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 **Greenwich**

An inspection led by HMI Probation

independent inspection of youth offending work

November 2015

Foreword

This inspection of youth offending work in Greenwich 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 Greenwich primarily because their performance showed it was a possible area of good practice relative to other inner London Youth Offending Services.

The most recent published[1] reoffending data showed an increase in Greenwich at 43.2% which was above the latest average figure for England and Wales at 37.4%.

Greenwich Youth Offending Service (YOS) had made a step change in performance since the last inspection in 2011. The YOS was strong in assessment and delivering good quality interventions. The Management Board had clear objectives and was successful in ensuring children and young people had access to a range of services designed to move them away from crime. There was still work to do to improve planning to address offending and ensure the provision of a full suite of health services. The YOS were aware of where they needed to improve and were constructively addressing the issues.

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

Paul Wilson CBE

HM Chief Inspector of Probation

November 2015

1 Published July 2015 based on binary reoffending rates after 12 months for the October 2012 – September 2013 cohort. Source: Ministry of Justice.

Key judgements

Summary

Reducing reoffending

Overall work to reduce reoffending was satisfactory. Good quality reports were produced for the courts and initial assessments were of a high standard. Plans did not always capture the issues identified in assessment and needed to improve. There were excellent education, training and employment services which delivered a high level of provision for children and young people.

Protecting the public

Overall work to protect the public and actual or potential victims was satisfactory. Reports and initial assessments contained thorough analysis of the risk of serious harm posed by children and young people. Multi-agency arrangements were working well and there was a strong partnership approach to risk of harm work. Plans to address the issues identified needed to improve and interventions to address the risk of harm were not delivered in all cases.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was satisfactory. Assessments were thorough and the YOS had appropriate multi-agency arrangements in place to manage vulnerability. Work to manage and reduce vulnerability was happening, though not always recorded and planning documents needed to improve. Management oversight processes were in place but were not always effective.

Ensuring that the sentence is served

Overall work to ensure that the sentence was served was good. Diversity issues and barriers to engagement were identified clearly by staff. Staff were good at motivating children and young people to engage with their sentences and used effective methods to improve compliance where required. Enforcement action was appropriate and timely. Plans did not always incorporate the issues identified at assessment and engagement with parents/carers was not good in all cases.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was good. There was strong strategic leadership and a clear plan for the YOS. The YOS Management Board was aware of it's responsibilities, and there was evidence of constructive challenge. There was a clear performance management framework and evidence that issues were escalated to, and addressed by, the Board. There were strong partnership arrangements, designed to ensure a commitment to providing young offenders with access to services.

Interventions to reduce reoffending

Overall the management and delivery of interventions to reduce reoffending was satisfactory. Case managers skilfully delivered interventions to reduce reoffending, and had access to a range of good quality multi-agency resources and interventions. A greater emphasis was needed upon interventions to manage the risk of harm to others. The YOS does not evaluate the success of its interventions effectively enough.

Recommendations

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

The YOS should ensure that:

1. staff produce good quality integrated action plans which address risk of harm, vulnerability and interventions
2. staff can recognise when significant changes in children and young people's lives require assessments and plans to be adjusted to reflect this
3. all staff understand the Multi-Agency Public Protection Arrangements and follow the correct procedures
4. victim work and restorative justice interventions are delivered in all appropriate cases
5. management oversight processes are improved to ensure deficiencies in assessment and planning are addressed
6. a physical health screening service for children and young people is available for YOS children and young people to access.

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

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Reducing reoffending

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Theme 1: Reducing reoffending

What we expect to see

As the purpose of the youth justice system is to prevent offending by children and young people we expect youth justice partners to increase the likelihood of successful outcomes by undertaking good quality assessment and planning, delivering appropriate interventions and demonstrating both positive leadership and effective management.

Case assessment score

Within the case assessment, overall 71% of work to reduce reoffending was done well enough.

Key Findings

1. Good quality reports provided the court with relevant information to assist sentencing.
2. Assessments of the causes of reoffending were of a high standard.
3. Plans did not effectively draw on the needs identified in assessments.
4. Reviews of assessments and plans to address reoffending were not always completed either when required or in response to significant change.
5. Staff understood effective practice and were good at sustaining children and young people's progress.
6. Education, training and employment (ETE) services were impressive and effective at delivering qualifications and employment.

Explanation of findings

1. We were pleased to see that in most instances, sufficient efforts had been made by workers to understand the reasons why children and young people had offended and to identify what may prevent reoffending. Good quality pre-sentence reports were provided to the courts in almost all inspected cases and assessments were comprehensive, thoroughly addressing the factors which influenced offending. We found a robust quality assurance process in place that ensured court reports provided sufficient insight to enable sentencers to appropriately sentence children and young people. This was an area of good performance for the YOS.
2. Following sentence, initial assessments were of a high standard. Staff were good at investigating the reasons why children and young people had offended. They engaged well with children and young people, gathered detailed information, demonstrated the ability to analyse that information and drew sensible conclusions. It was clear that in most cases staff understood why children and young people had offended and had identified accurately the factors which contributed to their offending.
3. Reviews of assessments, however, did not always occur when necessary with just under two-thirds of cases reviewed when required. Case managers were often aware of significant changes in the circumstances of children and young people but this did not always lead to a review of the assessment of the child or young person's situation. Reviews are important as they can lead to changes in approach and the use of different resources to address changing issues.
4. Plans for work in the community to reduce reoffending were good in just over half of the cases we inspected. Some plans did not meet the needs identified in the assessment. One of the main areas that did not feature clearly was how the YOS would intervene to address emotional and mental health.

Reviews of plans were good in over two-thirds of relevant cases. Where they were not, it was because reviews had not been completed in response to significant change. The YOS uses an integrated action plan (IAP) which addresses risk of harm, vulnerability and interventions. The function of this plan was poorly understood by some case managers and was not utilised effectively as a planning document in all cases.

5. Most plans for children and young people did have a strong focus on ETE, particularly on maintaining learning. The YOS staff had a good understanding of the links between a positive ETE outcome and the likelihood of reoffending.
6. The issues that we found concerning assessments, reviews and plans were present in the management of community *and* custodial cases. Furthermore, only half of the inspected custodial cases were managed as a single integrated sentence and there was evidence of a disjointed approach between the custodial establishment and the YOS.
7. Case transfers in and out of the YOS were managed well in 60% of cases. This could be improved by the YOS working with the National Probation Service and Community Rehabilitation Companies to ensure effective communication in all cases.
8. We found that interventions designed to reduce reoffending were consistent with the identified needs in the assessment and plans in nearly three-quarters of relevant cases. We saw inconsistency where interventions had either not been delivered in line with plans or not delivered at all.
9. Staff clearly understood the principles of effective practice and what works in reducing reoffending. Resources available to the YOS to enable work in the community were good, and where we saw interventions they were delivered well and consistently. Staff were knowledgeable, displayed good skills in engaging with children and young people and delivered effective interventions, which were regularly reviewed. Staff were good at reinforcing positive factors in work to reduce reoffending and overall we judged the quality of work to address reoffending as sufficient in nearly three-quarters of cases. Interventions were not delivered in all cases however. We saw some one-to-one offending behaviour work skilfully delivered by staff but the YOS needed to do more to challenge children and young people's motivation to change.
10. Education, training and employment outcomes for children and young people were very good. The percentage of children and young people who were in education, training or employment at the end of their order was 81%. Outcomes data, when compared with last year, indicated a sustained improving trend. The number of children and young people known to the YOS and not in ETE had decreased.
11. Partnership links made by the YOS to ensure children young people accessed the most appropriate schools, alternative provision, training providers and local colleges were excellent. The YOS was able to access an impressive variety of flexible provision tailored to individual needs for both pre and post 16 year old children and young people. Providers had a good understanding of the labour shortages in the area and aligned courses with local employment opportunities. We saw innovative projects which led to children and young people developing skills in the construction industry, complementing the needs of local employers. Providers met on a quarterly basis as part of the participation education training and employment panel to help develop provision and place children and young people on courses tailor made to their needs.
12. Education and training providers were well supported by the YOS and communication channels were effective. Providers kept case managers informed about the progress being made by children and young people. Links between case managers and ETE workers were very good both formally and informally. Case managers were knowledgeable about the work of the ETE worker and had a good understanding of the types of provision available throughout the area.
13. Communication between ETE workers responsible for both pre and post 16 was very effective and they benefited from being co-located. Effective and speedy interventions by ETE workers helped maintain children and young people's education by reducing exclusions. Joint working was excellent and helped

provide good outcomes in encouraging children and young people to remain in learning, and work towards gaining qualifications. Transition from school into further education was well managed and supported children and young people well.

