

Full Joint Inspection of Youth Offending Work in Wakefield

An inspection led by HMI Probation



Foreword

This inspection of youth offending work in Wakefield 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 (YOTs) 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 Wakefield YOT because analysis showed their performance had previously deteriorated in relation to reducing reoffending.

We were pleased that Wakefield YOT has achieved a reduction in the numbers of children and young people reoffending. The quality of work with children and young people who had offended has improved considerably since our last inspection in 2010. The YOT Management Board and management team have worked innovatively and mostly effectively to deliver better performance, but need to ensure that the quality of work continues to improve, gives sufficient focus to protecting the public, and is consistent across the YOT.

The recommendations made in this report identify the key areas where post inspection development work should be focused. They are intended to assist Wakefield YOT and its partners in their continuing improvement.



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HM Chief Inspector of Probation

October 2014

Summary

Reducing reoffending

Overall work to reduce reoffending was satisfactory. Reoffending rates had reduced, assessment and planning were good and sufficient focus was generally given to work to reduce reoffending. Work in custodial cases was good and reviews of assessments, plans and interventions were undertaken as required. Health related work was positive, properly linked to reducing reoffending, and attention was given to restorative justice and diversity factors.

Protecting the public

Overall work to protect the public and actual or potential victims was satisfactory. Good assessments took account of the risk of harm posed by the children and young people to others, and children and young people in custody were well served by the YOT. Planning to manage risk of harm to others was not fully effective and thereafter the general quality of work to protect the public was less effective. More attention needed to be given to victims' issues, whether potential or known victims. Improvement was needed to management oversight processes which support effective working, and to the recording of interaction with police colleagues.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was satisfactory. Assessments and work to protect children and young people, and to reduce their vulnerability, was good, but planning required some improvement. Children and young people in custody were well served by the YOT and work related to safeguarding was good, but management oversight of this area of practice was not always fully effective.

Ensuring the sentence is served

Overall, work to ensure that the sentence was served was good. Staff knew the children and young people well and generally involved them sufficiently in assessment and planning for the changes that they needed to make in their lives. Plans needed to be SMARTer¹ and more meaningful to children and young people. Sometimes more could have been done to ensure that children and young people took greater responsibility for their own compliance with their sentence. The YOT compliance panel was not always effective. However, when children and young people did not comply with their sentence the initial response was often appropriate. More attention should have been given to speech, language and communication needs, and although routine health screenings occurred they did not include a cognitive element.

¹ SMART: Specific – target a specific area for improvement, Measurable – quantify or at least suggest an indicator of progress, Assignable – specify who will do it, Realistic – state what results can realistically be achieved, given available resources, Time-related – specify when the result(s) can be achieved.

Governance and partnerships



Overall, the effectiveness of governance and partnership arrangements was satisfactory. Wakefield YOT had achieved reductions in the number of first time entrants to the youth justice system and performed well against other key targets. The information used by the Board was good, but could be further refined. We were pleased to see that youth justice was reflected in many key local plans. Management oversight of work in the YOT was not always fully effective, but the management team worked effectively together. There were good structural links with all key partners and proper attention was given to ensuring positive educational and health outcomes.

Interventions to reduce reoffending



Overall work related to the delivery of interventions to reduce reoffending was satisfactory. Performance had improved in key target areas. There was evidence of the delivery of good quality work designed to improve engagement and prepare children and young people to work to reduce their offending. Staff were committed and enthusiastic, but did not always ensure the delivery of effective work to reduce reoffending as well as to improve levels of vulnerability. Planning required some improvement.

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 rates continue to be reduced and the work of the YOT is of good quality. This should include monitoring outcomes across interventions types, in order to measure their effectiveness in reducing reoffending, to support quality assurance and service development (Director of Children's Services, YOT Manager)
2. The quality and range of information provided to the Management Board on both outcomes and quality should continue to be improved so that it is both comprehensive and useful for effective decision making, and include information from partners such as Health and Education, Training and Employment (YOT Manager)
3. The YOT should ensure that sufficient focus is given to reducing offending in individual cases, alongside addressing the welfare needs of the child or young person (YOT Manager)
4. The needs of victims should be given priority so that they are sufficiently protected through risk of harm work, have sufficient opportunity to contribute to referral orders and receive restorative justice opportunities wherever appropriate (YOT Manager)
5. To maximise the benefits of having a speech, language and communication specialist, the speech and language needs of all children and young people working with the YOT should be assessed, and, where appropriate, additional support provided (YOT Manager)
6. Recording of staff activity on the IT system detailing information sharing with other agencies and supervision of staff should be effective and routinely recorded (YOT Manager)
7. Lessons from training and local serious case reviews should be disseminated thoroughly, ensuring that all staff within the YOT are familiar with these. (YOT Manager)

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Reducing reoffending

1

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 70% of work to reduce reoffending was done well enough.

Key Findings

1. Reoffending rates had reduced.
2. Sufficient focus was given to work to reduce reoffending.
3. Assessment and planning were good.
4. Work in custodial cases was very good.
5. Reviews of assessments, plans and interventions were undertaken as required.
6. Health related work was positive and linked to reduce offending.
7. Proper attention was given to restorative justice and diversity factors.

Explanation of findings

- 1.1. One of the key outcomes for any YOT is the reduction of the number of children and young people who reoffend after receiving an initial conviction. The work of Wakefield YOT was making a sufficient contribution to reducing reoffending. There had previously been poorer performance in this area; this meant that the rate of decline in reoffending had been swifter than the national average, but had started from a worse position.
- 1.2. In order to prevent reoffending, we consider that it is vitally important for each child or young person to be assessed thoroughly and in a timely manner at the very start of the case. The YOT had to analyse the offence and all of the other information about the child or young person, in order to make it less likely that they would offend again. We found that this YOT made a proper initial assessment of the child or young person in over three-quarters of cases. Where they were less accurate, this was because the YOT had missed out important information about the child or young person's family and personal relationships, their living arrangements or their education, training and employment (ETE) status.
- 1.3. The Focus team (co-located from the Child and Adolescent Mental Health Services team (CAMHS)), when requested, would also carry out assessments and provide information to the Court about the suitability of different secure placements for a child or young person. It was apparent that a focus was given to these more complex and often higher profile cases, which ensured that the child or young person in custody was not forgotten by the YOT.
- 1.4. The quality of planning undertaken in custodial institutions was better than we often find. Most plans included work to address offending behaviour and responded to the assessment undertaken by the YOT. The YOT worked hard to ensure a smooth transition back into the community. We were impressed that the YOT worked jointly with the staff of the Young Offender Institution (YOI) at

Wetherby, delivering interventions which were followed up in the community. Transition plans for those leaving custody also contained the appropriate planning to ensure educational engagement was sustained on release.

Persistence in supporting a young person in custody

Tom was given an 18 month Youth Rehabilitation Order (YRO) for burglary (and other offences), but then set fire to his room in his care home, so received an 18 month Detention and Training Order and was sent to Wetherby YOI. Initially, staff at the YOI were not going to place him in the Keppel wing (for particularly vulnerable children and young people), but the case manager undertook an immediate personal visit to explain all of the young person's problems, including behavioural issues, violence, extensive previous convictions. He was later diagnosed as autistic. He had a Statement of Special Educational Needs, is Not in Education, Employment or Training (NEET), comes from a family known to the Criminal Justice System, and had been suicidal, so the YOI changed his allocation to the Keppel wing. Throughout this, the case manager continued to visit, make phone calls to the offender management unit on a regular basis and kept building a good relationship with the young person. As such, the young person had been kept safe, mostly not harmed himself nor committed further offences.

- 1.5. Pre-sentence reports (PSRs) are the main means by which advice is provided to the sentencing court. Over three-quarters of PSRs prepared by the YOT were assessed as good enough; they clearly assessed the risk of harm to others posed by the child or young person, their vulnerability and offered the right advice to the court on alternatives to custody. Oversight processes were robust and ensured that PSRs were of good quality.
- 1.6. In over three-quarters of cases, the YOT gave enough attention to diversity factors and keys to engagement with the child or young person, thinking about how these issues might affect their offending behaviour or their ability to understand and participate in interventions. However, in two cases, there was a lack of emphasis on speech, language and communication.

Good use of diversity factors

Harry had pushed the victim from a bike and then stole it. The victim sustained no injury. Harry was designated a Child in Need with Children's Services due to neglect and was being assessed by CAMHS for Attention Deficit Hyperactivity Disorder (ADHD) and also suspected Oppositional Defiance Disorder at the time of sentence. He had also received a statement for Emotional and Behavioural Difficulties. The identification of diversity issues at the earliest opportunity allowed the case manager to identify positive constructive 'activity based' interventions to engage Harry. The case manager had been able to take into account the age of the young person (12), his statement of Special Educational Needs, his mental health issues and decided creatively to purchase a pack of Super Hero 'Top Trumps' to play with Harry. This not only to effectively engage him in supervision sessions but also to help Harry to think of 'positive personal attributes' to have.

- 1.7. The personal circumstances of many children and young people change quickly, so assessments need to be reviewed to take account of this. We considered that, in the great majority of cases, the initial assessments were reviewed thoroughly and in a timely manner.
- 1.8. Whilst victim contact was undertaken systematically by the Victim Liaison Officers (VLOs), there was no process in place to ensure that the wishes of victims, for example for a letter of explanation or apology, were always reflected through restorative approaches and victim-focused interventions. However, some good work was seen on restorative justice and victims themselves confirmed that they had received strong support, saying that staff had provided "*Great moral support*" and that they "*Could not ask for a better person*". Of particular note was the Parent and Grandparent Group, which offered additional support to grandparents and parents/carers of children and young people who offend.

