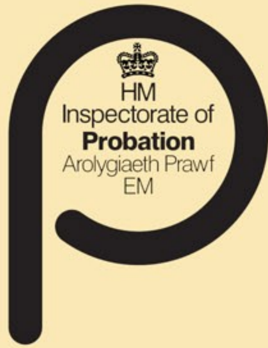

Full Joint Reinspection of Youth Offending Work in Newport

An inspection led by HMI Probation

independent inspection of youth offending work

June 2016

Foreword

This inspection of youth offending work in Newport is one of a small number of full joint inspections that we are undertaking annually with colleagues from the criminal justice, care and support, health and learning and skills inspectorates.

We chose to inspect in Newport in order to perform a reinspection following poor outcomes during our full joint inspection in 2014.

The published reoffending rate for Newport was 50.5%. This was higher than the previous year and higher than the average figure for England and Wales at 38.0%[1].

Newport Youth Offending Service (YOS) had made a step change in performance since the last inspection. The YOS was stronger in assessment and delivering good quality interventions. The YOS Management Board had clear objectives and was successful in making sure 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 manage vulnerable children and young people, and provide a comprehensive education, training and employment service. 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 Newport YOS in its continuing improvement by focusing on specific key areas.

Dame Glenys Stacey
HM Chief Inspector of Probation
June 2016

1 The reoffending rate that was available during the fieldwork was published January 2016, and was based on binary reoffending rates after 12 months for the April 2013–March 2014 cohort. Source: Ministry of Justice.

Key judgements

Summary

Reducing reoffending

Overall work to reduce reoffending was satisfactory. Good quality pre-sentence reports were provided to the courts. Staff were good at investigating the reasons why children and young people had offended. The quality assurance process did not make sure reviews of assessments and plans were of the required standard. The YOS did not sufficiently promote the benefits of the use of the Welsh language. There was no basic skills strategy in place to make sure literacy and numeracy levels for children and young people improved.

Protecting the public

Overall work to protect the public and actual or potential victims was satisfactory. Reports to court and initial assessments of risk of harm were sufficient. Too many reviews of assessments were not completed following a significant change or were of poor quality. Risk management plans did not contain a sufficient focus on victim issues or contingency planning. The Multi-Agency Public Protection Arrangements process was not embedded within the YOS.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was unsatisfactory. Reports to court and initial assessments of safeguarding and vulnerability were satisfactory but reviews of assessments were not undertaken or were incomplete following a significant change. Plans often did not contain sufficient focus on vulnerability and how it should be managed. The quality assurance process in place was not effective in making sure the quality of work to address vulnerability was sufficient.

Making sure the sentence is served

Overall work to make sure that the sentence was served was good. Reports and initial assessments were good at identifying diversity issues and barriers to engagement. The YOS was good at engaging children and young people and their parents/carers throughout the sentence. The appropriate use of compliance and enforcement action was evident in most cases. There was insufficient focus on assessing the physical and sexual health of children and young people.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was satisfactory. There was evidence of strategic leadership with a clear plan and direction of travel for the YOS. Partners were held to account through a clear performance management framework. Effective scrutiny arrangements existed for the YOS Management Board and there was involvement from local authority elected members in addressing youth crime. The YOS was well led by a knowledgeable management team.

Interventions to reduce reoffending

Overall, interventions to reduce reoffending was satisfactory. There was a suitable range of interventions available at the YOS. Staff thought innovatively about adapting existing materials or creating new ones to make sure there was engagement with the children and young people. Barriers to positive engagement were not always identified, especially with regard to focused work for girls and young women. Outcomes from new or existing interventions had not been fully evaluated and measured.

Recommendations

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

1. The YOS Management Board should make sure that a comprehensive plan to address all identified gaps in service provision or performance is in place.
2. The YOS Management Board should develop an education, training and employment strategy that overcomes barriers to progression, improves literacy skills and supports children and young people to make successful transitions into post-16 opportunities.
3. The YOS Management Board should make sure there is a strategy for the promotion of the use of the Welsh language.
4. The YOS manager should establish management oversight and quality assurance processes that are robust and applied to all aspects of the assessment, planning and review process.
5. The YOS manager should make sure that good quality plans and reviews are produced by the YOS, particularly in relation to risk of harm and vulnerability.
6. The YOS manager should make sure that assessments concerning physical and sexual health are completed, and a clear pathway for treatment or support is established and understood by staff.
7. The YOS manager should make sure that all staff must understand Multi-Agency Public Protection Arrangements and all relevant cases must be identified.

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

Case assessment score

Within the case assessment, overall 73% of work to reduce reoffending was done well enough.

Key Findings

1. Good quality pre-sentence reports (PSRs) were provided to the courts in most cases and assessments were comprehensive, thoroughly addressing the factors which influenced offending.
2. Staff were good at investigating the reasons why children and young people had offended.
3. Staff understood effective practice principles and were good at sustaining children and young people's progress.
4. The quality assurance process did not make sure reviews of assessments and plans were of the required standard.
5. The YOS needed to improve the promotion of the use of the Welsh language.
6. There was no basic skills strategy in place to inform planning and service improvement.

Explanation of findings

1. Good quality PSRs were provided to the courts in most cases and assessments were comprehensive, thoroughly addressing the factors which influenced offending. We found a quality assurance process in place that made sure court reports provided sufficient insight to enable sentencers to appropriately sentence children and young people. We judged, however, the quality of reports provided to the youth offender panel as sufficient in only one-third of cases. These reports needed to convey more information to the panel concerning the risk of harm posed by, and the vulnerability of, the child or young person. Local management oversight arrangements to make sure the quality of reports to the youth panel need to be strengthened.
2. Following sentence, staff 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 accurately identified the factors which contributed to their offending.
3. Reviews of assessments were completed to a sufficient standard in just over two-thirds of cases. 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 most of the cases we inspected. Some plans did not meet the needs identified in the assessment, some did not address care and

support arrangements in enough depth, and some were not sequenced sufficiently to deliver their intentions. Two of the main areas that did not feature clearly were how the YOS would intervene to address the children and young people's perception of themselves and others, or their motivation to change. Reviews of plans to reduce reoffending were insufficient in almost half of the relevant cases. This was because some reviews were not revised as required in response to plans or significant changes, and when they were done they were often of poor quality. The YOS did not have a management led quality assurance process in place for reviews of assessments or plans. This was an omission which needed to be rectified.

5. Plans in those cases where the child or young person was sentenced to custody were good in all cases. We felt the YOS worked well with custodial staff and sentences were delivered in an integrated manner.
6. We found that interventions designed to reduce reoffending were consistent with the identified needs in the assessment and plans in almost all relevant cases. Materials and other resources used were of a good quality and we were pleased to see numerous examples of good outcomes from the use of restorative justice interventions. Staff were good at reinforcing positives with children and young people in order to reduce reoffending in the future.
7. Most 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. Overall, we judged the quality of work to address reoffending as sufficient in over three-quarters of cases. We saw some one-to-one offending behaviour work skilfully delivered by staff but the YOS needed to do more to challenge and promote children and young people's motivation to change.
8. Most children and young people improved their levels of engagement within education, training or employment (ETE). While published data showed that the YOS had not yet met its targets on the number of hours that children and young people participated in ETE, recent, as yet unpublished data, showed good improvement in rates of engagement.