14. Planning for ETE after release from custody was good and ETE staff attended review meetings with children and young people in custody. We saw a clear focus on planning for transition early in the sentence to ensure ETE provision was in place at the point of release.

Example of notable practice

The YOS maintained a strong focus on ETE throughout the sentence; they had identified that the main reason June offended was to gain money. There was an education assessment from the Secure Training Centre on record, the YOS ETE worker attended the pre-release meeting and June was supported in securing a business administration apprenticeship shortly after release.

Quotes from children and young people

"Yeah, they sorted out the college for me."

"Before I came here [into custody], the YOS did help me with college yeah...yeah, they did help me."

15. More progress needed to be made in addressing substance misuse. The service had recently been commissioned and provision in this area was developing. We were reassured that performance issues were being addressed. The YOS had access to a clinical health team (CHT) to address emotional and mental health issues, and we saw evidence of effective working with children and young people and of joint working between health professionals and case managers. Plans, however, did not always identify emotional and mental health as an area of work, or reflect the involvement of the clinical health team.

16. There was a clear pathway in place for children and young people who scored 2 or more on the emotional and mental health and substance misuse sections of the ASSET[2]. An adapted version of the Screening Questionnaire Interview for Adolescents (SQIFA) would be completed by case managers in those cases. Although there was evidence of health interventions, we could not locate all of the SQIFA assessment forms in the cases we looked at. SQIFA forms were then discussed at the weekly CHT meeting to ensure that any further assessments were carried out and appropriate referrals made. This meeting consisted of a forensic psychologist, family therapist and substance misuse worker. The YOS did not have a physical health nurse and, therefore, children and young people were not having a formal assessment of their health needs other than through the mandatory ASSET. The YOS relied on health managers to carry out assessments and make necessary referrals to universal services; case managers had not received any training in the last 12 months on identifying and dealing with physical health needs. The YOS has plans for a nurse to be in place for three days per week by November 2015.

17. Cases were also reviewed on a regular basis at CHT meetings and, in particular, those where high need or risk had been identified. Case managers were also invited to attend these to participate in the discussions and to receive support, advice and insight into how to work with children and young people who exhibited health concerns. Other agencies were invited to attend where appropriate and we observed evidence of social workers and fostering agencies attending. This helped to ensure that all involved were aware of the issues and that professionals were held to account for actions that had been set at previous meetings. We saw that notes detailed the tasks, as well as how to help manage risk and

2 Structured assessment tool based on research and developed by the Youth Justice Board looking at the child or young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour.

behaviours. Case managers we spoke with reported that they found these meetings of significant use, that they provided good support and that the process was responsive, allowing them to discuss cases of concern.

Example of Notable practice

The case manager worked well with children's social care and the YOS clinical health team to agree the way forwards and deliver their plans. The forensic psychologist was instrumental in working with Jay's mother to ensure she understood and agreed to the approach planned and to work towards Jay being provided with the most appropriate specialist support in the right care placement.

18. There was no systematic assessment of sexual health for every child and young person on a statutory court order. We found an example where concerns about a young person's sexual health had been recorded but there was no evidence to show that this need had been addressed. One member of the health team was able to carry out work where issues had been identified around sexual health with children and young people. For example, with condom distribution or advice and signposting to other relevant services. Children and young people could also be referred to universal services at The Point[3].

19. It was encouraging to see a focus on ensuring that progress made by children and young people was sustainable post supervision, and the YOS was good at planning for the future and how children and young people would continue to progress once they no longer had support from the YOS. We saw some good examples of referrals to other agencies who would continue to work with the child or young person, and some clear exit strategies designed to move the child or young person from reliance on YOS services to other mainstream services.

Example of Notable practice

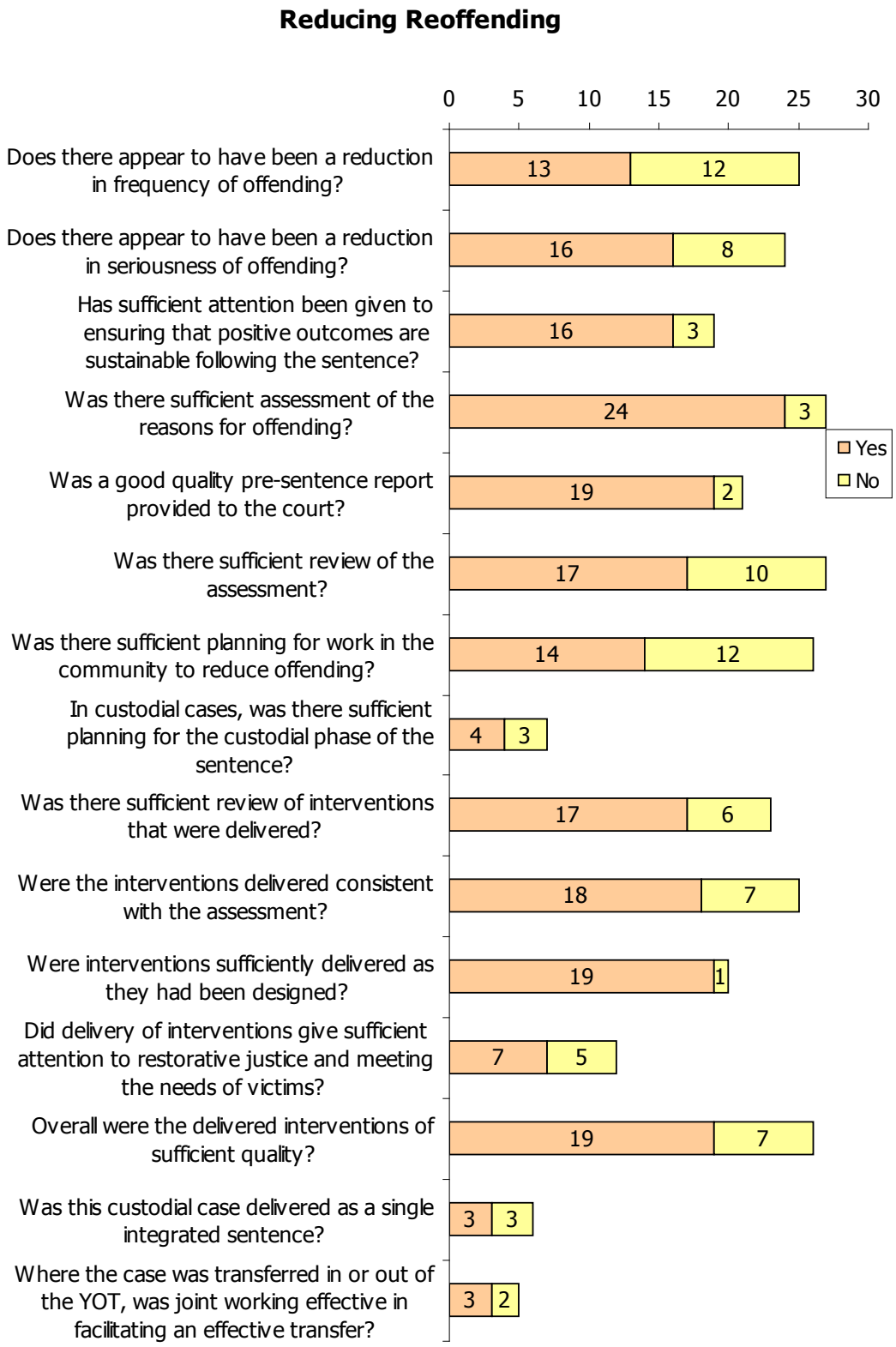
The YOS made good decisions in regard to the transition to probation. They decided that Jess was too young and immature to move directly to probation on release so asked that Jess be released to the supervision of the YOS. Jess had worked with the YOS during her bail term and they wanted Jess to "see a friendly face and have a hand hold" as Jess was released. They gradually introduced Jess to probation, holding a final three-way meeting before the transfer was finalised.

