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 **Newport**

An inspection led by HMI Probation

independent inspection of youth offending work

September 2014

Foreword

This inspection of youth offending work in Newport 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 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 Newport because a sustained rise in the frequency of reoffending was accompanied by high levels of first time entrants into the youth justice system.

Recently Newport has achieved a substantial reduction in the number of children and young people entering the youth justice system. However, it has not been effective in reducing reoffending. The published reoffending rate for children and young people in Newport at the time of the inspection was 37.6%. This remained worse than the average performance for Wales (37%) and for England & Wales combined (35.5%).

We found that the quality of work with children and young people who have offended had deteriorated markedly since our last inspection in 2010. The Youth Offending Service management board and management team need to ensure that the quality of work improves substantially and rapidly. They need to sufficiently focus the activity of the team to reduce reoffending and protect the public, and ensure provision is consistent across the service. In particular, urgent work is required to ensure that the Youth Offending Service management team works effectively.

We are pleased to note that senior managers accept our findings and have committed themselves to achieving rapid improvement.

The recommendations made on page three of this report identify the key areas where post-inspection development work should be focused. They are intended to assist Newport Youth Offending Service and its partners in their continuing improvement.

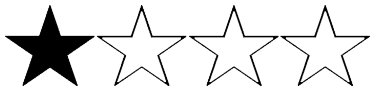
Due to the poor performance identified in this inspection we will return to Newport to undertake a further inspection, which is likely to occur 12 to 24 months from the publication of this report.

Paul McDowell

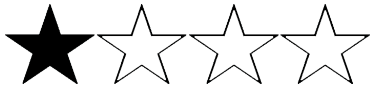
HM Chief Inspector of Probation

September 2014

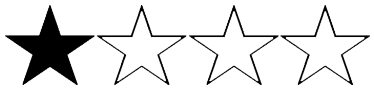
Summary

Reducing reoffending 

Overall work to reduce reoffending was poor. Not enough priority was given to work to reduce reoffending. More use should be made of partners to address welfare related needs so that the skills of the YOS can be focused effectively on reducing offending. The overall quality of work needed rapid and substantial improvement with staff held to account consistently and effectively for this. We found some good work within the Intensive Surveillance and Supervision team; however this was undertaken independently of the case manager. The YOS management team did not work effectively together. This made a substantial contribution to the general poor practice.

Protecting the public 

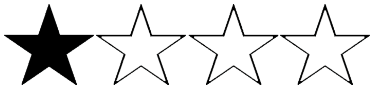
Overall work to protect the public and actual or potential victims was poor. Whilst assessment was better than in other parts of the YOS' work, thereafter the general quality of work was poor. Too often the work undertaken did not match the needs of the case, and in particular more attention needed to be given to known victims. Difficulties with this work were compounded by confusion over the operation of the YOS risk management panel and inadequate oversight by managers.

Protecting children and young people 

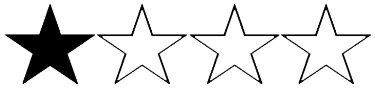
Overall work to protect children and young people and reduce their vulnerability was poor. The cause was often that vulnerability was considered solely with respect to child protection and deliberate self-harm, and ignored other risky behaviour such as use of alcohol or drugs, including when this was linked to offending behaviour. Ironically, in view of the priority given to welfare needs recognised elsewhere in this report, case managers did not recognise the broader understanding of vulnerability that applies throughout the youth justice system. Attention needed to be given to more effective joint working with Newport children's social services, including by ensuring that referrals made by the YOS are of good quality.

Ensuring the sentence is served 

Overall work to ensure that the sentence was served was unsatisfactory. Staff knew the children and young people well; however they did not involve them sufficiently in assessment and planning for the changes they needed to make in their lives. More could be done to ensure that children and young people took greater responsibility for their own compliance with the sentence. The YOS compliance panel was not effective. However, when children and young people didn't comply with their sentence the initial response was often appropriate.

Governance and partnership 

Overall, the effectiveness of governance and partnership arrangements was poor. The Management Board had not ensured that work to reduce offending was either effective or of sufficient quality. Neither was the information used by the management board useful in supporting this. Newport had achieved substantial reductions in the number of first time entrants to the youth justice system, and we were pleased to see that youth justice was reflected in key local plans, although there was further work to be done to ensure that these could be monitored effectively. The offer of services through the medium of the Welsh language needed to be more routine. There was no robust or consistent approach to ensuring the quality of practice and staff were confused by mixed messages. Complacency had developed about the importance of ensuring good quality practice and morale was low. Resolving these problems was critical to achieving sustainable improvement.

Interventions to reduce reoffending 

Overall work related to the delivery of interventions to reduce reoffending was poor. We struggled to find focused offending behaviour work being delivered. Staff did not have satisfactory tools to assist them to understand what interventions were available, and to target these appropriately to individual children and young people. There was no systematic planning to the acquisition of interventions, or to evaluating what interventions may have made a difference. Assessment and planning both required substantial improvement. More attention needed to be given to speech, language and communication and other relevant diversity factors.

Recommendations

Post-inspection improvement work should focus particularly on the following: (suggested primary responsibility for each is shown in brackets)

1. The Management Board should ensure that reoffending is reduced, the work of the YOS is of good quality and positive outcomes are achieved across all types of intervention. (Chief Executive Newport City Council)
2. Information used by the Management Board should be relevant, current, understandable and useful to effective decision making. (Chair of the YOS Management Board)
3. The YOS management team should work effectively, giving clear and consistent leadership to the YOS and ensuring good quality work. (YOS Manager and management team)
4. The quality of assessment, planning and delivery of interventions is improved, so that the YOS makes a sufficient contribution to reducing reoffending, protecting the public and reducing the vulnerability of children and young people. Partner agencies should contribute to assessments, and objectives relevant to their work included in plans. (YOS Manager)
5. There should be a systematic approach to assuring the quality of work that is effective in improving practice, consistently applied, and monitored by the Management Board. (YOS Manager and Chair of the YOS Management Board)
6. The YOS should ensure that sufficient focus is given to reducing offending in individual cases. Where appropriate, welfare needs should be referred to and addressed by partners. (YOS Manager and Director of Social Services)
7. The needs of victims should be given higher priority. They should be protected, contribute to referral orders, and access restorative justice where appropriate. (YOS Manager)
8. A broad range of interventions should be available to reduce reoffending which are used effectively. Staff should know what is available and be trained in their use. (YOS Manager)
9. The Management Board and key partners, particularly health and education, should ensure that children and young people with speech and language needs are able to engage effectively with the work of the YOS. (Chair of YOS Management Board)
10. Joint work with other children's services should be effective. It should be supported by consistent use of the children's services case management system, clear guidance and high quality referrals. (YOS Manager and Director of Social Services).
11. The role of the YOS police officers should correspond with current guidance; be used more effectively to protect the public, reduce reoffending and assist in reducing the vulnerability of children and young people. (Chair of the YOS Management Board and Police Representative on the YOS Management Board).
12. Educational attainment for children and young people known to the YOS should be improved. (Chair of the YOS Management Board and Education Representative on the YOS Management Board).

Contents

Reducing reoffending

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Theme 1: Reducing 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 41% of work to reduce reoffending was done well enough.

Key Findings

1. Reoffending rates remained too high.
2. Insufficient focus was given to work to reduce reoffending.
3. Interventions intended to reduce reoffending were not delivered as required by the needs of individual cases.
4. Work in custodial cases was generally good.
5. Assessment and planning both required substantial improvement.
6. Sufficient reviews were not undertaken of assessments, plans and interventions.
7. Staff were not held to account sufficiently for the quality of their work.
8. Intensive surveillance and supervision was positive.
9. The YOS management team did not work effectively, and this affected the quality of work.
10. Health related work was positive, although not clearly linked to reducing offending.
11. More attention needed to be given to victims and restorative justice.
12. Not enough attention was given to speech, language and communication needs, and other diversity factors.

Explanation of findings

1.1. The work of the YOS was not making a sufficient contribution to reducing reoffending. Over recent years there had been a steady rise in reoffending in Newport. Whilst initial indications were that the rise had ended, there was no evidence of a sustained reduction.

1.2. In many cases it was unclear what, if any, interventions designed to reduce reoffending had been delivered. There was usually no clear reason why, other than that the case manager had focused so much on welfare needs that there was no opportunity left to address offending related behaviour. This was in contrast to what we have found in many other inspections, where a reasonable attempt to deliver appropriate interventions had often been made even where assessment and planning was insufficient.

1.3. There was a clear link between planning and interventions delivered in less than half the cases. Almost two-thirds of cases did not include sufficient review of progress made – usually because no review had been undertaken. An inspector commented that *"if I reverse engineered many plans from what was actually done in the case, the plan would have read 'I'm here if you need me'"*. By not ensuring a sufficient emphasis on reducing their reoffending, children and young people were being let down.

