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 **Swindon**

An inspection led by HMI Probation

independent inspection of youth offending work

June 2015

Foreword

This inspection of youth offending work in Swindon 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 Swindon primarily because of its deteriorating performance relating to reconviction rates and high rates of reoffending by children looked after by the local authority.

We acknowledge that the measure of a Youth Offending Team's (YOT's) success can depend on changes in outcomes for small numbers of children and young people. This can explain a fluctuation in Swindon's reoffending rate, which rose considerably for a short time but has fallen recently to more closely reflect the national average: 38.6%[1] against 36.1% respectively. Swindon's custody rates are relatively low. However, while nationally fewer children and young people are entering the youth justice system, rates in Swindon are rising, with implications for resourcing by the YOT.

Overall, we found an evident commitment by Swindon YOT to keep the children and young people with whom it worked safe, enhance their well-being and help to reduce the likelihood of them offending again. The YOT formed strong relationships with its partners and service users to provide a wide range of good interventions. However, there were a number of gaps at an operational and management level in work to protect the public and in safeguarding. The YOT Management Board was interested and knowledgeable about the YOT, but had yet to put the governance, scrutiny and challenge structures in place to help direct and inform its work.

We have identified a number of areas where Swindon YOT has cause to celebrate its performance and highlighted others where there is scope for review. We have made a small number of recommendations in specific areas for improvement and look forward to Swindon's successful implementation of these.

Paul Wilson CBE

HM Chief Inspector of Probation

June 2015

1 Published January 2015 based on binary reoffending rates after 12 months for the April 2012 - March 2013 cohort. Source: Ministry of Justice.

Key judgements

Reducing reoffending

Protecting the public

Protecting children and young people

Ensuring the sentence is served

Governance and partnerships

Interventions

Summary

Reducing reoffending

Overall work to reduce reoffending was satisfactory. Case managers had a good understanding of the reasons why children and young people offended. They used their knowledge to provide sound information to court, both to inform sentencing decisions and to put appropriate intervention plans in place. A holistic approach with the family and specialist workers was taken to work to reduce the likelihood of reoffending. This led to a range of positive, sustainable outcomes that, some children and young people advised, could be accredited to their time with the YOT.

Protecting the public

Overall work to protect the public and actual or potential victims was unsatisfactory. The YOT often underestimated the level of harm a child or young person posed to others and the subsequent need to plan to manage this. Work relating to risk of harm was not always given sufficient priority, especially when there were other needs in a case to address. There was a lack of guidance and structures in place for managing high risk of harm cases and too little use was made of the expertise held by YOT police staff and the information they could access.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was unsatisfactory. The YOT worked proactively to manage safeguarding and vulnerability issues as they arose. Case managers made determined efforts to link with partner agencies and contributed to inter-agency safeguarding processes in order to protect children and young people. However, case managers were not good at assessing the vulnerability needs in their cases. There were issues relating to the quality of planning, and delays in the delivery of some specialist interventions.

Ensuring the sentence is served

Overall work to ensure that the sentence was served was good. The YOT's key asset was its staff. The YOT worked holistically with other agencies to build effective relationships with children and young people and their families. Case managers worked flexibly to take the specific needs of a case into account and remove potential barriers to engagement. They also took appropriate and effective measures to encourage and enforce compliance where necessary.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was unsatisfactory. The YOT Management Board had a clear appreciation of the role and importance of the YOT's work. However, the success of the YOT was underpinned by strong, informal relationships and ambitions rather than governance, scrutiny and challenge by its Management Board. The evident commitment to improving services lacked strategic direction and planning. Despite a range of internal assurance mechanisms, there was more to be done to ensure the effectiveness of work to protect the public and safeguarding.

Interventions

Overall, the delivery and management of interventions to reduce reoffending were satisfactory. The YOT had access to a good range of interventions to reduce offending behaviour, protect the public and safeguard children and young people. It also paid due consideration to addressing the needs of victims. Case managers gave thought to what should be delivered, and how, in order to achieve the greatest level of engagement by children and young people, many of whom showed positive progress in key factors linked to their offending behaviour.

Recommendations

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

1. the work of the YOT should be targeted, meet local need, and driven by a clear YOT strategy and effective delivery plan (Chair of YOT Management Board)
2. governance arrangements, at all levels, should provide appropriate support, scrutiny and challenge to the YOT's work and outcomes (Chair of YOT Management Board)
3. systematic, effective critical oversight of the YOT's work should be used to identify and help to address areas for improvement in practice relating to safeguarding, protecting the public, and children looked after by the local authority (Chair of YOT Management Board)
4. effective YOT and partnership working arrangements should promote the safeguarding of children and young people and the protection of the public and victims: specifically, assessment, planning, and the delivery of interventions should be of good quality and underpinned by effective joint working structures, protocols and guidance. (YOT manager)

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, delivering appropriate interventions and demonstrating both positive leadership and effective management.

Case assessment score

Within the case assessment, overall 74% of work to reduce reoffending was done well enough.

Key Findings

1. Almost all pre-sentence reports (PSRs) provided the court with good information on which to base sentencing decisions.
2. Case managers had a good understanding about why children and young people offended and put appropriate plans in place to reduce the likelihood that they would offend again.
3. Work undertaken to reduce reoffending was of good quality. It was reviewed and amended to reflect the progress made by the child or young person.
4. Interventions were delivered effectively, as planned, and reviewed appropriately.
5. A holistic approach, including family intervention, and flexible provision of education and training, produced positive outcomes.
6. The YOT gave careful thought to how to help children or young people continue the positive progress they had made throughout their sentence.

Explanation of findings

1. It was evident that case managers understood the reasons that children and young people had offended and we found few gaps in the quality of this work. Case managers provided good quality reports to the court, so providing sentencers with enough information on which to base their decisions. Some reports, however, contained too much description about the index offence that could have been condensed into a shorter analysis from the report writer's perspective.
2. Although in most cases there had been a thorough exploration of potential health issues, referral for specialist assessment was dependent on the availability of health practitioners. Informal conversations would act as a referral and prompt an assessment. Once initiated, however, specialists drew on the comprehensive assessment tools available to them to complete their work in a timely way.
3. In most instances, planning had been completed appropriately, for both the community and custodial setting. Case managers gave considered thought to the interventions needed to address those areas most closely linked to the child or young person's offending behaviour. They were not as good at planning how to change the level of the child or young person's motivation to change.
4. The majority of assessments and plans were reviewed sufficiently but the YOT should be aware that in some cases previous assessments were copied and labelled as reviews without sufficient update.
5. Initial referral order panels were sometimes convened late. However, lay members felt well-trained and supervised and we were pleased to note they wrote the sentence contracts with children or young people during these initial meetings. Review panels were held regularly, often at monthly intervals, in order to help maintain progress and encourage compliance.

Example of notable practice

We observed the determination and persistence of a referral order panel to successfully connect with a reluctant and difficult to engage young man, to ensure he understood the importance of his return to education, where he was bright and able, but refusing to attend.