Example of notable practice

Bob, who was 16 years old, had not previously engaged well with any ETE provision and was reluctant to do so again. The ETE worker spoke to him while in custody to ascertain his views on ETE post-release. The ETE worker then engaged with him throughout the licence to keep him interested and motivated. In doing so, he made sure he attended ETE provisions and supported him to do so. Once the licence had ended he continued to offer further support on a voluntary basis.

9. There were good links with a range of organisations to provide targeted input that raised children and young people's awareness about the effects of their offending behaviour. For example, the youth service provided valuable sessions on substance and alcohol misuse and the fire service raised children and young people's awareness about the consequences of nuisance emergency calls.
10. A few caseworkers did not fully understand the best ways for children and young people to access the labour market, but referred very few clients for specialist advice and guidance.
11. Some children and young people progressed into college courses. There was not effective or formal links with local colleges to make sure that children and young people received the best support to enable them to access and settle into college.
12. The work that many children and young people produced while engaged in YOS activities was often of a good quality. Those engaged in intensive supervision and surveillance activities improved their awareness of the culture, geography and history of Wales. They received useful, constructive feedback

about their behaviour. There was not, however, enough focus on giving them feedback that would encourage or guide them to improve their literacy or numeracy skills.

13. The YOS had adequate capacity that enabled it to meet the needs of Welsh speaking learners, but there was no strategy to strengthen this capacity. Overall, staff did not do enough to promote the use or value of the Welsh language, or to improve children and young people's appreciation of the employment potential that speaking Welsh offered.

14. The YOS had introduced potentially useful individual development plans for children and young people. Individual development plans for pre-16 pupils consisted of a useful one page profile and a small range of targets linked appropriately to pupils' aspirations and interests. The plans for post-16 pupils mapped their circumstances, priorities and aims. There were, however, no effective systems to monitor the quality and impact of these documents. In too many cases, the objectives set out for learners were not clear, specific or targeted enough. They did not clearly explain how individuals could overcome barriers to making progress that could have helped them to reduce the risk of offending behaviour.

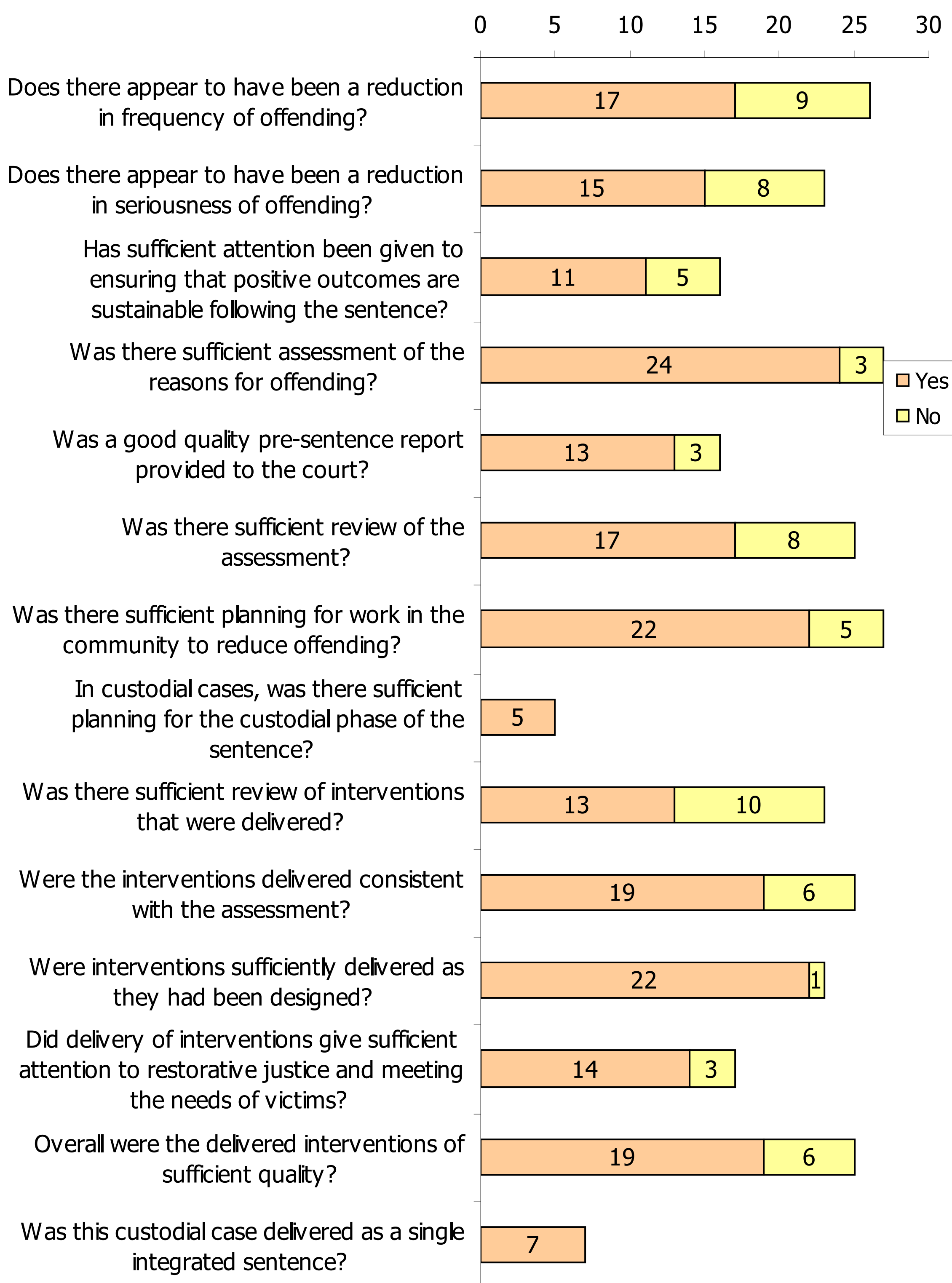
15. For post-16 young people, staff did not consistently use existing information well enough that would have enhanced the accuracy and reliability of their assessment of young people's circumstances and needs. Not enough account was taken of the detail contained in their statements of educational needs in planning, so that staff could make sure that young people received the best support to help them succeed.

16. Many children and young people had poor basic skills. In planning their support, staff did not give enough focus to the importance of improving basic skills and its relationship to reducing the risks of reoffending. Staff did not assess literacy and numeracy skills, and there was no analysis of whether children and young people improved these skills as a result of engagement with the YOS. There was no basic skills strategy in place to inform planning and service improvement.

