

Full Joint Inspection of Youth Offending Work in F cW XU`Y

An inspection led by HMI Probation



Foreword

This inspection of youth offending work in Rochdale is one of a small number of full joint inspections that we are undertaking annually with colleagues from the criminal justice, social care, health and learning and skills inspectorates.

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on the three National Youth Justice Outcome Indicators supported by other information, such as recent inspections – is of significant concern. Periodically, we also include high performing areas to establish a benchmark of good practice.

We chose to inspect in Rochdale primarily because their performance showed higher than average reoffending rates. As with other YOT's in England and Wales, work to prevent children and young people from entering the criminal justice system has been effective, with the result that those who are convicted of offences are more likely to have complex lives and present challenges when trying to reduce reoffending. In Rochdale 47% of young people reoffended, while the average for England and Wales was 35.8%. A note to explain how this figure is generated is included in Appendix 1.

Overall the work of the YOT was progressing, and staff worked well with most partner agencies to deliver a range of interventions that were designed to help children and young people stop offending. This was matched by good engagement by children and young people and their parents/carers, particularly in the early stages of contact. The YOT Management Team had shown a flexible and responsive approach. Although there were good relationships with children's social care services, education and the police at both strategic and operational levels and good relationships between the YOT health worker and YOT staff, services from health urgently needed to be improved.

Most of the work we saw was generally good enough, but about one-third of the cases examined required improvement and greater attention to a number of different areas. These included: assessment, planning, reviews and outcomes in relation to reducing reoffending, the likelihood that the child or young person may cause harm, and also their vulnerability. Addressing diversity issues and attention to victim safety also required improvement.

This work needed to be tackled by the YOT Management Board, which was falling short of the role we expect of a governance body in providing both challenge and support. Board members needed to be better sighted of the YOT's performance so that they could recognise success and address areas for improvement. The absence of any meaningful health involvement at a strategic level was a particular concern.

The recommendations made in this report are intended to assist Rochdale in its continuing improvement by focusing on specific key areas. We hope that the newly formed YOT Management Board holds all partners to account and supports the YOT Management Team to continue in its development of services to children and young people.



Liz Calderbank

HM Chief Inspector of Probation

September 2013

Summary



Reducing the likelihood of reoffending

Overall, work to reduce reoffending was good. The quality of assessments varied, some being very good, but the key theme around all assessments was a lack of analysis. Assessments tended to describe behaviours rather than analyse the reasons for offending. Courts had been appropriately advised about sentencing options and the needs of the child or young person. Communication between Early Break (a substance misuse service) and case managers needed to improve to have a clearer impact on the reduction of offending. The outcomes of interventions were not routinely collated or used to inform future practice. There was a good focus on education, training and employment resulting in high numbers of children and young people being placed in good quality provision, but again there was little evidence of how effective these had been in reducing offending or improving the child or young person's life chances.



Protecting the public

Overall, work to protect the public and actual or potential victims was good. Initial assessment of the risk of harm to others was good in over 70% of cases, but this fell to just over half when cases were reviewed. There was good partnership work with the police to help manage children and young people who posed a risk of harm to others. Victims of crime were generally pleased with the service they had received, but protecting them was not always a high enough priority. Plans did not reflect the work that needed to be done to manage the risk of a child or young person hurting someone else.



Protecting children and young people

Overall, work to protect children and young people and reduce their vulnerability was good. There was effective joint work with children's social care services. YOT staff were usually able to respond to vulnerability and safeguarding needs, although sometimes there was an underestimation of the risk a child might face, such as if they had a drug debt¹. All children and young people had been screened to identify whether they were at risk of sexual exploitation and this system appeared to be effective in identifying key issues and bringing everyone together to work to protect the individual.



Ensuring the sentence is served

Overall, work to ensure that the sentence was served was good. Diversity factors and barriers to engagement were not always identified and planned for. A number of children and young people reported difficulties in establishing effective relationships with some staff, but it was clear that there was also some very effective engagement too. Parents/carers were involved in assessments and were positive about the support they received. There were some communication issues evident between children and young people and the YOT; an example of this related to cooperation with their order. Several children and young people believed that they were subject to breach when YOT actions related to engagement, that is trying to gain cooperation.

¹ Some children and young people fall into debt to drug dealers as they have little legitimate means of funding drug misuse. Accruing a drug debt can lead to an increase in offending to pay off the debt or make the child or young person vulnerable to exploitation.

Governance



Overall, governance was unsatisfactory. The YOT Management Board did not provide sufficient challenge and was not fully effective in supporting the YOT. Health was not effectively represented at board level. The Board did not have enough knowledge about the success of the YOT; they did not collate outcome data in order to demonstrate what the YOT was doing well and areas for improvement. Effective practice was being driven by the YOT Management Team and in particular the YOT manager, who worked very effectively with partner agencies to deliver new projects, some of which have been used as good practice examples in this report.

Recommendations

Post-inspection improvement work should focus particularly on the following:

1. Data on appropriate local outcome measures, including health, education, training and employment, diversity and safeguarding, are received, scrutinised by the YOT Management Board and used to improve services to children and young people and their parents/carers (Chair of the YOT Management Board).
2. There is appropriate level health representation and active participation at the YOT Management Board. Held to account by the Board chair and other members, this should help to raise the quality of provision and demonstrate the value of health interventions in both reducing offending and improving child health and well-being (Chair of the YOT Management Board).
3. There is an information sharing policy in place between the YOT and all partner agencies which includes how consent from children and young people is sought, provided, and recorded. (Chair of the Management Board and Head of YOT).
4. Quality assurance arrangements, including management oversight, ensure that assessments and plans, and their reviews, are adequate and inform the delivery of interventions (Head of YOT).
5. Initial assessments and their reviews are completed to a sufficient quality with particular reference to risk of harm and the likelihood of reoffending (Head of YOT).
6. Records completed by the YOT staff more accurately reflect the work being undertaken (Head of YOT).

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Reducing the likelihood of reoffending

1

Theme 1: Reducing the likelihood of reoffending

What we expect to see

As the purpose of the youth justice system is to prevent offending by children and young people we expect youth justice partners to increase the likelihood of successful outcomes by undertaking good quality assessment and planning, deliver appropriate interventions and demonstrate both positive leadership and effective management.

Case assessment score

Within the case assessment, overall 65% of work to reduce reoffending was done well enough.

Key Findings

1. The quality of assessments was mixed, some being very good, but the key theme around all assessments was a lack of analysis. Assessments tended to describe behaviours rather than analyse the reasons for offending.
2. Courts had been appropriately advised about sentencing options and the needs of the child or young person.
3. Communication between Early Break (a commissioned substance misuse service) and case managers needed to improve to have a clearer impact on the reduction of offending.
4. The outcome of interventions was not routinely collated or used to inform or improve practice.
5. There was good focus on education, training and employment (ETE), resulting in high numbers of children and young people being placed in good quality provision.

Explanation of findings

1. Assessment

- 1.1. Assessments of the likelihood of reoffending often described the behaviours of children and young people, but did not analyse why they had offended. Assessments and plans did not identify drug debts which left some children and young people in a difficult position and possibly quite vulnerable.
- 1.2. Thorough information about ETE and living arrangements were included in most assessments. This was particularly important given the number of Looked After Children who were supervised by the YOT on behalf of other local authorities. The YOT, with both the police and children's social care services, had developed good working relationships with local children's homes and chaired regular meetings so that they were aware of, and got to know, about the children and young people who came into their area. The inter-agency systems involved in ensuring these children and young people were identified is one of the best we have seen.
- 1.3. We found that the assessments of children and young people who received a custodial sentence were often worse, with emotional and mental health needs rarely being fully considered.
- 1.4. Assessments were not always based on good enough information and had sometimes been copied without updating. Reviews did not always pick up missing information or recognise relevant changes.
- 1.5. We saw very little assessment of individual learning styles or of barriers to engagement.

An effective practice example

A good system of identifying and assessing the needs of vulnerable children and young people was found in 'Operation Madison'.

Police in Rochdale Division had developed a relationship with all 40 children's homes in the borough and had appointed liaison officers from neighbourhood teams to visit these homes weekly. Children and young people who arrived in the area from outside the borough were identified during these visits, any risks identified and in relevant cases services were notified with copies of the risk assessment going to Children's Services, Police Intelligence Hub, Education and the Local Children's Safeguarding Board (LSCB). The YOT was then able to ensure cases were transferred to them where needed.