20. We were pleased to see that the frequency of reoffending had reduced in over half of cases and the seriousness of reoffending had reduced in two-thirds of cases. In our view the child or young person was less likely to reoffend in just over one-third of cases we examined and a greater focus on effective planning and ensuring interventions were delivered could lead to more success in this area.

3 The Point is a one-stop-shop for young people offering a range of services designed to give young people advice and help.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 27 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the public

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Theme 2: Protecting the Public

What we expect to see

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

Case assessment score

Within the case assessment, overall 69% of work to protect the public was done well enough.

Key Findings

1. Reports to court and initial assessments of risk of harm were good.
2. Reviews of assessments were not completed in all instances following significant change.
3. The Multi-Agency Public Protection Arrangements (MAPPA) process was not followed correctly in all relevant cases.
4. The integrated action plan often lacked sufficient focus on risk of harm and how it should be managed.
5. Not all staff were trained in how to devise a good quality integrated action plan.
6. There were strong multi-agency arrangements in place to manage risk of harm.
7. Interventions to address the risk of harm were not always delivered.

Explanation of findings

1. It was encouraging to find that reports produced for the court contained a clear explanation of the risk children and young people posed to others in almost all the cases we examined. Case managers had made sufficient effort to understand and explain the reasons why a child or young person posed a risk of harm to others in most of the initial assessments we saw, and had more thoroughly developed the analysis from the pre-sentence reports.
2. Reviews of assessments were carried out to a sufficient standard less than two-thirds of the time. In cases where we deemed there should be a review, nearly half did not have one or were not reviewed in response to significant changes in the child or young person's life. Again, too many reviews were copies of previous assessments.
3. Plans to manage risk of harm needed to improve in many of the cases we looked at. Just over half met the required quality level. Common deficiencies included a failure to anticipate changes in risk of harm, a lack of clarity as to the planned objectives and contingency plans lacking clear detail. We also saw too many cases where a plan had not been completed. We found this disappointing following the high standard of assessment we had seen concerning risk of harm in reports and at the start of the orders. The YOS uses the IAP which incorporates planning for risk of harm, safeguarding and vulnerability and interventions. Many staff, however, appeared unfamiliar with the plan and there had been a lack of effective training in how to complete the IAP to a good standard. Where plans had been done they had been reviewed adequately in over two-thirds of cases. We found sufficient planning had been done during the custodial phase of a sentence in only one-third of relevant cases.

4. Detailed performance reports were provided to, and requested by, the management team and the YOS operated a quality assurance process which provided managers with a suite of information concerning the quality of assessments and plans. We saw some evidence of this being used to identify areas of improvement for staff. We found, however, that management oversight was effective in ensuring the quality of risk of harm work in just under half of the cases inspected. In some cases this was due to a failure to address deficiencies in assessment , however, the major reason was that deficiencies in planning had not been addressed. Managers needed to be more robust in following up with staff to ensure that those actions identified were completed. Overall, we judged the YOS had taken all reasonable steps to keep to a minimum the harm posed by children and young people in just over two-thirds of relevant cases.
5. Where cases were transferred out, while we did see some examples of good practice, we found that the level of communication with receiving services, such as the National Probation Service or Community Rehabilitation Companies, was not consistently good. In some cases, we could not see evidence of clear discussions concerning transfer and staff need to ensure that such discussions are recorded.
6. We found MAPPA had been appropriately engaged in most of the assessments and plans where it had been required. The YOS police officer demonstrated an understanding of child sexual exploitation but had limited knowledge of the MAPPA process, including the criteria for referring offenders. The YOS manager, however, had a good understanding and also had a seat on the Greenwich MAPPA panel. Overall, MAPPA and other multi-agency arrangements were effective in managing the risk of harm in nearly three-quarters of cases. This is a critical area of work and the YOS needs to ensure that all potentially high risk cases are being managed correctly. An example of work in this area where practice should have been better was where a young person placed out of borough by Greenwich had been accepted by a MAPPA panel as a level 2 high risk of harm case posing risks that needed active multi-agency management due to their offending behaviour. The case manager from the Greenwich YOS had attended the MAPPA panel and had entered the MAPPA actions along with their risk assessment (high risk) within the diary notes of the young person's Youth Offending Information System (YOIS) record. The case manager, however, had not reviewed the risk of serious harm until three months later. This meant the young person's risk of serious harm remained at medium risk with no MAPPA involvement during the intervening period, when it should have been high risk with MAPPA oversight, though the clinical health team did provide some additional input designed to manage the risk of serious harm.
7. Interventions to manage the risk of harm were consistent with plans in three-quarters of the cases we saw. Where they were not, the main reason was that while interventions had been delivered, no plan had been produced. Although this did not always negate the value of the interventions carried out there was scope for improvement. We found that the required interventions to deliver risk of harm work were delivered throughout the sentence just over two-thirds of the time. We came to the conclusion that clearer plans would have given the opportunity for more effective risk of harm work to be delivered.
8. The risk of harm to victims was effectively managed in less than two-thirds of the cases we inspected. The YOS must improve its use of the integrated action plan and ensure case managers devise plans to effectively manage the risks that children and young people pose to victims.
9. We were pleased to find that the YOS effectively utilised risk management panels and the serious youth violence panel as mechanisms to pool knowledge and took a multi-agency approach to managing risk of harm. The YOS also had a nominated liaison officer to the violence and organised crime unit (VOCU) which allowed rapid information sharing between the agencies involved.
10. The VOC (gangs) unit worked closely with schools to raise awareness of the issues around gang associations. Members from the unit also visited children and young people in custody to deter them from gang association and also to place conditions on them as part of their release.

Quotes from victims

"They [YOS staff] came home; they came to the house and did work on safety issues about being safe on the street, drug awareness, danger awareness."

"I would have [liked contact from the YOS] if [other victim] phoned me when it did happen because, as I said, I couldn't eat, I couldn't sleep; I couldn't get my head round it at all. I needed support then but now, I've just kind of…it's finished with now, as far as I'm concerned, he's been charged with it so, so let it be."