17. We found that Integrated Offender Management was well-established and well run. There were good links between the YOS and Integrated Offender Management, and opportunities to increase the number of children and young people being managed jointly. Considering that the YOS Management Board were aware that the YOS were dealing with a smaller number of more prolific individuals, this would be a sensible and effective way to address this issue.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 27 cases were inspected. The total answers, however, 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 68% 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. Too many reviews of assessments were not completed following a significant change or were of poor quality.
3. Risk management plans did not have sufficient focus on victim issues or contingency planning.
4. The Multi-Agency Public Protection Arrangements (MAPPA) process was not embedded within the YOS.
5. Interventions to address the risk of harm were not always delivered.

Explanation of findings

1. Reports produced for the court contained a clear explanation of the risks children and young people posed to others in nearly three-quarters of the cases we examined. Following sentence, 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 just over three-quarters of the initial assessments we saw, and had more thoroughly developed the analysis from PSRs. Reports to the youth panel, however, did not contain a sufficient assessment of risk of harm and this was an area for improvement for the YOS.
2. Reviews of assessments were carried out to a sufficient standard in only half of the relevant cases. In cases where we considered there should be a review, over half did not have one or were not reviewed in response to significant changes in the child or young person's life. Where they were completed they were often of insufficient quality and failed to incorporate and analyse all the available information.
3. Plans to manage risk of harm needed to improve in many of the cases we looked at. Only half met the required level of quality. Common deficiencies included a lack of clarity concerning information sharing arrangements, a failure to address victim issues with a sufficient response, and a lack of detail in contingency plans. Where plans had been completed they had been reviewed adequately in under half of the community cases. We found sufficient planning had been undertaken during the custodial phase of a sentence in almost all of the relevant cases.

Example of notable practice

The case manager did not understand why a risk assessment and plan was required before release (not after). There was some disjuncture between the contents of the risk assessment and plan, and vulnerability management plan, once the young person was released. The case manager seemed to defer all decisions about risk and vulnerability to the risk panel and could not articulate the relationship between the risk management plan and the risk panel action.

4. Detailed performance reports were provided to, and requested by, the YOS Management Team. 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 making sure the quality of risk of harm work in less than three-quarters of the cases inspected was sufficient. The two major areas requiring improvement were addressing deficiencies in assessment and planning. The YOS needed to make sure that quality assurance processes were robust, identify and address areas of weakness in the assessment of the risk of harm. While we did see a quality assurance process, that process was not sufficiently focused on planning and review, and did not result in the required level of performance in this area of work. Overall, we judged the YOS had taken all reasonable steps to keep to a minimum the harm posed by children and young people in nearly three-quarters of relevant cases.

5. There was one full-time police officer which was an adequate contribution. We noted this was a reduction from the two officers present at the time of the last inspection. The officer was co-located in the YOS. Such co-location brought obvious benefits, particularly in relation to intelligence sharing. The officer was new to the post and it was reassuring to see that they had both an intelligence and offender management background.

6. The officer had not yet had specific training in relation to working with children and young people nor, more specifically, on safeguarding. This was a deficit. The officer had also only received some very limited training on child sexual exploitation. The officer had a limited understanding of the MAPPA process, and again training would be beneficial considering the officer's potential involvement in this process. Their role was recently reviewed against the national Youth Justice Board model, however, the officer would benefit from a more clearly defined focus on the priorities of the role.

7. The officer undertook a significant amount of administrative work to service the restorative justice function and the bureau (out-of-court disposal) panel, and this could end up being to the detriment of one of the officer's core priorities of information sharing. The same issue was noted at the time of the last inspection.

8. The officer had limited contact with neighbourhood policing teams. This should be improved to better contribute to the work of the YOS.

9. With reference to MAPPA, we heard that there had been little training for caseworkers. It was disappointing that this had not been addressed having been raised in the previous inspection report. MAPPA referrals had been made inappropriately and this may be a reflection of this lack of training. It was not clear exactly how many children and young people were MAPPA eligible. It is imperative that all YOS staff understand what makes a case eligible for MAPPA, in order that the correct level of resources can be applied to manage the risk of harm involved. A review of the YOS caseload should be conducted and referrals made, where required, as a matter of urgency.

10. It was unclear whether, and how, information regarding the child or young person being managed under MAPPA is passed on so that it can be recorded on the MAPPA monitoring tool (ViSOR). Relevant training, and access to ViSOR by the YOS police officer, would improve the information flow and subsequent recording.

11. Victims of crimes committed by children and young people are given a good service. For instance, they are contacted by the police officer and visited by the dedicated victim worker, often accompanied by the police officer. The same level of attention given to victims, regardless of the apparent seriousness of the crime, is good practice and not only does this support the emphasis on restorative justice, it provides an explanation for high victim satisfaction rates.

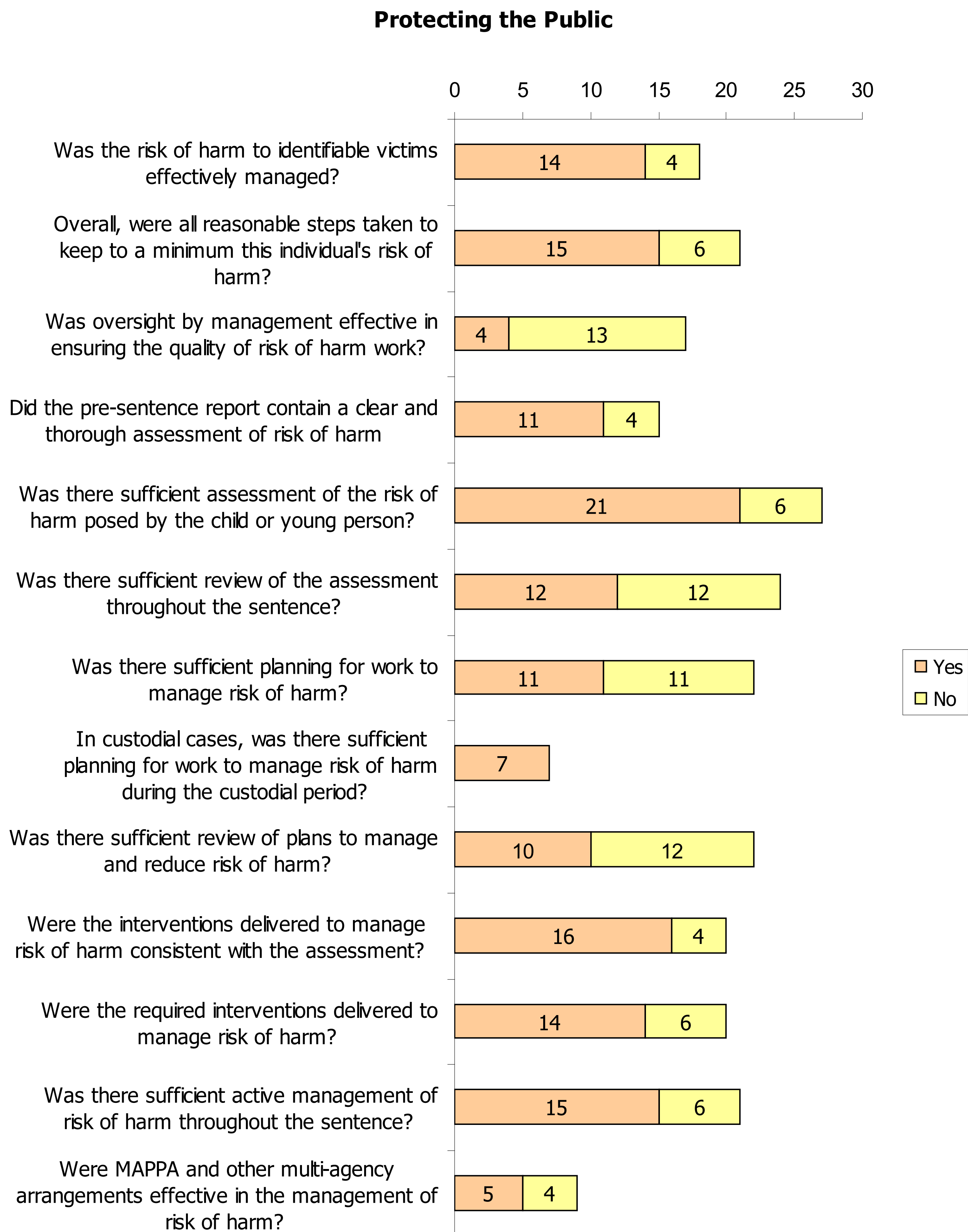
12. Interventions delivered to manage the risk of harm were consistent with plans in most of the cases we saw. Where they were not, the main reason was that while interventions had been identified they had not always been delivered. We recognised that, although it is often not possible to deliver plans

