HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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

An inspection led by HMI Probation

independent inspection of youth offending work

February 2015

Foreword

This inspection of youth offending work in Trafford 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.

We chose to inspect in Trafford primarily because they were performing well against all three key youth justice indicators and that following their inspection under the Core Case Inspection programme in 2009, their work had been assessed as requiring minimal improvement.

We were pleased to find that Trafford Youth Offending Service (YOS) had continued to prioritise reducing reoffending with the local rate[1] standing at 32.9%, which was below the 35.7% average performance for England and Wales. First time entrants had also reduced year on year, although whilst on site we learned of a recent increase which could have implications for the future work of the YOS.

Overall, we found an enthusiastic and committed staff group, that levels of performance had been maintained and that a large majority of work had been completed sufficiently well across each of the areas inspected. A wide range of interventions was available to children and young people and there was evidence of strong partnership working. Arrangements for health, education and learning for YOS service users were especially good. However, close examination of a small number of cases identified some systemic and governance issues relating to the safeguarding work of the YOS which require attention.

The recommendations made in this report are intended to assist Trafford YOS in its continuing improvement by focusing on specific key areas.

Alan MacDonald

HM Deputy Chief Inspector of Probation

February 2015

Key judgements

Reducing reoffending ★★★☆

Protecting the public ★★★★

Protecting children and young people ★★★☆

Ensuring the sentence is served ★★★★

Governance and partnerships ★★★☆

Interventions ★★★★

1 *Published October 2014 based on binary reoffending rates after 12 months for the January 2012 - December 2012 cohort. Source: Ministry of Justice*

Summary

Reducing reoffending

Overall work to reduce reoffending was satisfactory. A strong focus and priority was given to reducing reoffending. Assessment and planning were, for the most part done well, and children and young people were particularly well supported in meeting health and education needs. However, in a small number of cases, assessments and elements of plans were not satisfactory and these had not been identified through management oversight systems.

Protecting the public

Overall work to protect the public and actual or potential victims was good. Assessment and planning work to reduce the risk of harm was completed well in a large majority of cases. There were systems in place to ensure oversight of, and partner contributions to, the management of risk of harm. Delivery of victim work, restorative justice and reparation was well structured although evidence for the uptake of direct work with victims was lacking. Barriers to information sharing between the police and YOS, as a result of the recently reduced capacity of the seconded police officer, inhibited the use of intelligence as part of case management.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was satisfactory. Although the majority of work to protect children and young people was completed sufficiently well, we saw a small number of cases in which the assessment and planning of vulnerability was weak, and which, on further investigation, revealed a number of systemic problems. Work was child-centred and there was a positive working relationship between the YOS and children's social care in many cases. Interventions to reduce unnecessary use of custody were good. However, more complex safeguarding cases revealed deficits in the YOS's collective knowledge, levels of staff training, management oversight and governance arrangements.

Ensuring the sentence is served

Overall work to ensure that the sentence was served was good. Practitioners across the YOS demonstrated enthusiasm, commitment and knowledge of their cases. There was evidence of good working relationships with children and young people and their parents/carers, who were largely positive in their comments about their contact with the YOS. Diversity needs were met well and where barriers to engagement were encountered, these were generally dealt with constructively. The use of self-assessment tools was inconsistent and some children and young people felt their views were not fully taken into account.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was satisfactory. The governance arrangements for the YOS were complex, with separate board arrangements in place for oversight of performance and safeguarding. Performance against youth justice key indicators was good, although membership and attendance at the YOS Performance and Governance Board had been inconsistent from some partners. More use could have been made of available data to understand trends, drive performance improvement and provide challenge. Governance and oversight of YOS safeguarding work was not

sufficiently robust, lacked prominence on key agendas and did not feature in the local Youth Justice Plan. There was, however, some strong partnership work, particularly around health, education, training and employment.

Interventions

Overall the management and delivery of interventions to reduce reoffending were good. We found that the YOS had a good range of appropriate and accessible interventions available to children and young people. Where provision was external to the YOS, referral systems and pathways were in place. Most offence targeted work was undertaken on a one-to-one basis, although a number of group based interventions were also available. Materials used were focused on the reduction of reoffending. In a small number of cases, required interventions were not delivered.

Recommendations

Post-inspection improvement work should focus particularly on achieving the following outcomes within 12 months following publication of this report:

1. as a matter of priority, the management board should ensure its arrangements for the governance of YOS safeguarding practice are robust and effective (Chief Executive of Trafford)
2. safeguarding should be included as a core element in the annual Youth Justice Plan (Chair of YOS Management Board)
3. all YOS staff and managers should have up to date safeguarding training (minimum Level 3 for case managers and specialist practitioners), understand referral procedures and protocols relating to child sexual exploitation, and the role of host local authorities in cases where Looked After Children are placed in the Borough (YOS Manager and Chair of LSCB)
4. specialist (clinical) supervision from a children's social care manager should be in place for all YOS case managers responsible for complex cases involving safeguarding, in addition to YOS line management supervision (YOS Manager and Director of Children's Services)
5. the YOS lead professional for safeguarding should be sufficiently senior to be clearly accountable for ensuring the quality of practice within the service (Chair of the YOS Management Board)
6. YOS management oversight of safeguarding practice should ensure arrangements effectively identify and address vulnerability concerns (YOS Manager)
7. the existing partnership agreement in place between Trafford Children and Young People's Service and Trafford YOS should be updated to take account of recent developments (YOS Manager and Director of Children's Services)
8. the role, remit and current capacity of the seconded police officer should maximise their contribution to the YOS in reducing reoffending (YOS Manager and Greater Manchester Police)
9. the information flow between the YOS and the police should be maximised to promote the use of such intelligence in case management. (YOS Manager and Greater Manchester Police)

Please note – throughout this report all names referred to in the practice examples have been amended to protect the individual's identity.

Contents

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 78% of work to reduce reoffending was done well enough.

Key Findings

1. Work to address offending and reoffending was prioritised.
2. Assessments and plans to address reoffending were good.
3. YOS case managers were well supported by other specialist practitioners from health and education and learning.
4. Work with children and young people serving custodial sentences was well planned for and was delivered as a single integrated sentence.
5. Interventions were largely delivered in line with assessments.
6. The Case Planning Forum provided an effective platform to facilitate inter-agency discussion and share information relating to reoffending and the risk of harm to others in individual cases.
7. We considered that the holding of two or more joint supervision meetings for cases transferred to the National Probation Service (NPS) was good practice.
8. The underlying reasons for and potential impact on reoffending rates of a recent increase in first time entrants was not well understood or planned for.

Explanation of findings

1. Work to reduce reoffending had been prioritised by Trafford YOS and rates were below regional and national averages. Reduction of reoffending was a core element and focus of the Youth Justice Plan. Whilst there was a strong emphasis on prevention and early intervention, figures indicated that the first two-quarters of 2014 were showing significant rises in first time entrants for children and young people, with 22% relating to the possession of cannabis. The causes and impact of this increase on the future YOS workload were not clearly understood and consequently had not been addressed.

2. Assessment of factors relating to offending was done well, and it was pleasing to see that these were reflected in plans and, for the most part, in interventions. It was, however, disappointing to see that in a very small number of cases, assessments and plans had clearly been cloned and that this deficit had not been picked up or redressed by management oversight systems.

3. There was clear evidence of good quality planning in place for all but two of those cases in the community. Where it was insufficient, this was because the plan was not focused enough on reducing reoffending. Initial planning for work to address reoffending was good at identifying what interventions

were to be provided and how. In three cases we inspected where this was not sufficient, this was because it was unclear how the interventions would be delivered, or in what sequence they would be delivered.

4. We saw work with children and young people being appropriately paced, with delivery responsive to their changing circumstances. In many of the cases we inspected the use of good quality materials was well evidenced in the delivery of interventions to reduce reoffending.

5. The YOS had a range of appropriate offence based interventions to reduce reoffending, including programmes on the impact and dangers of car crime, raising confidence and self-esteem, understanding and dealing with conflict, issues relating to gang membership, weapons and knife crime, peer pressure and antisocial behaviour, and victim awareness. Interventions were mainly delivered on an individual, one-to-one basis, sometimes by specialists within the team. Case managers were clearly well supported by other specialist practitioners to deliver work to reduce reoffending.

