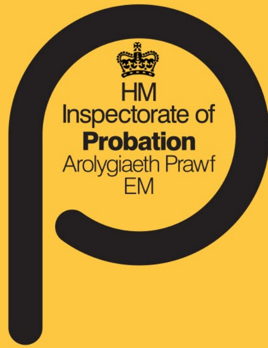


Full Joint Inspection of Youth Offending Work in **Newcastle**

An inspection led by HMI Probation

independent inspection of youth offending work

July 2016

Foreword

This inspection of youth offending work in Newcastle is one of a small number of full joint inspections that we do annually with colleagues from the criminal justice, social care, health and learning and skills inspectorates. We chose to inspect in Newcastle primarily because it seemed, from published data and our own trend analysis, that performance there was deteriorating.

Newcastle Youth Offending Team (YOT) was delivering satisfactory work with children and young people. The YOT had committed and tenacious case managers and specialist staff. Some good work was being done by individual case managers and other staff to reduce reoffending, protect the public and safeguard children and young people. Children and young people were well engaged and compliance work was carried out efficiently. Effective operational partnership arrangements had evolved and were working well in individual cases.

Governance and leadership at Partnership Board level was unsatisfactory with an absence of effective and accountable statutory partnerships driving the work of the YOT. This was characterised by the non-attendance at Board meetings of key partners, inadequate data analysis and no evidence of scrutiny, challenge or joint problem solving. The Board did not have enough impact on the operational work of the YOT. Better outcomes could have been achieved through greater strategic ownership holding the YOT and its partners to account and focusing on the specific needs of children and young people who have offended.

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

Dame Glenys Stacey
HM Chief Inspector of Probation
July 2016

Key judgements

Summary

Reducing reoffending

Overall work to reduce reoffending was unsatisfactory. Assessment of the factors leading children and young people to offend was largely carried out well. There was some good quality planning and interventions by individual case managers. Planning overall, however, was not cohesive enough and interventions did not always follow from either the assessment or the plan. A lack of appropriate and sufficient education, training and employment was a significant barrier to the YOT's impact on reducing reoffending.

Protecting the public

Overall work to protect the public and actual or potential victims was satisfactory. We found some good work to protect the public by case managers demonstrating strong assessments, planning and interventions. As with planning for work to reduce reoffending, however, plans were not always meaningful and measurable to the child or young person. This was a missed opportunity which meant that interventions to address risk of harm did not always address the specific risks posed. Risk of harm work was not reviewed in every case where a change in circumstances meant that it should have been.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was satisfactory. YOT staff understood what made children and young people vulnerable; either through their own actions or those of other people. We saw some effective safeguarding work by individual case managers, including where complex vulnerability had been recognised and supportive action taken to address it. Case managers contributed to children's social care services safeguarding meetings.

Making sure the sentence is served

Overall work to make sure the sentence was served was satisfactory. The YOT made consistently good efforts to understand and respond to barriers to engagement. Compliance work was carried out effectively with some excellent examples of professional discretion to manage a sentence as a whole and promote engagement. There was very good engagement with parents/carers at the pre-sentence report, assessment and planning stages but this needed to improve during delivery of sentences.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was unsatisfactory. The YOT was delivering satisfactory operational work to children and young people. We saw committed individuals but there was a lack of strategic ownership at Partnership Board level to drive, challenge and support the YOT to improve service delivery.

Interventions to reduce reoffending

Overall, the effectiveness of interventions to reduce reoffending was unsatisfactory. Some of the interventions available to children and young people were of a good quality. The victim's perspective was a consistent feature. The impact of interventions would be strengthened if they were used more rigorously and were more appropriate to individual need. Interventions were not sufficiently evaluated, meaning that the YOT was not clear about what work was having the greatest impact.

Recommendations

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

The local authority Chief Executive should make sure that:

1. the composition and activity of the YOT Partnership Board results in all partners contributing to, and being accountable for, the reduction in reoffending rates, the management of risk of harm and the protection of vulnerable children and young people who have offended.

The YOT Head of Service should make sure that:

2. children and young people, and their parents/carers, are fully involved in the assessment, planning, delivery and review of their cases
3. interventions address the areas identified in assessment and planning and are effectively evaluated
4. management oversight is consistent and effective resulting in all case management work being conducted to a good standard, including the delivery of interventions and review of work
5. Multi-Agency Public Protection Arrangements eligibility across the YOT caseload is reviewed and referrals made where appropriate
6. there are up to date service level agreements in place between health partnerships and the YOT
7. staff training needs are audited and met in line with business needs.

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

Contents

Foreword 1

Key judgements 2

Summary 2

Recommendations 3

Theme 1: Reducing reoffending 6

Theme 2: Protecting the Public 11

Theme 3: Protecting the child or young person 15

Theme 4: Making sure the sentence is served 20

Theme 5: Governance and partnerships 24

Theme 6: Interventions to reduce reoffending 29

Appendix 1 - Background to the inspection 33

Appendix 2 - Acknowledgements 35

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 61% of work to reduce reoffending was done well enough.

Key Findings

1. There was some excellent work carried out by individual case managers.
2. Assessments of the likelihood of reoffending was done well enough in most cases.
3. Planning for work to help children and young people stop offending was not done consistently well.
4. Interventions delivered did not always match the needs identified in the assessment and plan.
5. Reviews of work to reduce reoffending were usually undertaken when required.
6. Education, training and employment (ETE) provision lacked senior leadership.
7. Insufficient work to reduce reoffending was undertaken during the custodial phase.
8. Restorative justice interventions were excellent.

Explanation of findings

1. Pre-sentence reports (PSRs) were of a good quality and report authors were effective in advising the court. Sentencers described the reports as providing them with sound advice, enabling their understanding of a child or young person and guiding sentencing decisions. We did, however, see a small number of lengthy and descriptive reports which lacked analysis and insight.
2. Good assessment of the reasons for offending underpins a YOT's ability to carry out effective work with children and young people who have offended. In Newcastle, we saw comprehensive, analytical assessments carried out by case managers who demonstrated a good understanding of the reasons for a child or young person's offending. Assessments showed a balance between risks of reoffending and protective factors in children and young people's lives and parents/carers were well engaged in the assessment process.
3. The YOT used a health screening tool for all children and young people at the point of arrest. Case managers reported, however, that they did not feel confident in assessing health needs. This meant that the health needs of children and young people could not always be identified. This can have a significant impact on offending behaviour and the ability to engage with a statutory order.
4. The quality of planning was not as good as the quality of assessment. Planning for work to help children and young people stop offending was not done consistently well enough. We saw a number of plans that did not relate to assessed needs or did not include measurable targets. Authors had not fully engaged with children and young people and their parents/carers in the development of the plan. This lack of children and young people's understanding of their intervention plans limited the opportunity to impact on reducing reoffending.

Comments from children and young people

"I've never been asked, they just tell me what to do and when and where to be all the time."

"I think they did ask how I felt about stuff and that but I don't know if they would have changed anything like."

Comment from a parent

"Well not really, they explained it all and explained what he would have to do but I didn't really get involved, they know what he has to do."