due to legitimate circumstances, the required interventions to deliver risk of harm work were delivered throughout the sentence in only just over two-thirds of the cases.

13. The risk of harm to victims was effectively managed in over three-quarters of the cases we inspected. We found that in some instances the victim had not been clearly identified and, where they had been, assessment and planning in some cases did not effectively capture the risk to the victim or what needed to be done to reduce it. The YOS needed to improve its performance in this area and make sure case managers devised plans to effectively manage the risks that children and young people posed to victims.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 27 cases were inspected. The total answers, however, 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 63% 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 a significant change.
3. Plans often did not contain sufficient focus on vulnerability and how it should be managed.
4. Too many reviews of plans were of poor quality.
5. The quality assurance process in place did not focus on the quality of reviews.
6. There were stronger multi-agency arrangements in place to manage vulnerability and joint working with other agencies had improved.
7. A Gwent wide speech, language and communication needs service was now in place and a speech, language and communication needs worker was at Newport YOS two days a week.
8. Clear referral criteria and treatment pathways existed into substance misuse and Child and Adolescent Mental Health Services (CAMHS).

Explanation of findings

1. Most PSRs we examined contained a thorough explanation of the safeguarding and vulnerability needs of the child or young person. This was an area of strength for the YOS. Just less than three-quarters of initial assessments following sentence were of a good standard.
2. Assessments were good at considering: alcohol and drug misuse; ETE; care and support arrangements; physical, emotional and mental health issues. The YOS could make further improvements by making sure that assessments address all relevant behaviour and are clear about the nature or level of vulnerability of the child or young person.
3. Reviews, however, were only good enough in under half of the relevant cases. Where they were not good enough, this was mainly 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 satisfactory assessments in many instances, we were disappointed to find that vulnerability management plans were sufficient in just under half of the cases we saw. We found significant deficiencies in the quality of the contingency planning and often information sharing arrangements

between agencies were not clear. While case managers seemed more able at assessing vulnerability, they needed to improve their thinking about how to address and manage issues which made children and young people vulnerable.

5. Interventions delivered to address safeguarding and vulnerability were consistent with assessments in nearly three-quarters of the cases. Where they were not, there was either no assessment of what needed to be done or the identified interventions had not been delivered.
6. Reviews of plans were poor in two-thirds of the relevant cases we examined. This was because reviews had not been done when required or in response to a significant change. This was not good enough and the failure to review plans in response to changing circumstances could have lead to a failure to protect children and young people from harm. The quality of work in this area needs to improve quickly.

Example of notable practice

Chris had a history of self-harm and was further vulnerable by virtue of being a Looked After Child, having a history of going missing from home and his use of drugs. While in police custody prior to sentencing, he attempted to hang himself. This led to him being placed on Assessment Care in Custody Teamwork when entering the secure estate. At no point was he assessed as vulnerable by the YOS in any of the three Asset[2] assessments completed and at no point was a vulnerability management plan produced. The case manager did not refer the case to the YOS internal risk panel which would have given greater oversight, challenge and responsibility sharing. There was no evidence of management oversight in terms of the assessments, planning or review.

7. We found that the required interventions to effectively manage safeguarding and vulnerability were delivered throughout the sentence in just over two-thirds of relevant cases. Areas that needed more focus were alcohol misuse and making sure plans effectively addressed care and support arrangements. More effective planning by the YOS was required so that all aspects of safeguarding and vulnerability were addressed.
8. Effective management oversight is critical to make sure that the quality of work is of the correct standard. We judged management oversight to be effective in under two-thirds of the cases we examined. Managers had information available through the quality assurance process and performance reports but this was not always used to drive performance, particularly with reference to vulnerability planning and review. We judged that all reasonable steps had been taken to keep to a minimum the risk of children or young people coming to harm in just over two-thirds of cases and, in our view, this leaves significant room for improvement.
9. We found an increased understanding between the YOS and other social services staff about their respective roles and responsibilities in respect of reducing reoffending and delivering other positive outcomes for the children and young people they work with. This was partially achieved through management initiatives, such as joint training events and cross-team shadowing arrangements.
10. Our review of cases evidenced a wide range of communication between YOS staff and other children's services teams, and YOS staff cited increased familiarity with children's services' case management system as a useful tool to support this. We did not see sufficient meaningful information sharing to facilitate joint assessment or planning to deliver better outcomes for children and young people.
11. We found that knowledge and understanding about thresholds for referrals to children's services needed improvement among some YOS staff. We found also that the quality of YOS referrals to the duty and assessment team required improvement; specifically the quality of referrals would have benefited from a targeted focus on safeguarding concerns and more effective management oversight.

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.

Examples of notable practice

Good multi-agency safeguarding professionals meeting were held weekly to make sure all relevant partners (post-16 social worker, various case managers, drugs worker, missing person's team, police) were aware of the issues and changes happening in the case. Information was shared and lines of inquiry appropriately pursued.