Quotes relating to victim work

"We did a relationships [course] with the YOS lady, still doing it…[I've learnt] some stuff, I won't offend in the future because I understand it was wrong." (Male)

"I do [think the YOS will help me not reoffending in the future], I have learnt to be a better person, I have learnt to take more responsibility for myself and my actions." (Male)

6. Health, well-being, education, training and employment (ETE) interventions were well established at the YOS, with good networks and pathways in place with external providers. Needs in these areas were identified by YOS staff and built into plans to reduce reoffending in almost all cases. We were also pleased to see that the YOS continued to monitor engagement in ETE at the close of their order, and were able to report some positive results. In most cases in the community, there was an appropriate balance between work to address a reduction in reoffending and managing risk of harm to others. However, in a small number of cases, vulnerability issues were not well managed which is addressed further in a later section.

Health and ETE contributions to reduce reoffending

"S*peech, language, communication and hearing screenings were helpfully offered to all children and young people. This had resulted in three children or young people being referred for specialist assessment and treatment*." (Inspector)

"*There was good evidence of detailed discussions between case managers and health workers in relation to the planning of interventions. These links were consolidated in review meetings*." (Inspector)

"*Outcomes overall for children and young people known to Trafford YOS were good. The percentage of children and young people who were in ETE at the end of their order during the period 2013/2014 was around 70%*." (Inspector – quoting YOS data)

7. The way health services were delivered had been reviewed to improve access for children and young people. The 'Health Drop-in' to Child and Adolescent Mental Health Service (CAMHS) had clearly improved access to those children and young people involved in the YOS. This service development had been well received and had proved positive, particularly for those children and young people reluctant to engage with mental health services. The Speech and Language Therapist (SALT) was providing their service over two half days to enable increased opportunities for access.

8. In 2013/2014, 47% of the children and young people receiving Tier 3 substance misuse interventions had disclosed they also had mental health issues. This number was said to be rising year-on-year. The YOS had developed expertise to ensure that the needs of this group were met. There was a dual diagnosis protocol and pathway in place to ensure that children and young people's needs were identified in a coherent plan. The YOS substance misuse worker had completed a dual diagnosis qualification to better support staff and external health services in meeting children and young people's needs. In March 2014, information about dual diagnosis had been shared with YOS staff at an informal awareness session.

9. The YOS Case Planning Forum had a remit to systematically review any case assessed as high, or very high risk of reoffending, harm to others, or vulnerability. Multi-Agency Public Protection Arrangements (MAPPA) eligible cases which did not meet the high risk category could also be included. The Case Planning Forum was chaired by a YOS team manager and brought together all professionals currently involved in a case. It provided a mechanism for ensuring management oversight, as well as enabling YOS assessments to be informed by the other partners. Intervention plans were coordinated with activities being undertaken by others, and cases reviewed at regular intervals. In the Case Planning Forum observed by inspectors the consideration of reoffending was robust.

10. One potential weakness was the reliance on case managers' correct identification of the appropriate level of risk. Cases which may have been incorrectly assessed as low or medium risk would not automatically be referred to or be scrutinised by the Case Planning Forum.

11. Overall, the quality of pre-sentence reports (PSRs) was good. They drew on a range of information, including input from children and young people and their parents/carers. Proposals were appropriate in most cases. Where PSRs were not sufficient, we found that they lacked analysis or contained an insufficient assessment of risk of harm or vulnerability. The board member representing the youth court felt the YOS serviced the court extremely well and specifically commented on the quality of PSRs.

12. Work with children and young people in custody was good, both in terms of planning and delivery. There was sufficient planning throughout the custodial phase of the sentence for work to reduce reoffending in all of the relevant cases we saw. We observed strong working relationships between YOS staff and the custodial institutions to which most of the children or young people were sent.

13. For custodial cases, we saw good continuity of work, with activities undertaken in custody appropriately followed up or built upon during the community supervision period after release. In all of the cases we inspected, the YOS had ensured the requirements of the sentence were met. Where the child or young person failed to comply, in all cases the response of the YOS was appropriate.

14. There was one dedicated YOS police officer co-located with other YOS staff which was positive. However, since April 2014, only half of their time was dedicated to YOS work with the remainder spent on acting as the Neighbourhood Justice Panels coordinator. The impact on this officer's ability to meet the needs of their core YOS role was significant, particularly in relation to intelligence dissemination. They had become reactive and reliant on case managers providing information where and when they considered this relevant, rather than a constant exchange of intelligence between both groups of staff.

15. The YOS probation officer was seconded from the NPS. A clear protocol was in place that recognised their key role in supporting the transition of YOS cases to adult services, and in managing complex and high risk cases. Where cases were transferred, the probation officer coordinated three-way meetings between the child or young person, the YOS case manager and new probation offender manager. Two or more joint supervision meetings with the child or young person took place post-transfer, which we considered to be good practice.

16. Interventions took account of the needs of victims and restorative justice. Recently, two further workers for children and young people subject to restorative interventions had been appointed to work alongside the coordinator. This was a positive enhancement of the work but it was too early to judge its effectiveness.

Victim's views

"*I have been to the premises and I absolutely feel safe there…The youth team have been brilliant; they have been involved throughout the whole process.*" (Female)

17. YOS case managers had a good understanding of the principles of effective practice and of the importance of addressing external factors, such as peer influence and lifestyles to support work specifically targeting offending behaviour. The frequent use of mentors to support the integration of children and young people into pro-social lifestyles and activities was also positive.

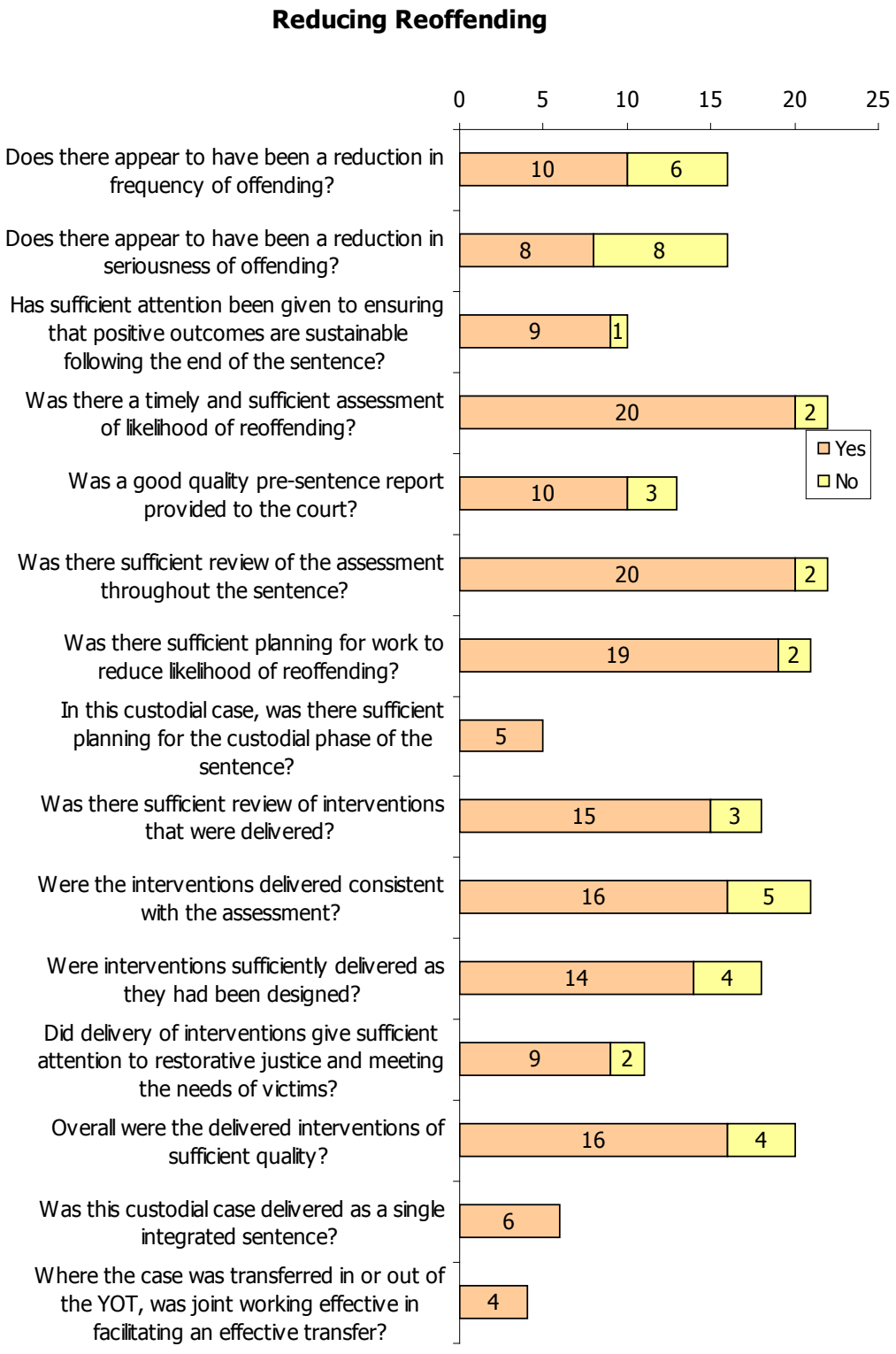
Quotes from children and young people

"*They help me with transport to get there, they phone me and make sure I am alright, they send me my timetable so I know where I have to be and what time.*" (Male)

"*Everything is getting done for me – they explain everything to me and they talk and they listen and if I don't understand they explain it to me.*" (Male)

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 23 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the Public

2

Theme 2: Protecting the public

What we expect to see

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

Case assessment score

Within the case assessment, overall 82% of work to protect the public was done well enough.