1.4. We were pleased to find some cases where the case manager had attempted to undertake effective work to reduce reoffending. Good attention was usually given to reinforcing those positive factors that may contribute to reducing reoffending.

1.5. We found a positive attempt to deliver offending behaviour related work in a number of Intensive Surveillance and Supervision (ISS) cases, including use being made of reparation and other activities as opportunities to discuss offending behaviour. However, ISS staff were left to get on with things independently of the case manager. We would expect the case manager to take the lead on the case, reinforcing the ISS element as part of their work and ensuring that delivery of interventions during the ISS period was consistent with their overall assessment and plan of work for the case.

1.6. Case managers had received training on restorative justice, although its take up within statutory case management had been slow. Victim contact was done systematically by the YOS police officers. However, there was no process to ensure that the wishes of victims, for example for a letter of apology, were always reflected in restorative approaches and victim-focused interventions. Sometimes it seemed that these were ignored by case managers. However when victims' wishes were followed it had a positive impact on them.

Comments from victims

"I had a letter from the lad . . . apologising. It really made me feel better because it is nice to know that there are people out there helping these young children that are getting into trouble"

"The letter of apology we have received from the person who stole was really beneficial. We put it on the wall for staff to read . . . "

1.7. Work in custodial cases was generally good. It was apparent that a focus was given to these more complex and often higher profile cases. The quality of planning undertaken in custodial institutions was better than we often find – most plans did include work to address offending behaviour and respond to the assessment undertaken by the YOS. In a few cases, the YOS ensured a positive transition back into education or training. In one good example, the YOS worked with Careers Wales to ensure a young person could return to his work based training provider after a short period in custody. However, in most cases case managers were not able to effect such a smooth transition.

Persistence in undertaking assessment in custody

Joe was remanded to custody due to the seriousness of his offence. The case manager visited him in order to complete an assessment. The time available was not sufficient. Therefore the case manager arranged an urgent second visit and returned to the custodial establishment to complete the work. This ensured that the assessment was comprehensive and that the PSR provided to the sentencing court included all relevant information.

1.8. Pre-sentence reports (PSRs) are the main means by which advice is provided to the sentencing court. Two-thirds were good enough. Some needed to be clearer about vulnerability, and not restrict this to consideration of the possibility of self-harm. Oversight processes to ensure that PSRs were good enough needed to be more robust and consistent. We were pleased to find that PSRs were often more concise than is sometimes the case. In some there was a helpful single paragraph that summarised the assessment of the reasons why the offence was committed. In combination these helped ensure that key information was clearly and readily available to the sentencing court.

1.9. Assessment and planning were not treated as sufficiently important. Whilst an initial assessment was completed in most cases, the great majority were not good enough. Evidence was often very limited, and was not sufficient to justify the conclusions reached, meaning that key factors that influenced reoffending were not always correctly identified. Assessments rarely made use of the potential contributions of health, substance misuse, education, police and other workers to ensure that they were robust and comprehensive. Insufficient use was made of information already available in other assessments or records.

1.10. The YOS had a substance misuse worker, employed by the Barnardo's B@1 service and based at the YOS, working on cases referred by case managers. At the time of the inspection there were five children and young people on his waiting list. Whilst there was a helpful contingency plan to deal with an influx of referrals; it had not been enacted at the time of the inspection, which left children and young people with unmet needs.

1.11. A clinical nurse specialist was based at the YOS, working with all children and young people with emotional or mental health needs following referral by case managers. The nurse was part of the Child and Adolescent Mental Health Services (CAMHS) team and had access to CAMHS notes and other CAMHS professionals where this was required. It was positive that he was able to make referrals to CAMHS directly, avoiding time on a waiting list.

1.12. Once case managers made referrals to the clinical nurse specialist and the substance misuse worker they were well supported by them. There was evidence of discussions with them in relation to the type of intervention required. Information was routinely shared about how a child or young person's condition might impact on their behaviour. The clinical nurse specialist was able to deliver a range of interventions that could contribute to reducing offending behaviour.

1.13. However the specialist health workers did not get involved in a case until after the initial assessment was completed. As a result children and young people were reliant upon the expertise of their case manager to identify their health needs. Case managers had received insufficient training to identify emotional and mental health concerns and their assessment of health needs was not good enough.

1.14. There was a lack of emphasis on speech, language and communication. No screening took place and case managers had received insufficient training to recognise the issues. Where needs were identified, there was confusion amongst staff as to what action to take. This could mean that if there was a link with offending behaviour it may be missed. It could also impact children and young people's ability to understand and participate in work to address their offending behaviour.

1.15. ETE (Education Training and Employment) assessments were not supported well enough by additional information. For example, there was poor recording of literacy and numeracy levels, learning styles or any additional learning needs the children and young people may have. Overall, case managers did not pay good enough attention to identifying the educational barriers of the children and young people they supervised. Where children and young people were recorded as having statements of educational need, the detail of these was not available. As a result, the YOS could not be sure that all the needs of these children and young people were being met.

1.16. Case managers needed to take a more investigative approach to undertaking assessment, for example seeking to use other sources to check what they have been told by the child or young person or their parent/carer, rather than just accepting it (e.g. checking education attendance or achievement records). They needed to recognise the value of assessment to effective planning and the delivery of interventions.

1.17. Reviews suffered from similar problems to initial assessments. In addition, in a quarter of cases without sufficient review this was because there was no evidence of one having been undertaken as required. Many of those recorded were largely a copy of the previous assessment with insufficient, or sometimes no update.

1.18. Less than half the cases had good enough planning in place for work to reduce reoffending. In some a plan had not been created. The most common area for improvement was that plans were unclear. In most cases they were not effective as a means of clearly communicating the case manager's detailed intentions, either to the child or young person or to anyone else who might need to know the plan. Plans were not routinely discussed with children and young people and their parents/carers as they were developed, to ensure that they understood them and that the objectives were meaningful, and that they appropriately reflected the child or young person's views on where they needed to make changes in their behaviour.

1.19. In referral order cases, reports to the community panel were often limited. The voice of the victim was not heard in initial panels, either through their attendance or through the report writer or other representative speaking on their behalf. Insufficient guidance was provided to panel members about the range of interventions that were available in each case. Members that we spoke to said they had never seen a victim at the panel. The objectives in the agreed contract were not meaningful to a child or young person, and they were not routinely given a copy of the contract that they had signed. In general we considered that panels were too ready to accept the lack of victim attendance and the poor quality of reports that they received. They needed to be more demanding of the YOS to ensure that the principles that apply to referral orders are met.

1.20. Not enough attention was paid to ensuring that good quality, targeted plans were in place to improve educational outcomes. Children and young people did not have individual learning plans that could be shared with other agencies, such as schools and Pupil Referral Units. Although many had additional learning needs, arrangements to provide learning support were not clearly identified.

1.21. We were particularly concerned that our comments to case managers on the quality of assessment and planning were sometimes met with surprise. The indication was they were not always expected to deliver work to the standards that are expected, and that we are increasingly used to seeing. However, we were pleased that case managers engaged with us positively and there was some evidence as the inspection progressed that our comments had been understood and responded to.

1.22. Case managers did not receive appropriate training to help them improve ETE outcomes for children and young people. In many cases, they were not always aware of the ETE interventions available.