5. We saw some thorough and timely reviews in individual cases but there were also too many instances where reviews should have been triggered by a change in circumstances and were not. This was a missed opportunity to evaluate and assess progress made, to reinforce positive achievements and to build motivation and aspiration.

6. Despite the considerable tenacity and commitment of YOT staff, access to ETE provision was poor and this acted as a significant barrier to positively impacting on the reoffending behaviour of children and young people. For the period 2014/2015, only 56.8% of children and young people working with the YOT were in full-time ETE. City-wide issues, such as: poor school attendance and low achievement for the most vulnerable children and young people, the lack of relevant entry level training and vocational employment opportunities for post-16 year olds hampered the YOT's progress in improving outcomes.

Example of notable practice

Ethan expressed an interest in learning to be a chef. The case manager demonstrated tenacity, and creativity in finding him a single day's taster which went so well that Ethan was offered a training placement at the restaurant. He subsequently became employed by the restaurant and worked long shifts over Christmas and the New Year, despite being very concerned about his upcoming matter in the Crown Court. Ethan went on to complete an NVQ.

7. In addition, basic literacy and numeracy assessments were no longer undertaken within the YOT. This meant that, too often, information about a childs or young person's academic ability and learning needs was difficult to ascertain quickly enough; particularly, and not unusually, when they had been out of education for substantial periods of time. The consequence of this in reducing reoffending was immediate in terms of meaningful occupation of children and young people's time and we noted that many offences were committed during school/training hours.

8. There is also of course the longer-term impact on reducing reoffending for children and young people who are not in appropriate education provision. Alternative provision for school-aged children covered a broad range of activities but further work needed to be done by the local authority to make sure that the quality of this provision was consistently good and was meeting the educational needs of those attending. Some of these placements did not meet the requirement of 25 hours of education per week, and often this was by a very wide margin. In the interim, YOT practitioners and the education specialist were actively checking these placements and making sure children and young people were safe and attending regularly.

Comment from a young person

"I'm still in school about to start my exams and they support me with that, they have contact with my school and they always ask how things are going with my school work."

Comment from a parent

"They've helped to turn him around really, all the courses and practical stuff they've involved him in has kept him out of trouble, it's given him something else to do instead of hanging round the street corners, it's also given him a sense of responsibility. He's talking now about getting a proper job and what he'd like to do. He's hardly seen any of his old friends since he started with [the] YOS, in fact he's started to make new friends now."

9. We saw some excellent restorative justice interventions. These were appropriate, well developed, meaningful and valued by victims. This is a significant area of expertise that the YOT has developed and should be commended for.

Comments from victims

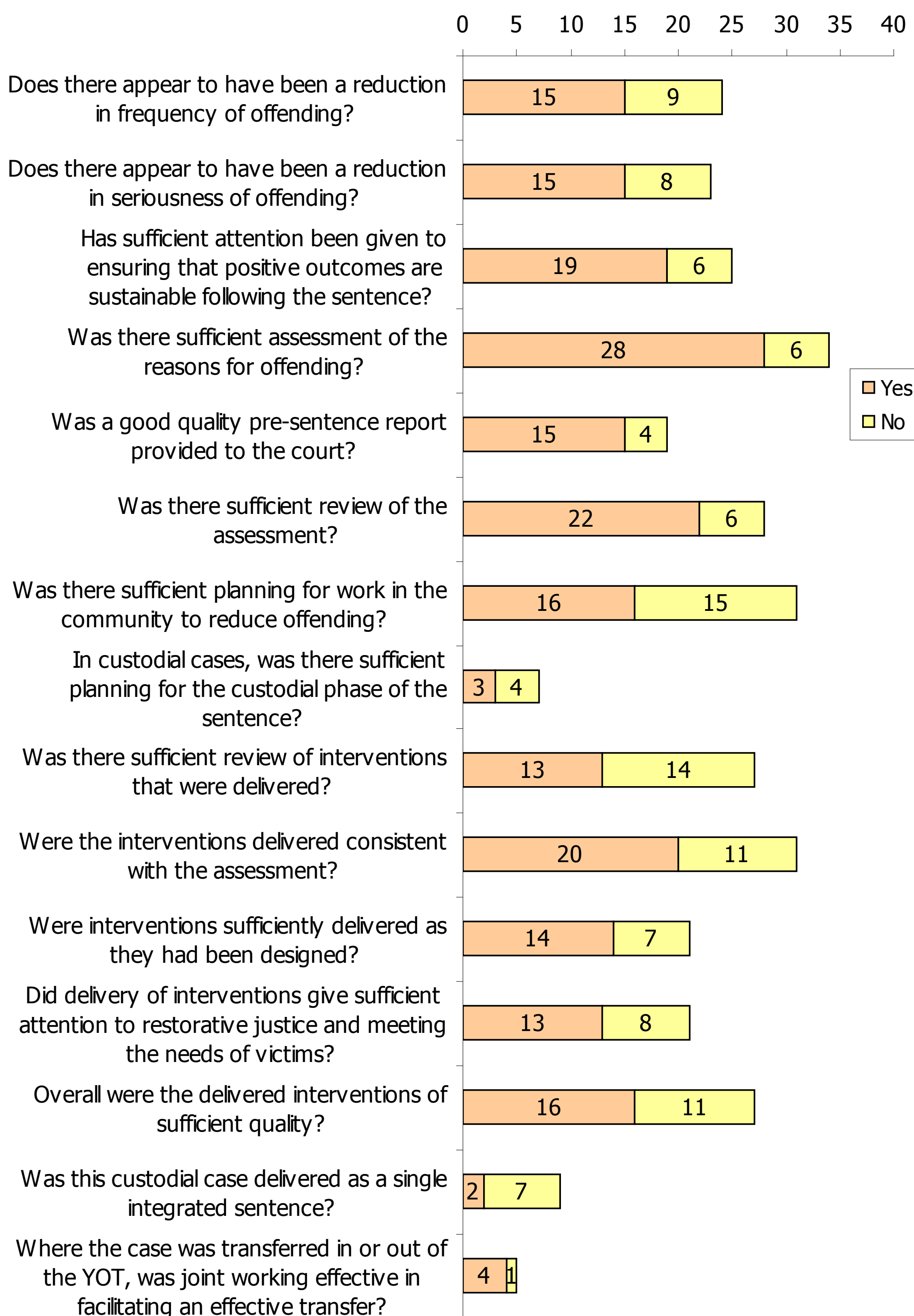
"I think they have offered lots of support to try and help to keep him out of trouble."

"Yes, and that's another thing that surprised me really, I didn't expect to be informed of what work they actually intended to do with him, but again I've found it good to be kept informed."

"They seem to offer as much support as possible and even though he is banged up at the minute, they have plans in place for when he gets out, they organised me going to see him and they seem to be doing a sterling job as far as I'm concerned."

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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

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 66% of work to protect the public was done well enough.