Key Findings

1. Risk of harm was assessed well in the majority of PSRs.
2. Assessments, plans and reviews to address risk of harm to others were, in the main, good.
3. The Case Planning Forum was effective in providing oversight of risk of harm in relevant cases.
4. The sharing of information and intelligence between the YOS and police was not well embedded in case management practice, and barriers were not understood.
5. Additional demands on the seconded police officer had reduced their capacity to fulfil core YOS work including intelligence and information sharing.

Explanation of findings

1. Assessment of risk of harm to others was found to be sufficient in a large majority of the cases inspected and this was communicated effectively in most PSRs. However, in about one-quarter of assessments, we found a number of deficiencies including issues with their timeliness, quality, and level of risk identified. Reviews were also done well in the main although again, about one in four were either not completed, not updated following a significant change in the child or young person's circumstances, or had been largely cloned from a previous review.

2. We saw strong evidence that appropriate work had been undertaken to address risk of harm to identifiable victims or potential victims. There were good systems in place for identifying victims, who were promptly contacted via a letter to establish if they wanted to be involved in restorative justice. Management oversight was given to any case which involved particular risks, such as those with sexual or domestic violence offences.

3. We found that planning for risk of harm work at the commencement of sentence was done sufficiently well four-fifths of the time. In a small minority of cases, no plan to manage risk of harm had been completed, or plans were not timely or responses and contingencies were not sufficient. Again, plans were appropriately reviewed in a large majority of instances, but in one-quarter of relevant cases, we found that either reviews which should have been completed were missing or were not of sufficient quality. Custodial cases were well managed, although in one case the risk management plan was not timely, and did not contain robust enough responses to identified risk.

4. In our observation of two cases at the planning forum, we saw that relevant assessments and plans were reviewed appropriately and benefited from the contributions of partner agencies. However, the YOS recognised the need to look at other cases to check screenings were correct and all potential risks were taken into account. Reviews and audits had revealed that some screenings had missed relevant and potentially dangerous behaviours such as illegal driving, which would be amended as a result.

Effective joint working

"*Multi-agency working prior to and after sentencing was…central to the positive outcomes. Agencies involved included the police, child care, YOS, education, independent fostering, mental health and specialist voluntary sector agency (Lucy Faithful Foundation). Alan's offences were serious and committed over a long period of time, and he was at significant risk of receiving a custodial sentence. Shared assessments and multi-agency planning enabled a robust intervention plan to be presented to the court, with a recommendation for a community sentence. The court could see the merit in this. Since being sentenced, risk of harm has been managed, the young person has not reoffended and is engaging with professionals, his placement and education.*" (Inspector)

"*There had also been assessments completed to assess how interventions should be delivered. Due to Angus having learning difficulties it was assessed that sessions should involve a warm up - work - cool down. The case manager used a 'How do you feel today?' resource as the warm up and built on positives from this. This then led into the intervention work. As Angus liked doing puzzles, the sessions ended with him doing a puzzle; he then associated this with the session coming to an end.*" (Inspector)

5. The seconded probation officer did not have an exclusively high risk of harm caseload but they acted as a point of reference in case discussions about risk of harm issues and clarity about what may constitute a serious risk to others. As noted, the quality of public protection work in the YOT was generally sufficient, but there was scope for improvement in some aspects of practice. More formalised use could have been made of the expertise invested in this role to drive up quality in this area of work.
6. There was some evidence of the dissemination of intelligence from the police to YOS case managers. The process for identifying intelligence relevant to children and young people on the YOS caseload was robust. The YOS police officer was able to 'flag' children and young people on the police intelligence database. Reports were automatically brought to the attention of the YOS police officer and on to the case manager. Unfortunately, we found relatively little evidence that this intelligence was embedded into case management practice and systems or acted on. It was not clear what the barriers were; whether this was because the information was not being sent or if it was not being placed on the case record system, YOIS. This warrants attention and resolution.
7. Such information deficits can have important practice and risk management consequences. For example, we saw one case in which a child or young person subject to YOS supervision had been arrested for threatening a sibling with a weapon in the family home, yet this information was not recorded on YOIS, nor had it been incorporated into managing the child or young person's risk of harm.
8. In our view, a significant contributory factor was the diversification of the YOS police officer's role that had reduced capacity to fulfil their original secondment remit, which included intelligence and information sharing.
9. Two cases in the sample were managed at MAPPA Level 1, which inspectors judged appropriate. As these were the only MAPPA cases we saw, we were not able to make definitive judgements about the effective operation of wider MAPPA in Trafford. The YOS manager was a member of and attended the Strategic MAPPA Board.

10. Trafford's model of Integrated Offender Management (IOM), known as 'Spotlight', was currently part of an ongoing review involving police, probation and youth offending services. Only a very small number of children and young people were subject to IOM arrangements (seven at the time of inspection). It was not possible to establish whether their inclusion on the cohort fed the police tasking process in a regular and coordinated way.

11. The YOS was committed to undertaking restorative work, and the 'Restorative Community Service' had been commissioned by the YOS to engage with victims and deliver restorative justice interventions. This included victim liaison work and the completion of one-to-one interventions with children and young people in order to develop their victim empathy.

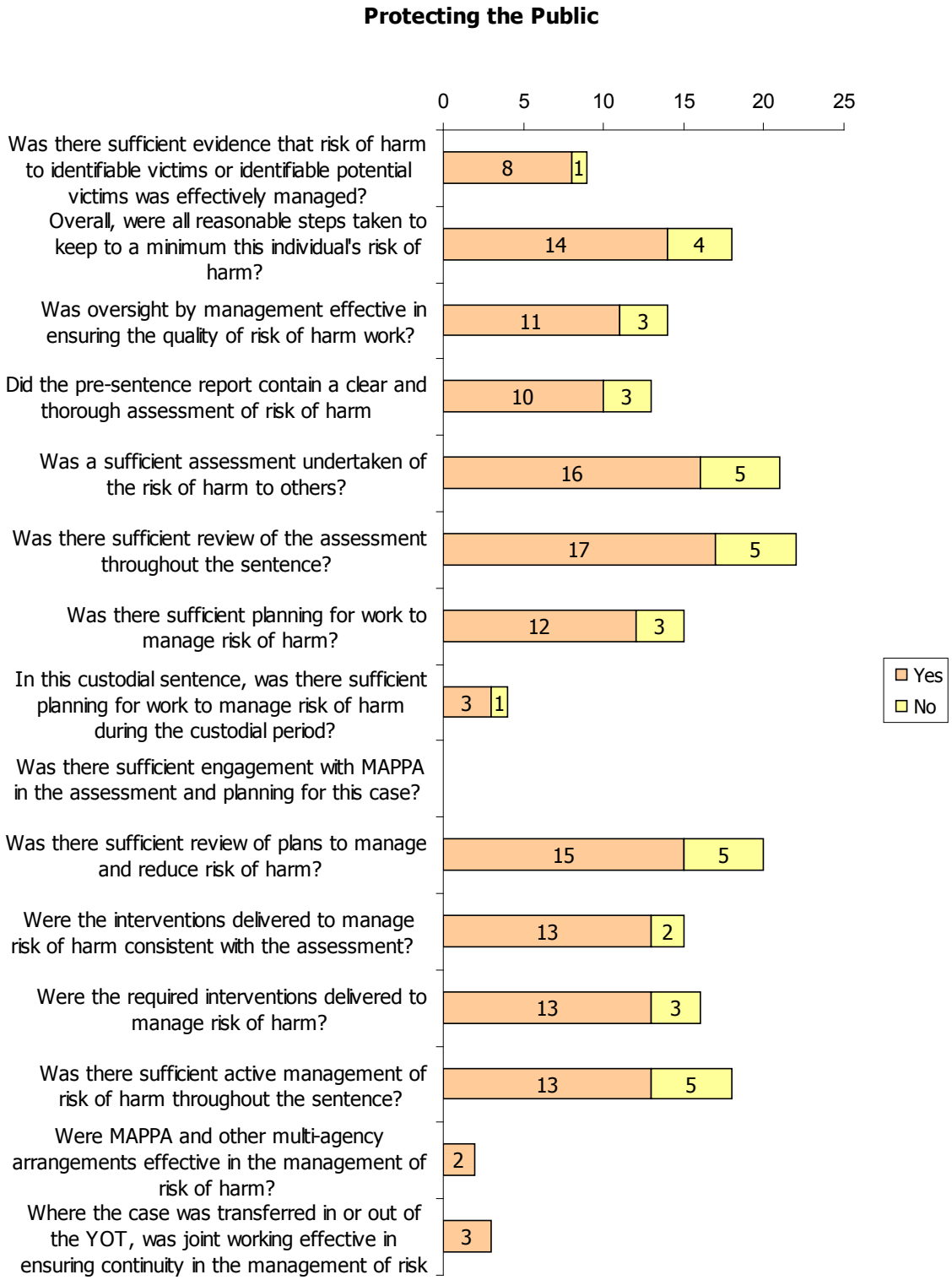
Promoting victim awareness: Quote from a young person

