

# Full Joint Inspection of Youth Offending Work in Staffordshire

An inspection led by HMI Probation



# Foreword

This inspection of youth offending work in Staffordshire 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 Staffordshire primarily because it was identified as a potential area of good practice.

The reoffending rate for Staffordshire was 42.1%, which was higher than the previous year and higher than the average figure for England and Wales of 38.0%<sup>1</sup>. Performance against the other national indicators, first-time entrants and use of custody was, however, significantly better than the England and Wales averages.

Staffordshire Youth Offending Service (YOS) had delivered a consistently strong performance against national youth justice indicators for several years but they had seen a recent rise in reoffending rates. The YOS Management Board had not responded sufficiently quickly to this development and additionally a number of key partners had not been represented on the Board. Health provision in the YOS had reduced significantly in recent months. Nonetheless there remained a competent and committed workforce dedicated to doing their best for children and young people in Staffordshire. Assessment, planning and review were done to a very high standard and we judged that the service could afford to become increasingly outcome-focused in its approach to children and young people.

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



**Dame Glenys Stacey**

*HM Chief Inspector of Probation  
June 2016*

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<sup>1</sup> The reoffending rate that was available during the first 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 reports were produced for the courts and initial assessments were of a high standard. A new planning format had been adopted and further work was required to make sure that plans captured the issues identified in the assessment as well as reflecting the views of children and young people. Strategies for dealing with children and young people with low levels of motivation to change needed further development.

### Protecting the public

*Overall work to protect the public and actual or potential victims was good.* Reports and initial assessments contained a thorough analysis of the risk of serious harm posed by children and young people. Multi-agency arrangements were good and there was a strong partnership approach to work to protect the public. Victims were well served by the YOS.

### Protecting children and young people

*Overall work to protect children and young people and reduce their vulnerability was good.* Assessments were thorough and the YOS had appropriate multi-agency arrangements in place to manage vulnerability. Work to manage and reduce vulnerability was generally good, however, the reduction in health secondees to the service may reduce the ability of the service to respond to vulnerable children and young people in the future.

## **Making sure the sentence is served**

*Overall work to make sure the sentence was served was good.* The YOS and its partners worked well to achieve positive outcomes for children and young people. Compliance was managed effectively. Barriers to engagement were identified and responded to, and children and young people together with their parents/carers were engaged meaningfully in the order.

## **Governance and partnerships**

*Overall, the effectiveness of governance and partnership arrangements was satisfactory.* Operational management of the service was effective, there was a well trained, competent workforce and there were examples of strong partnership working. The YOS Management Board had met regularly but there had been a number of significant gaps in representation, notably health and education. Reoffending rates had risen and the Board's response was unclear.

## **Interventions to reduce reoffending**

*Overall the management and delivery of interventions to reduce reoffending was good.* Staff had access to a wide range of resources. Outcomes achieved as a result of interventions had not yet been fully identified and evaluated.

# **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 make sure that:**

1. there is an effective Management Board with appropriate representation, who have a clear understanding of key practice issues in the YOS and have a full range of quality and performance information available to it
2. the YOS has access to suitable health resources across the county
3. the YOS has an effective response to the recent rise in reoffending rates
4. the YOS has effective strategies for managing a smaller cohort of children and young people who may display more challenging behaviour and lower levels of motivation to change
5. management information and quality assurance activity includes a focus on achieving and capturing positive outcomes for children and young people
6. the needs and vulnerabilities associated with children and young people placed in care establishments in Staffordshire from elsewhere in the country, and supervised by the YOS, are understood and addressed.

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

# 1

# Theme 1: Reducing reoffending

## What we expect to see

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

## Case assessment score

Within the case assessment, overall 78% of work to reduce reoffending was done well enough.

## Key Findings

1. Good quality reports provided the court with relevant information to assist sentencing.
2. Assessments were of a high standard.
3. Plans were generally good, but could better reflect education, training and employment (ETE) and the child or young person's views.
4. Assessments and plans were reviewed effectively as circumstances changed.
5. Not all children or young people who needed a substance misuse intervention accessed the service.
6. Reoffending panels were an encouraging response to rising reoffending rates.

## Explanation of findings

1. Overall, case managers had a good understanding of why children and young people had offended. Initial assessments were good in almost all of the cases we inspected and demonstrated an appropriate balance between strengths, vulnerability and risk of serious harm in the lives of children and young people. Pre-sentence reports (PSRs) were of a generally good quality and magistrates expressed confidence both in their content and the sentencing proposals contained in them.
2. The YOS had developed an Integrated Action Plan (IAP) to improve the quality of planning and the large majority of plans were good. We found that plans were informed by the initial assessment and identified desired outcomes, however, they did not always reflect the views of children and young people.
3. The lives of children and young people can change rapidly and we were pleased to see that reviews of assessments and plans took place in almost all cases, and there was good evidence of case managers updating both documents as the circumstances of the case changed.
4. Cases sampled by inspectors showed generally good support by YOS ETE staff and partners that helped children and young people into ETE. The YOS ETE team knew the children and young people well and understood their circumstances. In the best examples their work was characterised by early intervention, good liaison and information sharing between ETE staff, YOS officers, other agencies and education providers. This resulted in a good match between a child or young person's needs and their educational placement.
5. YOS ETE staff also provided good support for the small number of children and young people leaving custody. Inspectors saw good examples where ETE workers attended pre-release meetings and gained

a good insight into children and young people's aspirations and abilities. This helped them plan for children and young people to access courses and programmes quickly on their release.

