Inspection of Youth Offending Work
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To:	Alex Hopkins, Chair of Northamptonshire YOS Management Board
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From:	Helen Mercer, Director (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Northamptonshire

The inspection was conducted from 09 – 11 March 2015 as part of our programme of inspection of youth offending work. This report is published on the HMI Probation website. A copy will be provided to partner inspectorates to inform their inspections, and to the Youth Justice Board (YJB).

Context

The aim of the youth justice system is to prevent offending by children and young people. Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. We examined 34 cases of children and young people who had recently offended and were supervised by Northamptonshire Youth Offending Service (YOS). Wherever possible this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Northamptonshire was 38.0%. This was worse than the previous year and worse than the England and Wales average of 36.1%.

Overall, we found good work by staff who engaged well with children and young people and their parents/carers to develop the initial assessments, and used this information effectively to inform decisions in courts. Work to manage the risk of harm to others and to protect children and young people was also done well. The YOS have developed effective local policies but guidance supporting effective management oversight needed to be applied more consistently.

Commentary on the inspection in Northamptonshire:

1. Reducing reoffending

1.1. Courts receive pre-sentence reports (PSRs) to aid sentencing. The majority of these were of good quality, as were all of the reports provided to the youth offender panel. There was clear evidence that local management arrangements had been effective in ensuring the reports were of good quality. We were impressed by the local Referral Order Contract forms, which supported panels and staff in setting out SMART[2] requirements for the children and young people to complete.

[1] Published January 2015 based on binary reoffending rates after 12 months for the April 2012 – March 2013 cohort. Source: Ministry of Justice
[2] SMART: Specific, Measurable, Assignable, Realistic and Time-related

1.2. The initial assessment of the child or young person's likelihood of reoffending is key in understanding why they have offended and what may help to reduce their reoffending in the future. Assessments were thorough and provided a full picture of the child or young person's circumstances in almost all of the cases we inspected. One inspector noted that "*the case manager allocated to this case was also the PSR writer. She recognised the diverse needs of Kevin and his family, and called a professional's meeting pre-sentence to discuss the concerns, and what needed to be done by whom. The meeting assisted the YOS in formulating the risk and vulnerability plans*".

1.3. There had been a good enough review of the assessments in two-thirds of relevant cases. Where there were gaps, this was because a review had not taken place or there was an insufficient update of the child or young person's circumstances, particularly where there had been a significant change. Case managers sometimes used information from previous assessments, without making appropriate amendments.

1.4. Following on from the assessment, we look to see if there is a plan of work to help reduce reoffending. This was in place, and of sufficient quality, in three-quarters of the custodial cases and almost all of the community cases.

1.5. We found that one-third of the plans had subsequently not been reviewed well enough, either because the review had not taken place, or the plan had not been revised as required. However, in a positive example, an inspector commented that the "*Intervention plan had clear objectives and this had clearly been reviewed - objectives had been removed as they were completed and new objectives identified that related to the change in circumstances*".

1.6. We were pleased to find a good level of contact with children and young people during the custodial phase of sentences, both in and out of formal planning meetings.

1.7. There was only one case in our sample that, due to the serious nature of the offence, should have been subject to Multi-Agency Public Protection Arrangements, but had not been recognised as such. However, this was resolved quickly once we had made the YOS aware and we observed good partnership working with key organisations such as the Local Safeguarding Children Board.

1.8. Overall, we found that case managers had a sound level of understanding of what was likely to be effective in working with children and young people to help them stop offending, and improve the quality of their lives.

2. Protecting the public

2.1. We expect to see a detailed assessment of the risk of harm a child or young person poses to others, and plans to manage that risk, whether in the community or in custody. This should cover all relevant information, including past offending and behaviour, as well as the impact on victims. We found that this had been done well in over three-quarters of the cases in the sample.

2.2. We also look to see if there is a plan of work to help protect the public. This was in place, and of sufficient quality, in all but two of the community cases and in all but one of the custodial cases. We were particularly impressed by the well designed local joint risk and vulnerability plans, which supported staff in thinking broadly about the different risks posed by children and young people to themselves and others, and how those risks could be managed effectively.

2.3. However, one-quarter of reviews (of both assessments and plans for cases in the community) were not good enough, either because they had not taken place, or did not

ensure plans were revised as required. Missing information included new allegations or convictions, which were not considered properly when undertaking reviews.

