

# Full Joint Inspection of Youth Offending Work in Blackpool

An inspection led by HMI Probation



# Foreword

This inspection of youth offending work in Blackpool 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 education inspectorates.

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on the three National Youth Justice Outcome Indicators 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.

We chose to inspect Blackpool primarily because of concerns about its performance on the Outcome Indicators for both custody and reoffending, and to establish if action taken, after our critical Core Case Inspection in July 2009, had resulted in sustained improvements in performance.

Progress had undoubtedly been made by Blackpool since our last inspection. However, for a YOT to be fully effective, it must be supported by a Management Board that provides strategic leadership and direction for its managers. Board members must challenge practice, examine performance and drive the high quality provision of services to those children and young people who offend or who are likely to offend. We found that the YOT Manager and Chair of the Management Board were working hard to re-establish the Board in order to both support and scrutinise the work of the YOT. However, in the absence of a basic performance management system, they were unable to monitor performance effectively, review outcomes or hold partner agencies to account for their delivery.

Although children and young people engaged well with staff and generally complied with their order, the effectiveness of interventions was too often undermined by the quality of assessments. Further attention needs to be given at both an operational and a strategic level to managing the risk of harm children and young people might pose to others and their vulnerability. We were pleased to see that partnership working was continuing to develop, but information sharing between partner agencies was not always effective.

The recommendations made in this report are intended to assist the Blackpool Youth Offending Team in its continuing improvement by focusing on specific key areas.

*E. G. Calderbank .*

**Liz Calderbank**

*HM Chief Inspector of Probation*

*May 2013*

# Summary

## Reducing the likelihood of reoffending



*Overall, work to reduce reoffending was unsatisfactory, largely due to deficiencies in the assessment, which looked at why the child or young person had committed the offence. This had a 'knock on' effect to the production of relevant and effective plans. Although the delivery of interventions was strong, this was undermined where the assessment had not utilised information from partner agencies where appropriate, or identified the correct work to be done, or where the objectives in plans were not sequenced. There was little evidence of regular, effective reviewing of progress and where there were reviews, these did not generate appropriate changes in plans. We were pleased to see that custodial sentences were conducted as a single integrated sentence across both custodial and community elements. We found deficits in the quality assurance systems, although this was being addressed and a previous focus on pre-sentence reports had produced some high quality reports.*

## Protecting the public



*Overall, work to protect the public and actual or potential victims was unsatisfactory. Again this was mainly due to deficiencies in assessment and planning to manage risk of harm, which then drove through into delivery. Whilst staff appeared to understand the local policies and procedures, the assessments did not always record how they intended to manage the risk of harm for each young person, at whatever risk level, and then use meaningful tools to determine the way forward, drive delivery and help protect victims. Work to manage the risk of harm to others was delivered where it had been identified. The Risk Management Meetings were a useful forum, but did not appear to fully translate into practice and management oversight had not been effective in ensuring that this happened.*

## Protecting children and young people



*Overall, work to protect children and young people and reduce their vulnerability was unsatisfactory. We could see that the processes were in place but they were not being operated successfully. Case managers knew a lot about the children and young people and their lives, and were very committed to supporting them, but did not always recognise the things that made them vulnerable. This was particularly where their circumstances had changed and there was the risk that they may be harmed, either by others or by their own behaviour. Because assessments were often not good enough, planning how to manage vulnerability was also insufficient, whether using a formal plan or discussing simple contingency planning. Also, while interventions were delivered, they were not always appropriate. Managers overseeing the work had not picked this up, even when they had held meetings with staff. In our view, some staff's knowledge and understanding of safeguarding issues was not sufficiently broad enough to address all vulnerability issues.*

## Ensuring the sentence is served



*Overall, work to ensure that the sentence was served was good. Engagement with children and young people was good and was valued by them and their parents/carers. The children and young people and their parents/carers were usually involved in both the assessment and planning processes. Attention needed to be focused on identifying the barriers to compliance and planning how to address these before they become an issue. Good efforts were made to ensure that the young person cooperated with the order of the court, and, where necessary, enforcement was generally carried out promptly.*

## Governance



*Overall, governance in Blackpool was unsatisfactory.* A previously supportive but ineffectual Board was gradually changing to one populated by suitably senior representatives from partner agencies, but at the point of the inspection did not provide sufficient strategic leadership or ensure the delivery of effective outcomes. They also did not ensure partnership working was effective, partly due to the lack of information from the performance management system. Internal operational procedures were insufficiently robust and inconsistently applied, although they were being developed and implemented. Managers had worked hard to improve performance and had also ensured that the staff were travelling with them on this journey.

# Recommendations

Post-inspection improvement work should focus particularly on the following:

1. Partner agencies are represented on the Management Board by appropriately senior staff who are proactive in effectively supporting, and holding the YOT to account (Chair of YOT Management Board).
2. The provision of a performance management system which is used by the Board to:
  - identify, map and anticipate business needs,
  - utilise data to monitor the outcomes achieved by every child or young person,
  - evaluate the quality of interventions whether delivered internally or by other agency providers,
  - help determine how improvements can be achieved(Chair of YOT Management Board).
3. Improvements are made to strategic and operational practice to ensure management of risk of harm to others and vulnerability are central to work undertaken with children and young people (Chair of YOT Management Board).
4. Timely initial assessments and their reviews are completed to a sufficient quality with particular reference to risk of harm to others and vulnerability, using information from all appropriate sources including multi-agency staff within the YOT (YOT Manager).
5. Timely plans are meaningful to children and young people and their parents/carers and drive the delivery of appropriate interventions (YOT Manager).
6. All those involved with a case, work together throughout the sentence, in a way that makes sense to the child or young person and their parents/carers (YOT Manager).
7. Quality assurance arrangements, including management oversight, ensure that assessments and plans, and their reviews, are adequate and inform the delivery of interventions (YOT Manager).

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# **Reducing the likelihood of reoffending**

# **1**

# Theme 1: Reducing the likelihood of 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 63% of work to reduce reoffending was done well enough.

## Key Findings

1. The quality of assessment of the likelihood of reoffending was judged to be satisfactory in just under three-quarters of cases. However, one-third of assessments were not reviewed sufficiently well.
2. Pre-sentence reports (PSRs) were considered to be of good quality in over three-quarters of cases.
3. Plans for work to reduce the likelihood of reoffending were in place for over two-thirds of cases, but again were not reviewed sufficiently well.
4. The delivery of interventions was a real strength, as was the delivery of custodial work as a single integrated sentence.
5. Quality assurance systems required further development.