- 1.9. We also saw a DVD where a victim had been filmed talking about the effect a burglary had had upon her whole family. This was very powerful and was used to help children and young people to understand the effect of their behaviour, to good effect. One young person said *"It made me feel emotional"*.

Good work on restorative justice

John was convicted of robbery and sentenced to a 24 month Youth Rehabilitation Order (YRO) with Intensive Supervision and Surveillance and 3 months curfew. John and two co-defendants had attacked and robbed a lone male in a dark alley at night, whilst intoxicated. John always maintained he did not actively contribute to the serious assault and robbery but was guilty by association. He had no previous convictions and engaged well with his order. He had ADHD and this was problematical when he did not take his medication. We observed some good restorative justice work in this case. The VLO liaised well with the victim who agreed to come in to meet the young person to ask some questions about the assault and robbery. The VLO worked well to prepare the victim for the interaction, the case manager worked on a set of possible questions, and responses, that may occur, with John. For example, John was smirking when answering some questions and said he was nervous. The case manager went through how to deal with the smirking and how John should explain to the victim that he was nervous. The meeting took place in September last year and, although the victim could not attend, it went ahead. The case manager filmed the session and uses it in victim work with other offenders.

- 1.10. When a child or young person reaches the end of their sentence, it is important that the YOT plans to ensure that the good work done can continue to be effective when the child or young person completes their order. In the great majority of relevant cases we inspected, the YOT had thought and planned how to sustain the child or young person's good progress. There were good links with Targeted Youth Support (TYS). Health workers could also continue to work with a child or young person once their statutory order had ended if this was deemed necessary and appropriate.
- 1.11. The work of a YOT to reduce reoffending was the product of contributions from different organisations. For health, we found effective contributions from their representatives, for example, the Focus team offered a consultation process to case managers for cases where they felt there was a need for further help and support.
- 1.12. All children and young people that were made subject to a statutory court order had a health assessment carried out on them using the universal needs assessment as part of the '0-19 years' service, as well as a timely initial screening by the substance misuse team. Aspects of sexual health were covered in the initial health screening including being offered screening for Chlamydia. Further support to access mainstream sexual health services would then be offered if deemed necessary. The YOT also had access to designated Teenage Pregnancy nurses, if needed, and 20 members of staff were trained in the C-Card procedures allowing children and young people to be given sexual health information and condoms.
- 1.13. Proper consideration had been given to the health needs of children and young people and appropriate assessments, referrals and interventions had been carried out. This included supporting families to access mainstream health services. One case manager told us that a *"Real holistic approach was used"* by health staff. It was clearly recorded on the Asset where information from health staff had been used as part of the case manager's assessment. The health needs of children and young people in PSRs were also well assessed.
- 1.14. There was an appropriate pathway in place for children and young people who needed emotional and mental health support to get the necessary further assessments and interventions. This

included a Screening Interview For Adolescents being completed and then a consultation meeting with health staff, which helped to give a coordinated response and ensure that referrals were made to the appropriate services. However, there have been delays and this was currently being reviewed. It is important to be able to offer a swift service to children and young people to ensure that their motivation to engage is worked on at the earliest point possible.

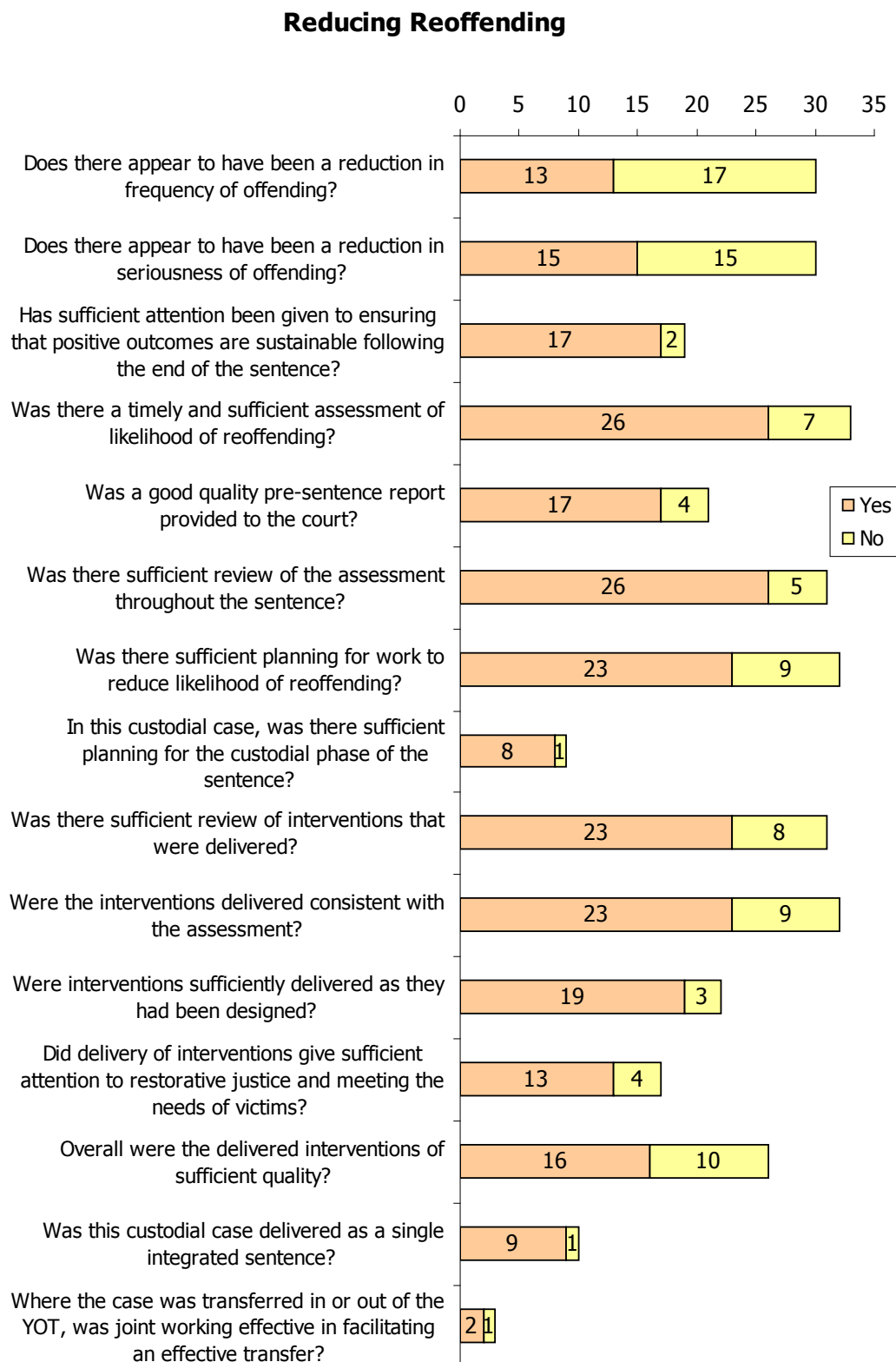
- 1.15. At the time of the inspection, the YOT had two substance misuse workers and there were no delays in children and young people accessing this service. The physical health needs of children and young people were being addressed. The YOT had recently started a six week health lifestyle programme which incorporated healthy eating, exercise, nutrition and personal hygiene. All children and young people open to the Youth Development and Support Service also received a Sports Activity Pass enabling them to access any local authority leisure facility in Wakefield. Health staff had also completed health promotion work such as being part of drugs awareness week and ran a campaign 'New Year New You'. These included links with a local Pupil Referral Unit and sexual health services.
- 1.16. There was a dedicated dual diagnosis worker who was a case manager and held cases where needed. Staff spoke highly of their work. This person would also co-work cases with Focus and received the necessary clinical supervision when this occurred.
- 1.17. The YOT had focused on strengthening the ETE team and this was now well resourced with clear roles and accountabilities. They demonstrated a great level of commitment and a strong focus on meeting the ETE needs of children and young people. As a consequence of this renewed focus, the percentage of children and young people known to the YOT who engaged in ETE activities had greatly increased over the last three years to approximately 80%.
- 1.18. The YOT had developed very good partnerships that benefited the children and young people. Staff at all levels had developed particularly supportive relationships which led to better engagement in interventions. Partnerships in the community were strong and had a clear focus on promoting the need and value of education. The YOT maintained good communications with schools and reacted promptly when ETE interventions failed to engage children and young people and needed to be reviewed. However, some schools did not provide sufficiently comprehensive information on the progress pupils were making, such as attendance and attainment.
- 1.19. We deemed that the ETE provision was good overall. There were comprehensive arrangements to support the pre-16 children in attending education via mainstream schools or specialist, behavioural and alternative provision. The Connexions worker was particularly proactive in gathering a wide source of information on the child or young person as soon as they left court to ensure an effective action plan to continue education or training. Much of the provision for children and young people focused on developing the necessary social and personal skills that would improve their further education and employment chances. Very few children and young people were involved in work or work placements.

Summary

Overall work to reduce reoffending was satisfactory. Reoffending rates had reduced, assessment and planning were good and sufficient focus was generally given to work to reduce reoffending. Work in custodial cases was good and reviews of assessments, plans and interventions were undertaken as required. Health related work was positive, properly linked to reducing reoffending, attention was given to restorative justice and diversity factors.

Data Summary

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



Protecting the Public

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Theme 2: Protecting the Public

What we expect to see

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

Case assessment score

Within the case assessment, overall 66% of work to protect the public was done well enough.

Key Findings

1. Assessments were good.
2. Children and young people in custody were well served by the YOT.
3. More attention needed to be given to victim issues.
4. Planning for work to manage risk of harm to others required improvement.
5. The joint Risk of Serious Harm and Vulnerability Panel, although multi-agency and well run, was not always effective.
6. Reviews of assessments and planning to manage risk of harm to others required improvement.
7. Interaction with police colleagues was not recorded properly.