Kim was assessed as having learning needs and behavioural issues. The case manager had undertaken a learning needs assessment and liaised with the speech and language therapist for advice on interventions. As a result of this, interventions were tailored to meet her specific needs. Additionally, the police applied in court for an antisocial behaviour injunction; the case manager successfully argued that this was not appropriate given her learning needs and that she had only recently received a referral order and had not yet had the chance to undertake any interventions with the YOS.

12. Treatment pathways for children and young people into one-to-one work, and more intensive speech, language and communication related services were embryonic. Accordingly, we were pleased to hear of plans to develop this pathway in the near future.
13. Clear referral criteria and treatment pathways existed into substance misuse and CAMHS. Interventions could involve providing advice to case managers or engaging in direct work with children and young people. Because the health staff maintained links with their employer agencies, it was possible to fast-track those presenting with greater need to more intensive services if this was required.

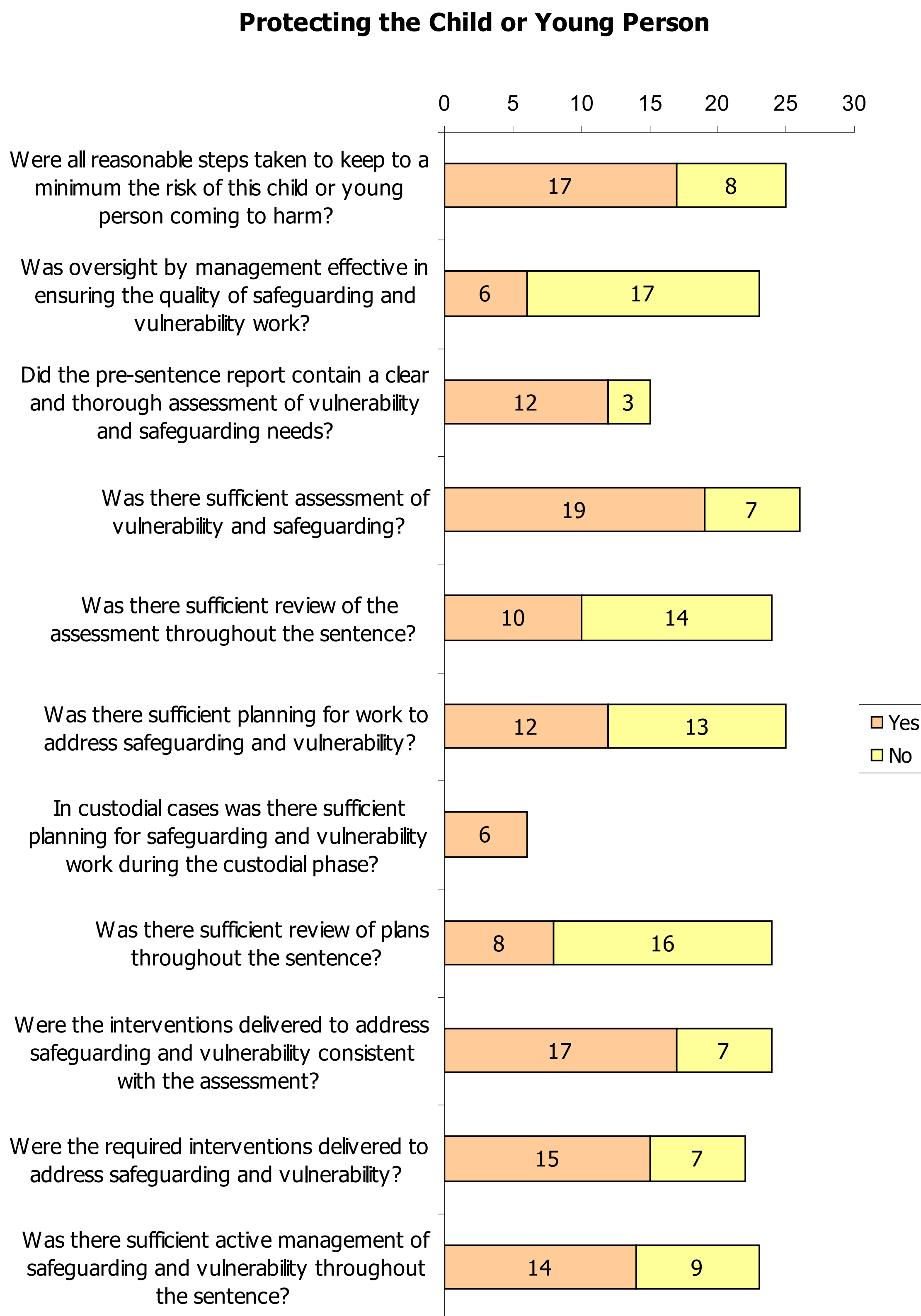
Example of notable practice

Fred had experienced emotional well-being issues prior to sentence, including family life where domestic violence was a feature. There were family alcohol and mental health issues and the death of a significant male role model. Fred had also been diagnosed with attention deficit hyperactivity disorder. He had experienced suicidal thoughts and had previously attempted to hang himself. Throughout the sentence his emotional well-being had been given a high priority and relevant monitoring and interventions had been delivered in the secure estate and post-release on licence. His vulnerability was monitored post-release via the YOS internal risk panel, and the specialist worker clearly had a good grasp of the key issues which enabled staff to maintain a good oversight, both within the YOS and with other relevant agencies.

14. The substance misuse service embraced a model for change centred on educating children and young people about harmful substances and motivational interviewing. The worker had recently attended cognitive behavioural training. The clinical nurse specialist delivers a range of interventions including dialectical behaviour therapy and cognitive behavioural therapy. Case managers screened for substance misuse or emotional and mental health issues only through Asset. They could, however, also discuss cases with the relevant specialist worker. Formal training to assist screenings in these areas had not recently been provided. Health workers understood that part of their role in the YOS was to educate staff about substance misuse, or emotional and mental health issues on an ongoing basis. In terms of the effectiveness of that approach to educating staff, we noted that staff frequently used medical terminology when discussing emotional and mental health issues.
15. If a case manager gave a child or young person a score of two or more on the relevant section of Asset, the case manager discussed the merits of making a referral to the substance misuse or CAMHS specialist for further assessment of the child or young person's needs. In relevant cases, referrals would then be made and the child or young person would be seen.

Data Summary

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



Making sure the sentence is served

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Theme 4: Making sure 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 82% of work to make sure that 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 with children and young people and their 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.
5. The YOS did not always explore a child or young person's language of choice or facilitate the use of it.
6. There was insufficient focus on assessing the physical and sexual health of children and young people.

Explanation of findings

1. We were pleased to see that diversity issues and barriers to engagement were addressed well in most of the PSRs 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 relevant factors.
2. Children and young people who had been supervised were asked to complete an e-survey on their views of the YOS. Only just over half had been asked which language they wanted to use during supervision and less than one-quarter felt they had been able to use their language of choice.
3. Almost all felt that at their first appointment what would happen over the course of their order was explained clearly. 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. Most also felt listened to, with 72% stating their views were always taken seriously and a further 15% 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. Initial planning sufficiently addressed barriers to engagement in just under two-thirds of the cases we saw. Barriers identified in assessment did not always flow through into the plan; one particular area that was overlooked was barriers affecting girls and young women. There was good involvement of the child or young person, their parents/carers or significant others, in the planning phase in just over three-quarters of cases. In most cases, over the length of the sentence we found that the YOS were good at engagement.