6. Practice around interventions in the community was an area of strength. It was uncommon for plans not to be delivered as intended. YOT workers made effective use of the good quality resources available, and ensured they took care to reinforce positive factors in their work. In general, they were good at balancing the focus of their work between reducing reoffending, managing the risk of harm to others and addressing vulnerability.
7. Case managers had a good understanding of the education and training needs of their children and young people. They had solid working relationships with the education welfare officer and youth engagement workers to identify and secure appropriate services. This not only benefited children and young people in the community but ensured seamless provision for those leaving custody. Education, training and employment (ETE) could be tailored to meet individual need. Post age 16 opportunities focused not only on employability but also on personal development, which was particularly important for hard to target children and young people who had not had good experiences of education. Exclusions were few and the percentage of children and young people who were in education training or employment at the end of their order was around 82%.

Quotes from children and young people

"*I've got some courses that I did at college…that was YOS and some other group…that was good. Without that I wouldn't have got into college. Yes, that was really useful.*"

"*…they literally got me into work experience…*"

Example of notable practice

A case manager worked with the YOT's restorative justice coordinator to provide an intervention that led to the young person avoiding a permanent exclusion from school.

8. There was a particularly good focus on the family unit, with a holistic approach taken in liaison with the YOT's parent worker. In all except two cases, sufficient work had been undertaken to help the child or young person engage with ETE. There were fewer indications that core offending behaviour work, focusing on attitudes to offending and motivation to change, was undertaken. There also appeared to be cases where we identified a need for work to address drugs misuse, but there was no evidence this had been delivered. We recognise that this may have been due to a lack of recording in the YOT relating to interventions.
9. Interventions were reviewed, sometimes on an ongoing basis, and objectives added as necessary. It was easy to follow the child or young person's journey in a number of cases where progress was recorded clearly on the intervention plan and the reason for new objectives made plain.
10. We noted that although custody cases were delivered as a single integrated sentence, the quality of work to address reoffending during the custodial phase was not as good as work in the community. The YOT's health professionals were not involved with children and young people during this time and there was no evidence that they were asked to contribute to licence conditions.
11. The YOT had identified, previously, a need for better sentence exit strategies and undertaken improvement work in this area. We were pleased to see that YOT workers were putting measures in

place to help sustain positive outcomes or progress a child or young person had made throughout their sentence. We felt insufficient consideration had been given to an exit strategy in only one case.

Example of notable practice

The case manager took Mark's Attention Deficit Hyperactivity Disorder into account by meeting him in a range of settings and collecting him when necessary for his appointments. She took him through a department store to test and reinforce his learning about how to deal with his feelings in a busy, chaotic setting.

12. By the time of this inspection, there appeared to have been a reduction in the frequency and seriousness of offending in over half the children and young people whose cases we looked at.

Quotes from children and young people

"*Seriously after 4 months I'm a completely different person, even my mum said.*"

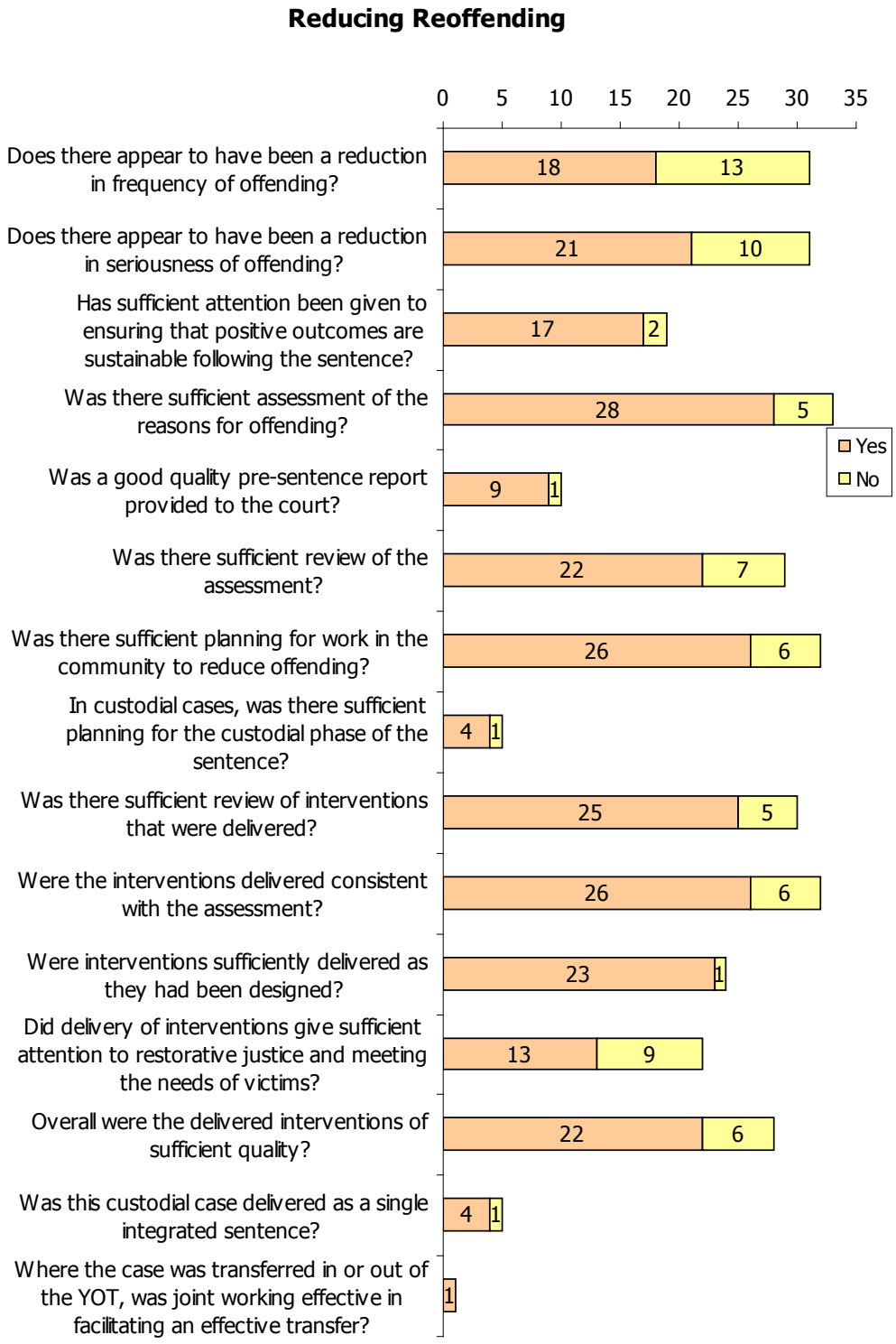
"*To be honest yeah, before like, when I first started YOS I was getting arrested 3 to 4 times a week and I ain't been arrested since like December now so YOS's helped me quite a lot to be honest.*"

"*When I was younger, my crimes were like burglary and stuff like that but I don't do that anymore 'cos like, that's not right.*"

"*They've sort of helped me stopped doing crime and that. They've actually helped me a lot 'cos I've done no crime.*"

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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 63% of work to protect the public was done well enough.