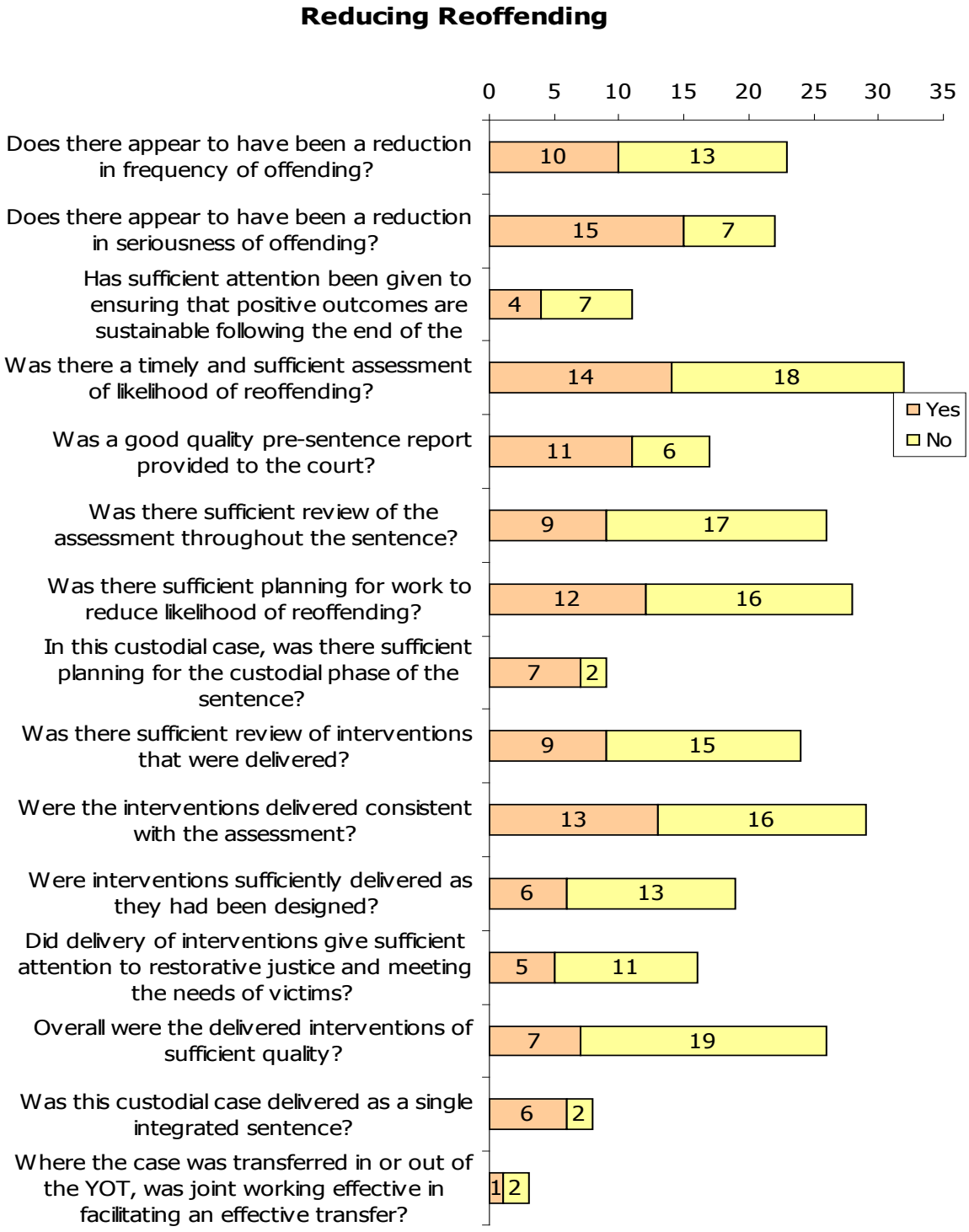
1.23. There wasn't a systematic and consistent approach to recording on the Child View case management system. Whilst examples were provided of instructions that had been given about recording, it was clear that they were not followed consistently. Case managers, information staff and managers needed to work together to agree and ensure adherence to recording standards that worked well for everyone. As one example, case managers and middle management believed that health workers recorded their work in one part of the system; but the substance misuse worker actually recorded his interactions elsewhere. This may lead to important information being missed as case managers did not know where to find relevant information about health interventions.

Summary

Overall work to reduce reoffending was poor. Not enough priority was given to work to reduce reoffending. More use should be made of partners to address welfare related needs so that the skills of the YOS can be focused effectively on reducing offending. The overall quality of work needed rapid and substantial improvement with staff held to account consistently and effectively for this. We found some good work within the Intensive Surveillance and Supervision team; however this was undertaken independently of the case manager. The YOS management team did not work effectively together. This made a substantial contribution to the general poor practice.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 32 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 51% of work to protect the public was done well enough.

Key Findings

1. Assessments were better than for other inspection themes, but still needed improvement.
2. Overall, work was good enough in only a third of cases.
3. More attention needed to be given to victims.
4. Planning for work to manage risk of harm to others required substantial improvement.
5. There was insufficient review of assessments and plans for work to manage risk of harm.
6. The risk management panel was not effective and staff were confused about its operation.
7. Oversight by managers did not ensure that work was of good quality.

Explanation of findings

2.1. We were pleased that staff understood the principles behind risk of harm work, but disappointed that they didn't apply these sufficiently to their work more often.

2.2. Too often the work undertaken to manage risk of harm to others did not match the needs of the case, even where pieces of work had been planned for. Required interventions were delivered in only a third of relevant cases. Overall, case managers were sufficiently active in managing risk of harm to others, through delivery of good quality work and by responding appropriately to changed circumstances, in only a third of relevant cases.

2.3. Assessment of the risk of harm posed to others was better than other aspects of assessment, but over a third were still not good enough. More account needed to be taken of known victims and previous relevant behaviour.

2.4. Thereafter, the quality of the work was generally poor. Two-thirds of assessments hadn't been reviewed as required. Many reviews were largely a copy of a previous assessment with insufficient update, and some just hadn't been undertaken. Regular reviews are essential to ensure that the assessment remains sufficiently current and reflects changed circumstances, including any improvement or deterioration in behaviour. Without an up to date assessment it is difficult to ensure that plans to manage risk of harm remain appropriate.

2.5. Planning for work to manage risk of harm to others was insufficient in two-thirds of cases. There were many cases without a risk management plan, where one was clearly required. Where planning was in place, more attention needed to be given to addressing victim issues. Plans needed to clearer and more precise so that the writer's intentions were clear to all who may need to use them. Plans also needed to include suitable contingency planning.

2.6. More attention needed to be given to planning for work to manage risk of harm in custodial cases. All relevant custodial cases should include an appropriate plan that identifies any work to be undertaken in custody to prepare the child or young person for release, along with a plan for work in the community that is ready for when the child or young person is released.

2.7. There was insufficient review of plans to manage and reduce risk of harm to others. Sometimes reviews were not undertaken as required, but in most cases they weren't of sufficient quality, often because deficits in the original planning hadn't been recognised. Confusion over the outcomes from risk management panels contributed to this. As a result plans may not remain suitable for the current circumstances.

2.8. Sufficient attention was given to assessing and managing the risk of harm to known victims in only half the relevant cases. In a few the victim had not been clearly identified by the case manager. However we found no evidence of victims coming to serious harm as a direct result of this lack of attention.

2.9. Oversight of risk of harm work by managers was not effective in just over three-quarters of relevant cases. In half of these there was no evidence of oversight being provided, and in most there were important deficiencies in assessment or planning that oversight should have identified and ensured were addressed, rather than countersign them as being good enough. We recognised that the YOS had previously used its own information systems to support timely oversight, and that this facility had been temporarily lost following the change of system. However managers should have taken earlier actions to address this situation.

2.10. There was a risk management panel in place, which should have contributed to both effective oversight and a high standard of work. However this process was very confused – for example some staff believed that actions arising from the panel would replace risk or vulnerability management plans, rather than requiring the plans to be updated. On occasions the required processes for referral to the risk management panel were ignored, with no reason given for this, even though all case managers understood the requirement to do this. Where actions to improve assessments and plans had been identified, there was no process to ensure that were addressed in a timely manner, prior to them being accepted by a manager.

2.11. We were pleased that the YOS had taken steps to improve operation of the risk management panels, following feedback provided after the first inspection fieldwork week. The subsequent panel that we observed was well run, and the YOS had developed a simple flow-chart to assist staff in understanding how to use the panels effectively.

2.12. Whilst there were no current Multi-Agency Public Protection Arrangements (MAPPA) cases being actively managed by the YOS in the community, neither had there been recent training for case managers to ensure that they remained aware of their key responsibilities to identify, notify and refer appropriate cases, and to integrate MAPPA arrangements into their work. The benefits such refresher training would bring were recognised by managers.

Summary

Overall work to protect the public and actual or potential victims was poor. Whilst assessment was better than in other parts of the YOS' work, thereafter the general quality of work was poor. Too often the work undertaken did not match the needs of the case, and in particular more attention needed to be given to known victims. Difficulties with this work were compounded by confusion over the operation of the YOS risk management panel and inadequate oversight by managers.

