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 **Cardiff**

An inspection led by HMI Probation

independent inspection of youth offending work

May 2016

Foreword

This inspection of youth offending work in Cardiff 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 Cardiff primarily because their performance showed the lowest 3 month and 12 month reconviction performance in Wales over a sustained period. The most recent published[1] reoffending data showed a decrease from the previous year to 41.8% but was still higher than the latest average figure for England and Wales at 37.9%. Reoffending frequency rates and the use of custody were also decreasing but still above the England and Wales average.

We found that reconviction and custody rates had continued to decrease since the latest published figures, and that the rates could at least in part be attributed to natural variations in comparatively small sample sizes. The Cardiff Youth Offending Service (YOS) was staffed by an experienced and committed staff group and supported by some effective partnership working. We identified scope for improvement, however, in the quality of the work with the children and young people. There was also a need for stronger leadership and oversight at every level in the organisation. The YOS had a sizeable range of interventions, but there was insufficient strategic oversight and planning of service provision, and insufficient monitoring and evaluation of their effectiveness in achieving positive outcomes for the children and young people.

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

Dame Glenys Stacey
HM Chief Inspector of Probation
May 2016

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

Key judgements

Summary

Reducing reoffending

Overall work to reduce reoffending was satisfactory. Court reports were of a good standard, and assessments of the causes of offending were timely and comprehensive. We found particularly good quality work in custodial sentences, and in managing the transfer of cases to adult probation services. There was some evidence of children and young people making positive progress, but more attention was required in sustaining positive outcomes following the end of supervision. We found little evidence of work with victims or restorative justice work.

Protecting the public

Overall work to protect the public and actual or potential victims was satisfactory. Reports to court gave clear explanations of the risk children and young people posed to others. Assessments of the risk of harm were sufficient, but planning to manage the risk of harm posed was insufficient in more than one-third of cases. Reviews of risk of harm assessments and plans were not always done, and not always sufficient when they were. Case managers had a good understanding of policies and procedures to manage risk of harm, but management oversight of work to manage risk of harm was insufficient. The YOS police officers had no access to ViSOR[2] and could have made more use of contact with neighbourhood policing teams.

2 ViSOR is a national confidential database that supports Multi-Agency Public Protection Arrangements (MAPPA). It facilitates the effective sharing of information and intelligence on violent and sexual offenders between the three MAPPA Responsible Authority agencies (police, probation and prisons).

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was satisfactory. Reports to court and initial assessments of safeguarding and vulnerability were good, but the quality of planning to address vulnerability was insufficient. Safeguarding and vulnerability were not always reviewed where necessary. We found, however, there was good liaison and joint working with Children's Services. We were concerned about the limited access to Child and Adolescent Mental Health Services. Management oversight of work to manage safeguarding and vulnerability was insufficient.

Ensuring that the sentence is served

Overall work to ensure that the sentence was served was satisfactory. Staff had a good knowledge of, and interest in, the children and young people with whom they worked. They paid good attention to diversity factors and barriers to engagement. There were good levels of contact with the children and young people and good levels of home visiting. In some cases restrictive requirements in criminal behaviour orders ran the risk of further criminalising the child or young person. Arrangements to respond to the needs of Welsh speakers were not good enough.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was unsatisfactory. A previous lack of effective leadership had weakened the YOS Management Board. It had not provided sufficient support to the YOS manager to strengthen the YOS management team to deliver improvements in practice. There was minimal use of performance data and local information to target service delivery and improve outcomes, and insufficient quality assurance processes to support improvements in professional practice. The YOS was staffed by a stable and experienced group of practitioners, and good partnership working had delivered some effective practice initiatives.

Interventions to reduce reoffending

Overall the management and delivery of interventions to reduce reoffending was satisfactory. Case managers had access to sufficient resources and interventions, and staff were planning and delivering services to a high standard. There was a well-established junior attendance centre fully integrated within the YOS. Practitioners were driving provision and development of interventions. There was no overarching strategy or policy to determine the range and content of provision, and there had been no recent, empirical needs analysis of the YOS caseload.

Recommendations

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

The Chair of the YOS Management Board should ensure that:

1. governance arrangements, at all levels, provide appropriate support, scrutiny and challenge to the work of the YOS and its outcomes
2. the work of the YOS is targeted, meets local need, and is driven by a clear strategy and effective delivery plan
3. there is sufficient access to Child and Adolescent Mental Health Services
4. there is sufficient exchange of information between the YOS and the police service.

The YOS Manager should ensure that:

5. the planning and review of work to manage the risk of harm posed to others is of sufficient quality
6. the planning and review of work to manage the safeguarding and vulnerability of children and young people is of sufficient quality
7. there is effective management oversight of the quality of work to manage risk of harm to others, and the safeguarding and vulnerability of children and young people
8. the YOS meets fully the needs of Welsh speakers, and promotes the value of Welsh as an employment skill.

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

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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, deliver appropriate interventions and demonstrate both positive leadership and effective management.

Case assessment score

Within the case assessment, overall 70% of work to reduce reoffending was done well enough.

Key Findings

1. Court reports were of a good standard.
2. Assessments of the causes of offending were timely and comprehensive.
3. Sentence planning covered the right things but needed to be clearer and better focused.
4. Work by YOS staff during children or young people's custodial sentences was good, and custodial and community phases were well integrated.
5. We saw little work with victims or restorative justice work.
6. There was very effective joint working between the YOS and the National Probation Service to ensure the smooth transition of cases between the two organisations.
7. Reviews of assessments and plans were sufficient when done, but more of the cases should have had them.
8. In half of the cases where we could make a judgement, the children and young people were making positive progress.
9. Some cases required more attention to sustaining positive outcomes following the end of supervision.

Explanation of findings

1. We were pleased to find that in the majority of cases that we inspected the case manager had made sufficient effort to understand why the child or young person offended and what might help reduce their offending. In a large majority of cases a good quality report had been provided to the court, and sufficient information was provided to enable sentencers to appropriately sentence children and young people.
2. Sentencers commented that oral reports were generally good and provided the information that was needed, and that there was no difficulty with clarifying any further points at the court hearing. They observed that the standard of written reports had improved over the last five years, and they now contained much more information.
3. We found, however, that some written reports were not sufficiently analytical, or could have been more concise. In some cases they provided insufficient assessment of the risk of harm posed by the child or young person to others, or of their own vulnerability. There was little evidence that police intelligence contributed directly to the content of pre-sentence or referral order panel reports. There was an established quality assurance process in place for court reports, but this had not picked up on these points in some cases.

4. In almost all cases there was a timely initial assessment in place at the start of the sentence. The majority had explored a wide range of factors that may have related to the child or young person's offending. In some cases, however, a good assessment of the factors themselves was not explicitly linked to their likely impact on the child or young person's likelihood of offending.
5. The most common areas requiring more investigation were the influence of family and personal relationships, and substance misuse. In some cases there was insufficient assessment of emotional or mental health, learning styles, and speech, language and communication needs. In many cases the 'What do You Think' self-assessment questionnaire had not been used to elicit the child or young person's view of their situation.
6. General health assessment sessions were delivered by the YOS health worker using the adapted Comprehensive Health Assessment Tool framework that covered all aspects of physical, sexual and mental health. Attendance was voluntary, but was part of a clear process to enable children and young people to get access to a comprehensive health assessment and subsequent health services as required.
7. For work in the community, planning to reduce reoffending was sufficient in the large majority of cases. Planning was particularly strong in relation to addressing education, training and employment (ETE), alcohol misuse, and physical health. Planning was also good in relation to mental and emotional health even though the assessment of this required improvement. In some cases greater attention could have been paid to the child or young person's living arrangements and local neighbourhood, family and personal relationships, and their motivation to change. Planning objectives needed to be expressed more clearly. Some were formulaic rather than personalised in their content and not written in language many children or young people would understand.
8. We inspected nine custodial cases and in the majority of them there was sufficient planning for work to reduce reoffending throughout the custodial phase of the sentence. In many of the cases, we saw that YOS staff took an active role in the process.
9. The referral order panel meeting we observed as part of the inspection was structured and efficient, and delivered in an informal and inclusive style. The case manager and volunteer panel members appeared experienced, confident and enthusiastic. The case manager led the proceedings, briefed the panel and concluded with an appropriate summary of the issues faced, and the decisions made. Contracts were signed and future panel dates set. In general, however, the detail of panel meetings was not well recorded in the case management system, and in some cases hand written notes were not copied into the electronic system.
10. Overall, the work delivered to address reoffending was of sufficient quality in two-thirds of cases. In some others there was no clear structure in the delivery of the work, the objectives were unclear, or insufficient effort was made to get the work done. This may in part relate to deficiencies in planning as previously noted.