Example of notable practice

The sentence plan was written in plain English and focused on what the young person would do using 'you', 'I' and 'will' statements. The young person's mother did not speak English well and so an interpreter was commissioned to facilitate the interview.

Quote from child or young person

"I talked a lot with my YOS worker. I had to look at what I did wrong and what I had to do to stay out of trouble. It was hard because I don't talk much. I'm glad my YOS worker kept on at me. I haven't offended for 8 months. That isn't bad for me."

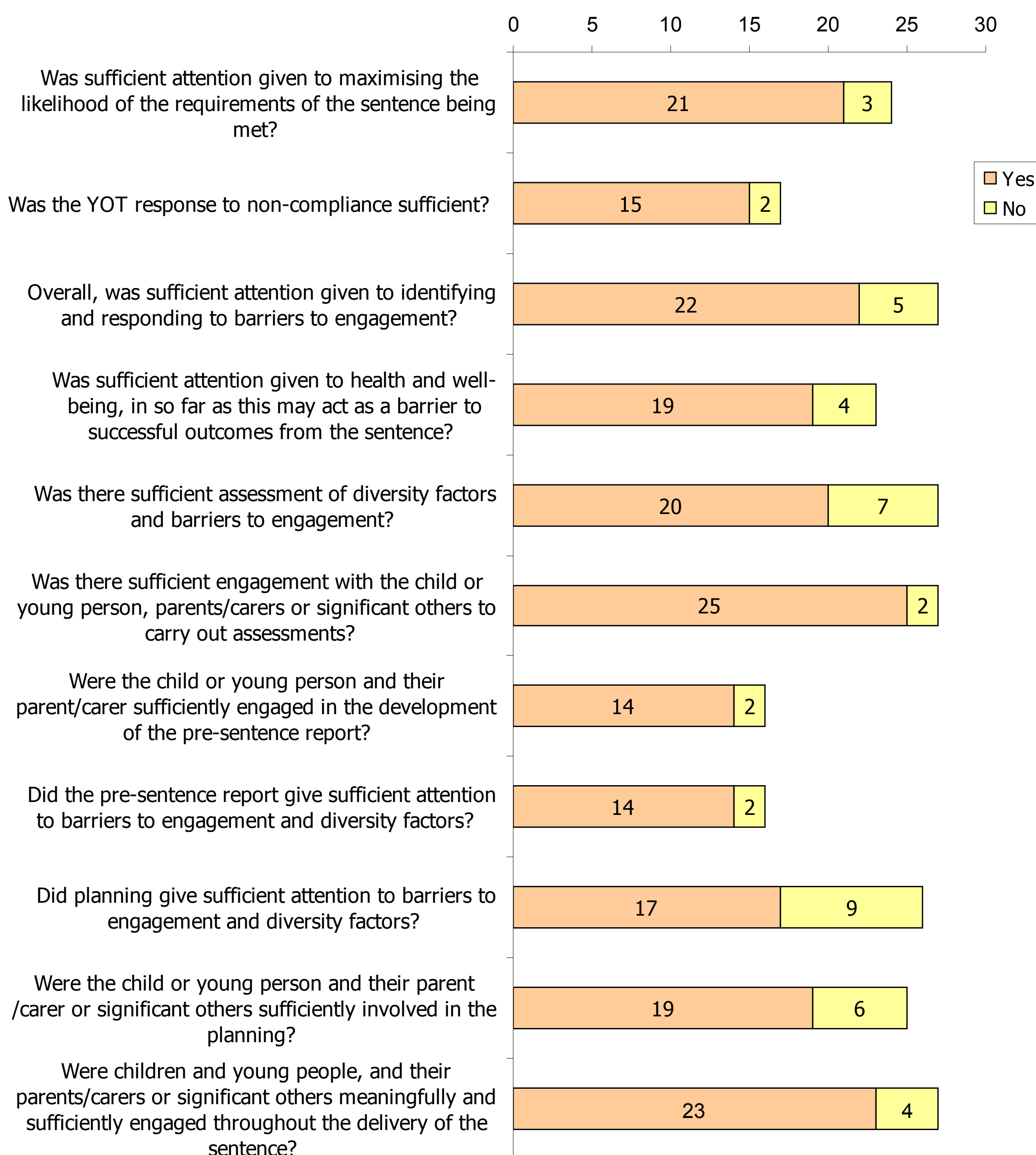
Quote from a parent

"I'm always kept informed of how my son is doing. I get invited to the planning meetings. I don't always get to say what should be done with my son."

5. The YOS successfully made sure that the requirements of the sentence were met in the great majority of cases. In some cases there was an insufficient response to compliance difficulties. 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 generally good at working to improve compliance using 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 most of 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.
6. We looked at the assessment of the physical well-being of children and young people and how the YOS made sure that general health did not become a barrier to making sure the aims of the sentence were achieved. We found that no physical health assessments took place. While case managers assessed a child or young person's physical health needs as part of the Asset assessment, no training regarding physical health had recently been provided for case managers.
7. Assessment of the sexual health of children and young people was not prioritised. Albeit case managers and health workers assessed needs in this area, and relevant children and young people were supported to access generic sexual health services, no recent formal training has been provided in this area and there was little by way of formal sexual health provision for children and young people who attend the YOS.
8. This was disappointing given it had been identified as an issue in our previous inspection. In this context, we were pleased to be told of plans in the near future to assess the general physical and sexual health, and immunisation status of children and young people who attend the YOS by linking into school nurse services.

Data Summary

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



Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

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

Key Findings

1. There was evidence of strategic leadership and a plan with a clear 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 performance management framework with evidence that issues were escalated to, and addressed, by the Management Board.
5. The Management Board had not made sure that, in the absence of physical health contributions to the YOS, it included a physical health service for children and young people.
6. The Management Board had not addressed all identified gaps in service provision or performance in a timely manner.
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. Some posts, however, were temporary and, therefore, the structure fragile.
9. Useful performance management tools were available to assist managers in addressing performance.

Explanation of findings

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

1.1. Strategic leadership had improved since our last inspection. The Management Board were aware of their responsibilities and the attendance and engagement of relevant partners was better than we had found previously. Partners were held to account and there was evidence of constructive challenge. We saw a developing performance management framework, and evidence that issues are escalated to, and addressed, by the Board.

1.2. There were clear partnership arrangements and a commitment to making sure that children and young people had access to required services. We found effective scrutiny arrangements for the Board and clear involvement from local authority elected members in addressing youth crime.