## Explanation of findings

### 1. Assessment

- 1.1. The assessments of the likelihood of reoffending were judged to be of sufficient quality in three-quarters of cases and staff engaged well with the child or young person, parents/carers or significant others to carry out the assessments.
- 1.2. Assessments rated as insufficient were untimely, or failed to take account of all available evidence; for example, failing to draw sufficiently on information or assessments held by others to identify vulnerability. The key diversity factors missed were age/maturity and learning styles.
- 1.3. The involvement of health services in the assessment, planning and delivery of interventions was inconsistent, and was determined by the case manager independently of specialist oversight from any of the health partners. As a result, health needs were not always identified and children and young people did not always receive coordinated and timely care from the YOT health nurse or the emotional and mental health worker. Contingency arrangements in the absence of these workers such as cover for annual leave or sickness was inconsistent, potentially causing delay in delivery.
- 1.4. We consider that it is vital to review periodically what is happening in a child or young person's life, as this can change very rapidly. In Blackpool, assessments were not reviewed sufficiently in almost one-third of cases, mainly because they were not undertaken when needed, e.g. after significant changes in the child or young person's life. A number had been copied from previous assessments but were not sufficiently updated.
- 1.5. For the court to make a fully informed decision about a sentence to be imposed on a child or young

person, they need the best information from a YOT. In Blackpool, over three-quarters of the PSRs were of good quality as was the advice given to sentencing courts in 82% of cases. Only three reports were not good enough either because of the vulnerability assessment or the lack of analysis. One had poor grammar and spelling.

### **Comment by an inspector**

*The YOT health nurse conducted thorough assessments of the children and young people referred to her. She appropriately considered areas including education information; children and young people's developmental history; family, peer and social relationships; strengths and resilience factors; activities and interests; and physical and medical history, medication and diagnosis. Her good working relationships with other related services such as the 'Looked After Children's' nurse, Pupil Referral Unit nurses, school nurses, WISH (sexual health and relationship programme), GP surgeries and secure settings all enabled the timely referral of children and young people into services where appropriate. A useful health information sharing tool enabled the exchange of information between these agencies.*

## **2. Planning for interventions**

- 2.1. Once sentenced, the YOT must plan how to deliver work to reduce the child or young person's likelihood of reoffending in the future. We found sufficient planning in three-quarters of cases.
- 2.2. Children and young people referred to the YOT substance misuse worker received good quality and timely assessments. Accessible interventions were delivered in a range of settings of the child or young person's choice (school, home and council buildings, including the YOT). The substance misuse worker supported caseworkers to deliver lower tiered interventions by providing them with a range of tools to enhance engagement and educate children and young people on substances (for example, the use of beer goggles or the drugs box).
- 2.3. The substance misuse worker reviewed the child and young person's initial assessment, learning style questionnaires, statement of educational need and other health reports when deciding on the most appropriate interventions. This worker then delivered useful interventions such as harm reduction interventions, smoking cessation programmes, and sexual health advice and condom distribution. Children and young people benefited from the worker's close links to the child or young person's specialist prescribing services, the substance misuse nurse and peer advice, guidance and links with the adult substance misuse services and teams.
- 2.4. Children and young people in the YOT experienced difficulties accessing and maintaining engagement with Children and Adolescent Mental Health Services (CAMHS). Despite being supported by a Memorandum of Understanding between CAMHS and the YOT, there was no prioritisation of this vulnerable group and the emotional and mental health worker had to refer into universal services, in line with other service users and often via their GP. Furthermore, Tier 3 YOT clients, who had disengaged with CAMHS, often found themselves being supported less effectively by the emotional and mental health worker while they secured a re-engagement into more appropriate services.
- 2.5. We found that school age children and young people known to the YOT benefited from a wide, supportive range of education provision that met their diverse needs. The transition at different key stages and throughout different provision was managed well to ensure that the diverse behavioural and learning needs of the children and young people were met. In order to re-engage children and young people in full time education, programmes were offered on a flexible basis allowing them to increase their hours at different sites. The YOT's education officer had built successful relationships with schools, sharing information and providing support to learners. Often, the officer challenged mainstream schools to accept and include children and young people who had offended. Assessments were carried out adequately on each child or young person in order to manage risk of harm to others satisfactorily.

### Case illustration

Erwin was subject to a youth rehabilitation order (YRO) with a number of requirements. His intervention plan identified accessing the protective factor of ETE as a target. The YOT Connexions advisor became involved in the case and provided support in completing job searches, a CV and applying for vacancies and college placements. Erwin's application to enrol at college was initially rejected due to his offending history. This was challenged by the YOT Connexions advisor who visited the college with the young person to discuss the decision and he successfully enrolled onto the course. His intervention plan was reviewed following this target being achieved and new targets agreed, which included regular attendance at his college placement.

- 2.6. We were pleased to see that each learner, including those who found it difficult to engage in ETE, had a comprehensive individualised education plan highlighting their objectives, the progress they were making and the levels they were reaching in different subjects. The education officer utilised this information well, to ensure learners were found the appropriate placement or course to continue learning once they reached 16 years of age. The plans provided useful insights to the young person's barriers to engagement and these were translated into measurable, short-term practical actions that were clearly aimed at overcoming each of the identified barriers. However, due to the recent introduction of this reviewing process, it was not possible to judge its effectiveness.
- 2.7. It is important for children and young people who receive custodial sentences to be given support and attention throughout and, in particular, for any sentence to be treated as single integrated process across both the custodial and community phases. We found this had happened in 88% of relevant cases. Planning was sufficient in the custodial phase in six out of the eight relevant cases.

### Case illustration

Paul was given detention and training orders in September, November and December 2012. The inspected order was made in November, but the Young Offenders' Institution (YOI) sought to treat them all as a single custodial sentence. The case manager resisted and completed a new assessment and excellent sentence plan. There was a single overarching objective to reduce reoffending, with several sensible objectives (covering compliance with the custodial regime, drugs, ETE and accommodation) but the real strength was the subsections in the objectives, which set out how and what Paul, and named others, would do and how this would help him, including the period after he was released. A good plan to manage his risk of harm to others was also created, which similarly identified real individuals and the right factors to be considered.

- 2.8. We found that plans were mostly reviewed sufficiently, although some reviews were not thorough enough, or did not revise the relevant plans as required. Five cases had no plans.