Key Findings

1. The YOT was not exploring risk of harm thoroughly enough and often underestimated the level of harm a child or young person posed to others and the need to plan to manage this.
2. Assessments and plans were not reviewed or updated well enough.
3. Too little use was made of police information systems and the expertise of the YOT police staff.
4. Interventions to manage risk of harm were not consistently delivered.
5. There was no effective written guidance or structures in place to help YOT workers manage cases where it was considered a child or young person posed a high risk of harm to others.

Explanation of findings

1. The YOT was responsible, in 33 of the cases we inspected, for assessing the risk of harm a child or young person posed to others. Case managers had made sufficient effort to do this in 14; in less than 50%. In three cases, there had been no assessment of risk. There was a range of issues relating to quality affecting both PSRs and assessments completed post sentence. Not all case managers had sufficient understanding around risk of harm and frequently focused their analysis on the current offence. As a result, previous serious offending behaviour was often overlooked and the level of risk of harm to others underestimated. Some case managers were not identifying relevant links between drugs use and offending behaviour. Reviews were not improving understanding around risk of harm; many were copied from previous assessments and were not updated sufficiently.
2. It stands to reason that good planning will link to the quality of assessment. We identified planning in the community as an area for improvement with the planned response too often not meeting the needs of the case. Some plans would have benefited from greater focus on future potential harm, with better contingency planning and more thought to how information would be shared with other agencies.
3. Plans for work in the community were not reviewed well enough. Health workers were not involved in case reviews and, as they shared little information through formal systems, there was a risk that case managers could remain unaware of issues that would impact on their work or that should be addressed at review stage.
4. By contrast, planning throughout the custodial period was normally reviewed appropriately.
5. We considered that the YOT had access to sufficient resources for work to reduce risk of harm, and case managers delivered appropriate interventions in many cases, often through a coordinated response with their specialist workers.

Example of notable practice

In Simon's case, the case manager worked closely with his social worker, the YOT nurse and parenting worker to ensure the smooth flow of indicative information, such as feelings of aggression by the young person. As a result, the YOT ensured work to manage risk of harm was prioritised appropriately, that AIM[2] work was undertaken in a seamless way, and a coordinated approach was taken to protecting victims.

6. However, there was more that should have been done to address risk of harm in over one-third of the 21 cases where there was a need to undertake such work. In three cases, no interventions had been delivered.
7. There were also gaps in assessment and planning around victims. We found that case managers were not often enough considering the impact of offending behaviours on actual or potential victims and planning how to manage or reduce this. We were pleased to note, nonetheless, that where case managers became aware of risks to victims, they took suitable action.
8. YOT police workers were not being used in a consistent way to help manage risk of harm to others. In some cases, there were serious gaps in information about a child or young person's offending behaviour that could have been addressed through greater use of police information systems and the expertise of YOT police colleagues.
9. We also saw examples of effective joint working between the YOT and the police.

Example of notable practice

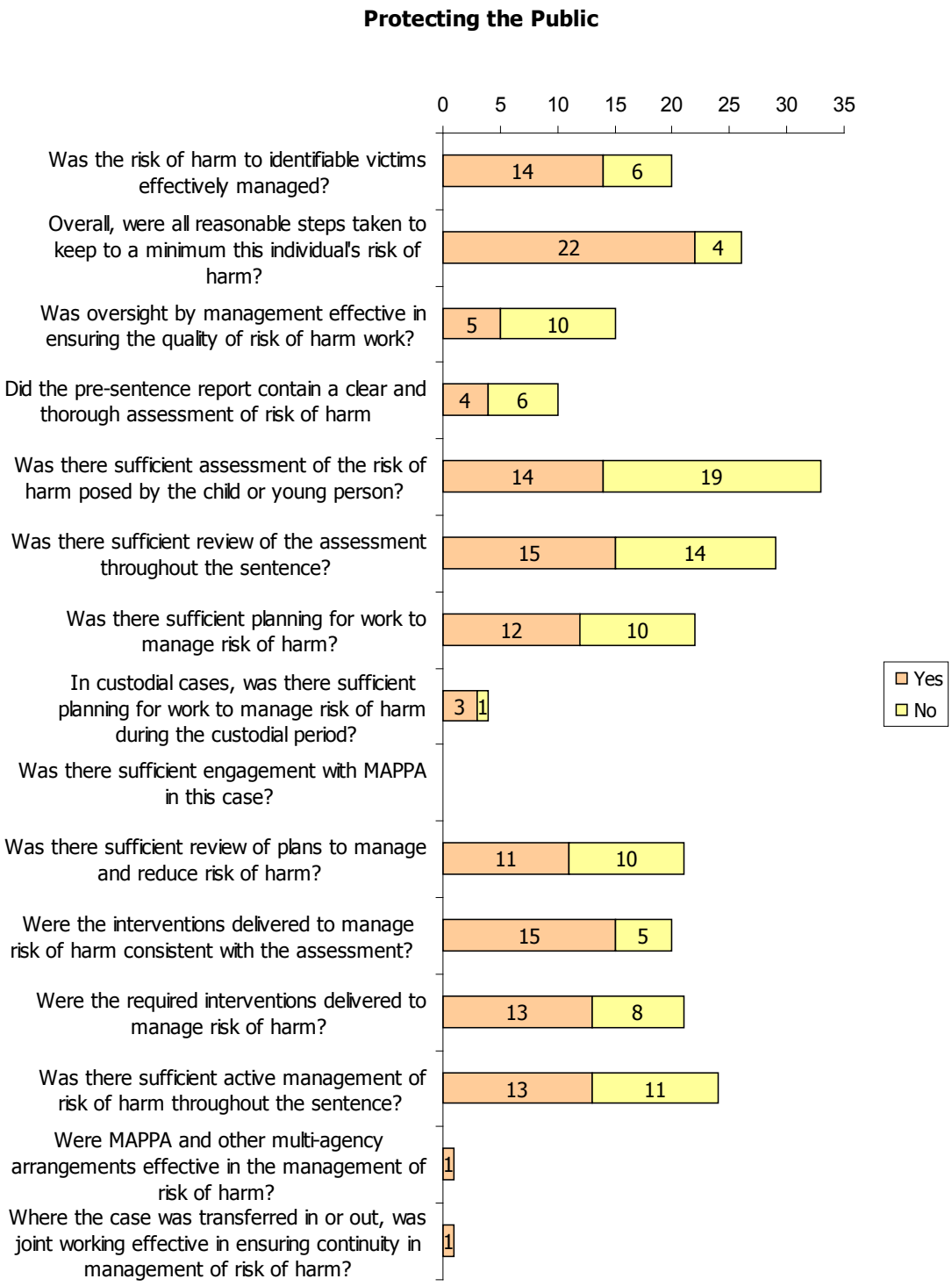
When YOT workers identified that one of their young people was, potentially, being exploited by an older drug offender, they worked swiftly with the police to arrest the offender and rehouse the young person.