Explanation of findings

- 2.1. Another key outcome for the YOT is to ensure that the public are protected from the risk of harm to others posed by the child or young person. We were pleased that staff understood the principles behind risk of harm work, but disappointed that they did not apply these sufficiently to their work more often. This meant that this was their weakest area of performance in the inspection. Assessment of risk of harm posed to others by the child or young person was good, although more account needed to be taken of known or potential victims and previous relevant behaviour. Having a good assessment, which gave the YOT sufficient information, meant that well over three-quarters of the PSRs provided to the courts had a clear and thorough risk of harm assessment.
- 2.2. However, the plans to manage risk of harm were not good enough in one-third of cases. Key areas missing included potential changes which could increase the risk of harm, victim issues, the YOT's planned response and contingency plans. In two cases, there were no plans to manage the risk of harm to others.
- 2.3. The work linked to managing risk of harm in over one-third of cases did not match the needs of the case, even where pieces of work had been planned for. However, in custodial cases, sufficient planning had taken place to manage the risk of harm to others and the required interventions delivered.

Integrating work throughout the custodial period and beyond

Mick had committed three robberies and one attempted robbery with others. Mick was the least culpable, but he could have walked away and instead he used violence. It seemed that things in Mick's life had recently started to go wrong and he did not cope with stress well. Mick's accommodation was always going to be an issue, but he was encouraged to maintain family contact during the custodial phase. His relationship with his girlfriend had broken up around the time of custody. However, the case manager ensured the sentence plan included an objective to maintain family contact, and he took Mick's mother to Wetherby YOI to meet her son, for review meetings and, most importantly, to undertake the Building Bridges programme together. The Juvenile Enhanced Thinking Skills programme (JETS) was also delivered at Wetherby YOI during the custodial phase. One of the victims of the robberies had opted into the victim contact scheme and had requested a licence condition precluding the young person from having contact with him. This was included in the licence conditions and the young person had not reoffended since being released from custody last summer.

- 2.4. It is important that the YOT's knowledge of the child or young person is kept up to date. In over one-third of inspected cases, the assessments were not reviewed as required and, in particular, this did not happen after a significant change in the life of the child or young person, such as their release from custody. A review did not happen in two cases, and in other cases more than half of the reviews were not good enough. We considered they were of insufficient quality because they did not ensure the plans were changed appropriately or deficits in the original planning had not been recognised. Some of these plans had been countersigned by managers. Oversight of risk of harm work by managers was therefore considered not effective in just less than half of the relevant cases, mostly because the deficiencies in assessment or planning were not identified and addressed, or necessary work delivered.
- 2.5. We found no evidence of victims coming to serious harm as a result of a lack of focus on the risk of harm to known or potential victims. In one-third of relevant cases, the YOT did not make sure that the risk to victims was thoroughly assessed and victims protected. Plans were not always adequate, nor was the work needed delivered to the child or young person. In two cases, the victim was not identified at all.
- 2.6. During the case assessment, we saw no evidence of communication with YOT police officers in community cases, although it was better in the custodial environment, where proper inquiries were made regarding the wishes of victims when drafting licence conditions. However, it later became clear that this may, in some cases, be a flaw in recording activity by YOT staff, rather than a lack of interaction with the police. This was because partner inspectorates found that there was a 'culture of intelligence sharing' established in the YOT. Case managers apparently asked for, and were provided with, intelligence to inform case management, safeguarding and the management of risk. Intelligence was also being provided to the police from case managers to initiate police action.
- 2.7. The police officer's role in providing intelligence was embedded in YOT and broader processes; they researched and provided intelligence to the Risk of Serious Harm and Vulnerability Panel (Risk Panel), Child in Need, Common Assessment Framework and targeted youth support meetings. There was evidence that staff were not solely reliant upon YOT police constables for intelligence sharing; YOT staff contacted the Integrated Offender Management (IOM) hub and neighbourhood policing teams to gather intelligence, and used the VLO who had access to other police computer systems.
- 2.8. The police officers had a key role in the management of children and young people who were subject to Conditional Cautions or Community Resolutions and they coordinated voluntary interventions. They were allocated the higher risk cases and this was consistent with the 'role of the YOT police officer' guidance. However, YOT staff did not have a dedicated single point of contact for reporting children and young people who were missing from home and were reliant on using the 101 (the police non-emergency) number.

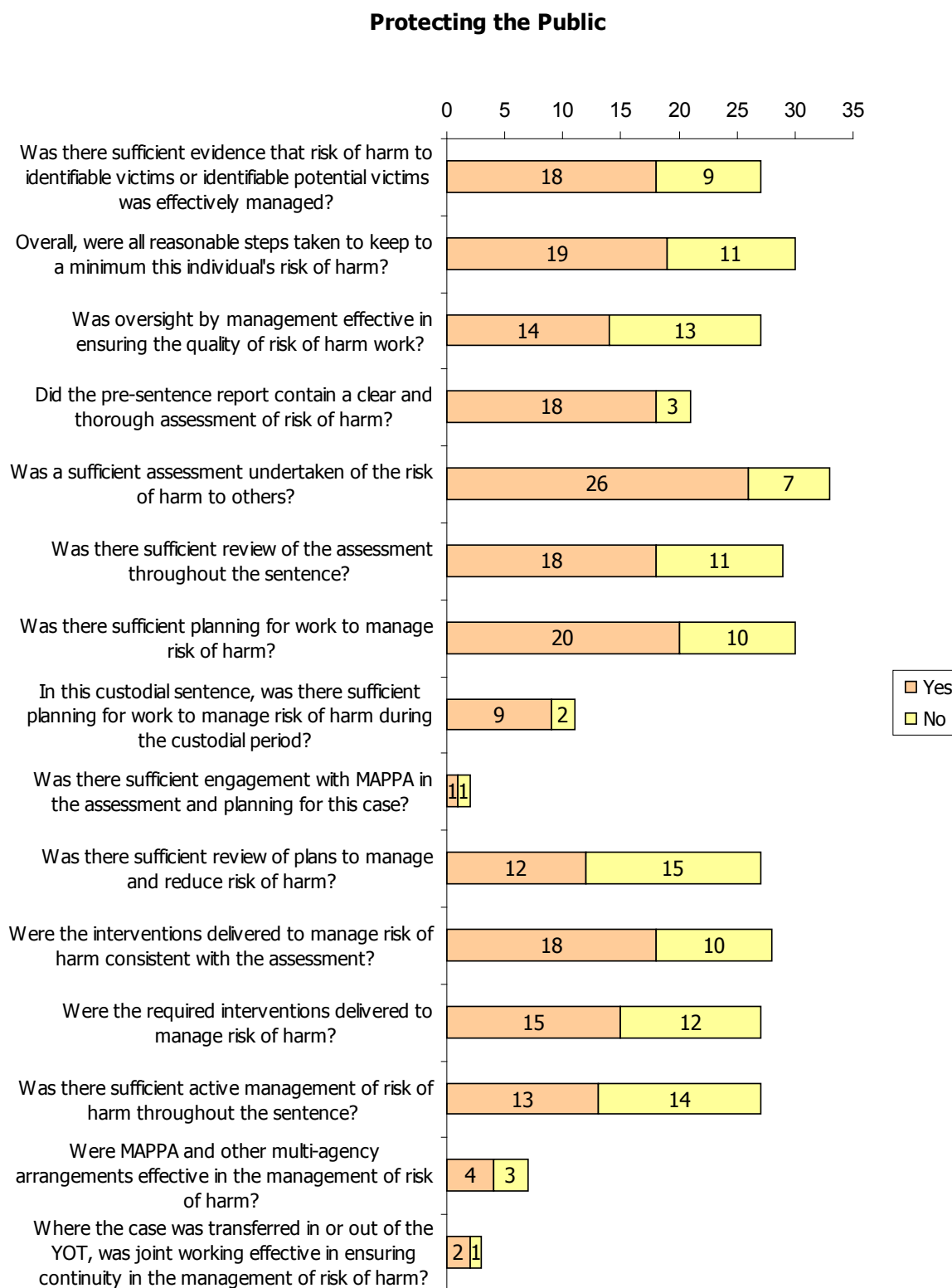
- 2.9. Liaison and diversion work was effective, with YOT staff based in the custody suite. They assessed children and young people coming into custody and, using a wide range of information, advised custody sergeants about appropriate disposals. Where the recommended disposal was a Youth Conditional Caution (YCC) or Community Resolution, the custody record was closed and a referral made to the YOT. The child or young person was researched by the YOT; reviewing YOT and police IT systems. They conducted a home visit and an Asset assessment was completed to inform a disposal recommendation. Where the disposal decision was a YCC, research and an Asset assessment were used to inform the conditions imposed. The same YOT process was adopted where the child or young person was a voluntary attendee or the arrest was out of hours.
- 2.10. The monthly joint Risk Panel contributed to effective oversight and a high standard of work. We were pleased that the YOT operation of the panel had improved following feedback provided by a peer review. The panel that we observed was well run, with contributions from various agencies, good information sharing and clear actions being given for the way the case was to be progressed, although it was not clear that these would always be followed up.
- 2.11. We were concerned that one case had not been referred to the Multi-Agency Public Protection Arrangements (MAPPA) when it should have been, although there was a simple process in place to ensure that staff could identify that a case should be managed under the MAPPA system. However, generally we found that the YOT, particularly at management level, made a valued and informed contribution to MAPPA with good quality referrals, comprehensive YOT risk management plans, reports and contributions provided in those critical few cases.
- 2.12. Only a small number of cases were transferred in or out of the YOT. Generally, joint working ensured a smooth transition and continuity of service regarding managing the risk of harm to others posed by the child or young person.