Quote from a child or young person

"*Yeah, they ask me questions and asked what I would do. The training and stuff that I have had will help me not to reoffend.*"

11. The good quality of work in custodial sentences was a particular strength, and in all but one relevant case the custodial and community phases were delivered as a single, integrated sentence. In the majority of cases we saw evidence of effective joint working, and found activity to address reoffending had been undertaken while children and young people were in custody. In many cases this was supported by a good working relationship with the local Young Offender Institution. YOS staff took advantage of its relatively close location.

Example of notable practice

A YOS careers adviser worked well with young learners in Parc Young Offender Institution, to help them plan their progression options before being released from custody. She attended detention and training order planning meetings in custody and met with children and young people to improve their awareness of the labour market and their understanding of what employers needed. In one case, this careers adviser's involvement in progression planning enabled a learner to attend a college interview under Release on Temporary Licence.

12. We found that in the majority of cases where it was required, work had been done to address ETE, family and personal relationships, and thinking and behaviour. Interventions to help with lifestyle, substance misuse and emotional and mental health, however, had only been delivered in half of the cases where it was necessary. In a small number of cases more attention could have been given to the possibility of using a restorative justice approach or activity. We saw little work involving victims in the cases we inspected.
13. The YOS did not have a strategy to focus staff on the important relationship between improving poor literacy and numeracy skills and reducing reoffending behaviour. There was no clear plan that focused staff attention on the importance of children and young people acquiring good basic skills, and no evaluation of whether their skills improved during their involvement with the YOS.
14. The careers advisers seconded to the YOS, however, helped the children and young people improve their knowledge and awareness of ETE opportunities and gave useful advice to help them plan their progression towards employment. They supported children and young people in their engagement in education, training and employment. Their assessments of learners with additional learning needs were thorough and clear, giving good advice to service providers on how to organise delivery to improve their chances of success.

Quotes from children and young people

"*Yeah, if I need a job then they will help me, they help you find a job and stuff, and if you need to go on a course or anything then they will help you. I am doing a course at the minute – life for learning, until I find a work placement, but they help with that also. At the end of it I get a formal qualification. So I am happy with the help they have given me and feel that they take my needs into consideration.*"

"*[The YOS] put me back in school. [It's] better for me yeah…keeps me out of trouble. They're gonna put me in college.*"

"*[The YOS] helped me look for a job, look for a new college, hobbies to do instead of hanging around the street.*"

Example of notable practice

The careers advisers worked well with local training and work placement providers. For example, they had secured an agreement with a national fast-food outlet to guarantee an employment interview for learners referred by the YOS.

15. There was good sharing of information about the children and young people's learning needs and achievements between YOS workers. Information about achievements, however, was not gathered in a way that enabled systematic analysis or that helped all staff use this well enough to plan a child or young person's progression. In a few cases, the information was not shared well enough with education partners, to enable them to plan the children and young people's learning effectively.
16. The YOS employed a health worker and a substance misuse worker who were located in an intensive interventions team. There were appropriate arrangements for exchanging information on health matters between YOS staff. There was, however, no systematic assessment of sexual health for every child and young person.
17. One of the seconded probation officers specialised in transition work and supervised all those cases likely to be transferred to adult probation services during their current order. This approach supported some very effective joint working between the YOS and the National Probation Service (NPS) to ensure the smooth transition of cases between the two organisations. Where there was only a short period of supervision remaining beyond the young person's 18th birthday the case remained with the transition worker, but otherwise it was transferred to an officer in the NPS or Community Rehabilitation Company (CRC).

Example of notable practice

During the inspection we observed a well prepared and delivered session by the transitions worker, with a young person who was soon to be transferred to adult probation services. Standard materials were used to make sure all necessary elements of the session had been covered. The emphasis was on reviewing the 'distance travelled' by the young person whilst subject to supervision in the YOS. It sought to build upon that work, and to set an outcome based agenda for future work. It helped to prepare him for the change in focus of the work with probation, and the different culture and approach he could expect during supervision.

18. In nearly one-third of community cases the assessments and plans had not been reviewed when required, but most reviews were timely and sufficient in the cases where they had been done. The record of some reviews was very brief and contained no update of the initial analysis. Some had not been done following a change in the child or young person's circumstances.
19. In one-third of the cases we did not find evidence that interventions had been delivered consistently with the identified needs or intervention plan for the child or young person, or that their delivery had been sufficiently reviewed. In many cases, sufficient progress had been made in relation to some of the factors to reduce reoffending, but often greater progress was required in relation to substance misuse and emotional and mental health.
20. In more than one-third of the cases where it was relevant, more attention could have been paid to ensuring that positive outcomes were sustainable following the end of the sentence. In some cases there was no exit planning, and a resultant lack of referral or signposting to other agencies or services.
21. The YOS had two integrated resettlement support officers whose primary function was to provide and support the delivery of intervention work across a range of disciplines to achieve the successful resettlement of children and young people. We were pleased to find that although located in the intensive intervention team this support was available to all statutory cases where it was needed, and was available for up to six months beyond the end of statutory supervision if required.
22. In the cases we inspected there appeared to have been a reduction in the frequency and seriousness of offending in half of those where it was possible to make a judgement. Similarly, we thought the child or young person was less likely to reoffend in half of the cases we examined. Only a small proportion appeared more likely to reoffend. A greater focus on effective planning and ensuring interventions were delivered could lead to more success in this area.

Quotes from parents/carers

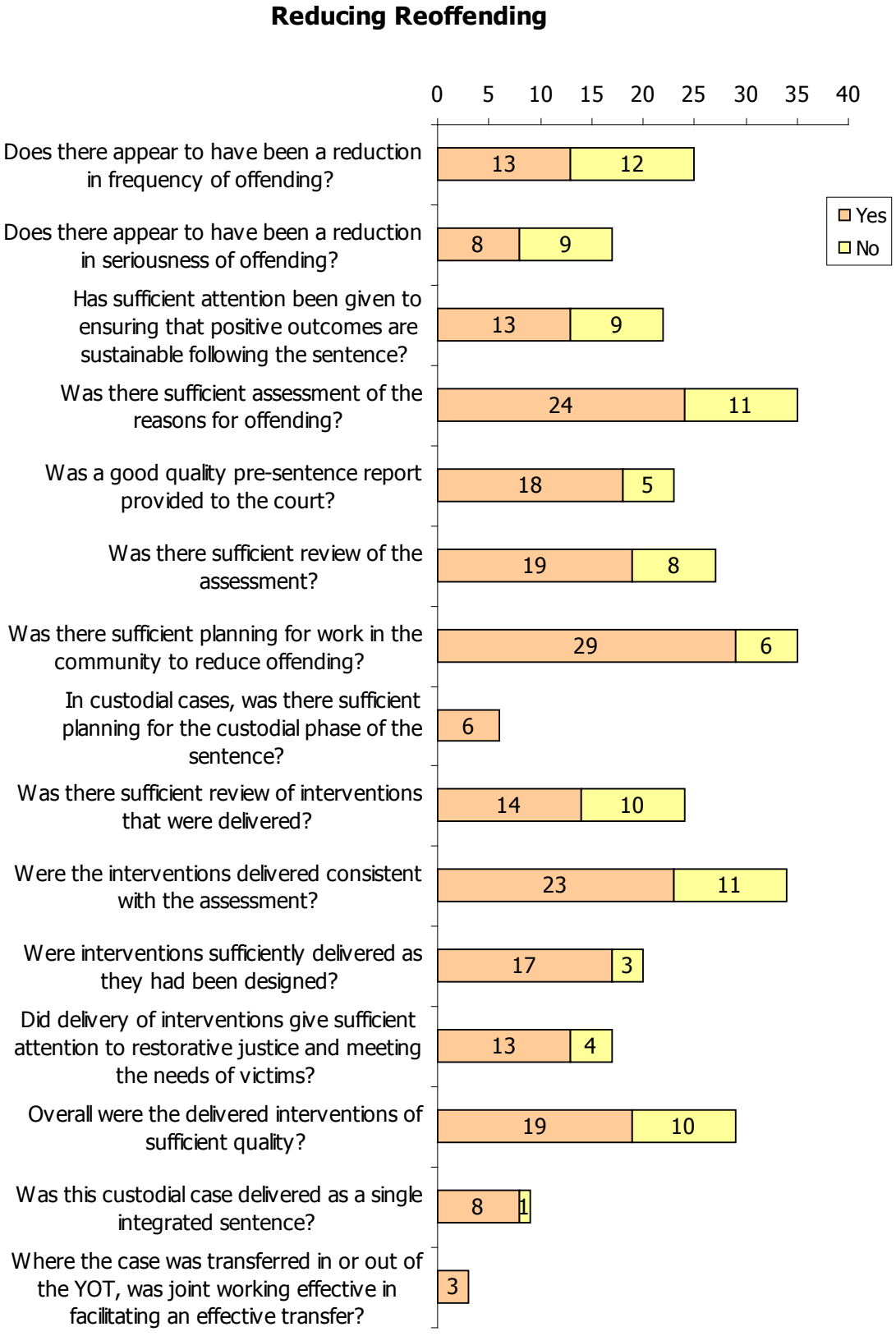
"*He [their son] is more mature and realises the things that he has done, it's all sort of clicked into place with him now. [The] YOS have played a big role in that.*"

"*He [their son] has calmed down a lot, you can have a conversation with him now without him kicking off, he is like a different person.*"

23. In most cases we saw an appropriate balance in the delivery of work with the child or young person between reducing reoffending, managing risk of harm and addressing vulnerability.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 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 70% of work to protect the public was done well enough.