1.3. The level of detailed performance information provided for the Board was good. The next step was to make sure that the data was interrogated sufficiently to allow an understanding of the issues and develop effective plans to tackle them. We thought the Board could improve its effectiveness by making sure it addresses identified gaps in service provision or performance in a timely manner. The Board should also explore how it can capture the views of service users and the wider community to improve service provision.

1.4. Senior managers were able to demonstrate a clear line of sight on front line services in the

YOS. Staff reported that they found senior managers visible, accessible and that generally communications and working relationships between the YOS and other children's services teams were positive and constructive.

1.5. While showing signs of improvement, we found that recently revised team management arrangements in the YOS were embryonic and remained fragile at the time of the inspection.

1.6. We were pleased to see the police contribution in their analysis of crime data presented to the Management Board. This enabled the group to understand offending patterns and emerging trends, and react accordingly. This was good practice and evidence of a strong commitment to continuous improvement.

1.7. We were told about impressive reductions in the number of first time entrants. We have noted a significant emphasis on preventative work and this may well be one explanation. Equally significant, however, may be a reduction of on-street police activity. The Board may wish to analyse the figures in more detail to establish the reasons for the reduction.

1.8. There is representation from health on the YOS Management Board. While this is in the form of the CAMHS manager for Gwent, his senior post sits within the families and therapies directorate of health. He is, therefore, a senior manager embedded in the directorate with responsibility for children's health in schools and health centres in Newport. We were assured that he was able to represent general health issues to the Board and back into the families and therapies directorate.

1.9. The Management Board had instigated a useful review of the YOS's ETE work, which identified numerous strengths, particularly in the development and coordination of pre-16 education provision and support. Senior leaders and managers received regular information about children and young people's participation in ETE. There were not, however, effective methods in place to analyse and evaluate the impact of support to make sure post-16 young people made the best progress in reducing reoffending behaviour. While staff recognised that a lack of engagement in ETE increased the risk of children and young people reoffending, there was no analysis of how well children and young people progressed successfully into ETE. Careers Wales had identified that around two-thirds of children and young people drop out of progression into ETE opportunities, but the YOS did not have a strategy to address this or benchmark improvement. The resources allocated to young people's post-16 progression into ETE were not sufficient to enable them enough guidance and timely support, targeted to their individual needs.

2. Partnerships – effective partnerships make a positive difference

2.1. We found that the YOS was effectively embedded into the wider children's services structure. There was evidence of staff groups being able to express an understanding of each other's objectives and roles, and a sense of their ability to influence those areas of work. For example, the YOS manager's genuine participation in quarterly children and family service management meetings.

2.2. We found that both the strategic director for people, as well as the Head of Children and Family Services, had engaged positively with the improvement process since the last inspection. They have shown commitment and enthusiasm, and were able to articulate a vision for greater integration of the YOS and other parts of children's services, including joint planning for implementation of the *Social Services and Well-being (Wales) Act 2014*, and the implementation of Assetplus.

2.3. The YOS had developed a good, collaborative approach to working in partnership with local secondary schools, the Pupil Referral Unit, and key local authority staff who were responsible for school learners' attendance and behaviour. It met with these organisations weekly and made a good contribution to this effective partnership that enabled pre-16 children to remain engaged in education. There were good arrangements in place to share information with schools and the local authority. This was reciprocated well so that the YOS was kept informed of the progress that its children and young people were making and of what additional support they needed. Schools' and local authority staff valued the information that the YOS provided about pupils at risk of offending

or who were known to the YOS. At the time of inspection, there was not effective contingency plans in place to make sure that the YOS carried out this important information sharing role if key members of staff were not available. YOS staff also supported local authority and school forums well to strengthen the range of provision for pre-16 children, such as the development of extended work experience placements.

2.4. The local authority had drawn together many support agencies to review the progress, on a monthly basis, of post-16 learners who were not in employment, education or training. The YOS made a good contribution to this group, sharing information about children and young people in a manner that enabled other support agencies to plan interventions that would help them to progress into, or improve their ability to progress into opportunities. This multi-agency approach resulted in prompt action being taken to make sure that the majority of children and young people received additional help to improve their engagement.

2.5. There was a good partnership with Careers Wales. A Careers Wales representative sat on the YOS Management Board, and a careers adviser attended the YOS for half a day a week. Around half of the children and young people, however, did not attend their careers guidance appointments. This meant that careers adviser's time could not be used effectively and in a planned way to raise children and young people's understanding of the labour market, the progression opportunities available to them, or to support them in making informed choices.

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

3.1. We found the YOS to be well led, with a knowledgeable management team who had a focus on performance and quality, and who were aware of areas where they needed to improve. There was a performance management framework and effective tools to assist managers in addressing performance, and we found evidence of regular supervision.

3.2. We felt that the quality assurance process allowed managers to identify required improvements, but that not all areas of work were part of this process, for example, reviews. Furthermore, management oversight needed to be more robust in making sure required actions were completed.

3.3. We were not convinced that the YOS was actively engaged at the right level in all required multi-agency activity, for instance, there was no evidence of management attendance at the child sexual exploitation forum.

3.4. We saw that the YOS that was more integrated into the wider delivery of children's services and was developing its focus upon interventions designed to address reoffending.

3.5. While showing signs of improvement, we found that recently revised team management arrangements in the YOS were embryonic and remained fragile at the time of the inspection.

3.6. There was a good system for managing the health staff at the YOS. The clinical nurse specialist received clinical supervision from the mental health lead for Gwent, and was operationally supervised by the YOS manager. The substance misuse worker was supervised by both their line manager from Barnardo's and the YOS manager. The speech and language worker was supervised by the manager of the local speech and language service and an operational manager at the YOS. This appeared to work well as all workers received regular supervision and felt well-supported.

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.

4.2. We were impressed by the recent investment in reducing reoffending among the Looked After Children population in Newport, especially among children and young people placed in residential

placements. Staff in Looked After Children teams and residential services expressed the extent to which they valued the innovation services provided by restorative officers for Looked After Children. Early signs suggested that reoffending could be significantly reduced among this cohort as a consequence of this work.

4.3. In relation to speech, language and communication needs, a Gwent wide service was now in place and a worker was at Newport YOS two days a week. Formal screening of children and young people was taking place and case managers had received training in identifying such needs. This was a Health Inspectorate Wales recommendation from the last inspection.

4.4. We were pleased to see that the YOS had focused upon the high number of children and young people going in to custody. A lead manager had examined why rates were high and identified that report proposals to the court were not offering robust alternatives to custody. There was good liaison with sentencers to explore what the YOS could offer in the form of community sentences. This enabled sentencers to be confident that community sentences were capable of delivering a structured programme to address reoffending and protect the public. Reports had improved through offering appropriate community sentences and custody rates had reduced significantly as a result.

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 77% of work relating to interventions to reduce reoffending was done well enough.