10. Where Multi-Agency Public Protection Arrangements (MAPPA) were in place, these were being used effectively to manage risk of harm. However, we identified two cases that may have benefited from a referral into MAPPA but no action had yet been taken to start this process. While the YOT police workers were clear about the process and potential positive outcomes linked to MAPPA, we were not assured that this appreciation was shared across the YOT, at an organisational or individual case manager level.
11. We understand that the YOT police workers carried a similar workload to their case manager colleagues, restricting their time to take a systematic, holistic approach to the provision and analysis of police intelligence or play an overarching role in MAPPA.
12. Work to manage risk of harm to others was underpinned by a Managing Risk Procedure. This was a short document setting out some basic procedures linked to the management of risk of harm to others and Child Protection cases. While supported by a number of joint working protocols, this lacked clarity, especially around MAPPA, and did not contain enough detailed guidance for the management of risk of harm within the YOT or in partnership with others.
13. While risk of harm could be discussed with managers and peers, there was no formal risk management forum to which to present cases. Such groups can provide additional insight and ensure a consistent, integrated approach to the protection of victims and the public. We considered this gap to be a barrier to the effective management of risk of harm.

2 The Assessment, Intervention and Moving-on Project (AIM) was set up in 2000 to support work with children and young people aged 10 to 17 years who display sexually harmful behaviour.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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 64% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Too often, assessment focused on Child Protection issues, suicide and self-harm, especially in PSRs.
2. Decisions about the level of vulnerability of a child or young person were often inaccurate.
3. The quality of planning at the start of the sentence for work in the community to address safeguarding and vulnerability was poor.
4. Assessments and plans were not reviewed well enough often enough.
5. There was a delay in the delivery of some specialist interventions.
6. YOT workers made an active contribution to inter-agency safeguarding processes and meetings.
7. Overall, the YOT worked proactively to address safeguarding issues as they arose throughout a case.

Explanation of findings

1. Threads of information relating to vulnerability, especially that linked to offending behaviour, were found to be spread throughout case files. Case managers were good at identifying the need for specialist assessments relating to, for example, emotional or mental health and substance misuse. However, they were not consistently pulling all the information they had together to analyse the nature of vulnerability in a case. Sometimes the screening was not being completed well enough, or information held by other agencies was not used to help inform the assessment. This lack of analysis made it difficult to make an accurate decision around the level of vulnerability in a case; we considered the level recorded to be inaccurate in 11 cases, which is unsatisfactory.
2. Often, in a PSR, the focus of vulnerability was confined to Child Protection and the risk of suicide or self-harm. Overall, we found enough information provided about safeguarding and vulnerability needs in three of the ten PSRs we looked at.
3. As a consequence of this, planning for children and young people suffered. There was a need for more careful planning to address safeguarding in relation to a range of areas; emotional or mental health, ETE, substance misuse, and family and accommodation issues. We noted that the YOT's health workers were not asked to contribute to the planning process, even in cases where they would be asked to deliver interventions. YOT plans did not take sufficient account of the emotional impact on children and young people of being in care and, as recognised by YOT management, there was still more to be done in making sure that 'other people's plans are [reflected] in our plans'. In seven cases there was no specific plan to manage safeguarding and vulnerability.

4. Assessments and plans were often copied at review stage with little update. There was too little thought given to the progress made and the changing needs of children and young people in regards to, for instance, health outcomes.
5. There were sufficient resources available to address safeguarding and vulnerability and in many cases a good range of appropriate interventions was delivered. There was evidence of consistently good interventions by the YOT nurse, with methods of delivery adapted to suit the child or young person's learning style.

Example of notable practice

The YOT nurse had developed a strong working relationship of trust and confidence with a vulnerable young person convicted of sex offences. Despite his emotional and behavioural difficulties, he responded well to her, speaking openly about his offending behaviour.

6. However, in a high number of cases, relevant specialist interventions had yet to be delivered by the time of our inspection. This was especially noticeable for ETE, family and accommodation issues and emotional or mental health. There was also a small number where there had yet to be a referral to U-Turn, the provider of substance misuse services.
7. However, overall, YOT workers demonstrated their considerable commitment to keeping children and young people safe, proactively responding to changes that could negatively impact on their well-being. Case managers were good at initiating links with partner providers on a case by case basis, and were evidently determined in their efforts to champion the cause of the children and young people with whom they worked.

Quotes from children and young people

"*They're helping me move out, they're on social services' case every time… every time I bring it up, they're on social services case like, and like a bit more harder than last time they spoke to them as well.*"

"*She's the best thing that happened to be honest with you.*"

8. The YOT should beware that in a small number of cases the focus on protecting the child or young person detracted attention from public protection, so that important work to minimise risk of harm to others was postponed, sometimes indefinitely.
9. The YOT understood its safeguarding responsibilities and had ready access to effective safeguarding policies and procedures. Case managers made appropriate use of the missing protocol and were using the child sexual exploitation screening tool, although not routinely in every case.