Key Findings

1. PSRs contained a thorough explanation of the risk of harm to others in the majority of cases.
2. Assessment of the risk of harm to others was done well enough in most cases.
3. Planning to manage the risk of harm posed to others was insufficient in almost half of the inspected cases.
4. Risk of harm to others work was not always reviewed as it should have been, for example, due to a change in circumstances.
5. Interventions to address the risk of harm to others did not always address the risks posed.
6. We found some good work to protect the public by individual case managers.
7. Management oversight of this area of work was not effective in over half of the cases.

Explanation of findings

1. The majority of PSRs contained a clear and through assessment of the risk of harm to others. To protect actual and potential victims and the wider public, the YOT should first assess what the child or young person might do, in what circumstances and when, who the victim might be and what might trigger the event. We saw a sufficient assessment of the risk of harm to others in three-quarters of cases.
2. Once an assessment has been completed, the task of the YOT is to work with the child or young person to devise a plan to prevent the circumstances or triggers occurring. In both community and custodial cases, we judged plans to be sufficient in around half of the cases that we saw. Where plans were insufficient, this was because the planned response to managing the risk of harm to others was unclear or did not meet the assessed needs.

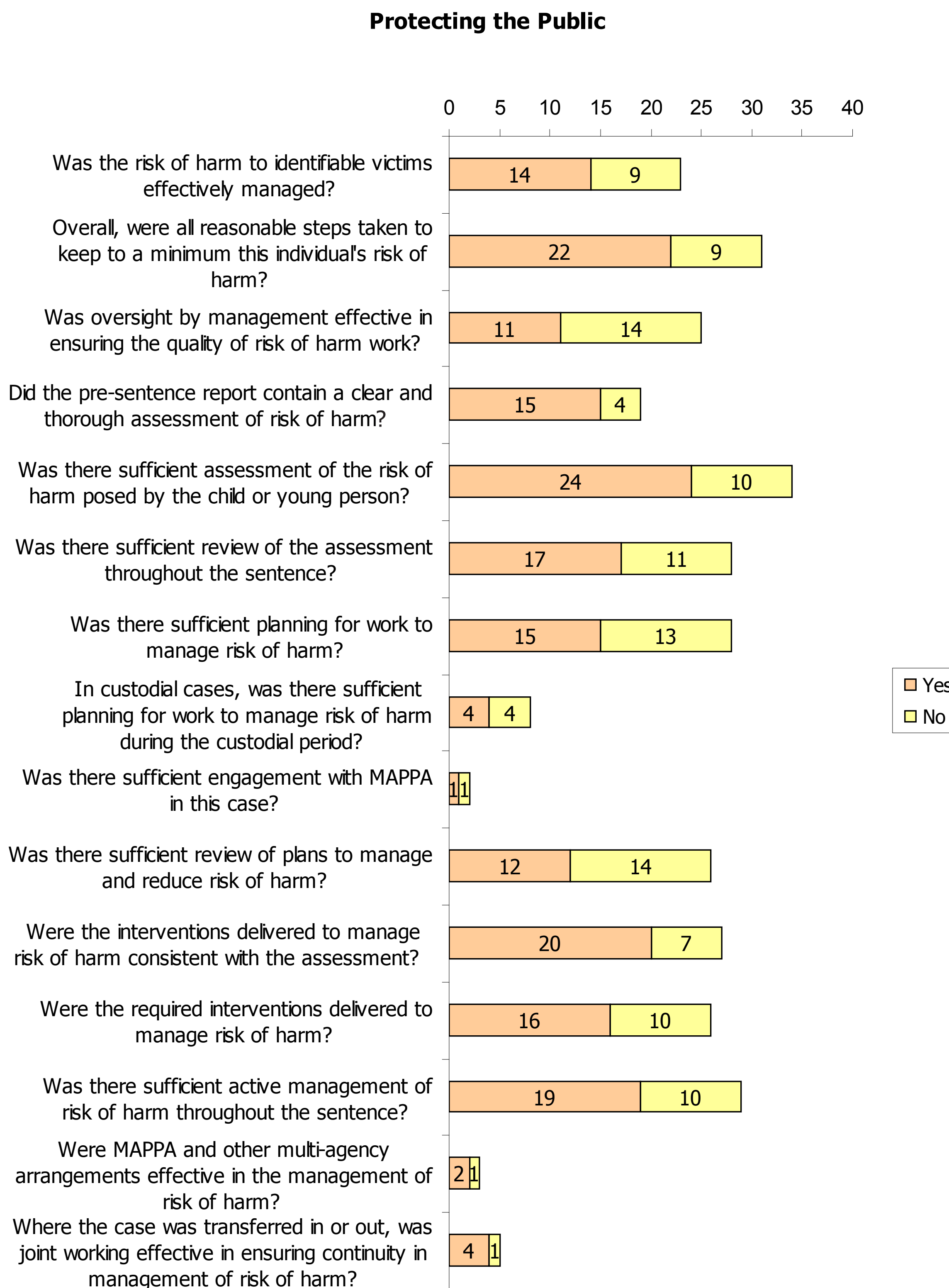
Example of notable practice

Phillip was very difficult to engage. Initial steps in terms of planning (such as for the initial panel meeting) were timely, but the effectiveness of the YOT response lessened over time. This appeared to be linked to the number of issues facing Phillip and the case manager's over willingness to give him the benefit of the doubt. The case manager demonstrated a loss of focus with regard to the sentence being served and meant that factors related to the risk of reoffending were not addressed. This was coupled with a lack of review of assessments and plans throughout the sentence, including when Philip committed a new violent offence.

3. There was a sufficient review of plans to manage the risk of harm to others in just under half of the cases where it was needed. In some cases, the review did not include new information and, in others, a review had not taken place in response to a change in circumstances.
4. In order to reduce the risk of harm to others, interventions delivered to children and young people must be consistent with their assessed need. We saw this in the majority of inspected cases.
5. Effective work with the police is vital to reducing the risk of harm to others and must be underpinned by good information sharing processes. In Newcastle, there was some evidence of information being shared by the police but this was neither systematic nor consistent. Much information was transferred verbally with an expectation that the YOT case manager updated the case management system. This approach was not rigorous enough.
6. There was no process on the police intelligence system to identify information about children and young people on the YOT caseload. Officers were not, therefore, drawn to important information on the police system. In one case, information known to police that a young person on the YOT caseload was alleged to have committed a rape was not shared with the case manager. There was some evidence that information from the YOT found its way back onto the police systems but, again, this was limited and not done systematically. In one case, information from the mother of one young person, detailing the fact that the young person had been the victim of an assault requiring 25 stitches to his face, was not passed to the police.
7. There has been a recent Multi-Agency Public Protection Arrangements (MAPPA) awareness raising session but, prior to this, training had not been provided for some time. It was not clear how many members of staff were due for refresher training or were in fact untrained. We were, therefore, concerned that MAPPA referrals were not being appropriately made. Indeed, in one case we looked at, a MAPPA referral was not made when it should have been and later a case manager asked for a MAPPA referral to be made when the case did not fit the criteria.
8. There was no coordinated multi-agency approach to the offending of the most prolific children and young people. Case managers did notify the police when a child or young person’s level of offending was so prevalent that they were categorised as being in the Newcastle Deter Young Offender cohort. The Deter Young Offender scheme is designed to identify prolific offenders and trigger activity by partners to work together to reduce reoffending. This categorisation, however, did not seem to generate any additional activity from a police or multi-agency perspective.
9. The apparent lack of strategic and partnership focus for the most prolific children and young people who have offended may help to explain high reoffending rates. The police had recently introduced a form of Integrated Offender Management for some adult offenders, although this was not available for children and young people. It would be of benefit for the YOT Partnership Board to examine whether this approach could be extended to some of the children and young people on the YOT caseload.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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