2.4. The risk of harm to victims who had been identified was managed well in all but four of the relevant cases. Effective management oversight of risk of harm work could be improved. There was evidence of action, but it did not always ensure that the deficits in plans were addressed, or that reviews were timely.

3. Protecting the child or young person

3.1. The initial assessment of safeguarding and vulnerability had been completed sufficiently well in all but four cases. The resulting plans were sufficient in all but one case, where YOS staff had not contributed sufficiently to a custodial plan to manage a young person's vulnerability.

3.2. The reviews of assessments and planning relating to safeguarding and vulnerability were not good enough in about one-third of the relevant cases. Children and young people's lives can change very rapidly. New and relevant information should trigger an update. In two cases, reviews had not taken place, and in four cases the review did not ensure plans were revised as required.

3.3. The effectiveness of management oversight could be more robust. Some individual managers provided skilful oversight, scrutinising work thoroughly and providing clear direction as to how the deficits could be addressed. However, this was not evidenced in a number of cases. The joint risk and vulnerability panel also provided useful direction to staff. One inspector noted that the "*Panel clearly identified the needs of the case, and planned for how the case manager and the other workers were going to support Dominic*".

4. Ensuring that the sentence is served

4.1. We found a high level of engagement in all but four cases between case managers, children and young people and their parents/carers (although parents/carers were not always sufficiently involved in planning). Case managers knew the children and young people they were managing and built positive relationships with them. One inspector noted "*What has enabled Oliver to progress on the order has been the willingness for the case manager and line manager to reassess their practice and adjust their approach to better meet the young person's needs. For example, they have used role-play and visual interventions to meet Oliver's learning style*".

4.2. Case managers gave particular attention to barriers to engagement, and other diversity or potential discriminatory factors, at the start of sentences in all but three cases. One inspector noted that the YOS "*have a detailed diversity assessment which had been undertaken with Steven who had moved with his family from Europe one year ago. Having completed the assessment it is pleasing to see this reflected in the Asset with reference to how to ensure Steven's diversity issues are considered in supervision. The Asset noted 'Steven's grasp of English is good, in the context of only speaking it for one year. Communication with Steven needs to be clear and uncomplicated, with frequent checks to ensure he has understood' *". Case managers also gave sufficient attention to health and well-being outcomes in all relevant cases.

4.3. In over half of the cases, the child or young person had complied with the requirements of their sentence, some after initial difficulties. This showed the dedication of case managers and their commitment to holding children and young people to account. We were pleased to find that where the child or young person had not complied with the requirements of the sentence, the response of the case manager was appropriate and

robust. Case managers had a good understanding of the expectations of the YOS when dealing with this.

Operational management

We found that almost all staff had a good understanding of local policies and procedures as well as the principles of effective practice with children and young people who have offended. Although staff spoke positively about the countersigning and management oversight process, we did find evidence to suggest it was not always fully effective.

It was encouraging to see that all case managers interviewed reported that they understood how the organisation's priorities affected their role in reducing reoffending. The majority felt that there was a positive and supportive learning and development culture in the organisation, but one identified the need for more up to date training in speech, language and communication needs.

Key strengths

- PSRs and reports provided to the youth offender panel were good.
- The joint risk & vulnerability management panels and their supporting documents were effective and useful to staff.
- Case managers knew children and young people and could accurately and concisely describe why they had offended.
- Case managers planned well to reduce reoffending and to protect the children and young people and the public.

Areas requiring improvement

- Case managers should be more receptive to changes in circumstances so that reviews of assessments and plans are undertaken when required, and are fully effective.
- Management oversight should ensure the timeliness, quality and effectivess of reviews.

We are grateful for the support that we received from staff in the YOS to facilitate and engage with this inspection. Please pass on our thanks, and ensure that they are made fully aware of these inspection findings.

If you have any further questions about the inspection please contact the lead inspector, who was Caroline Nicklin. She can be contacted at caroline.nicklin@hmiprobation.gsi.gov.uk or on 07766 290969.

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Note 1: As an independent inspectorate, HMI Probation provides assurance to Ministers and the public on the effectiveness of work with those who have offended or are likely to offend, promotes continuous improvement by the organisations that we inspect and contributes to the effectiveness of the criminal justice system.

Note 2: We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justiceinspectorates.gov.uk/hmiprobation.

Note 3: To request a paper copy of this report, please contact HMI Probation Communications at communications@hmiprobation.gsi.gov.uk or on 0161 240 5336.