerns had been identified. Other agencies were involved in planning for risk of harm to others in just half of the cases where we would have expected to see this.

Planning addressed specific concerns and risks related to actual and potential victims in 9 of 24 relevant cases. It was not clear how any risks to individuals would be managed or reduced, or whether opportunities for restorative justice had been considered. We expect plans to outline what action will be taken, and by whom, if circumstances change and risk increases. Change may be identified through the emergence of early warning signs or the breakdown/weakening of risk management strategies or protective factors, which can happen quickly. We were disappointed to find that contingency planning was sufficient in just 7 of 24 cases.

An example of incomplete planning for risk of harm to others noted by an inspector was as follows:

> *"James had violent fantasies of harming other people and this was not assessed or planned for. The YOS held a lot of information shared by children's social care and health services that highlighted James's isolation, poor self-esteem and lack of support from his parents. Yet none of this information was drawn upon in planning. Planning focused on a one-off session with the police on consequences of offending and did not focus on what would be done to understand and manage the potential risk of harm to others".*

Overall, planning to keep other people safe was inadequate.

3.3. Implementation and delivery

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

Our rating[27] for implementation and delivery is based on the following key questions:

	% yes
Does service delivery effectively support the child's desistance?	67%
Does service delivery effectively support the safety of the child?	**56%**
Does service delivery effectively support the safety of other people?	58%

The quality of implementation and delivery to support desistance was good. Case managers developed strong relationships with children and encouraged their engagement. However, work with partner agencies to keep children themselves, and other people, safe was not done consistently well. This meant that needs of children and any risk of harm concerns were not always effectively addressed. Victim issues were not prioritised in all relevant cases where we would have expected them to have been, and this undermined the overall quality of the work delivered to manage risk of harm to others. The findings in relation to risk of harm to others and safety and wellbeing drove the overall rating of 'Requires improvement' for implementation and delivery.

Does service delivery effectively support the child's desistance?

The services delivered were those most likely to support desistance, with sufficient attention given to sequencing and the available timescales in 25 out of 36 cases. In most of the cases where desistance factors had been planned for, interventions were delivered to address them. This reinforces the significance of effective planning and the delivery of meaningful interventions.

Service delivery reflected the diversity and wider familial and social context of the child in three-quarters of cases. In most cases, sufficient focus was given to developing and maintaining an effective working relationship with the child and their parents/carers, and to promoting opportunities for community integration.

In 28 of 36 cases, the delivery of services was proportionate to the type of out-of-court disposal, and completed within the required timescales.

Good practice example
Following on from planning, which had a good focus on desistance, the plan was fully and effectively implemented. For example, the case manager engaged the child with fitness and boxing activities, a referral was made to 'Forward Thinking Birmingham' for mental health support, weapons awareness work was delivered, and offending behaviour sessions were completed. There was also evidence of liaison with the

[27] 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.

alternative education provision to establish why the child was only receiving two days a week education, and this was escalated when no response was received. There was a focus on the family as a 'whole', with the YOS linking the child's mother in with a specific local community centre to help her overcome cultural and language barriers.

Overall, service delivery to support desistance was good.

Does service delivery effectively support the safety of the child?

Service delivery promoted the safety and wellbeing of the child in only 15 of 27 cases. There were 23 cases where other services were involved with the child, but we only saw them consulted with or involved in the delivery of interventions in just 12 cases. An inspector noted the following case example, which demonstrates how the poor coordination of services affected the intervention to keep the child safe:

"There is appropriate intervention being delivered to address some areas of concern, for example, mental health and exploitation. However, the case manager has difficulty in getting information from children's social care. This was not effectively escalated and for several weeks the case manager did not receive information about the social care plan. There was confusion over who would be completing an exploitation screening which did not actually get completed and, as a result, the case was not referred to the multi-agency exploitation panel when it should have been".

Overall the delivery of services to support safety and wellbeing requires improvement.

Does service delivery effectively support the safety of other people?