6. Assessments and IAPs generally identified children and young people's educational needs, however, this was less evident for those aged 16 years and over. Initial plans did not always contain specific actions that detailed how educational needs would be met. The actions to be taken were sometimes vague and did not go beyond the initial steps to be taken.
7. Performance information had not been routinely used by managers to review and plan the work of the ETE staff. There was a lack of available and relevant performance data. For example, the YOS had no way of knowing if they were effectively supporting children and young people's attendance at school.
8. Around one-fifth of the YOS caseload were placed in independent care homes in Staffordshire from outside the area. The YOS were supervising these children and young people on behalf of other Youth Offending Teams. The levels of intervention and range of difficulties presented by this group were significant and further analysis of the needs of this group was required.
9. The relationship between the police and YOS staff was generally good, however, there was sometimes a reluctance from the police to share information. In addition, information was not shared systematically back to the police by YOS staff. In one case, it was not clear to inspectors whether information regarding a violent domestic abuse incident between a boy on the YOS caseload and his 16 year old girlfriend had been shared with the police.
10. The YOS did not have any substance misuse workers based within their premises. Children and young people were referred to T3, the local substance misuse service provider, and some staff reported that if children or young people were reluctant to engage with the substance misuse service, it often resulted in them not accessing the help they needed.
11. Out of court disposals were dealt with by the police. We found that no panel was in place to decide whether it was appropriate to charge a child or young person. Considering the more serious impact of a charge and the impact of the increased workload on the YOS and the wider criminal justice system, this would be a sensible extension to the process of outcome decision-making. Indeed it was notable that a number of charged cases had been sent back from the youth court as it was felt that there was a more appropriate disposal option.
12. We were pleased to see that in two-thirds of the cases inspected there had been a reduction in the frequency and seriousness of offending.
13. Reoffending panels had been developed in response to the recent rise in reoffending rates. There was no opportunity for inspectors to observe a panel but there was evidence that they were used to bring together key staff when a child or young person had reoffended, in order to reconsider the approach to managing the case.
14. National performance data indicated that reoffending rates in Staffordshire had risen in the nine months prior to the inspection. We were told that this was, in part, attributable to the reduction in cohort size which was itself a consequence of the strong performance against the first-time entrant's indicator. It was clear that the YOS had taken steps to address reoffending, such as the introduction of reoffending panels. We found some cases where the child or young person had very low levels of motivation to either cooperate with the YOS or change their behaviour. The YOS's strategies for dealing with this group, which were likely to form an increasing proportion of the cohort needed further development by, for example, developing the motivational interviewing skills of staff.

## Examples of notable practice

James was a Looked After Child by a neighbouring authority and placed in a home in Staffordshire. James had two convictions for assaults on care home staff, the second committed shortly after he received his referral order for the first assault. The YOS called a reoffending panel which met with James and his key worker from his new care home to discuss his reoffending. This meeting clearly had a very positive impact on him and this was noted by the YOS and care home staff who commented on how he was much more settled. His behaviour towards staff and other children and young people improved and, for the first time, he meaningfully engaged in YOS work to address his offending and help him stay safe within the care setting.

Simon had a very turbulent relationship with his mother and there was a strong connection between his offending and his family relationships. The case manager had attempted to engage Simon's mother in work to improve her parenting and to help her become more consistent in her parenting. She was, however, reluctant to do this, seeing it as criticism of her ability to care for her children. The case manager approached the building resilient families team who were able to offer parenting advice as part of a wider package of support which was accepted by Simon's mother.

### Quotes from children and young people:

*"Yeah, it [offending behaviour programme] made me realise the friends I have are no good. I'm not friends with them anymore. They used to get me into trouble."*

*"Yeah, they have taught me like that offending isn't the way to go. Before, with fighting and stuff, I just didn't care, I could fight people in the middle of town but now I realise that cameras are watching me and my face gets known. Even on my Facebook, you know what I mean; everyone sees what you're doing."*

*"They asked me what I wanted to do and I said engineering or a building site and they got in touch with that Nova place in town and I got involved with that."*

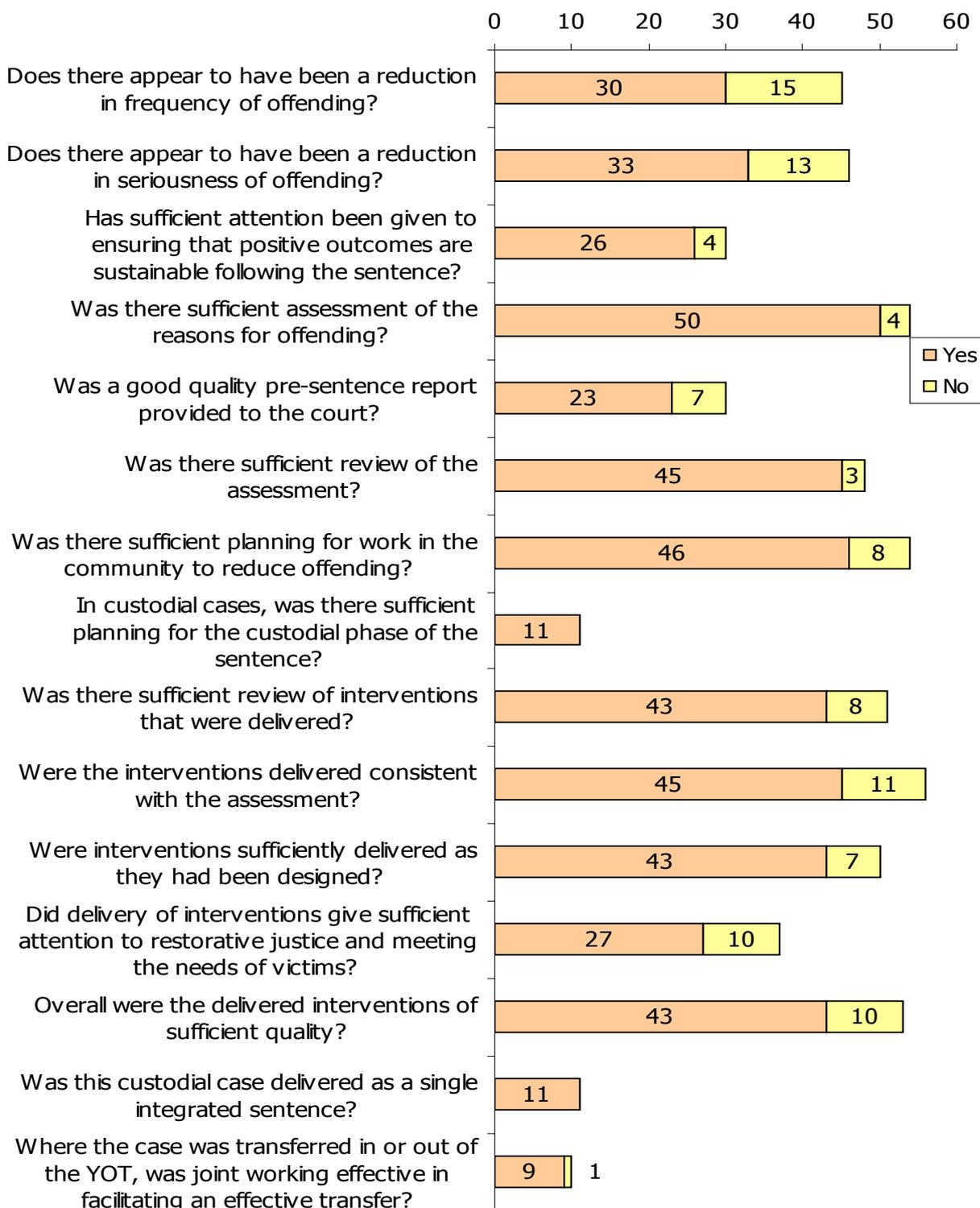
### Quote from a parent/carer:

*"I think time at YOS has definitely helped her not to reoffend in the future. I think she looks at things differently now than she did before, she thinks more about the consequences of her actions now than she did before. I think now she has a bit more compassion now for other people, so she thinks more about the victim now and the impact of her actions will have on them and that's something that we continue to work on but YOS started that process."*

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 57 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case.]

### Reducing Reoffending



# Protecting the public

# 2

## Theme 2: Protecting the public

### What we expect to see

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

### Case assessment score

Within the case assessment, overall 88% of work to protect the public was done well enough.

### Key Findings

1. Initial assessments of risk of harm were of a good quality.
2. PSRs made sure that courts were aware of risk of harm issues.
3. Risk of Serious Harm assessments were reviewed and updated as circumstances changed.
4. Multi-Agency Public Protection Arrangements (MAPPA) functioned effectively.
5. Victims of youth crime received a good service.
6. Interventions were consistent with the assessment and delivered effectively.

### Explanation of findings

1. In almost all cases we inspected there was a sufficient assessment of the risk of harm posed by children and young people to others. PSRs also clearly identified the risk of harm posed by children and young people in almost all cases examined.
2. Work to protect the public is often complex and case planning requires a wide range of factors to be taken into account. We were pleased to see that IAPs incorporated effective planning for risk of harm and we found planning was sufficient in almost all of the cases we inspected.
3. The YOS responded effectively to changes in children and young people's circumstances. There was clear evidence of assessments and plans being reviewed and updated in relation to protecting the public in the great majority of cases.
4. Management oversight of risk of harm was sufficient in over three-quarters of cases. Practitioners told us that the YOS had extensive quality assurance systems to make sure that work to protect the public received a high level of scrutiny and this was evident from the case records.
5. A small number of cases met the criteria for MAPPA. All of those cases were correctly identified and were being managed at the appropriate MAPPA level. Engagement with the local MAPPA unit was effective where multi-agency risk management was required.
6. There were two health staff seconded to the YOS, a mental health nurse and a physical health nurse. They had both contributed to MAPPA meetings.
7. There were three full-time police officers and three police funded victim liaison officers. This was a healthy contribution. We noted this was a change from the previous establishment of six police officers and no police staff, however, we did not consider that this was to the detriment of the effectiveness of

the work of the police. Two of the police officers were in the process of moving on, and at the time of the inspection a recruitment process was under way to fill these positions.

8. There was a system in place for the police officers to identify when all of the children and young people on the YOS caseload came to police attention. This was by way of a flag on the police intelligence system. There was evidence of information being shared by the police, however, this was not systematic and not consistent. Sometimes information was placed directly onto the YOS case management system by police staff, sometimes it was an email to a case manager that was copied onto the YOS case management system and sometimes it was the record of a conversation.
9. Victims of offences committed by children and young people were given a good service. They were contacted by the victim liaison officer with a presumption that all victims would be seen in person unless the victim decided otherwise. The same level of attention given to victims, regardless of the apparent seriousness of the crime, was good practice.
10. Where there was an identifiable victim or potential victim, the risk of harm to them from the child or young person was managed effectively in almost all cases examined.
11. Interventions to manage risk of harm were consistent with the assessment in most cases and inspectors judged that these interventions were also delivered in most cases. An inspector saw an example of skilled anger management work with a young person.
12. There was some evidence of gang related activity in Staffordshire, particularly in the north of the county. Staff had a good understanding of the issues associated with gangs and had developed interventions with children and young people in response. Information sharing with the police was effective.
13. The YOS had a significant number of children and young people placed in their area from other authorities. Where a risk of harm was present in these cases there was effective joint working with other Youth Offending Team (YOT) areas in all of the cases examined.

### Example of notable practice

Anthony was serving a seven year sentence for a violent offence. At his initial planning meeting, in custody, it was identified that he needed to address both this offence and his thinking skills. Unfortunately the two most appropriate programmes were not available. Anthony's case manager pushed both at the planning Board and with the psychology unit for Anthony to receive the required interventions. As a result of her persistence, it was agreed that the Young Offender Institution psychologists would deliver these programmes on a one-to-one basis, making sure that Anthony's offending and risk of harm was addressed.

### Quotes from children and young people:

*"I have to do a knife crime course because of this offence, I don't mind having to do it, I have to do it really."*

*"[YOS worker] keeps in regular contact with my mum to keep her up to date with what's going on and that. She texts her or rings her and sometimes my mum comes to meetings with me. I don't mind it to be honest, it keeps me right."*