Summary

Overall work to protect the public and actual or potential victims was satisfactory. Good assessments took account of the risk of harm posed by the children and young people to others, and children and young people in custody were well served by the YOT. Planning to manage risk of harm to others was not fully effective and thereafter the general quality of work to protect the public was less good. More attention needed to be given to victims issues, whether potential or known victims. Improvement is needed to management oversight processes which support effective working, and to the recording of interaction with police colleagues.

Data Summary

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



Protecting the child or young person

3

Theme 3: Protecting the child or young person

What we expect to see

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

Case assessment score

Within the case assessment, overall 75% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Overall, assessments and work to protect children and young people and to reduce their vulnerability was good.
2. Planning required improvement.
3. Children and young people in custody were well served by the YOT.
4. Work relating to safeguarding was good, with strong links with Children's Services.
5. Oversight by managers was not always effective in ensuring the quality of work.

Explanation of findings

- 3.1. Many children or young people who offend lead chaotic and sometimes dangerous lives. In the great majority of cases, the vulnerability assessment undertaken by the YOT was sufficient, taking into account almost all relevant factors such as their physical, emotional or mental health, the substances they were misusing or their ETE status.
- 3.2. There was insufficient formal planning in place to manage and reduce the child or young person's vulnerability in one-third of relevant cases in the community. In four cases, a plan had not been completed where one was required. One was late and others did not address areas such as barriers to engagement, proper objectives to manage vulnerability were not included in the sentence plan or sequenced properly when they did appear. Areas missed included planning for ETE, care arrangements and substance misuse.
- 3.3. Plans to manage vulnerability were better in custody, where nine out of ten relevant cases had sufficient planning in place for work to be done to manage safeguarding and vulnerability issues.
- 3.4. The right activities were undertaken in over three-quarters of relevant cases to manage and reduce the child or young person's vulnerability. Some interventions were not delivered, or appropriate referrals not made, to address safeguarding or reduce vulnerability. This was mostly because this work was not given the priority that was required. In general, the YOT did enough to keep the child or young person safe from themselves and others.
- 3.5. Oversight by management was effective in ensuring the quality of work to address safeguarding and reduce vulnerability in almost two-thirds of relevant cases. Overall, inspectors considered that there

had been a significant improvement in support provided to those classified as Children In Need and Looked After Children since the last YOT inspection.

- 3.6. The YOT were actively engaged at strategic and operational levels across a range of Boards and working groups to oversee and jointly plan the development of services for children and young people and their families. Relevant partner agencies reported positively that YOT staff had formed strong relationships and showed commitment to joint working.
- 3.7. Overall outcomes had significantly improved as a result of YOT staff working closely with staff from partner agencies. Regular information sharing and prompt communication between YOT and children's social care services staff helped to reduce risks or escalation of concerns, for example, when children or young people were in custody or went missing.
- 3.8. YOT staff were actively engaged in an extensive range of meetings in relation to individual children and young people and key safeguarding arrangements, such as Multi-Agency Risk Assessment Committee, MAPPA, Child Sexual Exploitation, substance misuse and missing children. Effective work had been undertaken by partners to prevent the criminalisation of Looked After Children involved in low level offences through engagement with staff in local children's homes and we were informed that, as a result, the number of police call-outs to children's homes had significantly reduced.
- 3.9. YOT Staff were familiar with thresholds for access to children's social services and for Child Protection. All staff in the YOT (including co-located health staff) received introductory safeguarding training, approved by the Local Safeguarding Children Board (LSCB), which enabled them to identify potential risk of harm to children and young people and to refer concerns. Staff were readily able to access higher level LSCB training according to individual needs. In all cases seen by inspectors, safeguarding risks to children and young people were identified and referred for assessment, where appropriate. Regular attendance at the Multi-Agency Safeguarding Hub by YOT staff further facilitated appropriate safeguarding referrals.
- 3.10. Staff had actively engaged in planning to ensure that children and young people were protected and supported. YOT staff regularly attended Child Protection Conferences and Core Groups and actively contributed to the development of Child Protection plans. Activity and support provided through the YOT was incorporated in the Child Protection plans in broad terms. YOT staff were also actively involved in planning for Looked After Children and care leavers, regularly attending Looked After Children reviews and planning meetings.
- 3.11. YOT staff had also formed strong relationships with TYS and the range of early help provision. This provision across the local authority was being reviewed and restructured in order to move towards improved coordination. The YOT had well-established networks with the existing range of universal support and early help provision, such as with schools, and with the Think Families and Troubled Families services. YOT staff worked well alongside staff from partner agencies to support and protect children and young people. For example, joint visits were undertaken, where appropriate, to children and young people and their families. Relationships were established with children and young people which enabled them to engage in direct work within the YOT or to access the support provided by partner agencies.
- 3.12. Work with Looked After Children was focused not only on offending behaviour but wider welfare issues, in conjunction with the Looked After Children social workers. This benefited a number of Looked After Children with complex needs and high levels of offending. Looked After Children held in custody, and those placed out of the area, also benefited from sustained support from the YOT staff. Sufficient remand accommodation was available, which was being further developed and enhanced through a dedicated social work post in the YOT.
- 3.13. The YOT health worker received safeguarding supervision every 12 weeks. The community CAMHS team had a 24 hour crisis team that children and young people could access outside of office hours. There was also a specific team for early intervention for children and young people displaying

any signs of psychosis. There was a process in place for accessing some services for substance misuse and emotional and mental health, and this was supported by a protocol about how to do this. However, it was acknowledged by the representatives of the Clinical Commissioning Group that some services were difficult to obtain. Managers spoke highly of the health services that were offered and delivered to children and young people. There was evidence that the health team were responding to the local needs of children and young people, such as the development of a healthy lifestyles group, and were planning sessions for girls and young women at risk of sexual exploitation. Any safeguarding concerns were raised through the YOT protocol.

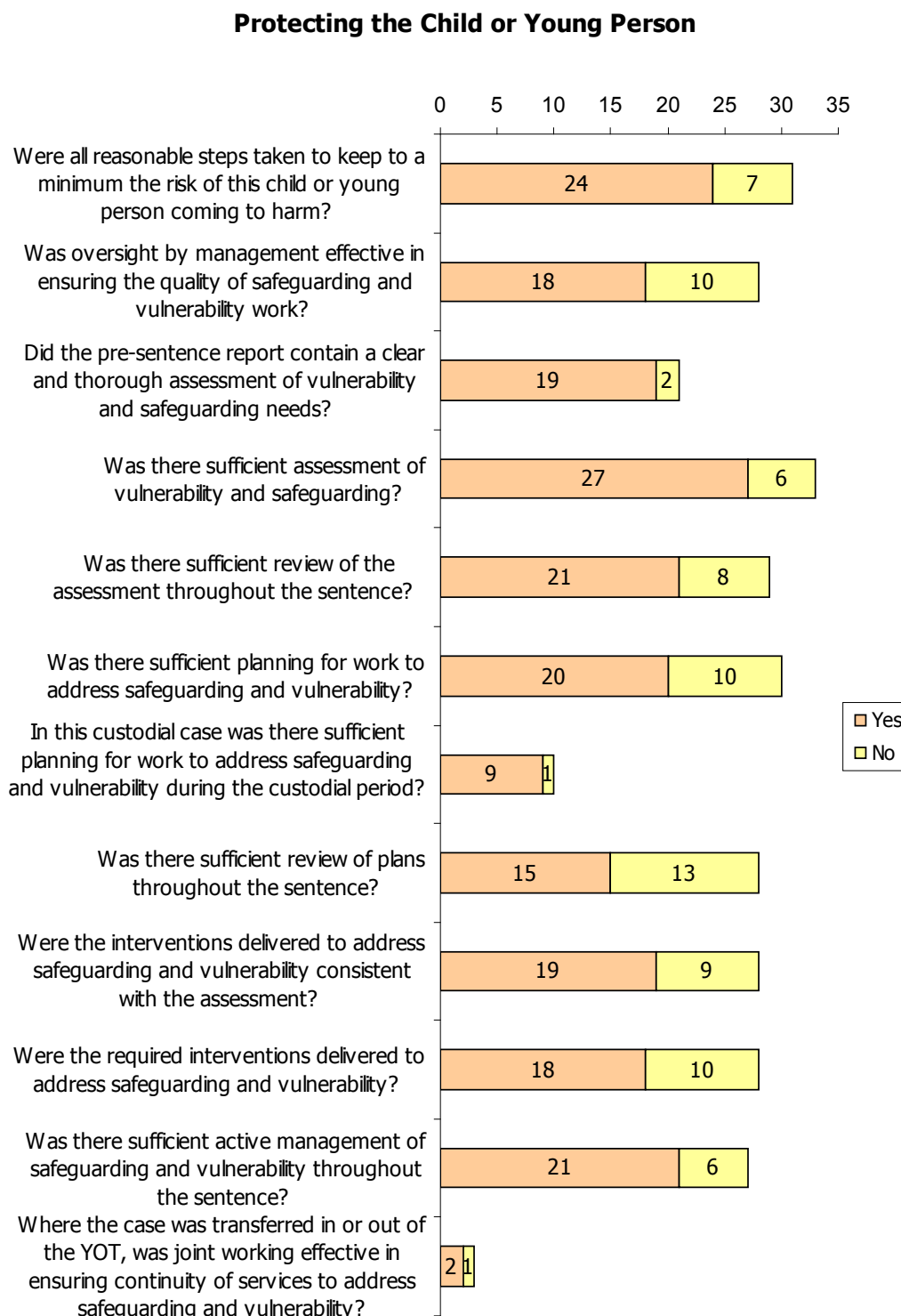
- 3.14. Only a small number of cases were transferred in or out of the YOT, but generally, joint working ensured a smooth transition and continuity of service for the child or young person.