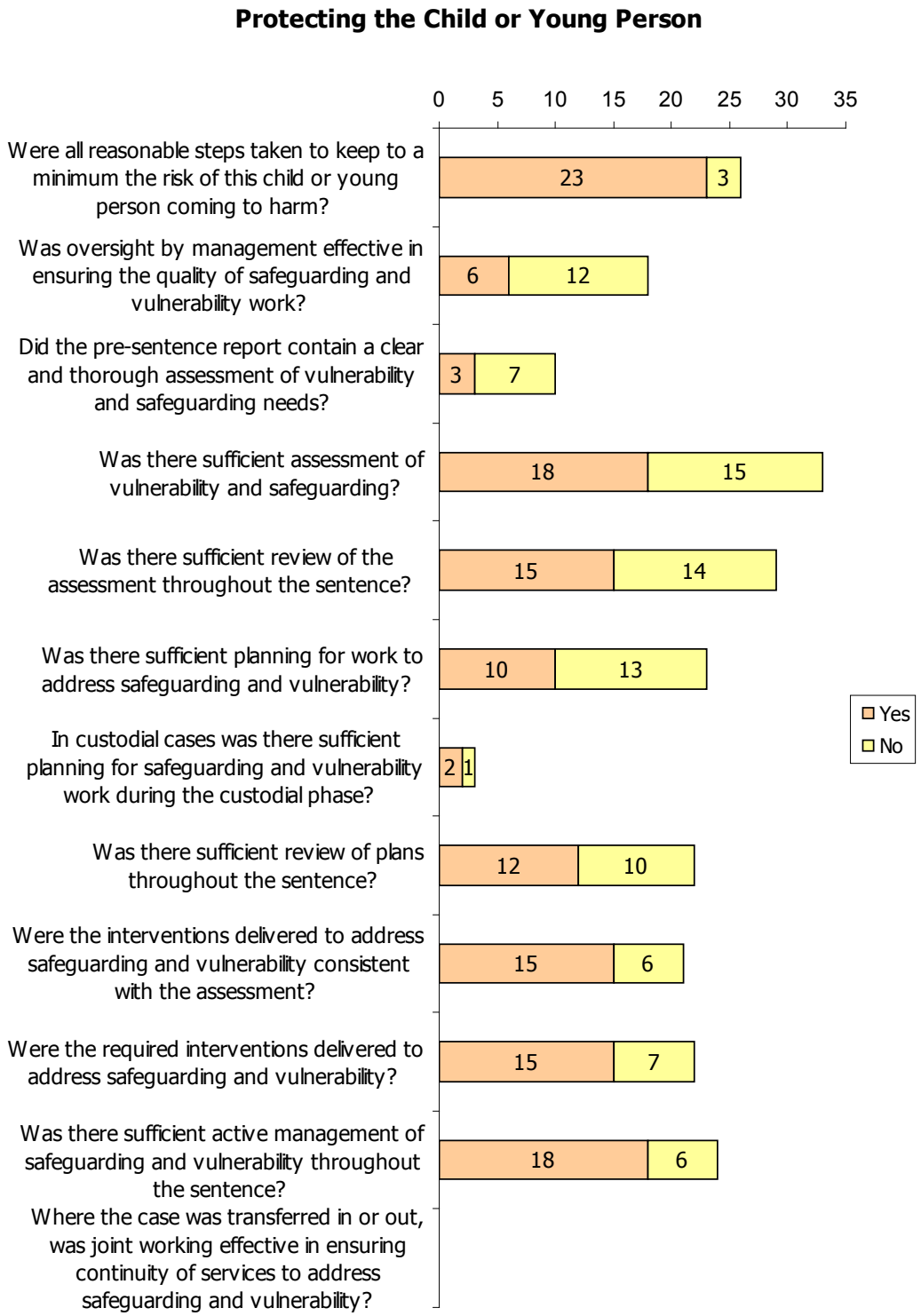
Example of notable practice

The case manager had demonstrated good instinct in Michelle's case and identified concerns Re: sexual exploitation and safeguarding, raised these appropriately with children's social care services and challenged successfully when she received an insufficient response.

10. In most cases, the YOT made an active contribution to Child Protection conferences, core groups and Team Around the Child meetings. Child Protection conference chairs were able to provide tangible examples of the positive impact YOT workers had had in terms of helping to reduce risks and improve outcomes for children and young people.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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 91% of work to ensure the sentence was served was done well enough.

Key Findings

1. The YOT and partner agencies worked hard and effectively to build relationships with children and young people and their families.
2. Case managers were good at assessing and taking account of the individual needs of children and young people and potential barriers to their engagement.
3. Thought was given to ensuring work to address compliance issues fit the needs of the case.

Explanation of findings

1. The YOT's interest in the children and young people with whom they worked was reflected in the excellent findings in this area of the inspection.

Example of notable practice

A YOT worker met with children and young people and their parents/carers pre and post court hearing in order to ensure they understood the court process and the details of the sentence given.

2. Across the YOT, there was evidence of good work to engage and build constructive relationships with children and young people and their families. The holistic family approach, often with the support of the parent worker, helped to identify the specific needs of the case, and how best to deliver interventions and remove barriers to engagement. The YOT's health professionals communicated directly with parents/carers, undertaking home visits when necessary and encouraging feedback from them about the service they offered and about the progress of the children and young people with whom they were working.
3. As might be expected, it took time and effort to build effective relationships in some cases, especially with those who had not worked with the YOT previously. Some of the children and young people providing us with feedback advised that they would have benefited from more support and information from the YOT at the beginning of their orders rather than having to rely on their parents/carers to understand what was happening after sentence. However, most felt their case managers took their fears and views into consideration.

Quotes from children and young people

"*Spoke about the support they'd give me and work around the offending that I'd be doing.*"

"*I think [the planning of my order] was just mainly rushed.*"

"*They never really ran through anything more than once and stuff like that.*"

"*I think for the first appointment or first couple that my mum was there to supervise what was going on to make sure it was all alright. I think that was just for the first couple…. it took a bit of the nerves away as well.*"

"*I didn't like it at the start and I thought it was all s*** but I'm not going to lie I saw hope and its definitely one of the reasons I'm not offending now.*"

"*They listened to me. They took my side all the way 50/50…I told them everything I wanted and what I wanted to achieve and all that. They took my side 50/50 and they added their side to it. It was all good.*"

4. In nearly every case, the child or young person and their parent/carer were involved in YOT processes, helping to shape the PSR, contributing to the assessment and plans and fully engaged in the delivery of services. We saw examples of desistence theory in practice; case managers identifying with the child or young person what they felt would help them stop offending and then taking a flexible, responsive approach to assist them achieve these objectives.