## 3. Delivery of interventions

- 3.1. The delivery of interventions was carried out by case managers and also specialists such as ETE, substance misuse and health workers, who worked well with children and young people.
- 3.2. Overall, we found that interventions were delivered in accordance with the assessments and plans. The materials and resources used were of good quality and delivered as their design had intended and in two-thirds of cases were also delivered in accordance with effective practice principles. Case managers had sought to reinforce positive factors in almost three-quarters of cases and sufficient attention had been given to areas such as living arrangements, ETE and neighbourhood.
- 3.3. In 60% of relevant cases, we considered that there was an appropriate balance between the reduction of offending, the management of risk of harm to others and addressing vulnerability, but we were concerned that there was insufficient attention being given to restorative justice in 60% of cases.

- 3.4. Where a child or young person has received a custodial sentence, it is always more difficult for YOTs to deliver interventions. However, we found that in four out of seven relevant cases, sufficient interventions by the YOT and/or the custodial institution were delivered to address likelihood of reoffending during the custodial phase.

We also found that there was effective joint working in facilitating a smooth transfer between custody and the community and continuity of services to address the likelihood of reoffending in all of the four relevant cases.

#### Comment from a young person

*"[At the YOT] for a couple of hours a day, sometimes I go to the gym, do re-offending work, working on what I did, why and how I could go about not doing it, used to do groups...I did knife crime, crime and consequences before, I do cooking".*

#### Case illustration

Despite some excellent intervention work by his caseworker and innovative referrals to partnership agencies, Carl was given a second 12 month YRO in January 2013. Risk of harm to others and vulnerability management plans were completed and reviewed bi monthly. Vulnerability Management Meetings were held monthly to assess whether targets had been met. The Multi-Agency Risk Assessment Conference (MARAC) coordinator and Youth Independent Domestic Violence Advisers (IDVA) were consulted to contribute to risk of harm assessments and reviews. The work delivered was focused and relevant in all relevant areas. Carl was allocated a mentor who met with him weekly and engaged very well, completing a variety of activities.

## 4. Initial outcomes

- 4.1. We judged that good progress had been made to some factors related to offending, such as living arrangements, ETE and neighbourhood. However, other factors such as family, substance misuse and perception of self and others had seen less progress. There were reductions in the frequency of offending in over half of the cases and seriousness of offending in two-thirds of the cases we assessed.
- 4.2. The YOT demonstrated initiative in creating opportunities for the children and young people known to them. There were some interesting projects such as the school summer holiday group, which engaged children and young people of different ages in constructive activities, when education and learning providers did not offer programmes. Children and young people participating in that programme learnt, and further developed, their social skills. The YOT had also recently piloted a 'Time to Grow' initiative which offered children and young people who had offended the opportunity to undertake pre-employment preparation in a working environment. One of the young people who had completed this programme had progressed and was now in employment with the local tourist office.
- 4.3. Attention was given to ensuring positive outcomes were sustainable in the long term, in over half of the inspected cases.

## 5. Leadership, management and partnership

- 5.1. Performance management within the YOT was underdeveloped. Core performance management information included the key national indicators and some local indicators. Effective work had been undertaken to ensure that this information was accurate following the previous inspection in 2009. However, systems were insufficiently established to enable managers to fully understand the service strengths and areas for development or the quality of the work undertaken. For example, managers

gave inconsistent information on whether case audits were routinely undertaken, none were seen on case files and no common themes arising from management oversight of casework were identified to inspection staff.

- 5.2. There was little evidence that staff supervision or other quality assurance arrangements had made a positive difference to most cases, although those case managers interviewed were overwhelmingly positive about the supervision and support that they received. The supervision and risk/vulnerability management policies were not applied consistently and actions given were not always followed up. Additionally the Risk Management Meetings (RMMs) and Vulnerability Management Meetings (VMMs) only considered those cases who were designated high or very high risk of harm to others or vulnerability. The Management Team had recognised that this was an area that needed further development and was reviewing the policy.
- 5.3. We did not consider that there were effective systems to monitor outcomes and support continuous improvement. But there was good monitoring by the HUB (Blackpool substance misuse service for under-25 year olds) of the number and nature of YOT referrals into their service, which accounted for 19% of their service users. This was achieved by the YOT substance misuse worker recording on both HUB (Framework i and Lilly) and YOIS IT systems. This enabled the YOT substance misuse worker to directly feed into the National Drug Treatment Agency, the Treatment Outcomes Profile and sexual health data, but we did not see evidence of this information being used by the YOT.
- 5.4. In our view, sufficient resources were almost always available to case managers to help children and young people reduce their likelihood of reoffending, but there were gaps in the provision of interventions to address attitudes to offending and motivation to change.
- 5.5. The integration of the YOT police officer into the YOT had been hindered by an underdeveloped job description<sup>1</sup>, which did not reflect her actual employment within the YOT, and information technology problems. Lengthy delays in procuring funding for the computer by the police, and a potential YOT relocation, meant she did not have efficient access to police systems in the YOT. The officer was not involved in the management of high risk cases and she had only recently been asked to provide intelligence information to the YOT.
- 5.6. We also found evidence of an ongoing strained relationship between the YOT and the police's 'Revolutions' Integrated Offender Management (IOM) team. In our view a resolution needs to be sought by both agencies to maximise the utilisation of the police officer so that she can play a full role as part of the YOT team, and to determine whether IOM is the best way to minimise the risk of harm to others and reduce the likelihood of further offending by children and young people within their referral criteria.