### Quotes from parents/carers:

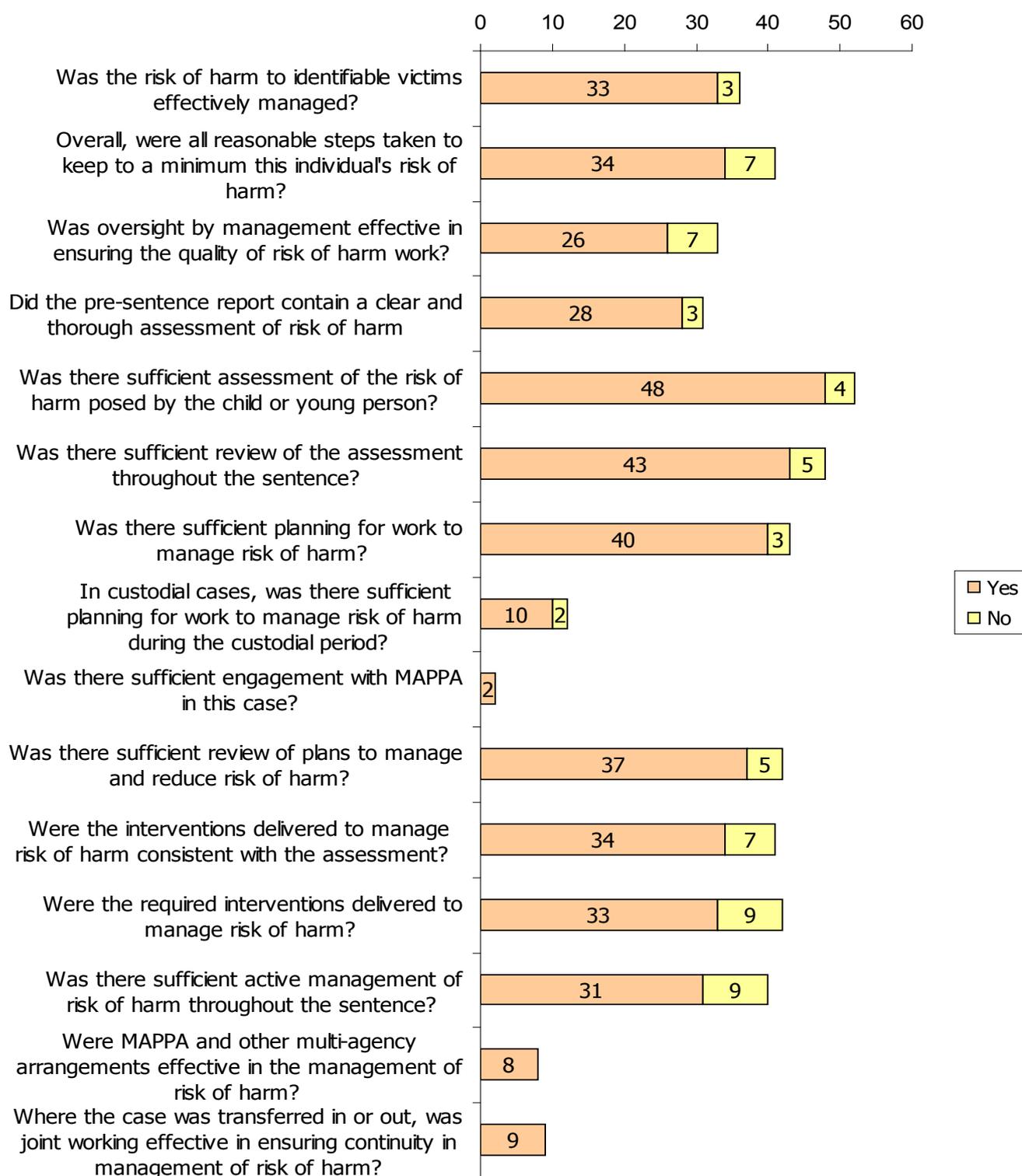
*"They've been doing stuff with him to try and get him to kind of reflect and see what or try and empathise with the victim of the crime. Try to get him to you know, how would you feel if that happened to you?"*

*"I think it's helped to make it...it's taken a long time, but it's made him become more aware that it is actually down to him. They've helped to get him that; yeah they have helped to get him to the point where he's starting to think a bit more. Before he reacts and stuff."*

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 57 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



**Protecting  
the child or  
young person**

**3**

# Theme 3: Protecting the child or young person

## What we expect to see

Whether the vulnerability of children and young people is due to the consequences of their own behaviour or the behaviour of others, we expect to see that they are kept safe and their vulnerability is reduced. This should be through good quality assessment and planning with the delivery of appropriate interventions, positive leadership and management, and an effective contribution to multi-agency child protection arrangements.

## Case assessment score

Within the case assessment, overall 86% of work to protect children and young people and reduce their vulnerability was done well enough.

## Key Findings

1. Initial assessments identified safeguarding and vulnerability issues effectively.
2. Planning and review of safeguarding and vulnerability was done well.
3. There were good working relationships with children's services.
4. A substantial Looked After Children population required a specific response.
5. Health services were not delivered consistently across the YOS.
6. Implementation of the housing protocol had not been timely.

## Explanation of findings

1. Almost all assessments identified the safeguarding and vulnerability needs of the child or young person. Where drug or alcohol misuse, ETE, care arrangements, physical or emotional health issues impacted on the child or young person's life, these were clearly identified. Assessments were evaluative, analytical and demonstrated an appropriate balance between identifying strengths and difficulties in children and young people's lives.
2. Most PSRs also identified the safeguarding and vulnerability needs of children and young people and courts could make informed sentencing decisions based on the information provided.
3. Planning and review of work relating to safeguarding and vulnerability was done effectively in most cases. Case managers had appropriately considered the information that was available to them and identified realistic actions that would help keep children and young people safe.
4. There were indicators of child sexual exploitation present in one-quarter of the cases inspected. YOS staff had identified and responded to the child sexual exploitation indicators appropriately. Inspectors saw one example of the Staffordshire child sexual exploitation risk factor matrix completed by a YOS worker. This was clearly written and the scoring was based soundly on the available evidence.
5. Contact between YOS staff and children's social care was positive and information sharing was mostly effective. Referrals from the YOS to children's services were appropriate and prompt. YOS attendance at Looked After Children reviews and Child Protection meetings was good. Similarly, an example was seen of a social worker attending a deter young offenders panel<sup>2</sup>.

<sup>2</sup> A multi-agency panel managing persistent young offenders.

