

An inspection of youth offending services in

# **Derbyshire**

HM Inspectorate of Probation, September 2022

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## **Foreword**

This inspection is part of our programme of youth offending service inspections. We have inspected and rated Derbyshire Youth Offending Service (YOS) across three broad areas: the arrangements for organisational delivery of the service, the quality of work done with children sentenced by the courts and the quality of out-of-court disposal work. Overall, Derbyshire YOS was rated as 'Good'. We also inspected the quality of resettlement policy and provision, which was separately rated as 'Good'.

We found a stable staff group, who consistently engage well with children and families and work hard to meet their needs. Supported by specialist staff, the YOS is delivering on its child-centred approach. Partnership and services were also an area of strength, although more needs to be done to ensure that children are receiving the correct education provision and that access to specialist and mainstream health services is equitable across the county. The YOS also needs to secure a permanent base in the south of the county to ensure equitable access to facilities countywide.

We found evidence of quality assessment for children on court orders and saw effective service delivery in the YOS statutory work. Assessment and the delivery of services to children were particularly impressive areas of practice.

Governance and leadership were identified as an area requiring development. Attendance at YOS Management Board meetings has been inconsistent. The board chair appreciates that significant improvements are necessary to strengthen governance arrangements, and work is underway to achieve this.

Out-of-court disposal processes are too complicated and require improvement. Most children are assessed twice before they begin an intervention. This causes delays and places unnecessary pressure on staff. The YOS would also benefit from reviewing its planning procedures, particularly around the recording of planning activity, and since our inspection the YOS has been exploring how it can streamline and simplify processes.

We found work on resettlement to be strong. It is supported by a policy that sets out how to keep children safe, ensure the safety of other people and meet victims' needs. It takes an individualised approach, is strengths-based and focuses on the future.

Meeting the diversity needs of all children is a priority for the board, as is addressing any issues of disproportionality. Staff routinely focus on children's learning needs, and the YOS has monitored and reduced the numbers of looked after children in the youth justice system. However, we found that it does not focus enough on ethnicity, heritage and understanding the lived experiences of children from black, Asian and minority ethnic backgrounds. Similarly, we did not see any specific approaches to working with or meeting the needs of girls, who are over-represented in the service, and this requires improvement.

In this report, we make eight recommendations to improve the work of Derbyshire YOS further. We trust that they will assist the service as it continues to develop.

**Justin Russell** 

**HM Chief Inspector of Probation** 

## **Ratings**

	yshire Youth Justice Service work started June 2022	Score	24/36
Overa	all rating	Good	
1.	Organisational delivery		
1.1	Governance and leadership	Requires improvement	
1.2	Staff	Good	
1.3	Partnerships and services	Good	
1.4	Information and facilities	Good	
2.	Court disposals		
2.1	Assessment	Outstanding	$\Rightarrow$
2.2	Planning	Good	
2.3	Implementation and delivery	Outstanding	$\Rightarrow$
2.4	Reviewing	Good	
3.	Out-of-court disposals		
3.1	Assessment	Good	
3.2	Planning	Requires improvement	
3.3	Implementation and delivery	Outstanding	$\frac{1}{2}$
3.4	Out-of-court disposal policy and provision	Requires improvement	
4.	Resettlement <sup>1</sup>		
4.1	Resettlement policy and provision	Good	

 $<sup>^{\</sup>rm 1}$  The rating for resettlement does not influence the overall YOS rating.

## Recommendations

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

#### The Derbyshire Youth Offending Service Management Board chair should:

1. make sure board members are aware of their role and responsibilities, secure consistent attendance and full engagement from all members and escalate as necessary if this cannot be achieved.

#### The Derbyshire Youth Offending Service Management Board should:

- 2. ensure that children's health needs are understood at board level, that the health provision within the YOS is sufficient to meet their needs and any barriers to accessing mainstream services are successfully addressed
- 3. ensure all access to education provision is suitable to meet children's needs and increase the proportion of school-age YOS children who are receiving their legal entitlement to education
- 4. make sure that all staff have access to suitable facilities that enable them to meet children's needs and deliver high quality services.

#### The Derbyshire Youth Offending Service should:

- 5. review current out-of-court disposal processes to reduce duplication and delay
- 6. develop a response to meeting the needs of black, Asian and minority ethnic children and girls supervised by the YOS
- 7. improve the processes and guidance for planning the delivery of interventions.

#### The Probation Service should:

8. allocate the designated full-time probation officer resource to the YOS, to support effective transitions and risk management.

## **Background**

We conducted fieldwork in Derbyshire over the period of a week, beginning on 20 June 2022. We inspected cases where sentences and licences had begun between 21 June 2021 and 15 April 2022; out-of-court disposals that had been delivered between the same dates; and resettlement cases sentenced or released during the same period. We also conducted 30 interviews with case managers.

Derbyshire is a large two-tier authority comprising eight borough councils. The county has around 75,000 children aged 10 to 17. 15 per cent of children live in deprived households, mainly in the north of the region. 96 per cent of the population are white British, 1.4 per cent mixed heritage, 1.4 per cent Asian and 0.3 per cent black.

