HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

Full Joint Inspection of Youth Offending Work in **Peterborough**

An inspection led by HMI Probation

independent inspection of youth offending work

April 2014

Foreword

This inspection of youth offending work in the Peterborough Youth Offending Service (YOS) 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.

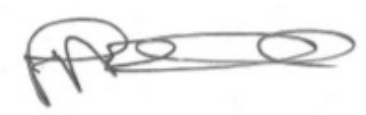
The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on the three National Youth Justice Outcome Indicators supported by other information, such as recent inspections – is of significant concern. Periodically, we also include high performing areas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

We chose to inspect in Peterborough primarily because they were performing well on all three of the Youth Justice Outcome Indicators and that their work, following assessment via our previous inspection programme, the Core Case Inspection, required minimum improvement.

Children and young people and parents/carers consistently complimented the work of the YOS. This level of affirmation reflected the high regard with which the service was held. Staff were actively and creatively working with children and young people to bring about lasting change in particular to reduce reoffending. We found evidence of good multi-agency working to protect the public and interventions were generally delivered well. We found considerable effort being invested in early prevention work both in the YOS and undertaken jointly with other agencies.

We were pleased to find that Peterborough YOS had continued to improve its overall performance since our previous inspection in 2012. Staff were committed to providing the best service and we saw evidence of the recommendations made in 2012 being implemented.

The recommendations made in this report are designed to help Peterborough YOS achieve excellence throughout all its work by focusing on specific key areas. We hope that the newly formed YOS Management Board embeds itself fully as it seeks to continue in its development of services to children and young people.



Paul McDowell

HM Chief Inspector of Probation

April 2014

Summary

Reducing the likelihood of reoffending 

Overall, work to reduce reoffending was satisfactory. Assessments were good and case managers consistently involved the children and young people and their parents/carers in the development of plans. Plans in custodial cases did not always contain an appropriate balance between the needs of the institution and the aspects that may reduce reoffending in individual cases. Pre-sentence reports were consistently concise and of a high standard. Case managers had access to a wide range of interventions, which they delivered well; although planning could have been better. There was a positive focus on education, training and employment, resulting in high numbers of children and young people being placed in suitable provision. Generally, assessments identified health issues well and referral pathways were clear with appropriate interventions being provided.

Protecting the public 

Overall, work to protect the public and actual or potential victims was satisfactory. We found several examples of individual pieces of work being done well in particular cases. There was good partnership work with the police to help manage children and young people who presented a risk of harm to others, including effective Multi-Agency Public Protection Arrangements. The victims of crime we interviewed were satisfied with the service they received and appreciated the flexibility of the YOS to work with them and the children and young people who had offended against them. However, these positives hid an inconsistent approach to risk of harm work.

Plans needed to be better derived from the information obtained from assessments. In custodial sentences, planning to manage the risk of harm to others needed substantial improvement.

Protecting children and young people 

Overall, work to protect children and young people and reduce their vulnerability was good. Staff within the YOS were excellent motivators for children and young people. Assessment, planning and reviews mostly met the requirements of the case and the necessary work was carried out within the YOS to ensure that children and young people were protected and their vulnerability reduced.

Pre-sentence reports contained a clear and thorough assessment of vulnerability in almost every case. Liaison between case managers and children's social care services was good and information sharing between the two departments was done well. Where cases were transferred in or out of the YOS, joint working arrangements needed further examination. Improvements in planning for work in custody are required to address safeguarding and vulnerability.

Ensuring that the sentence is served 

Overall, work to ensure that the sentence was served was good. The YOS benefited considerably from having excellent health provision. This made a substantial difference to the work with many of the children and young people. Case managers established good working relationships with children and young people and their parents/carers. There was appropriate assessment and the necessary actions were largely taken to address diversity and other factors that may act as barriers to engagement. The YOS took proper enforcement action when this was required in the case. Plans did not always identify how barriers to engagement would be addressed.

Governance and partnerships 

Overall, governance was satisfactory. We found good strategic partnerships in Peterborough with commitment to the work of the YOS. The refreshed Management Board had clear terms of reference and a reporting structure to the Safer Peterborough Partnership and was just completing its membership. Performance against the national indicators for youth justice (see Appendix 1) was regularly reported to the Board and the YOS was performing well against these. The Board recognised the need to develop what local information it required. This included data on the quality of work undertaken and its impact on children and young people and communities. The YOS was a member of a range of multi-agency boards and was well respected. While there was a clear quality assurance policy it had not yet fully been implemented. The views of service users were reported annually and were beginning to be used to make changes in the way services are delivered. Training and development opportunities were given a high priority in the YOS. At the time of the inspection, there were no links with higher education and research facilities.

Interventions 

Overall, the management and delivery of interventions was satisfactory. We found that there was positive leadership and partnership work to ensure that the intervention needs of children and young people were met. Assessments and plans met the needs of the individual, but diversity needs and barriers to engagement in all cases were not consistently met. While the quality of interventions was evident the sequencing was not sufficiently clear and the interventions did not always follow the assessment and plans for work to reduce the likelihood of reoffending. Health interventions were delivered particularly well. The YOS had produced some very good materials internally and we found evidence of YOS case managers reinforcing the achievements of children and young people. However, there was no systematic collation and evaluation of information to understand what interventions were making a difference. The impact of substance misuse interventions was inconsistent.

Recommendations

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

1. The YOS Management Board should develop the local information and performance data it requires to support its governance responsibilities and ensure that sustainable outcomes are achieved. The Board should specifically receive performance management reports in respect of safeguarding. (Chair of YOS Management Board)
2. In custodial sentences planning for work by case managers to manage the risk of harm during the custodial period needs greater attention. (YOS Manager)
3. Within planning, case managers need to better focus on how to manage barriers to engagement, diversity or discriminatory factors. (YOS Manager)
4. The YOS should improve the way data is collected and analysed in education, training and employment to ensure that there is clear evidence of outcomes which would provide good evidence of the overall quality of performance. (Chair of YOS Management Board)
5. The YOS needs to fully implement its quality assurance policy and report its findings to the YOS Management Board. (YOS Manager and Chair of YOS Management Board)

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Reducing the likelihood of reoffending

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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 72% of work to reduce reoffending was done well enough.

Key Findings

1. Assessments were timely and of good quality. Case managers actively involved children and young people and parents/carers.
2. Pre-sentence reports (PSRs) were consistently concise and met the needs of the court.
3. Plans were child or young person friendly, building on identified risks and strengths.
4. Plans during the custodial phase of the sentence were not thorough and often not timely.
5. There was a wide range of interventions available to the YOS. These interventions used suitable materials often developed by staff themselves. Often, the planning for interventions was not appropriately sequenced.
6. There were appropriate assessments and discussions with, or referrals to, health professionals within the YOS.
7. There was good attention on education, training and employment (ETE) resulting in high numbers of children and young people being placed in suitable provision, supported by good multi-agency work.

Explanation of findings

1. Assessment

1.1. Assessments of the likelihood of reoffending were of good quality. They were analytical and supported by different evidence to inform the judgements made. Just over four-fifths of assessments were reviewed as necessary; although a few reviews had been missed following a significant change in circumstances.

1.2. PSRs were of a good standard and provided thorough assessments to meet the needs of the sentencing court. All PSRs had been quality assured before they were presented to the court. There was evidence to show that this process was not merely a 'tick box' exercise for PSR writers.

Comment from interview with a young person

"My case manager wants to know about me and tries to find the roots of why I do everything".

1.3. Assessments of health issues were generally robust and referral pathways were clear with good interventions being provided. A comprehensive inventory of assessment tools was held within the

health section of the YOS, including screening tools for autism, communication issues, IQ, mood and cognitive assessments. The original basic health screening form was not effective. This had been re-vamped and re-launched leading to an increase in referrals. However, health outcomes were inconsistently recorded and outgoing health information was not updated properly.

1.4. ETE needs assessments linked to the likelihood of reoffending were good. The YOS education worker provided comprehensive information to support the initial assessment. This included current information on attendance, attitude and behaviour to education, as well as preferred learning styles. The co-location of the ETE officer alongside case managers worked well to ensure good information exchange to support assessments. However, formal links for referrals to ETE lacked clarity; the informal links worked exceptionally well and allowed for a rapid response when required.

1.5. Assessment of substance misuse was mostly thorough, although the links between this and the likelihood of reoffending were not always clearly described.

2. Planning for interventions

2.1. There was sufficient planning in place for work to reduce the likelihood of reoffending in 26 out of the 32 cases. Plans, overall, mirrored the reasons for offending that had been highlighted in the assessment. Case managers fully involved the child or young person in planning for interventions. A tool, devised by a case manager in the team, 'My Agreed Risks and Strengths' (MARS) was consistently used with the child or young person to identify the areas that they considered placed them at the greatest risk. They were then asked to reflect on their strengths before joint agreements were reached on plans to bring about change. We consider this to be good practice.

Illustration of an effective planning tool internally developed by YOS

The MARS intervention planning tool was used to good effect. The case manager was able to record his concerns based on the assessment scores and the child or young person was able to identify his too

Agreed points were recorded at the bottom. This document was then used almost as an agenda to the initial planning meeting prior to objectives being set. This methodology drew the young person into the planning process at the earliest stage and afforded them a degree of ownership of the plan. In addition, the child or young person came to the planning meeting well prepared for what could be a difficult session.

2.2. In contrast, the planning for work during the custodial phase of the sentence was not done well in over half of the relevant cases. This area requires further attention. While custody clearly removes the child or young person from the community for a period of time, inadequate planning is likely to have an adverse impact on reducing the likelihood of further offending once back in the community.

2.3. Where plans were not good enough, there was no single reason, but we identified that some of the plans were not done on time and there was insufficient integration of work that had been ongoing in the community. The latter is essential in order to maximise continuity and achieve positive outcomes.