Data Summary

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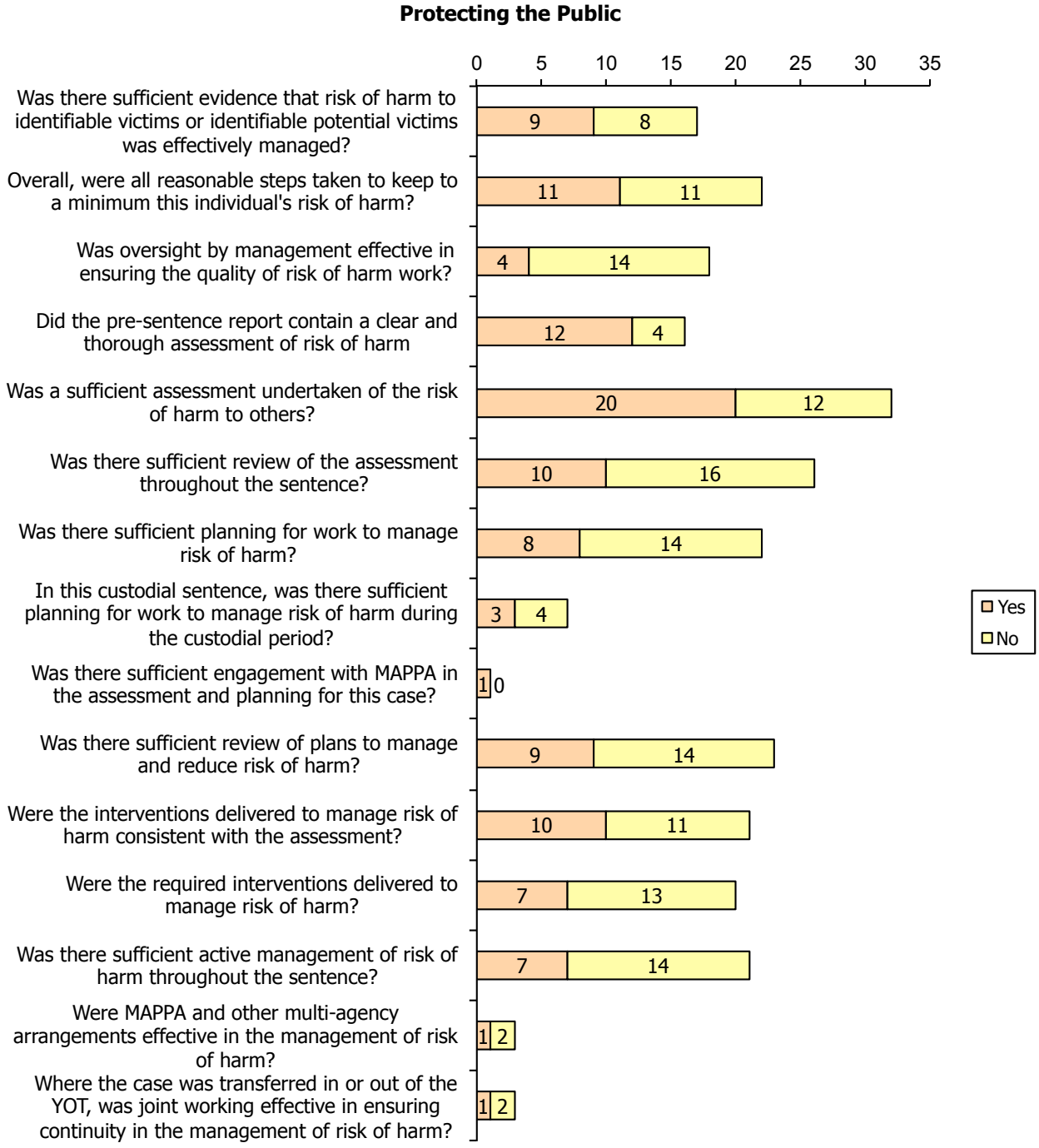


Protecting the child or young person

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 41% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Overall work to protect children and young people and to reduce their vulnerability was poor.
2. Some staff worked to an understanding of vulnerability that did not accord with current expectations.
3. Only half the assessments were good enough.
4. Planning required substantial improvement.
5. Oversight by managers was not effective in ensuring the quality of work.
6. There was much communication between the YOS and social workers elsewhere in the local authority, although the effectiveness of joint working was limited.
7. The quality of referrals to the children's services Duty and Assessment Team was not good enough.

Explanation of findings

3.1. Vulnerability was often understood solely with respect to child protection and safeguarding procedures, or the likelihood of the child or young person causing themselves deliberate self-harm. We and the YJB expect to see a much broader approach to vulnerability. Examples that we found where vulnerability should have been considered included missing school where the child or young person was doing things whilst not there that made them more vulnerable, the impact of older siblings who offend, difficulties in relationships with a parent when they have health issues, the impact of known health issues on self esteem, and being easily led or susceptible to peer pressure. Each could also have had an impact on offending behaviour.

3.2. Whilst a lot more should have been done to ensure high quality work to protect children and young people and reduce their vulnerability, we were pleased to find that there were no cases where shortcomings in the work had left any child unsafe.

3.3. The right things were done in only a third of relevant cases to manage and reduce the child or young person's vulnerability. In general, assessment and planning were not robust enough to maximise the likelihood of this happening in more cases.

3.4. Where required interventions had not been delivered, or appropriate referrals not made, this was primarily because the case manager had not recognised the need for this. As a result, work to address safeguarding and reduce vulnerability was sometimes not given the priority that it required.

3.5. We were concerned to find that there was sufficient formal planning in place to manage and reduce the child or young person's vulnerability in less than a quarter of relevant cases in both custody and the community. A plan had not been completed in two-thirds of the cases where one was required; including cases where the case manager had themselves assessed the level of vulnerability to be medium or high. In half the cases where there was a plan in place more attention needed to be given to contingency planning.

3.6. Oversight by management was only effective in ensuring the quality of work to address safeguarding and reduce vulnerability in less than a fifth of relevant cases. Often deficiencies in assessment and planning had not been addressed before they were accepted, and in many others oversight was required but had not been provided. As with risk of harm work, we were informed that the YOS had previously used information systems to help identify where oversight was required, and that these were not yet available in the new system. However we would have expected to see a robust attempt to cover this gap. On occasions we found quality assurance files completed by a manager that had still not recognised shortcomings in vulnerability assessment and management, even where these had apparently been examined. Confusion around the operation of the risk management panel also applied to this work.

3.7. Only half the assessments of safeguarding and vulnerability were good enough. As well as recognising the breadth of potential vulnerability factors, case managers needed to gather these together into a comprehensive assessment, and be clear on the nature of the vulnerability. In some cases there was no evidence of a vulnerability assessment even having been undertaken.

3.8. YOS and other children's services teams did not routinely share information that could inform assessments. Neither YOS case managers nor social workers appreciated the extent to which they could comprehensively inform the other's assessments. For example, most social workers we spoke to did not know that the YOS completed Asset assessments and had no idea of the extent to which they could have drawn upon these to inform initial and core assessments.

3.9. Neither sentence plans nor child care plans reflected the holistic needs of children and young people. Plans tended to include only objectives related specifically to the service drawing them up rather than including integrated aims for jointly achieving sustainable outcomes.

Case example – plans integrated child care and offending related matters

We saw one particularly good example of risk and vulnerability management plans that fully integrated child care issues alongside offending relating matters. The case manager had clearly linked placement changes and arrangements for contact with family members with potential escalations in the risk to others and of vulnerability. This practice demonstrated the potential for more integrated working, and a good level of understanding by the case manager of the broader issues.

3.10. We saw examples of extensive case consultation between YOS staff and social workers elsewhere within the local authority. Generally there was good attendance by social workers at YOS risk management panels and by YOS staff at Looked After Children reviews, Child Protection conferences and core groups as well as other professional meetings.

3.11. YOS referrals to the Duty & Assessment Team were not of good quality; they did not clearly articulate the risks and needs of children and young people. Similarly other children's social services teams were not good at sharing the outcomes of assessments and plans with YOS case managers in a timely manner or communicating decisions about case closures or placement changes.

3.12. Sometimes there were tensions between the YOS and social workers in other children's services teams particularly around key decision making, for example around whether a referral would be accepted. Clearer escalation routes were required for dealing with these.

Work to protect girl from possible sexual exploitation

Jodie was a 14 year old girl with very complex needs, who was displaying sexualised behaviour, regularly went missing and threatened to self-harm. The YOS assessed that she was at high risk of sexual exploitation and the relevant referral was made to Operation Artemis, a police-led operation to investigate possible cases of child sexual exploitation. An officer from the unit attended the YOS risk management panel. It was agreed that as part of the vulnerability management plan the officer would investigate Jodie's internet access in order to ensure she was not in contact with potential abusers. This was a good example of joint work to protect the child or young person following assessment by the YOS.

3.13. Generally the effectiveness of joint working between YOS and other children's services teams was limited. The consequences for children and young people were at best a disjointed service and at worst led to confusion and gaps in provision. Social workers in Children & Families teams were often not aware of the mental health or substance misuse resources available to children and young people being supervised by the YOS.

3.14. Current local authority policy prevented the YOS making use of the Prevention Team to help support children and families who did not meet the threshold for statutory social services involvement. This helps to explain why, elsewhere in this report, we have said that the YOS spent too much time addressing welfare issues, causing case managers to be diverted from undertaking effective work to reduce offending.

3.15. There was good liaison between the missing person project and the YOS, for example with a worker from the project attending the YOS risk management panel. However, the missing person database, Missing Individual Risk Assessment (MIRA), was not routinely checked and scrutinized by case managers.

