Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid
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To:	Alison Michalska, Chair of Nottingham City Youth Offending Team Management Board and Director of Children's Services
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From:	Alan MacDonald, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Nottingham City

The inspection was conducted from 06-08 June 2016 as part of our programme of inspection of youth offending work. This report is published on the HMI Probation website. A copy will be provided to partner inspectorates to inform their inspections, and to the Youth Justice Board (YJB).

Context

The aim of the youth justice system is to prevent offending by children and young people. Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. We examined 34 cases of children and young people who had recently offended and were supervised by Nottingham City Youth Offending Team (YOT). Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Nottingham City was 37.2%. This was worse than the previous year but slightly better than the England and Wales average of 37.8%.

Overall, we found that Nottingham City was a high performing YOT. Case managers were enthusiastic and knowledgeable, using an inclusive style to complete their assessments and plans and maximise positive outcomes. They engaged well with other workers and agencies to identify the individual needs in their cases and remove barriers to engagement. We found an innovative approach to management oversight but this had not yet made sure that assessment and planning were always properly recorded, and safeguarding and risk of harm measures applied consistently well.

Commentary on the inspection in Nottingham City:

1. Reducing reoffending

1.1. The YOT had provided the court with a pre-sentence report (PSR) in 22 of the cases we assessed. Almost all of these were of good quality, providing sufficient advice to help

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

inform sentencing decisions. Some were long but this reflected the complex nature of the cases. Report writers paid due regard to diversity and barriers to engagement but more than half the PSRs would have benefited from a discrete analysis of safety and well-being issues and how these linked to offending. Quality assurance processes made a positive impact on the standard of reports. We saw examples where managers had made suggestions for change in a constructive way and worked together with the case manager to implement these.

1.2. Practitioners worked hard to understand why a child or young person had offended and what might help to reduce further offending. They were able to explain the detailed circumstances of a case even where they had been involved for only a short while, drawing on the experience and views of others to help inform their analysis.

1.3. The quality of planning to reduce reoffending was variable. Case managers thought carefully about the work they were going to do in the community but were not always good at recording this at the start of sentence. In a small number of cases there were no documented targets or these lacked essential detail about who would do what and when. This was particularly evident in referral order cases. Conversely, we saw examples of plans which were comprehensive, with thought given to the priority of objectives. Some reflected the ambitions of the child or young person and made it easy for them to understand what they had to do to achieve their objectives successfully. Planning met the needs of the large majority of children and young people in custody.

1.4. Case managers continuously assimilated new information in order to understand changes in the child or young person's life and, in the main, changed their assessments and plans accordingly.

2. Protecting the public

2.1. We found a clear, thorough and sufficient explanation of the risk of harm a child or young person posed to others in the majority of cases we looked at. Case managers drew on the information available to them to understand issues and needs, and reach appropriate decisions about the level of risk of harm posed. In a small number of cases there was no documented assessment, there was too little focus on victims or it was difficult to understand the nature of the risk of harm posed by the child or young person.

2.2. Planning to manage and reduce risk of harm was generally of a good standard. There was, however, no recorded plan in four cases.

2.3. In the large majority of instances it was clear that risk of harm was being reviewed, with records being updated as necessary.

2.4. Victims and potential victims were not always given suitable priority. Plans tended to focus on work with the child or young person, and there were a small number of cases where plans should have set out, but did not, how victims and potential victims would be kept safe. We would also have expected to have seen greater emphasis on direct restorative justice. Conversely, we saw examples of good joint planning and liaison with the police to protect victims: to enforce a restraining order, to help monitor the behaviour in the community of a chaotic young person, and to make sure that appropriate action was taken in order to maximise positive outcomes following a further offence.

2.5. Multi-Agency Public Protection Arrangements (MAPPA) were not always applied effectively. In one case, where a young person was soon to be released from custody, the level of management was yet to be confirmed. In another, there was no mention in plans of MAPPA and how this would benefit the case. We were not assured that all case

managers understood MAPPA processes and the value this could add to the management of their cases.

3. Protecting the child or young person

3.1. We saw some excellent work to keep children and young people safe. The YOT was embedding Signs of Safety so that in many cases there was evidence of a multi-agency assessment of safety and well-being. We found, however, that case managers were not as good at pulling together all the information they held to accurately assess the nature of vulnerability in a case or how it influenced offending behaviour. This may explain why, in six cases, we disagreed with the severity levels assigned for safety and well-being.

3.2. This, in our view, affected the quality of planning. In four cases there was no plan to manage vulnerability and in another three, the plan did not meet the needs of the case. The YOT nurse played a key role with the children and young people and there was good planning in place to address physical health and alcohol issues. Case managers also worked well with other specialists to help identify and access suitable education and training.

3.3. In eight of the nine cases where the child or young person had spent time in custody we were pleased to see sufficient planning to manage safety and well-being issues.