2.4. The work of the inter-agency 'reducing offending panel' was effective. The objective was to target children and young people before they became involved in criminal behaviour and offer appropriate interventions. The YOS, housing providers and neighbourhood police teams were all represented and referrals were triggered by problematic or concerning behaviour by children and young people. The YOS police officer was often tasked with undertaking short interventions following discussions at this meeting.

2.5. Good joint agency meetings took place at schools throughout the area with the focus of maintaining attendance and preventing permanent exclusion; case managers were effective at engaging parents/carers and children and young people in the process of finding the right solution. Case

managers had a clear understanding of the links between non-attendance and reoffending. Case files identified a good level of discussion with children and young people and their parents/carers about the options available and the best way forward to progress. ETE was a feature in planning and review meetings including transition from custody to community. For children and young people who were transferring from custody the ETE officer was available to meet them on their first day of release.

Case illustration - Zakk

Originally, Zakk was on a four month youth rehabilitation order (YRO) following offences of assaulting a police officer and public order. He failed to engage with the YOS and was then re-sentenced to a four month detention training order (DTO) after breach. The underlying motivation for the offence was a significant dislike of police officers; an antipathy reinforced by his family. The YOS case manager started work to address alcohol-related problems and proposed he worked with the YOS police officer. Although initially reluctant, Zakk started to work with him, attending the gym and boxing club. Over time, Zakk developed a positive relationship with the YOS police officer and had changed his attitude towards police officers more generally. The YOS police officer has further reduced the likelihood of Zakk reoffending by supporting him to obtain vocational qualifications and was making employment enquiries on his behalf to Enterprise Peterborough.

3. Delivery of interventions

3.1. In almost three-quarters of the cases, staff delivered the interventions that had been planned to reduce the likelihood of reoffending, although formal reviews of this work were often not undertaken. In the majority of the cases, interventions had been delivered to address; family and personal relationships, the impact of the neighbourhood in which the child or young person was living, physical health, emotional and mental health and offending behaviour. However, more attention could have been given to further exploring substance misuse and the impact of lifestyle choices, in particular where these linked to the likelihood of reoffending.

3.2. We were pleased to find that interventions were largely well structured and used motivational techniques. We were able to clearly discover what had been planned, what had happened and what the case manager's assessment was following the completion of the session.

3.3. The YOS had access to a wide range of intervention materials, many of which had been designed by staff in the team. There was a degree of emphasis on cognitive behavioural therapy, although the interventions available were varied in order to cover different individuals' situations.

3.4. The resources and materials used to support the delivery of interventions in the community were of good quality and were consistently delivered as they were intended. We saw several examples of case managers using innovative and creative methods to meet the needs of the child or young person. This included using pictures to explore offending behaviour, role play and life story graphs depicting key significant points in the life of the child or young person. Case managers were affirming in their approach, had a good level of appreciation for the resources they were using and maintained a focus on the assessed needs of the case.

3.5. The YOS gave sufficient attention to restorative justice in over four-fifths of the cases where it was appropriate.

3.6. The sports officer was a key member of the health team and the YOS, providing a range of positive physical activities. These interventions had not only increased participation in and frequency of exercise but had improved the self-esteem of children and young people and impacted on reducing their levels of stress. This was evidenced by a range of tracking information that was kept, analysed and actioned. Case managers made good use of this resource and communication about progress

was readily provided. Children and young people and YOS staff themselves universally praised this ongoing work. This participation in exercise and sport suited many children and young people, as evidenced by the quote below.

Comment from interview with a young person

"It is easier to talk about stuff when I'm doing stuff not just sitting down".

3.7. The majority of the sessions were delivered to a high standard. Children and young people who were interviewed reported that it was the relationship they had with their case managers that symbolised the most important factor for them. This positive relationship allowed them to trust the case manager sufficiently to disclose sensitive information around their offending, views on authority and their lifestyles and enabled them to critically reflect on how to lead law abiding lives.

3.8. There was a protocol in place for managing the transition to probation as children and young people reached the age of 18.

3.9. The ETE officer had established links with local schools that were used well to try and ensure that children and young people of school age attended their school or alternative provision. Managed transfers and the use of pupil referral units effectively maintained children and young people's education. Internal links between the YOS and the local education service were good, particularly in respect of the placements to provide alternative provision to mainstream education.

3.10. Careers advice and guidance for post-16 young people was available on site with the ETE officer. External provision of information advice and guidance had recently been reduced and needed to be better promoted to young people in order to ensure they were clear about access. Excellent links with colleges within the area helped provide opportunities for young people to progress into education and training after finishing their court orders. Support for young people who were looking to access further education colleges was good and these transitions were well managed. Young people had access to opportunities to develop their curriculum vitae and were supported with job applications.

3.11. Good links were in place between the YOS and the other local authority services available for children and young people. Particularly good links were evident between the YOS and Not in Education, Employment or Training (NEET) workers within the local authority. Productive links have been made by the ETE officer into the NEET's local strategy which widened access for children and young people within the YOS.

ETE initiative illustration

The ETE officer had worked with the local college in developing specific courses that could be tailored to children and young people referred from the YOS. Study programmes offered by the college were focused on developing the personal and social development of children and young people alongside accredited qualifications. Children and young people could engage in a variety of different projects some of which were community based. The college responded quickly to referrals from the YOS providing immediate access to a course for children and young people on a roll on roll off basis.

The college, along with the YOS, had developed projects that provided a variety of activities throughout the school summer holidays. The summer project worked very effectively at bridging the gap between school and further education with a high number of young people progressing into training courses as a result. A high level of trust was in place between the YOS and the college who felt well supported by the YOS. The college had become skilled at selecting tutors with a specific skill in dealing with disengaged young people. A very high level of young people progressed from their study programmes to apprenticeships and more advanced courses as their confidence and self-esteem improved.

3.12. The ETE officer had worked well with the local college to develop courses tailored to children and young people from the YOS. The illustration below also gave examples of good outputs in relation to engaging ETE and colleges.

4. Initial outcomes

4.1. Almost three-quarters of the reviews of interventions delivered were good enough. In seven cases where the review was not effective, it was because it had not been undertaken, it lacked quality or not all interventions were reviewed. This often made it difficult for case managers to identify what was working and making a difference.

4.2. There had been a reduction in the frequency and seriousness of offending, since the start of the current sentence or release from custody in over half of the cases where there was a recent offending history to assess.

4.3. We look to see if the work is impacting on the behaviour of the child or young person. From the cases we saw, most progress had been made in physical health, emotional and mental health, self-esteem, lifestyles and improved relationships with family members. The least progress demonstrated through casework, related to the area of substance misuse.

4.4. Data supplied by the YOS showed that the percentage of children and young people known to the YOS who were classed as not in ETE had reduced from 42.6% in 2011-2012 to 35.8% in 2012-2013, with the current data indicating a continued improving trend.

Comment from parent

"The staff are patient, reassuring and brilliant and helped him with his reading and writing skills when he applied for college".

4.5. Reviews of ETE interventions routinely took place and a high level of detail was recorded to support the decisions made around the type of ETE intervention. The recording of progress made at reviews was adequate, although details did not sufficiently focus on the progress that had been made since the last review and how this linked to the overall objective for the child or young person.

5. Leadership, management and partnership

5.1. We saw effective partnership working between individual case managers at the YOS and specialist workers; the latter were respected for their contributions.

5.2. The Management Team were viewed with the highest confidence by case managers and considered to be supportive, knowledgeable and able to use escalation procedures as necessary.

5.3. Case managers had access to a range of resources for work to reduce the likelihood of reoffending. A full-time assistant psychologist, a specialist nurse practitioner, an ETE officer, a sports officer, an accommodation officer, a seconded police officer, a seconded probation officer and a specialist forensic practitioner were all integrated and/or based in the YOS. This was an excellent demonstration of the principle of YOTs as partnerships to address the multiple needs of children and young people who offend.

5.4. There were effective referral processes to alert the YOS when children and young people had been dealt with by the police and received a charge or a less formal sanction. The two way flow of intelligence between the seconded police officer and YOS staff was good. Information was shared verbally and then backed up by email. We saw examples of cases where intelligence provided by YOS staff resulted in positive police outcomes.

5.5. We were pleased to see that the work of the Youth Caution Consultation panel exceeded the requirements of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO). LASPO mandates that only children and young people who have had previous involvement with the police

are referred to the YOS. In Peterborough, all offences involving children and young people that were dealt with by the police, where the offence was appropriate and where an admission was made, were referred to the custody sergeant for a possible referral to the panel. Police, health and the YOS were represented on the panel.

5.6. Case managers had an appropriate understanding of the principles of effective practice with children and young people who have offended. In addition, we were satisfied that they understood local policies and procedures relating to safeguarding, management of risk of harm and effective enforcement.