## Summary

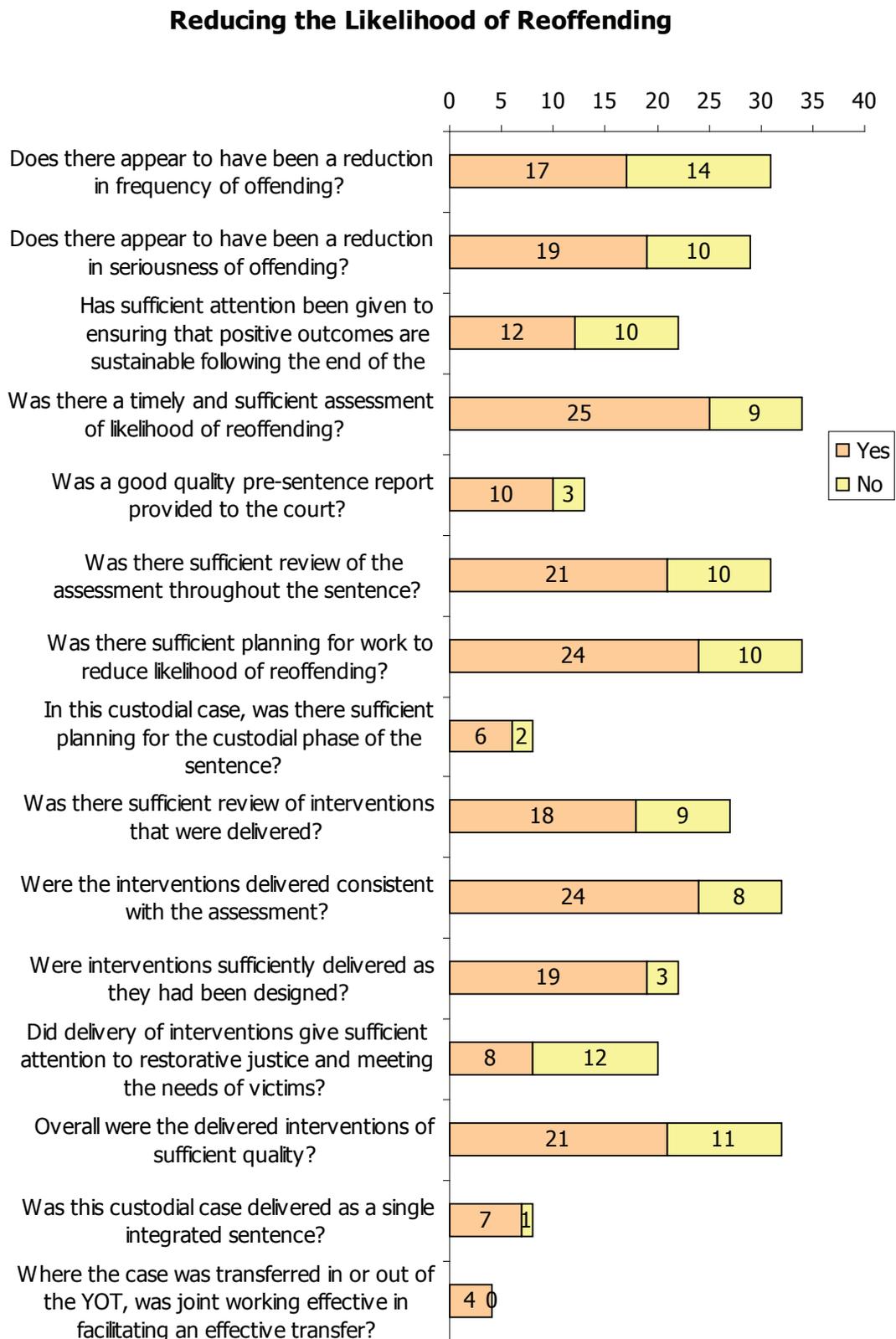
*Overall, work to reduce reoffending was unsatisfactory*, largely due to deficiencies in the assessment, which looked at why the child or young person had committed the offence. This had a knock on effect to the production of relevant and effective plans. Although the delivery of interventions was a strength, this was undermined where the assessment had not utilised information from partner agencies where appropriate, or identified the correct work to be done, or where the objectives in plans were not sequenced. There was little evidence of regular, effective reviewing of progress and where there were reviews, these did not generate appropriate changes in plans. We were pleased to see that custodial sentences were conducted as a single integrated sentence across both custodial and community elements. We found deficits in the quality assurance systems, although this was being addressed and a previous focus on PSRs had produced some high quality reports.

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1 The job description for the YOT police officer role should reflect the Association of Chief Police Officers and Ministry of Justice guidance

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



# Protecting the Public

# 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 62% of work to protect the public was done well enough.

### Key Findings

1. The assessment of the risk of harm to others was judged to be sufficient in over three-quarters of cases and all PSRs seen contained a clear and thorough risk assessment.
2. Reviews of risk of harm to others were considered unsatisfactory in over one-third of inspected cases.
3. Planning to manage risk of harm to others was judged to be unsatisfactory in almost half of inspected cases and there was a lack of timely and sufficient plans in those cases which required them.
4. Interventions to manage risk of harm were not delivered in almost half of the cases.
5. We judged that the risk of harm to victims had not been effectively managed in half of the cases.
6. Management oversight of risk of harm work was judged to be ineffective.

### Explanation of findings

#### 1. Assessment

- 1.1. The assessment of the risk of harm posed to others was judged to be sufficient in over three-quarters of cases. All reports to court contained a clear and thorough risk assessment.
- 1.2. In the majority of cases where the assessment had been judged to be insufficient, this was due to a number of reasons including the initial screening not being fully completed or a subsequent assessment not being undertaken. We also considered that not enough account had been taken of victim safety, and relevant previous offences or previous behaviour had been ignored.

### Case illustration

Whilst much of AI's case demonstrated innovative interventions, the case manager failed to consider information disclosed in the Statement of Special Educational Need in their initial assessment. The disclosure related to his displaying sexually explicit behaviour and using sexual language. The details of the incidents were not known and the YOT had not sought clarity, failing to request information from the author of the report and children's social care services. There was no evidence to suggest AI had been considered as a potential victim of sexual abuse. Further enquiries with children's social care services confirmed a series of incidents had occurred in 2008 and that the child had been referred to a specialist health service for sexually harmful behaviour. In the absence of relevant information the YOT was unable to demonstrate that they had fully considered AI's broader safeguarding needs and the wider public protection issues.

- 1.3. As with the likelihood of reoffending, we found that 37% of reviews of risk of harm to others were not considered to be of sufficient quality, generally because they were not timely, thorough or had not been undertaken following a significant change.

## 2. Planning for interventions

- 2.1. Just over half of the relevant cases had sufficient plans to address the risk of harm to others. In eight cases there was no risk management plan where we deemed that there should be, two other plans were not timely and others were unclear regarding the planned response.
- 2.2. The YOT convened RMMs and VMMs in cases where children and young people were assessed as posing a high (or above) risk of harm to others, or of being vulnerable. These meetings focused on the specific needs of the individual and were attended by staff from the YOT, but not by staff from partner agencies, thus missing the opportunity to obtain the fullest information regarding the child or young person. Information was shared and action points were agreed. These arrangements provided a structure to review and manage the risk of harm or vulnerability issues in priority cases. Unfortunately, we did not see evidence of these actions being followed up during supervision sessions, or in subsequent meetings.
- 2.3. Reviews of planning were insufficient in just under half of the cases, because they had not taken place, were untimely or were inadequate.

### Case illustration

Peter was given a YRO for drug offences. He was visited at home as part of his order. Whilst there, it was evident that his mother had facial injuries consistent with domestic abuse. The case manager had also identified that Peter's violent offending had been triggered by a volatile and potentially abusive relationship with his partner. The case manager identified the potential domestic abuse in the house and referred the case directly to the Multi-Agency Risk Assessment Committee. This did not address any immediate risk of domestic abuse faced by the young person's mother or partner. A more appropriate referral process would have been through the YOT police officer to identify any known abuse in the household and to put immediate safeguards in place.