Key Findings

1. There was a suitable range of interventions available at the YOS.
2. Staff thought innovatively about adapting existing materials or creating new ones to make sure there was engagement with children and young people.
3. Assessments to determine the suitability and eligibility of interventions were generally carried out sufficiently.
4. Case managers delivering interventions were enthusiastic and committed.
5. Plans to deliver necessary interventions were not always updated appropriately.
6. Barriers to positive engagement were not always identified, especially with regard to focused work with girls or young women.
7. Outcomes from new or existing interventions had not been fully evaluated and measured.

Explanation of findings

1. In most cases, assessments to determine the suitability of interventions that would lead to reducing reoffending were sufficient, clear and completed within appropriate timescales.
2. Case managers delivering interventions were generally enthusiastic and well-prepared for sessions. They had clear plans of what they wanted to achieve and were able to adapt the content and delivery of the material. They were skilled in keeping children and young people focused on the aims and objectives of the sessions.
3. Initial planning to determine what interventions would be provided and how they would be delivered was done sufficiently well in the vast majority of cases. There were, however, some examples where case managers had not identified and addressed individual needs and barriers to engagement. For example, plans rarely identified the need for specific interventions for girls or young women, or to address other diversity needs such as race and ethnicity.
4. Parents/carers were meaningfully engaged in planning for interventions and were seen as key players in achieving successful outcomes for children and young people.
5. We were pleased to note that there was sufficient planning for those children and young people in custody, and in the majority of cases in the community. The YOS had invested in resettlement workers, who worked with the children and young people in custody on a voluntary basis. They would

accompany case managers and workers from other agencies, such as Careers Wales, to meet with the children and young people in custody. This helped with planning to meet their needs prior to release, supporting delivery of a well-integrated sentence.

6. We observed 11 interventions which included a combination of one-to-one sessions, a referral order panel, and a risk and vulnerability planning meeting. We saw interventions being delivered in the YOS itself, but also visited locations such as a community farm and a fire station. Staff were also willing to travel to locations considerably further afield, such as the Big Pit[3], or local castles, to stimulate and educate the children and young people and improve their knowledge of their heritage.
7. There was good preparation of planning for delivery of interventions and staff knew both the children or young people, and the material they were using, well.
8. Inspectors considered that children and young people had been well-prepared for allowing the inspector to observe and demonstrated positive/respectful relationships with YOS staff. Boundaries regarding appropriate behaviour were maintained skilfully by the YOS staff.
9. The delivery of interventions was engaging and well paced and at a level suited to the individual. For example, the arson workshop at the fire station was highly motivational and a good example of relating the material to the personal circumstances of the child or young person.
10. Staff were thinking creatively and had developed a number of new interventions, for example, an arson one-to-one workshop, which had been researched and developed by the restorative officer for Looked After Children. We also saw the shoplifting DVD prepared by Newport YOS. It was considered to be helpful in that the child or young person could relate to their local environment, shopping centre and police station.
11. There was good evidence that the victim perspective and the consequences of offending behaviour on others featured throughout. The delivery of the assault workshop provided a good example of the victim worker and case manager working well to compliment each other and support the child or young person's engagement.
12. At the referral order panel meeting, inspectors were pleased to note that, during the closure of a referral order, the case manager took time to explain that the conviction was now spent unless an enhanced check was requested from the Disclosure and Barring Service[4]. It was, however, concerning that in another case the young person, whose compliance was an issue, was not encouraged to recognise the seriousness and implications of non-compliance further during the meeting.
13. There was a good range of interventions available at the YOS to support desistance, although the YOS might have benefited from collating them in a library, whether physical or electronic, to make sure all staff knew what is available to them.

Example of notable practice

Angie, who was 16 years old, was given a 12 month youth rehabilitation order (YRO) with a 4 month drug testing and treatment order for a variety of offences relating to her addiction to heroin. She was a Looked After Child and lived in a variety of supportive placements throughout the order. Innovatively, the case manager worked jointly with the Young Persons Substance Misuse Service (YPSMS) to develop a draft contract between the young person, the YOS and the YPSMS to agree to her undertaking drug testing and treatment as part of a YRO, if imposed by the court. The court took the advice of the case manager and imposed the order; the first in the area. On review, it was seen that she was no longer taking class A drugs, nor had she reoffended. The order was, therefore, revoked for good progress, a successful outcome.

3 Big Pit National Coal Museum is an industrial heritage museum in Blaenavon, Torfaen, South Wales.
4 The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children and young people. It replaces the Criminal Records Bureau and Independent Safeguarding Authority.

14. YOS practitioners were generally delivering interventions to reduce reoffending, but they did not always identify the need to review this work, either generally, or specifically after significant changes in the life of a child or young person. Plans did not change to meet the changes in the lives of children and young people. Where there were gaps, these tended to be in important areas such as family and personal relationships, thinking and behaviour, self-perception and motivation to change.
15. Inspectors considered that staff needed to improve their recording of the interventions they had delivered. We heard about some interesting interventions, but these were not always effectively recorded.
16. When inspecting the cases, inspectors did not see sufficient emphasis on interventions to manage the risk of harm to others, or the vulnerability of the children and young people themselves. Where needed, however, sufficient work was being undertaken to improve a child or young person's education or training, their lifestyle and to address substance misuse issues.

Example of notable practice

Bill, who was 16 years old, had a history of breaching his antisocial behaviour order (ASBO). At no point during his order, despite it being identified on his sentence plan and community intervention plan, did he undertake any interventions to address this. He was not a prolific offender or considered a high risk of harm to others, subsequently received a four month custodial sentence for a breach of his ASBO. The unsuccessful outcomes continued in that, soon after the expiry of his detention and training order licence, he received a nine month YRO for a further breach of his ASBO for a relatively minor transgression of the ASBO conditions.

17. We saw almost no collection of feedback from children and young people at the review stage. It was not clear what impact the interventions had had on embedding change. There were no mechanisms or systems in place to monitor and evaluate the effectiveness of all the interventions delivered, to make sure that successful outcomes could be replicated.

Quotes from children and young people

"*I didn't like the litter picking. Yeah – it helps to keep the streets and parks clean but I didn't learn anything. Painting the fences was better because I now know what you have to do, what brushes you use for different stuff. I might be able to get a job doing that.*"

"*As part of helping me to understand my arson offence I had to visit the Fire Service. The Fire officers talked to me in a friendly way and helped me realise how much more harm could have been caused. I could have killed someone. I'm glad I was able to speak to them. I won't be getting into any more trouble.*"

18. Case managers had positive and respectful relationships with the children and young people they supervised. They were able to appropriately challenge their views and to help them reflect on previous behaviour, the progress they had made and develop sustainable plans for the future. Staff affirmed good choices and positive decisions made by children and young people.
19. Children and young people were actively engaged in all the sessions we observed. Overall, we found that the delivery of interventions had generally contributed to reducing reoffending.

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, making sure 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:

08 February 2016 and 22 February 2016.

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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Criminal Justice Joint Inspection

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