Summary

Overall work to protect children and young people and reduce their vulnerability was satisfactory. Assessments and work to protect children and young people, and to reduce their vulnerability, was good, but planning required some improvement. Children and young people in custody were well served by the YOT and work related to safeguarding was good, but management oversight of this area of practice was not always fully effective.

Data Summary

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



**Ensuring
that the
sentence is
served**

4

Theme 4: Ensuring that the sentence is served

What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the 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 81% of work to ensure the sentence was served was done well enough.

Key Findings

1. Staff generally knew the children and young people with whom they worked, and got on well with them.
2. Children and young people were involved in developing plans, and understanding the changes that they needed to make in their lives.
3. Plans, including referral order contracts, needed to be more meaningful to children and young people.
4. More attention needed to be given to speech, language and communication needs.
5. More needed to be done to encourage children and young people to take responsibility for their own compliance.
6. The initial response to incidents of non-compliance was appropriate.
7. Health workers worked hard to engage effectively with children and young people, but more routine health screening was required.

Explanation of findings

- 4.1. The YOT was ensuring that the sentence given by the court was served by the child or young person. In over three-quarters of cases, staff had thoroughly assessed the child or young person's diverse needs and any barriers to engagement, with the occasional exceptions of speech, language and communication needs, learning needs and disability. Case managers were attentive to the child or young person's health and well-being in the great majority of cases, although in three cases, referrals had not been made. In almost all cases, staff had engaged with the child or young person and their parents/carers in order to complete the assessment.
- 4.2. The children or young people needed to be fully involved in determining the priorities for change; they need to understand why changes were required and know precisely what had to be done to enable the changes to happen. They must also understand the agreed plan. Their views should be reflected in how work was planned and undertaken. Over three-quarters of the reports examined paid attention to how barriers to engagement would be overcome. However, only two-thirds of cases had proper plans on how to overcome those barriers, for example, disability. More attention needed to be given to ensuring that the child or young person had sufficient opportunity to contribute their views on the causes of their offending as part of the initial assessment, and to ensure that these were addressed.

- 4.3. Referral order contracts are agreements made between the community panel, the child or young person, and their parents/carers. Contracts were not always written in a way that enabled the child or young person to make an informed decision about what they were signing. Objectives needed to be SMART.
- 4.4. We recognised that frequent use of home visits, whether by YOT staff, or multi-agency, could be both appropriate and useful in gaining information about the home life of the child or young person. For example, health workers went on home visits with the case managers. This allowed them access to the child or young person, to meet their parents/carers, and for them to gain further information and explain any intervention to the family. It was positive to see that support was also given to the wider family to help them address any health needs that had been identified.
- 4.5. However, we judged that sometimes the YOT made too much use of home visits. More needed to be done to ensure that the child or young person took some responsibility for their own compliance, for example, through agreeing to meet at a community venue rather than relying on the case manager to visit their home.

Complying with orders

One young person recognised that there is a punitive element "... it is not an easy ride".

Staff themselves recognised that enforcement activity needed to be more robust "The staff should say to young persons 'this is going to happen' rather than 'what do you want to do...?'".

- 4.6. In general, we observed that case managers sometimes allowed too much flexibility and did not hold children and young people to account sufficiently for their compliance. More needed to be done to motivate the child or young person and to overcome barriers to compliance. In half of the cases, children and young people did not comply with the requirements of their sentence, either because breach action was not taken when needed, or there was an insufficient response to unacceptable absences.
- 4.7. The YOT operated compliance 'Back on Track' panels. Its intention was to ensure that the reasons for non-compliance were understood, barriers to compliance were addressed and that appropriate defensible actions were in place. Referral order panels in Wakefield YOT were engaging and fair for all parties, and allowed children and young people to take part in decision making. They were fully embedded into case manager procedures, formed part of all breach proceedings, were underpinned by effective practice and YJB Case Management Guidance. However, the Panel discussion needed to be more structured in order to allow the child or young person and YOT to fully understand the expectations of them for the future. Plans needed to be reviewed and updated to reflect the actions and agreements from the Panel.
- 4.8. A child or young person's involvement with health services was voluntary, but it was accepted practice that if a child or young person agreed then these appointments could be classed as part of their statutory order. If they chose not to engage, the staff would try and motivate them. This would then be reviewed within the quarterly reviews of Asset and referred back, if appropriate. There was evidence that health interventions were being further developed. Two sessions had been completed with 'Street Doctors' and further sessions were being planned.
- 4.9. There was a clear process of confidentiality and consent. We saw that this was well recorded and that there were specific forms which indicated named services where a child or young person was happy for information to be shared. We also saw examples where staff had succeeded in getting children and young people to access health services.

- 4.10. The YOT had a part time Speech and Language therapist, who was employed by the Liaison and Diversion scheme, but would assess any child or young person open to the YOT. A speech and language screening tool for case managers had been developed. However, this was not being routinely used on all children and young people. If concerns were identified using this screening tool then the Speech and Language therapist would carry out a full assessment. Detailed reports stated which tests had been carried out and the results and meaning of these, as well as what support was needed.
- 4.11. Health and substance misuse workers had access to the YOT's IT system (YOIS). As a minimum, they would record attendance at appointments. Where appropriate, and with the agreement of the child or young person, they would also share other key information and we saw detailed notes of sessions completed. We noted systems were in place to ensure recording and sharing of information. A relevant and up to date information sharing protocol was in place. The YOT health worker also recorded information on the NHS IT system 'System1'

Good multi-agency working in individual cases

Mark was found guilty after trial for an offence of criminal damage. Intoxicated at the time of the offence, he maintained that he was not responsible for the actual damage to the wing mirror of a neighbour's car. Although the initial assessment in this case was not entirely timely, the case manager had planned well and used the specialist workers effectively. The substance misuse worker had 'tested' Mark throughout the delivery of the intervention, using scenarios to identify that he may have consumed alcohol, to review the plan and build on the young person's experience. The specialist education workers also ensured that reintegration plans were in place for Mark ready for the start of the next academic year to ensure a seamless transition which was pivotal in building on a healthy lifestyle for him.

- 4.12. The substance misuse team kept a paper copy of their assessment and care plan, which was then scanned and saved on to a central location, once a child or young person had completed their order. The Focus team did not have access to YOIS, but would request a copy of the Asset and reported that this information was also shared. Whilst all case managers and health workers were able to tell us about what work was being completed, the YOT could not assure itself that any information or updates had not been missed.
- 4.13. There was strong partnership working between the different areas of health, within the YOT and also with health workers in the secure estate. There were some discrepancies between health staff and the managers as to whether health staff attended reviews for a child or young person in custody. We were told that they previously went to all and aimed to bring back this service. The substance misuse service had a process in place where they met with the Young Person's Substance Misuse Services at Wetherby YOI to have a handover meeting. This ensured that all were aware of what work had been completed and any outstanding issues.
- 4.14. There was a clear system with no waiting time to initiate health assessments following the imposition of a court order. Interventions were delivered in a timely manner. Health staff felt that their caseloads were manageable. There were contingency plans in place to address any staff sickness absence to ensure that a continuous service was able to be delivered to children and young people.
- 4.15. The Focus team had weekly meetings that included monitoring the length of time taken to offer a consultation, new referrals, as well as each existing case. The team also completed reports for court. They offered information such as suitability of different types of secure placement. Each

child or young person had an assessment plan in place, as well as a subsequent care plan. The assessment plan detailed what would be done, and when, and was available to the referrer. These were reviewed every four to six weeks to help monitor the timeliness of assessments.

- 4.16. Since staff do not screen all children and young people, it may be that speech and language difficulties are not identified, the YOT could not assure itself that the methods used to communicate with children and young people always meet their needs. It was, however, positive that all staff at the YOT, including non case-handling staff, such as reception, had received training in working with those with dyslexia.
- 4.17. Only a small number of cases were transferred in or out of the YOT, but, joint working ensured a smooth transition and continuity of service to make sure that the sentence was served by the child or young person.