Examples of notable practice

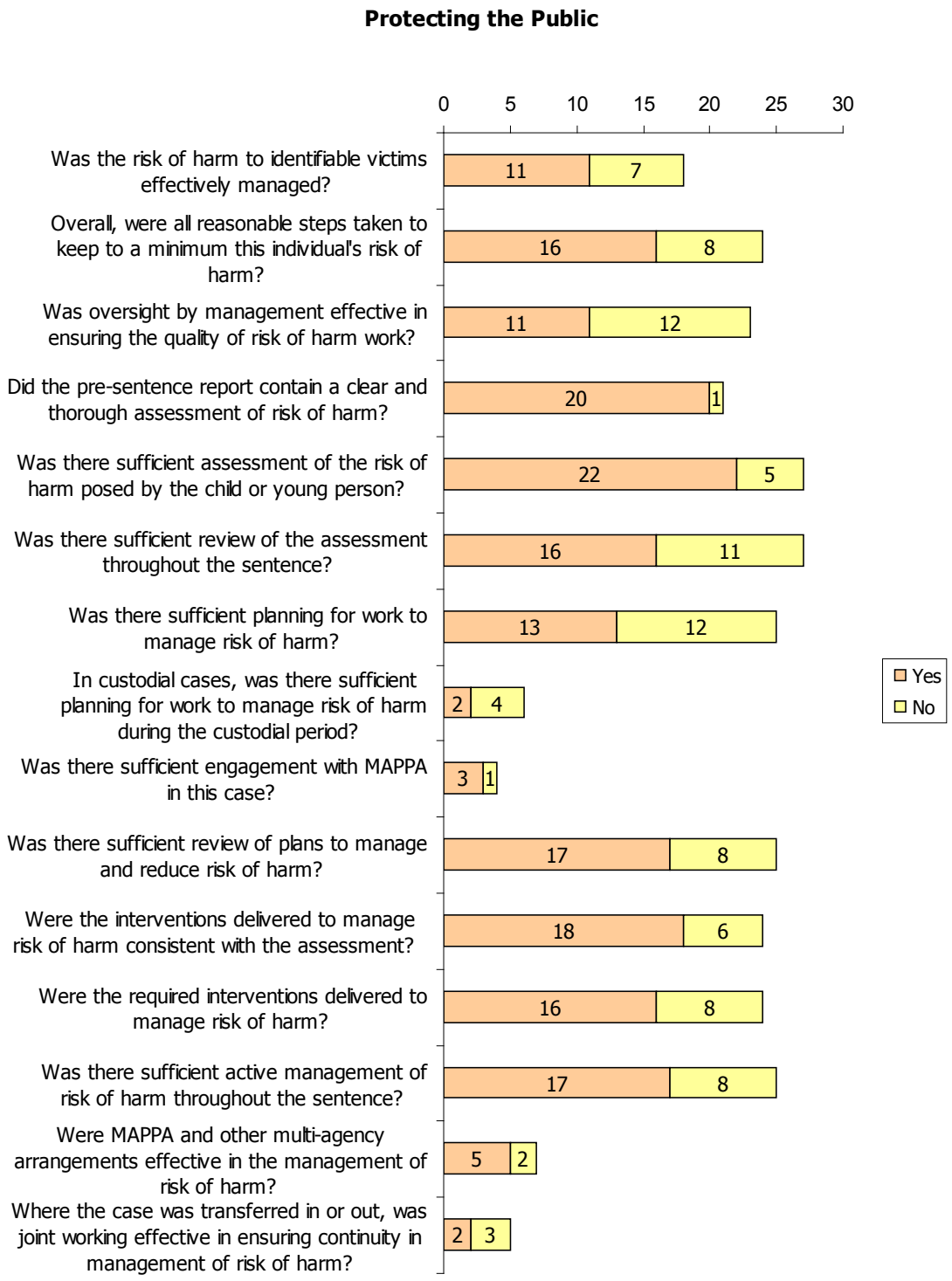
The YOS ran a risk management panel where young people were discussed. On one such panel, the VOCU presented evidence on four young people believed to be members of a local gang. As a result of the intelligence and joined-up problem solving, all four were moved away from Greenwich, and the families were provided with support through social services, housing and education.

Zack had gang affiliations and was suspected of supplying drugs. There was police intelligence to suggest Zack had been involved in numerous violent incidents related to gang activity. Zack had recently been placed in local authority care. At the start of the youth rehabilitation order, Zack was in denial over any gang affiliations and refused to engage with any interventions planned by the YOS. The case manager identified the areas of work as anger management, referral to drugs services, referral to Child and Adolescent Mental Health Services (CAMHS), referral to the St. Giles Trust for mentoring concerning gangs, stable placement, and support to achieve either a college place or apprenticeship. Zack initially wanted nothing to do with the YOS and would not engage with the case manager. Over time, the case manager has managed to build an effective working relationship with Zack, focusing on clear expectations, boundaries, being realistic in addressing presenting issues, empathising and not patronising, displaying patience and being consistent. Failures to report were dealt with swiftly and Zack was challenged when they failed to comply, a compliance panel was used during the order to re-establish attendance. Zack has opened up to the case manager and started to disclose details on gang life and previous activities concerning drug supply and violence. Zack has engaged with ETE, obtained an apprenticeship and has recently engaged with drugs services. Zack has moved to a new stable placement.

11. Intelligence held on police systems was generally researched and provided to case managers by the YOS police officer when asked for, and there was evidence that this information formed part of the risk assessment of the child or young person. The Metropolitan Police recorded all police contact with children and young people, for example arrests, stop and search, domestic incidents and missing person reports, on a form called a MERLIN. This was forwarded by the multi-agency safeguarding hub (MASH), to the YOS police officer to research and complete an up to date risk assessment. Once completed, this was returned to the MASH for dissemination to the appropriate authorities. On occasions, this information was shared directly by the YOS police officer with the case manager either by email or phone. The information was inconsistently entered onto the YOIS.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 27 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

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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 67% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Reports to court and initial assessments of safeguarding and vulnerability were good.
2. Reviews of assessments were not undertaken or were incomplete following significant change.
3. The integrated action plan often did not contain sufficient focus on vulnerability and how it should be managed.
4. Not all staff had been trained in how to devise a good quality integrated action plan.
5. There were strong multi-agency arrangements in place to manage vulnerability and joint working with other agencies was good.

Explanation of findings

1. Almost all pre-sentence reports we examined contained a thorough explanation of vulnerability and the safeguarding needs of the child or young person. This was an area of strength for the YOS. Most initial assessments were of a good standard and case managers demonstrated a good understanding of the safeguarding and vulnerability needs that applied to children and young people.
2. Assessments were good at considering alcohol and drug misuse, ETE, care arrangements, physical health and emotional and mental health issues. The YOS could make further improvements by ensuring all information from other agencies is utilised and that all assessments are clear on the nature or level of vulnerability of the child or young person.
3. Reviews, however, were only good enough in just under two-thirds of cases. Where they were not good enough this was either because the review was not completed or that it was not completed in response to a significant change in the child or young person's life, therefore, preventing the production of an up to date plan to manage vulnerability.
4. Despite good assessments, vulnerability plans were sufficient in just under half of the cases we saw. In most of the cases that were insufficient this was because a plan had not been completed. We were surprised to find this given the excellent partnership arrangements which were in place to manage vulnerability issues, such as the serious youth violence panel and the VOCU, and good links with the children's services department. We also saw clear evidence in the case files that safeguarding and vulnerability issues were being addressed. Interventions delivered to address safeguarding and vulnerability were consistent with assessments in nearly three-quarters of the cases. Our conclusion

is that the integrated action plan was not being used consistently well as not all case managers understood its function as a planning tool for managing vulnerability.

5. Consequently, reviews of plans were good in only just over half of the relevant cases we examined; in most cases where they were not good enough it was because they had not been completed. The interventions that were delivered by the YOS throughout the sentence we found to be appropriate and of a good standard in nearly three-quarters of cases. This is consistent with our finding that appropriate work was often being delivered but had not been underpinned by a plan. In conclusion, the required interventions to effectively manage safeguarding and vulnerability were delivered in under two-thirds of cases. Areas that needed more focus were emotional and mental health, and alcohol and drug misuse. More effective planning by the YOS is required to ensure that all aspects of safeguarding and vulnerability are addressed.
6. Effective management oversight is critical to ensure that the quality of work is of the correct standard. We judged oversight to be effective in just under half of the cases we examined. Managers have information available through the quality assurance process and performance reports but this is not used to drive performance particularly with reference to vulnerability planning within the IAP. All reasonable steps had been taken to keep to a minimum the risk of children or young people coming to harm in just under two-thirds of cases.

Quote from a child or young person

"My home life is fine (…) but to an extent, I still do feel unsafe because nothing has been done (…) there's no security matters to save me or to stop anyone from finding me or sending people to come and attack me again, if anything."

7. A child-centred approach to partnership, of sticking with children and young people and performing above expectation, was in evidence throughout this inspection. The YOS worked hard to ensure comprehensive multi-agency packages of support were put in place for children and young people. This included children and young people whose involvement with the YOS was soon coming to an end or where they had moved area and were under the supervision of another YOS. For example, the YOS had begun commissioning an intensive specialist placement on release from custody for a young person who was 17 years and 6 months old and this showed commendable commitment to his longer term well-being post YOS involvement.