3

Theme 3: Protecting the child or young person

What we expect to see

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

Case assessment score

Within the case assessment, overall 64% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. PSRs did not sufficiently address vulnerability in all inspected cases.
2. Planning to address vulnerability at the start of the sentence was only good enough in half of the inspected cases.
3. Reviews were not always undertaken in response to changes in circumstances.
4. Work to address safeguarding and vulnerability in custodial cases was inconsistent.
5. Interventions to manage safeguarding and vulnerability were consistent with the assessed need.
6. Transfer to other YOT services was consistently good and was well managed.
7. Access to specialist or universal services was not always available.
8. Case managers contributed to children's social care services safeguarding meetings.
9. There was some good safeguarding work by individual case managers.

Explanation of findings

1. We found some good safeguarding work by individual case managers and we saw cases where complex vulnerability issues had been recognised with supportive action taken to address it. Case managers contributed to multi-agency safeguarding meetings. Planning to address vulnerability at the start of a sentence, however, was mixed, and not always effectively recorded. Reviews were also not always undertaken in response to changes in circumstances.
2. Work to address safeguarding and vulnerability in custodial cases was inconsistent. We saw examples where case managers had worked incredibly hard in challenging circumstances to make sure that children and young people were kept safe; but this was not evident across the board. Transfer to other YOT services was consistently good and was well managed. Case managers were proactive and effective in securing transfer arrangements.
3. YOT staff understood the threshold for referral to children's social care and there were positive relationships between the two services. This was supported by attendance at YOT meetings by a member of the Multi-Agency Safeguarding Hub. Team managers in the YOT attended quarterly meetings that included all children's social care managers. This was a useful forum to share information, resolve concerns and helped to reduce the risk of services working in silos.

4. Plans completed by YOT workers took into account the risks of harm children and young people posed to themselves and led to appropriate interventions in almost all relevant cases. YOT workers routinely contributed to planning for children and young people on Child Protection plans or who were Looked After, by submitting reports and attending conferences, core groups and reviews. This meant that plans took into account the wide range of safeguarding and vulnerability needs faced by children and young people.
5. Where children and young people became Looked After as result of being detained in custody, arrangements were in place for them to be allocated to a children's social care social worker within ten working days. An independent reviewing officer was appointed and reviews took place in a timely manner. YOT staff and managers had been proactive in identifying and pursuing safeguarding concerns in relation to children and young people placed in custody. These concerns were progressed appropriately.
6. Staff understood their safeguarding responsibilities and had an awareness of children and young people's vulnerabilities, including those arising from child sexual exploitation, going missing or substance misuse, including new psychoactive substances. Staff contributed to safety planning for children and young people where there was evidence of their vulnerability increasing. There was proof of communication between YOT and children's social care staff about individual children and young people. This was helped by the availability of Total View which pulled through information from the separate electronic systems used by children's social care and YOT staff. A single electronic system would, however, further strengthen information sharing.
7. YOT workers had been proactive in working in partnership with other agencies to identify emerging vulnerabilities. This had included a major child sexual exploitation investigation involving girls and also a complex case review relating to the financial, emotional and physical exploitation of boys.
8. We saw some good multi-agency work to keep children and young people safe. The YOT contributed to multi-agency complex abuse meetings which were used to identify individual vulnerable children and young people and perpetrators, as well as patterns and trends. These supported a coordinated response including criminal investigations and disruption activity.

Example of notable practice

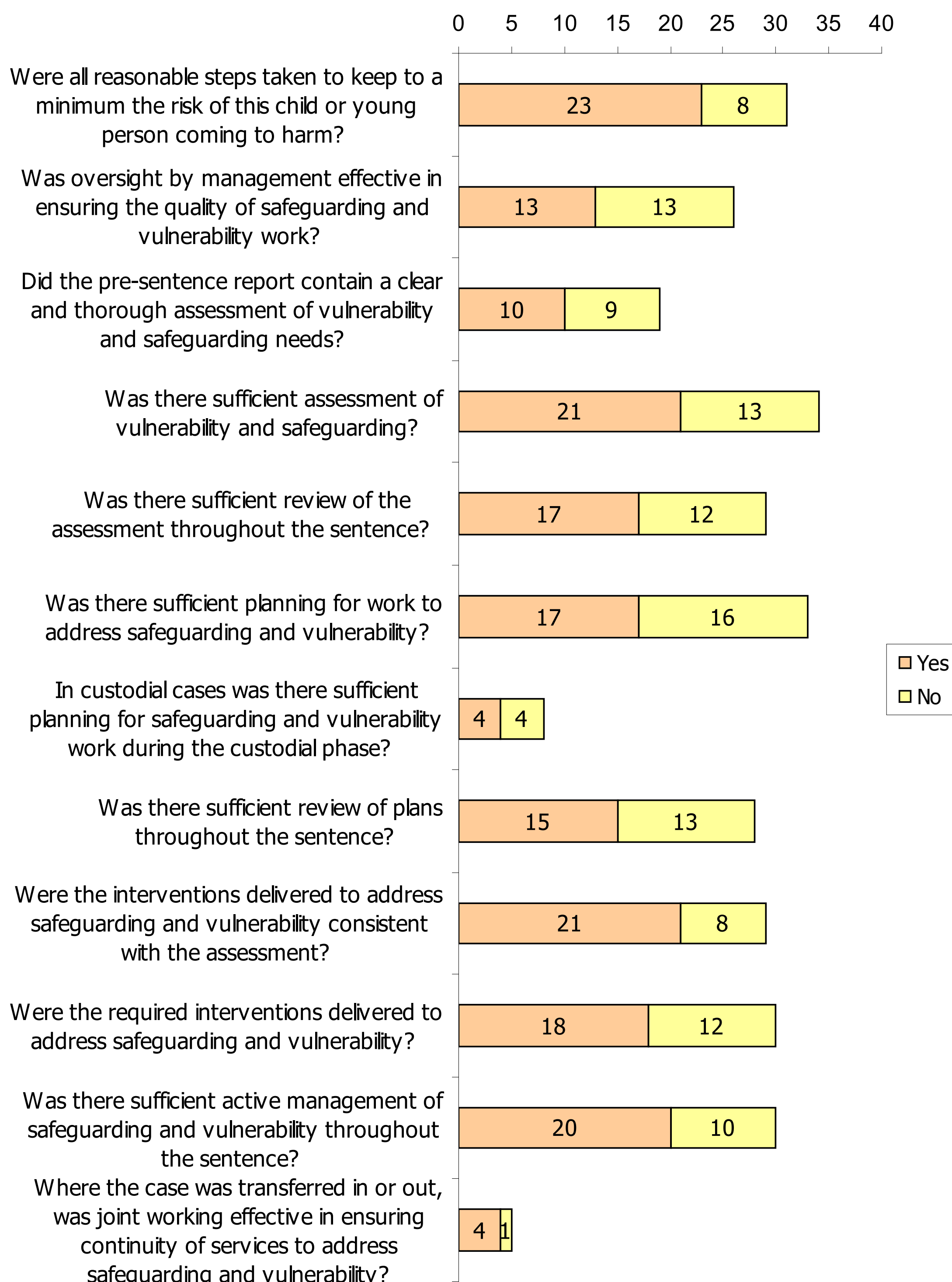
Bob's case showed some excellent holistic assessment, planning and delivery throughout his supervision period. This was a complex case and the case manager had put a high level of thought and analysis into her work. This was evident through consistent and thorough recording. Records indicated how the case manager was responsive to their audience and thought about the purpose of each assessment, report and piece of work. This showed an awareness of diversity and a purposeful approach to effective practice.