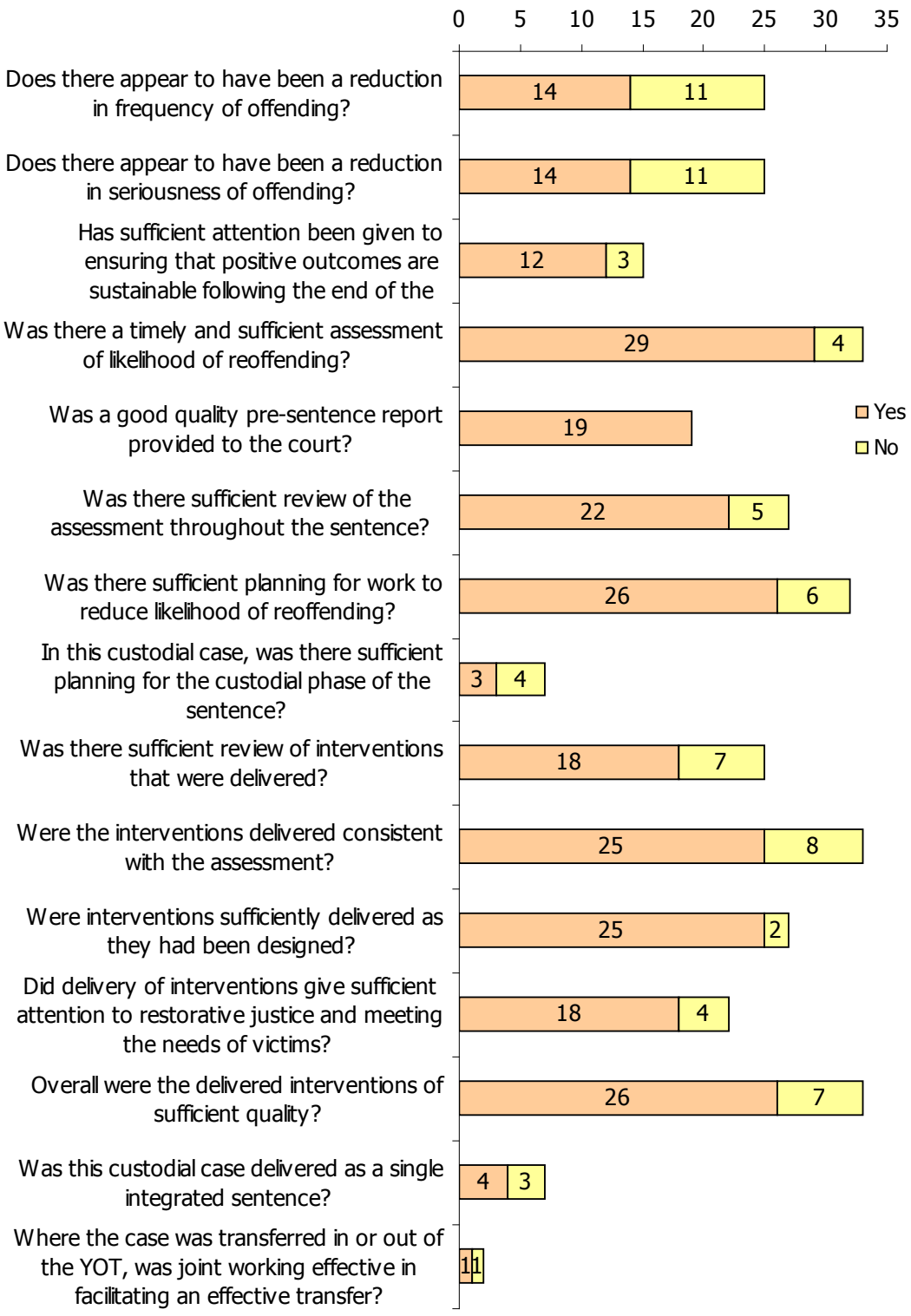
5.7. YOS staff had routine access to Liquid Logic, the children's social care database.

Summary

Overall, work to reduce reoffending was satisfactory. Assessments were good and case managers consistently involved the children and young people and their parents/carers in the development of plans. Plans in custodial cases did not always contain an appropriate balance between the needs of the institution and the aspects that may reduce reoffending in individual cases. PSRs were consistently concise and of a high standard. Case managers had access to a wide range of interventions, which they delivered well; although planning could have been better. There was a positive focus on ETE, resulting in high numbers of children and young people being placed in suitable provision. Generally, assessments identified health issues well and referral pathways were clear with appropriate interventions being provided.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 33 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

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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 78% of work to protect the public was done well enough.

Key Findings

1. PSRs included an appropriate assessment of risk of harm to others.
2. Where required, there was good engagement with Multi-Agency Public Protection Arrangements (MAPPA).
3. MAPPA were effective in the management of risk of harm to others.
4. Planning was sufficient in four-fifths of cases and would have benefited from proper integration with information obtained from assessments.
5. There was good partnership work with the police to help manage children and young people who presented a risk of harm to others.
6. The Formulation Meetings (helping to formulate plans and actions in complex cases) were largely effective, well chaired and identified actions.
7. Victims were systematically contacted and offered a range of services. They were satisfied with the service they received from the YOS.
8. In custodial sentences, planning to manage the risk of harm to others was not consistently done well.
9. Assessments and reviews of risk of harm to others were generally carried out, but were not always consistent.

Explanation of findings

1. Assessment

1.1. There was a good assessment of the risk of harm to others carried out in 28 out of 33 cases. The main area for improvement was that screenings were not carried out at appropriate stages and some of them lacked detail. Additionally, some of the assessments were not undertaken when required, relevant convictions were ignored and assessments did not draw adequately on information from other agencies. The latter is critical, as full information results in better assessments.

1.2. Reviews of risk of harm to others were sufficient in just under 90% of cases. This demonstrates an area of significant strength in the YOS.

1.3. We were delighted to see that all except one inspected PSR contained an appropriate assessment of risk of harm to others.

1.4. Overall, we found a largely consistent approach to risk of harm work, with the majority of staff clearly understanding and responding to the underlying principles of public protection responsibilities.

1.5. Recent training had been provided to YOS case managers in relation to a renewed focus on risk of harm work with a clear distinction for risk of serious harm. This learning opportunity was seen as positive by staff in the team.

2. Planning for interventions

2.1. Planning for work to manage the risk of harm to others was done well in four-fifths of cases where this was required. The most common explanation for insufficiency was risk management plans not being completed on time and the plans not drawing on information contained in the assessment.

Case illustration

Tia had multiple health needs, including eating issues, substance misuse and self-harming. There was good engagement between the YOS case manager and health professionals, resulting in an appropriate specialist assessment and ongoing support. An Attention Deficit Hyperactivity Disorder (ADHD) assessment was undertaken and Tia was provided with medication. A mental health assessment was completed and support was provided by the psychologist within the YOS. Good engagement was effected with the sports officer, who worked through self-image and weight problems and introduced her to gym work and boxing. Tia also accessed online mentoring and counselling and was latterly linked into adult mental health services to cater for transition issues.

2.2. The YOS effectively used formulation meetings to plan for interventions. These meetings included the YOS psychologist, case manager, facilitator and relevant others. We were impressed with this process not only in terms of how well it was managed but the role it played in risk of harm work.

Formulation meeting

The formulation meeting was designed to explore the issues and factors in a challenging case and to formulate an action plan for intervention.

The meeting was led well by the facilitator who used a technique called the Predisposing, Precipitating and Maintaining Model, (PPMM) to structure the session. This looked at the history, current issues, and personal feelings of the child or young person and then went on to formulate an action plan. The meeting was inclusive, eliciting contributions from all those present, identifying appropriate triggers for offending and a clear course of action was agreed.

The model structured the inputs and ensured that information concerning all aspects of the case was captured. We particularly liked the shift from risk posed to the vulnerability of the child or young person that the model prompted when it looked at the thoughts and feelings of the young person. This enabled a holistic view of the child or young person to be formed and led to an action plan which not only covered the risk of serious harm that he posed to others but also his vulnerabilities as well.

2.3. The YOS has enhanced its direct work with victims. There is a clear contact policy and it was encouraging to see this being applied in several examples that we saw.

2.4. In custodial sentences, it was disappointing to see that planning for work to manage the risk of harm was not done well in four out of the seven cases. While there were no shared reasons for this, it was evident that required interventions had not been included in the plan and planning for release was not thorough.

2.5. There was one case we inspected that was transferred into the YOS. We found that joint working arrangements were not effective in this case in ensuring continuity in the management of risk of harm. This needed some attention by the YOS, for drift can quickly feature in a such a case and lead to risk of harm to others.

2.6. The YOS had a good understanding of the support required by children and young people in meeting their ETE needs. Working links between case managers and the ETE officer were exceptionally good and benefited from being co-located. They worked hard together at helping children and young people maintain their attendance at education and training provision. Informal links were very effective and enabled a rapid response where required.

3. Delivery of interventions

3.1. In 20 out of 30 cases there was evidence to demonstrate that interventions identified in the assessment to manage the risk of harm to others had been delivered well. However in one-third of the cases assessments and/or plans had not been produced leading to gaps in the delivery of interventions. This finding is an area that requires further attention by the YOS.

3.2. Similarly, where interventions were required to be delivered throughout the sentence to manage the risk of harm, in 10 out of 30 cases this did not take place.

3.3. We were pleased to see that reviews of assessments were done well in just over four-fifths of the cases. This meant that in most cases, reviews had been completed; they were timely, of sufficient quality and revised as circumstances changed.

3.4. Specifically tailored interventions, for example in a crisis, were adjusted to take into account the change in circumstances. This helped to reduce the risk of harm to others. In particular, we were impressed to see how a case manager had sequenced the delivery of interventions to take into account a complex set of behaviours and circumstances which posed a risk of harm.

Case illustration - Dwayne (Good delivery of interventions)

In this complex case, the sequencing and use of mental health resources in the work with Dwayne was excellent. Anger management interventions were held back to allow the clinical psychologist to make detailed assessments giving indications as to the underlying factors behind the violence. On some occasions the anger was instrumental (in Dwayne's offending behaviour) and at other times spontaneous and unprovoked. This sequencing achieved better outcomes for Dwayne.

3.5. In one-third of the cases we did not see clear evidence about the risk of harm to identifiable or identified victims being reduced. Nevertheless we were satisfied that appropriate arrangements were in place to engage with identified victims. All of the victims interviewed, performance reports read and feedback questionnaires considered showed that victims were positive about the service they received from the YOS. They had been contacted appropriately, initially by letter and then either by a follow-up telephone call or visit to the home. Victims reported that they felt reassured that work was being done with the children and young people who had offended against them. A number had taken up the offer of restorative justice meetings. All of the victims who had face-to-face meetings with the children and young people universally commented that the sessions had been well organised, were flexible and they felt able to engage with the process in a safe environment.

Comment from victim

"They (the YOS) were very flexible with arranging meeting times and locations around my doctor's appointments".

Comment from victim

"They (the YOS) were good at explaining restorative justice to me and how good it was for him and me".