2. Planning for interventions

- 2.1. Case Planning Forums (CPF) were held in the YOT for all children and young people who were transferred in, who were assessed as being a high risk of harming others, or a high likelihood of reoffending. This was a multi-agency meeting where professionals could discuss a case and agree what needed to happen to either prevent reoffending or the public from being harmed. These forums demonstrated good information sharing and the development of joint work to meet individual and community needs.
- 2.2. In two-thirds of all cases, there was a plan in place to reduce the likelihood of reoffending. Plans covered the assessed needs in the case and we noted that there was good attention to planning for ETE and for living and parenting arrangements.
- 2.3. Planning for those in custody was less good, and often did not match the actual work that was taking place in the institution.
- 2.4. Where plans were not good enough there was no single reason but we noticed that custody plans were not always coordinated with the work that was ongoing to help children and young people resettle in the community.

3. Delivery of interventions

- 3.1. Case managers had access to a wide range of resources and understood the principles of effective practice. Interventions were delivered in the way that they were designed to be delivered, but not always linked to the individual's assessment.
- 3.2. We noted that some children and young people had a lot of adults involved with them. They found this confusing, particularly understanding how information was shared between professionals. Some found it difficult to trust their case manager as a result. Where there were good relationships, children and young people were very positive about this.
- 3.3. The YOT educational welfare officer (EWO) was skilled at understanding the educational needs of children and young people and was well established in the YOT with effective working relationships with case managers. Links with local schools and the local authority were good, ensuring that

Comment from interview with a young person

"She is really friendly. She seems to care, whereas some of the others care because it is their job. She seems to genuinely want to help people. That helps. I can talk to her...about my offending and everything."

Comment from interview with a young person

"I felt like I could speak to [female YOT worker] personally, about personal problems as well as my offending. I felt like she was actually there to help me."

children and young people of school age were attending school or alternative provision while completing their orders. The EWO worked well to increase the children and young people's motivation and levels of participation.

3.4. The YOS had dedicated resettlement workers who both visited young people in custody and continued to work with them on discharge, by delivering interventions in the community. In all the custody cases inspected, case managers told us that resettlement workers were delivering interventions linked to their custodial sentence plan to be delivered in the community. Disappointingly, most did not have a detailed knowledge of what was being undertaken in either custody or in the community, thus they were unable to reinforce the work being done in their contact with the child or young person. Resettlement staff were able to give examples of their work, most of which was linked to practical needs such as accommodation and ETE in the community, but it was not always clear how this linked to the work of the case manager, or how children and young people were helped to understand the roles of the different people they were working with.

3.5. It was often difficult to know what work had been completed as the electronic records contained little detail. Others working with the child or young person did not always know what had been done. This was a particular issue for those who were working with the substance misuse service Early Break. Although a recent change in worker had improved informal communication systems, the information that Early Break gained at both the initial assessment and at the review stages was unknown to case managers, making it difficult to include this work in plans to reduce reoffending or to monitor if these interventions were being effective.

Comment from interview with a young person

One young person gave us an example of the different approaches he had experienced:

"I feel like he is just saying, you're not going to offend again. He will say 'You're not going to offend again, are you?' And I will just say no. Obviously you are going to say no aren't you? Whereas [previous worker] would say, 'If you do offend again, why don't you try doing this instead?'"

The following are quotes from young people about their experience of Early Break:

"I got assistance from Early Break, which helped me a lot. That is for drugs. I used to take cocaine, but now I only smoke weed."

"YOT re-referred me to Early Break...yeah. Yeah it has helped, definitely. I still get help. All right, yeah. She comes in every week and helps us to prevent using drugs. It is working. I've been off drugs for six months."

"It hasn't helped me cut down on my drug use, or stopped me drinking or going out partying. It is just taking up more of my time. No offence."

"It has not helped me one bit. I'm still taking the same amount of drugs as I was before."

"Early Break don't do nothing. It is only you who can stop yourself from taking drugs, isn't it?"

3.6. The children and young people who were interviewed felt that it was the relationships that they had with their workers that represented the most important factor for them. This was true for both offending work and how they viewed their order and the YOT. It was this relationship that made the most difference. A positive relationship meant that they could trust the worker enough to discuss honestly the issues around their offending and their lifestyles. This helped them identify various pathways out of offending.

3.7. Only two of the children and young people interviewed stated that they had benefited from involvement with Early Break. Most said that although they could see what the agency was trying to do they felt that it had little impact. Early Break had provided a report for each of the cases in

our sample where they had been involved. None of these reports gave an indication of the level of substance misuse at the start of the contact, or what progress had been made. Attendance was recorded.

4. Initial outcomes

- 4.1. Just over half of the reviews we saw were good enough. In 9 of the 15 cases where the review was not effective, it was because the review was a copy of the previous assessment and had not been updated as the case had progressed. This meant that case managers often found it difficult to see where progress was being made or which interventions were making a difference.
- 4.2. We look to see if the work is having an impact on the child or young person's behaviour. From the cases we saw, most progress had been made in ETE, in improving the living arrangements and in the child or young person's perception of themselves and others. A high proportion (84%) of children and young people interviewed told us that having worked with the YOT; they now had a better understanding about why they had offended.
- 4.3. Data supplied by the YOT showed that nearly three-quarters of all children and young people attending the YOT were in ETE with the vast majority of children aged under 16 successfully maintained in education or an alternative provision.
- 4.4. Least progress had been made in the areas of family and personal relationships, motivation to change, physical health and substance misuse.
- 4.5. In only half of the cases was enough consideration given to planning for the end of the order; that is to make sure that the child or young person has the appropriate provision when the involvement of the YOT finished.

5. Leadership, management and partnership

- 5.1. We saw good partnership working between individual practitioners at the YOT, with specialist workers respected for their inputs.
- 5.2. YOT managers were seen by case managers as open and supportive and had been used appropriately to escalate cases where needed.
- 5.3. The Deputy YOT Manager attended the weekly Spotlight selections meeting. Spotlight is Rochdale's version of an Integrated Offender Management unit. This is a jointly operated partnership involving police, probation and other local service providers covering areas such as drug services, housing, employment and training. The aim was to work together to reduce reoffending through a measured combination of relevant interventions and closer supervision. Inputs were usually reserved for the most serious and most prolific offenders. The YOT were fully engaged in the issues relating to children and young people, as this provided additional resources to help encourage particular children and young people not to reoffend.
- 5.4. Careers advice and guidance were available at the YOT office and a variety of offsite locations. Careers advisors were clear about their role and had built good working relationships within the YOT. The level of information provided by case managers was good, with a holistic approach being taken to support children and young people. The service benefited from being centrally located within the YOT office, which helped facilitate a good level of informal communication. Career advisors were skilled at working with children and young people with specific and complex needs and were clear about the opportunities available throughout the Rochdale area. Good relationships had been built with a network of accredited training providers across the area. Interviews were well planned and took account of transition points such as year 11 (Key Stage 4) to plan for progression into further education or training. Providing opportunities for the development of employability skills through work placements for children and young people known to have offended continued to be challenging.