"*I understood how people felt after certain crimes, I got a view of the other side…it doesn't just affect them in the short time but in the long-term as well, crime has a long term effect on people*." (Male)

12. Engagement with victims was promoted by sending out information packs and then following up with telephone calls. Once engaged, victims were offered flexible contact, including home visits, letters, and telephone calls. However, the take-up of direct conferences between victims and offenders was low. Workers were creative in trying to offer alterative solutions for victims such as letters of apology or an opportunity to have a say in what reparation activity was undertaken by the child or young person. Staff reported that eight letters of apology had been completed in the last three month period.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 23 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the child or young person

3

Theme 3: Protecting the child or young person

What we expect to see

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

Case assessment score

Within the case assessment, overall 82% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. The majority of work to protect the child or young person was sufficient.
2. Work was child-centred, and where children and young people were subject to child protection planning arrangements, the YOS were active participants in core groups and other meetings.
3. There were good working relationships in cases involving Looked After Children, and offending rates were low amongst this group.
4. Intensive Fostering had helped to prevent unnecessary custodial sentences.
5. Placements for children and young people remanded to local authority care, emergency arrangements, and accommodation for homeless children and young people were in place and responsive to need.
6. There was good awareness of risk to children and young people who were missing and child sexual exploitation, but responses were not always consistent with the level of risk, particularly in more complex cases.
7. Although the majority of work was done to a sufficient standard, there were concerns about practice in a small number cases which were not well managed. In these cases, there were issues in the quality of vulnerability assessments, planning and management oversight were issues.
8. Closer examination of these cases revealed systemic weaknesses including, level of safeguarding training, lack of social work supervision and governance arrangements.
9. The Case Planning Forum did not systematically ensure children's social care oversight of joint work in cases in where there were safeguarding or vulnerability concerns.

Explanation of findings

1. The headline figures for work to protect children and young people were good, and the majority of the work we looked at in the fieldwork was done well enough. However, the lines of enquiry followed by partner inspectors looked in more detail at those cases in which the work was unsatisfactory. This highlighted deficiencies in practice as well as more systemic weaknesses. Accordingly, we found a more mixed picture than the headline figures might initially suggest.

2. PSRs largely contained clear assessments of vulnerability and safeguarding needs but, overall, assessments were not good enough in nearly one-quarter of the sample, with a similar proportion not being reviewed appropriately. The quality of assessments was variable and we found examples of documents which had clearly been cloned from previous work. Such deficits had not been identified or rectified through active management oversight and scrutiny.

3. We were pleased to find that language and communication training had been provided by the SALT to local Magistrates to improve their understanding of how to work effectively with children and young people appearing at court, and meet their needs.

4. Planning was sufficient in a large majority of cases inspected. Nevertheless, work which had not been done well was indicative of wider systemic problems. Roughly one-quarter of plans were not reviewed sufficiently well, and it was significant in this context that we found that the interventions which were required to address safeguarding and vulnerability had not been delivered.

5. Vulnerability plans were in place but a number lacked depth about all aspects of risk in the case and how these would be managed effectively. Others were not specific enough in outlining all issues of vulnerability and their potential impact. Contingency plans were also in place but not always related to the potential risks to the individual child or young person. A deficit in a number of plans (including missing children's plans) was too great a focus on information sharing and process rather than measuring and assessing the impact of work done to mitigate them.

6. We found some instances where more than one agency had vulnerability plans in place but there was little coordination between them. As a result, some actions appeared in one set of plans but not others. This meant it was not clear who was responsible for particular actions.

7. We looked in detail at the collective knowledge and skills set in the YOS and arrangements for oversight of safeguarding practice. In a small number of cases, we found some confusion about procedures, safeguarding terminology, and the respective responsibilities of YOS staff, the local authority, the home authority (in cases where children and young people were placed from outside Trafford) and, in one case, children's home staff.

8. No social workers were seconded to the YOS, although four staff were social work qualified. The YOS safeguarding lead was appropriately qualified but was not experienced in children's social care and, as a practitioner, did not have the seniority required for this role. None of the YOS managers were qualified social workers, despite being experienced in YOS work, and they lacked detailed knowledge and understanding of relevant procedures. Children's social care did not provide formal supervision of social work practice to qualified practitioners within the YOS to ensure that generic social work skills remained honed and up to date. As a result, especially in more complex cases, systems to ensure high quality management and oversight were not robust enough to give direction and accountability for safeguarding practice at an operational level.

9. The Youth Justice Plan identified domestic violence, Eye Movement Desensitisation Programming and Appropriate Adult work as priorities for training. Whilst a record of training undertaken by staff was maintained, it lacked clarity. Practitioners said that training in child safeguarding was freely available to YOS staff. Managers were expected to be trained to Level 4, and case managers to Level 3, but records indicated that too few staff had received this level of training.

10. As a consequence of these systemic and organisational issues, workers and managers at all levels were not clear about some child protection procedures and, therefore, did not follow them. A referral for a Section 47 child protection inquiry was delayed in one case and there was a lack of understanding about important child protection processes. The deficits which we saw in the response to some complex issues of safety and vulnerability (albeit in a small number of cases) was symptomatic of these issues.

11. The Case Planning Forum which we have noted, was effective in providing oversight of offending and risk of harm to others, but was less robust in addressing vulnerability concerns which was part of its core remit. Although social care staff were invited to Case Planning Forum meetings, the lack of a children's social care manager to specifically take account of safeguarding meant that thresholds to social care services were not always sufficiently considered.

12. There was a link social worker for the YOS in each of the four local social care teams. Where YOS cases were not already open to social care but it was considered they met the threshold criteria, the common assessment framework was used as a tool along with a single assessment referral form. Nevertheless, planning was not joined up and we did not always see the role of social care fully included in YOS case planning.

13. Furthermore, child protection and safeguarding did not feature in the local Youth Justice Plan, which we found a significant omission. As a result, we found no regular monitoring or empirical evaluation of the safeguarding performance specific to the YOS.

14. There was good evidence of effective practice. All new cases were checked with children's social care to ensure contact with social workers was clearly established from the outset. The work of the YOS was child-centred and where children were subject to child protection planning arrangements, YOS staff were active participants in core groups and other meetings. Where children were subject to statutory social work intervention or were Looked After Children, there was generally good evidence of information sharing between agencies, although in one case involving a particularly vulnerable young person, no record was found that some valuable intelligence regarding possible perpetrators of child sexual abuse was passed to police.

15. It was also pleasing to see some extremely good work undertaken to prevent unnecessary custodial sentences through the use of Intense Fostering called Multi-Dimensional Treatment Foster Care (MDTFC) and support, which aimed to address behavioural issues through long-term placements with an intensive programme of care.

Case illustration

Charlie was a 14 year old white young man. He had a long history of not attending school, offending and going missing. As an alternative to custody, he was made subject to a Youth Rehabilitation Order with a condition to undertake the MDTFC programme. Over a period of nine months, he learnt to change his behaviour through intensive support from his foster carers and a team of specialist workers, including a skills coach and education worker. As he came to the end of his programme, his health and self-confidence had improved and he was doing well in school. At the end of the programme, he will 'graduate' with a clear plan of support that builds on what he has learnt.