3.6. Most children and young people had taken part in victim awareness work. A number had produced letters of apology to their victim and one moving letter was written by a young person to his mother. In this instant, the relationship was clearly at a breaking point and it was encouraging to see how the work carried out by the case manager had led to the young person writing to his mother. Children and young people commented that victim awareness work had not only helped them to appreciate how their offending had impacted on others, but it helped them to overcome feelings of anger when they had been victims themselves.

3.7. It was not always clear how the interventions delivered by the YOS were intended to reduce the risk of harm to others, since a number were not systematically evaluated to see what impact they were having. A planned evaluation dimension in all interventions will assist in understanding better what works.

4. Initial outcomes

4.1. In two-thirds of cases, work to manage the risk of harm to identifiable victims or identified victims had been done well.

4.2. We found that appropriate steps to minimise risk of harm to others by the child or young person had been done well in 21 out of the 30 cases. In some cases the victim had not been identified, the assessment lacked relevant details, the right work had not been done and the plans to address the risk of harm to others did not adequately integrate victims' issues.

5. Leadership, management and partnership

5.1. We inspected one case that had been referred to MAPPA at the time of initial planning and assessment. We were very glad to see that this had been done entirely appropriately and that the multi-agency arrangements had been put in place to manage the risk of harm to others. MAPPA eligibility had been recognised, classifications were correct and MAPPA plans included relevant information.

5.2. The YOS had a well established relationship with the Integrated Offender Management (IOM) scheme. This partnership was effective in managing children and young people who presented a risk of serious harm to others.

5.3. The ETE officer had well established links with local schools and colleges that were used positively to try and ensure that children of school age attended their school or alternative provision. Managed transfers and the use of pupil referral units were effectively used to maintain children and young people's education. Internal links between the YOS and the local education service were good, particularly in respect of the placements to alternative provision.

5.4. The deployment of the police officer in the YOS was effective and consistent with current guidance. The YOS engaged well with the skills provided by the police officer. Advice to other staff was regularly provided where cases were considered to be higher risk (either of risk of harm to others, vulnerability or likelihood of reoffending).

5.5. The YOS had a clear public protection policy which was revised in January 2013. It set out not only its intentions, but identified practical steps that would be taken in its work to protect the public. There was a YOS public protection champion who received a bi-weekly report from the performance officer outlining current high risk cases, including details of previous and planned YOS risk management meetings that could be used to plan future risk management discussions. Progress reports were produced and presented to the Management Board. These included information on the numbers and categories of Risk of Serious Harm forms completed in the reporting cycle, emerging themes in terms of offence type and programme provision. There were clear guidelines around partnership working through service level agreements and resourcing.

Integrated Offender Management (IOM)

Nominations of children and young people for adoption onto the IOM scheme and children and young people already on the IOM cohort were discussed at weekly YOS management meetings.

When a child or young person was on the IOM cohort or being considered for inclusion, the YOS police officer attended the multi-agency city council led case review meetings where adoption/ removal and a Red, Amber and Green (RAG) status of offenders was discussed. RAG status denoted a combination of the level of engagement with interventions and current offending of the child or young person and indicated the level of 'enforcement' and 'disruption' the IOM team conducted. Also present at these meeting were: police, drugs services, mental health services, Job Deal, probation, the prison service, local housing providers, National Association for the Care and Resettlement of Offenders (NACRO) and Drink Sense. Decisions regarding adoption, removal or a change of status were made collectively. The profile of the child or young person on IOM was raised with the partnership through these meetings.

There was a rational division of responsibilities regarding the management of the child or young person on IOM with the YOS managing interventions and the police managing disruption and enforcement.

The YOS police officer conducted all of the visits to the child or young person on the IOM cohort. However, if they were raised to become 'red nominals' then they received the same enforcement and disruption action that adults received; this had only happened on one occasion.

Mechanisms were in place in the IOM to ensure that enforcement and disruption action was proportionate and only taken when necessary.

[Note: Enforcement related to action taken to ensure compliance, and disruption was a process used by police intelligence staff to interrupt potential offending through actions such as 'stop and search'.]

5.6. Management oversight of risk of harm work was not effective in almost one-quarter of the cases where this was required. In some cases this was because oversight had not been provided when it should have been but the key reason was that deficiencies in assessment and planning had not been addressed well enough.

5.7. We were pleased to find that the YOS had a clear policy and procedures for the management of risk of harm to others that was understood by all staff. Further robust implementation will ensure that the gaps identified will be covered.

Case illustration - Harry

Harry had reoffended and a PSR was being prepared for the new offences. The response of the case manager was excellent, in managing the increase in risk and vulnerability, by using a robust multi-agency approach. Arrangements were put in place inviting all of the professionals involved in the case. Together, the multi-agency group designed and updated the plan to manage the risk of harm and vulnerability. Actions were appropriately allocated to the relevant workers with whom there was good consultation by the case manager. Additionally formulation meetings had taken place at the YOS and chaired by a mental health professional. The case manager had also raised the risk level to medium and produced a sufficient risk management plan.

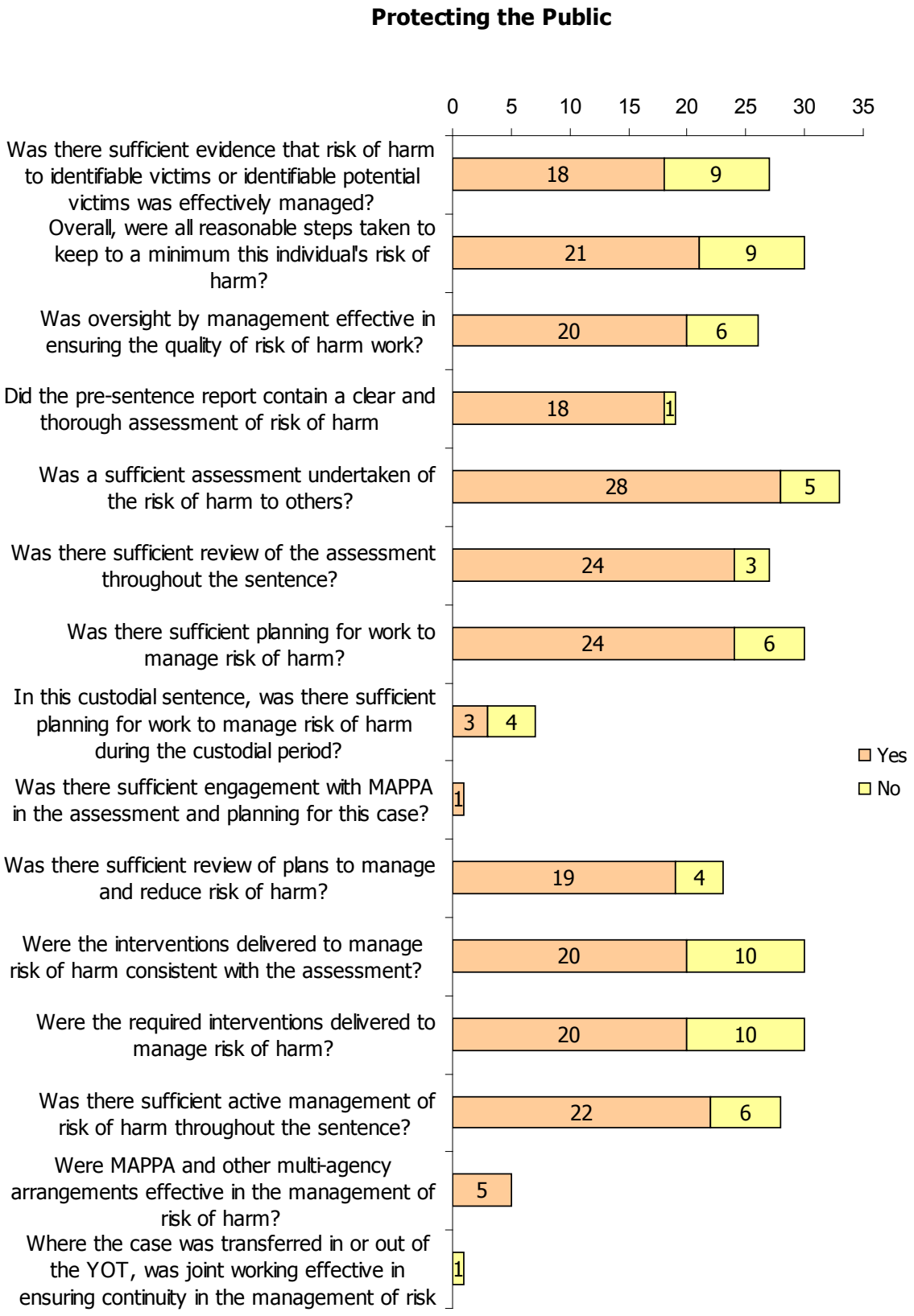
Summary

Overall, work to protect the public and actual or potential victims was satisfactory. We found several examples of individual pieces of work being done well in particular cases. There was good partnership work with the police to help manage children and young people who presented a risk of harm to others, including effective MAPPA. The victims of crime we interviewed were satisfied with the service they received and appreciated the flexibility of the YOS to work with them and the children and young people who had offended against them. However, these positives hid an inconsistent approach to risk of harm work.

Plans needed to be better derived from the information obtained from assessments. In custodial sentences, planning to manage the risk of harm to others needed substantial improvement.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 33 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



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 82% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Assessments and reviews were generally done well.
2. PSRs contained a clear and thorough assessment of vulnerability in nearly every case.
3. There were clear policies and procedures in place to support staff working in accordance with Child Protection requirements and the common assessment framework (CAF) to safeguard and promote the welfare of children and young people.
4. Planning and delivery of interventions met the needs of most cases.
5. Oversight by managers was not consistently effective.
6. There was a clear focus on keeping the child or young person safe.
7. Planning for work in custody to address safeguarding and vulnerability was not consistent.