9. Performance management and quality assurance systems were underdeveloped. Managers did not have access to a suite of performance management data. For example, reports were not available in relation to data, such as: the number of referrals made to children's social care or their outcomes, the use of the escalation policy or attendance by YOT staff at Looked After reviews or Child Protection conferences. This limited the scrutiny of these activities and did not support robust monitoring of performance in these areas.
10. Links were in place between the YOT and the Local Safeguarding Children Board (LSCB), although the LSCB had not had a focus on the work of the YOT. It had not received data or results of audits which would allow it to scrutinise or challenge the work of the YOT. This was a gap that had been identified and plans were under development to make formal reports to the Board in future.

11. The YOT managers had contributed to the work of the YOT Partnership Board through sitting on sub-groups. A YOT safeguarding audit was completed annually and the outcome reported to the LSCB. This demonstrated the service's understanding of, and commitment to, making sure appropriate safeguarding standards were in place and that they were kept under review.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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

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 YOT will maximise the likelihood of successful outcomes by effective engagement with them and their families, responding to relevant diversity factors including paying attention to their health and well-being, and taking appropriate action if they do not comply.

Case assessment score

Within the case assessment, overall 74% of work to make sure the sentence was served was done well enough.

Key Findings

1. The YOT made good efforts to understand and respond to barriers to engagement.
2. There was excellent engagement with parent/carers at the PSR and planning stage but this needed to improve during delivery of the sentence.
3. Compliance work was carried out efficiently and we saw some excellent examples of the use of professional discretion to manage a sentence as a whole, and engage effectively with children and young people.
4. Plans were created for children and young people rather than with them. Too many of the children and young people did not understand their intervention plan.

Explanation of findings

1. The work of the YOT and its partner agencies will be limited if a child or young person is not motivated to stop offending. The case manager must, therefore, engage and involve both children and young people and their parents/carers if work to reduce reoffending is to be effective. This cannot be done without first recognising the individual needs of the child or young person, and of their parents/carers, and then responding accordingly. Good engagement requires clear communication, good quality assessment and planning and an active consideration of individual needs.
2. The YOT made consistently good efforts to understand and respond to barriers to engagement at all stages of their work with children and young people. We saw an appropriate balance between work to address reoffending, risk of harm and vulnerability in most cases. In three-quarters of assessments, sufficient attention was given to identifying and responding to barriers to engagement.

> **Comment from a young person**
>
> *"Aye she actually asks you stuff like what's happening like in your life every day. You know what I mean? How've you been, what's your weekend been like? Anything like that. Or if she can help you out she'll help you. It's just giving that bit of support and that. You know what I mean?"*

3. There was excellent engagement with parents/carers at the PSR and assessment stages with appropriate engagement in almost all cases. Engagement was not as strong in the planning stages

and also needed to improve during the delivery of orders. Effective engagement with parents/carers can be a significant additional factor in the success of the work delivered by the YOT and provides an opportunity for the YOT's work to be reinforced.

Comment from a young person

"It's good that my caseworker talks to my family I like them to be involved, my mam would want to be involved anyway, so she would probably get in touch with my caseworker herself."

4. In a number of instances, plans had been created by case managers and then had to be explained, meaning that not all plans were understandable or meaningful to children and young people. In just under one-third of cases, we judged that the child or young person and their parents/carers had not been involved in the planning.
5. Sufficient efforts had been made to understand why a child or young person had offended and, therefore, what might have helped to stop them offending in the future in over three-quarters of cases. In almost one-quarter of cases, the YOT's response to barriers to engagement was not good enough.
6. Reviews of the delivery of interventions were completed in three-quarters of relevant cases but these were not always of a sufficient quality. Where we did see reviews, more should have been done to address attitudes, motivation and barriers to engagement.
7. Compliance work, making sure that the child or young person carries out the sentence of the court, was delivered in a timely and appropriate fashion. We saw some excellent examples of the use of professional discretion to manage a sentence as a whole and to best engage with children and young people. Case managers demonstrated tenacity and commitment in delivering the sentences of the courts.