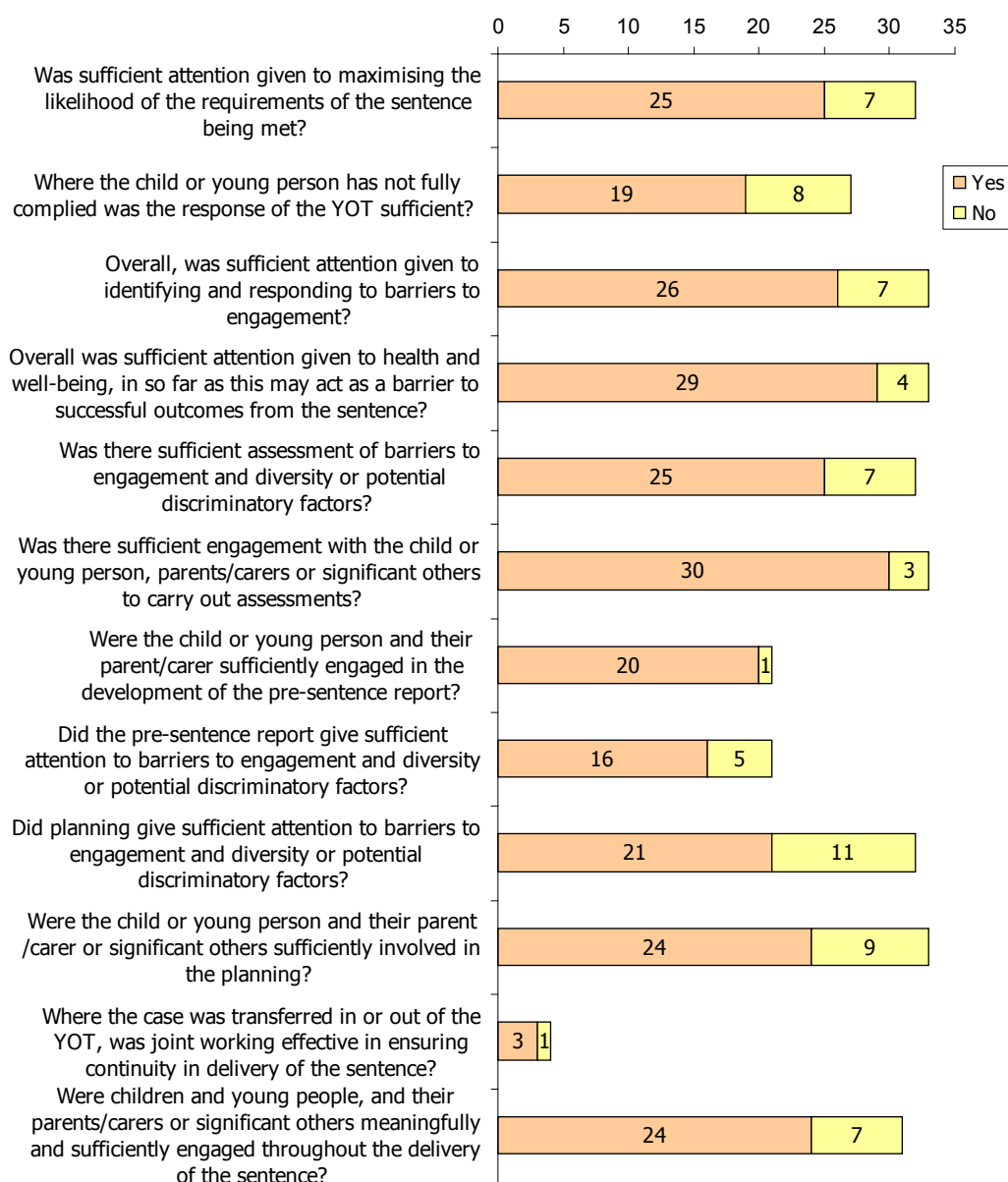
Summary

Overall work to ensure that the sentence was served was good. Staff knew the children and young people well and generally involved them sufficiently in assessment and planning for the changes that they needed to make in their lives. Plans needed to be SMARTer and more meaningful to children and young people. Sometimes more could have been done to ensure that children and young people took greater responsibility for their own compliance with their sentence. The YOT compliance panel was not always effective. However, when children and young people did not comply with their sentence the initial response was often appropriate. More attention should have been given to speech, language and communication needs, and although routine health screenings occurred they did not include a cognitive element.

Data Summary

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

Ensuring that the Sentence is Served



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 have been effective in reducing reoffending.
2. Sufficient attention was given to the quality of work by the Management Board and by managers, but the quality assurance process was not always effective.
3. The recording of staff activity and supervision was not always accurate.
4. Youth justice had a high profile in key local partnership plans.
5. The data used by the YOT Management Board was generally sufficient to enable it to hold the YOT to account for current performance.
6. The YOT management team worked effectively together.
7. There were good structural links between the YOT and key partners such as Wakefield Children's Services and West Yorkshire Police.
8. Proper attention was given to ensuring positive educational and health outcomes for children and young people known to the YOT.
9. The YOT should continue monitoring outcomes in order to improve services.

Explanation of findings

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

- 5.1.1 Leadership and Governance by the YOT Management Board and within the YOT worked well. Both contributed to significantly reduced reoffending, although the YOT was on a journey to achieving reoffending rates which were comparable to many other areas in England and Wales.
- 5.1.2 Wakefield YOT had a Youth Justice Plan (YJP) in place, to aid delivery of services and improve quality assurance. This plan anticipated future needs. Its priorities and targets took good account of targets set by other key partners, their strategies and plans. The YJP met the requirements of national guidance, identifying, for example, the ethnicity and gender of Board members. Minutes of meetings evidenced that the Board sought to ensure that the objectives of the YJP were met.
- 5.1.3 We considered that effective leadership within the YOT, and strong partnership arrangements, ensured that safeguarding children and young people, and the needs of Looked After Children, were appropriately prioritised. YOT representatives were widely engaged in the work of the LSCB and were represented on the LSCB, its sub-committees and working groups. As a result, the YOT had been actively involved in the development of a range of safeguarding initiatives, for example, on child sexual exploitation and domestic violence. The benefits of this were evident in cases sampled by inspectors.
- 5.1.4 The YOT manager was the Children's Champion for the LSCB. They contributed well at a 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 YOT Management Board. At a strategic

level, the YOT was well embedded into wider structural arrangements for children's services. Youth justice targets were included in a variety of local plans including Children's Services, the District Outcomes Framework and the annual plan of the West Yorkshire Police and Crime Commissioner. YOT staff were represented on a LSCB sub-committee. The LSCB had established a multi-agency audit programme, which had already begun challenging partners on completion of previous actions and YOT staff were represented on the relevant sub-committee.

- 5.1.5 The YOT had engaged in Serious Case Reviews (SCRs) commissioned by the LSCB. Action plans resulting from the findings had been progressed, monitored by the YOT and LSCB. Learning from SCRs had been disseminated through a number of LSCB multi-agency seminars and internal YOT events. However, when asked, case managers were not able to identify the key lessons for the YOT from recent SCRs.
- 5.1.6 One of the themes from a recent local SCR concerned where information was recorded and accessible on case files. Managers had taken action to get staff to record information on the electronic system. However, our inspection found that regular and consistent recording by staff continued to be an issue. An audit undertaken by YOT senior managers in June 2014 also found significant inconsistencies in the recording and filing of supervision records.
- 5.1.7 Staff were readily able to access advice and support on safeguarding issues from managers and from social work colleagues within the YOT. Managers ensured that the needs of Looked After Children were appropriately addressed and had established close working relationships with the various teams within the local authority children's services. The YOT Management Board had also made Looked After Children a priority area for the YOT for the coming year.
- 5.1.8 The YOT had begun to undertake internal audits of safeguarding practice. At the time of this inspection, YOT representatives were part way through auditing YOT involvement in Child Protection conferences. This was yet to embed and too early to have evaluated the impact, but we were encouraged to see the YOT working towards performance improvement in this way.
- 5.1.9 The Board acted robustly but supportively to maintain a focus on ensuring the quality of practice. They challenged the YOT on performance, seeking more analysis of the available data to get to the root of any problems, thus demonstrating their clear understanding of the local and national outcome priorities for the YOT. The Board particularly commended the YOT's manager's use of other members of YOT staff to report on performance, ensuring that communication between staff and the Board was not limited to the sharing of minutes. Where appropriate, the YOT had set the agenda of the Board, for example, the YOT prioritised the problem of Looked After Children being criminalised as a result of incidents that happened in children's homes.
- 5.1.10 We therefore considered that performance management within the YOT had significantly improved since the last inspection and the peer review. This had been supported by the appointment of a data analyst, which was unique thus far in our current inspection programme. The YOT was now focusing its efforts on obtaining neighbourhood breakdown data and making comparisons with other areas in West Yorkshire. The data analyst attended the West Yorkshire data group, assisting with wider benchmarking.
- 5.1.11 The YOT identified that their reoffending figures had been adversely affected by a few individuals. For example, when they looked at the reoffending toolkit, they found high reoffending amongst the 10 to 13 year old cohort; one young person was distorting the results, allowing them to focus their work. However, they accepted that they still needed more data, including around Looked After Children and those classed as a Child in Need. We considered that the YOT had put a lot of effort into improving the quality of its scoring of Assets; including in the case planning meeting, the practitioner forum and the evaluated information from the recent assessment training being delivered externally. Accurate scoring at the start of sentence and during the sentence will, in the future, enable the YOT to measure the journey of the young person in relation to some of the secondary outcome measures.

- 5.1.12 The accuracy of information was now more robust and the range of information had been gradually expanded beyond the key performance data required by the Youth Justice Board (YJB). Some performance information had been developed to respond to management queries and those from the YOT Board. This had been benchmarked through links with neighbouring YOTs.
- 5.1.13 However, the analysis of data was insufficiently developed to inform managerial decisions. In many cases, individual case managers and support workers had an adequate understanding of the progress and achievement made by each child or young person. However, data was not used sufficiently well to monitor the attainment different groups of learners made and to identify trends for improvement. Managers acknowledged that performance management information needed to be further developed, rationalised and used by staff at all levels to support quality assurance and service development.
- 5.1.14 We were pleased to see youth justice clearly identified within the relevant local plans; to see it identified so clearly and widely was unusual. Some more work was needed to refine the performance management system, and develop SMART objectives for the Board, that supported effective performance management and accountability at an operational level.
- 5.1.15 The YOT Management Board had broad representation, including the usual Criminal Justice Partners but also representatives from other agencies such as housing and health, and good attendance. The police were well represented on the Board by a Chief Superintendent, which showed both a strong commitment to the YOT and representation at an appropriately senior level. The Board was chaired by the Director of Children's Services of Wakefield City Council. Members reported that the Board meetings were a safe environment where positive challenge was welcomed, and that there was an open and healthy relationship between them. This was evidenced by minutes from Board meetings.
- 5.1.16 There had been a health representative on the YOT Management Board who was representing Public Health and the former Primary Care Trust. As of June 2014, there was now a member representing the Clinical Commissioning Group, as well as a new person representing Public Health England. Both of these people were from an appropriate level and able to make decisions about the health services for children and young people at the YOT. We were told that information about health staff and outcomes goes to the Clinical Commissioning Group but that this information was not passed to the YOT Board. However, it was important that all information was shared with the YOT Board to ensure that all health services were scrutinised about their contributions and they were held to account for services delivered. There was historic evidence that action had been taken and that changes had been made to health services at the YOT.
- 5.1.17 YOT health staff outcomes were being monitored by Mid-Yorkshire Hospitals NHS Trust. However, neither the YOT manager responsible for these staff, the line manager from the Trust or the staff themselves, were aware of the data or what was actually being collated. Neither manager was asked to provide information to the YOT Board. This meant that key information about the health needs of children and young people, and interventions delivered, was not being used by the YOT to help inform future services. Appropriate service level agreements were in place which outlined staff accountability and responsibilities. However, these did not state how health outcomes would be monitored.
- 5.1.18 There was a specific Joint Strategic Needs Analysis (JSNA) for children and young people, which was completed in 2010. However, more recently, information about children and young people was included in the generic JSNA, so that this can be kept as a 'live' document.
- 5.1.19 There were very positive reviews by all health staff at the YOT. Health staff felt supported and received line supervision from the YOT as well as clinical supervision from their retrospective agency, where appropriate. Regular meetings also occurred between the YOT manager with responsibility for the health staff and the manager from the respective agencies. One health worker told us that access to supervision was *"Better than anywhere I've worked"*, another stated *"Both managers are proactive"* and that they *"Feel really supported"*. Peer support sessions occurred between the health

worker, substance misuse team and dual diagnosis workers. Staff spoke positively of these. Although supervision occurred on a regular basis to help monitor the cases and what interventions were being carried out, there was some concern that the outcomes were not being monitored or analysed for YOT Health staff.