The YOS has consistently performed well against national key performance indicators. Children in Derbyshire enter the justice system at a significantly lower rate than they do on average across the rest of England and Wales. There are low rates of reoffending and the number of children sentenced to custody is lower than the national average. This is against a backdrop of increasing recorded crime in the county.

Referral orders make up the majority of statutory YOS cases, and 84 per cent of out-of-court disposals are community resolutions. Violence against the person is the most common offence, and the YOS is increasingly focusing on issues of serious youth violence. 45 per cent of YOS children are open to children's social care. Just under a third have special educational needs, and a similar number have been assessed as exploited children.

The YOS is a partnership between Derbyshire children's services (including the education service), Derbyshire Constabulary, Derbyshire Probation Trust and NHS Derbyshire. At the time of the inspection, there were two Clinical Commissioning groups in Derbyshire. Different regional approaches and priorities create some challenges for the YOS, due to differing thresholds and waiting times. This means that not all children have equal access to the mainstream health services necessary to their rehabilitation and desistance. The region is transitioning to an integrated commissioning model, which presents an opportunity to create consistent and equitable access to health services.

Although Covid-19 restrictions have largely been lifted, finding suitable office accommodation is an ongoing challenge. The YOS office in the south of the county was affected by ventilation issues during the pandemic, which resulted in the building being closed. The venue has re-opened partially, and work is scheduled to enable it to fully re-open, however the timescales are 12-15 months. Court closures have also been a challenge for the service, with increasing numbers of children having to travel longer distances for sentencing.

## **Domain one: Organisational delivery**

To inspect organisational delivery, we reviewed written evidence submitted in advance by the YOS and conducted 11 meetings, including with staff, volunteers, managers, board members, and partnership staff and their managers.

Key findings about organisational delivery were as follows:

#### 1.1. Governance and leadership



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

Requires improvement

#### **Strengths**

- The board chair is the Director of Early Help and Safeguarding and is knowledgeable about the work of the YOS.
- The board chair and Head of YOS are aware of the deficits in the board's current impact, and plans are in place to increase the board's membership and strengthen its impact.
- An external review of current board processes was carried out in May 2022 and has been used to inform a recent improvement plan.
- A new and highly motivated Head of YOS was appointed in May 2022, and the staff team have welcomed this permanent appointment.
- Funding from the Office of Police and Crime Commissioner is used to provide the YOS's speech and language and substance misuse provision and contributes to a jointly commissioned appropriate adult service.
- Just prior to the inspection the clinical commissioning groups agreed ongoing funding for the enhanced case management psychologist posts and the wellbeing workers will be permanently funded by the Local authority after October 2022.
- Staff feel supported by their direct line managers, who are viewed as knowledgeable and accessible.

#### **Areas for improvement**

- The board does not currently function adequately. Key partners do not attend board meetings consistently, and one of the last four meetings had to be terminated as it did not reach quoracy. An extra-ordinary board meeting was also cancelled due to unavailability of partners. Dedicated staff and committed team managers have maintained the service's performance in the absence of clear strategic leadership from the board.
- The board does not have clear processes in place for monitoring delivery of the youth justice plan and the YOS improvement plan.

- Board members do no not sufficiently scrutinise available data to ensure the YOS and the partnership are consistently meeting the needs of all children that the YOS is working with.
- Internal procedures require review by YOS leaders to ensure they are not overly bureaucratic, and that staff have the time and space to deliver high-quality services to children and families.
- Two of the three new board members have not received an induction to help them to understand the function of the board or the requirements of their role.
- At the time of the Inspection there was only a 0.5 Probation Officer in post rather than a full-time probation officer as per the YOS's allocated resource.
- The YOS does not have an allocated probation service worker to support the
  effective transition of YOS children to adult services, and the board has yet to
  resolve this.
- The board does not understand the education needs of all YOS children and cannot be confident that they are being offered suitable provision or are receiving their legal entitlement to education.
- The board has not assessed whether the health services currently provided by the YOS are sufficient to meet children's needs, or addressed barriers to accessing mainstream health services that affect children in some parts of the county.
- Leaders do not thoroughly understand the diverse needs of the children supervised by the YOS.
- Not all processes for the three Derbyshire YOS teams, for example the risk and safety and wellbeing panels, are aligned to support consistency in practice.

#### 1.2. Staff



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

Good

#### **Strengths**

- The YOS staff are motivated, committed, and resilient. They consistently
  deliver high-quality work that is creative and bespoke to meet the needs of
  children and support desistance. They are skilled at balancing risk
  management and safeguarding work.
- Staff feel supported by their direct line managers, and inspectors found that management direction is having a positive impact on practice.
- Staff are satisfied with the frequency and quality of their supervision, and inspectors noted evidence of supervision and effective guidance in case notes.
- 21 of 22 staff who responded to our survey felt that their training needs were mostly or fully met.