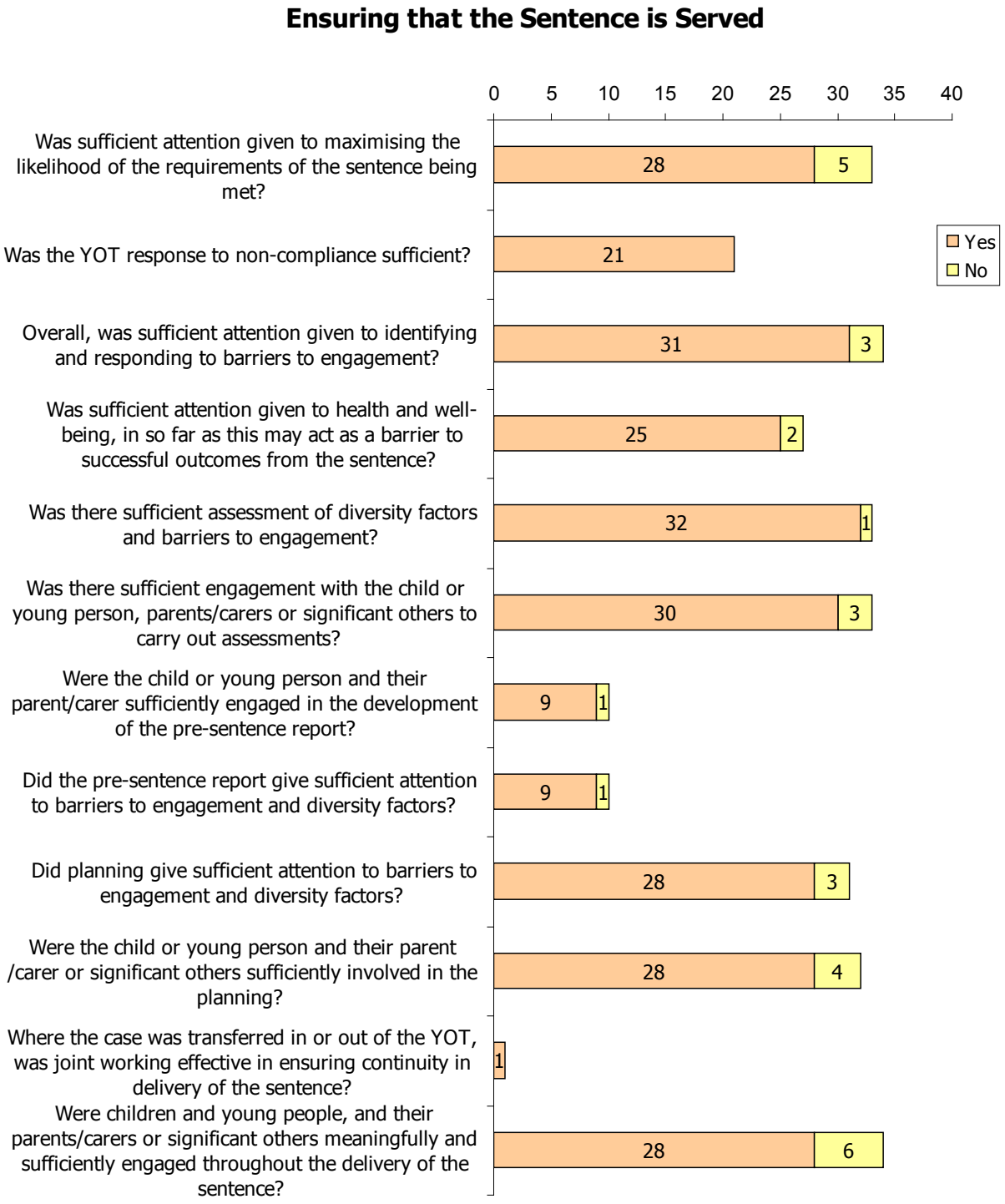
Quote from parent/carer

"*… they came to my house. They always used to be there if I needed them on the other end of the phone.*"

5. This approach was manifest throughout the sentence, including where action was needed to aid compliance. A fair number of children and young people did not immediately take the requirements of their order seriously, and the YOT took effective action in every case. In some instances this involved convening a compliance panel, in others case managers changed the way of working with the child or young person to promote engagement. Health care appointments were not required as statutory and therefore failures to attend were not used in breach proceedings. However, we were pleased to see that where children and young people failed to attend appointments with U-turn, the drugs prevention worker made a concerted effort to re-engage them and to draw up exit plans where appropriate. Where cases were returned to court for a breach hearing we saw careful consideration given to disposal proposals. We were pleased to see that work to encourage compliance often led to an improvement in engagement levels by the children and young people.
6. Although many of the children and young people working with the YOT went on to be arrested or charged for other offences (sometimes committed before the order being inspected), we saw evidence of a suitable response by the YOT in almost every instance.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

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

Key Findings

1. The YOT was a valued partner in Swindon's strategic agenda.
2. The YOT Management Board did not drive the direction of the YOT or provide enough challenge.
3. The YOT was committed to improving services but there was no structured approach to this.
4. There were strong, positive relationships at all levels both within the YOT and between the YOT and other agencies and the community.
5. Effective partnership working was linked to the strength of relationships rather than sound partnership agreements, systems and guidance.
6. There were gaps in joint working practice with children's social care.
7. There were a range of effective systems in place for gathering feedback from stakeholders.
8. The YOT's genuine commitment to management oversight and quality assurance was not improving the management of risk of harm to others or safeguarding work.

Explanation of findings

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

1.1. The YOT was a respected partner in the One Swindon strategy. Its latest business plan reflected national and local authority priorities and focused on providing the right support and enablers to help children and young people change their lives. The YOT worked well with other agencies to help to achieve this.

1.2. Agencies represented on the Board did not always actively contribute to meetings and there was little evidence of robust challenge and guidance to the YOT from the Board. Due to the time lapse between Board meetings, many members saw themselves as relatively new and unqualified to comment in-depth on the work of the YOT.

1.3. YOT Management Board members had an understanding of the local and national outcome priorities for, and the work undertaken by, the YOT. They were able to explain the trends in the YOT's performance against Youth Justice Board (YJB) indicators, set in the context of a small population; that is, that a spike in reoffending rates was caused by two incidents involving small numbers of children and young people. However, there was no expectation by the Board that the YOT dig more deeply into and learn from these incidents, explaining that the delay in receiving YJB data made it difficult to do so in a timely way.

1.4. Reducing the number of children and young people sentenced to custody was a priority for the local authority, and both councillors and senior officers understood the effective role the YOT was playing in helping to achieve this.

1.5. The local authority convened a range of boards, with senior managers sitting on a number of these, and with a measure of overlap. The YOT Management Board was not a priority for some partners who did not consistently attend but relied instead on feedback at other meetings. As such, key negotiations often took place outside the YOT Board arena, and it was not clear what value the Board added to the YOT.

1.6. The YOT, with other providers, introduced a number of good and sometimes innovative initiatives that were of benefit to children and young people who offend but these were not driven by the Board, were not part of a strategic plan and were not underpinned by an assessment of need. The YOT's annual plan met YJB minimum criteria but was high level and contained no specific objectives. It did not include work to address additional, locally identified, specific needs of Swindon's children and young people who offend. We were encouraged to learn about the new common customer cohort needs assessment approach to be introduced later this year which should help the YOT more carefully target its ambitions and interventions.

1.7. Governance arrangements were not sufficiently robust, with performance management information in a number of areas underdeveloped. Data reports were provided to the YOT Management Board but, in the main, the YOT decided the priority areas for scrutiny.

1.8. The YOT Management Board did not provide effective oversight of the work of the YOT in relation to critical areas of their work. There is no evidence that it requested any more information than the YOT chose to provide. In the main, the YOT data report focused on high level performance against national outcome measures and there was no system in place for the Board to undertake regular in-depth analyses of, for instance, Looked After Children, safeguarding and public protection activity.

1.9. A range of data relating to ETE was available to the YOT but, again, not scrutinised regularly by the Board. Data systems used by partners for collecting information were not always aligned, making it difficult to assess the true picture around ETE and identify outcomes for the YOT's children and young people after referral to education providers.

1.10. The YOT manager was adept at identifying factors that were affecting, or had potential to affect, local offending trends or the smooth running of YOT services. He is to be commended for discovering and securing money to finance a number of projects, including a review of delays in access to On Trak (the local authority's counselling service) which led to successful funding bids for more counsellors.

2. Partnerships – effective partnerships make a positive difference

2.1. There were strong, positive relationships at all levels both within the YOT and between the YOT, other agencies and the community.

2.2. The local authority's focus on encouraging effective partnership working had led to the co-location of the YOT with Children's Social Care Services. Additionally, the YOT now formed a component part of the Restorative Youth Services team, alongside U-Turn and On Trak. Co-location had enhanced the visibility of and communications with the YOT. There was evidence of a more joined-up approach to work with children and young people and swifter access for them to health provision.

2.3. However, effective joined-up working was often linked to the strength of relationships between practitioners or management. There was a need for more formal, up to date, partnership arrangements and guidance in order to ensure consistency and help sustain implied practice. Links with the local college, for example, were good on an informal level and we learned of good examples of reciprocal work. Students were involved, as part of their college courses, in focus groups to help the YOT identify modern subcultures and improved ways of working with children and young people. In addition, the YOT police officer had developed a red card, time out system for children and young people that had reduced exclusions from ETE.