Explanation of findings

1. Assessment

1.1. Over four-fifths of assessments of vulnerability were done well although there were some occasions where drawing together information from other agencies would have better informed the assessment. Additionally, while reviews were generally carried out, the information was not adequately integrated and clear outcomes were not identified.

1.2. Most YOS assessments seen in relation to children and young people subject to Child Protection plans or looked after plans were of a good standard, appropriately considering historical information, risk and protective factors.

1.3. All bar one PSR contained the necessary information to inform the court about safeguarding and vulnerability needs of the child or young person. This was impressive and demonstrated the priority that the YOS gave to these matters.

1.4. YOS staff routinely accessed Liquid Logic, the children's social care services database to identify cases where there were safeguarding issues.

1.5. YOS staff consistently used a 'traffic light' tool to provide guidance to distinguish between healthy and harmful sexual behaviours of young people.

1.6. Those children and young people who may be at risk of child sexual exploitation were not screened by the YOS. Staff were unaware of the child sexual exploitation team in children's social care services and reported that they had not received training in child sexual exploitation. Discussion with social workers demonstrated a lack of awareness of services and support available in Peterborough, where child sexual exploitation may be presenting a risk for children and young people. Senior managers were aware of this and reported that the Local Safeguarding Children Board (LSCB) was due to roll out child sexual exploitation training across the workforce.

1.7. Health and safety was a focus on many of the college courses that post-16 young people could access. We saw evidence of appropriate risk assessments taking place before young people embarked on a college course. Heath and safety training was routinely carried out as part of the college course chosen by the young person. Where personal protective equipment was required for a specific training course, this was made available to the young person referred from the YOS.

2. Planning for interventions

2.1. Planning in the YOS for work to address safeguarding needs to reduce vulnerability of the child or young person was done well in almost three-quarters of cases, although some plans for vulnerability were not always completed following assessment. It was pleasing to see that the majority of plans included a focus on emotional, mental and physical health, substance misuse, ETE and living arrangements.

2.2. YOS team leaders attended the Multi-Agency Support Group (MASG). MASG met fortnightly to discuss, plan, review and co-ordinate packages of support to those cases that were de-escalating following an assessment by children's social care, or where a CAF was in place. MASG provided agencies with a forum to share information and determine what interventions were required to assist, respond and coordinate a range of early help services to children and young people. The YOS used the CAF well to assess the needs of children and young people and now needed to evaluate the impact of this preventative work.

2.3. Reports were provided to Child Protection conferences when a child or young person was known to the YOS. The case manager took into consideration the historical background of the case, the levels of risk of harm to others and those to the child or young person. In the majority of cases these reports were shared with the child or young person and their family prior to the meeting.

2.4. In most of the Child Protection cases, case supervision and management overview was evident. However, decision-making often lacked rationale and supervision was task-focused and did not always demonstrate reflective practice. This was supported by the safeguarding audit completed by the YOS. Supervision and case management decisions were stored in a variety of different places within the IT systems. As a result, YOS case managers often struggled to find them, stating that they could be located in several different places. This meant that important information was not readily accessible to YOS case managers of the actions and interventions required.

2.5. We found that there was a good structure for health workers around risk identification and management.

Case illustration

With one young person, the health worker recognised the risk escalating in the home and alerted the relevant social worker who convened a Children in Need meeting with the result that the young person was placed in foster care where progress could be made.

2.6. Health workers made good efforts to ensure that vulnerability was considered in a range of cases and these included substance misuse cases and also, as an example, one young person with bulimia, where vulnerability needed to be taken into account.

2.7. Forward planning for ETE needs of children and young people being released back to the local area was appropriate, with support having been put in place at the point of release.

3. Delivery of interventions

3.1. In the vast majority of cases, the YOS had delivered the required interventions throughout the sentence to address safeguarding needs and reduce vulnerability. In four-fifths of cases, the interventions that had been delivered were consistent with the assessment and plan. All interventions were not always properly linked to assessment and planning.

3.2. The YOS made good use of the Troubled Families programme[1] (called Connecting Families in Peterborough) with appropriate criteria being met and clear expectations of the nature of assessment and ongoing support that was required to protect the child or young person and assist the level of support within the family. Health initiatives within the YOS supported this programme well.

3.3. We saw examples of good support from the consultant psychologist when a referral to outside health services was not being processed quickly enough. The case was picked up by health internally, an assessment completed which resulted in the emotional and mental health assessment score being raised, a supportive formulation meeting taking place and a referral to the Looked After Children psychologist with a neurodevelopmental assessment planned to follow. This demonstrated excellent detail and commitment to address an individual child or young person's need.

3.4. The YOS police officer routinely provided good intelligence to the clinical psychologist for Looked After Children in order to support the protection of the child or young person.

4. Initial outcomes

4.1. The management of safeguarding and vulnerability by the case manager was active and effective throughout the delivery of interventions in just over three-quarters of the cases we inspected. Where this was not done well, more priority on safeguarding should have been given by the case manager.

4.2. Oversight by managers was effective in almost four-fifths of the cases. This meant that gaps in the management of safeguarding and vulnerability were largely addressed in the majority of cases

4.3. Core groups and Child Protection conferences were well attended by YOS staff.

4.4. We saw evidence of YOS staff undertaking a range of home visits, working directly with individual children and young people and their parents/carers to reduce vulnerabilities. The children and young people and their parents/carers were actively involved in the planning process in almost all cases. All cases had clearly recorded ethnicity, culture and language information. Where appropriate interpreters were used with children and young people and families where English was not their first language.

4.5. Review risk meetings were regularly held, when required, to consider escalating risks and ensure planning was in place to address and reduce vulnerability risks.

4.6. In all bar one case, we considered that the case managers had sufficient access to the resources that they required to carry out work to reduce vulnerability and address safeguarding needs.

4.7. Overall, we found that the YOS had done enough work to keep the child or young person safe either from themselves or from others in the majority of cases.

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1 The Troubled Families programme is an initiative aimed at 'turning around' 120,000 families by the end of this Parliament. These families are characterised by there being no adult in the family working, children not being in school and family members being involved in crime and antisocial behaviour.

Case illustration - Wayne

Wayne was a 16-year-old child on a community order for an offence of robbery. He lived with his father who was on a methadone (heroin substitute) programme. Wayne was classified as a 'Child in Need' by Children's Services. The YOS case manager had balanced Wayne's welfare and vulnerability concerns with the need to make sure that work on his offending behaviour was undertaken. This was achieved through regular contact with Wayne's social worker, home visiting to obtain a full picture of his personal circumstances, and regular sessions focusing on his offending.

5. Leadership, management and partnership

5.1. The YOS Head of Service and team leaders recognised and prioritised children and young people in need of protection. Seconded social workers within the YOS were actively involved in the social work forum and spent time working with children's social care services, which had developed a shared understanding of respective roles.

5.2. YOS staff had a strong understanding of their safeguarding responsibilities. Staff were enthusiastic and had a passion to develop and enhance their knowledge, skills and understanding to promote the service and improve outcomes for children and young people and their families.

5.3. Managers had recently commissioned monthly safeguarding performance reports that included children and young people missing from home and care, children at risk of sexual exploitation and the number of referrals the YOS made to children's social care services. However, this initiative was relatively new and had not been fully implemented. Therefore, while it was showing potential, the impact or outcomes were not yet demonstrated.

5.4. The YOS Management Board did not regularly receive performance reports on safeguarding issues within the YOS.

5.5. Learning from serious case reviews was disseminated from the LSCB and discussed at team meetings.

5.6. Escalation policies were in place and understood by YOS staff. However, there had been no instances of the escalation procedure being used in the past 12 months. Managers reported that this was because there are good informal relationships between staff and, therefore, the issues are quickly resolved at an early stage.

5.7. Safeguarding audits had recently been completed internally by the YOS and were scheduled annually. We found that there had been a significant gap in these being completed. Analysis of themes arising from audits was reported to the LSCB sub group. The YOS Head of Service was a member of the LSCB.

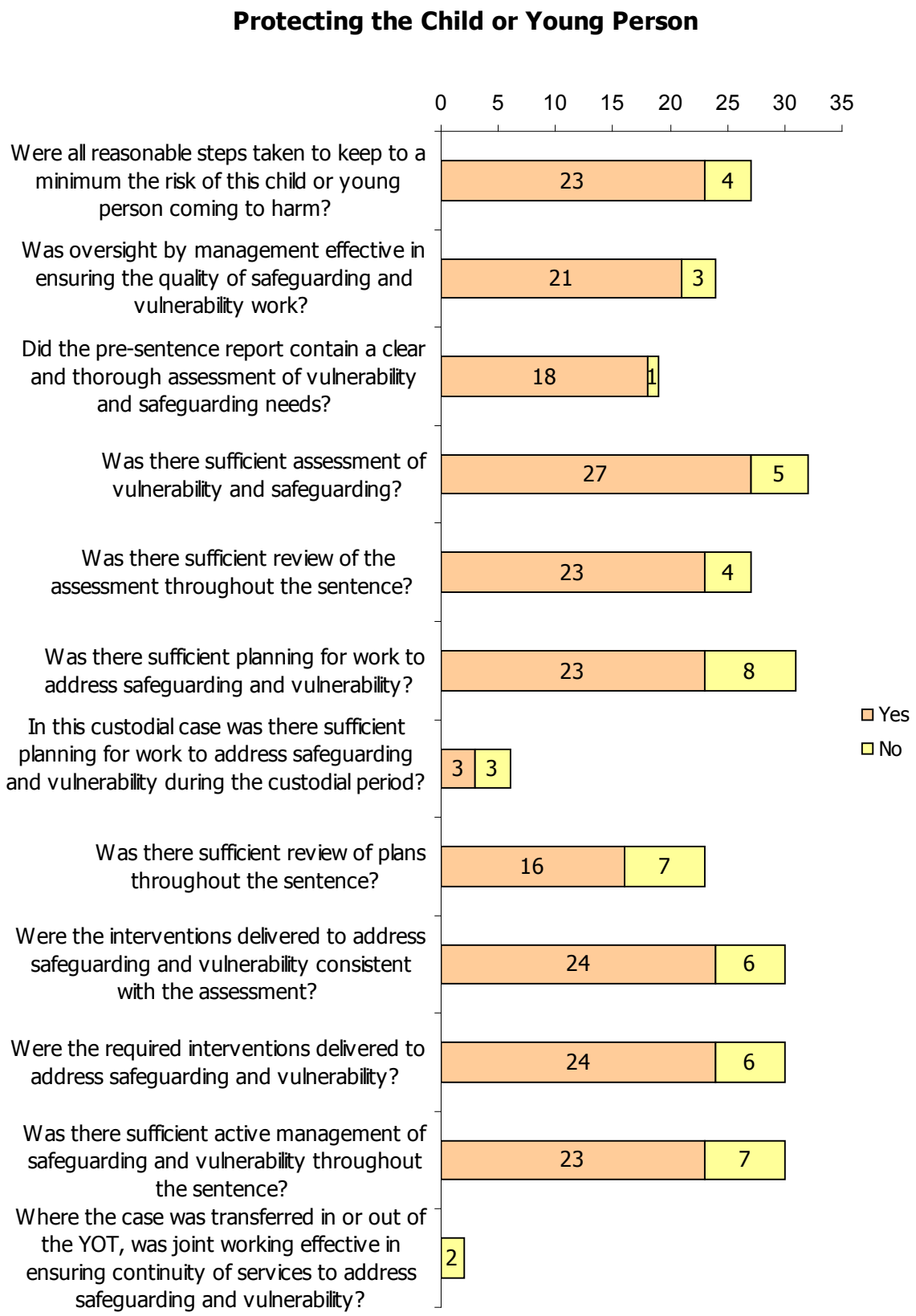
5.8. All case managers interviewed understood the local policies in relation to safeguarding and vulnerability.