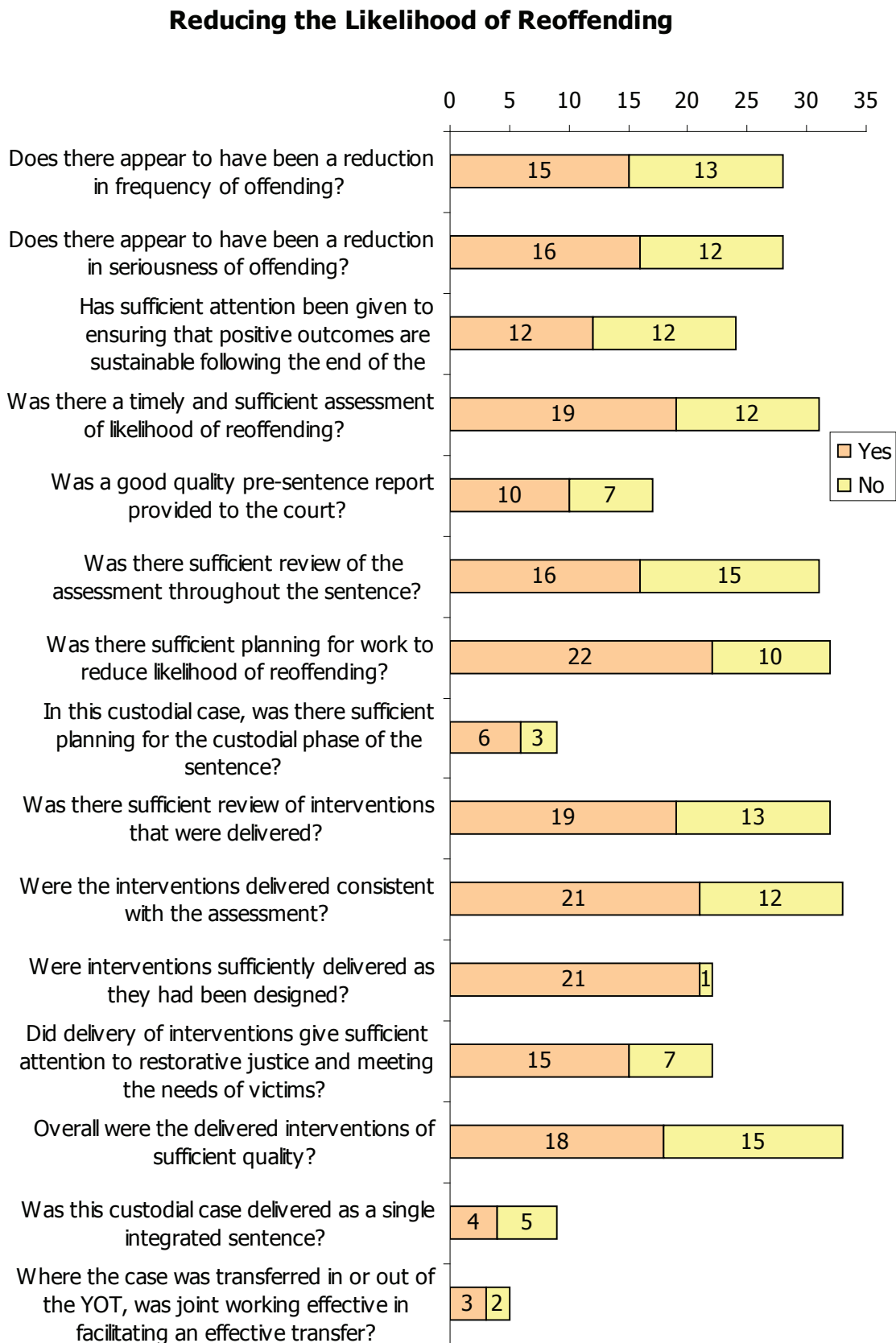
- 5.5. Rochdale was one of only four YOTs in the region to join the North West Resettlement consortium. This gave children and young people from Rochdale priority to attend specific group work programmes in Hindley Young Offenders Institution. There was also dedicated space at Hindley for YOT workers to meet and deliver interventions to children and young people who would be returning to Rochdale. The consortium also provided the opportunity for a high level of liaison between staff in Hindley and the YOT.
- 5.6. There was little collection and analysis of data to monitor the overall quality of provision or outcomes for children and young people, either at an operational level or by strategic managers.

Summary

Overall, work to reduce reoffending was good. The quality of assessments varied, some being very good, but the key theme around all assessments was a lack of analysis. Assessments tended to describe behaviours rather than analyse the reasons for offending. Courts had been appropriately advised about sentencing options and the needs of the child or young person. Communication between Early Break (a substance misuse service) and case managers needed to improve to have a clearer impact on the reduction of offending. The outcomes of interventions were not routinely collated or used to inform future practice. There was a good focus on education, training and employment resulting in high numbers of children and young people being placed in good quality provision, but again there was little evidence of how effective these had been in reducing offending or improving the child or young person's life chances.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the Public

2

Theme 2: Protecting the Public

What we expect to see

Victims, and potential victims, of crime have the right to expect that everything reasonable is done to manage the risk of harm posed by children and young people who have offended. We expect to see good quality assessment and planning with the delivery of appropriate interventions, and positive leadership, effective management and partnership work which reduces the risk of harm to others.

Case assessment score

Within the case assessment, overall 65% of work to protect the public was done well enough.

Key Findings

1. Initial assessment of risk of harm to others was sufficient in over 70% of cases.
2. Reviews of risk of harm were good enough in just over half of the cases.
3. There was good partnership work with the police to help manage risks.
4. Victims of crime were generally pleased with the service they had received.
5. Plans did not reflect the work that needed to be done to manage the risk of harm.

Explanation of findings

1. Assessment

- 1.1. The majority of initial assessments of risk of harm were done sufficiently well and pre-sentence reports contained a clear outline of risk factors. Where we thought the assessment was not done well enough this was because previous relevant behaviours had been ignored or the potential impact on victims was not clear enough.
- 1.2. Reviews of risk of harm were sufficient in just over half of the cases and, as we found with the likelihood of reoffending, these were often copies of previous assessments which did not reflect significant changes or remedy problems with the initial assessment. The assessment of the level of risk was inconsistent and in some cases the child or young person's compliance with the order was used to reduce risk of harm levels too quickly.

Case illustration

In one case a 15 year old had a public order offence. He was assessed as posing a low risk of harm to others, despite there being three separate occasions where he demonstrated some worrying behaviours towards young women. Little consideration had been given to the impact of his learning disability to see if he actually understood what acceptable behaviour was.

- 1.3. The Multi-Agency Public Protection Arrangements (MAPPA) case in our sample was supervised by another police force, and the YOT had liaised with that force to keep the victim safe. However, the case had not been referred for consideration to the local MAPPA when there was a new potential risk within Rochdale.

2. Planning for interventions

- 2.1. There was a plan in place to manage risk of harm in 65% of cases. The CPF provided an opportunity for review of risk and we noted that the work to manage risks was often better than the records demonstrated.

Case illustration

Following an assault on his girlfriend, 17 year old George was assessed as posing a high and continued risk of harm to his victim. The YOT and the prison worked together to manage the risks and ensured that he was unable to contact his ex-girlfriend. This in turn allowed children's social care services to work with her to keep her and her children safe. During his time in custody, George disclosed that he was struggling to cope; he was involved in a fight with another young person and threatened to harm himself. The prison took measures to keep him safe. Prior to his release, a plan was put in place to control his movements and minimise the opportunity to contact his ex-girlfriend. He undertook work on healthy relationships in order to minimise the risk of harm to others in the future. This case illustrates that the further harm George posed to his ex-girlfriend could be managed alongside the risk he posed to himself.

- 2.2. Where plans to manage risk of harm were not good enough (in 9 out of 26 relevant cases) either enough attention was not given to diversity factors that acted as a barrier to engagement, or planned responses were not sufficient.

3. Delivery of interventions

- 3.1. All six of the victims we interviewed were positive about the service they had received from the YOT victim liaison officer. They had all been contacted appropriately, first by letter and then by either a follow up telephone call or home visit. Victims felt reassured to know what work had been undertaken with the children and young people who had offended against them. Four of the victims had taken up the invitation to take part in restorative justice by attending the reparation order panel. One victim had also visited one young person in custody. All victims who met the children

Comment from child or young person when asked whether victim work had made a difference

"yeah, it made me think about them but also what had happened to me. That helped with some of my (issues)..."

and young people said that the meetings had been well organised and they had felt able to express their views in a safe environment. Also, they had all had an opportunity to contribute towards the child or young person's referral order plan.

- 3.2. Most children and young people who were interviewed had done some form of victim awareness work. Many did not think that this work should be done in a group, but were positive about the work when it was completed on a one-to-one basis. A number of children and young people noted that not only did this work help them to understand how their offending had affected their victims, but that it also helped them to understand, or come to terms with, their own feelings when they had been victims of crime.

Comment from child or young person when asked whether victim work had made a difference

"It was a bit useful and I now know how the victim feels personally. It gave me more awareness and made me think twice. I've been a victim of crime when I was assaulted."

- 3.3. Interventions delivered were consistent with the plan in just over half of the cases. Case managers often reacted to risks when they became obvious, but more thorough reviews would allow for more proactive and accurate amendments to plans to accommodate changes in the child or young person's circumstances.

- 3.4. It was not always clear how the interventions were intended to reduce risk of harm to others. Children and young people were not clear about why they were undertaking some programmes or how this work was part of the order.
- 3.5. The YOT had robust specialist assessments and procedures for the management of children and young people who sexually abuse or display sexually harmful behaviour. There was joint work between specialist trained YOT staff and trained social workers from children's social care services. This included joint assessment and the delivery of interventions to this group of children and young people managed either by the YOT or Children's Social Care Services.

4. Initial outcomes

- 4.1. In two-thirds of cases risk of harm to victims had been effectively managed.
- 4.2. In just over two-thirds of the cases we judged that the YOT had done enough to manage risk of harm. Where this had not happened it was due to problems with the ongoing review of risks, or the right work not being done with children and young people.

5. Leadership, management and partnership

- 5.1. Case managers appeared to have an understanding of the procedures for the management of risk of harm. However, the work undertaken often did not match the plans that had emanated from the assessments, and nor did they trigger a robust and thorough review.
- 5.2. Management oversight of cases had not rectified the deficiencies in assessment and planning in just over half the cases.
- 5.3. The YOT Management Team were good at engaging important partners in the identification and management of risk of harm, including the police, MAPPAs and other specialist teams.