6. Where Looked After Children had gone missing from their care placements, YOS staff were, in some cases, unaware of the outcome of the return meeting offered to them when they were back in their placement. These meetings were used to identify whether the children and young people were exposed to exploitation or other forms of abuse while missing. The effect of this was that important information relating to children and young people's vulnerability may not have been available to the YOS.
7. A housing protocol was in place but it had been a recent development and its implementation had been delayed. Some YOS staff were unaware of important case law, for example, the Southwark Judgement, which had significant implications for homeless children and young people aged 16 and 17 year old.
8. The YOS had established the Management of Risk Forum (MORF) which was used to consider cases presenting both high risk of harm, and safeguarding and vulnerability concerns. Two MORF meetings were observed and both had good attendance from partner agencies. The MORF provided a good forum for them to meet and share their insight and assessment. This was clearly useful to the case manager in their management of the case. It also led to partner agencies agreeing to collaborate, for example, the Child and Adolescent Mental Health Service agreeing to contribute to the social worker's Family Group Conference.
9. There were two health secondees to the YOS, a mental health nurse based in Newcastle-under-Lyme and a physical health nurse based in Lichfield. Case managers were very positive about the work of their seconded health colleagues. Not all health staff recorded on the YOS case management system and as a consequence of this, the impact of their work was not always fully apparent. At the time of the inspection, the physical health worker was leaving the service and there were no plans to appoint a replacement.
10. YOS staff had access to sufficient resources to address the safeguarding needs in almost all cases examined, and interventions aimed at addressing safeguarding and reducing vulnerability had been delivered well in most cases.
11. Management oversight of the quality of work to address safeguarding and vulnerability was sufficient in less than two-thirds of inspected cases. This was mostly because managers had not made sure that key interventions to reduce vulnerability had been delivered.

### Example of notable practice

Louise disclosed that she and her sister were being sexually exploited and threatened. The YOS understood that the safety of one sister affected the other and that it was important to work with and protect both girls. Louise's sister was over 18 years old and children's services were unable to support her. The YOS completed preventative work with the sister, negotiated for them to be accommodated together safely and continued to work with Louise after the end of her sentence in order to make sure that the girls had continued joint agency support.

### Quotes from children and young people:

*"I wanna do it at my pace like. Don't wanna get into something and not feel confident about it. I'm gonna be thinking to myself, hold on a minute, I've put all the effort in to get into the course and now I'm not liking it. I need to think to myself what I like and I need to go along with it then and stick to it do you know what I mean. At the same time it stops me reoffending."*

*"I tell them stuff that the carers don't even know and they keep it to themselves unless it's putting me in danger or something like that. But it's because I can kind of trust them, that's what makes it really good."*

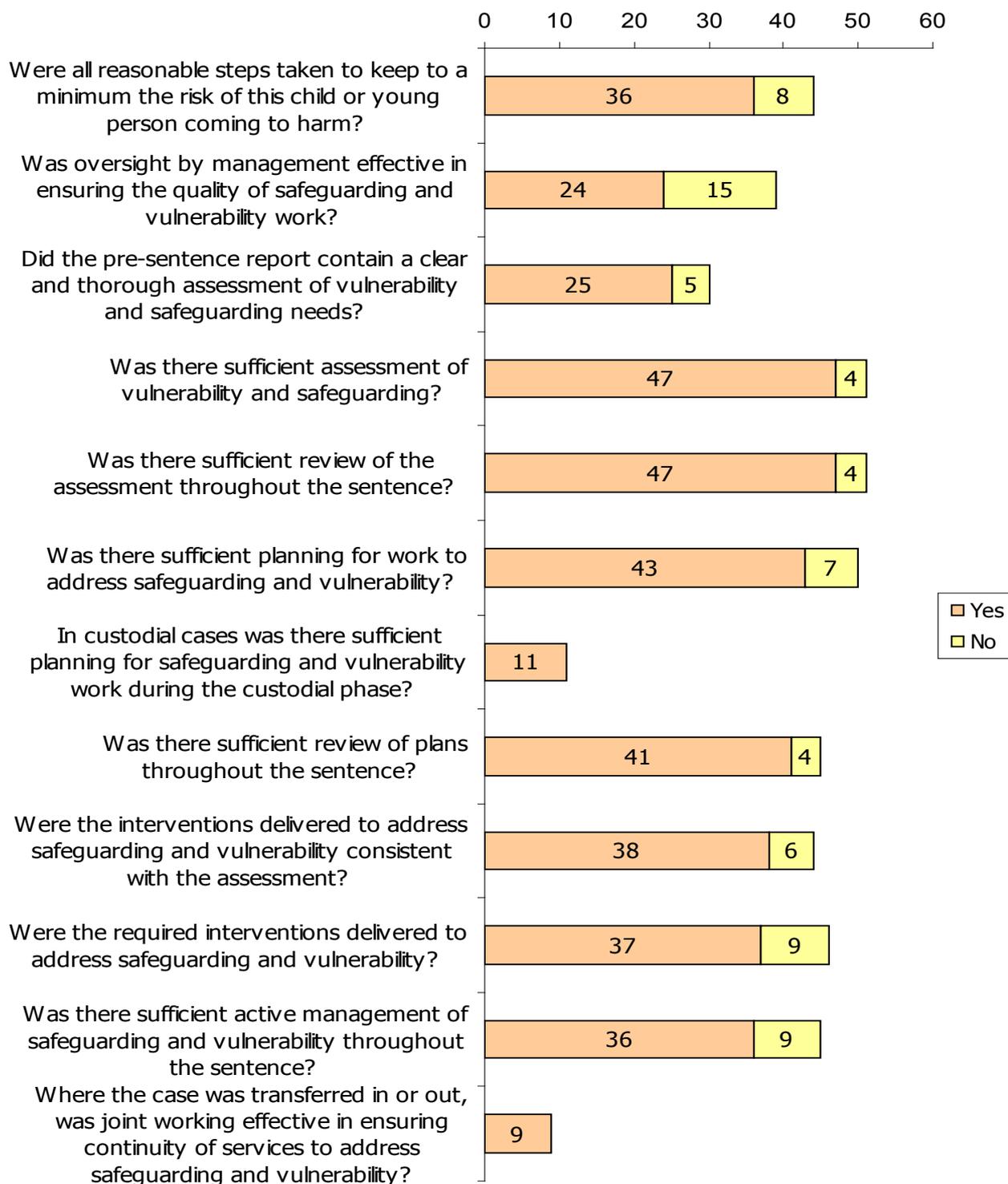
### Quote from a carer:

*"[The YOS worker] is really good at keeping us informed about the work that she is doing with [young person]. Just lately they have been doing work on his past experiences and behaviour, so she is really good at keeping us informed about their plans and what they are working through, so it's really helpful to enable us to keep an eye on his moods and emotional state."*

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 57 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



**Making sure  
the sentence  
is served**

**4**

# 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 89% of work to make sure the sentence was served was done well enough.