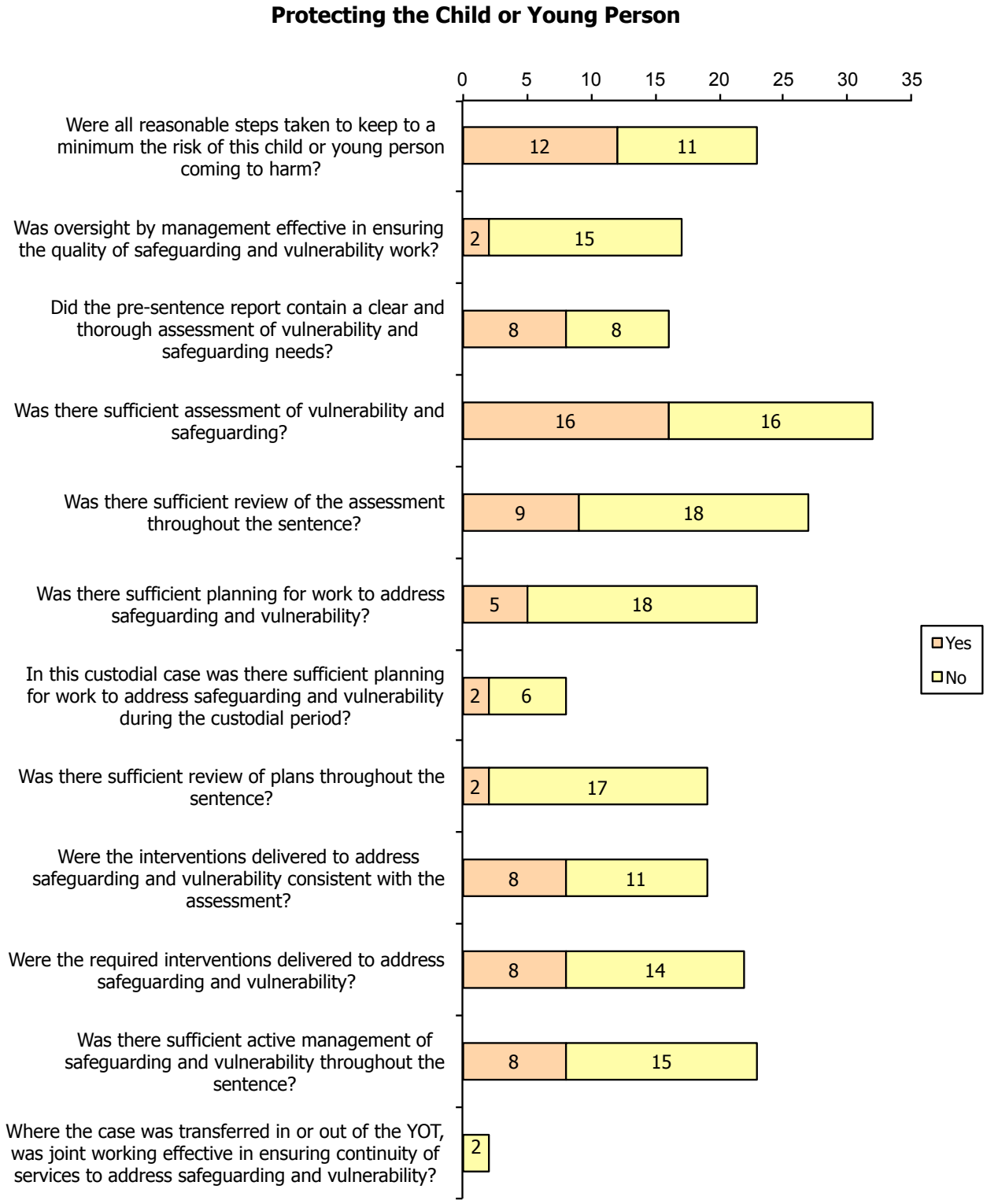
3.16. YOS support and administrative staff had not received training in the contribution they could make to safeguard children and young people and reduce their vulnerability.

Summary

Overall work to protect children and young people and reduce their vulnerability was poor. The cause was often that vulnerability was considered solely with respect to child protection and deliberate self-harm, and ignored other risky behaviour such as use of alcohol or drugs, including when this was linked to offending behaviour. Ironically, in view of the priority given to welfare needs recognised elsewhere in this report, case managers did not recognise the broader understanding of vulnerability that applies throughout the youth justice system. Attention needed to be given to more effective joint working with Newport children's social services, including by ensuring that referrals made by the YOS are of good quality.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 32 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Ensuring that the sentence is served

4

Theme 4: Ensuring that the sentence is served

What we expect to see

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

Case assessment score

Within the case assessment, overall 62% of work to ensure the sentence was served was done well enough.

Key Findings

1. Staff generally knew their children and young people and got on well with them.
2. Children and young people were not involved enough in developing assessments and plans, and understanding the changes that they needed to make in their lives.
3. Plans, including referral order contracts, were not meaningful to children and young people.
4. Not enough attention was given to speech, language and communication needs, and other diversity or potential discriminatory factors.
5. The purpose of the compliance panel was not well understood by staff or managers.
6. Not enough was done to encourage children and young people to take responsibility for their own compliance.
7. The initial response to incidents of non-compliance was appropriate.
8. Health workers worked hard to engage effectively with children and young people, but there was no routine health screening.

Explanation of findings

4.1. Staff generally knew the children and young people and got on with them well. However, that is not a substitute for effective engagement of them and their parents/carers in actual work to reduce reoffending and protect the public. More attention needed to be given to ensuring that children and young people had sufficient opportunity to contribute their views on the causes of their offending and have these clearly reflected as part of the initial assessment.

4.2. It is the child or young person who has to make changes in their behaviour so that they stop offending and are less likely to cause harm to others. Case managers did not involve them enough in determining the priorities for change, helping them to understand why changes were required, and ensuring that they knew precisely what needed to be done to enable them to happen. Children and young people should clearly understand the agreed plan, and their views on how change can be achieved reflected in how work is planned and undertaken. Substantial improvement was required in all these when planning the work in the case.

4.3. Children and young people were sufficiently involved in development of the PSR in only half the relevant cases, primarily because the YOS had not ensured that they understood the PSR before it was used in court.

4.4. Almost three-quarters of PSRs gave sufficient attention to diversity factors or barriers to engagement with the sentence. However only half the relevant plans gave sufficient attention to these. Often the plans didn't address the impact of factors that had already been identified.

Comment from young person illustrating why clearer planning is sometimes needed to respond to diversity factors

"I don't remember things well . . . it would be good if we met the same time each week instead of different days . . . I get confused because it is different all the time"

4.5. Referral order contracts are an agreement between the community panel, the child or young person, and their parents/carers. Children and young people were not automatically provided with a copy of the agreement that they had signed, which is unacceptable. Neither were contracts written in a way that enabled the child or young person to make a truly informed decision about what they were signing

Meet and greet prior to referral order panels

The YOS operated a meet and greet approach prior to referral order panels whereby a volunteer would welcome the child or young person to the building and put them at their ease before taking them into the panel. They also ensured that they understood the report that had been written. This was effective in improving their involvement in the discussions at the panel.

4.6. We considered that sufficient attention had not been given to health and well-being outcomes, in particular as they may act as a barrier to a successful outcome from the sentence, in a third of relevant cases. For example systems to assess and plan for additional learning needs were poor. Access to services such as speech and language, educational psychology and behaviour support were too limited. Children and young people with poor skills in literacy and numeracy did not always get the support they needed.

4.7. No physical health screening took place and case managers had not received training regarding physical health. Overall assessment of physical health was insufficient. In 2012 the school nurse service had offered to conduct physical health and immunisation screening in the YOS. This had not been implemented. It is critical that physical health screening is offered, as these children and young people do not always access mainstream services. This can also contribute to the quality of assessments.

4.8. There was no formal sexual health provision for children and young people who attended the YOS. If a need was identified the child or young person would be supported to access generic sexual health services. However, the YOS did not offer routine sexual health screening.

Case example - Helping stop use of cash card to obtain money for drugs

Jo used his cash card to withdraw money to buy drugs. He wanted to stop doing so. The substance misuse worker discussed the reasons why Jo wanted to stop taking drugs and devised pictures to depict these reasons. He then produced a laminated credit card size note with the pictures for Jo to keep on top of his cash card in his wallet. Jo reported that this helped him to stop and think when he was at the cash machine and ultimately reduced his drug use.

4.9. Children and young people were not routinely screened by the YOS substance misuse worker, since he only worked with those where the case manager had identified a link to offending behaviour and had made a referral to him.

4.10. We recognised that frequent use of home visits was sometimes appropriate; however too much use was made of them. Sometimes more needed to be done to ensure that the child or young person took some responsibility, for example through agreeing to meet at a community venue rather than relying on the case manager to visit their home. In general we observed that case managers sometimes allowed too much flexibility and didn't hold children and young people to account sufficiently for their compliance. More sometimes needed to be done to motivate the child or young person and to overcome barriers to compliance. However, when a child or young person didn't comply with the requirements of the sentence the initial response was sufficient in just over two-thirds of relevant cases.

4.11. The YOS operated a compliance panel. Its intention was to ensure that the reasons for non-compliance were understood, barriers to compliance were addressed and appropriate defensible actions put in place. This was a good idea which operated well in many YOTs. However it was clear from case assessments and from observation that the panel was neither effective nor its purpose well understood. There were a number of examples, for instance, where a child or young person hadn't turned up for their compliance panel, without a reason being provided, but where no robust plan of action then followed. In such cases we would normally expect to see either a decision to move to breach proceedings, perhaps whilst further efforts were made to understand the reason for non-attendance, or at a minimum a clear plan to seek to re-engage the child or young person prior to a final decision on breach. In such circumstances it is difficult to understand how "hope they will attend another appointment" is a sufficient response, however a response similar to this was found on a number of occasions. On referral orders, decisions about response to non compliance ultimately lie with the panel; however panel members reported that concerns about compliance were rarely brought to them.