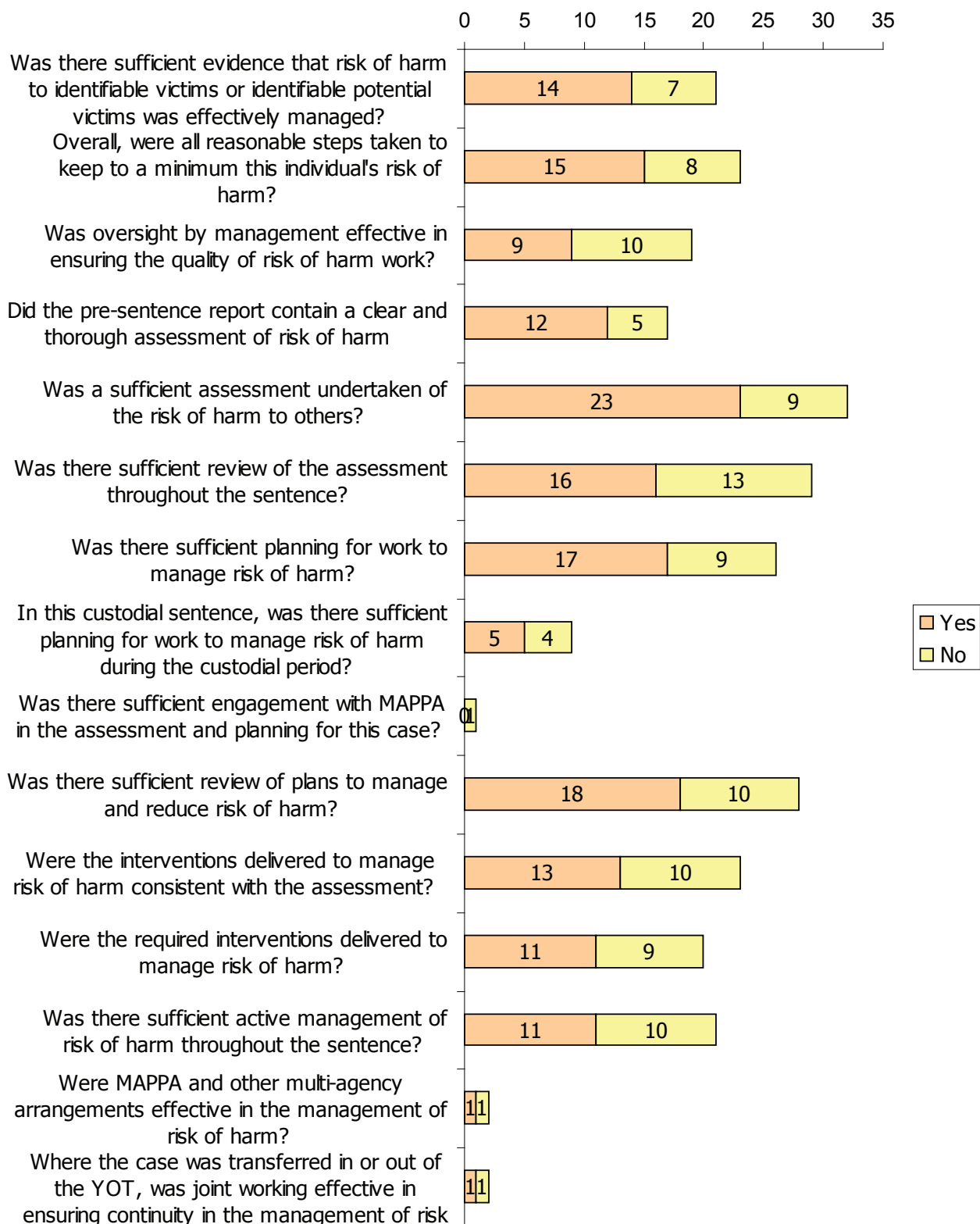
Summary

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Data Summary

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Protecting the Public



Protecting the child or young person

3

Theme 3: Protecting the child or young person

What we expect to see

Whether the vulnerability of children and young people is due to the consequences of their own behaviour or the behaviour of others, we expect to see that they are kept safe and their vulnerability is reduced. This should be through good quality assessment and planning with the delivery of appropriate interventions, positive leadership and management, and an effective contribution to multi-agency child protection arrangements.

Case assessment score

Within the case assessment, overall 66% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. There was effective joint work with children's social care services.
2. YOT staff were usually able to respond to vulnerability and safeguarding needs, although sometimes there was an underestimation of vulnerability levels.
3. The vulnerabilities that some children and young people faced due to having drug debts was not recognised or planned for.
4. All children and young people had been screened to identify whether they were at risk of sexual exploitation with appropriate referrals being made when needed.

Explanation of findings

1. Assessment

- 1.1. Sufficient assessments and reviews of vulnerability and safeguarding had taken place in two-thirds of all cases.
- 1.2. In two cases an assessment of vulnerability had not been undertaken at all and in eight cases the vulnerability classification was too low.
- 1.3. In respect of drug use, potential vulnerabilities were not always recognised. For example, a number of children and young people had amassed drug debts and had no legitimate way of paying these off; this had the potential to increase their vulnerability.

Case illustration

Peter, who was 14, was a child in need due to neglect. He lived at home with his parents. The case record clearly showed that he was physically small for his age and there were concerns about his weight as he did not appear to be receiving enough food. The YOT had assessed him as low vulnerability; this was not consistent with the assessment by children's social care services.

In this and in other cases, the involvement of children's social care services had rightly been seen as a resource that might help to protect the child or young person, but sometimes the level of vulnerability was reduced too quickly and before joint work had time to be effective.

- 1.4. Where Child Protection assessments had been undertaken by children's social care services, YOT case managers had supported these with appropriate exchanges of information. Where appropriate, YOT staff provided reports to child protection conferences covering detailed information including the consideration of historical background and levels of risk of harm to others and to the child or young person. Children's social care services assessments seen were up to date and had been regularly reviewed to include emerging concerns.
- 1.5. Those children and young people who may be at risk of child sexual exploitation were screened by the YOT and where appropriate referred to the multi-agency specialist sexual exploitation team. This team, called Sunrise, assessed and supported children and young people at risk of sexual exploitation, in partnership with services who were already engaged with the individual or family. Good communication had been established. Staff within the YOT had received training in child sexual exploitation.
- 1.6. There were sufficient vulnerability plans in place for seven of the nine custody cases, and we saw evidence of joint visits from YOT staff and social workers to children and young people while they were in custody.
- 1.7. Referrals to the Child and Adolescent Mental Health Service (CAMHS) were generally undertaken by the health worker following the initial assessment, but case managers also had the ability to make direct referrals in her absence. More recently, CAMHS were processing referrals in a more timely manner according to the severity of need identified.

2. Planning for interventions

- 2.1. Just over half of the plans to manage vulnerability and safeguarding were good enough.
- 2.2. We noted attention to planning around living and care arrangements and for ETE, but less attention to plan for the vulnerabilities arising from substance misuse, physical, emotional and mental health.
- 2.3. Case managers had access to and contributed to plans held by other agencies including children's social care services and children's homes providers.

3. Delivery of interventions

- 3.1. Interventions were delivered to address safeguarding needs in line with the plan in 59% of cases. Sometimes there was no clear link between the interventions and the assessment and in five cases the planned interventions were not delivered. In some cases the necessary interventions were not recognised by case managers.

Case illustration

One young person interviewed explained that, as he had debts relating to his drug usage, he had problems travelling to the YOT. The dealers he owed money to knew he attended the YOT. He had reported this but felt that nothing was done. He was resigned to his situation and thus felt that he just had to put up with it and would avoid those individuals. He told us:

"I've got bad drug dealers after me. I told YOT but...you've just got to dodge them."

- 3.2. There was no dedicated CAMHS worker provided at the YOT, although we understood a CAMHS practitioner was available by telephone on a daily basis to discuss specific cases if required. CAMHS were developing community based services which it was hoped would provide more flexible access to services for those children and young people who were in contact with the YOT. However, for those children and young people who were given an appointment via the YOT, these were by letter which we considered was unlikely, on its own, to be enough to motivate this group of children and young people to attend for an appointment.

4. Initial outcomes

- 4.1. Children and young people interviewed were generally very positive about the support they had received from YOT staff to help keep them safe. They gave a number of examples of how they had been supported.
- 4.2. The YOT had done enough to keep children and young people safe in two-thirds of cases where action was needed. In the eight cases where that had not happened, we found five cases where the planning was not good enough, four where the assessments had missed key issues and three where the YOT had not done what they had planned to do.