Key Findings

1. Reports to court gave clear explanations of the risk children and young people posed to others.
2. Assessments of risk of harm were sufficient.
3. Planning to manage the risk of harm posed was insufficient in more than one-third of cases.
4. Reviews of risk of harm assessments and plans were not always done, and not sufficient when they were.
5. Case managers had a good understanding of policies and procedures to manage risk of harm.
6. Management oversight of work to manage risk of harm was insufficient.
7. The YOS police officers had no access to ViSOR and could have made more use of contact with neighbourhood policing teams.

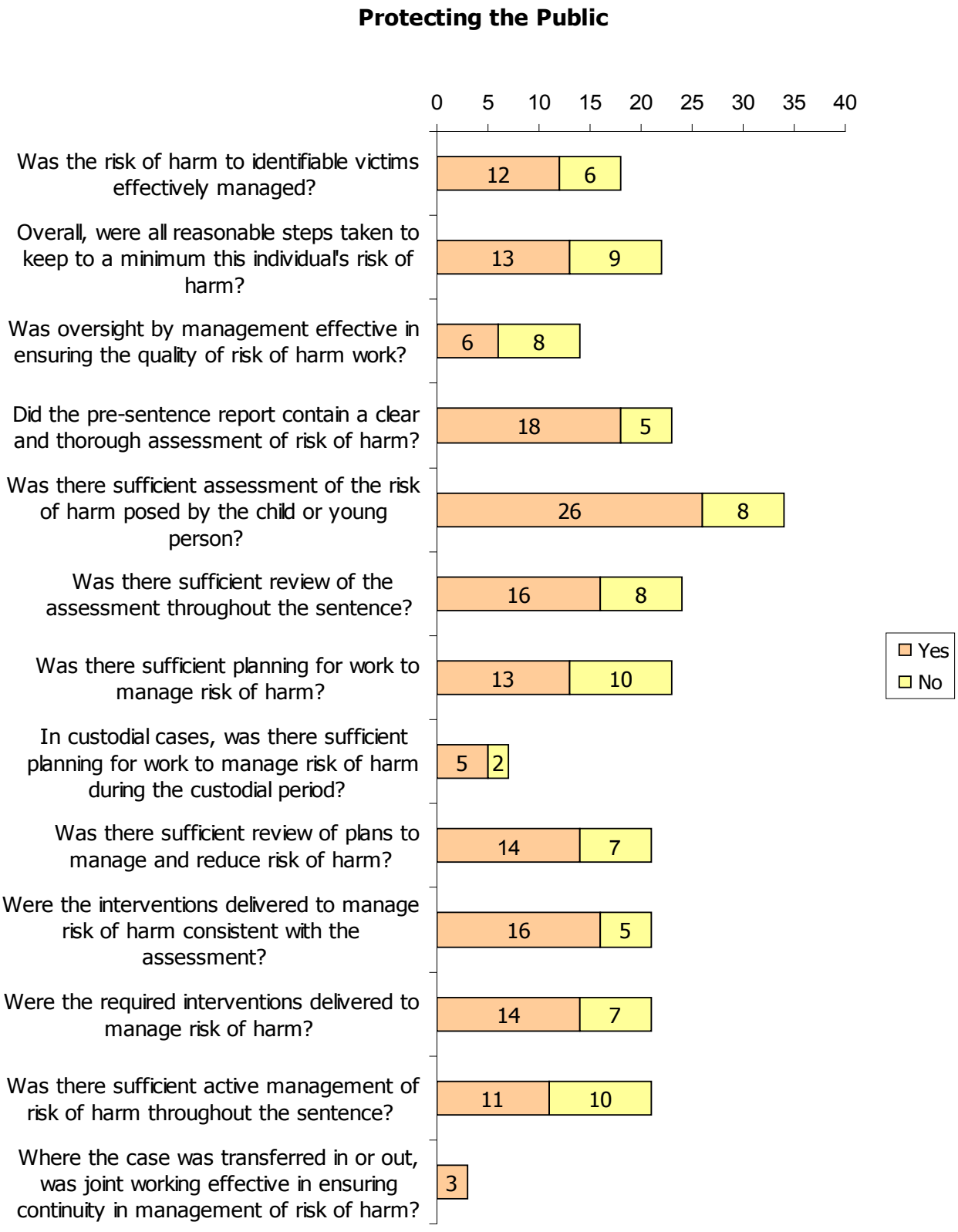
Explanation of findings

1. Reports produced for the court contained a clear explanation of the risk of harm children and young people posed to others in more than three-quarters of 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 a similar proportion of the initial assessments we saw. Some assessments required greater clarity about the nature or level of the risk, and more consideration of potential victims. In a small number of cases actual victims had not been identified.
2. Planning at the start of the sentence for work to manage risk of harm to others was insufficient in more than one-third of the cases we inspected. An initial plan had not been prepared where necessary in half of these cases, while qualitative areas for improvement included consideration of victims, planned responses to risk, and contingency planning. The quality of this work for children and young people serving the custodial part of a sentence was better, and was sufficient in five out of seven relevant cases.
3. The YOS had a clear strategy for a risk led approach to the supervision of cases, and within this there was comprehensive policy and guidance covering the management of high risk of harm cases. All children and young people presenting a high risk of reoffending, serious harm or vulnerability, together with all those eligible for Multi-Agency Public Protection Arrangements (MAPPA), custody cases, and sex offenders, were reviewed at a routine case planning forum.

4. The case planning forum provided a useful opportunity for round the table discussion, including all of the professionals involved in a case. The meetings we observed would have benefitted from more disciplined chairing in which there was an explicit summary of the review of progress against the plan, and statement of actions and work required to be completed prior to the next review. The meetings were handled well administratively. In general we found that contact logs noted when planning forums had taken place but failed to record action points and other key information.
5. In the cases we inspected we found insufficient review of the risk of harm to others posed by the child or young person throughout the sentence in one-third of relevant cases. In addition to those where the quality required improvement, some reviews had not been undertaken within an appropriate timescale, and others had not been done following a significant change in circumstances. In the same proportion of cases there was insufficient review of risk management planning throughout the sentence, usually because a review had not yet been undertaken.
6. The case manager had access to sufficient resources for work to manage risk of harm to others in all of the cases we inspected. As a consequence of deficiencies in assessment and planning, however, in one-third of cases the interventions required to manage risk of harm had not been delivered. There had been insufficient active and effective management of the risk of harm to others in half of the cases posing such a risk. However, we saw effective joint working to facilitate a smooth transfer and continuity of service to address risk of harm in all three cases that had been transferred out of the YOS.
7. As a result of the need to improve the assessment and planning to manage risk of harm to others, we considered that overall the YOS had not done enough to keep to a minimum the child or young person's risk of harm to others in more than one-third of relevant cases.
8. In more than half of the cases where it was required, the oversight by team managers or the case planning forum had not ensured the deficiencies in risk of harm work identified above had been addressed.
9. Almost all of the case managers we met had a good understanding of local policies and procedures for the management of risk of harm. There were no cases being managed at MAPPA Levels 2 or 3 in the sample we inspected; however, there was evidence of good partnership working between the YOS and the MAPPA, and of appropriate referrals being made.
10. It was unclear whether, or how, information regarding children and young people was forwarded so that it could be recorded on ViSOR, for example, when a registered sex offender moved out of the area. Relevant training, and access to ViSOR by the YOS police officers, would have improved the information flow and subsequent recording.
11. The YOS police officers had limited contact with neighbourhood policing teams, and they could have been used to improve communication between these teams and the YOS for their mutual benefit.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 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 69% 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. The quality of planning to address vulnerability was insufficient in more than half of the cases where it was required.
3. Management of vulnerability was not always reviewed where necessary.
4. There was good liaison and joint working with Children's Services.
5. We were concerned about the limited access to Child and Adolescent Mental Health Services (CAMHS).
6. Management oversight of work to manage safeguarding and vulnerability was insufficient.