- Some practitioners are AIM2/AIM3 trained, and managers have received AIM management supervision training. Harmful sexual behaviour cases are jointly allocated in line with best practice.
- The YOS workforce is largely reflective of the cohort of children, although
  would benefit from having more male workers. In the last year there has been
  an increase in black, Asian and minority ethnic staff, and this reflects similar
  changes in the YOS cohort.
- There is a thorough induction process in place. New members of staff described feeling fully prepared for the role. Induction includes training and observation opportunities, with reduced caseloads to support this.

#### **Areas for improvement**

- Some staff are concerned that work is not allocated equitably among practitioners, taking into account part-time working, and pay grades. Some staff indicate they are struggling to manage their workloads without working excessive hours.
- Joint case-allocation arrangements are not always suitable; for example, some high-risk cases are jointly allocated to family support workers, who should not be expected to hold high-risk cases, and their line manager. However, in practice, the family support worker delivers all of the work.
- The cohort of YOS volunteers does not reflect diversity of YOS children and their families, and the YOS should seek to improve the diversity of its volunteers.
- Appraisal processes are not being used consistently across all teams to promote and support the development of all staff.
- Staff have not received diversity training that focuses on working with children from black, Asian and minority ethnic backgrounds so that they can meet the needs of the changing profile of the YOS cohort.
- Despite girls being over-represented in the YOS, there is no specific organisational direction or guidance to assist staff in working with them.

#### 1.3. Partnerships and services



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

Good

#### **Strengths**

- Inspectors assessed that, in the large majority of cases, the YOS had sufficient access to services to meet children's needs, across desistance, safety and wellbeing, and managing risk of harm to others. The services available were well-coordinated with agencies working together to deliver interventions.
- The YOS has an up-to-date analysis of the needs of children.

- The YOS captures children's views through the use of Viewpoint, exit interviews and the quality assurance processes. The current intervention plan was devised in response to feedback from children.
- The YOS has worked closely with local authority children's homes, the Crown Prosecution Service and the Police to prevent the criminalisation of children by promoting, where appropriate, a diversionary approach to offences committed care homes.
- Service delivery promotes opportunities for community integration, including access to mainstream services, in almost every case inspected.
- We were impressed with the youth multi-agency public protection arrangements (YMAPPA) and the relationships formed between the YOS and the YMAPPA chair.
- The YOS is using resources such as the speech and language therapist to maximise its impact and effectiveness.
- The YOS education worker has been in post since January, and their work was noted as a strength in casework.
- Wellbeing workers are supporting children to attend meetings and access any additional help they need. In addition, the YOS has two link Child and Adolescent Mental Health Service (CAMHS) practitioners.
- There are a range of restorative projects, including garden maintenance, a disability riders club, charity shop work and working with horses. Children are asked about their interests to try to match them to suitable projects.
- Staff report good working relationships with social workers from children's social care. Inspectors noted effective joint working between the two services, which supported the effective safeguarding of children.
- There is a commitment to ensuring that suitable accommodation is available
  for all children who need it. A recently commissioned service includes selfcontained supported accommodation; this will be kept available for emergency
  accommodation, which will be accessible to YOS children.
- The YOS police contribute effectively to managing risk in casework and to delivering the out-of-court processes.
- Psychologists seconded to the YOS have devised and oversee the delivery of an enhanced case management model. They provide guidance and direction to case managers and professionals working with children whose lives are complex and who present with concerning risky behaviours.

#### **Areas for improvement**

- We did not see any specific approaches to working with and meeting the needs of girls or black, Asian and minority ethnic children.
- The YOS does not understand the overall educational provision for children well enough. This is a particular concern when almost 30 per cent of the cohort are not receiving their legal entitlement to education. It is not clear how this is being addressed.

 Access to specialist and mainstream services is not equitable for all children across the county.

#### 1.4. Information and facilities



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

Good

#### **Strengths**

- The YOS has robust quality assurance processes in place that promote effective service delivery to children, and it shares learning with the wider service and partners.
- The YOS has good facilities to deliver its work to children in the north of the county. There are interview rooms and a child-friendly space where children can spend time and staff can run groupwork sessions.
- The service has policies and procedures in place to support the delivery of quality services to children, and staff understand those that are relevant to them.
- Specialist staff and other services share information well to support joint working and delivery services effectively.
- All staff are issued with laptop or tablets, which are configured to connect securely to the council's network from any Wi-Fi or cellular network facility, enabling staff to work remotely and flexibly.
- A central team produces information reports for the YOS management team and the board. The team has an identified person who consistently completes this task and understands the work of the YOS. There are plans to migrate to Power BI, which will enable the YOS to share data on performance with partner organisations.
- ICT arrangements allow YOS staff to access and exchange the right information with partners, providers, and other key stakeholders.
- The YOS has good processes in place for gathering feedback from children, and gave inspectors an example of how it had used this to influence service delivery.
- Nottingham Trent University's positive evaluation of the enhanced care management model and wellbeing workers role has been used to secure long-term funding for these projects, which will continue to support high-quality services for children.