Quotes from Children and Young People:

"I did self-harm quite a bit. My last YOT worker...I told all of them, and they helped me. I haven't done anything for about nine months.

"Yeah. I'm gay. I can't remember if it was [male YOT worker] or [another worker], but one of the workers gave me leaflets for these meetings that homosexual people have. I didn't ever go to them, but it is nice that the support is there."

5. Leadership, management and partnership

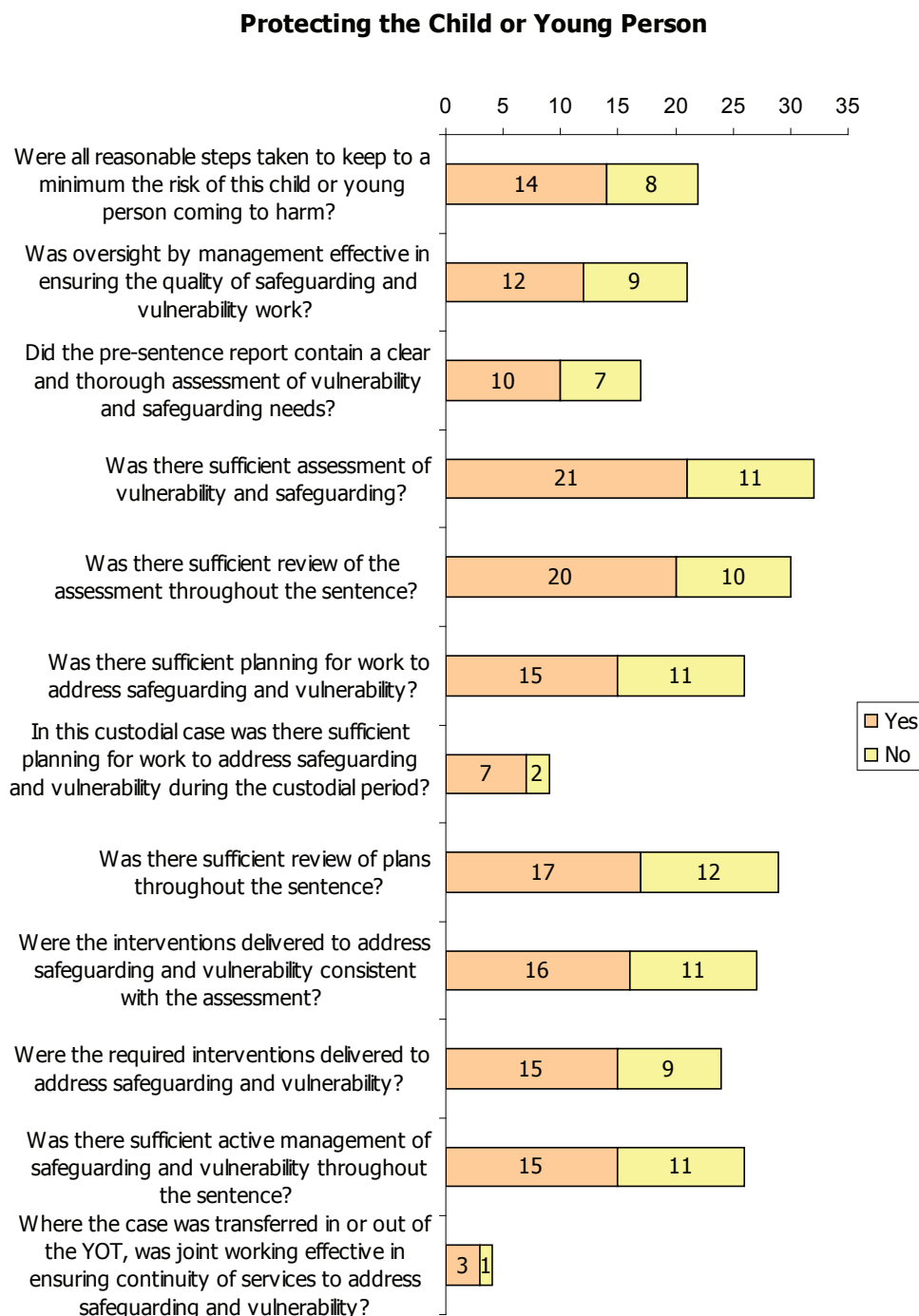
- 5.1. Performance management information on safeguarding and Looked After Children issues within the YOT was routinely collated and analysed by the YOT manager. The findings were reported to senior managers and the key strategic groups such as the Local Children's Safeguarding Board and the children's social care services Senior Management Team.
- 5.2. The YOT contributed well to the development of local Child Protection arrangements. Representatives from the YOT attended the LSCB and some of its sub groups, and other safeguarding forums such as MAPPA. Looked After Children placed in the area by other authorities, and known to the YOT, were effectively supported and the YOT regularly meets with private residential service providers to assist with the prompt notifications of placement and to discuss current issues.
- 5.3. Effective joint working between the YOT and children's social care had been established, the YOT management team had taken the opportunity to improve this area of practice during the reorganisation of the councils services to children. Clear protocols were in place for thresholds relating to child protection and to define respective responsibilities between children's social care services and YOT services. Escalation procedures were clearly established by the LSCB, although it had not been necessary for these to be used by the YOT.
- 5.4. Operational management of work was effective in overseeing safeguarding and work with Looked After Children within the YOT. Social work staff within the team received regular supervision which included case discussion and direction. As a result, the quality of work we saw on such cases was good. In some cases this involved direct case work and in all access to a range of appropriate activities. The work undertaken by staff within the YOT in relation to these cases was appropriately recorded and recording was sufficiently up to date.
- 5.5. Social work staff within the YOT had regular access to safeguarding training provided by the LSCB, which they valued. Staff were able to demonstrate how this learning was used to improve the quality of their casework.
- 5.6. All case managers interviewed understood the local policies in relation to safeguarding and vulnerability.
- 5.7. Health managers had not provided appropriate clinical supervision or a suitable environment for the YOT nurse.

Summary

Overall, work to protect children and young people and reduce their vulnerability was good. There was effective joint work with children’s social care services. YOT staff were usually able to respond to vulnerability and safeguarding needs, although sometimes there was an underestimation of the risk a child or young person might face, such as if they had a drug debt. All children and young people had been screened to identify whether they were at risk of sexual exploitation and this system appeared to be effective in identifying key issues and bringing everyone together to work to protect the individual.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



**Ensuring
that the
sentence is
served**

4

Theme 4: Ensuring that the sentence is served

What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the YOT will maximise the likelihood of successful outcomes by effective engagement with them and their families, responding to relevant diversity factors including paying attention to their health and well-being, and taking appropriate action if they do not comply.

Case assessment score

Within the case assessment, overall 69% of work to ensure the sentence was served was done well enough.

Key Findings

1. Diversity factors and barriers to engagement were not always identified and planned for.
2. A number of children and young people reported difficulties in establishing effective relationships with some staff, but it was clear that there were some very effective relationships between children and young people and YOT staff.
3. Parents/carers were involved in assessments throughout the order and were positive about the support they received.
4. Some children and young people do not fully understand the processes to ensure compliance.

Explanation of findings

1. Assessment

- 1.1. Assessment of diversity factors and potential barriers to engagement were sufficient in just 42% of cases. We noted that there was little assessment of learning styles or speech, language and communication needs. When relevant information had been provided about individual needs, the assessments often did not analyse the impact of these on the child or young person's ability to engage and comply with the order.
- 1.2. Many of the children and young people interviewed discussed the importance of the relationship they had with the YOT worker as being central to their compliance with the order. Where there were good relationships, children and young people felt that they would be helped to comply. Not all children and young people had a positive relationship with workers. In particular, some found the number of staff working with them confusing. Several of those with a number of professionals had difficulties; we saw cases where there were up to nine workers involved.
- 1.3. A common concern amongst children and young people was about how information was shared between different staff members; we saw few explicit confidentiality agreements signed by children and young people to confirm that they knew why and when information would be shared.
- 1.4. Interviews with children and young people showed a wide variance in the levels of understanding of their orders, for example, what the YOT is for, the work being conducted, why particular issues needed to be looked at. Some understood completely. Some really did not.
- 1.5. There was good engagement with parents/carers; we saw this in almost all cases. Home visits were used to establish relationships with parents/carers and it was clear that parents valued the efforts made by staff. This often started at the PSR stage.