Example of notable practice

This was clearly a very complex case with behavioural, cognitive, social and emotional issues to address. Baz was assessed as needing a Child Protection plan in late 2014, which was later reduced to a child in need plan and thereafter managed at 'team around the child' level. Those involved in the 'team around the child' have provided a positive package of intervention and support for this young person and in doing so made positive change possible and changed the life of this young person for the better. The case manager referred the young person to the fire cadets where he was described as a very positive member of the team and was able to develop many skills and improve his self-esteem and perception of self. This experience will stand him in good stead for the future.

8. Where there were both social work and YOS interventions, there were very few gaps in joint assessment, planning, support and provision of services. Evidence from electronic case records was of a strongly integrated YOS, with a high degree of co-working with social workers. The impression was of a service that was strongly collaborative, but not always good at capturing that collaboration and demonstrating it through case records.

Example of Notable practice

Kris was a Looked After Child and there was a coordinated response by the YOS and children's services to address Kris's accommodation issues and try and establish some stability in Kris's life. The YOS also identified all the key agencies - drugs services, housing, ETE and CAMHS and attempted to get Kris to engage with these agencies with varying degrees of success over the short three month order.

9. Social workers and their managers spoken with during the inspection clearly explained the analysis underpinning their decision making, and could demonstrate a range of interventions proportionate to children and young people's assessed need. Analysis was well recorded on the good practice examples offered. The rationale underpinning decision making was not always readily apparent from the case record. This meant that those consulting the record, who were not part of the collaborative decision making process, may not have been able to respond appropriately to the child or young person's needs.
10. Social care staff that we spoke to were aware of the objectives for their service and where that fitted with strategic plans for the YOS. A number of positive factors came up repeatedly, such as co-location, a strong willingness to work together and an understanding that the child or young person was at the centre of their work. Several positive examples were demonstrated at every stage of the journey of the child or young person from early help to pathway plans.
11. Social work staff interviewed were very committed to joint working with the YOS, and integrated collaborative systems such as the risk management panel ensured that information was shared and interventions were coordinated. While written plans or performance information was available to social workers and their managers and was used by them, their priority appropriately remained as the importance of providing integrated services to children and young people.
12. The YOS police officer attended the regular risk panel meetings where the most vulnerable children and young people posing the greatest challenge were discussed. This was a multi-agency meeting and we saw evidence of a holistic approach to managing children and young people. There was good attendance by the police from both the YOS and the VOCU and evidence of effective information sharing.
13. There was a clear understanding of the dangers of radicalisation of children and young people and good examples of how the warning signs of this had been identified and managed by staff within the YOS.

Example of Notable practice

A young person had stopped engaging with education and with her social worker. She had been referred to the YOS for a youth intervention, during which time she made disclosures including her desire to convert to Islam. A referral was made to the prevent team who, although they were already aware of her, found that the additional intelligence was of significant assistance to them.

14. In the great majority of cases, sufficient effort had been made to understand and explain how emotional or mental health issues related to safeguarding, or reduced a child or young person's vulnerability. In almost all cases inspected, physical health, alcohol misuse and drug misuse issues were addressed.
15. Health staff within the YOS employed by Oxleas NHS Foundation Trust had received safeguarding training at the appropriate level which included input concerning child sexual exploitation. Drug and alcohol misuse services were provided by Addaction, their staff had completed Local Safeguarding Children Board training at level one and additional internal e-learning training to support this. Addaction

staff had either completed child sexual exploitation training or will have by the end of September 2015, since this had been required as part of a merger between the previous provider KCA and Addaction. Staff we spoke with had a good understanding of child sexual exploitation issues and how to make necessary safeguarding referrals. Any safeguarding concerns were raised through the YOS protocol and managers in both agencies had been informed.

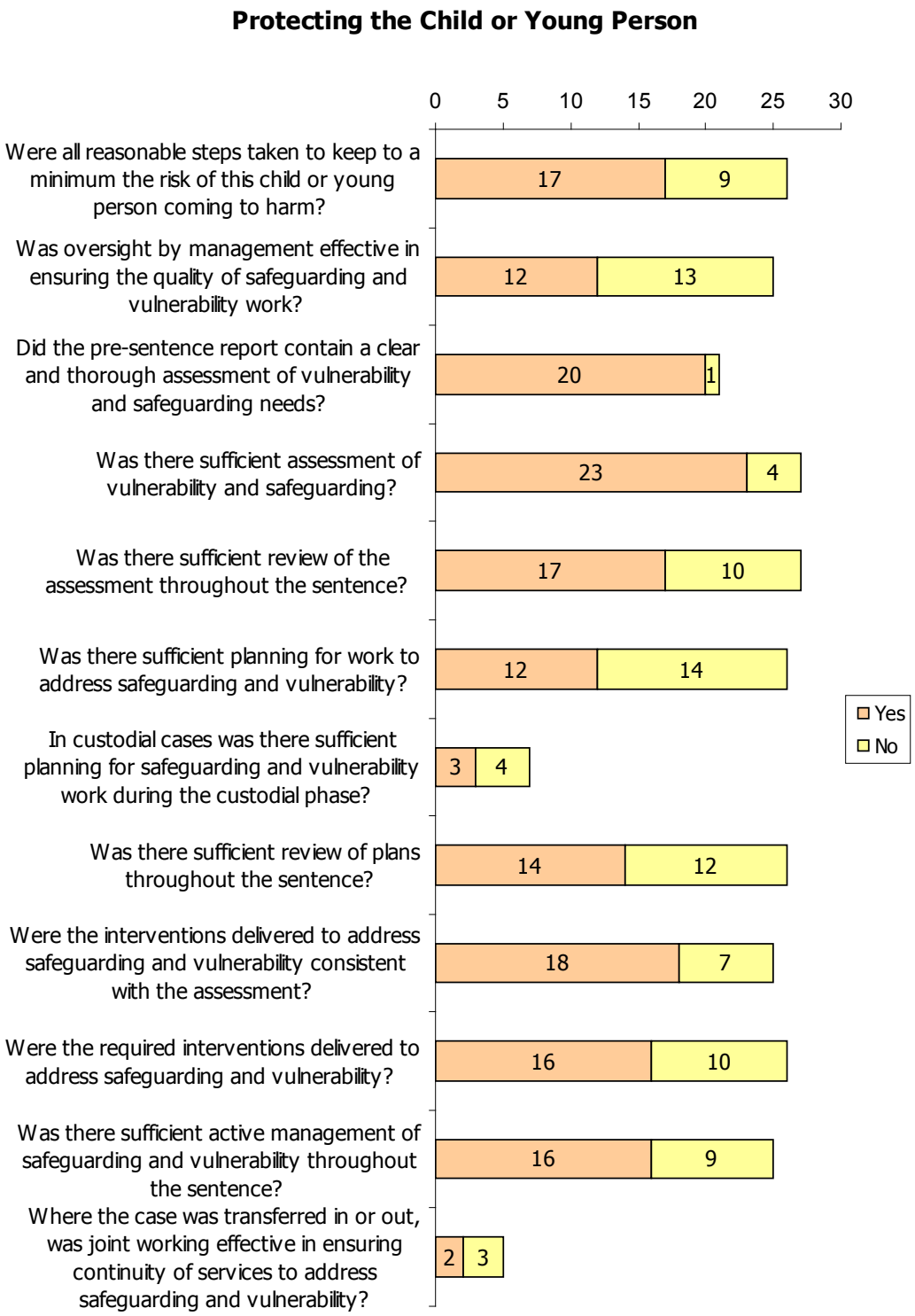
16. The community CAMHS provision had a 24 hour crisis team enabling children and young people to access relevant support outside of office hours. There were also mechanisms in place to ensure that those children and young people who were displaying acute behaviours could be seen by relevant professionals in a timely manner.