- 5.1.20 The ETE strategy was out of date by several months although there was an informal awareness on what areas needed to be developed next responding to the participation strategy for Wakefield.
- 5.1.21 The YOT was developing greater staff understanding of dyslexia to ensure the additional learning needs of many children and young people were met. However, the assessment of literacy and numeracy needs required improvement. The YOT did not have sufficient knowledge and understanding of these needs before they planned ETE activities with each child or young person. Advanced plans were in place to begin screening children and young people for dyslexia.
- 5.1.22 Adult Probation Services had historically made a positive commitment to the work of the YOT and the Board, although, at the time of the inspection, it was unclear how this would be affected by the substantial changes underway in that organisation. However, the National Probation Service had placed a new representative on the Board to enable proper liaison in the future. Interviews confirmed that the YOT worked well with courts to assist in the efficient and effective administration of justice for children and young people who had offended.

5.2. Partnerships – effective partnerships make a positive difference

- 5.2.1 At a strategic level, the links between the YOT Management Board and local partnerships were very positive. The recent significant reduction in first time entrants to the youth justice system was impressive, albeit from a low base. This was evidence of how local partnership working could be effective, and also served to build confidence and understanding between partners. The YOT was well regarded by their partners and were seen as proactive, innovative and productive. Partners had ensured sufficient access to the range of specialist staff that was required, so that the YOT was appropriately staffed, and services delivered, by partner agencies.
- 5.2.2 Wakefield YOT were well engaged in local IOM with robust arrangements at both strategic and operational levels. The YOT had a positive approach and IOM processes were well established. Case managers nominated children and young people for adoption into the project and approximately 10% of the IOM cohort were children or young people from the YOT. The IOM team allocated a number of 'Deter Young Offenders' to the YOT Police Constables to work with. They were expected to visit their members of the cohort at least once a week.
- 5.2.3 The YOT held monthly selection and deselection meetings with YOT staff, staff from Wetherby YOI, Think Families, YOT Police Officers and a police IOM evaluator attending. It was evident that the IOM process selected and deselected the children or young people appropriately and that decisions about whether they were 'Catch and Control' or 'Resettle and Rehabilitate' were balanced and based on intelligence. The IOM evaluator shared information about children and young people who were 'Catch and Control' to a police team, to inform disruption and enforcement action. Processes were in place to escalate children or young people to 'Catch and Control' without waiting for the next selection meeting. The IOM police lead was satisfied that all children and young people managed by the YOT, who met the criteria for the IOM, were included in the cohort.

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

- 5.3.1 The YOT management group were an effective management team. Their efficient workforce management supported quality service delivery in many cases, but there was still work to do to ensure that there was a consistent and sustained approach to high quality practice throughout.

- 5.3.2 We observed a 'case planning' meeting, and a 'practitioner forum' that, in different ways, provided evidence of appropriate challenge to, and affirmation of, the quality of assessments. Within the remit of the Quality Assurance strategy, the YOT had two main case management and oversight panels. The first was a weekly case planning meeting which included a representative from Family Services as well as a VLO. The purpose of that meeting was to provide quality assurance of statutory orders and out of court disposals. The second was the vulnerability and serious harm panel which met every four weeks. The purpose of that meeting was to provide oversight of all cases where children and young people were assessed as high or very high risk of serious harm or vulnerability and to monitor actions against plans.
- 5.3.3 Encouragingly, practitioners were a key ingredient of the quality assurance process. The relatively newly formed YOT Peer Quality Assurance Group had practitioners undertaking themed audit activity of a range of aspects of YOT business. Initial activity focused on case inspections using HMI Probation's case assessment tool. It found, alongside some positive findings, that there were inconsistencies in the quality of assessments. That finding led to the recent provision of 'Developing Assessment and Intervention Skills training'; evaluation of which was positive.
- 5.3.4 Staff had frequent supervision and were content with its quality. However, the same issues were sometimes identified in subsequent supervision records, with insufficient evidence that effective actions had always been taken to address them. The YOT had in place formal procedures for addressing staff competence and grievance issues.
- 5.3.5 Training was wide ranging and generally effective, with staff expected to report back on training at team meetings. We noted that in addition to the practitioner and case planning fora, the Youth Development and Support Service also ran four 'development days' per year, with workshops on areas of interest, such as themed aspects of safeguarding and preventing child sexual exploitation. Health staff were able to access mainstream training at the YOT, as well as from their respective agencies, which helped to ensure that they were kept up to date. We saw that in return, health staff had carried out presentations and delivered training for YOT staff and with magistrates. We also saw evidence that case managers were kept up to date by health workers, for example, by the sharing of web links.

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

- 5.4.1 Staff were enthusiastic, committed to their work and wanted to learn to improve. Management ensured that training was supported at all levels.
- 5.4.2 We saw evidence that the substance misuse team were monitoring their outcomes. This included completing the Young Persons Outcome Record required by Public Health England. The service had targets, such as, having a care plan in place within 2 weeks of starting an intervention and 15 working days to start to deliver an intervention for children and young people needing specific services. For the period of 2012-2013, it was reported that both of these targets had been achieved 100% of the time. Other information on the number of children and young people accessing the service, interventions delivered and types of drug and alcohol misused, was also recorded. The Focus team were also monitoring their work, such as, the number of referrals, assessments and discharges. In addition they had commissioned a piece of work on how to measure outcomes.
- 5.4.3 With reference to education outcomes, the analysis of data was not yet fully developed to inform managerial decisions. In many cases, individual case managers and support workers had an adequate understanding of the progress and achievement made by each child or young person known to the YOT. However, collected data was not used sufficiently well to monitor the attainment of different groups of learners and to identify trends for improvement.

5.4.4 The YOT had regularly engaged with higher education, pilot programmes and other bodies to help independently evaluate the effectiveness of work undertaken. It was open to its work being scrutinised, performing well in the YJB's Custody Pathfinder project and welcoming peer reviews. The YOT's response to the SCR was regarded as exemplary by the chair of the LSCB. Evidence was noted of local evaluations of interventions, for example, the impact of the multi-agency 'Do it Different' group. However, there was not yet an overarching and comprehensive assessment of all of the interventions being delivered by staff, which may have assisted management to decide where to focus investment to the best effect.

Summary

Overall, the effectiveness of governance and partnership arrangements was satisfactory. Wakefield YOT had achieved reductions in the number of first time entrants to the youth justice system and performed well against other key targets. The information used by the Board was good, but could be further refined. We were pleased to see that youth justice was reflected in many key local plans. Management oversight of work in the YOT was not always fully effective, but the management team worked effectively together. There were good structural links with all key partners and proper attention was given to ensuring positive educational and health outcomes.

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 73% of work related to the delivery of interventions to reduce offending was done well enough.

Key Findings

1. Wakefield YOT had been effective in reducing reoffending by children and young people.
2. There was evidence of good quality interventions being delivered designed to improve engagement and prepare children and young people to work to reduce reoffending.
3. Staff commitment to supporting and encouraging the children and young people was commendable, but did not ensure the delivery of effective work to reduce reoffending.
4. Planning required some improvement.
5. Case managers were aware of the range of interventions that may be available to them for work to reduce reoffending.
6. Plans were not always meaningful to children and young people, or to others who needed to use them.
7. Case managers understood the principles of effective practice, but needed to adhere to these in their work with children and young people.

Explanation of findings

- 6.1. Wakefield YOT had been effective in substantially reducing reoffending by children and young people. Positive leadership, effective management and partnership work had ensured that intervention needs were met and there had been generally good outcomes in inspected cases. The YOT was attentive to the wide needs of the children and young people with whom it worked. The staff team was enthusiastic and extremely committed. In most cases, the initial assessment of likelihood of reoffending was good enough, with diversity factors identified and assessed sufficiently well.
- 6.2. The YOT engaged with children and young people, and their parents/carers, well. However, in some instances the child or young person was not sufficiently listened to or their views incorporated in the assessment. In over one-quarter of cases, plans were not routinely discussed with children and young people, and their parents/carers.
- 6.3. Planning to address likelihood of reoffending could have been better. Over one-quarter of plans did not clearly identify what interventions were to be provided or how they were to be delivered.

The YOT were piloting 'one plan', where a single plan was supposed to incorporate all objectives, whether relating to sentence planning, managing vulnerability or risk of harm to others. This was clearly work in progress, with case managers not remembering to include the objectives to manage risk of harm to others even when instructed to during supervision sessions.