Example of notable practice

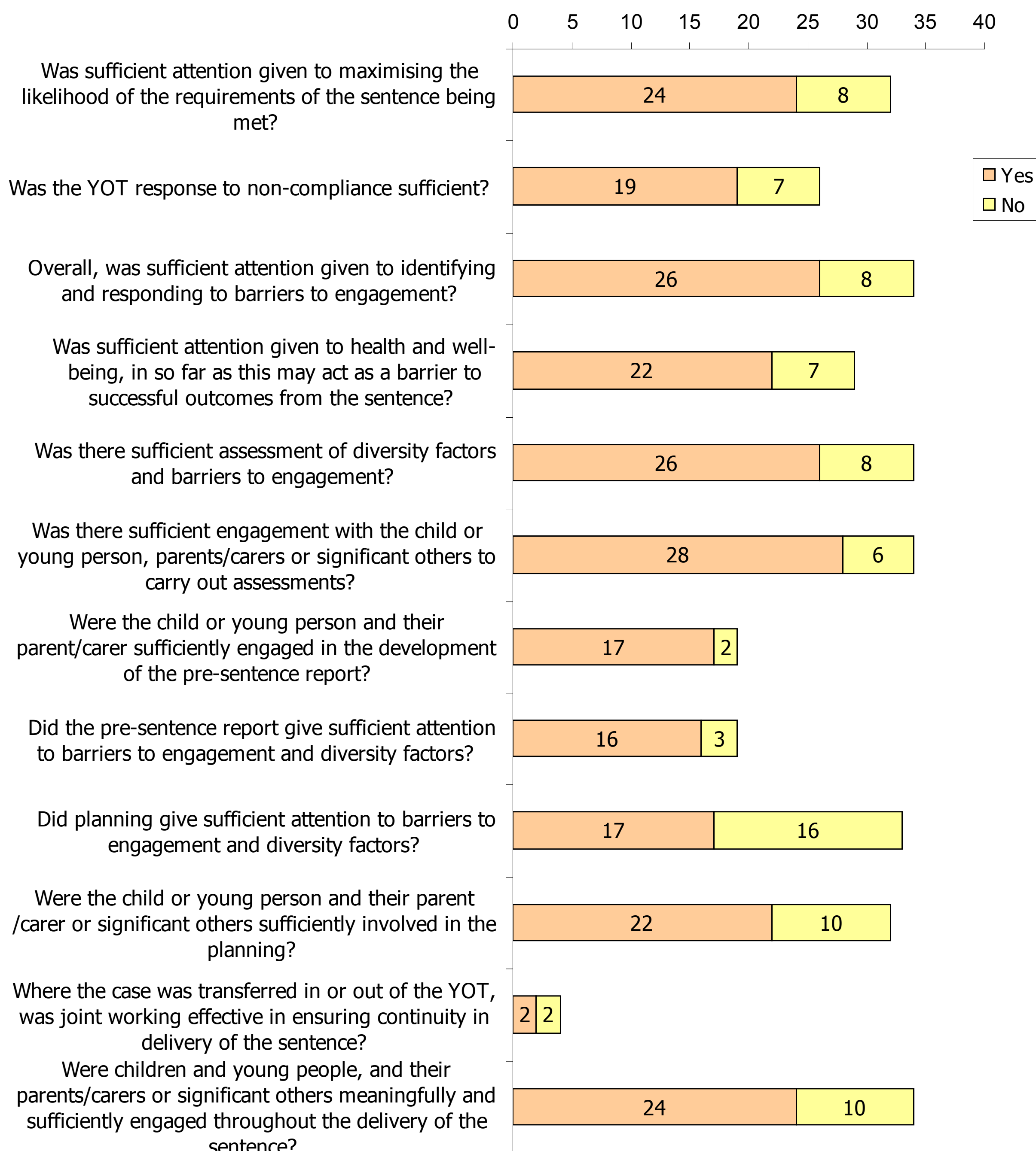
Paul was regularly coming to the attention of the police for antisocial behaviour and ultimately a referral order was imposed. The key underlying trigger to the offending was an anti-authoritarian and discriminatory attitude towards the police.

Paul and his family were under threat of eviction as a consequence of his behaviour.

The case manager's response was firm, fair and proactive. Upon Paul's refusal to sign his referral order he was returned to court. Just prior to the court date he attended the YOT office of his own accord, apologised to the case manager and said that he would sign the contract and work with the YOT. The court dealt with this by allowing the order to continue. The case manager and reparation worker had to overcome Paul's attitudinal and motivational issues through trying a variety of engagement strategies with Paul and his mother. Paul's response to the case manager's determination was incredibly positive with significant progress being made, including no further antisocial behaviour and he became more motivated and aspired to fulfil his goals.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 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 YOT to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

Key Findings

There were consistent and significant deficits at Partnership Board level from all five statutory partners.

1. Performance reporting was ineffective due to a lack of attendance and ownership from statutory partners.
2. We saw good examples of partnership working at case level.
3. The YOT enjoyed a partnership with the University of Northumbria which allowed for a rigorous and quick response to local issues.
4. Operational managers had the required level of knowledge and skills to assess and improve the quality of practice.
5. The YOT's quality assurance systems were largely process driven.
6. The learning culture of the YOT could be further developed by linking training to business need.

Explanation of findings

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

1.1. The YOT Partnership Board had met quarterly, although there were consistent and significant gaps in attendance from all five statutory partners. There was insufficient representation at the Board, either to make sure partners contributed to decisions or to provide any accountability. As a consequence, the Board was unable to either hold the YOT's statutory partners to account or make sure that they contributed to the delivery of effective youth justice outcomes.

1.2. We saw evidence of performance reporting to the Partnership Board but the absence of key partners blocked the impact of this reporting. The regular analyses provided by the YOT manager of local offending and offending related factors were not used by the Board to influence the appropriate commissioning and delivery of services. The Partnership Board agenda was largely determined by the YOT. There was no evidence of joint problem solving or planning. We did see examples of good partnership working at case level. Where cases had been escalated to the Partnership Board in order to facilitate access to services, however, this had not always been successful.

1.3. There was no membership of the Partnership Board by a statutory education lead and this had been acknowledged by the local authority as requiring a permanent and sustainable solution. The Secondary Head Forum representative attended regularly and was a strong advocate on the Board in terms of ETE matters but this did not replace the requirement for a senior statutory education lead.

1.4. ETE data reports and case studies were regularly tabled at quarterly Board meetings, providing important performance information and raising key issues and concerns about, for example, poor levels of engagement. There was, however, little evidence of positive actions taken as a result of

these issues being raised. In contrast, important strategic 'root and branch' reviews within the local authority of, for example, the pupil referral unit and the fair access panel, were already having some impact in making sure children and young people with the most complex and challenging needs were receiving more appropriately matched education placements.

1.5. The YOT Partnership Board had not scrutinised information about children and young people who were Looked After or subject to Child Protection plans. Only small numbers of Looked After Children were known to the YOT at the time of the inspection, however, the lack of data meant there had been no opportunity to identify developing themes or trends. Child sexual exploitation was not an agenda item at the Partnership Board and inclusion of this would have assisted members to focus on the most vulnerable children and young people.

1.6. There was an absence of data being requested or provided to the YOT Partnership Board about all areas of health. Some data was being collated about health interventions and outcomes, such as nationally required information on substance misuse, but this was neither specific to children and young people known to the YOT nor shared with the YOT Partnership Board. Information sharing is crucial if health contributions are to be appropriately scrutinised, leading to greater accountability and a credible health service for children and young people supervised by the YOT.

1.7. Police attendance at the YOT Partnership Board was poor and added little value. Police crime trend data was not presented to enable the group to understand and react to offending patterns and emerging trends.

1.8. A Youth Justice Plan was in place which aided the delivery of local and national youth justice objectives by identifying needs and setting priorities. In addition, the Board had done some work to analyse and improve the reoffending statistics. This was a positive and welcome move. The impact of this work will necessarily be limited, however, if the lack of engagement of partners and accountability are not addressed.

2. Partnerships – effective partnerships make a positive difference

2.1. Partnership work at an operational level was generally good. We found that operational partnership arrangements had evolved and there was a commitment to making sure children and young people had access to the necessary services. This work was not underpinned sufficiently by robust strategic arrangements across the statutory partnerships.

2.2. Communication between schools, the local college, training and employment providers and the YOT were mutually beneficial and effective for those children and young people participating regularly in ETE. Providers were highly complimentary about the work of the YOT, and the quality of support and information they received about children and young people. Safeguarding arrangements were prioritised in service level agreements and the YOT made sure that appropriate risk of harm assessments of the child or young person and the provision was completed prior to placements being agreed.

2.3. The recent re-introduction of the local authority's fair access panel to address attendance and behavioural issues across city schools was already accessing more appropriate placements for a small number of children and young people known to the YOT and this must continue to improve. In addition, significant improvements were being made at the pupil referral unit, with more robust systems for placement allocation, monitoring and recording attendance. The YOT's pre-16 specialist maintained a strong presence at the pupil referral unit; her work there was valued and contributed to the broader multi-agency work required for many of the children who attended.