Explanation of findings

1. We found sufficient effort had been made to understand and explain the vulnerability and safeguarding needs of the child or young person in three-quarters of the cases we inspected. The only notable areas for improvement were in the assessment of emotional and mental health in relation to their impact on vulnerability, and in a small number of cases a need for better liaison with children's social care services.

Quotes from children and young people

"*[The YOS is] really good, I've been here for nearly two years so I get on well with all of them. I can talk to them and I feel that they consider me. I don't think there is anything bad and I get on well with them all.*"

"*[My case manager] rings me all the time to make sure I am ok, she cares about me.*"

2. We also saw cases where the case manager had not identified some potential risks in relation to the possibility of child sexual exploitation that required consideration, and possibly investigation.
3. All except two of the pre-sentence reports we examined contained a thorough explanation of the safeguarding and vulnerability needs of the child or young person, which was an important strength in the work of the YOS.

4. Although assessment work in relation to safeguarding and vulnerability was good, we found that planning to address these needs was insufficient in more than half of the cases where it was required. In half of these cases a vulnerability management plan had not been produced at the start of the sentence. The most notable areas for improvement related to planning to address emotional and mental health problems, and alcohol misuse.
5. For physical health, ETE, substance misuse and care arrangements, the work in relation to managing vulnerability was better. Planning to address safeguarding and vulnerability was also better for those children and young people serving the custodial period of a sentence.
6. In more than one-third of cases where there were safeguarding and vulnerability needs, however, there was insufficient review of the child or young person's assessment throughout the sentence. Most of the reviews that had been done were of sufficient quality, but reviews had not been undertaken within an appropriate timescale or following a significant change in circumstances. We also found that planning to address these issues was insufficient in more than half of the relevant cases, and in most of these cases plans had not been reviewed at all.
7. The case manager had access to sufficient resources to manage safeguarding and vulnerability in all of the cases we inspected. In more than two-thirds of vulnerable cases interventions had been delivered that were consistent with the needs of the child or young person. As a consequence of deficiencies in assessment and planning, however, in more than one-third of cases interventions required to manage vulnerability had not been delivered. We judged there had been insufficient active and effective management of safeguarding and vulnerability by the case manager in more than one-third of the applicable cases. However, we saw effective joint working to facilitate a smooth transfer and continuity of services to address safeguarding and vulnerability in the three cases that were transferred out of the YOS.
8. As a result of the need to improve the assessment and planning to manage safeguarding and vulnerability, we considered that overall the YOS had not done enough to keep the child or young person safe, either from themselves or from others in more than one-third of relevant cases.
9. We found limited evidence of effective management oversight of work to reduce the vulnerability of children and young people. In the large majority of the cases where oversight by team managers or the case planning forum was required, it had not ensured the deficiencies in work to manage vulnerability had been addressed.
10. Almost all of the case managers we met had a good understanding of local policies and procedures for the management of safeguarding and vulnerability. However, some YOS staff lacked confidence in their understanding of Child Protection thresholds, and appeared reluctant to escalate vulnerability issues that concerned them.
11. We saw evidence of YOS staff sharing relevant risk information with Children's Services to inform initial assessments. We also found evidence of YOS staff contributing to the development of Child Protection and Looked After Children plans, although written plans did not always adequately reflect the contributions of the YOS. We saw ample evidence in case files of YOS and social work staff sharing information with each other in respect of children and young people on shared caseloads. Communication between staff was regular and routine both in terms of one-to-one case discussion and attendance at relevant planning forums, including the YOS case planning forum.

Example of notable practice

For some time YOS staff had had full read only access to the Children's Services case database, CareFirst, initially accompanied by the necessary training. More recently the Children's Services intake and assessment team had been given access to the YOS case database, ChildView, and similarly training in its use had been provided by the YOS to Children's Services staff.

12. Copies of Child Protection or Child In Need meeting minutes were available to YOS staff through their access to CareFirst, but these documents were not marked as hyperlinks within ChildView, and their existence was often not recorded in the contact log or elsewhere. As a result, it was possible for the information they contained to be overlooked.

13. The ability of YOS staff to check for themselves whether a child or young person was known to Children's Services, rather than having to make a referral to obtain this information, was clearly of organisational benefit. On the negative side, however, it required case managers to make a record on the ChildView contact log of such checks, and of their accessing any documents or information held on CareFirst, otherwise there was no evidence to managers and colleagues to confirm that it had been done.

14. In a few cases the YOS had not obtained details from the NPS or CRC of parents/carers or close family members known to be under adult probation supervision. This was important, so that any risk they posed to the child or young person's well-being could be assessed.

15. Cases of Children who were Looked After (by the local authority) and also under YOS supervision were jointly worked with the case manager and social worker and this gave the YOS access to a greater range of interventions through the Children's Services department. A multi-disciplinary 'Team Around the Family' arrangement provided support for cases closed to Children's Services, but there was no dedicated parenting worker.

Example of notable practice

The YOS held weekly health meetings that were attended by the health and substance misuse workers and also a service manager from the CAMHS team that was involved with the YOS. This was a positive initiative in evaluating the emotional, physical and mental health needs of the children and young people.

16. We were concerned about the access to CAMHS for YOS cases. There were substantial delays for children and young people being seen by the service and in one case an individual had waited for 18 months. As a result of these delays, the risks to both the child or young person themselves, and to others were not being effectively managed.

17. There were a number of health care initiatives in relation to mental health but these were not always comprehensively documented within the case records we examined. None the less, the additional input from locating a mental health nurse within the YOS would have provided an improvement to the availability of advice, support and education for the children and young people. They would also have provided a source of advice for other practitioners within the YOS.

18. There were significant difficulties with young people accessing suitable services upon reaching 18 years of age. An initiative to address this area was being explored by the local health board.

19. The availability of resources that catered for children and young people with additional learning needs was also limited, and did not take enough account of the broad range of complex learning needs that these children and young people had.

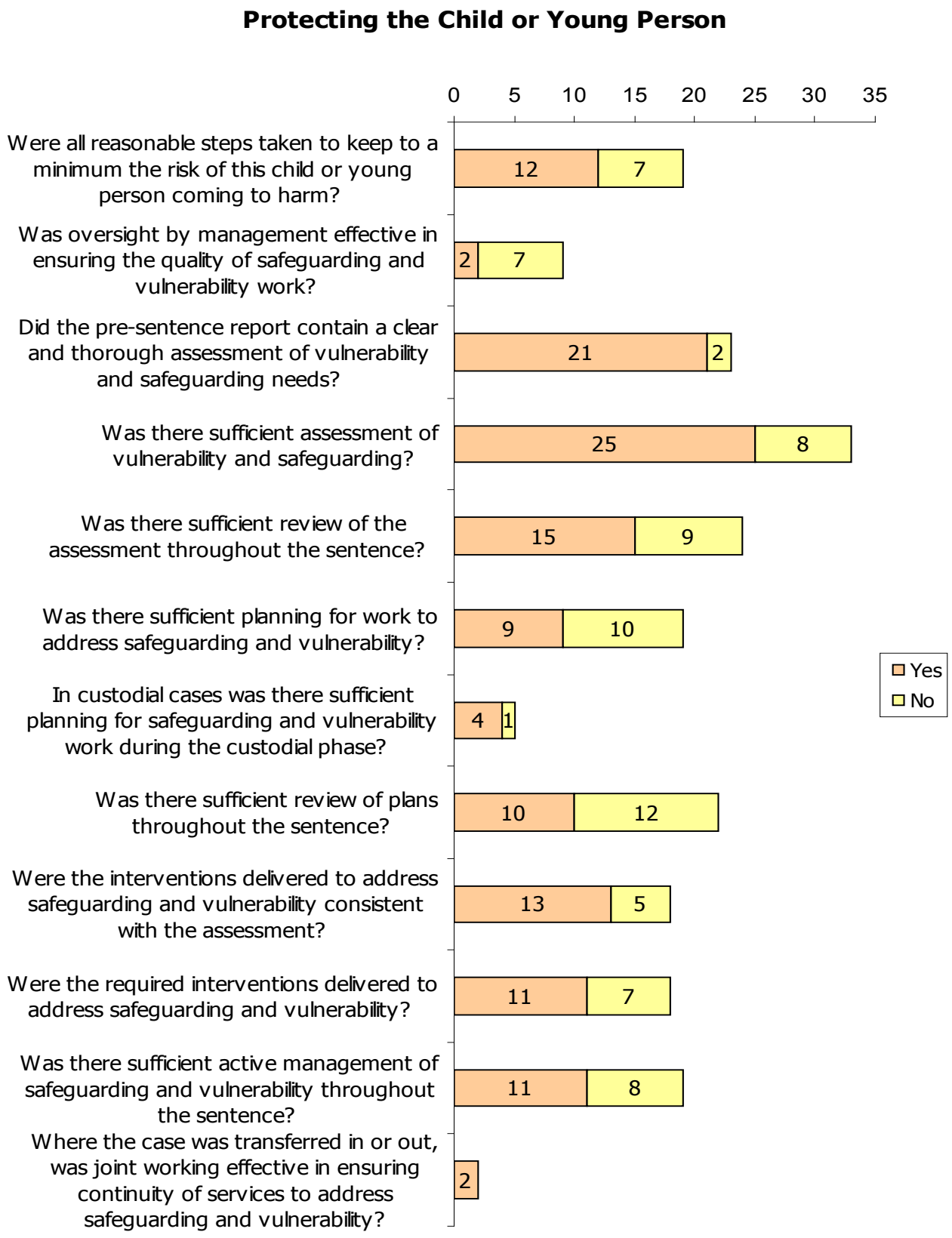
20. Several YOS staff workers said that many school head teachers were still reluctant to accommodate YOS service users. However, the local authority's recent establishment of a fair access panel, which had brought together education partners to discuss vulnerable learners at risk of disengaging from education had started to improve this situation. The YOS education officer attended this panel and had been effective in improving schools' awareness of the support the YOS provided to learners and schools. This has started to improve head teachers' willingness to accommodate YOS learners.