#### **Areas for improvement**

• The YOS has not had a suitable a venue for its work with children in the south of the county since its base there was closed due to ventilation issues.

- Not all policies take diversity into account to ensure that staff consider all children's individual needs and circumstances and know what is expected of them in this area of work.
- The YOS is not able to access the same health information for children in all parts of the county.

#### Involvement of children and their parents or carers

The YOS aims to focus more on its engagement and participation work so that there is ongoing collaboration with children and their parents or carers to influence and shape developments in the service. The management board is considering how to take account of children's views at a strategic level. A young person who recently ended their engagement with the YOS attended the latest board meeting to discuss their experience and advise on what could be improved. During our inspection we met with the young person, who valued the opportunity to attend the board meeting. The YOS is considering making her a regular board attendee.

The YOS gathers the views of children and their parents or carers through the use of Viewpoint and exit interviews, and also as part of its quality assurance processes. When a case is quality assured, the process includes contacting the child and their parents or carers to gain their perspective. We considered this to be an effective way of triangulating information. The 'my action plan', which case managers use to plan work with children, was devised by a working group of children, staff and the YOS speech and language therapist.

Before the inspection fieldwork, the YOS contacted, on our behalf, children who had open cases at the time of the inspection, to obtain their consent for a text survey. We delivered the survey independently to the 24 children who consented, and 10 replied. They were asked to rate the YOS on a scale of one to 10. Seven gave it a 10, two rated it eight and one a seven. Children commented:

"My case worker was amazing, she helped me through so much and helped me change in many ways. Turned me into a calmer person and helped me to not retaliate and learn to walk away from a situation".

"They worked really well with me and co-operated really well with me as well. They also listened to my problems and found a solution how to not make them again because they helped me solve my problems and see that I should take responsibility about my behaviour".

"They gave me advice on how to get rid of the people I couldn't say no to".

During this inspection, inspectors spoke directly to five children and two parents or carers. They considered the YOS workers to be skilled and capable, and the services they received to be 'quite good' or 'very good'.

One child told us about his positive experience of the YOS and his worker:

"Everything she does is positive; she doesn't just make me do things she asks me what I'm interested in and gives me choices".

He gave an example of how his case worker had helped him to get into college and, when discussing his progression options, he was able to choose between mechanics,

construction, and bricklaying. He felt that, because of this, he had developed a good relationship with his case manager.

A child who was no longer working with the service told us:

"I had to do reparation and they helped me with a housing association and I'm still working with them now. They helped me get mental health support and I am still accessing it now. They helped me with everything I needed. She literally would do anything; I miss working with her".

One child told us about how their worker had helped to motivate them:

"With reparation I was not happy about the idea of it and she could tell that I didn't want to do it but tried to make it as good as she could. I did some gardening which I actually enjoyed, but was proper dreading it. She gave me a few options to choose from".

#### One parent told us:

"Whilst you wouldn't choose to be in a situation where they are involved, it's been plain sailing, AND they've been brilliant".

## **Diversity**

The YOS management board has a stated commitment to addressing the diversity needs of all children. It has also set a priority to reduce any over-representation of groups of children in the youth justice cohort. However, we found that it does not consistently monitor its progress towards these aims, and we were not confident that the board understands the needs of the cohort sufficiently well to support the service to deliver on its ambitions.

The YOS leadership team and the board are aware that they need to learn more about how they are currently meeting the needs of children from minority backgrounds, as well as of girls. Minority ethnic children make up 11 per cent of the YOS cohort, which means they are over-represented, given that only four per cent of 10- to 17-year-olds in Derbyshire are from a minority ethnic background. Recently this over-representation has been increasing, and the reasons for it need to be examined at a strategic level.

Similarly, there needs to be a better understanding of the needs of girls, who make up approximately 18 per cent of the YOS cohort. We noted that, in one case, a girl who had experienced sustained male violence in her formative years was allocated a male case worker, and the service had not considered whether this was appropriate. The YOS needs to consider what causes girls to offend, and whether a gendered approach to delivering services is required.

The YOS takes a bespoke approach to meeting the needs of each child. However, to do this well, the leadership team needs to make sure that all staff have the knowledge, skills and confidence to explore all elements of identity, and they need clear direction on what is expected.

Case managers take account of the diversity needs of children effectively in the provision of services. We saw some responsive work to understand children's learning and neurodiversity needs and to adapt interventions to make them appropriate for the individual children's abilities.

## **Domain two: Court disposals**

We took a detailed look at 15 community sentences and no custodial sentences managed by the YOS.

#### 2.1. Assessment



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

Outstanding

Our rating<sup>2</sup> for assessment is based on the following key questions:

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	100%
Does assessment sufficiently analyse how to keep the child safe?	100%
Does assessment sufficiently analyse how to keep other people safe?	87%

Assessment of desistance was consistently impressive; it met our standards in every case we inspected. It was evident that case managers took into account the YOS's child-centred approach and applied their knowledge about adverse childhood experiences to analyse offending and the needs of children. Their assessments were informed by information held by other services, which they used to gain an understanding of the child's history and circumstances. Case managers considered challenges and barriers to engagement thoughtfully, and actively involved the child and their parents or carers in the assessment process.