- 2.4. Where plans were in place, victims' issues were not addressed sufficiently and planned responses were unclear. This was replicated in the custodial phase.
- 2.5. Although there were no MAPPA (Multi-Agency Public Protection Arrangements) cases in the sample, it was reported in interviews that the YOT was well engaged in relevant meetings about children and young people they were overseeing. It was said that staff attended meetings well prepared with sensible suggestions on managing the child or young person's behaviour. An example was given of a young person, soon to be released from a YOI, where the YOT ensured that there was good liaison with the YOI and monitored the progress of interventions offered there.

## 3. Delivery of interventions

- 3.1. The delivery of interventions to manage risk of harm to others was not always consistent with both the assessment and the plan, where they existed. Given the shortcomings of the assessments and plans, nearly half of the cases requiring interventions did not receive them and this was mainly due to the case managers not recognising the need for them.
- 3.2. In almost two-thirds of cases, therefore, we judged that there was insufficient active and effective management of risk of harm, mostly because this work was not prioritised, delivered as planned or at all. We were concerned that staff, again, had not identified where there had been significant

changes in the lives of the children and young people and therefore had not responded to, or reviewed, the risk of harm factors appropriately.

#### **4. Initial outcomes**

- 4.1. We felt that the risk to identifiable and potential victims had not been effectively managed in half of the cases because they were not identified at the assessment and planning stages. Despite this, we judged that, overall, the YOT had done enough to keep the individual's risk of harm to victims to a minimum in almost two-thirds of cases.

#### **5. Leadership, management and partnership**

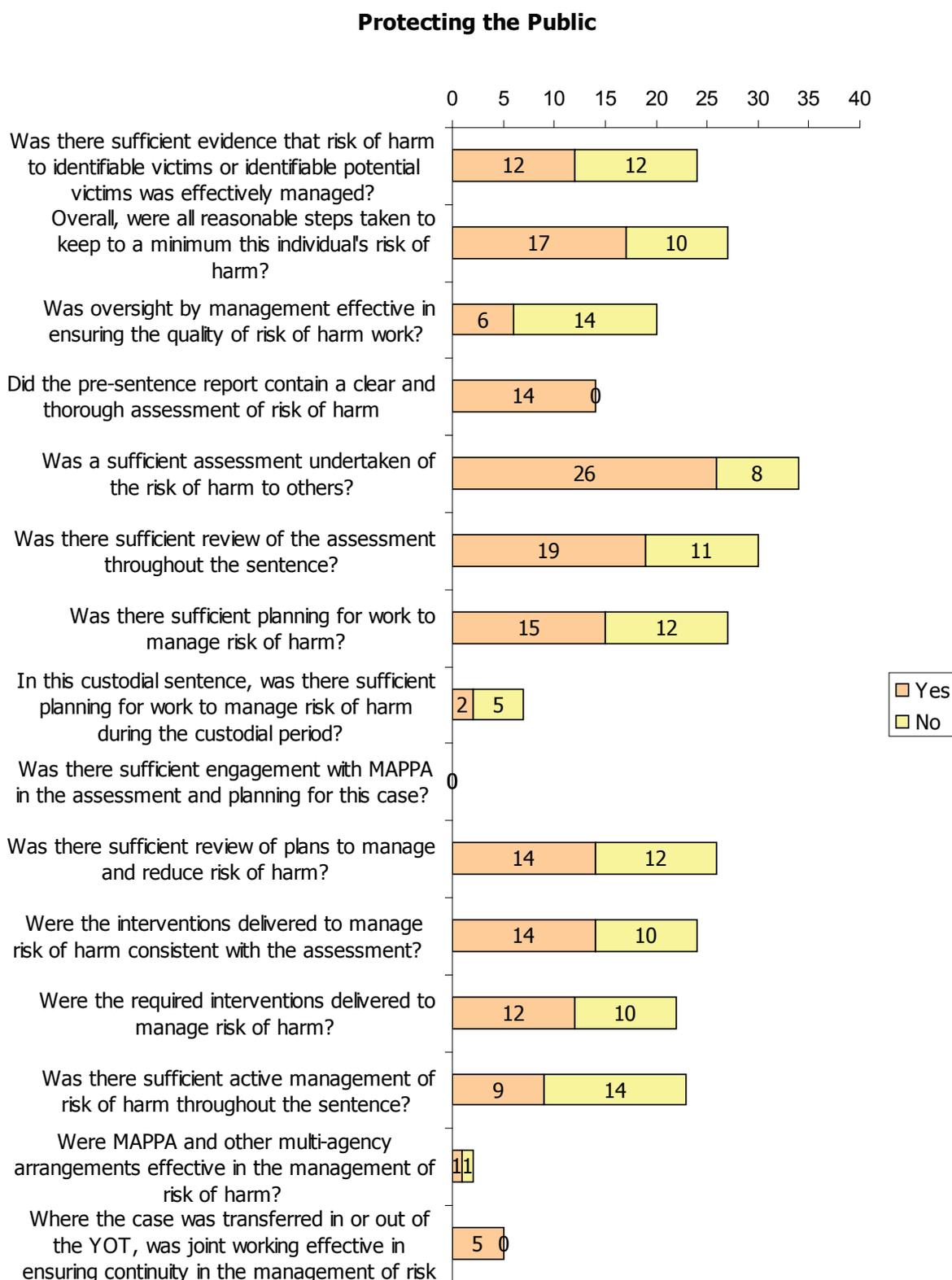
- 5.1. In all cases, there were sufficient resources available to the case managers to manage risk of harm. However, we judged that management oversight of work to manage the risk of harm to others was ineffective and, again, this was mainly due to deficiencies in assessment and planning not being addressed.
- 5.2. We considered that almost three-quarters of the staff identified had demonstrated a sufficient understanding of the local policies for managing risk of harm to others.

### **Summary**

*Overall, work to protect the public and actual or potential victims was unsatisfactory.* Again this was mainly due to deficiencies in assessment and planning to manage risk of harm, which then drove through into delivery. While staff appeared to understand the local policies and procedures, the assessments did not always record how they intended to manage the risk of harm for each child or young person, at whatever risk level, and then use meaningful tools to determine the way forward, drive delivery and help protect victims. Work to manage the risk of harm to others was delivered where it had been identified. The RMMs were a useful forum, but did not appear to fully translate into practice and management oversight had not been effective in ensuring that this happened.

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



**Protecting  
the child or  
young person**

**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 57% of work to protect children and young people and reduce their vulnerability was done well enough.