2.4. Links were in place between the YOT and the LSCB, although the LSCB had not had a strong enough focus on the work of the YOT. It had not received data or results of audits which would allow it to scrutinise or challenge the work of the YOT. This was a gap that had been identified and plans are in development that will make formal reports available to the Board in future.

2.5. The YOT's managers have contributed to the work of the Partnership Board through their membership of sub-groups to the Board. A safeguarding audit is completed annually and the outcome reported to the LSCB. This demonstrated the YOT's understanding of, and commitment to, making sure that appropriate safeguarding standards were in place and reviewed.

2.6. The drug and alcohol service was part of the YOT's management structure with agreed referral pathways. There was no service level agreement in place between the YOT and the educational psychology service and no up to date service level agreement between the YOT and Child and Adolescent Mental Health Services (CAMHS). There have been meetings between the YOT and CAMHS and both recognised that these meetings need to be further developed. Without service level agreements it is difficult for partners to hold one another to account.

Comments from children and young people

"*Yes I've done stuff with my caseworker about the trouble I've been in and who I hang around with and the consequences of my actions.*"

"*To make us think I suppose, about like how what I do affects like other people, and so I didn't come back.*"

"*Av learnt about consequences and stuff and I didn't wanna end up in jail, a wanna get a job and stay outta jail.*"

2.7. There were two YOT police officers. Both were experienced officers, with one having an offender management background. The strategic lead, a Chief Inspector, was new in post having taken over five weeks before the inspection.

2.8. YOT police officers had good relationships with YOT case managers. The police officers, however, spent far too much time on administrative work, including servicing the out-of-court disposal function, which was not the best use of warranted police officers' time. As a result, we saw limited evidence of other relevant activity, such as joint visits to homes and prisons. This type of activity can add real value in achieving a reduction in reoffending.

2.9. The YOT has forged an impressive partnership with the University of Northumbria. This has been a key factor in evaluating some innovative practice as well as being the driving force responding to local issues; for example, through the whole city response to new psychoactive substances. The YOT actively contributes to a number of local multi-agency strategies to make sure they achieve successful outcomes for children and young people.

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

3.1. Workforce management is an important component of a well managed YOT. In Newcastle we found that team managers had the required level of knowledge and skills to assess and improve the quality of practice. Quality assurance and supervision was not always regular, but on the whole, staff valued the support that they received. The YOT's quality assurance systems were largely process driven and while this provides a level of reassurance to managers, there was scope for a greater focus on quality and consistency in order to maximise the impact of management oversight in individual cases. Performance management was in evidence but the links between this and a coherent training plan for the YOT should be further developed.

3.2. Staffing capacity to support the effective delivery of ETE outcomes was insufficient. The literacy and numeracy coordinator post had been time limited and ended several months before the inspection, and a second pre-16 ETE specialist post had also been taken out to achieve budget savings.

3.3. The two remaining education specialists were well established within the YOT, experienced in their fields and highly regarded by practitioners. Case managers worked closely with them to make sure programmes for children and young people receiving this provision were appropriate and regularly reviewed. ETE data about individual children and young people was robust. Informal verbal information sharing about ETE was common practice but it was not clear whether this was always being recorded systematically.

3.4. The CAMHS staff member in the YOT received regular clinical supervision from their Trust and health quality assurance audits were being further developed.

3.5. The YOT police officers did not routinely access Careworks (the YOT case management system) and there was a reluctance from YOT police officers to record information on Careworks. If YOT police officers could update information directly onto this system, this would allow case managers to see fuller and more timely information.

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

4.1. There was no evidence that the Partnership Board used performance data or other information, such as feedback from children and young people, to improve practice or outcomes. Nonetheless, we saw a commitment to innovation driven by the YOT and this was something of which the YOT was rightly proud.

4.2. Some, but not all case managers at the YOT, felt that they had been provided with sufficient training to enable them to do their job. There was a range of training available, although this was not always linked to staff's personal development plans. This meant that training was not always targeted to individual needs or refreshed as necessary. There was a learning culture in the YOT but this could have been better developed by a more cohesive approach, linking business needs and priority to the learning and development of YOT staff and managers.

4.3. The two ETE specialists received regular supervision, had undertaken mandatory training and could access further training as part of their professional development.

4.4. We saw that training of case managers on a variety of health topics over the last 12 months had taken place. This included foetal alcohol syndrome, attention deficit hyperactivity disorder and smoking cessation; not all of this was mandatory. This had helped to improve staff awareness of the health needs of children and young people. In addition, the drug and alcohol service ran bi-monthly briefings around new psychoactive substances for all staff from the local authority to attend. Case managers, however, reported that they did not feel sufficiently trained in assessing the health needs of children and young people.

4.5. The YOT police officers had not been appropriately trained. The police officers had received limited child sexual exploitation training and no specific safeguarding training. Further training of the police officers to develop their understanding of the MAPPA process would be beneficial.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

What we expect to see

There is a broad range of quality interventions being delivered well. We expect to see that these are based on assessed needs with appropriate planning to maximise the likelihood of sustainable outcomes being achieved. Effective leadership and partnership work need to be evident in the delivery of interventions.

Case Assessment Score

Within the case assessment, overall 63% of work on interventions was done well enough.

Key Findings

1. There was a suitable range of interventions available for work with children and young people who had offended.
2. Assessments to determine the suitability and eligibility of children and young people for specific interventions were not always carried out sufficiently.
3. Case managers delivering interventions were enthusiastic and determined but too often lacked training in delivery.
4. Planning to deliver interventions was not always comprehensive, related to need or regularly reviewed.
5. Barriers to positive engagement were not always identified or addressed.
6. Outcomes from interventions were not routinely measured or evaluated.

Explanation of findings

1. There was a range of interventions available to children and young people. The majority of these were of a good quality. The YOT did not always undertake assessments which would determine the suitability of the child or young person to undertake interventions. Initial planning to determine which interventions would be provided and how they would be delivered was not done sufficiently in half of the relevant cases. The YOT had not identified and addressed individual needs and barriers to engagement, or sequenced delivery appropriately. For example, some plans did not include learning styles, issues around age or maturity or barriers to engagement. Parents/carers were not meaningfully engaged in planning for interventions in enough cases.
2. There were some strengths in the way that interventions were being delivered but the standard of one-to-one delivery with children and young people was inconsistent and not always systematically delivered. Children and young people had to fit in to the schedule according to the availability of programmes, rather than a bespoke approach suited to the needs and abilities of the child or young person.
3. Work carried out with individual children and young people by different practitioners was not always integrated. For example, in one intensive supervision and surveillance and programme review, the case manager was not clear about the work being delivered concurrently by the local substance misuse service.
4. YOT 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. Where there were gaps, these tended to be in important areas such as thinking and behaviour, substance misuse and ETE.