Case managers routinely considered diversity factors relating to learning disabilities or neurodivergence in the delivery of services. However, in the cases of the girls, there was little exploration of how gender might impact on desistance factors and how interventions might be tailored to promote the girls' engagement and progress. The large majority of the cases we inspected were those of white British children. In the small number of cases where the child was from a black, Asian or minority ethnic background, the case manager had not fully considered the significance of this and had not paid enough attention to the child's experiences of racism or discrimination.

In assessments, case managers paid sufficient attention to understanding the child's levels of maturity, and ability and motivation to change, as well as their likelihood of engaging with the court disposal. They focused on identifying the child's strengths and positive factors and set out how these could be strengthened through delivering suitable interventions.

Assessment of children's safety and wellbeing was a strength and was sufficient in every inspected case. In six of the 15 cases, the child had been subject to a child protection plan or section 47 proceedings – these were children who were highly

 $<sup>^2</sup>$  The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. A more detailed explanation is available in the  $\underline{\text{data}}$  annex.

vulnerable, and they were appropriately assessed as such. In all but one case the assessment clearly set out the controls and support that were required to keep the child safe. Case managers made full use of information and assessments provided by other agencies to understand any risks to the child's safety and wellbeing. In the large majority of cases, there was a detailed understanding of any risks of potential adverse outcomes for the child, and any concerns that may impact on their wellbeing, such as substance misuse or parental neglect. Inspectors agreed with the case manager's classification of concerns in all but one case, where it had been underestimated.

Assessment overall was well balanced, giving equal attention to desistance, the safety and wellbeing of the child and risk of harm to the public. Information from other agencies was used well to inform risk assessments, which were comprehensive and demonstrated a good analysis of the nature and focus of specific risks, internal and external controls, and whether risk was escalating. In assessments, case managers paid sufficient attention to the needs and wishes of the victim/s, and opportunities for restorative justice, in all but two cases.

#### 2.2. Planning



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

Good

Our rating<sup>3</sup> for planning is based on the following key questions:

	% 'Yes'
Does planning focus sufficiently on supporting the child's desistance?	73%
Does planning focus sufficiently on keeping the child safe?	80%
Does planning focus sufficiently on keeping other people safe?	87%

Overall, inspectors found that the quality of planning was strong. There were areas for improvement for example, the child-focused 'my action plan' was a suitable document, but it did not routinely include all the information associated with the plan of work. This information was often contained in the assessment, in the case notes or in meeting minutes, but not pulled together in a specific and cohesive manner. For referral orders, the contract put in place by the panel did not contain the level of detail required or reflect the work that was being delivered. In these cases, the contract would benefit from being supported by a more focused intervention plan that could be monitored and reviewed throughout the court order.

In most cases, planning for desistance was built on the assessment of desistance factors. Planning was sequenced and took into account timescales for delivering interventions. Case managers considered the child's personal and social circumstances and took into account their level of motivation and ability to comply with the order. They paid attention to the child's learning needs and any adaptations

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<sup>&</sup>lt;sup>3</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. A more detailed explanation is available in the <u>data annex</u>.

that needed to be made to the delivery of interventions. The majority of children were fully involved in the planning process, as were their parents or carers, where appropriate. The 'my action plan' template incorporated the child's perspective. In most cases, planning took account of the child's goals and their diverse needs, although the plans sometimes lacked a focus on gender. In the large majority of cases the child's needs were balanced with the attention given to victims and their wishes and protection.

The consistency of planning to keep the child safe and promote their wellbeing was an area of strength. Planning sufficiently promoted the child's safety and wellbeing in almost every case. Inspectors noted a good level of planning with other agencies to support the child's wider needs and to promote their safety in the majority of cases. However, in a small minority of cases, this joint working with other agencies was not good enough, and as a result those cases were assessed as insufficient. The risk and safety and wellbeing panels added value to the planning process as did the children at risk of exploitation panel, which promoted multi-agency planning.

Planning to keep other people safe was done well enough in all but two cases and was competently undertaken. The multi-agency approach to achieving this was a particular strength. Inspectors saw examples where children were highly vulnerable but equally posed a risk of harm to others. Workers were able to understand the interrelated nature of the risks and this was evident in their approach to planning. The level of consideration given to victims in the planning process was impressive in its consistency. An area for development relates to contingency planning and the recording of this. The lives of children can change very quickly and plans that are understood by all professionals should be in place so they know as to what immediate action should be taken if concerns increase.