4.12. In a few cases, young people provided feedback about the ETE provision they attended and this had resulted in a change of placement. However, overall the YOS did not pay good enough attention to listening to the views of children and young people about the quality or suitability of the ETE they received. The completion rates for children and young people attending the various kinds of provision were low. Older children and young people attending work based training were often not ready for this move and did not receive the support needed to help them successfully make this transition.

Support to attend ETE placement and change behaviour

Lee received a new sentence following breach of his previous one. This included an education requirement. The case manager took a positive approach to his work with Lee such that compliance for the new sentence was excellent. Work included providing transport to school to help develop a positive routine; addressing any disruptive behaviour in ETE as part of YOS supervision sessions; and ensuring that YOS sessions were matched to Lee's low attention span. Interventions specifically addressed the reasons behind Lee's offending. Support was provided to Lee's mother to assist her in motivating him to comply with his sentence. Lee made substantial improvements to his behaviour and had not reoffended to date.

4.13. As children and young people cannot normally be required to undertake treatment for health issues, effective engagement is critical to the success of the intervention. Health workers worked well with them and offered good flexibility in order to maintain this. We saw creative efforts by both of them. There was evidence that they would see children and young people in a variety of environments. For example, the substance misuse worker would discuss a young person's substance misuse whilst kicking a football about. The clinical nurse specialist would meet a child or young person in the town centre if they were concerned about attending the YOS. These were intended to help children and young people feel more comfortable and improve engagement.

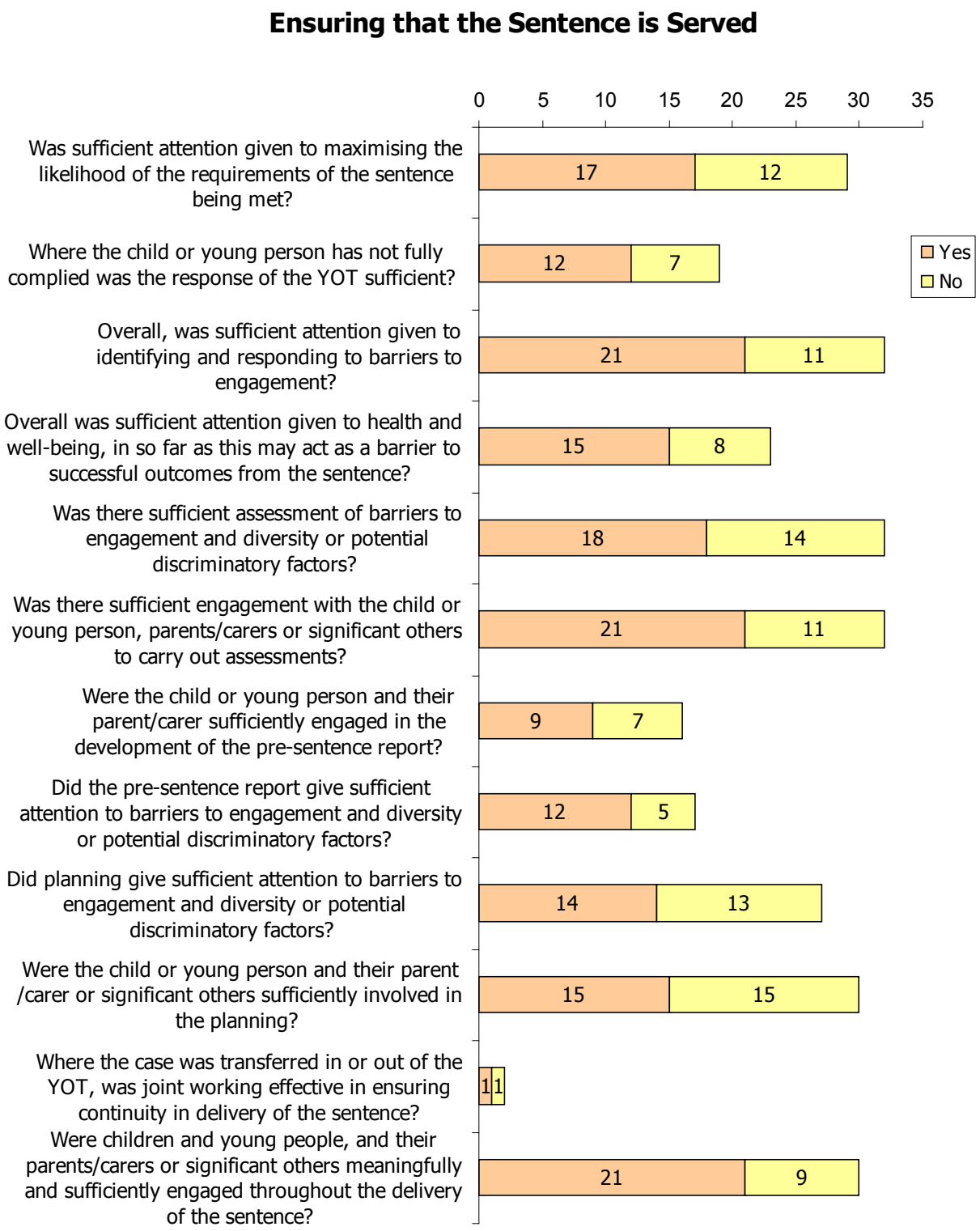
4.14. Staff had not received sufficient training in assessing speech and language difficulties. Therefore they could not be sure that the methods used to communicate with young people always met their needs. It was positive that some staff had received training in working with those with Autistic Spectrum Disorders; and although there had not been sufficient training, some staff were aware of issues faced by those with dyslexia.

Summary

Overall work to ensure that the sentence was served was unsatisfactory. Staff knew the children and young people well; however they did not involve them sufficiently in assessment and planning for the changes they needed to make in their lives. More could be done to ensure that children and young people took greater responsibility for their own compliance with the sentence. The YOS compliance panel was not effective. However, when children and young people didn't comply with their sentence the initial response was often appropriate.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 32 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. These enable the YOT to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

Key Findings

1. Governance and leadership arrangements had not ensured that work to reduce offending was effective and of good quality.
2. Insufficient attention was given to the quality of work by the Management Board and managers.
3. Youth justice had a high profile in key local partnership plans.
4. The data used by the management board was not sufficient to enable it to hold the YOS to account for current performance.
5. Substantial improvement had been made in the number of children and young people entering the youth justice system for the first time.
6. The YOS management team did not work effectively together.
7. The work of YOS police officers did not make the most effective use of their skills.
8. Structural links between the YOS and Newport Children's Services were not effective in ensuring good joint working.
9. There were insufficient positive educational outcomes for children and young people known to the YOS.
10. Insufficient attention was given to the availability of services using the Welsh language.
11. Little emphasis was given to the monitoring of outcomes in order to improve services.
12. Service users were not routinely asked for their views, in order to improve services.

Explanation of findings

5.1. Leadership and governance – criminal justice and related objectives are met

5.1.1 Governance and leadership within the management board and within the YOS had not been effective in significantly reducing reoffending, nor in ensuring that the core practice in the YOS was acceptable. Reoffending rates remained high in comparison to many other areas in England and Wales.

5.1.2 We were pleased to see youth justice clearly identified within the Newport Improvement Plan and the Single Integrated (partnership) Plan – indeed to see it identified so clearly is unusual. More work was needed to develop measurable meaningful objectives that supported effective performance management and accountability at an operational level.

5.1.3 The YOS Management Board had broad representation and a good attendance rate, although sometimes the named representative should attend more consistently, rather than send a substitute. The board was chaired by the Chief Executive of Newport City Council. This was a positive decision that provided an important signal about the importance of this work.

5.1.4 Members reported that board meetings were a safe environment where positive challenge was welcomed, and that there was an open and healthy relationship between them. This was supported by minutes from board meetings.

5.1.5 The board focused on monitoring achievement of outcomes, through the quarterly balanced scorecard. However there was too much data and board members didn't understand much of it, which meant they were not able to use it effectively to hold the YOS to account for its performance. There needed to be a greater focus on producing information that helped explain performance and so more usefully informed the Board's response to core performance issues (e.g. why isn't performance as we would want, or what made the difference?).

5.1.6 There was no routine attention by the board to the quality of practice. This was a substantial omission and needed to be a systematic part of the agenda.

5.1.7 Members recognised that data often represented historical performance, and that more current outcome measures needed to be developed. It is important that this work is given some priority, to help the board respond to current performance.