## Key Findings

1. Barriers to engagement and diversity issues were generally identified in initial assessments.
2. Engagement panels were a good response to children and young people at risk of enforcement action.
3. There was good partnership working between the YOS and the police.
4. Staff displayed a high level of personal commitment to engaging with children and young people.
5. Enforcement action through courts was used appropriately.

## Explanation of findings

1. In most assessments and court reports we examined, diversity factors and barriers to engagement were identified appropriately. When undertaking assessments and preparing reports, engagement with both children and young people and their parents/carers was good.
2. The YOS successfully made sure that the requirements of the order were met in the great majority of cases. In a small number, however, reporting requirements were insufficient for the needs of the case. Some children and young people had particularly low levels of motivation to change their behaviour, for example, where they were a regular cannabis user. Children and young people accessed the substance misuse service through an external provider and some declined to access the service. When this happened there were few effective strategies for making sure they received the necessary intervention.
3. The YOS had developed engagement panels which were held when children and young people were not complying with the order. Those panels brought key professionals together with the child or young person and their parents/carers. Their purpose was to review the progress of the order, make sure the child or young person was aware of the consequences of not complying, and to identify any aspects of the order that had gone well and could be built upon. We were unable to observe a panel, but evidence on case files indicated that they were an effective response to non-compliance. We judged that almost all of the practitioners we interviewed had a good understanding of compliance and enforcement practice.
4. Where non-compliance with the court order had become an issue, we judged that the YOS response, including breach action through the courts, was appropriate in almost all cases.
5. Information sharing between partners and within the YOS did not always alert ETE staff in a timely manner when children and young people began to experience problems in their education. In a minority of cases this led to children and young people spending unnecessary time out of education.

YOS staff would benefit from the routine collection of attendance data and information so that they can intervene at the earliest possible opportunity to support children and young people.

6. The YOS had established targets for completion of reparation hours for each of its three operational teams. This had been in response to a backlog of uncompleted reparation hours building up across the service. While reparation was an important component of the delivery of court orders, some staff told us that the effect was that reparation was being delivered in preference to other higher priority activities in order to meet team targets.
7. There was clear evidence of the partnership working between the YOS and the Integrated Offender Management scheme. This enabled information sharing and joint responses with the police to the most persistently offending children and young people.
8. Out of court disposals were largely dealt with by the police. Prevention referrals took place after community resolutions and cautions have been decided and administered. A number of children and young people had been charged with offences which were subsequently sent back from the court to be considered for out of court disposals. Staffordshire had not adopted multi-agency panel arrangements which have become increasingly the norm. Such arrangements have the potential to improve the quality of pre-court decision-making.
9. The quality of the records of interventions carried out by health professionals was variable across the different roles and agencies linked to the YOS. This meant that the impact of health referrals and interventions was largely unknown.
10. Children and young people, together with their parents/carers, were engaged meaningfully in their court orders in the great majority of cases we examined. Staff displayed a high level of personal commitment to the children and young people they were working with, and this was evident in both the case manager interviews with inspectors and the views expressed at a focus group involving YOS operational managers.

### Examples of notable practice

The case manager had recognised that Colin was not reoffending but that his refusal to engage and comply was bringing him back to the courts and there was a serious risk of a custodial sentence as a result of breach of the order. A good argument was made to the court to resentence and simplify the conditions of his order, which proved more realistic and Colin started to respond well and comply. The case manager recognised they were the only professional that Colin had not pushed away and they were sticking with him and seeking to work at a level of engagement he could cope with.

There was only two months direct involvement from Staffordshire YOS before a particular case was transferred to another area. They made a judgement about what was achievable in that time and undertook some one-off pieces of work designed to develop insight and build motivation. Once the transfer was confirmed they liaised with the other YOT and developed an intervention plan together, balancing the assessment with the resources available in that area.

### Quotes from children and young people:

*"I don't know, it's just how he talks to me. He actually understands me that much, he knows what my brain's doing."*

*"I get on well with my YOT worker, she is the only one that I have stuck with."*

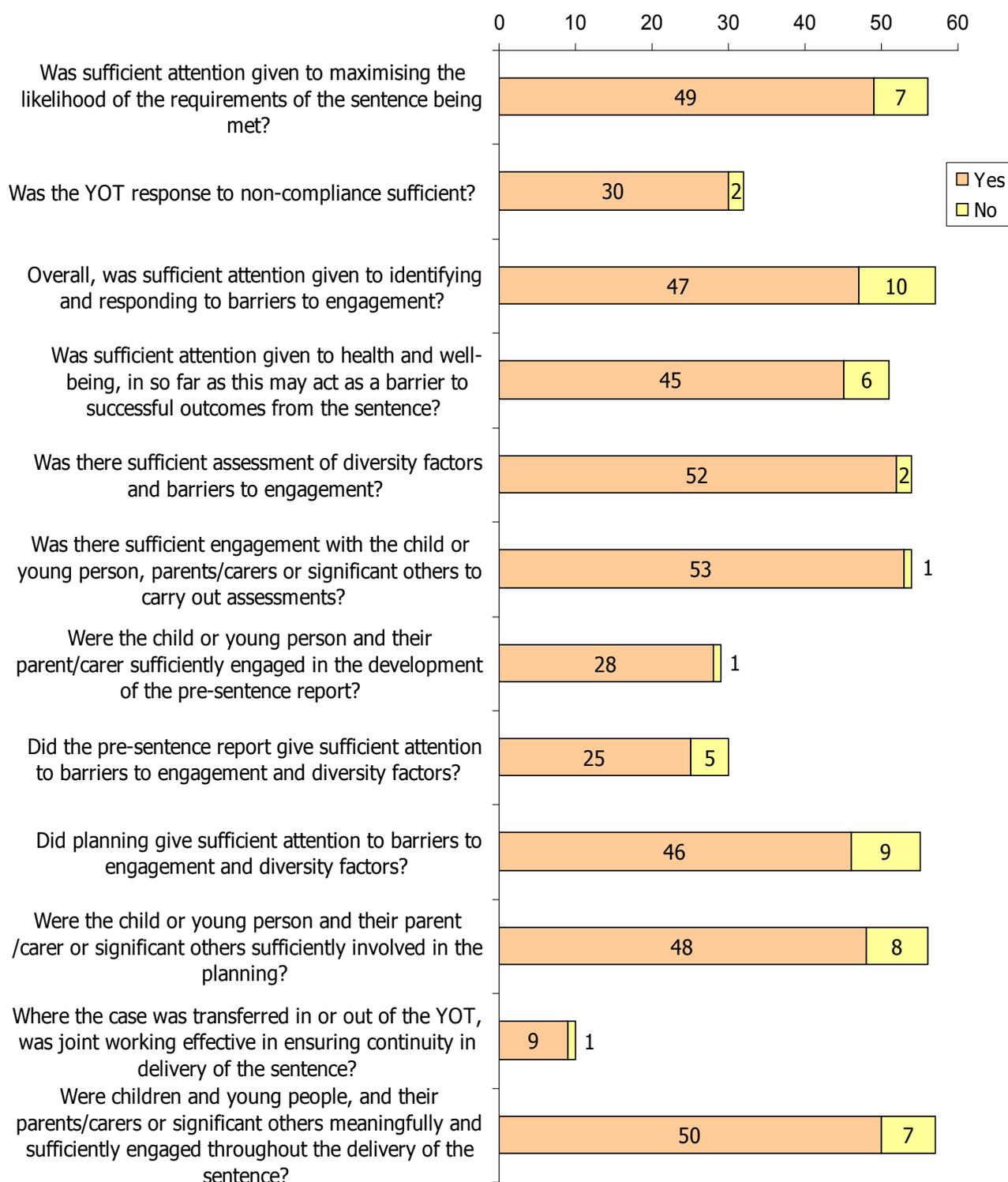
*"[YOS worker] keeps in regular contact with my mum to keep her up to date with what's going on and that. She texts her or rings her and sometimes my mum comes to meetings with me. I don't mind it to be honest, it keeps me right."*