One parent said:

"If you met [my son] two years ago- he never used to come home, never came home, and when I did get him home he used to trash the place, example - doors. He used to get arrested for his behaviour, he didn't talk to me, nothing. And they've helped him by calming him down. He didn't know how to handle his feelings. In a way of them talking to him they've made him sit down, taught him how to express his feelings without getting violent, and he's got himself a routine which is the best thing he needed. I tried my best to discipline him - I tried everything, I got the police involved, everything, but there was no disciplining the kid. He would not listen. Plus I'd gone through a divorce, so everything was new for him, so he had loads to handle and it just got too much for him. They helped him to talk about stuff; they helped him to calm down."

2. Planning for interventions

- 2.1. In a similar way to assessments, plans often failed to take account of diversity factors especially speech, language and communication needs.
- 2.2. Reference was often made in plans to the use of compliance and breach as methods to manage reoffending and risk of harm to others. Not enough attention to getting engagement right at the start and then maintaining this was apparent. Case managers and YOT managers spoke about compliance and breach and the numerous systems that were in place, but this was complicated and confusing to children and young people. They often used the word breach to cover a range of non-compliance issues, which as outlined earlier, the children and young people found confusing.

A selection of comments from children and young people about the compliance and breach processes.

"You don't even really have to offend to go back to court. You just get a breach here. I've been breached before. I had about three or four months left and I breached. They took me back to court and gave me a 12 month Youth Rehabilitation Order (YOR) when I had a nine month YOR at the start. They gave me three months extra for a breach. No, it wasn't really fair, because I broke my leg and I couldn't walk. I had no doctor's note, so I couldn't prove it. I had a cast and everything; you could see that I had a broken leg. Angry, man."

"I think the breach thing and the warning system is wrong. People are not reoffending but they are still getting breaches from YOT...I know it's a court order, so they have to come and that, but obviously you are bound to miss about three appointments in 12 months."

"When you do something wrong...what they do...I've noticed this. With all my appointments I've stuck to them and gone to them all, but when you do one thing wrong they give you all the negative stuff. They don't give you any positives. They don't say 'Well you've done this wrong, but on the other hand you have been going to all your appointments'. They don't do that, they just dog you. [The breach process]: I think it's a joke. Because if you breach once, it is an automatic breach. Even if you are five minutes late, you have a breach. Back in court. You get three chances on this ISS (Intensive Support and Supervision). If you don't come to three appointments you are breached. I can have six appointments in one day. If I miss three of them, I'll be breached."

3. Delivery of interventions

- 3.1. Children and young people and their parents/carers were meaningfully engaged by case managers throughout the work with them in two-thirds of cases.

- 3.2. There were a number of projects designed to promote compliance, including the Saturday engagement group. This voluntary group was well attended, often by some of the children and young people who would not comply with other parts of their orders. The group had been set up and was run by two men who had previously been involved with the criminal justice system. They seemed to have credibility with the children and young people who attended, and ran a range of sessions focusing on motivation and the practical implications of being involved with crime. These sessions were well received by children and young people and they knew that the two workers passed information on to case managers. It was unclear how this project fitted with other parts of the compliance processes.
- 3.3. Children and young people also had access to mentors and the targeted youth support service; we saw examples of where this worked well, although their work was not always included in plans.

4. Initial outcomes

- 4.1. Sufficient attention was given to identifying and responding to barriers to engagement in just half of all cases. More attention was paid to ensuring health and well-being outcomes, including ETE. For nine children and young people, case manager responses did not help them to engage with the order, in these cases we saw that sometimes that the child or young person was not given the right encouragement or motivated to comply.
- 4.2. Of the 34 cases we assessed, the child or young person complied with the order fully in nine cases; and in a further eight cases they complied after initial difficulties. In the remaining 16 cases the child and young person did not comply. Of these, just under half responded positively to the compliance and breach process.

5. Leadership, management and partnership

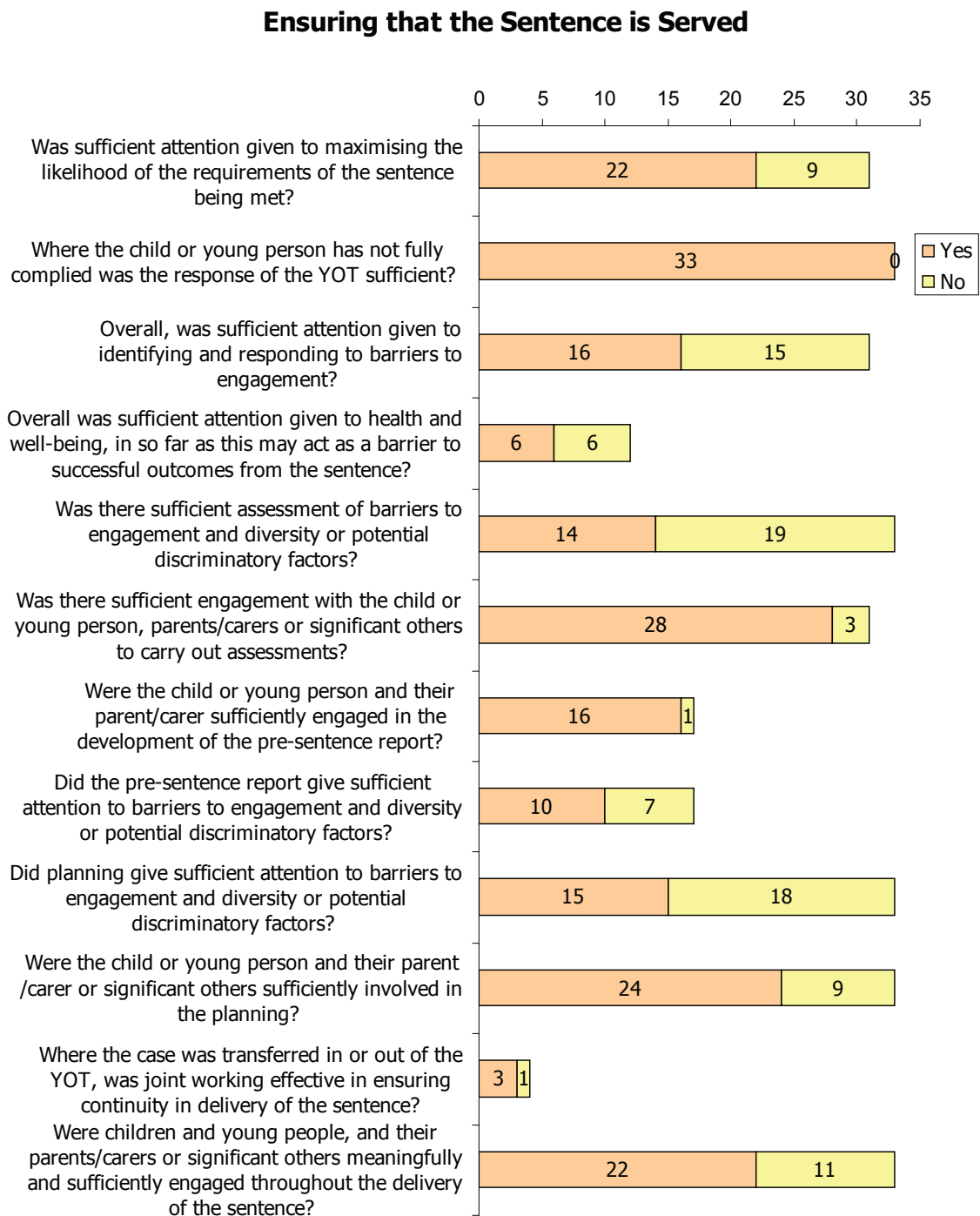
- 5.1. All case managers demonstrated an understanding of the policies and procedures for ensuring compliance.

Summary

Overall, work to ensure that the sentence was served was good. Diversity factors and barriers to engagement were not always identified and planned for. A number of children and young people reported difficulties in establishing effective relationships with some staff, but it was clear that there were also some very effective engagement too. Parents/carers were involved in assessments and were positive about the support they received. There were some communication issues evident between young people and the YOT; an example of this related to cooperation with their order. Several young people believed that they were subject to breach when YOT actions related to engagement, that is trying to gain cooperation.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Governance

5

Theme 5: Governance

What we expect to see

The YOT¹ partnership and Management Board², provides sufficient governance to meet national and local criminal justice objectives, and delivers effective outcomes for children and young people who offend or who are likely to offend and the local community. Equality of opportunity and wider diversity issues are prioritised throughout. The YOT has developed partnerships, which work together to ensure effective outcomes for children and young people who offend or who are likely to offend and the local community. The YOT has in place workforce management that enables staff to deliver quality engagement and effective outcomes for children and young people who offend or who are likely to offend, and the local community.