## Key Findings

1. Over one-third of inspected cases did not have a sufficient assessment of vulnerability.
2. Almost one-third of the cases that should have had a plan to manage the child or young person's vulnerability did not have one and, where there was a plan, many were insufficient.
3. Almost two-thirds of cases were not reviewed properly.
4. Delivered interventions were not always in line with assessments and plans and more than half of the required interventions were not delivered.
5. We judged that the YOT had not done enough to keep the child or young person safe in almost half of the cases initially inspected.
6. Management oversight of the work to manage vulnerability was ineffective.
7. Staff had access to sufficient resources to deliver this work in almost all cases.

## Explanation of findings

### 1. Assessment

- 1.1. We judged that more than half of the reports inspected did not contain a clear and thorough assessment of vulnerability and this also applied to over one-third of all cases. This was mainly due to assessments not being undertaken and failing to recognise or ignoring, relevant behaviour.

### Case illustration

Rosalind was given a very short referral order for drugs offences, with only three objectives outlined on the contract. Indirect reparation was carried out, a referral to health was instigated and a very thorough entry was made on the system by the health worker. The young person had been missing from home on a number of occasions having left the family home in Lancashire after she made allegations of sexual abuse against a family member. The case manager identified that Rosalind had a series of older boyfriends and assessed that she may have been, or may currently be, the victim of child sexual exploitation. The case manager used the YOT police officer effectively to conduct research on her current boyfriend and her background in Lancashire. It was identified that an initial investigation had been conducted into her vulnerability to child sexual exploitation whilst still in her home location. Through a thorough assessment of the intelligence available the case manager was able to confirm that she was not vulnerable to sexual exploitation.

- 1.2. Staff did not always draw adequately on information from other agencies. This is particularly important because there are many private children's homes in Blackpool and, as a result, the YOT was often asked to 'caretake' cases for other YOTs. If information was not received promptly, or at all, from other YOTs and children's social care services, this could result in a poorer service to these children and young people.
- 1.3. We were pleased to note that although there were some individual issues with cases where children and young people were looked after, generally we judged that the assessment (and subsequent delivery) with children and young people who were looked after, was strong.
- 1.4. Half of the cases were not reviewed sufficiently well. In some cases this was because a significant change had not been recognised, such as leaving custody, or because reviews were not completed in a timely manner.
- 1.5. We found evidence of duplication in health assessments. Case managers completed the initial assessment and consistently completed the YOT mental health screening tool with the child or young person. However, the mental health screening tool was not used to inform a Screening Questionnaire Interview for Adolescents (SQIFA) assessment or interventions by the specialist health practitioners who conducted their own individual assessments. The physical health nurse and emotional and mental health worker both conducted holistic assessments capturing family relationships, the child or young person's emotional mental health, substance misuse, physical health needs, lifestyle and environment. One of the health assessment tools had not been approved by the relevant agency. Nor had either the physical health nurse or the emotional and mental health worker discussed or reviewed their full clinical caseload with their health manager.
- 1.6. The YOT could not be assured that all risks and vulnerabilities had been correctly identified and appropriate referrals and interventions sought or delivered. This valuable information was not routinely used to inform risk and vulnerability assessments because health professionals were not invited to VMMs or RMMs.

#### Comment by an inspector

*Qualitative information is not proactively sought from health agencies and 'facts' are often accepted without seeking clarification. This has resulted in some assessments being founded on incomplete information.*

## 2. Planning for interventions

- 2.1. Planning to address vulnerability was not considered sufficient in almost half of the inspected cases. A range of issues were missed including ETE, care arrangements and emotional and mental health.

### Case illustration

Victor was sentenced to a YRO and had been assessed as a high risk of harm to known victims and himself, due to his sexual behaviour and his poor understanding of the impact of his behaviour on others. He was arrested a week after the initial sentence date for the inspected order and charged with a sexual offence, to which he later pleaded guilty. Prior to the charge, his mother informed the YOT that there had been other allegations of behaviour of a sexual nature, yet no review was completed. In addition, no vulnerability plan was completed, even following his remand into custody. Each of these changes in circumstances was not reflected adequately in the assessment or review of his case.

- 2.2. In ten cases in the sample, there was no plan noting how the issues of the child or young person's vulnerability were to be managed. Other plans were not timely, gave insufficient attention to barriers to engagement or did not make information sharing arrangements clear. We expect agencies to coordinate their planning arrangements so that where children and young people are subject to either child protection or Looked After Child planning processes, plans are coordinated and understandable to all concerned.

### Comment by an inspector

Staff were aware of escalation processes for resolving professional disagreements and we saw examples where this had been effectively used. However, in some cases, staff had escalated concerns, but were not aware of the outcome. Managers acknowledged that a prevalent area for escalated concerns was the lack of clarity on respective roles and responsibilities between YOT staff and social workers, in particular in relation to care leavers known to the YOT. For example, in one case a lack of clarity of who was responsible for accommodating a care leaver on discharge from custody resulted in the vulnerable young person being left to drift between ad hoc accommodation.

- 2.3. We found no vulnerability management plan in two of the custodial cases where we would have expected to see one.
- 2.4. In almost two-thirds of cases, plans to manage vulnerability were not reviewed sufficiently, which meant that not all plans were revised as required.

### 3. Delivery of interventions

- 3.1. In almost two-thirds of cases, interventions to manage vulnerability were delivered in line with the assessment and plans.

#### Case illustration

Louis was 15 and had a history of multiple offences of dishonesty to fund his substance misuse. He lived with his parent and siblings, but the atmosphere at home was strained, his mum not feeling confident to manage Louis' challenging behaviour. A member of the family had been harming themselves as a result of the stress bought about by Louis' behaviour in the home. During Louis' detention in a secure training centre (STC) this had stopped, but had started again once they knew Louis was coming home. The case manager made a safeguarding referral to children's social care services in respect of the self-harming incidents. The case manager, having talked to the family, Louis and staff at the STC, made arrangements for everyone to visit Louis to talk about how his behaviour affected them. As a result each was better able to understand the impact of their behaviours on the other and on their mother. Louis was then able to successfully return home on release from custody.

- 3.2. Given the shortcomings of the assessments and plans, the work done in over half of the inspected cases was not what we felt was needed. This was largely due to the right interventions not being recognised by the case manager, but also referrals not being made to the appropriate specialists, or to children's social care services where needed.
- 3.3. There was not enough active and effective management of vulnerability in nearly half of the cases, and in most cases this was because interventions were not delivered and the work to address safeguarding was not given sufficient priority.
- 3.4. Changes in the child or young person's situation were not recognised or responded to appropriately and therefore reviews were insufficient. Although we had observed evidence of home visits, for a number of reasons in three cases home visits were not carried out as required to protect the child or young person. In one case, immediate action was not taken to protect the child or young person.