16. We also found good work between the YOS and services to Looked After Children to support those who were at risk of reoffending. Offending rates by Looked After Children have been consistently low. Where children and young people were subject to statutory social work intervention or were Looked After Children, there was good information sharing between agencies. Other strategic groupings were beginning to look more closely at factors influencing offending.

17. Systems were in place to ensure that suitable placements were available to children and young people remanded to the care of the local authority and appropriately overseen by Independent Reviewing Officers. Emergency placements and access to secure beds had led to reductions in overnight remands in police cells. Arrangements for obtaining accommodation for homeless children and young people were appropriate and responsive to need.

18. Other safeguarding and welfare needs, particularly around health and ETE were comprehensively met with good quality provision. All children and young people in the case sample had received a structured health screening that identified health issues well. There was evidence of appropriate discussions with, and timely referrals to, health professionals within the YOS and referral arrangements were clear.

19. Speech, language, communication and hearing screenings were offered to all children and young people, and there was access to the YOS counsellor, CAMHS and substance misuse workers following dedicated assessments. Referrals were responded to promptly and specialist assessment and interventions were delivered.

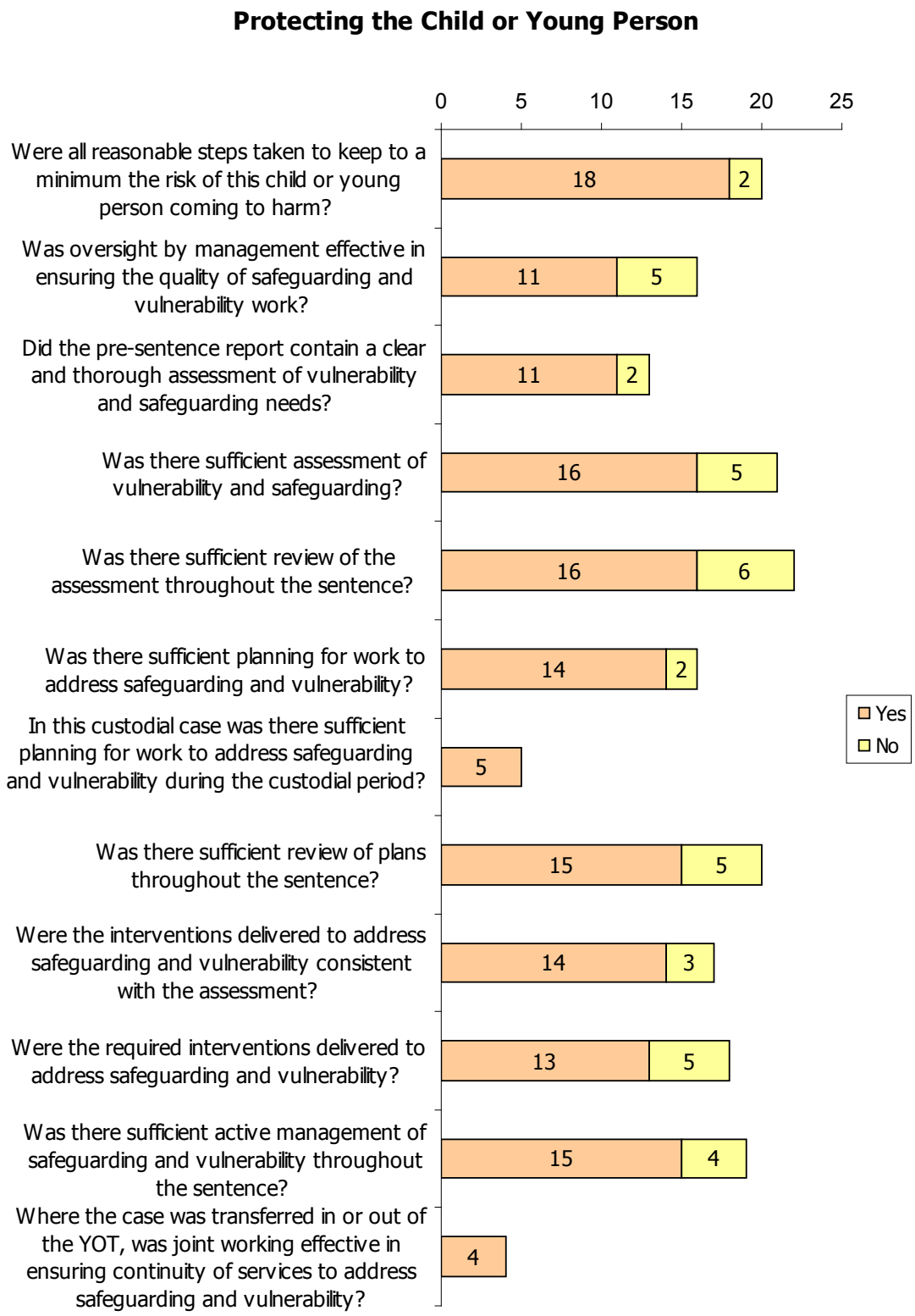
20. In 2013/2014, 85% of children and young people in contact with the YOS had received outstanding immunisations in accordance with national programmes. Those who required it were referred to specialist health services outside the YOS and we saw positive support for children and young people making the transition to adult services, often through a dedicated transitions panel.

21. Positive ETE outcomes for children and young people known to Trafford YOS have already been highlighted. In addition, the YOS informed us that 70% of children and young people were in ETE at the end of their order (2013/2014) and, of those referred by the YOS to the Connexions run activity programme, 85% had a positive ETE outcome.

22. Joint working was excellent and helped provide good outcomes in encouraging children and young people to remain in learning, and work towards gaining qualifications. Where children and young people were accessing training providers or colleges, risk assessments took place to ensure that they were managed. Good links between the YOS and providers promoted the exchange of information needed to reduce risk. Effective communication between the YOS and its partners ensured that information on poor punctuality and attendance was identified quickly and acted on.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 23 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 93% of work to ensure the sentence was served was done well enough.

Key Findings

1. Work to engage children and young people and their parents/carers was good.
2. The commissioning of a User Voice project to promote the engagement of service users was a welcome development.
3. Attention to health and well-being was done extremely well, with children and young people being well supported to access and remain engaged in health and ETE provision.
4. Case managers were able to identify and, in most cases, overcome barriers to engagement.
5. Direct YOS ETE provision was of very good quality and there were strong links to local providers.
6. Local custody rates were low and positive work was done to minimise use of disruptive custodial sentences.
7. Use of self-assessment tools was not consistent. Children and young people's priorities were not always clearly reflected in plans and interventions.

Explanation of findings

1. There was evidence that engagement with children and young people and their parents/carers was effective, and that, in a majority of cases they were able to contribute to their assessments and plans. In interview, case managers clearly knew their cases well, spoke positively about service users, worked flexibly to promote engagement, and demonstrated a strong focus on the importance of securing the active participation of children and young people and their parents/carers. It was pleasing to see engagement facilitated in a number of ways and that case managers were flexible in holding sessions outside formal office settings, for example at the YOS 'Bike Kabin' project, regular home visits and local community venues.

Good practice examples: Keeping children and young people engaged

"*The Breach Decision Panel helped to identify barriers to Gordon's compliance and enabled him to re-engage with his order prior to being returned to Court.*" (Inspector)

"*The case manager impressed us with their attempts to engage and re-engage Conrad, even in the face of explicit statements by him that he would not comply…[He] had a long history of acquisitive offending and substance misuse, but the case manager was still looking to build a positive relationship and opportunities for change, and this commitment, 'stickability' and consistency was encouraging to see.*" (Inspector)

2. Different ways of working with children and young people effectively promoted engagement, including one-to-one and group work, and coordinating different appointments for the same day. The YOS nurse had participated in the local 'Staysafe' service to increase the opportunities for contact with children and young people with whom it was harder to engage and to deliver sexual health advice.

Quotes from children and young people

"*I get on well with my [caseworker], we understand each other.*" (Male)

"*I really like her she is really nice, she just understands and that's good.*" (Male)

3. The YOS had commissioned the 'User Voice'[2] organisation to engage with children and young people whose orders were either current or had recently ended, in order to examine engagement with young women and develop a peer mentoring scheme. The children and young people themselves fed back the findings directly to the YOS managers.
4. There were still a small number of cases in which the effective engagement, and active participation was less evident. In particular, the What do YOU think? self-assessment tool was not used consistently across all cases inspected, and even where it was, we did not necessarily find that it had been used to inform planning and interventions. In some cases, children and young people and their parents/carers had not had their views fully taken into account in the development of plans.