Sufficient attention was given to the protection of actual and potential victims in only 12 of 21 cases where risk issues had been identified. In some cases, we found limited work undertaken to address risk of harm issues, and when work was done it was often generic and not always relevant to the particular risk of the case.

Poor practice example

The offence involves the child (who has autism) taking a knife into school with the stated intention of harming a specific child with whom he has a grievance. No contact was made with the school to establish details of the offence or the intended victim. No direct contact was made with the victim to gain their views or establish if there were any ongoing concerns. The assessment highlighted concerns about how the child might respond to future arguments but there was no evidence that this had been explored during the intervention.

Overall, the service delivered to manage the risk of harm to others requires improvement.

3.4. Joint working

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

Our rating[28] for joint working is based on the following key questions:

	% yes
Are the YOT's recommendations sufficiently well-informed, analytical and personalised to the child, supporting joint decision making?	**19%**
Does the YOT work effectively with the police in implementing the out-of-court disposal?[29]	52%

In most cases, the YOS did not play an integral role in the out-of-court disposal decision-making process and we judged the quality of YOS input, and therefore the overall rating for this joint working standard, to be Inadequate. In the cases where we expected to see the YOS working together with the police to implement the out-of-court disposal, it was done effectively in just over half of the cases.

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

We considered recommendations by the YOS for out-of-court disposal outcomes, conditions and interventions to be appropriate and proportionate in 10 of the 19 cases where they were made. The recommendations considered the degree of the child's understanding of the offence and their acknowledgement of responsibility in just six cases. The YOS made a positive contribution to determining the disposal in only 8 of 35 cases where it would have been appropriate to do so.

The YOS did not meet children before the out-of-court disposal was decided and, as a result, did not always fully understand their personal circumstances and needs prior to disposal decisions being made. This meant that the YOS could only offer input on recommendations in relation to the circumstances of the offence and not an up-to-date assessment of the child.

Local practice is still driven by the ACPO Gravity Matrix National Guidelines, and just over half of the cases related to offences of violence, including sexual violence. Children automatically receive a YCC if the offence involves possession of a weapon.

Our view was that, in some cases, the necessary interventions could have been delivered via a less onerous disposal than a YCC, particularly as in 30 cases the child had never received any prior intervention by way of a community resolution or equivalent. In these cases, it was not clear if a community resolution had been considered, as the rationale for joint disposal decisions was recorded in just four of the inspected cases.

[28] 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.

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

In most cases, the YOS does not deliver interventions to children who are given a community resolution; they receive one session which is delivered by the police. In one case, the rationale offered to an inspector for the imposition of a YCC rather than a community resolution was that "the child needed support and intervention from the YOS". The YOS should consider how current arrangements might be impacting on the decisions made about disposals and ensure that more onerous disposals are not imposed unnecessarily, and that children can receive the help they need without having to be brought into the criminal justice system.

In less than half of cases was enough attention given to the child's understanding, and their parent/carers' understanding, of the implications of receiving an out-of-court disposal.

Overall, the YOS's contribution to the out-of-court disposal decision-making process was Inadequate.

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

The YOS works effectively with the police in implementing the out-of-court disposal in just over half of the cases. The police were updated on progress and outcomes in a sufficient and timely manner in only just over a quarter of cases. Enough attention was given to compliance with, and the enforcement of, conditions of out-of-court disposals in 22 out of 27 cases.

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.[30]

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

Domain one: organisational delivery

The youth offending service submitted evidence in advance and the Chief Executive of Birmingham Children's Trust, the Assistant Chief Executive of Birmingham Children Trust and the Chair of the YOS Board 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 99 interviews with case managers, asking them about their experiences of training, development, management supervision and leadership. In the second fieldwork week 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 15 meetings, which included meetings with managers, partner organisations and staff. The evidence collected under this domain was judged against our published ratings characteristics.

Domain two: court disposals

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

We examined 62 court disposals. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of 5), 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.