Example of notable practice

The YOS education officer liaised well with schools to ensure that learners received the assessments they needed to best plan their future. For example, the YOS education officer secured a school's agreement to refer one child at risk of permanent exclusion for formal assessment, which identified an autistic spectrum condition. This helped the education officer to plan provision that would better suit the learner's needs and enabled the child to access provision offering GCSE level qualifications.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 35 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 81% of work to ensure the sentence was served was done well enough.

Key Findings

1. Staff had a good knowledge of, and interest in, the children and young people with whom they worked.
2. Case managers paid good attention to diversity factors and barriers to engagement.
3. There were good levels of contact with the children and young people and good levels of home visiting.
4. In some cases restrictive requirements in criminal behaviour orders (CBOs) ran the risk of further criminalising the child or young person.
5. Arrangements to respond to the needs of Welsh speakers were not good enough, and the value of Welsh as an employment skill was not promoted.

Explanation of findings

1. A particular strength in the work of the staff at Cardiff YOS was their knowledge of, and interest in, the children and young people with whom they worked. We found that effort had been made to identify and understand diversity factors and barriers to engagement in most of the cases we saw. In general, staff were good at motivating the children and young people and building working relationships with them.
2. In almost all cases, staff had made a clear effort to engage with children and young people, their parents/carers, and significant others in seeking to understand the factors in the case. This contributed to the good quality of pre-sentence reports, most of which gave sufficient information about diversity factors and potential barriers to engagement. As noted earlier, the only notable areas where more attention was sometimes required related to learning styles and speech, language and communication needs. The assessment of learning style was not done automatically in all cases.

Quotes from children and young people

"*Yeah, there have been no barriers or anything like that and I felt that the YOS motivated me to comply with my sentence.*"

"*Yes it's been all good…they are motivating me with my sentence plan.*"

"*[Yeah, I was late once and had to go back to court but then I was told just to carry on. [The] YOS help motivate me to comply by saying that I have done so well and that and to keep it going.*"

3. In the cases we inspected there was little evidence of a structured induction process that introduced the child or young person to the work of the YOS, and the opportunities and responsibility that came with being under supervision. Most cases did not have a paper copy of the intervention plan signed by the child or young person.
4. In contrast, we saw prompt starts to contact following sentence, good levels of contact with the children and young people, and good levels of home visiting, the latter almost always being done where this was particularly necessary. Contact logs, however, did not always indicate that within these good levels of contact a sufficient amount of structured, offence focused work was taking place.

Quotes from a child or young person

"*Yeah [I've had problems coming to the YOS]…I got trouble with a lot of people…[so the YOS] started coming to my house.*"

5. In three-quarters of cases in our sample sentence planning paid sufficient attention to barriers to engagement and other diversity or potential discriminatory factors.

Example of notable practice

Bryn had previously been subject to two referral orders which he had breached through non-attendance. When making an assessment for a youth rehabilitation order (YRO), the report author looked back over the contacts with Bryn and noticed that he had attention deficit hyperactivity disorder and possible autistic traits, and got very anxious with new people, new environments and new processes. He spoke to the school who confirmed that Bryn managed best when he had advanced notice of meetings and there was consistency with who attends and where the meetings are, and that delays can trigger a bad reaction from Bryn. Having spoken to Bryn and his father about future contacts on a YRO, the report author made a proposal confident that previous non-compliance could be overcome. The result was that Bryn was now four months into his order and had attended and engaged with all appointments.

6. The children and young people and their parents/carers were also sufficiently well involved in the setting and delivery of sentence plans. We concluded that overall, in most cases the YOS gave sufficient attention to the health and well-being outcomes for the child or young person, insofar as they may act as a barrier to successful outcomes from the sentence.
7. YOS staff monitored vulnerable children and young people entering ETE, enabling them to respond to any emerging difficulties that the children and young people experienced, and to intervene in a timely manner. This helped the children and young people to overcome barriers and succeed in the opportunities they were given.
8. The YOS had access to translation facilities so that they could send out communications to children and young people in languages other than English, and good use was made of interpreters to interview service users whose English is poor. This was important given recent increases of Czech, Roma, Polish and Latvian speakers in Cardiff. We did not find, however, any broader and more strategic response to this change, particularly in relation to gauging the impact of language on the successful delivery and impact of services, or whether service users from different ethnic backgrounds might require services or interventions with a different content. No formal feedback was obtained from children and young people or their parents/carers specifically focused on this issue.
9. The YOS arrangements to respond to the needs of Welsh speakers were not good enough. There were a small number of staff who were learning Welsh, but the availability of bilingual pro forma letters or learning and activity resources in Welsh was poor. Most signage for the public was only in English. A

few of the YOS staff assumed that Welsh speakers would be able to communicate in English and that this was sufficient to meet their needs. The YOS did not do enough to encourage either children and young people or staff to recognise Welsh as an employment skill.

10. Half of the cases in our sample had complied fully with their order or licence. One-third had not complied, while the remainder had complied following initial difficulties. The YOS response where the child or young person had not fully complied with their sentence was sufficient in three-quarters of those cases.
11. More than one-third of the children or young people from the cases in our sample had been arrested or come to the notice of the police for alleged offending since the start of their supervision. One-quarter of the sample had been convicted of a breach of their order or licence, and one-quarter convicted of an offence, including offences committed prior to the current sentence.
12. The police service in Cardiff had an active approach to dealing with antisocial behaviour and were using antisocial behaviour orders and CBOs to address this. We saw evidence in some cases of blanket conditions in such orders, particularly in relation to exclusion zones, which would have been difficult for many children and young people to abide by, and certainly by the child or young person in the cases concerned. This increased the likelihood of them breaching the order, and of them appearing before the courts, and had the potential to increase the number of children and young people convicted of a further offence.
13. In some of these cases there appeared to be a tension between the YOS case manager and the police, with case managers disagreeing with the proposal to impose a CBO, or with the proposed requirements within it. While there was a multi-agency panel process to consider those suitable for out of court disposals there was no formal joint process to review decisions on charging children and young people.

Example of notable practice

Aidan was a 15 year old boy diagnosed with attention deficit hyperactivity disorder but who the case manager suspected may also have autistic traits. The case manager felt that had this been diagnosed, then his behaviour may have been interpreted differently, and he might not have come to the attention of the criminal justice system. During his supervision by the YOS Aidan's behaviour deteriorated and he was regularly coming to the attention of the local police. In response, and without any multi-agency discussion, the police applied for a CBO, which was the granted by the court. He had been careful not to breach the order but the case manager was concerned that if he did Aidan would be at risk of receiving a custodial sentence, which would significantly destabilise him and potentially lead to a further deterioration in his behaviour.

14. There was a system in place for the YOS police officers to identify when children and young people on the YOS caseload came to police attention. This was by way of a flag on the police intelligence system. This was not used systematically however, and flags were not placed for all relevant children and young people on the YOS caseload, leaving potential gaps in intelligence sharing.
15. Overall, we found limited evidence of two-way intelligence sharing, with the police officers placing all relevant information directly on to the YOS case management system. One possible reason for this was that some intelligence was passed informally, with no official record being made.
16. The police service was not using the Police Early Notification to YOSs System, as advocated by the *National Standards for Youth Justice Services*[3]. This system sends an automated secure email direct to the YOS containing details of children and young people aged under 18 years old who have been arrested. It would have avoided the need for the YOS police officers to spend significant amounts of time sifting through police records of arrests.