#### 2.3. Implementation and delivery



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

Outstanding

Our rating<sup>4</sup> 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?	93%
Does the implementation and delivery of services effectively support the safety of the child?	87%
Does the implementation and delivery of services effectively support the safety of other people?	93%

Case managers were skilled at engaging with children and their parents or carers to support desistance. They delivered thoughtful and creative interventions, which resulted in a good level of compliance. Case managers took time to understand the

<sup>&</sup>lt;sup>4</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. A more detailed explanation is available in the <u>data annex</u>.

needs of the children and families, and worked hard to meet them. Service delivery took into account the child's circumstances, their diversity needs, and their ability to change, pitching interventions appropriately to promote engagement. Case managers paid attention to building on children's strengths and enhancing their positive factors. They made efforts to engage them in mainstream services that can offer support beyond the end of the YOS intervention and promote ongoing desistance.

Joint working with other agencies was a strength in practice to promote children's safety and wellbeing. Inspectors noted that there was a high level of coordination and information exchange between the agencies involved with most of the cases. Mental health and emotional difficulties featured in a number of cases, and these needs were met well, with the support of the wellbeing workers a particular strength.

#### **Good practice example**

Service delivery supports the safety of the child, with regular information-sharing between agencies. Interventions are tailored, and delivery is evidenced in case diaries. Key factors like friendship groups and risk of exploitation are explored with the child. The wellbeing officer delivers sessions alternated with the case manager to attend to emotional concerns and anxiety. Drug and alcohol interventions are also delivered to the child at their home. Sessions have involved the use of diagrams to explore problems and feelings. Work has been done with the child's parent in regard to setting boundaries, and interventions around effective communication with their child have been delivered. The delivery of work is timely and proportionate and responsive to the risk issues.

In general, there was good coordination between agencies to monitor the risks that some of the children posed to others. Appropriate services were available to address and manage risk of harm. We saw positive examples of suitable interventions to address excessive alcohol use, violent behaviour, knife crime and anger management, and to develop empathy for victims.

#### 2.4. Reviewing



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

Good

Our rating<sup>5</sup> for reviewing is based on the following key questions:

	% 'Yes'
Does reviewing focus sufficiently on supporting the child's desistance?	79%
Does reviewing focus sufficiently on keeping the child safe?	87%
Does reviewing focus sufficiently on keeping other people safe?	79%

<sup>&</sup>lt;sup>5</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. A more detailed explanation is available in the <u>data annex</u>.

In most cases, formal reviews were completed at key points in the order or when there was a significant change in a child's circumstances. There is some room for improvement in a minority of cases in terms of reviewing diversity factors and the personal circumstances of the child. In reviews, case managers responded appropriately in assessing any new offending behaviour. They carried out referral order reviews and assessed positive progress and responses to delivered interventions. Reviewing activity in some cases resulted in changes in the frequency of reporting; in others, changes in the child's needs and circumstances resulted in new referrals being made for additional support. In most cases, reviewing involved the children and their parents or carers and was an opportunity for them to give their view on the work being delivered and progress made.

#### **Good practice example**

There is ample evidence to demonstrate ongoing review of desistance. AssetPlus is completed by the case manager and the case is also regularly reviewed via the risk and safety and wellbeing panel meetings. Due to the good progress made and completion of all plan targets, the referral order is revoked for good progress. Finally, the child's protective factors are developed by supporting him to complete an apprenticeship.

Reviewing to respond to changes in the child's safety and wellbeing was done well enough in most cases, and this was supported by the YOS panel processes and input from other agencies. Where it was required, reviews of safety and wellbeing resulted in changes to the interventions being delivered.

Reviewing risk of harm to others was timely in every cases inspected but did not lead to a change in the plan of work in every case. In two cases we assessed as insufficient; the risks related to males who entered relationships with vulnerable females during their YOS intervention. In these cases, the potential risks to the safety of the girls were overlooked.

In the large majority of cases, the reviewing of risk of harm to others was thorough and informed by information held by other professionals and agencies. Discussions at the risk and safety and wellbeing panels resulted in actions being set and followed up and all relevant cases had been referred to YMAPPA, which added an extra layer of oversight.

## **Domain three: Out-of-court disposals**

We inspected 23 cases managed by the YOS that had received an out-of-court disposal. These consisted of 11 youth conditional cautions, no youth cautions, 12 community resolutions and no other disposals. We interviewed the case managers in 15 cases.

#### 3.1. Assessment



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

Good

Our rating<sup>6</sup> for assessment is based on the following key questions:

	% 'Yes'
Does assessment sufficiently analyse how to support the child's desistance?	83%
Does assessment sufficiently analyse how to keep the child safe?	65%
Does assessment sufficiently analyse how to keep other people safe?	74%

Assessment of desistance was an area of strength. In every case, the case manager used information held by other services, and in all but one case there was involvement from the child and their parent or carer. This resulted in assessments that gave a full picture of the child, their life and circumstances and the factors linked to their offending. Case managers took a child-centred approach and considered both static and dynamic factors and how these may impact on the risk of further offending. There was a focus on identifying and enhancing the child's interests and developing positive factors in their life. Case managers routinely considered the needs and wishes of victims, which was positive; however, they could have paid more attention to exploring opportunities for restorative justice. Similarly, in six cases, inspectors felt that case managers could have paid closer attention to diversity factors. Case managers took into account barriers to engagement and progress and considered how these might be addressed to promote and support engagement. This was reflected in our findings for the implementation and delivery of services to children.