Key Findings

1. Overall, we judged that governance was not effective.
2. The YOT Management Board did not provide enough challenge and support to the YOT.
3. Health was not effectively represented at board level.
4. The Board had not been able to collate useful outcome data that demonstrated what the YOT was doing well and areas for improvement. Effective practice was being driven by the YOT Management Team and in particular the YOT manager, who worked very effectively with partner agencies to deliver new projects, some of which have been used as good practice examples in this report.

Explanation of findings

1. National and local criminal justice objectives are met

- 1.1. There had not been a stable Management Board for a period of time. The previous Chair, the Interim Assistant Director of Children's Social Care Services, had chaired three meetings. The focus of these meetings was to develop a method of reporting useful information and data which the Board could analyse. A new Board Chair had been appointed and had held their first meeting. The new Board is responsible for the merger of Rochdale and Bury YOTs which has been ongoing for the past 18 months and due to be completed once the new premises have been finished.
- 1.2. The Board had not been effective in holding partners to account, especially health, nor had they been of help to the YOT in understanding why the reoffending rates had been high and difficult to reduce.
- 1.3. Some effective work had been undertaken in response to local needs, including the response to child sexual exploitation and to the number of Looked After Children coming into Rochdale.
- 1.4. It was disappointing to see that the results of an audit undertaken by the Youth Justice Board in January 2013 had not yet been acted on. A number of findings in this inspection were also highlighted in the audit including the lack of analyses and the cloning of reviews.

1 We use the term YOT as this is in the legislation but this refers to all partnerships delivering services to children and young people who have offended or who are likely to offend.

2 This is likely to be broader than stated as it also relates to any strategic body which has responsibility for work with children and young people who have offended and/or those who are likely to offend. In legislation, the overall responsible person is the local authority Chief Executive.

2. Effective partnerships make a difference

- 2.1. Whilst there were many examples of effective partnerships including with education, children's social care services and the police, it is of concern that health involvement had been inconsistent.
- 2.2. Apart from using the National Youth Justice Outcome Indicators, the Board had not yet collated or used data sufficiently to analyse YOT performance. Outcome data and information on the quality of work was not available and nor had it been routinely requested by the Board to hold the YOT to account. It is difficult to establish what is working and what to focus on when this is not known. This may explain the YOTs inability to improve beyond satisfactory performance in about two-thirds of the work.
- 2.3. There is a service level protocol between Rochdale YOT and Rochdale CAMHS in place, but this is out of date and has not been regularly reviewed. An up to date service level protocol, which is regularly reviewed, would help to ensure that the services provided to children and young people are assessed as being appropriate to their needs.

3. Effective workforce leadership and management supports quality service delivery

- 3.1. Although staff described managers as effective, we judged that management oversight of the quality of assessments and reviews was only effective in around half of the cases.
- 3.2. In the last 18 months, YOT managers have been covering both Rochdale and Bury YOTs. This has been demanding. Recently, there have been appointments to support the management team, although these are just being established. This has happened alongside a significant reorganisation and transformation of services due to efficiency savings and a critical Ofsted report of Children's Services. Although the quality of delivery often dips during significant change and the YOT has lost staff through this process, it is credit to the management team that the changes to the YOT have been managed in a positive way, and that services to YOT children and young people have remained mainly good enough.
- 3.3. The YOT staff were very open to the inspection and saw it as a means of improving services. Most had seen improvements to training and development opportunities and a few staff commented on the much improved relationships with children's social care services. It is rare for us to find such positive joint work.
- 3.4. Staff had received training in a number of practice areas including interventions, diversity and child protection. Fewer staff had received training in speech, language and communication.
- 3.5. The developments made by the management team in response to Looked After Children had impacted on practice, these children and young people received a good service regardless of whether they were Rochdale children and young people or not. Staff recognised the particular difficulties they faced and worked hard to overcome these.

4. Positive outcomes are achieved and sustained

- 4.1. Senior managers were clear about their priorities to improve the overall ETE offer for children and young people who were supervised by Rochdale YOT. A strong focus was on building links with providers within the community and developing specific courses to help personal and employability skills. This was taking place through good partnership links with organisations such as the Rochdale Connections Trust and the local provider group.
- 4.2. Partnerships in the community such as the Eagle and Child project (see below) were very effective at engaging children and young people who found it difficult to engage with more formalised learning. However, the YOT and the education representative recognised the need to develop more opportunities for children and young people to work with employers to build their personal and employability skills.

Case illustration: An example of effective education and training provision:

The Eagle and Child

The YOT had developed a good relationship with an employer to provide valuable opportunities for children and young people to develop a range of skills within a commercial setting. The Eagle and Child was a public house/restaurant on the outskirts of Bury. Children and young people were following a horticulture course at NVQ Level 2, growing vegetables in an area behind the public house which had been professionally landscaped to provide raised bed polytunnels and an area for customers to dine outside. An area was also set aside for hens which the children and young people cared for. Produce grown in the garden was used in the restaurant as were the eggs. Children and young people had the opportunity to develop skills in basic food preparation and customer service. As part of the programme the project was linked to NACRO who provided support with English and mathematics. Topics such as health and safety were carried on in a real working environment and children and young people responded well to the way this was contextualised to the work environment. Those attending were motivated, engaged and could identify the skills they were developing, particularly their personal and employability skills. Although the project was relatively new, two of the former trainees have already been employed by the company.

- 4.3. Limited numbers of formal meetings were taking place between health, YOT, CAMHS and Early Break managers. This was a missed opportunity to discuss trends in the health and care needs of children and young people currently engaging with the YOT. There was also a gap where partnership managers could discuss staffing issues, such as workforce planning and training requirements.
- 4.4. Data was not robust enough to help the Board understand whether there was true progress. An example is that the Board were not able to identify what factors were impacting on the reoffending rates. We also saw little evidence of partnerships with higher education and other research bodies to aid thinking and development in this area.

Summary

Overall, governance was unsatisfactory. The YOT Management Board did not provide sufficient challenge and was not fully effective in supporting the YOT. Health was not effectively represented at board level. The Board did not have enough knowledge about the success of the YOT; they did not collate outcome data in order to demonstrate what the YOT was doing well and areas for improvement. Effective practice was being driven by the YOT Management Team and in particular the YOT manager, who worked very effectively with partner agencies to deliver new projects, some of which have been used as good practice examples in this report.

Appendices

Appendix 1

Contextual information about the area inspected

Rochdale had a population of 211,700 as measured in the Census 2011. The youth population (those aged between 10-17 years old) accounted for 11% of the population. This was higher than the average for England and Wales as a whole, which was 9.4%.

The percentage of the youth population with a black and minority ethnic heritage was 20% (ONS, mid-year estimate 10-17 year olds, black and minority ethnic 2009). This was higher than the average for England/Wales, which was 14.1%.

Reported offences for which children and young people aged 10-17 years old received a pre-court disposal or a court disposal in 2010/2011, at 38 per 1,000, were higher than the average for England and Wales of 33 (Youth Justice Board 2010-2011).

The proportion of young people in Rochdale aged 16-18 who were not in education, training or employment is estimated at 6.7%. This is higher than the average for England which is estimated at 6.1% (Department for Education 2012).

Youth Justice Board indicators

The Youth Justice Board indicators are national measures of YOT work and performance:

Reoffending measures:

(i) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a class A drug on arrest, the proportion who reoffend within a 12 month reporting period. This reoffending proportion for Rochdale was 47%, worse than the 35.8% for England/Wales as a whole.

(ii) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a Class A drug on arrest, the average number of reoffences within 12 months, per 100 such children and young people. For Rochdale, there were 1.83 offences per child or young person who reoffends, worse than the 1.03 for England and Wales as a whole.

(Data based on April 2010 to March 2011 cohort)

First time entrants measure:

The number of children and young people who received their first reprimand, final warning or court conviction (and thus entered the youth justice system) in a 12 month period, as a proportion per 100,000 10-17 year olds in the general local population. The figure for Rochdale is 393, compared to 595 for England and Wales as a whole.

(Data based on October 2011 to September 2012 cohort)

Use of Custody measure:

The number of children and young people receiving a conviction in court who are sentenced to custody in a 12 month period, as a proportion per 1,000 10-17 year olds in the general local population. The figure for Rochdale is 1.06, compared to 0.72 for England and Wales as a whole.

(Data based on January 2012 to December 2012 cohort)

Appendix 2

Contextual information about the inspected case sample

In the first fieldwork week we looked at a representative sample of 34 individual cases up to 12 months old, some current, others terminated. These were made up of first tier cases (referral orders and reparation orders), youth rehabilitation orders (mainly those with supervision requirements), detention and training orders and other custodial sentences.