3 National Standards for Youth Justice Services, Youth Justice Board for England and Wales, April 2013.

Data Summary

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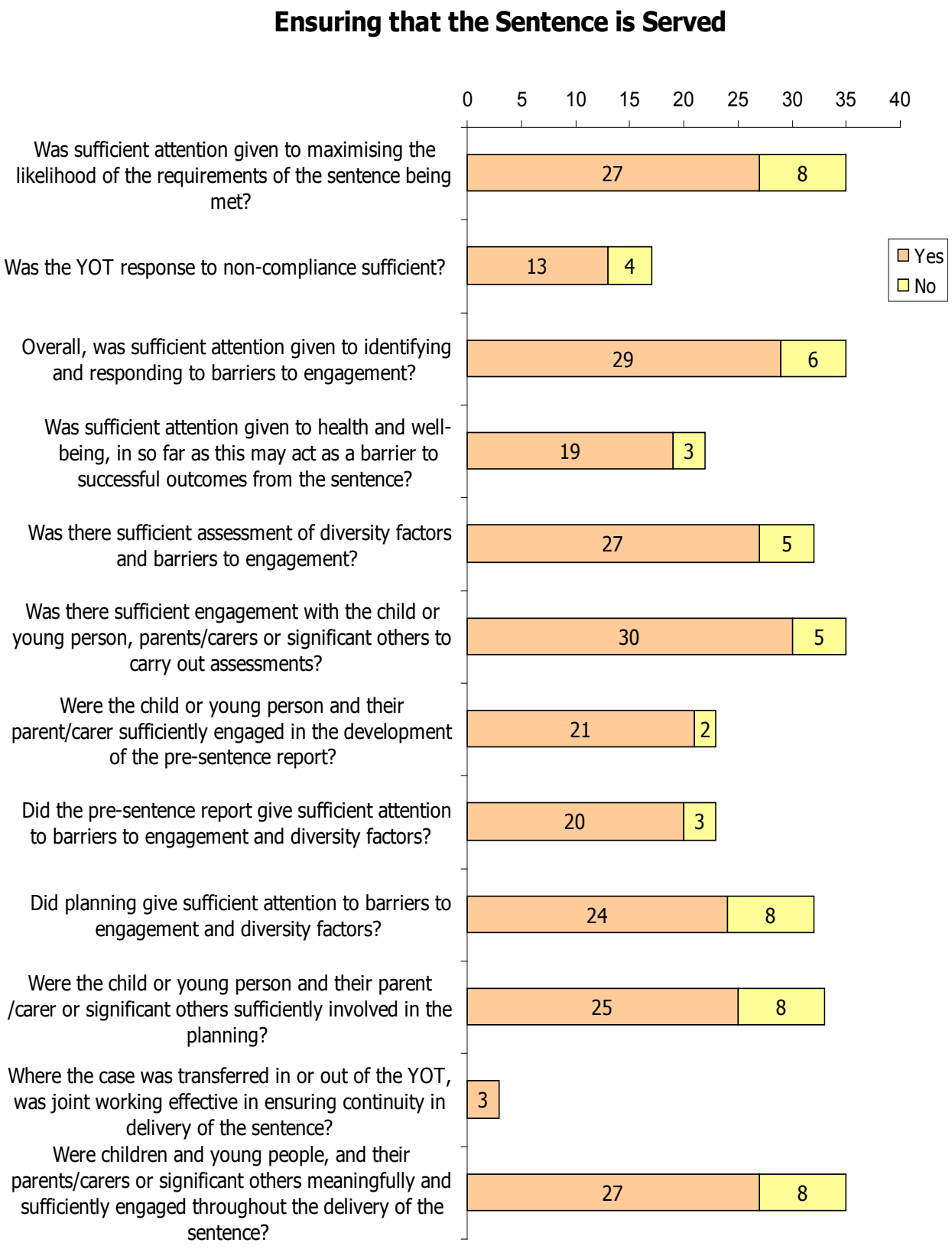

Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

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

Key Findings

1. All of the key partners were represented on the YOS Management Board but a previous lack of consistent leadership had weakened its effectiveness.
2. The Board had not provided sufficient support to the YOS manager to strengthen the functioning of the YOS management team to deliver improvements in the quality of practice.
3. There was no system in place for the Board to undertake regular in-depth analyses of particular YOS activities.
4. There was minimal use of performance data or other local information to target service delivery, and improve practice and outcomes.
5. There were insufficient quality assurance processes to support improvements in professional practice.
6. Good partnership working had delivered some effective practice initiatives.
7. The YOS was staffed by a stable and experienced group of practitioners.

Explanation of findings

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

1.1. The YOS was located within the Social Services department of the local authority and the Management Board was chaired by the Director of Social Services. The Board met quarterly and all of the key partners were represented.

1.2. In addition to a Chief Inspector as the police service member, the local Police and Crime Commissioner sat on the Board. A number of people thought he had brought an added rigour to the Board's deliberations, but there were also concerns given his external relationship with the police service - a key statutory partner. For the immediate future it was planned that his place on the Board would be taken by his deputy. At the same time the chairing of the Board was to be taken over by the Chief Executive of the City Council.

1.3. A previous lack of consistent leadership of the Board had resulted in inadequate support from health and education and a general absence of direction for the YOS. The YOS manager had been operating at a more strategic level to compensate for this weakness in the Board.

1.4. On balance, the Board membership did not have sufficient operational expertise and had struggled to give the necessary strategic attention to achieving improved performance. It had been unable to provide sufficient support to the YOS manager, to assist her in strengthening the functioning of the YOS management team so that it could deliver the improvements required in the quality of practice and outcomes for the children and young people.

1.5. More recently, leadership of the Board had stabilised and the Board had undertaken a review of its functioning that recognised the need to review terms of reference, and for members to

be more active in holding the YOS to account. In our view, Board members needed to take stronger ownership of the YOS and more responsibility for championing its work within their own organisations.

1.6. The local authority had a focus on prevention and diversion and this had been reflected in the YOS, which had developed a strong and innovative approach to preventative work. This reflected the policy of the Welsh Government that children and young people should be seen as children first and as offenders second. Its success had led in part to a reduced, but more serious, caseload of statutory work in the YOS. This may have partly contributed to the reconviction and reoffending rates being higher than expected.

1.7. While the resulting need for an increased emphasis on preventing further offending by the children and young people on statutory orders was recognised by some individual Board members, this did not appear as a specific focus of Board meetings. There was an incomplete understanding of the offending and needs profiles of the statutory caseload and no clear and shared strategy in place to reduce reoffending.

1.8. A preoccupation of the Board had been to maintain basic functioning and resources, and it had sought minimal local information from its partners relating to those people with whom the YOS worked. For example, the Board did not have an analysis of crime data to give an understanding of offending patterns and emerging trends, and react accordingly, such as the trend in the increasing use of so-called 'legal high' drugs. There was no current and comprehensive needs analysis for the YOS statutory caseload. Child sexual exploitation did not appear as a specific issue on Board meeting agendas, even though regular information on this subject would have assisted the Board to focus on those at the greatest risk of harm.

1.9. While the range and nature of interventions provided by or available to the YOS appeared to be broadly appropriate, there was no clear strategic approach to the development and delivery of interventions to reduce offending. Instead, it was largely practitioner led in response to the presenting needs and issues of workers caseloads, rather than part of an informed plan under direction from the Board.

1.10. The YOS had introduced 'results based accountability reporting' into the Board. This gave a helpful and pertinent commentary on specific areas of work but did not always provide sufficient detail of interventions and their outcomes. It required stronger analysis coupled with recommendations for action.

1.11. The Board needed to take a stronger lead on professional performance and quality improvement. There was no system in place for the Board to undertake regular in-depth analyses of particular YOS activities or areas of work, particularly in relation to their quality and effectiveness. It had not set a clear framework for quality management and improvement. A quality assurance audit had been undertaken in 2014, but these were not done routinely.

2. Partnerships – effective partnerships make a positive difference

2.1. Good working relationships were in place at Board level with all key agencies, and the YOS saw its partners as remaining supportive even though increasing budgetary constraints was leading to some retrenchment in provision. So far, however, this had not significantly affected any operational relationships.

2.2. A review in May 2014, commissioned by the South Wales Police and Crime Commissioner had produced guidance to define the role of the YOS police officer and was broadly in line with the national Youth Justice Board (YJB) model. As a result, both the officers and the nature of their work had changed to be more clearly focused on the core roles as defined by this new guidance document.

2.3. There were two full-time police officers in the YOS which represented a healthy police contribution. Both were appropriately co-located in the YOS, although there remained scope to realise more of the potential benefits this brought, particularly in relation to intelligence sharing.