[30] 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. Forty per cent of cases selected were those of children who had received out-of-court disposals three to five months earlier. This enabled us to examine work in relation to assessing, planning, implementing and joint working. Where necessary, interviews with other people significantly involved in the case also took place.

We examined 37 out-of-court disposals. The sample size was set to achieve a confidence level of 80 per cent (with a margin of error of 5), 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 62 court disposals and 37 out-of-court disposals. In each of those cases, we inspect against four standards: assessment; planning; implementation/delivery; and 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 lowest banding at the key question level, recognising that each key question is an integral part of the standard.

Lowest banding (key question level)	Rating (standard)
Minority: <50%	Inadequate
Too few: 50-64%	Requires improvement
Reasonable majority: 65-79%	Good
Large majority: 80%+	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 10 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 2 – 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?	71%
Does assessment consider the diversity and wider familial and social context of the child, utilising information held by other agencies?	82%
Does assessment focus on the child's strengths and protective factors?	82%
Does assessment analyse the key structural barriers facing the child?	79%
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?	74%
Does assessment give sufficient attention to the needs and wishes of the victim/s, and opportunities for restorative justice?	39%
Is the child and their parents/carers meaningfully involved in their assessment, and are their views taken into account?	77%
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?	56%
Does assessment draw sufficiently on available sources of information, including other assessments, and involve other agencies where appropriate?	58%

Does assessment analyse controls and interventions to promote the safety and wellbeing of the child?	49%
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?	44%
Does assessment draw sufficiently on available sources of information, including past behaviour and convictions, and involve other agencies where appropriate?	61%
Does assessment analyse controls and interventions to manage and minimise the risk of harm presented by the child?	44%

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?	76%
Does planning take sufficient account of the diversity and wider familial and social context of the child?	69%
Does planning take sufficient account of the child's strengths and protective factors, and seek to reinforce or develop these as necessary?	73%
Does planning take sufficient account of the child's levels of maturity, ability and motivation to change, and seek to develop these as necessary?	69%
Does planning give sufficient attention to the needs and wishes of the victim/s?	42%
Is the child and their parents/carers meaningfully involved in planning, and are their views taken into account?	69%

Does planning focus sufficiently on keeping the child safe?	
Does planning promote the safety and wellbeing of the child, sufficiently addressing risks?	45%
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?	55%

Does planning set out the necessary controls and interventions to promote the safety and wellbeing of the child?	51%
Does planning set out necessary and effective contingency arrangements to manage those risks that have been identified?	28%
Does planning focus sufficiently on keeping other people safe?	
Does planning promote the safety of other people, sufficiently addressing risk of harm factors?	48%
Does planning involve other agencies where appropriate?	51%
Does planning address any specific concerns and risks related to actual and potential victims?	40%
Does planning set out the necessary controls and interventions to promote the safety of other people?	48%
Does planning set out necessary and effective contingency arrangements to manage those risks that have been identified?	27%

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?	73%
Does service delivery reflect the diversity and wider familial and social context of the child, involving parents/carers or significant others?	75%
Does service delivery build upon the child's strengths and enhance protective factors?	73%
Is sufficient focus given to developing and maintaining an effective working relationship with the child and their parents/carers?	85%
Does service delivery promote opportunities for community integration including access to services post-supervision?	80%
Is sufficient attention given to encouraging and enabling the child's compliance with the work of the YOT?	85%
Are enforcement actions taken when appropriate?	70%

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?	63%
Is the involvement of other organisations in keeping the child safe sufficiently well-coordinated?	54%
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?	54%
Is sufficient attention given to the protection of actual and potential victims?	43%
Is the involvement of other agencies in managing the risk of harm sufficiently well-coordinated?	61%

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?	79%
Does reviewing focus sufficiently on building upon the child's strengths and enhancing protective factors?	82%
Does reviewing consider motivation and engagement levels and any relevant barriers?	76%
Is the child and their parents/carers meaningfully involved in reviewing their progress and engagement, and are their views taken into account?	73%
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?	64%
Is reviewing informed by the necessary input from other agencies involved in promoting the safety and wellbeing of the child?	68%