17. We found that despite specific needs being identified, not all referrals and subsequent interventions had actually occurred or were timely. One case identified that substance misuse was an issue; the intervention plan stated that the referral would be made within a month of the order starting. Four months into the order an audit identified that this referral had not been made. It was confirmed during the inspection that this young person was seeing a mainstream Addaction worker. This was not recorded however on the YOIS.

18. There was a good relationship between the YOS and health providers. The clinical health team meetings were an example of this and showed that YOS health staff would offer advice, support case managers and help to put plans in place to reduce children and young people's risk of harm and vulnerability.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 27 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 YOS 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 79% of work to ensure the sentence was served was done well enough.

Key Findings

1. Reports and initial assessments were good at identifying diversity issues and barriers to engagement.
2. Overall the YOS was good at engaging children and young people and parents/carers throughout the sentence.
3. The YOS effectively delivered the requirements of the court in most cases.
4. The appropriate use of compliance and enforcement action was evident in most cases.

Explanation of findings

1. We were pleased to see that diversity issues and barriers to engagement were addressed well in most of the pre-sentence reports and assessments we looked at. Staff had made a clear effort to engage with children and young people, their parents/carers or significant others in order to understand the pertinent factors. The YOS could further improve in this area by ensuring it makes every effort to engage with parents/carers and that assessments reflect the views of parents/carers.

Example of notable practice

The case manager recognised the importance of understanding the family structure, culture and attitude to offending; addressing this was integral to changing the young person's offending behaviour. The YOS had started to do this by gathering information from colleagues in other agencies and verifying the information given by the family. A referral to Families First[4] had also been made which will further support the family as they experience difficulties, such as being evicted from their home.

2. Children and young people who had been supervised were asked to complete an e-survey on their views of the YOS. Almost all felt that at their first appointment with the YOS what would happen over the course of their order had been explained to them. Most children and young people said they had been asked to explain why they had offended and what they thought would stop them offending in the future. Children and young people also felt listened to, with 57% stating their views were always taken seriously and a further 29% saying their views were taken seriously most of the time. Almost all of the children and young people who completed the survey felt that the work they had done with the YOS had made them a lot less likely to offend.

4 Greenwich Families First programme helps people who have a range of issues which may include involvement in youth crime or antisocial behaviour.

Quotes from parents/carers

"We felt that they didn't [work with us]. While the work was being done, it was with the children. They engaged with the kids, I'd come down, and that was it they left."

"Well, they did explain, they did explain you know. They do give support, at that time...different sessions ...They did explain to us and we've had some visits… they speak to him, they talk to him because at that time it's sort of like he's losing interest in people, losing interest in people that he doesn't think are helping him out."

Quotes from children and young people

"Good; [relationship with YOT worker] because I understand how everything she explains to me. If I do not understand something, she really explains to me until I understand this. She explains to me and we're doing work together."

"I was very supported. No matter what they always gave me opportunities. And they opened a lot of doors. When I came out [of custody], they sorted me out and trying to get me into college and that and now I'm in college."

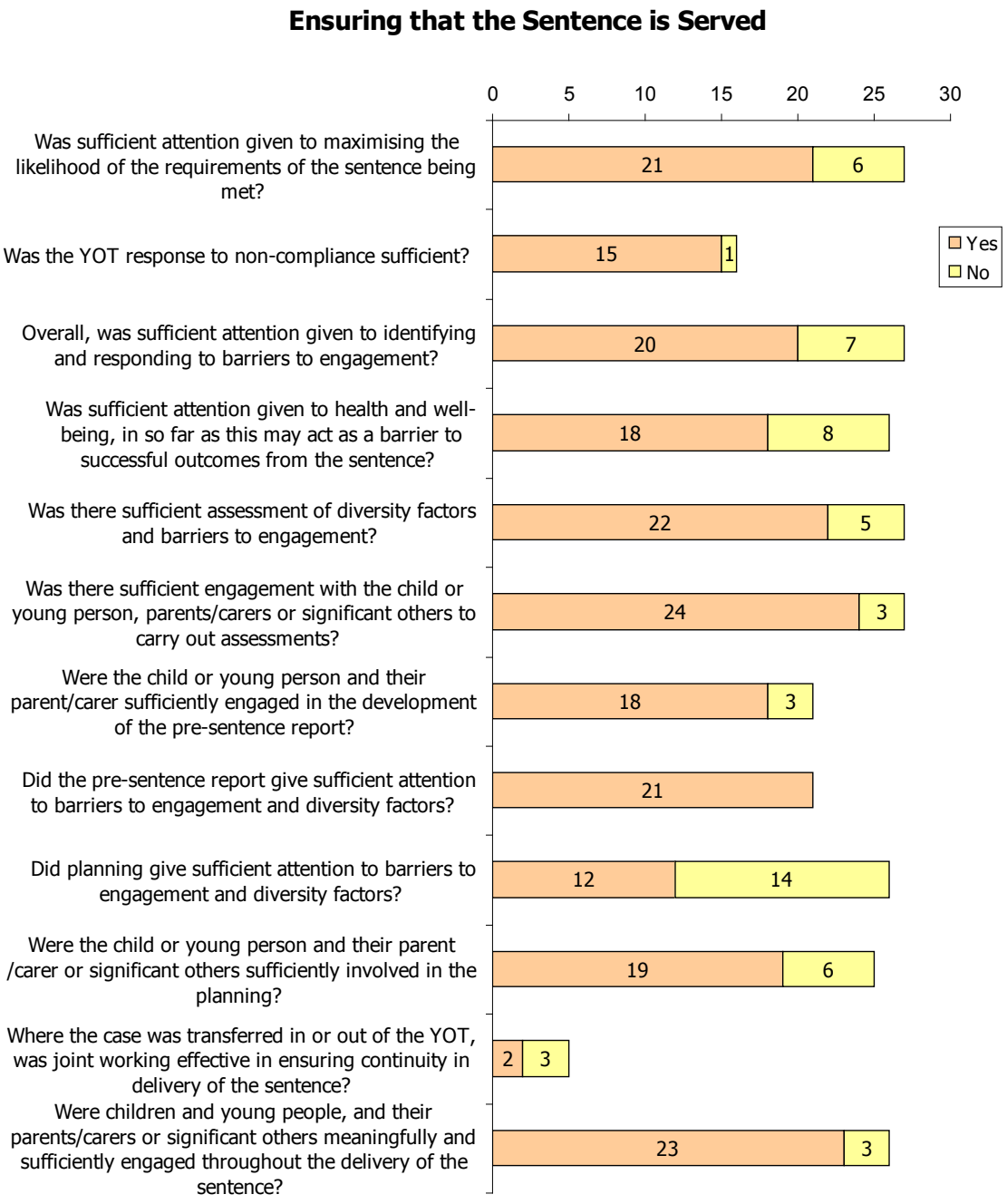
3. Initial planning using the IAP sufficiently addressed barriers to engagement in just under half of the cases we saw. Barriers identified in assessment did not always flow through into the plan; one particular area that was consistently overlooked was speech, language or communication needs. There was less involvement of the child or young person, parents/carers or significant others in the planning phase, with just over three-quarters of cases reflecting effective engagement. Over the length of the sentence we found that in most cases the YOS did a good job of engaging children and young people, parents/carers and significant others.
4. The YOS successfully ensured that the requirements of the sentence were met in over three-quarters of cases. In some cases, reporting requirements were insufficient for the needs of the case, we also found that the YOS needed to be clear that the child or young person or parents/carers understood what was expected of them. In a minority of cases additional requirements made by the court were not addressed. Where children and young people did not comply the YOS was good at working to improve compliance, using individual one-to-one motivational techniques and compliance panels. If necessary the YOS involved the police or returned individuals to court appropriately. The YOS response to non-compliance was good in almost all the cases we saw and all staff had a good understanding of local policies and procedures for supporting effective engagement and responding to non-compliance.
5. The YOS police officers attended a weekly pre-court panel meeting including ETE workers, a parenting worker, restorative justice officer, business support and group leader. In this meeting children and young people who had been arrested and bailed by police to the YOS for a decision on the most suitable outcome were discussed. Depending upon the decision, the police officers administered cautions and conditional cautions where required. The police officers also delivered a number of interventions including weapons awareness and crime and consequence, although there was no evidence of evaluation of the effectiveness on the child or young person. There was early preventative work with children and young people referred into a weekly triage meeting who had not come through the police custody route but had been identified by youth workers, with diversionary interventions delivered. This was an innovative provision that was, in part, assisted by the co-location of all children and young people's services in Greenwich.