- 6.4. In five cases we inspected, plans did not focus on reducing reoffending. Other factors which were not included were meeting the identified needs of the child or identifying the sequence in which the objectives should be delivered. Furthermore, the YOT did not always ensure that the plans were reviewed to take into account the progress of the child or young person against their objectives.

Poor case management and a lack of management oversight

Michael was convicted of theft and sentenced to a 12 month YRO with 80 hours of unpaid work. He had an established offending history of acquisitive crime to pay for his drug/alcohol use and the current offences were committed whilst on a previous YRO for handling stolen goods. Michael had a diagnosis of ADHD and mental health concerns were recorded on YOIS. However, the initial assessment was not completed in a timely manner and failed to grasp the main issues which contributed to the offending behaviour. His parental contact had ceased and he stopped taking medication for ADHD, instead self-medicating with Cannabis and alcohol, but this was not fully addressed in the assessment. Factors relating to his vulnerability were not sufficiently explored and although he was assessed as medium, no vulnerability management plan (VMP) was completed. Previous poor motivation was not addressed. During the five months of the YRO he was seen only twice by his case manager (although he was fully complying with his Unpaid Work requirement). No interventions had been undertaken at all and some meetings had not been recorded. When subsequently sentenced for burglary as an adult, Probation took on management of the case, but no handover meeting or arrangements were recorded. Since transition to Probation in December, Michael had not reoffended.

- 6.5. The plans that emerged from the Referral Order panels were poor. They did not always reflect recommendations within a PSR, often contained objectives for the YOT rather than the child or young person, were rarely outcome focused and many failed to incorporate reparation. In addition, panels were not always held in a timely way. It was difficult to see how the child or young person would have felt engaged with their sentence in those instances.

SMART objectives when planning

Rick was convicted of attempted burglary and two previous burglaries (dwelling and non-dwelling) and sentenced to an 18 month YRO with curfew and supervision. The case manager produced a strong intervention plan – '3 x sessions (with case manager) to explore victims' perspectives and will include one session regarding RJ with (VLO)' and 'Activity requirement initial sessions planned x 3 at City Limits YJC and will be reviewed thereafter'. Outcomes were good in this case with a steady reduction in Asset scores and no further offending. Rick had moved to a new area and was breaking associations with some of his anti-social peers. He was a candidate for early revocation with one last objective - to engage effectively with ETE. Revocation would occur when this could be evidenced. The planning had been SMART throughout and this was an example of clear goal setting that was achievable.

- 6.6. Having planned what to do with the child or young person, in just under three-quarters of cases, the YOT generally delivered these interventions. However, sometimes they missed interventions on emotional and mental health, thinking and behaviour, and family and personal relationships. This was because the YOT did not recognise the need during the initial assessment or did not deliver the interventions right from the start of the order. The YOT had access to good quality interventions and

delivered them as their design intended, almost always giving proper attention to restorative justice for the victims and reinforcing positive factors in the child or young person's life.

- 6.7. The range of interventions available to the YOT was varied and extensive including cognitive behavioural therapy-based interventions, knife crime interventions, ETE, sports and leisure ('Etiquette and Manners' on the golf course), physical health, emotional and mental health, drugs and alcohol. Case managers were positive about the interventions available to them, which were easily accessible, with outline sessions and timings provided.
- 6.8. We observed YOT staff delivering good quality interventions designed to address motivation to engage, physical health and family and personal relationships, which were well planned, structured, delivered and resourced. However, during our observations, none of the offence focused interventions were being utilised.
- 6.9. We inspected a number of cases where young males had committed offences within the home setting, often against their mothers. It was positive that, in partnership with others, a successful bid had been made to deliver the 'Building Bridges' programme in the community which would include mentoring support and an evaluation programme by Sheffield Hallam University. We inspected a number of cases in custody where the child or young person had successfully undertaken 'Building Bridges'; one case entry said the young person had been encouraged by another young person to do the programme because "*It was good*". Another young person confirmed that the work of the YOT "*Has helped me stay out of custody*".

Support for the child or young person and their family

Tony received a four year custodial sentence for robbery offences against vulnerable older people on the street - one of whom received a very serious injury. He had a dysfunctional home life, with a mother who befriended him rather than mothered him. He was vulnerable to predatory older males. He had a drug habit that he needed to feed. The YOT provided support to Tony's partner, who was a critical person in his life. She lived over 40 miles away, but visited him at weekends. The case manager had liaised with her and encouraged her to act as a positive influence in helping Tony make the right decisions when he became stressed. This has had a positive impact on the start Tony has made to his lengthy licence period.

- 6.10. There was not always sufficient attention paid to delivering risk of harm and likelihood of reoffending interventions, with some case managers overly focused on the child or young person's personal circumstances. Work in custodial cases was good, with appropriate offending related interventions, including JETS, and good relationships forged with, and help offered to, the family members of the child or young person in custody.
- 6.11. We observed some interesting interventions, especially the various arts projects undertaken between the YOT and Hepworth Gallery. The Hepworth Gallery offered an excellent accredited summer arts programme that promoted inclusivity particularly well. Children and young people explored their creativity and developed good teamwork whilst experiencing a sense of pride in their achievements and in their town. The YOT monitored performance on these projects and noted a low reoffending rate from the summer group last year. Additionally, the 'music project' motivated children and young people, as well as building their self esteem, musical and communication skills, with a successful outcome for one young person, who now studies music at college.
- 6.12. Assessment of offending related behaviour and planning for work to reduce reoffending were not sequenced appropriately or SMART, making it less likely that the most appropriate interventions could be consistently identified and delivered. Not all health workers within the YOT had developed a clear intervention plan for the children and young people with whom they were working. This

meant that there may have been a lack of clarity for the child or the young person and staff about the actual plan of work and whether an outcome had been achieved. Few completed intervention plans clearly indicated what tools or resources would be used to achieve the intended outcomes, or in what sequence they would be delivered. There was also little evidence of the child or young person having been involved in the development of the plan.

- 6.13. Custodial cases were delivered as a single integrated sentence and sufficient attention was given to ensuring that positive outcomes were sustainable following the end of the sentence.

Summary

Overall work related to the delivery of interventions to reduce reoffending was satisfactory. Performance had improved in key target areas. There was evidence of the delivery of good quality work designed to improve engagement and prepare children and young people to work to reduce their offending. Staff were committed and enthusiastic, but did not always ensure the delivery of effective work to reduce reoffending as well as to improve levels of vulnerability. Planning required some improvement.

Appendix 1

Contextual information about the area inspected

Wakefield had a population of 325,837 as measured in the Census 2011. The youth population (those aged between 10 and 17 years old) accounted for 9.6% of the population. This was slightly 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 6.5% (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 13.8 per 1,000, were lower than the average for England and Wales of 18.5 (Youth Justice Board 2012-2013).

The proportion of young people in Wakefield aged 16 to 18 years old who were not in education, training or employment is estimated at 5.3%. This is equal to the average for England which is estimated at 5.3% (Department for Education 2014).

Youth Justice Board indicators

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

Reoffending measures:

(i) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a Class A drug on arrest, the proportion who reoffend within a 12 month reporting period. This reoffending proportion for Wakefield was 31.7%, better than the 35.4% 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 Wakefield, there were 1.09 offences per child or young person who reoffends, worse than the 1.03 for England and Wales as a whole.

(Data based on October 2011 – September 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 Wakefield is 279, compared to 432 for England and Wales as a whole.

(Data based on April 2013 – March 2014 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 Wakefield is 0.34, compared to 0.51 for England and Wales as a whole.

(Data based on July 2013 – June 2014 cohort)

Appendix 2

Contextual information about the inspected case sample

In the first fieldwork week we looked at a representative sample of 33 individual cases up to 12 months old, some current, others terminated. These were made up of first tier cases (referral orders and reparation orders), youth rehabilitation orders (mainly those with supervision requirements), detention and training orders and other custodial sentences.

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

Appendix 3

Acknowledgements

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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:

16 June 2014 and 7 July 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

ADHD	Attention deficit hyperactivity disorder
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
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
DTO	Detention and training order: a custodial sentence for the young
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
JETS	The Juvenile Enhanced Thinking Skills programme
JSNA	Joint strategic needs analysis
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
Interventions; <i>constructive</i> and <i>restrictive</i> interventions	<p>Work with an individual that is designed to change their offending behaviour and/or to support public protection.</p> <p>A <i>constructive</i> intervention is where the primary purpose is to reduce the likelihood of reoffending.</p> <p>A <i>restrictive</i> intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others.</p> <p>Example: with a sex offender, a 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.</p> <p>NB. Both types of intervention are important</p>
IOM	Integrated offender management
Likelihood of reoffending	See also constructive Interventions
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
NEET	Not in education, employment, or training
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
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	<i>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</i>
SCR	Serious case review
SMART	Specific – target a specific area for improvement, Measurable – quantify or at least suggest an indicator of progress, Assignable – specify who will do it, Realistic – state what results can realistically be achieved, given available resources, Time-related – specify when the result(s) can be achieved
SIFA	Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers
TYS	Targeted youth support
VLO	Victim liaison officer
VMP	Vulnerability management plan: a plan to safeguard the well-being of the individual under supervision
YCC	Youth Conditional Caution
YJB	Youth Justice Board for England and Wales
YJP	Youth Justice Plan
YOI	Young Offenders Institution: a Prison Service institution for children and young people remanded in custody or sentenced to custody
YOIS	Youth Offending Information System: one of the two electronic case management systems for youth offending work currently in use in England and Wales
YOS/YOT/YJS	Youth Offending Service/Youth Offending Team/Youth Justice Service. These are common titles for the bodies commonly referred to as YOTs
YRO	The youth rehabilitation order is a generic community sentence used with children and young people who offend

Appendix 8

Role of HMI Probation and Code of Practice

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

www.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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