Summary

Overall, work to protect children and young people and reduce their vulnerability was good. Staff within the YOS were excellent motivators for children and young people. Assessment, planning and reviews mostly met the requirements of the case and the necessary work was carried out within the YOS to ensure that children and young people were protected and their vulnerability reduced. PSRs contained a clear and thorough assessment of vulnerability in almost every case. Liaison between case managers and children's social care was good and information sharing between the two departments was done well. Where cases were transferred in or out of the YOS joint working arrangements needed further examination. Improvements in planning for work in custody are required to address safeguarding and vulnerability.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 33 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 YOS 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, 89% of work to ensure the sentence was served was done well enough.

Key Findings

1. Assessment of diversity factors and barriers to engagement was good with appropriate planning to address these issues.
2. There was excellent health provision in the YOS and we found evidence of the sports officer and clinical psychologist engaging well with children and young people.
3. Children and young people and their parents/carers consistently commended their engagement with the wider YOS staff team.
4. Children and young people and their parents/carers were actively enabled to participate in the development of PSRs, consideration of interventions and formulations of assessments.
5. Partnership work with ETE was impressive.
6. Appropriate decisions were made when enforcement action was necessary.
7. Plans did not always identify how barriers to engagement would be addressed.

Explanation of findings

1. Assessment

1.1. Assessment of diversity factors and potential barriers to engagement was done well in just over four-fifths of cases. This meant that obstacles to achieving positive outcomes had been properly identified.

Case illustration - Mohammed

Mohammed had Attention Deficit Hyperactivity Disorder (ADHD) and Dyspraxia which had contributed towards his challenging behaviour. Four months ago he was sentenced to a 12 month referral order for attempted robbery. Given that the case manager perceived that Mohammed was in danger of missing appointments, she instigated a number of activities to try to prevent this happening. These included texting him on the morning of each appointment, keeping sessions short and focused, checking on his contact details as he regularly changed his mobiles and keeping good communication links with his father. He has not yet breached his order which is a positive outcome.

1.2. The majority of the children and young people interviewed spoke about the importance of the relationship they had with the YOS case manager as being crucial to their compliance and commitment to their order.

1.3. Every PSR we inspected showed that the child or young person and their parents/carers had been correctly involved in the preparation and development of the report.

1.4. Nineteen out of twenty PSRs identified relevant diversity factors and potential barriers to engagement.

1.5. In almost every case we inspected we were satisfied that the YOS had provided an appropriate level of focus on the health and well-being outcomes for the child or young person as these related to potential barriers to bring about positive change.

2. Planning for interventions

2.1. It was disappointing to find that just over one-quarter of the plans did not include how diversity factors and obstacles to engagement would be addressed. However, where this was done it was done very well.

Case illustration - Vic

The case manager had demonstrated commendable commitment to diversity issues and to going the extra mile to engage with Vic and his complex needs. In an effort to more fully understand the implications of Foetal Alcohol Spectrum Disorder (FASD), he engaged with specialists in the community mental health team and obtained useful guidance on how best to work with Vic. Particular attempts were made to engage him in ETE by producing a bespoke set of supervision sessions looking at education and vocational options within a highly motivational approach. The worksheets from the sessions were sent to the care home keyworker and to the local careers advisor at the public library.

2.2. We found that the child or young person and their parents/carers had been engaged well in the planning process in 90% of cases. This meant that opportunities had been given to reflect their views on where changes needed to be made.

2.3. Physical health screenings were systematically undertaken by the paediatric nurse within the YOS and sexual health elements were also dealt with in the YOS through a part-time resource worker. The sports officer complemented this work and had linked his contribution more explicitly into YOS aims and plans.

2.4. Much good partnership working between the main college in Peterborough and the ETE officer had helped develop study programmes particularly focused on the diverse needs of children and young people who had offended. There was a history of children and young people from the YOS successfully progressing into further education and training. Good partnership working was illustrated by the joint project providing a well-planned programme of activities throughout the school summer holidays, mentioned earlier. Young people who were unable to access a specific course directly were provided with alternatives to prepare them for their training.

3. Delivery of interventions

3.1. Health workers within the YOS linked well with all current interventions and also provided significant support and leadership to specific and relevant elements, including sexually harmful behaviour and increasing awareness of relevant health issues.

3.2. In one out of the two cases inspected that were transferred in from other areas, joint work was not effective in ensuring a seamless transfer and continuity of delivery of the sentence. However, this was the result of information not being received by the YOS.

3.3. Generally, the child or young person and their parents/carers or families had been appropriately and purposefully engaged throughout the delivery of the sentence in just over nine-tenths of cases. This is a key strength in the YOS.

3.4. In a small number of cases, children and young people did not receive the education they were entitled to. Some received only a few hours a week and this did not meet their educational needs. The local authority had not responded quickly enough to arrange suitable alternative provision.

3.5. We interviewed seven children and young people and three parents/carers. All universally spoke very well of YOS staff and reported good relationships with case managers. The children and young people praised their case managers whom they felt tried to understand them.

Comment from parent/carer

"The staff are patient, reassuring and brilliant and helped him with his reading and writing skills when he applied for college".

4. Initial outcomes

4.1. The YOS had given excellent attention to health and well-being, in particular as these may act as barriers to achieving positive outcomes in 27 out of 28 cases where this was considered necessary.

4.2. Sufficient attention had been given, throughout the sentence, to identifying and responding to diversity factors and barriers to engagement in over four-fifths of cases.

Case illustration - Larry

The aim of this meeting was to hold a one-to-one session with Larry and begin a 'life history graph' to analyse significant events in his life, and to introduce a new family support worker to the parents. Larry was 12 years old and had ADHD with a conduct disorder. His behaviour at home had been problematic, with his resorting to criminal damage within the home to achieve what he wanted. He had recently begun taking medication for the ADHD and this did appear to have calmed his behaviour. The predominant offending history was shoplifting, although there had been an incident of criminal damage.

On arriving at the home, Larry was in the garden building a shed. He wanted to show off his work, which was positive, and the case manager gave appropriate affirmation. Larry did try and use his work to avoid the one-to-one session. However, the case manager managed this appropriately, setting boundaries for the work and getting him into the house where a one-to-one session was conducted using art to draw pictures of significant events in his life. These were then used to promote discussion. This intervention worked well with Larry, who revealed his opinions and thoughts on various issues. The case manager was enthusiastic and engaged the young person well.

4.3. In just over nine-tenths of cases inspected, the correct attention had been given to ensuring that the child or young person engaged with the YOS to meet the requirements of the sentence.

4.4. Overall, three-quarters of the children and young people complied fully, or after some initial difficulties with their sentence. The decisions made following non-compliance were largely appropriate in all except one of these cases.

4.5. We saw evidence of health workers striving to maintain good engagement with children and young people throughout their intervention – one said, *"I work harder and give the work a clear purpose and help the young person see that"*. Positives outcomes were demonstrated from engagement and joint ownership was well sought.

4.6. We found evidence in several cases of case managers working with parents/carers to overcome barriers that children and young people were having with education. Case managers were skilled

at working with children and young people of school age who were in danger of being excluded from their education. We saw examples of early interventions enabling the child or young person to remain in school.

Case illustration - Taz

The purpose of the session was to engage Taz in an activity that would promote fitness and build self-confidence. The sports officer was motivational and encouraged Taz to engage in the activity well. Taz was responsive and there was a good relationship between the two.

Good motivational approaches were used by the sports officer with Taz. The establishment of trust allowed the sports officer to engage Taz with other aspects of his life and discuss issues such as alcohol use, accommodation and relationships. It was clear that the sports officer's advice was not being ignored.

5. Leadership, management and partnership

5.1. The consultant psychologist, who headed up the health team within the YOS, provided a particularly good service.

5.2. External health providers indicated that, *"the YOS added value to what we provide"*, but it was not always clear who did what and when.