6. There was evidence of the VOCU working with children and young people to divert them from gangs. This ranged from school engagement to working with children and young people prior to their release from custody to set the conditions of their release.
7. Where children and young people had breached conditional cautions or referral orders, the police officers were responsible for gathering evidence and arranging for the court summons to be prepared. Home visits with case managers were also regularly undertaken by the YOS police officers.
8. There was clear evidence of partnership working between the YOS with the VOCU, the missing persons unit, the MASH, Jigsaw[5] delivery staff and MAPPA. There were numerous examples given of intelligence having been shared and acted upon.
9. We looked at the state of health provision for children and young people. We found that a child or young person's involvement with health services was voluntary unless there had been a requirement for a substance misuse intervention as part of their statutory order.
10. YOS health staff were flexible in their approach and would complete home visits, see children and young people in a variety of settings and during out of office hours where required. Health professionals were co-located in the YOS building which was beneficial in that case managers could access health professionals and have advice and guidance from them and it supported integrated working. We saw evidence in one case of the forensic psychologist taking the lead and acting as the specific point of contact with a young person's family. It was acknowledged by all professionals involved that this had worked well.
11. YOS health workers and substance misuse workers have access to YOIS and record on this system. CAMHS workers did not have access to their provider's health system RIO. This meant that information was not recorded on their health system and conversely information could not be obtained from there. The substance misuse worker did not have access to the system used by Addaction in the YOS building, but could access the system at The Point where most children and young people were seen.
12. Staff from Addaction sat on YOS panels to ensure that they were aware of the cases and that the correct resources and interventions were in place. We were told that further work had started on crosschecking information to ensure that children or young people with an ASSET score of 3 or 4 were referred to the service.

5 An offending behaviour programme providing interventions tailored to work with young people from Standard through to Intensive levels.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 27 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 should be 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. There was strong strategic leadership with a clear plan and direction of travel for the YOS.
2. The YOS Management Board was aware of its responsibilities and was attended by relevant partners.
3. Partners were held to account and there was evidence of constructive challenge.
4. There was a clear performance management framework, with evidence that issues were escalated to, and addressed, by the Management Board.
5. The Management Board had not ensured that health contributions to the YOS included a physical health service for children and young people.
6. Strong partnership arrangements were in place and there was a commitment to ensuring young offenders had access to services.
7. Effective scrutiny arrangements existed for the Management Board and there was involvement from elected members in addressing youth crime.
8. The YOS was well led, by a knowledgeable management team who were aware of areas for improvement.
9. Useful performance management tools were available to assist managers in addressing performance.
10. There was evidence of regular supervision, but staff could be assisted by more focused input on quality issues.
11. The YOS was integrated into the wider delivery of children's services but retained its own identity and focus upon youth offending.

Explanation of findings

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

1.1. The Management Board reporting structure had been revised and its membership streamlined within the last 12 months. We found the membership to be appropriate with members aware of their responsibilities in delivering services to children and young people and wider stakeholders.

1.2. There was a clear strategic plan in place for the YOS and strong strategic leadership focused on delivering the plan. There was evidence of positive challenge within the Management Board and activity to hold each other to account. The Management Board received detailed performance information concerning the YOS and utilised this information to initiate and review action plans designed to improve the performance of the YOS.

1.3. We were pleased to see an effective scrutiny process in place for the Management Board and the involvement of elected members in the delivery of services to address youth crime.

1.4. Information provided to the Management Board was detailed and comprehensive. Data on positive education training and employment outcomes was included in quarterly reports. More qualitive information needed to be presented to the Management Board and formally recorded. The Management Board had a strong focus on prioritising education training and employment as a key part of the YOS work. The Board had a good understanding of the links between ETE and re-offending. Management Board members used their links to the local authority to help support the education, training and employment aspects of YOS work. The Management Board presented sufficient challenge to the education, training and employment aspect of the YOS work.

1.5. The operational management of ETE was very effective and benefited from the Management Board member for ETE overseeing many of these areas.

1.6. The police representative on the Management Board was a Detective Chief Inspector, who was responsible for all matters relating to public protection. He had the appropriate level of authority to commit resources as required. He took an active role on the Board by monitoring performance and regularly challenging the performance presented by the YOS to the Management Board.

1.7. The Management Board had a delivery plan and its priorities were reviewed annually. A particular focus for the police was early intervention work and the development of preventative structures to reduce reoffending.

1.8. There was good attendance by the Clinical Commissioning Group at the Management Board and this was at a level enabling appropriate decisions to be made. The head of the YOS and the head of the YOS Management Board sit on the Young People's Emotional Health and Well Being, Substance Misuse and Domestic Violence Joint Commissioning Group and so information that was required about the services provided was discussed in these forums. There was, however, insufficient evidence that all relevant information about health provision was available to the Management Board. For example, a report was discussed at the Young People's Emotional Health and Well Being, Substance Misuse and Domestic Violence Joint Commissioning Group on the 04 June 2015 where it was identified that performance by Addaction required improvement in some areas. This key information was not included in the minutes from the YOS Management Board dated the 15 June 2015. It is important that all collated information is shared with the YOS Management Board to ensure that health contributions specifically for the YOS based health services are scrutinised appropriately and that they are held to account, to ensure that a credible health service is provided for children and young people.

2. Partnerships – effective partnerships make a positive difference

2.1. We found strong strategic partnerships in place within Greenwich that were committed to ensuring children and young people who had offended had access to pathways designed to move them away from crime. We were impressed by the YOS' ability to place itself at the heart of these partnerships while maintaining the focus on the specialised needs of the children and young people it was working with.

2.2. An important element of successful partnership is a shared culture. All of the professionals interviewed articulated Greenwich's highly positive shared culture around the provision of services to children and young people.

2.3. Continually improving ETE outcomes was a priority for Greenwich YOS. Senior managers in the YOS that oversee the ETE work were well placed within their local authority roles to ensure that youth and children's services within the borough serve the children and young people known to the YOS extremely well. The work of the YOS was well integrated with wider local authority services, which benefit from being co-located. The very specific needs of children and young people known to the YOS were well understood and were prioritised equally well with other vulnerable children and young people within the borough.

2.4. It was positive to see there was good integration between health services across the borough and the YOS and this was something that all agencies were proud of across all levels. For example, at the clinical health team meetings, health staff sat on panels such as the pre-court disposal and high risk panels and the YOS manager sat on commissioning groups. As part of this, all agencies wanted to ensure that children and young people had access and links to services and to avoid duplication.

2.5. It had been recognised by the YOS and its partners that there were performance issues with the substance misuse services that were being provided. An action plan had been devised and there were regular meetings to help ensure that improvements were being made. There was, however, a lack of clarity between providers and commissioners over the content of service provision and outputs, outcomes and targets were under review at the time of this inspection.

2.6. A joint strategic needs assessment was carried out in 2012. A specific Children and Young Persons profile was refreshed annually to help ensure that services reflected the needs identified. Despite that assessment and review process, there had been no specialist physical health provision for children and young people attending the YOS for some time.

2.7. The Local Safeguarding Children Board (LSCB) was reported as having a highly functional relationship with the YOS and was well integrated with the YOS Management Board, with a clear distinction around the LSCB's role in 'challenging' the YOS Management Board to ensure that it was meeting its safeguarding responsibilities. The LSCB's work plan included cross-cutting issues such as the Task and Finish Group regarding peer on peer abuse, and an audit on the multi-agency approach to gangs. While there was as yet no outcome to these processes, they will, when successfully completed, add value to the multi-agency partnership's understanding of youth crime issues.