2.4. The YOT would have benefited from more formal links with partners in order to enhance service delivery in a small number of areas. For instance, case managers had found it difficult to help children and young people access courses at the college. This issue could have been ameliorated through better working agreements relating to the admissions policy.

2.5. There was also potential for tighter joint working with Swindon's Children's Social Care Services. The interface with Family Contact Point was still a work in progress. The local authority was working hard to fill a number of social worker vacancies and services were improving. However, there were still examples of Children's Social Care being slow to respond to concerns raised by the YOT. There was a reluctance to use the escalation process, leaving children and young people at possible risk. The lack of commonality between the departments' IT data systems made it difficult to link the work being undertaken by social care and the YOT, potentially reinforcing silo working. It was good to see that the YOT had a dedicated case manager for cases involving Looked After Children. Having one point of contact in the YOT should lead to improved communication and joint working with Children's Social Care.

2.6. The YOT played an instrumental role in the Swindon Safeguarding Children Board's Multi-Agency Risk Panel. An excellent and important initiative, this was set up to help protect children and young people who went missing or were at risk from sexual exploitation. The YOT had been successful in getting its partners to recognise and respond to wider issues and the remit of the group had been successfully expanded to consider the risks associated with wider criminal exploitation. This helped to ensure a more effective and better coordinated response to children and young people groomed by criminal gangs as drug runners or dealers.

2.7. While participation in regular management forums ensured that senior managers in the YOT were actively engaged with their colleagues in Children's Social Care Services, the YOT did not participate in the six-weekly Child Protection leads' meetings. This could be a missed opportunity to strengthen the YOT's engagement with, and contribution to, the safeguarding agenda.

2.8. There was no effective system in place for ensuring the YOT received a complete picture of children and young people coming to the notice of the police. However, the YOT police officer compiled on a daily basis the information available, and shared this with colleagues. We noted that where this information related to those already managed by the YOT it was used effectively by the respective case manager. However, information relating to other children and young people was entered onto the YOT's computer information system with no trends analysis. We share the YOT's concern that a child or young person may have committed multiple offences, and their offending behaviour have become entrenched, before having the opportunity to work with the YOT. This could be a lost opportunity to help positively influence the level of first time entrants to the youth justice system.

2.9. The YOT's volunteer scheme was seen as a beacon of good practice by the local authority. A panel of 60 volunteers, spanning a wide age range, supported the YOT's work. They were involved in referral orders, mentoring and the provision of appropriate adults in legal proceedings and reparation, for instance. There was evidence that they were well trained and supported by the YOT, and felt committed to the work they undertook. The YOT was rightly proud of its school volunteer scheme, which won a national award. Year six pupils were recruited and trained to deliver crime prevention messages to their peers in other schools. Currently, we understand, this is delivered to schools with which the YOT already has associations. We would urge the YOT to take a more targeted approach, to maximise the positive outcomes of the scheme.

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

3.1. Case managers were confident in the ability of their managers to support them and help improve the quality of their work.

3.2. There was evidence of regular supervision, following a set agenda that considered personal well-being and development, alongside the quality of case work. Social workers acting as case managers in the YOT also had access to clinical supervision which ensured they were kept up to date with the latest developments in children's social care.

3.3. Protocols and memorandums of understanding were in place for all health care providers except the speech and language therapist. These were all in need of updating and needed to be clearer about aspects such as lines of accountability, targets and expectations. The link between YOT operational management and direct line management of some health practitioners (for example, the nurse and Child and Adolescent Mental Health Services) was limited and there was no evidence of joint supervision or appraisals, or sharing of the contents of these. It was difficult, therefore, to ascertain how operational management monitored the work and outcomes of the health professionals.

3.4. In the main, case managers felt they received enough training to be able to fulfil their roles and deliver interventions.

3.5. At least three YOT workers had had AIM assessment and intervention training which enabled them to recognise and respond appropriately to children and young people who display sexually abusive behaviour. They had good access to safeguarding training, including training on child sexual exploitation, and were able to evidence its impact on their practice. However, not all workers were up to date. We noted that one case manager had not had any health related awareness training since joining the YOT, and several case managers advised that they would like to improve their knowledge relating to speech, language and communication.

3.6. While the YOT kept a log of training, this was not up to date. As a consequence, it was difficult to monitor the skills mix of the team effectively and ensure key courses were being undertaken.

4. Learning organisation – learning and improvement leads to positive outcomes

4.1. The YOT had an impressive range of systems in place to gather information on which to base service improvements and reinforce good practice.

4.2. These included the collection of feedback from the children and young people with whom they worked. They did this on a case by case basis but also indicated their dedication to this through their early completion of HMI Probation's e-survey for Swindon[3].

4.3. There were procedures in place for assuring the quality of reports provided to court. Sentencers completed feedback forms comprehensively and thoughtfully, providing comments that echoed some of our own observations. A peer review system was used effectively to check the quality of PSRs before their submission to the courts.

4.4. A Section 11 Audit[4] was completed annually, and reported and responded to through the Swindon Safeguarding Children Board. The YOT also considered the recommendations of HMI Probation's thematic inspections, setting out actions and monitoring progress against these.

4.5. The YOT had devised a Peer Risk, Assessment, Intervention and Safeguarding Evaluation (PRAISE) process. Focused around HMI Probation's inspection criteria, it encouraged a whole YOT approach to assessing case management. Undertaken regularly to analyse individual cases, it had been used effectively to identify trends in practice and inform further, more in-depth analyses of specific areas. One example of this was the assessment of the management of cases involving children looked after by the local authority, the results of which were important but are now out of date. While there may be relatively few children looked after by Swindon Local Authority who offend, the percentage is high in relation to the national average. The YOT had plans to continue to assess the quality of work for Looked After Children but had yet to implement these, potentially leaving some of its most vulnerable children and young people at higher risk of offending.

3 HMI Probation asks each YOT to encourage the children and young people with whom it works to complete a questionnaire providing the inspectorate with some key characteristics about respondents and their experience of the YOT.

4 An assessment of how well local partner agencies are meeting their responsibilities under Section 11 of the *Children's Act 2004* to safeguard and promote the welfare of children.

4.6. The YOT also completed fortnightly Signs of Safety meetings to provide peer support and challenge, and promote a shared approach to problem solving in complex cases. We understand these were unpopular at first and applaud the YOT for pursuing their cause so that they are now welcomed across the team.

4.7. To complement this, regular line management checks were performed on the work of case managers, to see if case management processes were being completed and to sufficient quality. It was disappointing to see that case managers were not necessarily addressing areas identified as needing improvement.

4.8. The YOT's commitment at a senior level to management oversight and quality assurance is to be commended. However, despite the range of systems in place and the time dedicated to this work, there was no evidence that it led to overall improvements in the management of risk of harm to others or safeguarding work.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

What we expect to see

The work with children and young people to reduce reoffending should include a broad range of good quality interventions. They should take account of individual need and ability, be delivered well, and monitored and evaluated to ensure their effectiveness. Where children and young people are working with more than one agency, there should be evidence of integrated partnership working.