Quotes from children and young people

"*I feel like I was listened to [but] I don't feel they took what I said into account though.*" (Male)

"*They listed…activities I could do, and I chose one. But I didn't do that in the order. They chose… basically they set my order how they liked it.*" (Male)

Quote from a parent/carer

"I think he has fallen down the middle, I think if he could have carried on with one case worker it would have been so much simpler but that's not always the case." (Female)

5. Diversity needs were, in the main, appropriately identified and addressed by case managers. As noted earlier, they were well supported by their specialist YOS colleagues. We saw evidence that learning styles were regularly assessed and that support around speech, language, and communication needs (a significant barrier to engagement for many children and young people) was used extensively.
6. Children and young people were offered onward referrals for interventions that provided support to enable them to achieve and maintain a healthy lifestyle. Holistic health assessments, often completed over several appointments, included detailed assessments of individual children and young people's communication and sexual health needs.
7. We saw excellent work to actively engage and promote participation in learning. Internal links between the YOS education team and case managers worked well, and benefited from being co-located. Links between the YOS, training providers and local college were excellent, and there was provision to support children and young people in accessing and/or re-engaging with learning opportunities.

---

2 *User Voice is a charity, led by majority ex-offenders, which aims to reduce offending by presenting the voice of the people in the criminal justice system: www.uservoice.org*

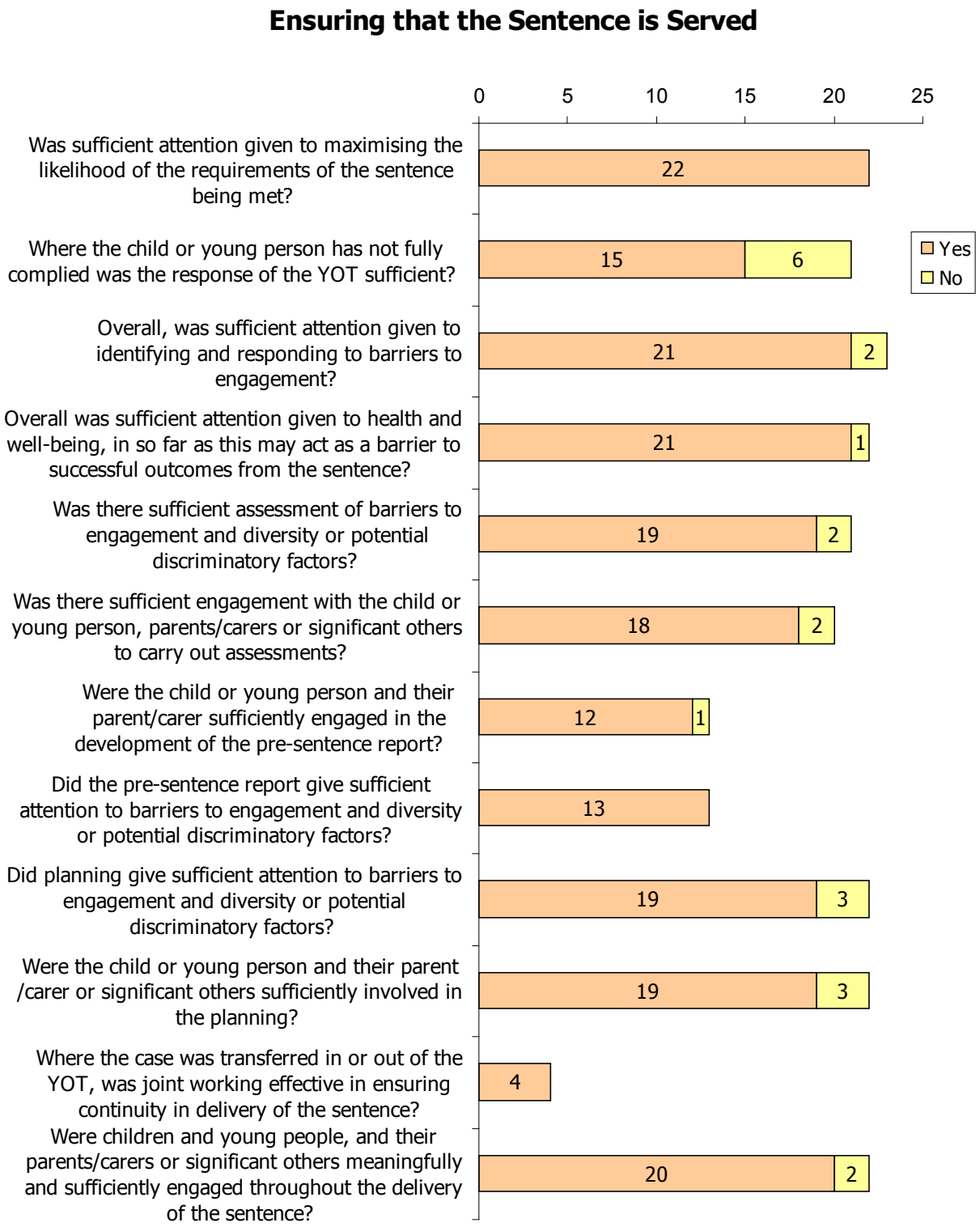
Promising practice: Integration of learning

"*Good work had been completed at integrating English and Maths into programmes run by the Trafford YOS. In one community based project a bicycle repair workshop (Bike Kabin) had been set up which enabled children and young people to obtain a short qualification which enhanced their employment prospects within this work.*" (Inspector)

8. The YOS worked well with alternative education provision within the area with a strong focus on maintaining children and young people in learning. The YOS, along with the alternative providers (and where appropriate, parents/carers) worked very effectively at providing high levels of individual support to meet the diverse needs of children and young people.
9. Custody rates in Trafford were below the national and regional average. Given the disruptive impact which custody has on children and young people's lives, including continuity of family relationships, engagement in learning, training or work, and future life chances, it was encouraging to see that work to divert children and young people from custody was prioritised. The Intensive Fostering initiative was a very positive development.
10. We noted that, in the current year, girls and young women were over-represented in the custody figures. However, the numbers were small, and occurred against a backdrop of there being no use of custody for females in the previous year.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 23 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

Effective governance, partnership and management arrangements are in place. These enable the YOS to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

Key Findings

1. A review of the functioning and membership of the YOS Management Board was in progress at the time of our inspection.
2. Membership was at an appropriate level of seniority, but attendance was variable. There was a lack of evidence to demonstrate that board members had provided sufficient scrutiny and challenge to hold the YOS fully to account.
3. Internal governance meetings oversaw the governance arrangements within the YOS, but lacked sufficient oversight of the annual quality assurance plan. The selection of the priority areas for practice improvement did not include safeguarding.
4. We were pleased to see there was a system of governance visits focused on social care practice, but a greater strategic focus was needed on child safeguarding.
5. The YOS had arrangements for delivery of a wide range of services; those to address health needs and ETE were particularly impressive.
6. There was no systematic evaluation of the effectiveness of the services provided by the YOS, or its partner organisations.
7. All practitioners we met thought they received an appropriate level and quality of supervision and support from their managers.
8. There was a staff training record but no forward training plan related to the current business plan. Practitioner training in safeguarding was not yet to a sufficient level.
9. The YOS safeguarding lead was held at practitioner level rather than by an appropriate manager.
10. While findings from quality assurance activities resulted in appropriate actions, they were not used to inform specific action plans to address any shortcomings found.
11. We were pleased to find the YOS was involved in a critical friend review process in which members of Trafford's Local Safeguarding Children Board undertook a review of the quality of safeguarding work.

Explanation of findings

1. Leadership and Governance – offending is reduced and other criminal justice and related objectives are met

1.1. The YOS was managed by a 'Performance and Governance Board' - a sub group of the Safer Trafford Partnership Board, but was line managed within the Children and Young People's Service. The board was chaired by the NPS Assistant Chief Executive, and key partners were represented on the board at an appropriate level of seniority. The Joint Director (Health) was the senior manager

with responsibility for the YOS and sat on the board. However, the complex governance matrix meant that the Director holding the specific lead for children's social care and safeguarding was not a representative, which we felt was a gap.

1.2. A comprehensive youth justice strategy was integrated with the YOS operational plan, but greater focus was needed on safeguarding and child sexual exploitation.

1.3. Board meeting minutes contained a RAG (red/amber/green) rating process for monitoring progress on items, with an ongoing actions list.