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

3.1. The YOS had recently restructured and was in the process of recruiting staff to fill permanent management and operational posts. Over the past year locum staff had been used more extensively to cover newly created roles vacated by staff who had left during the recent reorganisation. The new structure was clear and appeared to provide operational staff with access to sufficient management time and a more equitable division of the work.

3.2. Most staff were satisfied that their line manager had the skills necessary to assess, support and actively help them improve their work, but they also felt that there needed to be an improvement in the quality of the countersigning and management oversight of risk of harm and safeguarding work.

3.3. All staff felt they had been trained sufficiently to do their jobs, but did identify the need for future training to develop their skills, particularly with reference to speech language or communication needs.

3.4. Training for the YOS police officer was generally through e-learning. The sergeant was in the process of obtaining the officers personal development and training records to complete a training needs assessment.

3.5. The YOS police officers were valued and well regarded by peers and managers, being co-located and fully integrated within the YOS. They had full access to, and a good understanding of, the police IT systems located within the YOS. A large proportion of the working day was taken up by checking and updating MERLIN forms, which are notification forms for incidents involving children and young people. Once complete, the MERLIN is returned to the MASH. With the exception of the administrative burden of the MERLIN forms, the police officers were generally doing what the revised College of Policing and Youth Justice Board guidance says they should be.

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

4.1. We saw evidence that the YOS was a learning organisation and promoted a culture which looked at identified performance or quality issues as opportunities to learn and improve. The organisation was not always successful in that approach as we saw in the partial success of the YOS quality assurance process.

Example of Notable practice

Senior managers responsible for ETE within the YOS quality assured the alternative provision to which children and young person known to the YOS were referred. Providers who were not found to be good were not used by the YOS.

4.2. We saw an example of a strong response from the Management Board to a performance issue within the YOS. The Management Board commissioned a critical learning review and then an extended learning review. This allowed a thorough analysis of the issues and provided the information necessary to construct a clear plan to improve the situation within the YOS. We were reassured to see that the YOS addressed the performance issues robustly and constructively.

4.3. A culture of learning within the YOS was evident and this was supported by the wider ethos of Greenwich Children's Services. All YOS staff were encouraged to reflect on their work and to continually develop their skills.

4.4. The children and young people within the YOS had access to the wider provision of services available to children and young people within the borough. Even though the numbers of children and young people from the YOS were small it was fundamental to all professionals who worked with them that they were given the same priority as any other vulnerable group. Staff were clear that children and young people known to the YOS had very specific needs as a group, however, staff were encouraged to ensure that they were not defined by their offending and to look for ways to help them progress and to present them with real alternatives to offending behaviour.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

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 73% of work to deliver interventions was done well enough.

Key Findings

1. Case managers skilfully delivered interventions to reduce reoffending and reviewed their work as needed.
2. The YOS had access to a range of good quality multi-agency resources and interventions.
3. Integrated action plans did not always contain a clear intervention plan.
4. The YOS did not always ensure there was enough emphasis placed upon interventions to manage the risk of harm to others.
5. There was not enough focus on victim work and restorative justice.
6. The YOS did not always evaluate the success of the interventions it delivered.

Explanation of findings

1. Of the 27 cases we looked at in week 1 of the inspection, we found that despite the limited quality of some plans, YOS practitioners were delivering interventions to reduce reoffending and reviewing their work as needed. There were few cases where no interventions had been delivered. Where there were gaps, these tended to be in areas such as emotional and mental health, substance misuse and, to a lesser extent, family and personal relationships, self-perception and motivation to change. We acknowledge, however, that there were examples of good work that had not been recorded.
2. In some cases, we would have expected to see a greater emphasis on interventions to manage risk of harm to others. Sufficient and appropriate work, however, was being undertaken to improve children or young peoples living arrangements, ETE, attitudes to offending, and lifestyle.
3. A good range of interventions were available and we saw examples of their effective use to achieve positive outcomes. YOS practitioners demonstrated their skill in partnership working, and reinforcing the positive factors in a child or young person's life during the delivery of interventions.
4. In the main, the YOS kept children and young people and their parents/carers involved throughout the delivery of their sentences. In many cases, the YOS put arrangements in place towards the end of a sentence to help sustain any positive progress the child or young person had made.
5. The YOS had access to a range of good quality multi-agency resources and interventions. Although we found a gap in group work programmes, the YOS had already identified this and was working to address it.

6. Opportunities for children and young people to improve their English and mathematics were good. The YOS through its 'rapid English' course provided good support for children and young people in developing their confidence and skills.
7. Practitioners utilised relevant resources and structured them appropriately. They employed a positive approach and strong engagement skills during their delivery. There was an evident focus on reducing offending among children and young people and case managers went the extra mile to identify and address individual needs and barriers to engagement in order to achieve this.

Quote from a child or young person

"Yeah, the YOS made me think. I was like: "I just want to keep doing whatever I'm doing. And they said: 'No, you're going to change paths.' So, the YOS made me aware of the impact of what I'm doing on people."

8. One of our inspectors attended and observed a range of interventions, which included a reparation project at Eco Park which was found to be engaging and enriching for the young person involved, and an arts project.

Example of notable practice

A young person, having completed the arts project, fed back that he had found it life changing and, with the confidence this gave him, had enrolled on a music course at college.

9. We visited The Point, a one-stop-shop for youth services which gave children and young people access to an impressive range of providers. We consider this was a good place for children and young people which had a comprehensive menu of resources which were heavily utilised by children and young people.
10. We saw 'Headscape Greenwich', an online resource which allowed all children and young people in the borough access to information around emotional and mental health topics and enabled them to complete evidence based questionnaires to help them receive support. It was interactive and included quizzes, activities, information to read, and videos to watch while allowing children and young people to self-refer to relevant services. It covered a wide range of topics including drinking and drugs, anxiety, gender identity, eating disorder and family problems and also provided advice on how to deal with those issues.
11. From a wider perspective, 'Greenwich Project Mosaic' was a joint initiative that brought together different faith leaders from across Greenwich. It supported faith leaders to have an understanding of areas of the YOS' work, such as gangs, in order to support children and young people and help increase their safe access to provision.
12. We recognise that work with victims has been progressing. This would benefit from more structure and tighter joint working arrangements to provide greater support for victims and strengthen its impact. For example, on victim safety, licence conditions, and MAPPA and to increase the potential for restorative justice.
13. We observed helpful discussions during an internal YOS practitioner's forum but this would have benefited from more formal structure. This could be as simple as making and disseminating a note of discussions, which would benefit both the case being explored and maximise the learning of those practitioners not attending.

14. Referral order plans needed more consistency. A more rigorous and standardised approach was required by panels to ensure every child or young person leaves with a well structured, comprehensive and helpful plan.

Example of Notable practice

The case manager found there was ongoing animosity between the perpetrator and victim and that Mary (the perpetrator) found it difficult to accept that her behaviour towards her victim was wrong or to understand its impact on the victim. The behaviour was ongoing and the case manager was concerned that it would escalate, about the effect on the victim and that this could affect the family's housing status. The case manager worked closely with the victim worker, housing estate officer and neighbourhood policing, meeting with Mary and her family, and the victim and her family, to help to understand and address the issues in the case. She also arranged for Mary to have a prison visit to raise her level of motivation to change. As a consequence, Mary appeared to become more aware of her actions and their consequences, and has not reoffended since the end of her sentence.

15. We saw some very good work being undertaken by the YOS but it could do more to measure the success of the interventions it delivers. Only by doing this is the YOS able to evaluate the impact and effectiveness of its provision.

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 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

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

Fieldwork for this inspection was undertaken on the weeks commencing:

07 September 2015 and 21 September 2015.

In the first fieldwork week we looked at a representative sample of 27 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:

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Appendix 2 - Acknowledgements

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Criminal Justice Joint Inspection

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