*"I couldn't stick with my order and kept going back to court for breach but now obviously I am sticking with it especially over the past three months cause I don't want to go to jail and I have a baby on the way."*

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 57 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



# **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. The YOS had a stable, competent and committed workforce.
2. Quality assurance processes were strong but could become more outcome-focused.
3. The Board had acted swiftly to appoint an interim Head of Service in response to a vacancy.
4. Key agencies had not been represented at the Management Board for some time.
5. The Board had not responded quickly enough to a sharp rise in reoffending rates.
6. The Board had insufficient oversight of the YOS's safeguarding practice.
7. Health representation in the YOS was reducing and the partnership response appeared weak.

## Explanation of findings

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

- 1.1. A YOS Management Board was in place and met quarterly. There had, however, been a number of gaps in representation in the previous year, notably from the health sector and ETE. We were pleased to hear that suitable representation from ETE had recently been agreed by the Board.
- 1.2. The YOS Board did not have sufficient oversight of the effectiveness of the ETE support offered to children and young people. During the period when there had been no education representative, the Board received no performance information on how well children and young people were supported into ETE. Previous performance information that the Board did receive was too limited in its scope and failed to provide a sufficient insight into the effectiveness of the work around ETE. We found no evidence that ETE matters were aired in any meaningful way at Board level.
- 1.3. There had been a recent significant rise in the reoffending rate spanning a number of reporting quarters. Reoffending panels were an encouraging practice response, however, there was little evidence of the Management Board taking action to understand the reasons for the increase or identify broader partnership strategies for reducing reoffending.
- 1.4. There had been insufficient attention to safeguarding at a strategic level. There were some references to safeguarding issues in Management Board minutes but the Board has not been provided with data or audit results on YOS safeguarding work. The YOS's 2015/2016 action plan made little reference to safeguarding issues in the priority areas for developing practice.
- 1.5. There has been no regular attendance of the YOS Management Board by health sector members senior enough to make decisions about service provision. Limited performance data had been received by the Board from the YOS. There was little outcome data available to be viewed and no health needs assessment had been carried out. It was, therefore, not possible for the YOS to determine what services were needed and in what capacity. Without this the Management Board were unsighted about health provision and performance.

## **2. Partnerships – effective partnerships make a positive difference**

- 2.1. We found a mixed picture in relation to partnership working in Staffordshire. There were good working relationships between the local authority and police. The partnership arrangements with the health sector were less effective. Health commissioners and providers were unclear as to the arrangements for funding the YOS health posts. As a result, two seconded health staff had recently left the service and at the time of the inspection there was no plan to replace them. As a consequence there were no physical health specialist staff in the YOS.
- 2.2. The health landscape in Staffordshire was complex with several commissioning bodies and providers operating across the local authority area. A mental health nurse was based full-time in the YOS in the north of the county. In addition, Midland Psychology provided staff for Ten-19, who were commissioned by Staffordshire County Council to provide a mental health and therapeutic support service for children and young people engaged with the YOS. There was co-location of these services in each sub-office at least once a week with a consultant forensic psychologist and two clinicians. The case manager focus group were very positive about the work of the mental health nurse and Ten-19, stating they were visible and available for consultation and discussion about cases.
- 2.3. Although there was no ETE representation on the YOS Management Board, and management information was very limited, practitioners told us that they had access to a good range of ETE providers who were able to meet the needs of children and young people referred by the YOS. This was supported by our findings from the inspection.
- 2.4. There were good links between the YOS and children's services. The Head of the YOS was a member of the Local Safeguarding Children Board and the YOS was also represented on a number of Local Safeguarding Children Board sub-groups. The YOS was well integrated into the range of Children's Social Care services. It was an integral part of Specialist Safeguarding Services and the manager reported directly to the strategic lead. The head of the YOS also attended many strategic and operational groups including MAPPA, missing panels and building resilient families.

### **Example of notable practice**

**P**Peak Pursuits is an outdoor education based provider which uses a mix of outdoor activities, social skill practice, one-to-one intensive support and academic work. John clearly engaged with the provision and gained significant benefit in terms of personal and social skills. The work was closely linked to YOS plans and there was good communication with all agencies.