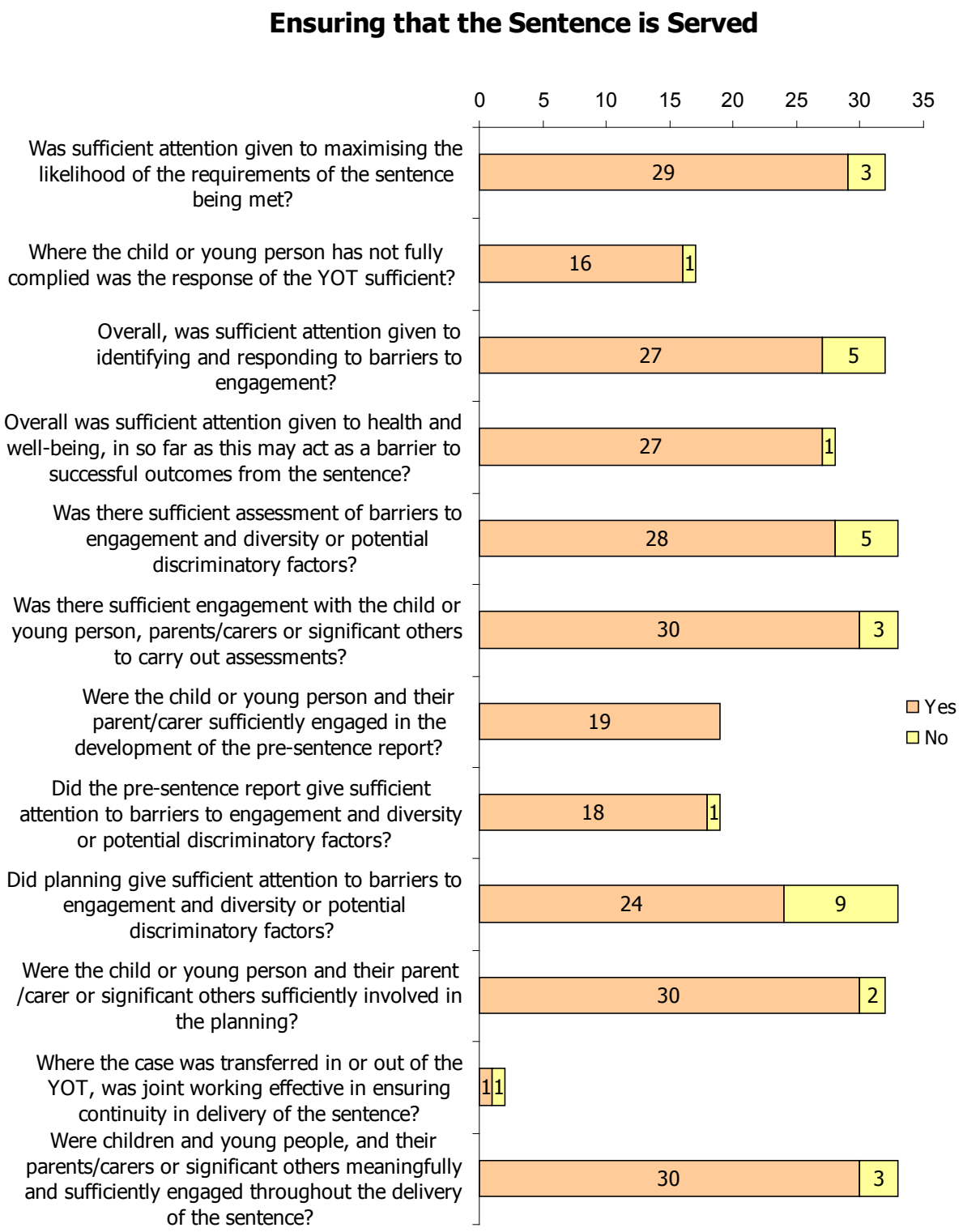
5.3. All case managers showed an understanding of the policies and procedures for maximising and ensuring compliance.

Summary

Overall, work to ensure that the sentence was served was good. The YOS benefited considerably from having excellent health provision. This made a substantial difference to the work with many of the children and young people. Case managers established good working relationships with children and young people and their parents/carers. There was appropriate assessment and the necessary actions were largely taken to address diversity and other factors that may act as barriers to engagement. The YOS took proper enforcement action when this was required in the case. Plans did not always identify how barriers to engagement would be addressed.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 33 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Governance and Partnerships

5

Theme 5: Governance and Partnerships

What we expect to see

Effective governance, partnership and management arrangements are in place. In particular the YOS partnership and Management Board provide effective governance to ensure that national and local criminal justice objectives are met, and positive outcomes are achieved for children and young people who offend or who are likely to offend, their victims and the local community. Equality of opportunity and wider diversity factors are prioritised throughout. Partnerships are in place working together well to ensure effective outcomes. Workforce management arrangements are in place within the YOS that enable staff to deliver quality engagement and achieve effective outcomes. The YOS is a learning organisation that continually reviews and evaluates the quality and effectiveness of its services in order to improve and sustain positive outcomes.

Key Findings

1. Following a review in 2013, a newly constituted Management Board, with new terms of reference and a reporting line to the Safer Peterborough Partnership had been established. The Board was not yet complete – courts representation on the board was a gap but this was being pursued along with an elected member and potential young person.
2. Performance information against the national indicators for youth justice was regularly presented to the Board and the YOS was performing well against these.
3. Local data, in particular the effectiveness of interventions, required evaluation and further development.
4. Strategic and other managers worked together well and continued to do so when the management board was in flux. Partners seconded staff, as required, and ensured that the YOS had a range of specialist workers delivering services.
5. The YOS was represented on a range of appropriate multi-agency boards within the larger strategic landscape and was clearly well regarded.
6. The YOS had a clear quality assurance policy but it was not being fully implemented.
7. Service user views were reported upon and were at the initial stages of impacting on service delivery.
8. Workforce development was given a high priority with training and development opportunities, along with regular supervision, being valued by staff.

Explanation of findings

1. Leadership and Governance – criminal justice and related objectives are met

1.1. Attendance by health and probation representatives at Management Board meetings had been inconsistent. While there were specific reasons in each case, lack of attendance by statutory partners has a significant impact on the effectiveness of the Board. There were still gaps too. It had been difficult to attract a representative from the courts service and the Board had no elected members. We have seen significant benefits in other YOTs from the Chair of the Youth Court Bench (not withstanding any safeguards regarding independence being applied) and elected members who cover both children and young people and crime being part of the Board and encourage the YOS to pursue these options.

1.2. New terms of reference for the work of the Management Board had recently been agreed and there were plans in place for the Board to develop a quality assurance framework to include case audit and learning reviews.

1.3. With the exception of NEET data, the Board's primary source of evidence of performance was progress against the national indicators for YOTs in England. We saw little evidence of local quality indicators and outcome measures being discussed at Board meetings.

1.4. The Board was on its third Chair in just over 24 months and this has hampered its leadership role.

1.5. Appropriate scrutiny arrangements were in place for the newly constituted management board through the Safer Peterborough Partnership and local authority scrutiny committee.

1.6. Strategic leaders worked together well, and the YOS was represented on a range of appropriate multi-agency boards.

2. Effective partnerships make a positive difference

2.1. The YOS Head of Service had oversight of the leaving care team and was a member of the children's social care management team. This had helped both services to work together well.

2.2. Partners ensured sufficient access to the range of specialist staff that were required, so that the YOS was appropriately staffed and a range of services delivered.

2.3. Peterborough YOS and the Young Men's Christian Association (YMCA) had a long history of working together to support young people establish themselves. A YOS case manager was currently seconded to the YMCA as coordinator of 'Better Together', a volunteer recruitment and training resource.

2.4. There was a new youth to adult transitions protocol (signed 10 February 2014) in place between the YOS and probation trust covering case management, case transfers and unpaid work arrangements. An arrangement was in place, where the seconded probation officer spent one day a week at the probation office, where he could see all transferred cases. This provided for continuity of supervision for the young person and also helped the probation officer to keep up to date with probation systems and practices. We consider this to be good practice.

2.5. The MAPPA coordinator reported good contact with the YOS probation officer, who held all such cases and made appropriate referrals.

2.6. Senior managers were clear about the key priorities to improve the quality of ETE interventions. The task now was to build on the excellent links the YOS had with the wider local authority education and youth service systems and further expand the options available to children and young people from the YOS.

2.7. The quarterly ETE report to the Board provided information on the progress being made, with good analysis of the NEET data. However, the Board had identified that more detailed information was required on an individual basis, which was starting to be a feature of reports to the Board. The ETE report provided the Board with sufficient information to challenge the YOS. Regular meetings took place between the board ETE representative and the YOS Head of Service. The Board had a good understanding of the ETE strengths and areas for improvement for the YOS.

2.8. A key strength of the Peterborough YOS was its very effective partnership links with local schools and alternative education provision throughout the area.

2.9. An effective protocol existed between the YOS and the Cambridgeshire and Peterborough NHS Foundation Trust, with comprehensive clinical objectives and clear aims for health work.

3. Effective workforce management supports quality service delivery

3.1. The YOS clearly valued training and development for all groups of staff within it. Staff spoke highly of the opportunities provided to them to undertake their current roles and for future development. They believed that the culture of the organisation promoted learning and development.

3.2. Staff spoke positively about their managers and, specifically, about the quality of supervision and support they received. They universally reported the excellent leadership their Head of Service provided.

3.3. The YOS recognised and celebrated success - examples were provided of colleagues being nominated for the Council's excellence award, which in one year was awarded to the whole YOS. One-to-one supervision included a record of compliments received and staff were regularly thanked and congratulated at team meetings.

3.4. Good levels of training were provided by health staff to the YOS, either through internal provision or through external health providers. YOS staff, for example, had recently undertaken sexually harmful behaviour intervention training.

4. Learning and improvement increases the likelihood that positive outcomes are achieved and sustained

4.1. Workforce development was given a high priority and training and development opportunities along with supervision were valued highly by staff, for example, two members of the team had been supported to obtain their social work qualification. Staff could access training through the local authority and also their home agencies and were supported in doing so.