3.4. Case managers were clearly reflecting on changes in the cases they managed and, in the large majority, had reviewed their assessments and plans and updated these appropriately.

3.5. There was evidence of good work to protect both boys and girls at risk of child sexual exploitation. Case managers had identified when a child or young person was at risk, and taken appropriate action, in the large majority of cases we looked at.

4. Making sure the sentence is served

4.1. The YOT is to be commended for its work in this area. Case managers used creative approaches to help build positive relationships, encourage the engagement of children and young people and their parents/carers, and enhance the positive impact of their work.

4.2. We found a strong emphasis on health and welfare, especially where this was important to the successful completion of orders. Case managers were inquisitive and drew on the information available to them to help identify, understand and take account of individual need and potential barriers to engagement. They had strong links with specialist services such as Vanguard Plus (the gangs team), Head 2 Head (for mental and emotional health), Priority Families (their Troubled Families team) and community groups, such as Passages. This helped to further their understanding of, and their engagement with, children and young people and their families.

4.3. Practitioners recognised the importance of consistency and trust. As such, when children or young people moved out of county during their orders, case managers continued to demonstrate their interest by maintaining meaningful contact with the host YOT and completing monthly home visits.

4.4. More than half of the children and young people complied fully with the requirements of their sentences. The YOT took appropriate action in cases where this did not happen, returning the order to court when required.

Operational management

Case managers were positive about their work. They were committed to achieving the best outcomes for children and young people and were also able to demonstrate their understanding of effective practice. All of those interviewed felt well supported by their managers and considered they had received sufficient training to fulfil their roles, including how to recognise and respond to a range of diversity issues. Almost half, however, advised that they would benefit from more skills development work in relation to speech, language and communication.

The introduction of the practice specialist role provided an innovative approach to management oversight. This was popular among case managers and, coupled with the range of multi-specialist meetings held, was making a positive difference. We noted, however, that improvement was not always evidenced in assessments and plans and, in a small number of cases, safeguarding issues had been overlooked. The YOT had embraced AssetPlus and was developing new and helpful guidance to support it. The introduction of this new practice framework coincided with the time frame of a number of cases in our sample and we recognise that this may have affected the quality of management oversight during this time.

Key strengths

- Pre-sentence reports provided the courts with good quality information about why a child or young person offended and made sound, individualised proposals for sentencing.
- The YOT engaged consistently well with children and young people and their parents/carers to build effective relationships and understand the needs of a case.
- Case managers understood and took account of the individual needs of children and young people and potential barriers to their engagement.
- There was an inclusive approach to review, with case managers continually integrating information from a range of sources to reframe their assessments and plans.
- Assessment and planning for the custodial phase of a sentence met the needs of the case.

Areas requiring improvement

- There should be a detailed plan to reduce reoffending in the community in every case.
- Assessment and plans should consistently reflect the needs and views of victims.
- Case managers should make sure their analysis of safety and well-being is recorded clearly, takes account of all relevant issues and behaviours, and leads to an appropriate classification.
- Management oversight should make sure that Multi-Agency Public Protection Arrangements and safeguarding processes are applied effectively and that assessments and plans are properly recorded.

We are grateful for the support that we received from staff in the YOT to facilitate and engage with this inspection. Please pass on our thanks, and make sure that they are made fully aware of these inspection findings.

If you have any further questions about the inspection please contact the lead inspector, who was Vivienne Clarke. She can be contacted at Vivienne.Clarke@HMIProbation.gsi.gov.uk or on 07972 273026.

Copy to:

YOT Head of Service	*Shelley Nicholls*
Local Authority Chief Executive	*Ian Curryer*
Lead Elected Member for Children's Services	*David Mellen*
Lead Elected Member for Crime	*Nicola Heaton*
Police and Crime Commissioner for Nottinghamshire	*Paddy Tipping*
Chair of Local Safeguarding Children Board	*Chris Cook*
Chair of Youth Court Bench	*c/o Gillian Young*
YJB Business Area Manager	*Peter Ashplant*
Ofsted – Further Education and Skills	*Paul Joyce*, *Stephen Miller*
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Ofsted – Links	*Lynn Radley, Caroline Prandas*
Care Quality Commission	*Jan Fooks-Bale*
YJB link staff	*Lisa Harvey-Messina, Paula Williams, Linda Paris, Rowena Finnegan*
YJB Communications	*Ali Lewis, Rachel Brown, Summer Nisar, Adrian Stretch*

Note 1: As an independent inspectorate, HMI Probation provides assurance to Ministers and the public on the effectiveness of work with those who have offended or are likely to offend, promotes continuous improvement by the organisations that we inspect and contributes to the effectiveness of the criminal justice system.

Note 2: We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justiceinspectorates.gov.uk/hmiprobation.

Note 3: To request a paper copy of this report, please contact HMI Probation Communications at communications@hmiprobation.gsi.gov.uk or on 0161 240 5336.