The sample sought to reflect the make up of the whole caseload and included a number of those who are a high risk of harm to others, are particularly vulnerable, are young women or are black and minority ethnic children and young people.

During this inspection the consultation with children and young people and parents/carers was undertaken on our behalf by User Voice. This was a pilot and we thank Rochdale YOT for their valuable feedback. User Voice interviewed a range of children and young people who came to the YOT and helped them complete a questionnaire. More detailed and in-depth interviews were then held with a smaller number of children and young people. The information gathered by User Voice has been incorporated into this report, although the views expressed did not affect the percentage scored reported. At the end of the inspection two children and young people and one parent attended the feedback session with representatives of Rochdale and were able to give their views directly.

Appendix 3

Acknowledgements

Lead Inspector	Yvonne McGuckian, HMI Probation
Deputy Lead Inspector	Les Smith, HMI Probation
Inspection Team	Dan Carrick, <i>Care Quality Commission</i> Fergus Currie, <i>Care Quality Commission</i> Rob Bowles, <i>HMI Constabulary</i> Paul Eveleigh, <i>HMI Constabulary</i> Beverley Reid, <i>HMI Probation</i> Andrew Martin, <i>Local Assessor</i> Pietro Battista, <i>Ofsted</i> Linda Steele, <i>Ofsted</i> Chris Dosset, <i>User Voice</i> Anne-Marie Douglas, <i>User Voice</i> Peter Nzekwu, <i>User Voice</i> Ricky Sykes, <i>User Voice</i>
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Assistant Chief Inspector	Julie Fox, <i>HMI Probation</i>

Appendix 4

Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work in a small number of local authority areas each year. It focuses predominantly on the quality of work in statutory community and custodial cases during the sentence up to the date of inspection. Its objective is to seek assurance that work is being done well enough to achieve the right outcomes. The four core themes for this inspection are:

- reducing the likelihood of reoffending
- protecting the public
- protecting the child or young person
- ensuring the sentence is served.

Methodology

Fieldwork for this inspection was undertaken on the weeks commencing:

24-28 June 2013 and 8-12 July 2013.

YOTs are informed 11 working days prior to the inspection taking place. The primary focus is the quality of work undertaken with children and young people who have offended, whoever is delivering it. Cases are assessed by a team of inspection staff with local assessors (peer assessors from another YOT). They examine these with case managers, who are invited to discuss their work in depth, are asked to explain their thinking and to identify supporting evidence in the record.

Prior to, or during, this first week we receive copies of relevant local documents. During the week in between, the data from the case assessments are collated and a picture about the quality of the work of the YOT emerges.

The second fieldwork week is the joint element of the inspection – HMI Probation are joined by colleague inspectors from the police, health, children’s social care services and education to explore in greater detail the themes which have emerged from the case assessments. In particular, the leadership, management and partnership elements of the inspection are explored, insofar as they contribute, or otherwise, to the quality of the work delivered.

During this week we also gather the views of others, including strategic managers, staff and service users – children and young people, parents/carers and victims, and where possible observe work taking place.

At the end of the second fieldwork week we present our findings to local strategic managers, the YOT Management Team, YOT staff and other interested parties.

Publication arrangements

A draft report is sent to the YOT for comment three weeks after the inspection, with publication approximately six weeks later. In addition, a copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group and the Youth Justice Board. Copies are made available to the press and placed on our website.

FJI reports in Wales are published in both Welsh and English.

Further details about how these inspections are conducted can be found on our website in the document ‘Framework for FJI Inspection Programme’ at:

<http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work>

Appendix 5

Scoring approach

This describes the methodology for assigning scores to each of the core themes:

- Reducing the likelihood of reoffending.
- Protecting the public.
- Protecting the child or young person.
- Ensuring that the sentence is served.

Inspection staff examine how well the work was done across the case - from assessment and planning to interventions and outcomes, focusing on how often each aspect of the work was done well enough. This brings together performance on related elements of practice from all inspected cases.

Each scoring question in the inspection tool contributes to the score for the relevant section in the report. In this way the core themes focus on the key outcomes.

This approach enables us to say how often each aspect of work was done well enough, and provides the inspected YOT with a clear focus for their improvement activities. Each core theme is assigned a percentage (quantitative) score which, along with a descriptor, is then given a provisional star rating.

Case assessment score	Descriptor	Star rating
80% +	Very good	★★★★
65% - 79%	Good	★★★☆☆
50-64%	Unsatisfactory	★★☆☆☆
< 50%	Poor	★☆☆☆☆

Each of these themes contains elements of leadership, management and partnership which cannot be evidenced through the scoring system for individual cases, and which are a particular focus of the work of partner inspectorates. A moderation process then takes account of these elements to determine the final descriptor.

Additional modules are scored on a similar basis.

If there are serious and unaddressed shortcomings, in individual cases, relating to the risk of the child or young person suffering or inflicting harm that leaves someone at risk, then this may constitute a limiting factor to the star rating.

Further details of this process can be found on our website.

<http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work>

Appendix 6

Criteria

The aspects of youth offending work that are covered in the core themes in this inspection are defined in the Inspection Criteria for Full Joint Inspection. A copy of the inspection criteria is available on the HMI Probation website at the following address:

www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work

Separate criteria are published for each additional module inspected, which are available from the same address.

Appendix 7

Glossary

ASB/ASBO	Antisocial behaviour/antisocial behaviour order
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the child or young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAF	Common Assessment Framework: a standardised assessment of a child or young person's needs and of how those needs can be met. It is undertaken by the lead professional in a case, with contributions from all others involved with that individual
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
CJS	Criminal justice system. Involves any or all of the agencies involved in upholding and implementing the law – police, courts, Youth Offending Teams, probation and prisons
CPF	Case planning forum
DTO	Detention and training order: a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
EWO	Education welfare officer
FTE	Full-time equivalent
HIW	Healthcare Inspectorate Wales
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
Interventions; <i>constructive</i> and <i>restrictive</i> interventions	<p>Work with an individual that is designed to change their offending behaviour and/or to support public protection.</p> <p>A <i>constructive</i> intervention is where the primary purpose is to reduce the likelihood of reoffending.</p> <p>A <i>restrictive</i> intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others.</p> <p>Example: with a sex offender, a <i>constructive intervention</i> might be to put them through an accredited sex offender programme; a <i>restrictive intervention</i> (to minimise their risk of harm) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case.</p> <p>NB. Both types of intervention are important</p>
ISS	Intensive Surveillance and Supervision: this intervention is attached to the start of some orders and licences and provides initially at least 25 hours programme contact including a substantial proportion of employment, training and education
Likelihood of reoffending	See also <i>constructive</i> Interventions
LSC	Learning and Skills Council

LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others
Nacro	National Association for Care and Resettlement of Offenders
Ofsted	Office for Standards in Education, Children's Services and Skills: the inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
Pre-CAF	This is a simple 'Request for Service' in those instances when a Common Assessment Framework may not be required. It can be used for requesting one or two additional services, for example health, social care or educational
PSR	Pre-sentence report: for a court
RMP	Risk management plan: a plan to minimise the individual's risk of harm
Risk of harm to others	See also <i>restrictive</i> Interventions
'Risk of harm to others work', or 'Risk of Harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using <i>restrictive interventions</i> , to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others
RoSH	Risk of Serious Harm: a term used in Asset. HMI Probation prefers not to use this term as it does not help to clarify the distinction between the <i>probability</i> of an event occurring and the <i>impact/severity</i> of the event. The term <i>Risk of Serious Harm</i> only incorporates 'serious' impact, whereas using 'risk of harm' enables the necessary attention to be given to those offenders for whom lower <i>impact/severity</i> harmful behaviour is <i>probable</i>
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm
Scaled Approach	The means by which Youth Offending Teams determine the frequency of contact with a child or young person, based on their RoSH and likelihood of reoffending
SIFA	Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers
SQIFA	Screening Questionnaire Interview for Adolescents: Youth Justice Board approved mental health screening tool for Youth Offending Team workers
VMP	Vulnerability management plan: a plan to safeguard the well-being of the individual under supervision
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution: a Prison Service institution for children and young people remanded in custody or sentenced to custody
YOIS+	Youth Offending Information System: one of the two electronic case management systems for youth offending work currently in use in England and Wales
YOS/YOT/YJS	Youth Offending Service/Youth Offending Team/Youth Justice Service. These are common titles for the bodies commonly referred to as YOTs
YRO	The youth rehabilitation order is a generic community sentence used with children and young people who offend

Appendix 8

Role of HMI Probation and Code of Practice

Information on the role of HMI Probation and Code of Practice can be found on our website:

www.justice.gov.uk/about/hmi-probation

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

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