4.2. Service user views were reported upon annually and were starting to improve practice, for example targeted home visiting. There is scope for more of this.

4.3. The YOS did not yet undertake case audits, for example considering a theme where there were safeguarding concerns, so that these could be reported to the Management Board and incorporated into future development plans.

4.4. Health professionals within the YOS continued to receive training and were updated on health information – an example of this was the recent training on FASD which had enabled health workers to be more aware of signs and symptoms and the possible effects on children and young people who were attending the YOS. It was notable that two of the health-related cases seen in this inspection included FASD diagnoses.

4.5. We saw evidence to show that appropriate training in developing areas such as child sexual exploitation would be coming to the YOS soon.

4.6. We were pleased to see that the YOS Youth Justice Plan 2013-14 had identified key themes for development that we consider will impact on the achievement of positive outcomes.

Summary

Overall, governance was satisfactory. We found good strategic partnerships in Peterborough with commitment to the work of the YOS. The refreshed Management Board had clear terms of reference and a reporting structure to the Safer Peterborough Partnership and was just completing its membership. Performance against the national indicators for youth justice (see Appendix 1) was regularly reported to the Board and the YOS was performing well against these. The Board recognised the need to develop what local information it required. This included data on the quality of work undertaken and its impact on children and young people and communities. The YOS was a member of a range of multi-agency boards and was well respected. While there was a clear quality assurance policy it had not yet fully been implemented. The views of service users were reported annually and were beginning to be used to make changes in the way services are delivered. Training and development opportunities were given a high priority in the YOS. At the time of the inspection, there were no links with higher education and research facilities.

Interventions

6

Theme 6: Interventions

What we expect to see

This is an additional module and focuses specifically on interventions intended to reduce the likelihood of reoffending. We expect to see a broad range of quality interventions delivered well, linked to appropriate assessments and plans and which maximise the likelihood of sustainable outcomes being achieved. Effective leadership and partnership work needs to be evident in the delivery of interventions.

Case assessment score

Within the case assessment overall, 74% of intervention work was done well enough.

Key Findings

1. We saw some evidence of good leadership and partnership work to ensure that the intervention needs of children and young people were met.
2. Assessments and plans met the needs of most of the cases but would have benefitted from a fuller examination of diversity needs and barriers to engagement.
3. The quality of interventions was good and there were several examples of interventions that had been designed internally.
4. There was no systematic collation and evaluation of information to understand which interventions were making a difference and achieving positive outcomes.
5. The impact of substance misuse interventions was inconsistent.
6. Health interventions were delivered particularly well.
7. Case managers consistently affirmed the children and young people when they successfully completed their interventions.

1. Overview of findings

1.1. We saw evidence of management involvement and facilitation of formulation, risk review and compliance meetings. We observed a team meeting led by the YOS Head of Service. This meeting had a clear agenda focusing on budget, performance and quality issues, and also looked at developing practice. The vast majority of meetings were well planned. The formulation meetings used a well defined cognitive behavioural model and elicited good quality information from the participants which allowed focussed assessment and appropriate planning.

1.2. The YOS based its interventions on best practice, developing some internal programmes from established 'What Works' models. The next step is for the YOS to evaluate the quality of its interventions, outcomes, determine what is working and to use this information to improve its targeting of interventions with children and young people.

1.3. Drug and alcohol services needed to be developed. While there was provision through an external provider, feedback was not universally positive. We observed committed staff who were somewhat frustrated by the YOS's lack of use of the data they could provide in this area. Improved data sharing between the two agencies and a better understanding of the information available could improve relations and outcomes for children and young people.

1.4. We saw some good examples of effective partnerships including 'Froglife' reparation services and the boxing gym. Both appeared to work well with the children and young people to motivate them to address the factors associated with their offending behaviour and personal circumstances.

1.5. The assessment of children and young people's eligibility for interventions was good and interventions delivered were generally consistent with assessments and plans.

1.6. There was clear evidence of good quality planning in place for the great majority of community cases. Initial planning for work to address the likelihood of reoffending was good at identifying what interventions were to be provided and how.

1.7. The YOS delivered good quality interventions and was particularly strong in delivering interventions designed to address motivation to change, physical health, neighbourhood, family and personal relationships and emotional and mental health.

1.8. We observed a planning meeting attended by a young person and parent where they were given time to give their views on the interventions required to bring about positive change. It was clear that the YOS staff valued their input and listened to what they had to say. Two home visits were also observed where parents were present - on both occasions their input was sought and listened to respectfully.

1.9. The great majority of cases utilised good quality materials and other resources to deliver interventions to reduce the likelihood of reoffending. The YOS had well established external partnerships and wide range of internal interventions. Interventions were delivered as their design intended, incorporated restorative approaches and staff consistently reinforced positive factors to reduce reoffending. This was an area of strength for the YOS.

1.10. We observed the delivery of a one-to-one session on knife crime, the case manager utilised a DVD and discussion with the young person on their views of the issues. The session was well structured and worked well to engage the young person.

1.11. The range of interventions available to the YOS was varied; there were a number of cognitive behavioural therapy based interventions, thinking skills, anger management, decision-making, specialist knife crime interventions, ETE, sports and leisure – physical health, emotional and mental health, drugs and alcohol. These options were accessed well by case managers as they worked with children and young people.

1.12. Health, well-being and ETE interventions were well established at the YOS. The specific needs of children and young people were identified by YOS staff and built into plans to reduce the likelihood of reoffending in the vast majority of cases.

1.13. We observed a well structured sports intervention at the local gym which built motivation into the activity and fully engaged the young people involved.. Again we saw evidence of strong health participation in formulation meetings, with the health lead facilitating the meetings extremely well.

1.14. There was evidence in the great majority of cases that sufficient attention had been given to ensuring that outcomes were sustainable. There were a small number of cases where follow-on services had been identified.

1.15. The YOS had good performance figures and low reoffending rates. Again, staff had a good understanding of the principles of effective practice. However, the reasons for this good performance were not sufficiently understood, with little evaluation about what and why certain programmes and approaches worked with children and young people. This would allow staff to have a greater understanding of what is effective and when and enable better targeting of resources.

Summary

Overall, the management and delivery of interventions was satisfactory. We found that there was positive leadership and partnership work to ensure that the intervention needs of children and young people were met. Assessments and plans met the needs of the individual but diversity needs and barriers to engagement in all cases were not consistently met. Whilst the quality of interventions was evident the sequencing was not sufficiently clear and the interventions did not always follow the assessment and plans for work to reduce the likelihood of reoffending. Health interventions were delivered particularly well. The YOS had produced some very good materials internally and we found evidence of YOS case managers reinforcing the achievements of children and young people. However, there was no systematic collation and evaluation of information to understand what interventions were making a difference. The impact of substance misuse interventions was inconsistent.

Appendices

Appendix 1
Contextual information about the area inspected

Peterborough had a population of 183,631 as measured in the Census 2011. The youth population (those aged between 10 and 17 years old) accounted for 10.1% of the population. This was higher than the average for England/Wales as a whole, which was 9.5%.

The percentage of the youth population with a black and minority ethnic heritage was 24.5% (Census 2011). This was higher than the average for England/Wales, which was 18.3%.

Reported offences for which children and young people aged 10 to 17 years received a pre-court disposal or a court disposal in 2012/2013, at 21.1 per 1,000, were higher than the average for England/Wales of 18.5 (Youth Justice Board 2012-2013).

The proportion of young people in Peterborough aged 16 to 18 who were not in education, training or employment is estimated at 7.4%. This is higher than the average for England, which is estimated at 5.7% (Department for Education 2013).

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 Peterborough was 29.5%, better than the 35.9% 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 further offences within 12 months, per 100 such children and young people. For Peterborough, there were 0.73 offences per child or young person who reoffends, better than the 1.04 for England and Wales as a whole.

(Data based on January 2011 to December 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 Peterborough is 496, compared to 484 for England and Wales as a whole.

(Data based on July 2012 to June 2013 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 Peterborough is 0.71, compared to 0.52 for England and Wales as a whole.

(Data based on October 2012 to September 2013 cohort)

Appendix 2
Contextual information about the inspected case sample

In the first fieldwork week we looked at a representative sample of 33 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.

Appendix 3
Acknowledgements

Lead Inspector	Avtar Singh, *HMI Probation*
Deputy Lead Inspector	Helen Davies, *HMI Probation*
Inspection Team	Jon Nason, *HMI Probation* Gary Smallman, *HMI Probation* Stephen Miller, *Ofsted* Linda Steele, *Ofsted Children's Social Care* Rob Bowles, *HMI Constabulary* Fergus Currie, *Care Quality Commission* Susan Scott, *Local Assessor* Jay Willis, *User Engagement Officer*
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Assistant Chief Inspector	Julie Fox, *HMI Probation*

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 five 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
- governance and partnerships

Methodology

Fieldwork for this inspection was undertaken on the weeks commencing:

27th January 2014 and 10th February 2014

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, social care 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. This evidence, with others, contributes to our assessment of the quality of governance and leadership.

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 YJB. 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% +	Good	
65% - 79%	Satisfactory	
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
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
FTE	Full-time equivalent
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
Interventions; constructive and restrictive interventions	Work with an individual that is designed to change their offending behaviour and/or to support public protection. A *constructive* intervention is where the primary purpose is to reduce the likelihood of reoffending. A *restrictive* intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others. Example: with a sex offender, a *constructive intervention* might be to put them through an accredited sex offender programme; a *restrictive intervention* (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. NB. Both types of intervention are important
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 constructive 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
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 *restrictive* 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 restrictive interventions, 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 *probability* of an event occurring and the *impact/severity* of the event. The term *Risk of Serious Harm* only incorporates 'serious' impact, whereas using 'risk of harm' enables the necessary attention to be given to those offenders for whom lower *impact/severity* harmful behaviour is *probable*
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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