Case managers assessed how to keep children safe well enough in just under two-thirds of cases. Inspectors disagreed with the classification of safety and wellbeing concern in nine of the 23 cases. In these cases, inspectors considered the risk had been underestimated and risks such as witnessing domestic abuse and the impact of this had not been fully considered. Where assessments were good enough, there was good cross-referencing to information held by children's social care, and the case manager had considered the child's vulnerability to exploitation as well as their emotional and mental health concerns.

<sup>&</sup>lt;sup>6</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. A more detailed explanation is available in the <u>data annex</u>.

In the majority of cases, the assessment of risk of harm was analytical and thorough. Case managers liaised with other professionals, such as schools and children's social care to access information, which enabled them to consider patterns of behaviour and what this might mean in terms of risk of harm to others. Inspectors agreed with the risk classification in most cases. Where they did not agree, this was because the risk of harm had been underestimated, as not all past behaviours and patterns of offending had been considered.

#### Good practice example

The risk of harm assessment is robust, as it captures the imminence of the assaults, which are frequent and could potentially cause serious harm, and the use of knives. The risk in this case was unpredictable and could happen at any time. The assessment analyses who might be at risk, in what circumstances and how any risks to the safety of others could best be managed.

#### 3.2. Planning



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

Requires improvement

Our rating<sup>7</sup> for planning is based on the following key questions:

	% 'Yes'
Does planning focus on supporting the child's desistance?	86%
Does planning focus sufficiently on keeping the child safe?	61%
Does planning focus sufficiently on keeping other people safe?	74%

In almost every case, sufficient account was taken of the child's personal circumstances, as well as their wider familial and social context. Planning was proportionate and, in almost every case, there was an appropriate focus on the issues and needs identified in the assessment.

Planning did not, in every case, reflect the work that was delivered to support the child's desistance. Planning took place in different meetings and discussions with other professionals and, while this was not always well recorded on the planning document, we assessed it as sufficient in most cases. Planning would be strengthened through the consistent use of one plan, which would allow case managers to carry out timely reviews of the effectiveness of the work being delivered and to assess whether any revisions were required. It would also assist in the sequencing of interventions to make sure they would be delivered within the available timescales.

Planning did not routinely take sufficient account of the child's strengths and protective factors and seek to reinforce or develop these. Case managers did not

<sup>&</sup>lt;sup>7</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. A more detailed explanation is available in the <u>data annex</u>.

always plan opportunities for community integration, including access to mainstream services following completion of out-of-court disposal work.

This example of planning demonstrates a consistent theme noted by inspectors:

"The written planning document to support the child's desistance does not represent the planning activity seen in this case; most planning is evident in action plans and contact logs. There is evidence of meetings with children's social care but no joint planning."

Despite the identified gaps, planning for desistance was an area of strength. Case managers engaged well with children and their parents or carers to plan interventions. In the majority of cases, planning addressed the issues that had been identified and assessed as linked to offending. We were pleased to see that planning gave sufficient attention to the needs and wishes of victims in 14 out of 19 relevant cases.

Planning to support the child's safety and wellbeing was the weakest area of planning, and this requires improvement. The absence of a coordinated plan meant that there was no recorded continency planning in place. In cases where there was a low level of safety and wellbeing concern, the 'my action plan' was the only document used. If there was a higher level of concern, the AssetPlus contingency planning section was used. Inspectors found that this was not done consistently and the processes in place were not promoting effective contingency planning for safety and wellbeing.

Similarly, contingency planning for managing the risk of harm to others was poor; The issues again were linked to the planning process and the planning documents used. That said, we saw good evidence of case managers involving other agencies and professionals in planning.

## 3.3. Implementation and delivery



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

Outstanding

Our rating<sup>8</sup> for implementation and delivery is based on the following key questions:

	% 'Yes'
Does service delivery effectively support the child's desistance?	100%
Does service delivery effectively support the safety of the child?	<b>78</b> % <sup>9</sup>
Does service delivery effectively support the safety of other people?	96%

The lowest score for this area of practice related to safety and wellbeing. Given the narrow margin between ratings, and taking into account quality of service delivery

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<sup>&</sup>lt;sup>8</sup> The rating for the standard is driven by the lowest score on each of the key questions, which is placed in a rating band, indicated in bold in the table. A more detailed explanation is available in the <u>data</u> annex.

<sup>&</sup>lt;sup>9</sup> Professional discretion applied to raise rating from 'Good' to 'Outstanding'.

we observed overall, we used professional discretion to raise this rating from 'Good' to 'Outstanding'. Inspectors were impressed by the robustness of the interventions delivered to children receiving diversion disposals, and the capacity staff had to engage children with these voluntary interventions.

The services delivered to support desistance were sufficient in every case. The consistent quality of the work was outstanding. Work was tailored to meet children's needs. Staff took a creative approach to engaging children, and they also maintained regular contact with parents and carers. Case managers were responsive to changes in the child's circumstances; for example, they made referrals to the YOS education worker when placements broke down. They considered children's learning styles and diversity issues, and suitably addressed any barriers to engagement.