Does reviewing lead to the necessary adjustments in the ongoing plan of work to promote the safety and wellbeing of the child?	59%
Does reviewing focus sufficiently on keeping other people safe?	
Does reviewing identify and respond to changes in factors related to risk of harm?	47%
Is reviewing informed by the necessary input from other agencies involved in managing the risk of harm?	52%
Is the child and their parents/carers meaningfully involved in reviewing their risk of harm, and are their views taken into account?	38%
Does reviewing lead to the necessary adjustments in the ongoing plan of work to manage and minimise the risk of harm?	33%

Domain 3 – 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?	59%
Does assessment consider the diversity and wider familial and social context of the child, utilising information held by other agencies?	65%
Does assessment focus on the child's strengths and protective factors?	68%
Does assessment analyse the key structural barriers facing the child?	64%
Is sufficient attention given to understanding the child's levels of maturity, ability and motivation to change?	46%
Does assessment give sufficient attention to the needs and wishes of the victim/s, and opportunities for restorative justice?	27%
Is the child and their parents/carers meaningfully involved in their assessment, and are their views taken into account?	76%
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?	43%
Does assessment draw sufficiently on available sources of information, including other assessments, and involve other agencies where appropriate?	57%
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?	34%
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?	50%

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?	68%
Does planning take sufficient account of the diversity and wider familial and social context of the child?	68%
Does planning take sufficient account of the child's strengths and protective factors, and seek to reinforce or develop these as necessary?	62%
Does planning take sufficient account of the child's levels of maturity, ability and motivation to change, and seek to develop these as necessary?	62%
Does planning take sufficient account of opportunities for community integration, including access to mainstream services following completion of out of court disposal work?	70%
Does planning give sufficient attention to the needs and wishes of the victim/s?	33%
Is the child and their parents/carers meaningfully involved in planning, and are their views taken into account?	59%
Does planning focus sufficiently on keeping the child safe?	
Does planning promote the safety and wellbeing of the child, sufficiently addressing risks?	46%

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?	48%
Does planning include necessary contingency arrangements for those risks that have been identified?	36%
Does planning focus sufficiently on keeping other people safe?	
Does planning promote the safety of other people, sufficiently addressing risk of harm factors?	46%
Does planning involve other agencies where appropriate?	50%
Does planning address any specific concerns and risks related to actual and potential victims?	38%
Does planning include necessary contingency arrangements for those risks that have been identified?	29%

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?	69%
Does service delivery reflect the diversity and wider familial and social context of the child, involving parents/carers or significant others?	75%
Is sufficient focus given to developing and maintaining an effective working relationship with the child and their parents/carers?	81%
Is sufficient attention given to encouraging and enabling the child's compliance with the work of the YOT?	86%
Does service delivery promote opportunities for community integration, including access to mainstream services?	83%
Does service delivery effectively support the safety of the child?	
Does service delivery promote the safety and wellbeing of the child?	56%
Is the involvement of other agencies in keeping the child safe sufficiently well utilised and coordinated?	52%

Does service delivery effectively support the safety of other people?	
Is sufficient attention given to the protection of actual and potential victims?	57%
Are the delivered services sufficient to manage and minimise the risk of harm?	65%

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?	53%
Do the recommendations consider the degree of the child's understanding of the offence and their acknowledgement of responsibility?	32%
Is a positive contribution made by the YOT to determining the disposal?	23%
Is sufficient attention given to the child's understanding, and their parents/carers' understanding, of the implications of receiving an out of court disposal?	49%
Is the information provided to inform decision making timely to meet the needs of the case, legislation and guidance?	66%
Is the rationale for joint disposal decisions appropriate and clearly recorded?	12%
3.2.1 Does the YOT work effectively with the police in implementing the out of court disposal?[31]	
Does the YOT inform the police of progress and outcomes in a sufficient and timely manner?	26%
Is sufficient attention given to compliance with and enforcement of the conditions?	81%

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

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