1.4. Attendance at recent board meetings had been less than optimal, particularly in relation to representatives from the police and education services. The board intended to meet quarterly, but had only held two business meetings in 2014. A workshop was held in September 2014 to start a functional review, including membership, utilising the YJB Guidance 'Modern Youth Offending Partnerships'[3].

1.5. The board appeared to be successful in maintaining the commitment of partner agencies to operational resources with the exception of the reduced time available for the seconded police officer. This had not been sanctioned by the board.

1.6. We found that health delivery reflected local priorities. The current integration agenda was not detracting from delivery of these services, although some arrangements for governance, including those for monitoring health outcomes required further development.

1.7. The health representative on the YOS Performance and Governance Board was of appropriate seniority and provided a valuable public health perspective. Whilst performance of the three key national indicators was routinely monitored by the board, other health related reports were received by exception only. Further monitoring was carried out by the wider governance arrangements within the Children's Trust. However, monitoring arrangements to measure impact and ensure positive health outcomes for children and young people were not well developed.

1.8. Some members of the board felt they wanted more information and discussion at meetings, facilitated by a reduced agenda. The annual Youth Justice Plan had been examined in detail by the board, but some members wanted more influence in the content rather than signing off the completed document. One member noted that, while YOS information was presented to the board at meetings, it was not always sent to members at other times, such as when meetings were cancelled or when business was deferred to a subsequent meeting. The ability of board members to provide sufficient scrutiny and challenge, and to hold each other and the YOS to account was, therefore, restricted.

1.9. The youth justice function of the YOS was well supported by its board, reporting to the Safer Trafford Partnership Board, and we found a strong focus on a primary youth justice function of preventing reoffending at all levels in the YOS.

1.10. Child safeguarding was not a standing item on the board agenda, and one member expressed the view that this was not core business of the board. There were other sub-groups of the Safer Trafford Partnership Board, Trafford Children's Safeguarding Board, and the Children's Social Care Governance Group at which such concerns could be tabled. This had the effect of reducing the YOS Performance and Governance Board's oversight of this key area of responsibility. Although specific safeguarding issues (for example, children being remanded in police cells overnight) had been discussed, it was not clear how the robustness of YOS safeguarding practice more generally was systematically evaluated or challenged. For instance, child sexual exploitation was a significant concern for the police service, but this did not appear to have featured at board meetings within the last two years.

3 *Modern Youth Offending Partnerships – Guidance on effective youth offending team governance Youth Justice Board 2013*

1.11. Other key issues facing the YOS were an increase in first time entrants in the current financial year, and how the YOS would be prioritised in relation to other local services in the face of budget cuts, neither of which had been formally considered by the board. The YOS had planned for budget savings in the next year, helped by previous investment in preventative work having been successful in reducing current levels of demand. However, it was not clear that the causes and potential impact on YOS workloads of the rise in first time entrants had been actively identified or fully addressed by the board.

1.12. The work of the board was supported by an Internal Governance Meeting. This comprised the YOS manager and operational managers who identified a number of themes that were audited and accompanied by an action plan. The meeting reported to the board, and other local governance groups. However, whilst this work avoided the board being drawn into an inappropriate level of detail of YOS activity, we considered that too much reliance and responsibility was placed on the YOS itself for selecting the particular areas for scrutiny.

1.13. In our view, the YOS Performance and Governance Board had insufficient oversight of the annual quality assurance plan, and the selection of the priority areas for practice improvement.

2. Partnerships – effective partnerships make a positive difference

2.1. Membership of the YOS Board included a commissioning manager from the Local Children and Families department. While not directly involved in the commissioning of services by the YOS or their procurement, they had advised the YOS on the structure and management of services to be commissioned for domestic abuse interventions and for obtaining feedback from service users through User Voice. It was encouraging to see that these services had been procured on the basis of needs identified by case managers.

2.2. It was pleasing to find that the YOS was represented on key local partnerships such as the Safer Trafford Partnership Board and the Local Safeguarding Children's Board, and was informed by local and national priorities. There were also appropriate linkages to MAPPA, as well as other Greater Manchester forums.

2.3. The Greater Manchester Police and Crime Commissioner had instigated a Manchester-wide joint strategic needs analysis on crime to which the YOS was a party. However, the YOS had not undertaken any structured needs analysis of the service user population for which it was responsible, in order to anticipate and plan for future demands.

2.4. Contracts were in place for the delivery of a wide range of services, and we were particularly impressed by the nature and quality of interventions to address health needs and ETE. Effective work was also supported by good joint working as well as specifically commissioned services, such as a fair access protocol for access to secondary education services where normal admission procedures and/or provision had failed. Agreements were in place with most partner organisations for information exchange relating to individual cases which aided joint working.

2.5. There were difficulties in obtaining services to support work with some children and young people in relation to access to accommodation (particularly for 16 and 17 year olds), and mental health for those in transition to adult services. In some cases, practitioners experienced difficulty meeting Multi-Agency Referral and Assessment Team thresholds for access to social work assessment or more specialist/intensive provision.

2.6. In all of the individual cases in the sample assessed by inspectors, we considered the case manager had access to sufficient resources in the case for work to reduce reoffending, manage risk of harm and address any safeguarding concerns.

2.7. The YOS interface and working relationship with children's services was generally sufficient, although we have identified a number of systemic concerns arising out of an examination of a small number of cases. The existing YOS/children's social care protocol was very dated and did not reflect recent developments.

2.8. It was encouraging to find that the YOS probation officer secondment had been maintained. There was a clear rationale and focus for their work which was governed by a protocol which recognised their key role in supporting the transition of YOS cases to adult services, and in managing complex and high risk cases.

3. Workforce management - Effective workforce management supports quality service delivery

3.1. The YOS had adopted the YJB National Supervision Framework for the frequency and quality of staff supervision, and all of the practitioners we met during the inspection spoke positively about their managers and specifically about the quality of supervision and support they received. Supervision was used as an opportunity for team leaders to review cases and development needs.

3.2. YOS staff training was recorded. However, training and development, particularly around child protection, safeguarding and child sexual exploitation, did not feature in the training priorities referenced in the Youth Justice Plan. We did not see a dedicated YOS training strategy or plan.

3.3. In relation to child sexual exploitation, case managers had received some training (provided internally through a member of staff who acted as a board, 'child sexual exploitation champion') in the YOS and was linked with Manchester-wide initiatives to address this issue. However, as noted, staff had not received the appropriate level of training.

3.4. The YOS was represented at a number of Greater Manchester forums which were, variously, working to promote best practice in work with girls and young women, review and align arrangements for IOM sub-regionally, and deliver training designed to ensure that common issues were delivered cooperatively across local YOSs, for example in restorative justice.

4. Learning organisation - leaning and improvement leads to positive outcomes

4.1. The YOS undertook a significant amount of quality assurance activity. A quality assurance framework based on self-assessment was in place. It aimed to provide a consistent system to set performance improvement targets and support the continuing improvement of YOS work. Evidence to support its effectiveness was mixed.

4.2. The quarterly YOS Internal Governance Meeting, comprising the management team, prioritised a small number of issues each year to audit and sample. There was an accompanying action plan against which progress was regularly monitored. Although safeguarding training had been identified as a priority, this had not been delivered to the requisite level.

4.3. In our view, the YOS Performance and Governance Board had insufficient oversight of the quality assurance plan. As noted above, the priority areas for practice improvement were determined by the YOS Internal Governance Meeting rather than the YOS Performance and Governance Board.

4.4. We were pleased to see that the YOS participated in a number of activities which opened up their practice to external scrutiny. The YOS had participated in peer reviews, and following training on the HMI Probation methodology, they joined in with a mock inspection across the Greater Manchester YOSs. However, the impact of these activities was not always clear and recommendations/changes to practice arising out of them were not referenced, in the Youth Justice Plan for example.

4.5. The Trafford Safeguarding Children Board (TSCB) operated a critical friend review process in which members of the TSCB undertook a review of the quality of safeguarding work of various services including the YOS. Such a review had been undertaken by three TSCB members (including a 'safeguarding expert') shortly before the inspection. They reviewed a YOS self-assessment audit and relevant performance information and followed this up with a visit in which the findings of the audit, current practice, and details of specific cases were discussed with various YOS staff, including the Head of Service. The review made several recommendations relating to staff development and training and the dissemination of information from the board within the YOS.

4.6. While individual and group work with service users was quality assured and audited, there was no systematic evaluation of the effectiveness or outcomes of these activities, whether in-house by the YOS, or by partner organisations. Neither did we find any evaluation of health outcomes. The YOS did monitor Asset health scores, and these showed reductions over time in some cases, but this information related to individual probability and not to long-term outcomes for children and young people.