### 4. Initial outcomes

- 4.1. We judged that the YOT had not done enough to keep the child or young person safe in almost half of the cases initially inspected. This was mainly due to insufficient assessment and planning leading to the required work not being undertaken to manage vulnerability issues and poor engagement or cooperation with other agencies.

## Case illustration

Marie (aged 15) had been sentenced to a YRO for a violent offence. She was living with her father, a registered sex offender. She had previously been the subject of a child protection plan during 2005 when the criminal proceedings against her father were taking place. The Awaken project (multi-agency work with children and young people at risk of sexual exploitation) was also involved with Marie due to a recent episode regarding her boyfriend, who was being proceeded against for sexual offences against another child. We were concerned that the case manager had not explored how the arrangements for Marie to live with her father had been made, nor whether or not an assessment of this arrangement had been undertaken by children's social care services. Despite further worrying information being known to the YOT, she was designated low for vulnerability, no planning was done to manage vulnerability and no referral was made to children's social care services.

- 4.2. However, when we later reviewed some further cases, the picture had improved with regard to safeguarding concerns. These had been appropriately recognised and referred to children's social care services for assessment. YOT staff had worked well with partner agencies to protect these children and young people including attending child protection conferences and the core group meetings of workers directly involved in the protection. They had also contributed to the child protection plans and attended Looked After Children reviews for those children and young people known to the service, demonstrating some effective joint working.

### Comment from a young person

*"I just had a big meeting with my social worker, YOT, people from the home...having a discussion and sharing information".*

## 5. Leadership, management and partnership

- 5.1. In all but one case, we considered that the case manager had access to sufficient resources available to manage vulnerability.
- 5.2. We judged that management oversight of vulnerability work was not effective in almost three-quarters of cases. Again, this was mainly due to deficiencies in assessment and planning not being addressed and the ineffectiveness of the VMM, but also the manager's failure to ensure that required services were delivered by the YOT or other agencies.
- 5.3. All staff seen demonstrated sufficient understanding of their roles and responsibilities to safeguard children and had attended relevant multi-agency safeguarding training. Of those interviewed, almost all felt that countersigning and management oversight of safeguarding work was an effective process.
- 5.4. Managers within the YOT also evidenced a robust understanding of safeguarding issues, some with extensive previous experience in social work and safeguarding services, which assisted in enabling close collaboration with children's social care services. For example, managers in the YOT had recently attended a children's social care services management meeting to discuss YOT developments, and the YOT had established procedures for those Looked After Children both remanded and sentenced to custody.
- 5.5. Staff awareness and knowledge of safeguarding had been enhanced through the recent appointment to the team of social workers from children's social care services. This had also assisted YOT workers' understanding of the thresholds for referral to this agency.
- 5.6. Despite this, we found that the work to manage the wider vulnerability issues of the children and young people generally was not sufficiently well planned, managed or reviewed.

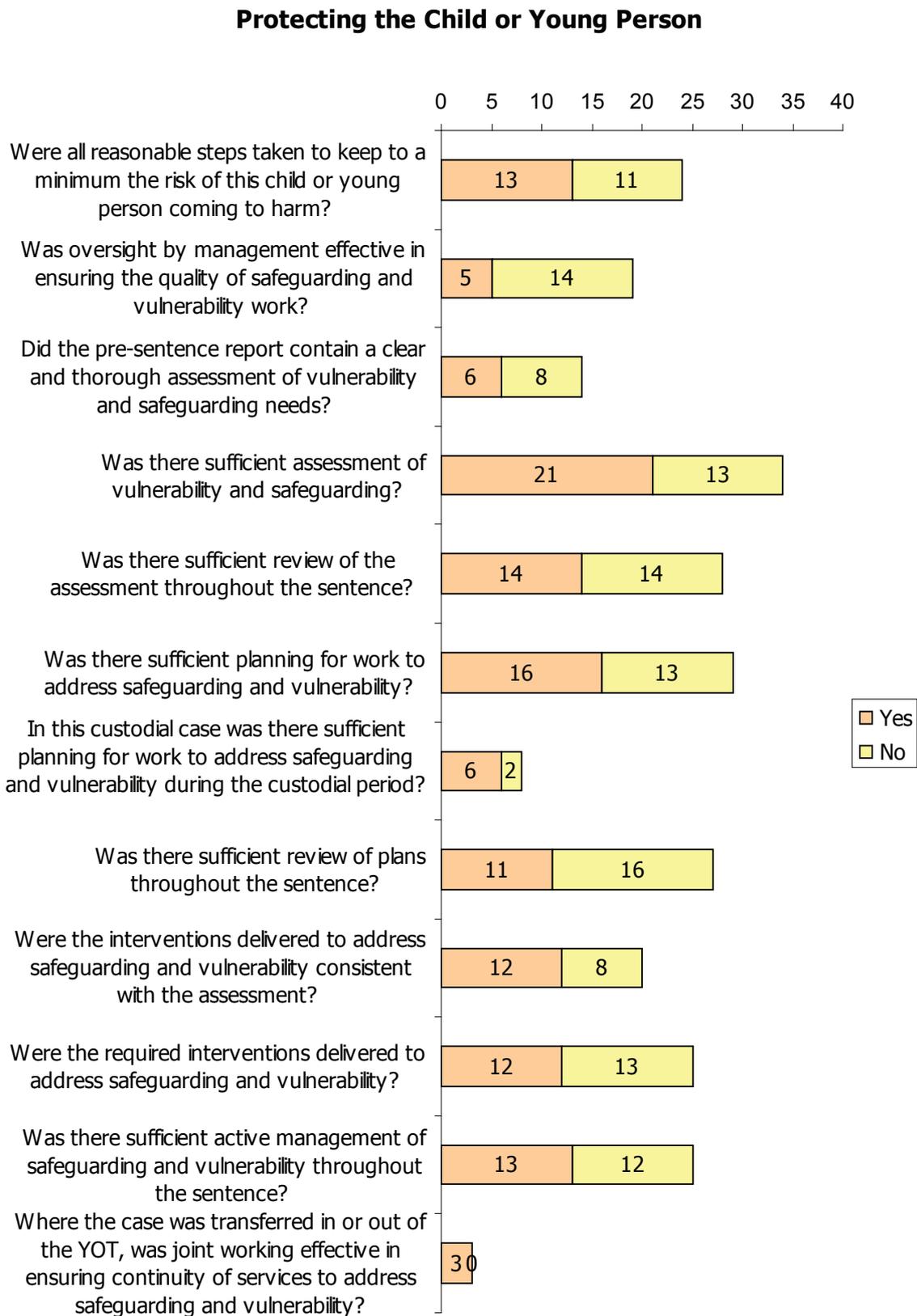
- 5.7. There was good partnership sharing of information between the Department of Health, police and the Substance Misuse Commissioning Team who sent out harm reduction notifications. These were graded on a traffic light system and consisted of a poster to help users, professionals and the public understand the emerging risks about local drug use, for example, drug purity.