Case assessment score

Within the case assessment overall 79% of work relating to interventions was done well enough.

Key Findings

1. Case managers made good effort to understand what could help reduce offending behaviour.
2. Suitability and eligibility were considered thoroughly, along with the best approach to take in the delivery of interventions.
3. A good range of appropriate interventions was available and being delivered by the YOT with its partner agencies using a flexible, holistic approach.
4. Thought was given to how best to deliver interventions, including how to reinforce existing positive factors.
5. The YOT demonstrated its commitment to victims through the work of a dedicated worker and range of restorative justice and reparation opportunities.
6. Children and young people made progress during their sentences in some of the key factors linked to their offending behaviour.

Explanation of findings

1. Case managers had a good understanding of what needed to be done to help reduce the likelihood that children and young people would reoffend. This was not limited to the type of intervention. Due consideration was also given to the sequencing and style of delivery that best met the needs of the case.
2. YOT workers were mindful of the changing needs of children and young people and were able to adapt the course of action being taken. We were impressed to find examples where the thinking behind these changes had been noted on intervention plans.
3. A holistic family approach helped to reinforce key messages for, and progress made by, the children and young people. Close working with the parent worker facilitated a coordinated, seamless service and helped parents gain the confidence and skills to positively influence the journey of their children away from offending.
4. The YOT's Intensive Supervision and Surveillance workers worked in a fully integrated way with case managers to provide a full timetable of events. StreetGames Swindon, a local authority provider aimed at engaging more children and young people with sport in the community, played a key role in this. Children and young people on sentence had the opportunity to gain skills, confidence and qualifications through their contact with StreetGames, and to help pass these on as ongoing volunteers with the project. In more than one instance, StreetGames helped to source alternative forms of education for children and young people not benefiting from their time at school.

5. There was a good range of interventions on offer to the YOT. Of these, we observed and explored a small number. We noted that the well-being of children and young people was always at the heart of an intervention. There was a good level of engagement between YOT workers, other workers and children and young people, to build and maintain strong relationships and engagement with the interventions being delivered.
6. YOT staff are to be commended for drawing on their skills to develop and adapt their own internal programmes. The Driving Offences Group Programme is an example of this. Still under development, it has been amended to meet the changing needs of the YOT's caseload and to incorporate an element of evaluation.
7. The Weapons Programme was well thought out and built around good quality materials. It focused not only on the carrying of knives but also on objects picked up to be used as weapons at a scene of a crime. The use of an interactive video produced by the Metropolitan Police was very engaging and well suited to children and young people. The programme had been delivered to seven young people last year, none of whom had been arrested for weapon offences since.
8. In response to a YJB initiative on Joint Enterprise the YOT had put together a simple worksheet to introduce the concept to children and young people. Being convicted under joint enterprise rules is a considerable risk for children and young people and we were pleased to see the steps being taken to raise awareness about this. A more systematic and managed approach to developing this work would ensure all relevant children and young people could gain from it.
9. We noted a small number of areas of delivery that could be developed further: making more use of the Youth Justice Centre programme and the enhancement of courses through greater use of group work (although we acknowledge the difficulties inherent with so doing in a small YOT). There was also an apparent need to deliver more work relating to substance misuse, and work to change children and young peoples' attitudes to offending, or their motivation to change their behaviour. In some cases it was unclear what was being delivered and the YOT could benefit from more detailed recording of work being undertaken.
10. We looked at three cases where the child or young person who had offended was looked after by Swindon's Local Authority but another YOT was taking care of the case. It can be difficult for home YOTs to stay effectively involved in such cases and we were pleased to see that in two of them Swindon YOT remained actively engaged with colleagues in the host YOT to ensure work to reduce reoffending was delivered and reviewed.
11. Overall, the YOT demonstrated a good level of commitment to victim work. Systems were in place for engaging victims from the outset. Their needs were considered by a dedicated Restorative Justice worker, with due consideration given to reparation and mediation, both in the community and custody. Victims were kept up to date where they wished to be with the progress of the case, and feedback was sought about their experience with the YOT. We learned of some excellent examples of successful mediation. A range of reparation activities was on offer, some of which helped to improve skills for the children and young people. Victims were also offered direct reparation; in one example a young person completed gardening for a victim whose car he had damaged. Restorative justice was encouraged and the YOT had produced a promotional film which was provided to all parties. Victim awareness work was undertaken by the reparation worker or by case managers, and managers checked to make sure it was being delivered in appropriate cases. However, the focus of case managers appeared to be on the child or young person who had offended rather than the victim and we found some disconnect between the work taking place with victims and the level of knowledge of case managers about this.

Example of notable practice

Justin had been involved in a burglary. He completed a four session Victim Empathy programme with the YOT reparation worker as part of his order. She was able to draw on Justin's family's own experience of being a victim of crime. Initially unremorseful for his offence, he began to appreciate the negative impact of his behaviour on the householder.

12. With the help of the YOT and the interventions being delivered, children and young people were making progress against key objectives. The most notable progress related to their family and personal arrangements, ETE and their lifestyles.

13. In recognition that many of the children and young people with whom they worked would benefit from an improvement in their communication skills, the YOT recruited a speech and language therapist. To complement this, they secured funding from their Police and Crime Commissioner to implement a national Rapid English Course programme. The package is effective at improving the neatness of hand writing, and helping participants to gain confidence in reading aloud. While it was offered on a voluntary basis, the YOT had done well to secure a 77% attendance rate at sessions and achieve some positive outcomes. A case manager noted that one of her young people had improved his literacy levels by an encouraging 30%.

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 Teams 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

YOTs are informed approximately 11 working days prior to the inspection taking place.

Fieldwork for this inspection was undertaken on the weeks commencing:

02 March 2015 and 16 March 2015.

In the first fieldwork week we looked at a representative sample of 34 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 YOT 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 YOT Management Team, YOT 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 YOT for comment three weeks after the inspection, with publication approximately six weeks later. In addition, a copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group and the YJB. Copies are made available to the press and placed on our website.

FJI reports in Wales are published in both Welsh and English.

Further details about how these inspections are conducted can be found on our website in the document '*Framework for FJI Inspection Programme*' at:

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

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	Vivienne Clarke, *HMI Probation*
Deputy Lead Inspector	Steve Woodgate, *HMI Probation*
Inspection Team	Joe Coleshill, *HMI Probation* Sue McGrath, *HMI Probation* David Rankine, *Local Assessor* Andrea Crosby-Josephs, *Care Quality Commission* Andrew Reed, *HMI Constabulary* Stephen Miller, *Ofsted Learning and Skills* Nigel Parkes, *Ofsted Social Care* Luke Hunka, *User Engagement Officer, User Voice*
HMI Probation Support Services	Lynne Osborn, *Support Services Officer* Pippa Bennett, *Support Services Manager* Oliver Kenton, *Assistant Research Officer* Alex Pentecost, *Communications Manager*
Assistant Chief Inspector (Youth Justice)	Helen Mercer, *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: 978-1-84099-705-7