Interventions to reduce reoffending

6

Theme 6: Interventions

What we expect to see

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

Case assessment score

Within the case assessment, overall 83% of interventions work to was done well enough.

Key Findings

1. A wide range of YOS interventions were available to children and young people.
2. Children and young people were supported to access external services, assisted by strong operational partnerships.
3. There was good evidence on file of appropriate materials being used in interventions.
4. Health and ETE interventions were accessible and largely of good quality.
5. Some planned interventions were not delivered or not delivered sufficiently well.
6. Evaluation of the impact of interventions was partial.

Explanation of findings

1. In the 23 cases sampled, we found that interventions to reduce reoffending were delivered consistently well. The suitability and eligibility of the child or young person for specific interventions to address reoffending had been sufficiently assessed in all but two cases, and delivery was generally consistent with assessments and plans. In almost all cases, assessments of reoffending had been reviewed when required and to a sufficient standard. There was clear evidence of the delivery of interventions in line with initial plans in three-quarters of the cases we looked at.
2. However, in five cases, planned interventions had not been delivered. Where insufficient interventions had been delivered, these related mainly to addressing unsatisfactory living arrangements, drug misuse and emotional or mental health. In the majority of cases, the interventions delivered were sufficiently reviewed by the YOS.
3. The YOS had well-established external partnerships to support this work, and a wide range of internal services. Many YOS interventions to address reoffending were designed as group programmes but were delivered individually, reflecting the small YOS caseload and, consequently, not having enough cases requiring the same programme at the same time. However, the individual delivery was often done directly by the relevant programme specialist, or by the case manager supported by the specialist. Case files often contained evidence of materials being used in a thematic and programmed way.

4. A wide range of interventions was available to the YOS. Whilst many were delivered by YOS staff themselves, others, including education work, were delivered jointly with other agencies or by other organisations under contract, such as the work with User Voice. The work had also been supported by the development of effective working relationships with key partner agencies. For example, the YOS was running a programme 'Act Like A Man', (which focused on peer issues and stereotypes) that had been developed by Manchester Primary Care Trust.
5. In the 'Act Like A Man' session, ground rules were agreed by all participants, inductions were completed and aims were clear. Facilitators used a good range of appropriate materials that were relevant and accessible to the people attending, including the use of videos, current news topics and films. The language used was easy to understand and led to open engagement and in-depth personal discussions by all participants. Facilitators were very enthusiastic and demonstrated respectful male/female pro-social modelling. Participants were challenged appropriately and praised for their open contributions.
6. The YOS had been effective in supporting staff and their partner organisations to develop and deliver a good range of interventions within the service. The YOS had an excellent provision in health, education and training. Mental health services were well-established, dedicated physical health and substance misuse support was in place, as were well utilised counselling, speech, language and communications provision.
7. Likewise, there were strong linkages to a range of ETE providers, including alternative provision with a strong focus on maintaining children and young people in learning.

Practice examples

"*It was good to see that the education coordinator had worked to embed literacy and numeracy into courses delivered by the YOS. This effectively reinforced learning and illustrated to children and young people the benefit of developing these skills.*" (Inspector)

"*We observed work in the case of a young person excluded from an educational behavioural school due to poor behaviour. As an alternative he attended three sessions per week at the YOS of between one hour or more in duration. The school had sent the YOS the educational material to be completed. The young person worked well on an individual basis. There was good use of praise and encouragement and he confirmed that he found it a much better learning environment than school. The case manager had taken account of the young person's learning needs and was actively looking for effective ways to adapt work accordingly. Sessions were planned for the daytime when he had previously offended and when he would normally be at school to ensure he was making constructive use of his time.*" (Inspector)

8. The 'Bike Kabin' project provided a reparative element to supervision. Attendance at six sessions constituted the formal reparation component of a community sentence, although children and young people could also attend voluntarily. Members of the public donated unclaimed or unwanted bicycles which participants repaired and refurbished with the restored bicycles donated to local charitable or community causes. As well as being reparative, the participants also learned useful skills which could be accredited by a nationally recognised qualification in bicycle maintenance. There appeared to be scope to make greater use of this project as part of the statutory reparative element of supervision.
9. We observed preparations to deliver an individual session of the 'Wrecked 2' programme, which aimed to increase understanding of car crime, its impact on others, and its danger to the child or young person themselves. The case worker was well prepared to run the session, focusing on the child or young person's previous Taking Without Owners Consent offences, and his need to develop a better understanding of the potentially fatal outcome. The programme was well constructed and made relevant by using real life examples and local settings that they could relate to. It used good quality

video film and supporting materials.

10. The User Voice project engaged children and young people in a session designed to elicit their views of YOS provision. Although a child or young person led the discussions, User Voice ensured that the meeting stayed focused on their agenda and appropriately moved participants on. Staff were clearly experienced and competent at eliciting the deeper thoughts of the children and young people about the subjects which were discussed. Facilitators were fair and ensured balanced views about positive and negative experiences voiced in the meeting, and that all those present were included in the discussions.
11. A YOS 'Men's Group', was run at the Old Trafford Youth Club. The session observed was attended by three children and young people, two as part of Intensive Supervision and Surveillance requirements and one attending voluntarily. The group was run weekly and involved a mixture of group discussions, individual discussions and ad hoc activities. The rationale was to provide a relaxed environment where participants were exposed to pro-social modelling, and were able to participate in activities. At the session observed, we saw evidence of constructive challenge (addressing thinking and behaviour), individual discussion of welfare concerns, risk and offending
12. The 'Restorative Community Service' delivered restorative justice work, including victim engagement and liaison as well as one-to-one victim empathy work with children and young people. The take-up of direct victim-offender interventions was limited, but there was evidence that letters of apology were used and that victims were able to state what form of reparation activity should be undertaken by the child or young person.

Appendices

Appendix 1 - Background to the inspection

Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work, predominantly in statutory community and custodial cases, in a small number of local authority areas each year.

The majority of the Youth Offending Services selected for these inspections are those whose performance – based on reoffending rates, National Youth Justice Outcome Indicators and 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.

The primary purpose of the Youth Justice System is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, ensuring the sentence is served and governance and partnerships.

Criteria

A copy of the inspection criteria is available on the HMI Probation website:

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

Methodology

The YOS was informed approximately 11 working days prior to the inspection taking place.

Fieldwork for this inspection was undertaken on the weeks commencing:

10 November 2014 and 24 November 2014

In the first fieldwork week we looked at a representative sample of 23 individual cases up to 12 months old, some current, others terminated. The sample 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. Cases were assessed by a team of inspection staff. They examined these wherever possible with case managers, who were invited to discuss their work in-depth, explain their thinking and identify supporting evidence in the record.

We also received copies of relevant local documents.

During the week in between, the data from the case inspections was collated and a picture about the quality of the work of the YOS developed.

The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We explored the lines of enquiry which emerged from the case inspections. The leadership, management and partnership elements of the inspection were assessed, with a particular focus on reducing offending.

We also gathered the views of others, including strategic managers, staff and service users – children and young people, parents/carers and victims, and observed work taking place.

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

Scoring Approach

Details of how our inspection judgements are made 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/

Publication arrangements

A draft report is sent to the YOS 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/

Role of HMI Probation and Code of Practice

Information on the role of HMI Probation and our 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:

HM Chief Inspector of Probation

1st Floor, Manchester Civil Justice Centre

1 Bridge Street West

Manchester

M3 3FX

Appendix 2

Acknowledgements

Lead Inspector	Colin Barnes, *HMI Probation*
Deputy Lead Inspector	Steve Woodgate, *HMI Probation*
Inspection Team	Jo Dowling, *HMI Probation* Cheryl Austin, *Local Assessor* Jan Fooks-Bale, *Care Quality Commission* Ian Elliott, *HMI Constabulary* Karen McKeown, *Ofsted Social Care* Stephen Miller, *Ofsted Learning and Skills* Shauna Dacres, Paula Harriott, *User Engagement Officers, User Voice*
HMI Probation Support Services	Stephen Hunt, *Operations Officer* Rob Turner, *Operations Manager* Oliver Kenton, *Assistant Research Officer* Alex Pentecost, *Communications Manager*
Assistant Chief Inspector	Julie Fox, *HMI Probation*

Criminal Justice Joint Inspection

Arolygiad ar y Cyd Cyfiawnder Troseddol

HM Inspectorate of Probation
Civil Justice Centre
1 Bridge Street West
Manchester
M3 3FX

ISBN: 978-1-84099-693-7