2.4. The active approach of the police dealing with antisocial behaviour and using ASBOs and CBOs, sometimes with restrictive conditions that the children and young people would find difficult abiding by, appeared to be at variance with the approach to view the children and young people as children first and offenders second. It also had the potential to run counter to the Welsh Government's *Rights of Children and Young Persons (Wales) Measure, 2011*, that encourages services to focus on early intervention and holistic multi-agency support, and the promotion of a culture of identifying and promoting effective practice to improving outcomes for young people. Resolution of this potential area of conflict between needs of victims and the wider community on one hand, and the children and young people of the YOS on the other, required the attention of the Board.

2.5. Although there was a joint agency panel to administer cautions and conditional cautions, there was no similar panel in place to decide whether it was appropriate to charge a child or young person. Consequently, for those children and young people known to the YOS there was no opportunity for the YOS to contribute to the police decision on charging.

2.6. The YOS had a good and well-established relationship with adult probation services. While the NPS had reduced its seconded staff to two probation officers and a probation service officer, they provided a valuable service to the YOS. One of the seconded officers supervised all cases likely to be transferred to the adult service, as a jointly funded transitional post. The YOS had piloted the use of such posts and this arrangement was now being rolled out across Wales.

2.7. All cases were transferred initially to the NPS, but given that some might then be re-allocated to the CRC, they also maintained a link with the CRC, particularly as the Integrated Offender Management unit was located within that organisation.

2.8. The YOS appeared to be well embedded into the children's services department. Both the Director of Social Services and elected council members expressed confidence in the YOS manager and clearly valued her expertise in respect of the prevention and restorative justice agendas.

2.9. The YOS had a strong partnership with Careers Wales[4], and a Careers Wales manager attended YOS Board meetings regularly.

2.10. The health contribution to the YOS was problematic in that the CAMHS provision was commissioned over a wide area, and resources were only provided to those who were diagnosed with a mental illness. There was no formal psychiatric input into the YOS, and assessment for emotional and behavioural needs could only be provided by the YOS because the health worker happened to be sufficiently competent in this field.

2.11. It was encouraging to note, however, a number of new initiatives that were planned with the health board that would improve the services available to YOS cases, including a nurse-led early psychosis identification initiative for 14-25 year olds.

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

3.1. The YOS was staffed by a relatively stable and experienced group of practitioners. All of the staff we met received formal professional supervision on a monthly basis, and team managers were readily available for informal support. There was no formal observation of practice by line managers, and this may have been a missed opportunity to help in the spreading of good practice between staff. The health and substance misuse workers were being supervised alongside case managers as part of a multi-disciplinary team, as a result of a reduction in the number of team managers.

4 Gyrfa Cymru Careers Wales is the trading name of Career Choices Dewis Gyrfa Ltd (CCDG), a wholly owned subsidiary of the Welsh Government which was formed on 1 April 2013. It provides the all age, independent and impartial careers information, advice and guidance service for Wales.

3.2. While staff considered their professional supervision was good, we concluded that supervision and routine management oversight had not been sufficient to address the various shortcomings in practice we found. The regular case planning forums had the potential to provide additional professional oversight and direction, but in practice were focused on the exchange of information and joint planning rather than identifying areas for practice improvement.

3.3. YOS staff had access to relevant training, and this had included training and briefings related to child sexual exploitation. Some staff identified further input was required in relation to recognising and responding to speech, language or communication needs. We also considered that further work was required to embed training on child sexual exploitation, since not all of the potential risks requiring consideration and possible investigation were identified in every case we saw.

3.4. Almost all of the staff appeared to have a sufficient understanding of the principles of effective practice, and of all local policies and procedures relevant to their work. The seconded staff we met felt supported and well integrated in the YOS. Some YOS staff described themselves as being 'self-supporting', and as having plenty of contact with their YOS team manager but comparatively little contact with the YOS manager.

3.5. The two YOS police officers were relatively new in post and while they were experienced officers, they did not have an offender management background. We were concerned that they had not had specific training in relation to working with children and young people, nor more specifically in safeguarding. They had received some police training on child sexual exploitation. They had limited understanding of the MAPPA process, and this was another area where training was required.

3.6. The seconded probation staff reported receiving good professional supervision within the YOS and also had the additional support of a link manager in the NPS. They were able to attend staff engagement events run by NPS, and had a direct links into the probation management structure.

3.7. The careers advisers employed within the YOS were well supported by a manager from Careers Wales, who ensured they had good access to training opportunities.

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

4.1. There was little evidence that the YOS or the Management Board used performance data or other information, such as feedback from children and young people, to improve practice or outcomes. The YOS could do more to analyse and monitor the effectiveness of interventions delivered, and use this information to improve its targeting of resources and improve outcomes for children and young people.

4.2. There were few quality assurance processes to support the formal and informal supervision of staff by their managers. The YOS did have a quality assurance case auditing form for use by team managers but how or whether this was being used was unclear. There was also a system for the quality review of pre-sentence reports.

4.3. It was good to see that case managers were able to indentify progress made by the children and young people on their caseloads. We found, however, that in many cases this was not captured in a sufficiently clear or consistent way in the case records for it to be used systematically.

4.4. The YOS health worker also had a good sense of the impact being achieved with the children and young people. Likewise, there was no systematic means to capture this information and use it to enhance the effectiveness of service delivery.

4.5. Individually, members of the YOS Board appreciated the importance of evaluation and feedback to support improvement. The education member on the YOS Board had a good understanding of what the YOS needed to do to evaluate the progress of children and young people progress in developing the skills and behaviours they needed to avoid further offending behaviour.

4.6. The YOS, however, did not gather and analyse data effectively on the literacy and numeracy levels of the children and young people under its supervision. Their basic skills were not routinely assessed when they engaged with the YOS, apart from an initial assessment for those attending the Intensive Surveillance and Supervision (ISS)[5] programme. As a result it was sometimes unclear with what levels of literacy, and therefore what progression opportunities, they could cope. There was no evaluation of whether their skills improved during their involvement with the YOS, or with the partner agencies to which they were referred.

4.7. The probation member of the Board recognised that there had been no analysis of reoffending by those whose supervision transferred from the YOS to adult probation services. This could provide valuable information to guide work with young people who were passing through one of the most risky points in the 'offender journey'.

4.8. Sentencers appreciated the aggregated performance information they received but thought that the absence of a process to provide feedback on the individual histories of selected cases was a missed opportunity to reassure them about the value of the work of the YOS.

4.9. The YOS had a process to gather user feedback on completion of supervision, but in most cases feedback had not been obtained from the children and young people, or their parents/carers. In the 12 months ending September 2015 less than one in ten of the children and young people dealt with by the YOS had completed feedback forms. The feedback from those completed was very positive; well over three-quarters said they had found the YOS helpful and were positive about the future following its intervention. These findings were consistent with our own e-survey data.

4.10. The junior attendance centre[6] run by the YOS was an established and significant component of its provision to address offending related issues and behaviour for children and young people under statutory supervision. Despite this there was no evaluation of its effectiveness.

4.11. In contrast, as part of its court diversionary work the YOS operated an antisocial behaviour team and neighbourhood reparation panels. These services were grant funded and as a result reporting on throughput and activity, alongside the evaluation of outcome and impact indicators, was built into their processes. The team was also trying to capture softer 'impact' measures such as improved school attendance, and used the adapted YJB tool to track offending outcomes. This approach to evaluation could equally be applied to many of the YOS services provided to statutory cases.

5 Intensive Surveillance and Supervision is a programme of intervention attached to some orders and licences and provides initially at least 25 hours programmed contact per week, including a substantial proportion of employment, training and education.

6 The junior attendance centre operated on alternate Saturdays and provided a structured programme of activities to address offending behaviour and improve social skills. The centre was open to all YOS cases, including those required to attend as a specific requirement of their court order.

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

Key Findings

1. Case managers had access to sufficient resources and interventions to reduce reoffending, manage risk of harm to others, and address safeguarding.
2. Experienced and committed staff were planning and delivering services to a high standard.
3. There was a well-established junior attendance centre fully integrated within the YOS.
4. Practitioners were driving provision and development of interventions.
5. There was no overarching strategy or policy to determine the range and content of provision.
6. There had been no recent, empirical needs analysis of the YOS caseload.

Explanation of findings

1. Case managers had access to sufficient resources and interventions to reduce reoffending, manage risk of harm to others, and address safeguarding in all of the cases we examined. Children and young people were able to access most the interventions they required without being on a waiting list for a long period of time. We were aware, however, that on occasions there could be difficulties in accessing accommodation and mental health interventions.
2. We found the suitability and eligibility of the child or young person for specific interventions to address reoffending had been sufficiently considered in most cases. In just over one-third of cases, however, initial planning for work to reduce reoffending did not clearly outline what interventions were to be provided and how. Overall, the delivery of interventions failed to make a sufficient contribution to reducing reoffending in nearly half of the cases we examined, principally because insufficient interventions were delivered.
3. In our observations of practice we saw experienced and committed staff planning and delivering services to a high standard. Service users and partner agencies were generally satisfied with the services they had received and the way in which the work was undertaken.