5.1.8 More needed to be done to support use of the Welsh language. There had been no recent reference to this in the Board. There was nothing within the YOS reception to indicate that it was positive about providing services in Welsh. Neither was the Welsh language incorporated into telephone or other greetings. There was no guidance about how to respond if a Welsh speaker called the YOS.

5.1.9 The police were well represented on the board, by a Superintendent (local commander) and the partnership Inspector. This showed both a strong commitment to the YOS and representation at an appropriately senior level.

5.1.10 There was health representation on the board but this was only in relation to emotional and mental health. There was no representation of other health services. We were informed that *"health is rarely on the agenda"* at meetings and that health is *"rarely seen as an issue that needs any attention"*. Without systematic and regular information about all services, the board cannot effectively assess the effectiveness of the work nor decide which services to commission.

5.1.11 The education representative was new to the role and so it was too soon to say how effectively she would raise the profile of education and improve resources and service delivery.

5.1.12 Probation had historically made a positive commitment to the work of the YOS and the board, although at the time of the inspection it was unclear how this would be taken forward due to the substantial changes underway in Probation.

5.1.13 The YOS manager contributed at local level to the work of the regional Children's Safeguarding Board and ensured that links were made between this wider safeguarding agenda and the work of the YOS Management Board.

5.1.14 At a strategic level the YOS was not sufficiently well embedded into wider structural arrangements for children's services. Specifically in the last 12 months, senior managers recognised that some of the other competing demands faced by children's services had taken precedence over YOS business.

5.2. Partnerships – effective partnerships make a positive difference

5.2.1 At a strategic level the links between the YOS and the management board into local partnerships were broadly positive.

5.2.2 The recent significant reduction in first time entrants to the youth justice system was impressive, albeit from a low base. It was evidence of how local partnership working can be effective. It served to build confidence and understanding between partners.

5.2.3 Disposal decisions, in most instances of low level offending by children and young people in Newport without a previous criminal record, were made by a YOS police officer. This had helped ensure a consistent and creative approach. In combination with the 'bureau '[1] it had meant that all restorative

1 Newport bureau consisted of a senior police officer, a YOS case manager and a community member. Offences by children and young people were referred to the bureau for an initial disposal decision unless they were of sufficient gravity that they could only be dealt with by the courts. The bureau received a report about the child or young person and would decide whether to issue a formal caution or conditional caution, together with referral to relevant agencies if appropriate, or to refer the case for prosecution.

justice disposals, and a high proportion of cautions issued, led to appropriate referral for early intervention work through local authority prevention services. This had coincided with a significant reduction in first time entrants to the criminal justice system and was believed to be the main reason for this.

5.2.4 Newport operated a bureau approach to most other instances of offending by children and young people. The bureau panel decided the initial disposal. Whilst the bureau process was observed to run effectively, the effectiveness of the interventions arising from it was less clear. There was no routine monitoring or evaluation of the outcomes determined at the bureau and no analysis had been conducted, to date, of its effect on reoffending; although the new YOS plan recognised that this needed to be developed.

5.2.5 Two police officers were seconded into Newport YOS. This represented an appropriate level of resourcing. The officers were well regarded by colleagues in the YOS, and recognised as part of the team. They spent the vast majority of their time conducting victim contact and supporting the bureau. It is unusual for police YOS staff to be utilised in this way and it did not make effective use of their skills.

5.2.6 In particular it was not in line with the joint Association of Chief Police Officer (ACPO)/ YJB guidelines on police officer deployment in a YOT. These place greater emphasis on information exchange including close liaison with neighbourhood policing teams, supporting management of higher risk of harm cases managed by the YOS, managing cases on the Integrated Offender Management cohort and assisting case managers in locating and dealing with children and young people who are in breach of their order. Whilst some of these were happening on occasions, the time left for this was restricted. The role should be amended so that it has sufficient focus on the critical areas of work highlighted above, and makes a more substantial contribution to reducing the vulnerability of children and young people, protecting the public and reducing reoffending.

5.2.7 Involvement of the YOS management team at children's services team manager meetings was limited; this meant that YOS managers were not well informed about developments in the wider environment. YOS workers and social workers in other children's services teams did not have a clear understanding of each others' roles and responsibilities. We were pleased to note the very recent initial draft of a joint working policy between YOS and children's services, and hope that implementation will bring about more effective working relationships.

5.2.8 Confusion about access to secure e-mail and about YOS staff access to the children's services case management system (CCM), coupled with a lack of confidence by YOS staff in using CCM, hampered the effectiveness of information sharing between YOS and wider children's services teams.

5.2.9 The YOS worked well in partnership with a range of providers to ensure that children and young people received appropriate education and training. However, many of those of statutory school age were not receiving the required hours and some only received a few hours of education. There was an equally unsatisfactory picture for those above statutory school age with a lack of options suited to the needs of this group. Not enough was being done to persuade employers and training providers to engage with YOS children and young people.

5.2.10 Overall, the local authority did not pay enough attention to improving educational outcomes for children and young people known to the YOS. It did not take good enough account of the needs of children and young people who had offended in its strategic planning processes. It did not routinely collect or analyse data on their educational performance or prioritise them as a group requiring specialist support within inclusion service plans.

5.2.11 The local authority 'Managed Moves Panel' worked effectively to find suitable provision for children and young people with behaviour and attendance problems. The panel included the YOS education worker. Panel members valued her contributions and the good quality information she provided. This helped them refer children and young people to appropriate provision.

5.2.12 There had been a lack of continuity in education support at the YOS due to periods of maternity leave. The education department had provided inadequate cover. This had significantly disrupted the support that partner agencies received from the YOS, and the quality of assessment and planning within the YOS.

5.2.13 Service level agreements were in place with Aneurin Bevan Health Board who employed the clinical nurse specialist, and with Barnado's who employed the substance misuse worker. Both were out of date. Regularly reviewed up-to-date agreements would help ensure that services remain appropriate to the YOS needs.

5.2.14 Newport YOS were well engaged in local Integrated Offender Management (IOM) arrangements at both strategic and operational levels.

5.3. Workforce management – effective workforce management supports quality service delivery

5.3.1 The YOS management group did not work well as an effective management team. Managers adopted differing approaches to the role of a YOS and its priorities for reducing offending and thereby making a difference to the life chances of the children and young people with whom it works. Staff were aware of contradictory messages sometimes exhibited by managers. There was consequent confusion amongst staff about what was expected, and this affected the performance and cohesion of the YOS team as well as being disempowering to other managers. Ensuring that the management group works effectively is critical to the YOS's ability to make rapid and sustained improvement.

5.3.2 There was no systematic or consistent approach to ensuring quality of practice. Supervision records and discussions with staff indicated that managers took very different approaches to this. Where quality assurance was undertaken this sometimes related more to checking that processes had been applied rather than challenging the quality of work. Where the quality of work had been reviewed, the same issues were often identified in subsequent records, with insufficient evidence that effective action had been taken to address them.

5.3.3 The YOS was not included in well established performance management and quality assurance activities routinely carried out in children's services; a deficit which also hampered senior management's awareness of YOS performance.

5.3.4 There was a good system for managing the health staff. The nurse specialist was clinically supervised by the mental health lead for Gwent, and operationally supervised by the YOS manager. The substance misuse worker was supervised by both his line manager from Barnardo's and the YOS manager. Both workers received regular supervision and felt well supported.

5.3.5 Induction of the most recent police officer into the YOS was insufficient. It was undertaken over two weeks but primarily involved spending time with a range of individuals with whom she was going to work, with no core training suitable for the role, for example child safeguarding or on the case management system.

5.3.6 It was noticeable that the level of administrative support available to the YOS, relative to its size, was substantially less than we often find. Indeed there was a lack of co-ordination of many aspects of work, which in other YOTs would often be the responsibility of administrative staff.

5.3.7 There had recently been a reduction in the resources available to address ETE needs in the YOS. Whilst there was still an education worker post, this was now only funded for 1 ½ days each week. This had considerably reduced the time available for work with children of statutory school age. The post was to be line managed through the social services department. This left the worker without adequate professional support and supervision from the education department.

5.3.8 The arrangements for Careers Wales had been reviewed and a worker attended for one afternoon every two weeks. YOS workers had increased their referrals and this new arrangement appeared to be successful.

5.4. Learning organisation – learning and improvement increases the likelihood that positive outcomes are achieved and sustained

5.4.1 Staff that we met were committed to children and young people, generally enthusiastic and wanting to learn and improve.

5.4.2 The local education authority did not include services provided through the YOS within its self-assessment arrangements. Senior managers did not monitor or review plans, interventions or outcomes for children and young people who offended. The YOS had appropriately produced an action plan that contained education improvement objectives. However, these did not have measurable targets and there was no clear picture of how well children and young people involved with the YOS were progressing with their education.

5.4.3 There were no clear systems to monitor and therefore ensure the quality of health services provided to children and young people. Outcomes were collated for substance misuse work in order to satisfy funding criteria. Outcomes were not collated for the work of the clinical nurse specialist. In neither case was there any direct evaluation of whether this work reduced reoffending.