5. There was insufficient emphasis on interventions to manage the risk of harm to others, or the vulnerability of the children and young people themselves. The delivered work was not of sufficient quality because there was no clear structure to delivery, the aims and objectives were unclear and the response of the child or young person was unclear. There was also sometimes insufficient access to CAMHS.

Example of notable practice

Lewis (male, white, 17 years old) had experienced difficult domestic relationships throughout his childhood and was both a victim and perpetrator of abuse. His recent involvement with the YOT was thwarted by poor compliance which was possibly linked to underlying substance misuse issues (legal highs in particular), living arrangements (supported accommodation where there is known association with others likely to be involved with the criminal justice system) and faltering attitude and motivation. Substance misuse, the volatility of his relationships and the resulting impact on his emotional well-being and outlook were likely to be key regarding his motivation, but due to the ongoing poor compliance there had been no meaningful delivery of interventions in this case. Lewis did originally express a willingness to address his substance misuse, though due to persistent non-engagement, this failed to take place. Other planned aspects of work (group work to address domestic abuse/relationship issues, emotional well-being and mental health) also failed to get started (partly due to the service cancelling/rearranging). The case was transferred to a new case manager at the five month stage and they had at least taken appropriate steps to return the case to court.

6. Effective groupwork methodologies were understood by some case managers. Some of the case managers delivering interventions were enthusiastic and had 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 not always skilled in keeping children and young people focused on the aims and objectives of the sessions.

7. We observed a number of interventions which included a combination of one-to-one sessions, group activities delivered outside the YOT and referral order panels. We saw interventions being delivered not only by the YOT itself, but also by external providers. This worked well in some cases, although deficiencies in assessment and information sharing had led to some difficulties in cases where external agencies were delivering services alongside the YOT.

8. Children and young people were not always prepared sufficiently for groups and individual activities, which meant that delivery of interventions, were not always fully effective. A lack of information regarding a child or young person's learning style led to delivery, in some instances, which was not always at a level suited to the individual.

9. We also saw some very good work being done. Children and young people and their parents/carers acknowledged that a number of practical activities were being used to support children and young people into gaining work experience and moving them towards employment. This was particularly the case for those young people aged over 16 years old.

Comment from a parent

"Yes, loads he's been on lots of different practical courses and he's involved with the skill mill now which he really enjoys, it's the stuff like that that has really made a difference with my son."

Example of notable practice

David (male, white British, 15 years old) was given a 6 month youth rehabilitation order for being carried in a stolen vehicle (Aggravated Taking without Consent or TWOC) with a 10 day activity requirement. He had a challenging family background and had failed to engage well with ETE. The initial sentence plan was short and focused on supporting him to find useful activity (learning about drugs, Street Doctors group, supporting him to join a local cricket club and reparation hours) rather than initially focusing on offending behaviour. In a review there had been some mention of him going missing and, in the last assessment, a 'white powder' had been found, but the case manager had made appropriate checks regarding child sexual exploitation and received assurances from police intelligence. The reviewed plan moved further (ongoing reparation, the four week victim awareness group, TWOC workbook and a session on cannabis) so addressing offending behaviour more. The plans were clear and written in simple language, but did not specify this had been done to meet his learning disability. Over the course of the order the case manager identified appropriate interventions to deliver, supported David in finding a cricket club (but he did not attend) but had completed victim awareness, a TWOC workbook and substance misuse, all of which were appropriate. David took part in the sessions and completed written work, which demonstrated his understanding of the principles set out in the interventions. Contact entries from the case management system also confirmed that the case manager reinforced the messages in the interventions. David attended and completed the work and, apart from an opportunistic shoplifting offence, had not been convicted of committing any further offences. The case manager, as part of her exit planning, wrote to all relevant individuals advising them of the planned timetable for David.

10. Victims' perspectives featured well throughout the delivery of interventions. The Victim Awareness programme and restorative justice activities provided a good example of the victim worker and case manager working well to compliment one another and best support children and young people's engagement.

Comment from a victim

"*My experience of it [the referral order panel] was very positive, it was handled in a very good manner. I didn't feel like the young man had been pushed or coerced into it, or anything and I honestly think that he has gained something from it.*"

11. At referral order panel meetings, children and young people and their parents/carers were fully informed of the contents of panel reports, prior to the panel taking place.

12. The collection and analysis of feedback about specific interventions was limited and we saw almost none of this at the review stage. The impact of interventions was, therefore, unclear. The YOT, in partnership with the University of Northumbria, is developing mechanisms to monitor and evaluate the effectiveness of all of its interventions, and this is likely to be a valuable initiative.

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:

25 April 2016 and 09 may 2016

In the first fieldwork week we looked at a representative sample of 34 individual cases up to 12 months old, some current, others terminated. The sample included a number of those who are a high risk of harm to others, are particularly vulnerable, are young women, or are black and minority ethnic children and young people. Cases were assessed by a team of inspection staff. They examined these wherever possible with case managers, who were invited to discuss their work in depth, explain their thinking and identify supporting evidence in the record.

We also received copies of relevant local documents.

During the week in between, the data from the case inspections was collated and a picture about the quality of the work of the YOT developed.

The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We explored the lines of enquiry which emerged from the case inspections. The leadership, management and partnership elements of the inspection were assessed, with a particular focus on reducing offending.

We also gathered the views of others, including strategic managers, staff and service users, children and young people, parents/carers and victims, and observed work taking place. Engagement with service users was undertaken on our behalf by User Voice.

At the end of the second fieldwork week we presented our findings to local strategic managers, the YOT Management Team, YOT staff and other interested parties.

Scoring Approach

Details of how our inspection judgements are made can be found on our website.

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

Publication arrangements

A draft report is sent to the YOT for comment three weeks after the inspection, with publication approximately six weeks later. In addition, a copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group and the YJB. Copies are made available to the press and placed on our website.

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

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

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

Role of HMI Probation and Code of Practice

Information on the role of HMI Probation and our Code of Practice can be found on our website:

www.justiceinspectorates.gov.uk/hmiprobation

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

HM Chief Inspector of Probation

1st Floor, Manchester Civil Justice Centre

1 Bridge Street West

Manchester

M3 3FX

Appendix 2 - Acknowledgements

Lead Inspector	Helen Mercer, *HMI Probation*
Deputy Lead Inspector	Caroline Nicklin, *HMI Probation*
Inspection Team	Jenny Daly, *HMI Probation*
	Ruth Johnson, *HMI Probation*
	John Evans, *Local Assessor*
	Catherine Raycraft, *Care Quality Commission*
	Ian Elliott, *HMI Constabulary*
	Stella Butler, *Ofsted Further Education and Skills*
	Janet Fraser, *Ofsted Social care*
	Tracy Harland, *User Voice*
HMI Probation Support Services	Adam Harvey, *Support Services Officer*
	Stephen Hunt, *Support Services Manager*
	Oliver Kenton, *Research Officer*
	Alex Pentecost, *Communications Manager*
Assistant Chief Inspector (Youth Justice)	Alan MacDonald, *HMI Probation*

HM Inspectorate of Probation
Civil Justice Centre
1 Bridge Street West
Manchester
M3 3FX

ISBN: 978-1-84099-754-5