Quotes from children and young people

"*Yeah, victim, crime, advice – I've done everything, it was more helpful to me and made me realise what went on with me.*"

"*I understand how victims feel so I feel more considerate towards the victim.*"

4. Apart from groupwork delivered by the intensive supervision and surveillance team and a junior attendance centre, most work within the YOS was delivered individually. Team managers acknowledged that their staff mainly used bespoke interventions which were identified at the pre-sentence report stage or during initial assessment and planning. As a result, practitioners were driving provision and development of interventions, and where there were gaps in provision it was up to practitioners to be creative in finding solutions.

5. This promoted innovation but had led to inconsistencies in service delivery, where some cases were referred to a particular intervention whereas other similar cases were not. It may also have led to resources being underused. There were currently 16 children and young people on the caseload of the junior attendance centre, which represented a considerable decrease in numbers over recent months. Although this resulted in an underuse of the resource there had been no formal response or action plan from YOS managers to address the situation.

6. Interventions had been mainly developed in-house, often using elements of packages designed elsewhere and adapted by YOS practitioners. The YOS had a library of offending behaviour resources and materials that was stored electronically. This has not been kept up to date and regularly reviewed, although additional interventions had been added to the list when required. There was general agreement that this material was not as well organised and accessible as it could be.

7. The intensive interventions team was in the process of redesigning their programme of interventions and planned that this would be organised more coherently and made more accessible to practitioners. But overall, the range and content of provision was not determined by an overarching strategy or policy. While case managers were knowledgeable about the needs of their individual cases there had been no recent, empirical needs analysis of the YOS caseload, or of other children and young people who had come to attention of the police.

8. Referral order panels were planned and delivered by the case manager while the corporate support for the process was provided by administrative support staff. While the panel meetings were delivered well, the process was not properly supported. The case manager had to set up the room and brief the panel members at the last minute. None of the staff involved had worked together before or had an opportunity to prepare for delivering the sessions. This may have at least in part been due to the loss of the referral order coordinator post that previously undertook the practical and administrative arrangements.

9. Historically, referral orders were managed by non social-work trained case managers. Although these staff had received some in-house training they were not all sufficiently trained for some of the higher risk cases now being made subject to referral orders, and in some instances had insufficient understanding of risk of harm issues. We were pleased that the YOS planned that such cases should be managed by social-work trained staff in the future.

10. The YOS was running a well-established junior attendance centre that was fully integrated within the YOS. The staff were experienced and the groupwork sessions appeared to benefit the children and young people attending. There were timely starts to attendance and good liaison and exchange of information between the centre, YOS case managers and parents/carers. The centre reported that while 30% of referrals did not attend, 80% of those who started completed their programme.

11. The junior attendance centre manager determined the programme of activities that was available, and case managers could select those sessions that were needed on a case by case basis. The centre ran group sessions on sexual health, financial literacy, knife crime, and substance misuse. It was staffed by an experienced group of workers.

Example of notable practice

In the records of children and young people attending the junior attendance centre, contact entries clearly stated the module title for the work undertaken in the session, rather than a note that only confirmed the child or young person's attendance. This was helpful to other workers involved in the case, to confirm what work had been done in the session and what might usefully be followed up and reinforced with them.

12. The junior attendance centre provision was available to all YOS cases and not only those subject to a YRO or ISS. The centre reported high rates of attendance and completion, but there was no analysis of the effectiveness of the intervention. Data was sent to the YOS on a monthly basis, and measured outcomes in terms of reoffending, but the data was not aggregated or used to evaluate practice and improve services. In line with local police concerns, YOS managers said there was an increased need to address antisocial behaviour but it was not clear what had been done to address this.

13. Programmed work with children and young people who had committed sexual offences was available through Barnardos. As an appropriate alternative, some case managers had been trained to deliver this work using similar materials on an individual basis.

Example of notable practice

The YOS ran a range of structured groupwork sessions. One was called 'Who want to be a millionaire?', a practitioner led, locally developed initiative, designed to provide drugs and alcohol education and build motivation to tackle these issues further. It was consisted of a single hour session based on the game show format designed to promote engagement through interaction with the children and young people on these issues. It provided a gateway to other drug and alcohol services that could be accessed on an ongoing basis.

14. These groupwork sessions had been provided for some time and the YOS now planned to deliver them to all cases on the ISS Programme as part of a package of services delivered to children and young people focused on drug and alcohol issues. There was, however, no specific evaluation process to the sessions, for example, to measure the proportion of those attending whose motivation to engage with substance misuse issues increased, or the proportion who went on to take up ongoing services.

15. We saw little work involving victims in the cases we inspected, and in some there was insufficient consideration of the need to protect the victim as part of the process. There was evidence of contact being made by the YOS victim officer, but few attempts to engage victims in the work of the YOS were successful. The YOS had also struggled with retaining volunteers who supported the victim work. These difficulties had not been helped by the victim officer post being vacant for some while previously.

16. The YOS ran a range of community reparation projects which the children and young people participated in as part of their orders. One example was a church led community environment project to convert waste ground into a community garden facility. The YOS was providing two-thirds of the labour, mostly through reparation hours. We met with one young person at the project who had completed his reparation hours as part of his order and was continuing on a voluntary basis.

Example of notable practice

The YOS worked with a good range of partner agencies to enable service users to access progression opportunities. It included schools, work-based learning providers, key colleges, specialist learning providers and employers. Staff liaised well with these providers to help children and young people make effective transitions into ETE. Staff used opportunities for children and young people to have taster opportunities before committing to a particular progression route.

17. The YOS education worker responded effectively to early intervention requests to support school pupils. However, there were no effective systems in place to monitor the level of this workload or its impact on the education workers statutory caseload work. Staff were not clear about contingency plans that would apply if the education worker was on a leave of absence.

18. We saw good examples of learners being referred to partner agencies who could help improve their literacy. However, there was not enough evaluation of the impact or effectiveness of these referrals. There were no systems in place to measure how well learners developed other work related skills (such as team working, following direction and time keeping), or to measure the impact of interventions on children and young people developing or improving behaviours and skills that reduce reoffending.

19. Children who were Looked After and also subject to YOS supervisions were jointly worked with the case manager and social worker and this gave the YOS access to a greater range of interventions through the Social Services department. There were good examples of YOS staff and social workers in the Looked After Children team working together to improve engagement with children and young people, such as the coordination of appointments. Staff worked effectively together to help children and young people understand and appreciate the potential benefits of accessing relevant services, such as accommodation, health or education, both in terms of supporting them to stay safe and also in terms of increasing the likelihood of them successfully completing their sentences.

20. There was a clear process to enable children and young people to get access to a comprehensive health assessment and subsequent health services as required. General health assessment sessions were delivered by the YOS health worker using the adapted Comprehensive Health Assessment Tool Framework, to support case managers in undertaking an accurate initial assessment of health issues.

21. The YOS health team reviewed all referrals collectively to decide which worker was best to lead on meeting the needs of the individual. Some health interventions were delivered internally, such as sexual health, drugs and alcohol education. Other health services were accessed as required via NHS provision. The YOS health worker felt there were good arrangements for exchanging appropriate information on health matters with other YOS staff. There were good links to refer into external services where required, except for CAMHS which was a serious omission.

22. Structured sessions to address substance misuse were delivered either by the substance misuse worker, or by case managers, supported by her guidance if required. The health worker was a qualified nurse, and delivered work relating to physical and sexual health. Her professional background enabled her to provide a degree of support and guidance in relation to mental health problems in the absence of a mental health practitioner within the YOS team.

Example of notable practice

While in custody a referral was made for a forensic psychologist to work with a young person in relation to domestic violence he witnessed as a child. The same worker continued to work with him on release. Case records evidenced good collaboration between the forensic psychologist and case manager. When the young person became nervous about the subject matter he would be discussing with the psychologist, the case manager sat in on the session to provide extra support.

23. There were a number of initiatives in relation to mental health care but these were not always comprehensively documented within the case records we inspected. It was evident that some young people and their families would have benefited considerably from a 'family therapy' type intervention. While practitioners did their best to support families they did not have sufficient time or expertise to undertake a structured therapy programme.

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 YOTs 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:

30 November 2105 and 14 December 2015.

In the first fieldwork week we looked at a representative sample of 35 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.Engagement with service users was undertaken on our behalf by User Voice.

At the end of the second fieldwork week we presented our findings to local strategic managers, the YOT 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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