5.4.4 Routine use was not made of data from Asset assessments, nor was the impact of the delivery of interventions used, to monitor improvements in the different aspects of work that may be related to offending.

5.4.5 Staff did not carry out baseline education assessments and as a result could not measure the progress made by children and young people. The YOS did not collect data on educational achievement in order to monitor outcomes.

5.4.6 The YOS did not routinely seek and use the views of service users to improve its services, although it recognised that it needed to address this.

Summary

Overall, the effectiveness of governance and partnership arrangements was poor. The Management Board had not ensured that work to reduce offending was either effective or of sufficient quality. Nor was the information used by the management board useful in supporting this. Newport had achieved substantial reductions in the number of first time entrants to the youth justice system, and we were pleased to see that youth justice was reflected in key local plans, although there was further work to be done to ensure that these could be monitored effectively. The offer of services through the medium of the Welsh language needed to be more routine. There was no robust or consistent approach to ensuring the quality of practice, and staff were confused by mixed messages. Complacency had developed about the importance of ensuring good quality practice and morale was low. Resolving these problems was critical to achieving sustainable improvement.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

What we expect to see

We expect to see a broad range of quality interventions delivered well, clearly linked to appropriate assessments and plans and which maximise the likelihood of sustainable reductions in reoffending being achieved. There should be good quality engagement with children and young people and their parents/ carers at all stages of the work, so as to maximise the likelihood of positive change being achieved. Effective leadership and partnership work needs to be evident in the delivery of interventions.

Case assessment score

Within the case assessment overall 43% of work related to the delivery of interventions to reduce offending was done well enough.

Key Findings

1. Newport YOS had not been effective in reducing reoffending by children and young people.
2. There was little evidence of good quality interventions designed to reduce reoffending being delivered, although there were some examples of creative and positive work.
3. There was insufficient determination to ensure effective work to reduce reoffending.
4. Assessment and planning required substantial improvement.
5. Case managers were unaware of the range of interventions that may be available to them for work to reduce reoffending.
6. There had not been a systematic approach to acquiring or developing interventions, nor to training staff in their use.
7. Plans were not sufficiently meaningful to children and young people, or to others who may need to use them.
8. Case managers understood the principles of effective practice, but needed to ensure that they adhered to these throughout their work with children and young people who have offended.

Explanation of findings

6.1. The YOS had not been effective in substantially reducing reoffending by children and young people in Newport, although there had been positive outcomes in some individual cases.

6.2. As described elsewhere in this report there was little evidence of good quality and effective interventions having been delivered. Much more determination was needed to ensure that an appropriate balance was struck between dealing with welfare

Comment from children and young people on interim outcomes from their work with the YOS

"it made me realise how the other person I robbed felt wasn't very nice . . . I felt mean afterwards"

"They have helped me have a better relationship with my Mam . . . I am really happy with this"

". . . .my friends are bad influences on me . . . the tag has helped me because I've had to change my friends. I can't go out [in the evening], which is when they go out."

needs and undertaking work to reduce reoffending in individual cases; so that case managers could be effective in their primary role to reduce reoffending, which was critical both to the residents of Newport and to the future opportunities for the children and young people with whom they worked.

6.3. Neither was sufficient attention given to ensuring that any positive outcomes were sustainable following the end of the sentence.

6.4. Whilst case managers knew individual children and young people well, and often got on with them well, this was not always the case. The following quotations from children and young people will help illustrate this:

Comment from children and young people

"I really like my case manager . . . I feel like I can go to [him] with anything. He listens to me and understands me"

"I don't like telling them anything because I don't trust them . . . I feel like their judging p?!&s me off"*

"Yes, they're alright . . they are helpful . . they keep regular contact as well .."

6.5. Overall, assessment of offending related behaviour and planning for work to reduce reoffending were poor, making it unlikely that the most appropriate interventions would be identified and delivered. Assessment of the suitability of the child or young person for specific interventions was apparent in only a third of cases.

6.6. Few intervention plans clearly indicated what tools or resources would be used to achieve the intended outcomes. There was also little evidence of the child or young person having been involved in the development of the plan.

6.7. We seek to observe the delivery of work to reduce reoffending during the inspection. No opportunities were provided to us to do this, and when case managers were asked to identify opportunities they were unable to provide them for us. Whilst there was some evidence of creative interventions having been delivered, there was little evidence of good quality materials being used.

6.8. There had not been a systematic approach to the acquisition of interventions to address offending related behaviour. Case managers were not aware of the range of interventions that colleagues used. Neither was there anything available to staff to help them match a specific child or young person's offending and diversity characteristics to the most appropriate intervention. Overall case managers considered that they didn't have a suitable range of interventions available to them. In particular they said that more attention needed to be given to ensuring that interventions were age appropriate.

Use of DVD to address shoplifting

Jade was convicted following a shoplifting offence which was motivated by a desire to be like her friends, but without the money to achieve that. The case manager used a DVD showing the impact of shoplifting as the means to prompt a detailed discussion about the impact that shoplifting had on others. Seeing the impact and discussing it with her case manager had a positive effect on Jade.

6.9. Case managers recognised that they needed better training in the range of interventions available and how to deliver them, along with better support to target them effectively.

6.10. In particular they had not received sufficient training to support them in identifying and responding to speech language and communication needs, nor in wider diversity or potential discriminatory factors. The impact of this was apparent in assessments and plans, where only just over half had given sufficient attention to diversity factors and barriers to engagement. In combination this meant that case managers could not be confident that they were able to undertake work with children and young people who have offended in a way that would maximise the likelihood of a positive outcome from that work.

6.11. All case managers that we spoke to had a sufficient understanding of the principles of effective practice with children and young people who have offended; however, too often these principles were not being applied in the way that work was undertaken. The substantial lack of review of assessments, plans and interventions was an example of this. Overall only a quarter of cases included interventions delivered in line with effective practice.

Comments from children and young people

"When they agree a time to meet they should stick to it . . . it gets annoying when they don't"

"I don't think they all work as a team because nobody ever knows what's going on man"

"We get on when it is my normal case manager, but [sometimes] I get different [ones] . . . they don't tell me when they are sending someone else"

"Yes, they're alright . . they are helpful . . they keep regular contact as well . ."

6.12. It is important that case managers model pro-social behaviour when working with children and young people, and that children and young people understand that all the professionals they are working with are equally committed to them and co-ordinate their work with each other. The following quotations illustrate that this was not always the case.

6.13. A number of children and young people gave negative comments on the quality of the YOS premises. For example one said *"I hate coming to this building, look at it, it's horrible . . ."*

Summary

Overall work related to the delivery of interventions to reduce reoffending was poor. We struggled to find focused offending behaviour work being delivered. Staff did not have satisfactory tools to assist them to understand what interventions were available, and to target these appropriately to individual children and young people. There was no systematic planning to the acquisition of interventions, or to evaluating what interventions may have made a difference. Assessment and planning both required substantial improvement. More attention needed to be given to speech, language and communication and other relevant diversity factors.

Appendices

Appendix 1

Contextual information about the area inspected

Newport had a population of 145,736 as measured in the Census 2011. The youth population (those aged between 10 and 17 years old) accounted for 10.4% of the population. This was higher than the average for England and Wales as a whole, which was 9.5%.

The percentage of the youth population with a black and minority ethnic heritage was 13% (Census 2011). This was lower than the average for England and Wales, which was 18.3%.

Reported offences for which children and young people aged 10 to 17 years old received a pre-court disposal or a court disposal in 2012/2013, at 28.9 per 1,000, were higher than the average for England and Wales of 18.5 (Youth Justice Board 2012-2013).

Youth Justice Board indicators

The Youth Justice Board indicators are national measures of YOT 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 Newport was 37.6%, worse than the 35.5% for England and Wales as a whole.

(ii) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a Class A drug on arrest, the average number of reoffences within 12 months, per 100 such children and young people. For Newport, there were 1.22 offences per child or young person who reoffends, worse than the 1.02 for England and Wales as a whole.

(Data based on April 2011 to March 2012 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 to 17 year olds in the general local population. The figure for Newport is 611, compared to 444 for England and Wales as a whole.

(Data based on January 2013 to December 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 to 17 year olds in the general local population. The figure for Newport is 1.35, compared to 0.51 for England and Wales as a whole.

(Data based on April 2013 to March 2014 cohort)

Appendix 2

Contextual information about the inspected case sample

In the first fieldwork week we looked at a representative sample of 32 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	Ian Menary, *HM Inspectorate of Probation*
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Inspection Team	Tony Rolley, *HM Inspectorate of Probation*
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	Oliver Kenton, *Assistant Research Officer*
	Alex Pentecost, *Support Services Manager (Communications)*
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:

12th May 2014 and 2nd June 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.

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.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

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.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

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:

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

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
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.justiceinspectorates.gov.uk/hmiprobation

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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