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

- 3.1. A long serving Head of Service retired very shortly before the inspection fieldwork commenced. We were pleased to see that the partnership had moved quickly to appoint an experienced Head of Service in an interim role, leaving no gap in the strategic management of the service.
- 3.2. The YOS had a relatively stable workforce and most staff displayed commitment, skills and knowledge. They also demonstrated an understanding of the principles and key YOS policies in relation to effective practice, managing risk of harm and managing vulnerability.
- 3.3. There were robust quality assurance systems in place at an operational level and all key case documents appeared to be subject to a quality assurance process. Much of the quality assurance activity related to youth justice processes and there was a need for the YOS to become more outcome-focused in its approach to quality assurance.

- 3.4. All case managing staff were satisfied that their line manager had the skills to assess, support and actively help them improve their work.
- 3.5. The YOS police officers were valued and well regarded by peer colleagues and managers. They were co-located and fully integrated into the service.
- 3.6. The YOS had seen a significant rise in reoffending rates in the months prior to the inspection taking place. Reoffending panels were a good response but most practitioners we spoke to were unaware of the rise in reoffending rates.

**Quote from a carer:**

*"All the workers that we've had contact with have all been really committed, or have come across as being really committed to trying to get the kids back on a decent path."*

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

- 4.1. We judged that staff were mostly sufficiently trained to do their jobs. Some training that had previously been delivered needed to be updated. This was evident in speech, language and communication work, and also MAPPA. Staff informed us that training in child sexual exploitation and domestic abuse had been comprehensive and invaluable.
- 4.2. Practitioner staff told us that they were expected to deliver Tier 2<sup>3</sup> substance misuse assessments and interventions, although some felt that they were insufficiently trained for this type of work.
- 4.3. The YOS had a Youth Justice Plan which contained a small number of learning related actions and there was also a separate training plan.
- 4.4. A Management Board newsletter was produced after each Board meeting and circulated to all staff informing them of the issues discussed. We were disappointed to find that few staff actually read it. While it was clearly good practice to keep staff informed, a more accessible approach to communication was needed.

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<sup>3</sup> Tier 2- targeted prevention and early intervention with children and young people who are using substances.

# **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 83% of work using interventions to reduce reoffending was done well enough.

## Key Findings

1. Practitioners were skilled in the delivery of interventions.
2. Staff generally had access to a wide range of interventions.
3. Work with children and young people was reviewed and updated as required.
4. Managers observed practice and fed back to their staff on the quality of work being delivered.
5. Health related interventions were delivered inconsistently across the service.
6. There was limited understanding of outcomes achieved through the delivery of interventions.

## Explanation of findings

1. We observed nine interventions with children and young people which included a combination of one-to-one and group work sessions, reparation and risk panels. All of the interventions observed were delivered to a consistently high standard.
2. The intervention, delivered by the YOS, was consistent with the reasons for offending identified in the assessment and consequent plan in most cases we inspected. There were, however, a small number of cases where either no intervention had been delivered or it was unclear to the inspector what had been delivered.
3. The YOS reviewed the interventions as the case progressed and we saw evidence of this taking place in most of the cases examined. Interventions were adjusted to take account of developments in the case.
4. Most interventions that were delivered effectively addressed both risk of harm and the child or young person's vulnerability.
5. Many of the children and young people supervised by Staffordshire YOS were in care and we saw evidence of good communication between YOS staff and care staff when interventions were being delivered. This was particularly important where the intervention touched on sensitive issues which could have triggered challenging behaviour from the child or young person.
6. A wide range of interventions were used, however, some staff told us that interventions were not well catalogued and were in need of updating. Some staff undertook internet searches to find resources to be used with children and young people. There was no process for quality assuring the material obtained in this way.

7. Children and young people were actively engaged in the sessions we observed. These sessions were well planned and engaged the children and young people effectively.
8. We were pleased to hear from staff that managers regularly observed their practice. This was confirmed by children and young people whose sessions we observed, who told us they were used to having observers in the room during their sessions with YOS staff.
9. There was a mixed picture in relation to interventions to improve health outcomes. A young people's health group was delivered in Newcastle-under-Lyme which provided valuable information and advice on a range of health issues, however, this resource was not available in other areas of the county.
10. Practitioners informed us that they were expected to deliver basic substance misuse advice to children and young people although they did not feel adequately trained for the role. Children and young people with more serious substance misuse behaviour were referred to T3. There was limited evidence of the effectiveness of these arrangements recorded on the case files examined during the inspection.
11. There was little information available overall on the effectiveness of interventions and to what extent desired outcomes were being achieved.

### Examples of notable practice

Kevin was given a six month referral order for possession of an air rifle in a public place and possession of cannabis. The case manager, although delivering most of the interventions, drew upon the skills of others within the team to carry out specific pieces of work. The YOS police officer worked with Kevin to look at the effect gun crime has on communities, the YOS probation officer did work helping this young person to understand law in relation to possession of guns and other weapons and another YOS worker, who had worked in a prison, worked through the reality of spending time in prison. This was a good example of the impact the multi-agency YOS can have on challenging offending behaviour and attitudes and reducing offending.

An inspector observed a groupwork session with four children and young people, identified either through their index offence or intelligence shared with the police, as being involved in gang activity. They were taken through a series of scenarios outlining the negative impact of gangs on children and young people's lives. They also discussed strategies for extricating themselves from gang affiliations. The intervention was skilfully delivered and covered a number of sensitive issues for the children and young people. The inspector judged that the session had a positive impact on the children and young people.

An inspector observed a session held as part of the health groupwork programme. The programme is delivered by the YOS seconded nurse together with a YOS support worker. Four boys attended and topics covered on this occasion were exercise, diet and personal hygiene. The boys took the opportunity to ask about other health related issues which, although due to be discussed at a future meeting, were addressed by group leaders. All of the boys appeared to find the intervention beneficial and the inspector judged that the intervention was likely to assist in the desistance journey from offending.

# Appendices

# Appendix 1 - Background to the inspection

## Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work, predominantly in statutory community and custodial cases, in a small number of local authority areas each year.

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on reoffending rates, National Youth Justice Outcome Indicators and supported by other information, such as recent inspections – is of significant concern. Periodically, we also include high performing areas to establish a benchmark of good practice.

The primary purpose of the youth justice system is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, 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:

29 February 2016 and 14 March 2016

In the first fieldwork week we looked at a representative sample of 57 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 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](http://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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