#### **Good practice example**

The case worker delivered all aspects of the plan and supported Jamie to engage. He was enrolled on a college placement that did not work out and another was swiftly found. Unfortunately, he did not want to attend this placement, despite a YOS worker accompanying him to the college on his first day. Jamie was offered CAMHS support but declined it, so the worker explored difficult feelings and emotions with him. Work was done to look at the impact of offending on others, including the wider community. Jamie's presenting (but undiagnosed) learning needs were taken into account in the delivery of work. The worker clearly had a good relationship with Jamie, his mother and grandad, and had a good knowledge of the family dynamics.

In the large majority of cases, the YOS worked well with other services and agencies to manage the safety and wellbeing of children. Case managers worked effectively with other services, such as children's social care, to promote children's safety and wellbeing. The YOS risk and safety planning meetings and discussions at the exploitation panel improved the quality of safeguarding work. Where cases were assessed as insufficient, this was mainly due to gaps in communication and partnership working.

The quality of work to manage risk of harm for children on out-of-court disposals was excellent in its consistency. Children appropriately received informal diversion disposals; at the same time, case managers attended to any risk of harm posed to others and did not compromise on the attention given to victims.

#### 3.4. Out-of-court disposal policy and provision



There is a high-quality, evidence-based out-of-court disposal service in place that promotes diversion and supports sustainable desistance.

Requires improvement

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

Our key findings were as follows:

#### **Strengths**

- The YOS offers a range of options to divert children from the justice system and works with partners to achieve this with the lowest level of intervention. Overall, outcomes are good and there is evidence of sustainable desistance.
- There is good input from partners at the out-of-court disposal panel, which supports a holistic approach.
- There is good analysis of reoffending rates, which are broken down by disposal, and outcomes for children are positive.
- The quality of services delivered to children on out-of-court disposals, together
  with low reoffending rates, suggests that the rate of first-time entrants in
  Derbyshire is low because children are genuinely being diverted from the
  justice system and receiving the help they need.
- Children receiving an out-of-court disposal have the same access to services and support as those subject to a statutory order.
- The level of contact with victims has significantly increased over the past 12 months.

#### **Areas for improvement**

- The out-of-court disposal processes are unduly complicated, with overly onerous assessment processes that are time-consuming for staff and cause unnecessary delays to children starting their interventions.
- The YOS strategy for out-of-court disposals does not reflect up-to-date practice, and it is not aligned with the protocol for out-of-court disposals.
- The panel's 'voting system' for deciding on an out-of-court disposal is not robust. Ultimate responsibility and accountability for these decisions should rest jointly with the YOS and police partners, and should not be decided on a vote.
- Out-of-court disposal panel members do not have a shared understanding of when youth cautions should be used and what the intervention involves.
- The current out-of-court disposal policy does not offer guidance on how diversity, safety and wellbeing and risk factors should be taken into account when considering the most suitable disposal for a child.
- We could not be confident that children and their parents understand the implications of accepting an out-of-court disposal.
- The policy of imposing a youth conditional caution for knife possession can result in children's tariffs being increased unnecessarily in one case, a young child with significant mitigation and no previous convictions was not considered for a community resolution when it would have been appropriate to do so.
- The rationale for imposing a specific out-of-court disposal is not routinely recorded on case files.

#### 4. Resettlement

#### 4.1. Resettlement policy and provision



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

Good

We inspected the quality of policy and provision in place for resettlement work, using evidence from documents, meetings, and interviews. To illustrate that work, we inspected four cases managed by the YOS that had received a custodial sentence.

Our key findings were as follows:

#### **Strengths**

- The resettlement policy describes the arrangements for delivering a highquality service for children. It sets out how to keep children safe and ensure the safety of other people, and addresses victims' needs. Our findings in terms of YOS resettlement work indicated that the aims of the resettlement policy had been achieved in most cases.
- The YOS takes an individualised approach to resettlement work, which is strengths-based and focused on the future.
- The resettlement policy takes sufficient account of structural barriers to effective resettlement and recognises the role of a pro-social identity shift.
- Arrangements for access to and exchange of information from partners, providers and other stakeholders are clear.
- Suitable and timely accommodation is available for most children leaving custody.
- There is appropriate access to services, including education, training and employment and healthcare.
- The YOS has good relationships with the secure establishment where most Derbyshire children are placed, and this supports effective release and community planning.

#### **Areas for improvement**

- Not all staff who are working with children in custody and planning for their release have had specific training on this area of work.
- The resettlement policy should set out expectations for staff who work with diverse groups such as children from black, Asian and minority backgrounds and with girls. It cannot be assumed that specific issues and challenges will be identified and addressed by the YOS's overarching individualised approach to practice.

## **Further information**

The following can be found on our website:

- inspection data, including methodology and contextual facts about the YOS
- a glossary of terms used in this report.