## **Summary**

*Overall, work to protect children and young people and reduce their vulnerability was unsatisfactory. We could see that the processes were in place but they were not being operated successfully. Case managers knew lots about the children and young people and their lives, and were very committed to supporting them, but did not always recognise the things that made them vulnerable. This was particularly where their circumstances had changed and there was the risk that they may be harmed, either by others or by their own behaviour. Because assessments were often not good enough, planning how to manage vulnerability was also not good enough, whether using a formal plan or discussing simple contingency planning. Also, whilst interventions were delivered, they were not always appropriate. Managers overseeing the work had not picked up this up, even when they had held meetings with staff. In our view, some staff's knowledge and understanding of safeguarding issues was insufficiently broad enough to address all vulnerability issues.*

## Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



**Ensuring  
that the  
sentence is  
served**

**4**

## Theme 4: Ensuring that the sentence is served

### What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the 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 73% of work to ensure the sentence was served was done well enough.

### Key Findings

1. Ensuring that the sentence was served was a particular strength of this YOT.
2. Diversity and barriers to engagement were sufficiently well assessed in almost three-quarters of cases.
3. Children and young people and their parents/carers were involved in over three-quarters of the assessments, in the preparation of 92% of the court reports and in almost two-thirds of cases during the planning process.
4. Children and young people, their parents/carers and victims spoke highly of the service they had received from the YOT.
5. Generally, the YOT paid sufficient attention to compliance and enforcement where necessary.

### Explanation of findings

#### 1. Assessment

- 1.1. The YOT staff were good at making sure they understood the things that prevented the children and young people from fully engaging with the YOT, and did this sufficiently well in nearly three-quarters of the cases inspected. Where it was not well assessed, this was mainly around the assessment of learning styles and age or maturity. These issues were also not addressed in half of the PSRs seen.

### Case illustration

James was subject to a YRO with a number of requirements. He had been subject to a Statement of Special Educational Needs whilst in statutory education and had significant learning difficulties. He found it difficult to build up relationships with professionals and was self-conscious about his learning difficulties and admitting the severity of them. The case manager built a positive relationship with this young man over a period of time and accessed a copy of his statement in order to fully understand his needs. Appointments were given at the same time of day and when James was resentenced to an intensive surveillance and supervision requirement, the case manager ensured that the timetable was colour coded. This enabled him to comply with his order, because he easily understood where his appointments were taking place (by colour), as he had difficulty reading the standard timetables.

- 1.2. In nearly all cases, children and young people and their parents/carers had engaged in the assessment and the preparation of the court report.

## 2. Planning for interventions

- 2.1. In over one-third of cases, the initial planning arrangements did not pay sufficient attention to barriers to engagement; that is, the things that get in the way of a child or young person working positively with the YOT. Those factors that were missed by the case manager in developing the plans included being 'looked after', gender and sexuality.
- 2.2. In almost two-thirds of cases, children and young people and their parents/carers were sufficiently involved in planning the work. In a number of cases, the social worker was not sufficiently involved with the planning for a Looked After Child.

## 3. Delivery of interventions

- 3.1. The engagement of children and young people and their parents/carers carried on, to a greater extent, throughout the sentence in most cases.

### Comment from a young person

*"They try their best to keep you out of trouble, they've done a lot of things for me and my family, like financial stuff...keeping me occupied with college and that".*

### Case illustration

Niels was subject to a YRO with a requirement of ISS. He was 'looked after' by the local authority and placed in foster care. He was reluctant to engage with professionals, particularly children's social care services, as he associated them with what he perceived to be negative outcomes within his life. He did, however, form a good relationship with his YOT case manager following a lot of effort and persistence from them. Niels' attendance at interviews and engagement with the YOT case manager, was reasonably good. As he grew older, Niels was transferred by the local authority from a social worker to a leaving care worker and the YOT case manager identified that he was unlikely to engage effectively with them, due to his concerns over their involvement in his life. However, as the YOT case manager had a positive relationship with this young man, they arranged a joint appointment with the leaving care worker for an initial meeting so that together they could explain the benefits of engagement. This strategy and joint working was effective, as Niels then worked well with the leaving care worker and, as a result, felt more comfortable with his current placement.

## 4. Initial outcomes

- 4.1. In most cases, the YOT paid sufficient attention to the health and well-being of a child or young person. Where this was not the case, it was mostly due to agencies not coordinating their work properly and a failure to ensure that any improvements made were sustainable in the long-term.

### Case illustration

Leo was made subject to a referral order in relation to drugs offences. He and his parent attended the initial panel and agreed for a referral to be made to the YOT substance misuse worker for an assessment. However, despite this action being part of the contract and agreed by the panel, the substance misuse worker and case manager agreed between themselves that the case manager would assess needs in this area and a specialist assessment was not undertaken. Only one awareness session was delivered throughout this order which, in our view, was insufficient, as substance misuse was a considerable risk factor in the likelihood of Leo reoffending. This deficiency in delivery of interventions was not addressed, as there were no review panels held to monitor the progress of the order.

- 4.2. We were pleased to see that the YOT gave the right amount of attention to identifying and dealing with the things that stopped children and young people engaging with the YOT, in over three-quarters of cases. The remaining insufficiencies were judged to be the result of not identifying those issues at the assessment stage.
- 4.3. We judged that the YOT generally paid sufficient attention to ensuring that children and young people complied with the requirements of the sentence. Where this was not true, it was because attention had not been paid to the things that might get in the way – such as a child or young person having difficulty following a written timetable.
- 4.4. Over half of the children and young people complied with the sentence, either completely, or after some initial difficulties. The YOT responded appropriately to most of them although there were occasions where we considered that not enough effort was made to understand the reasons why the child or young person had not attended their appointments.

### Comment from a parent/carer

*"It's not just them doing the sentence; it's the family...I'd be absolutely lost without YOT helping me; they've been an enormous help...they've given him plenty of chances, they've helped him with alcohol and drug issues, his offending, I can see this attitude changing, he was so happy when they got him involved with the Prince's Trust, and so excited when they got him his first ever interview at the council".*

## 5. Leadership, management and partnership

- 5.1. Most case managers understood the local policies and procedures for supporting engagement and responding to non-compliance.

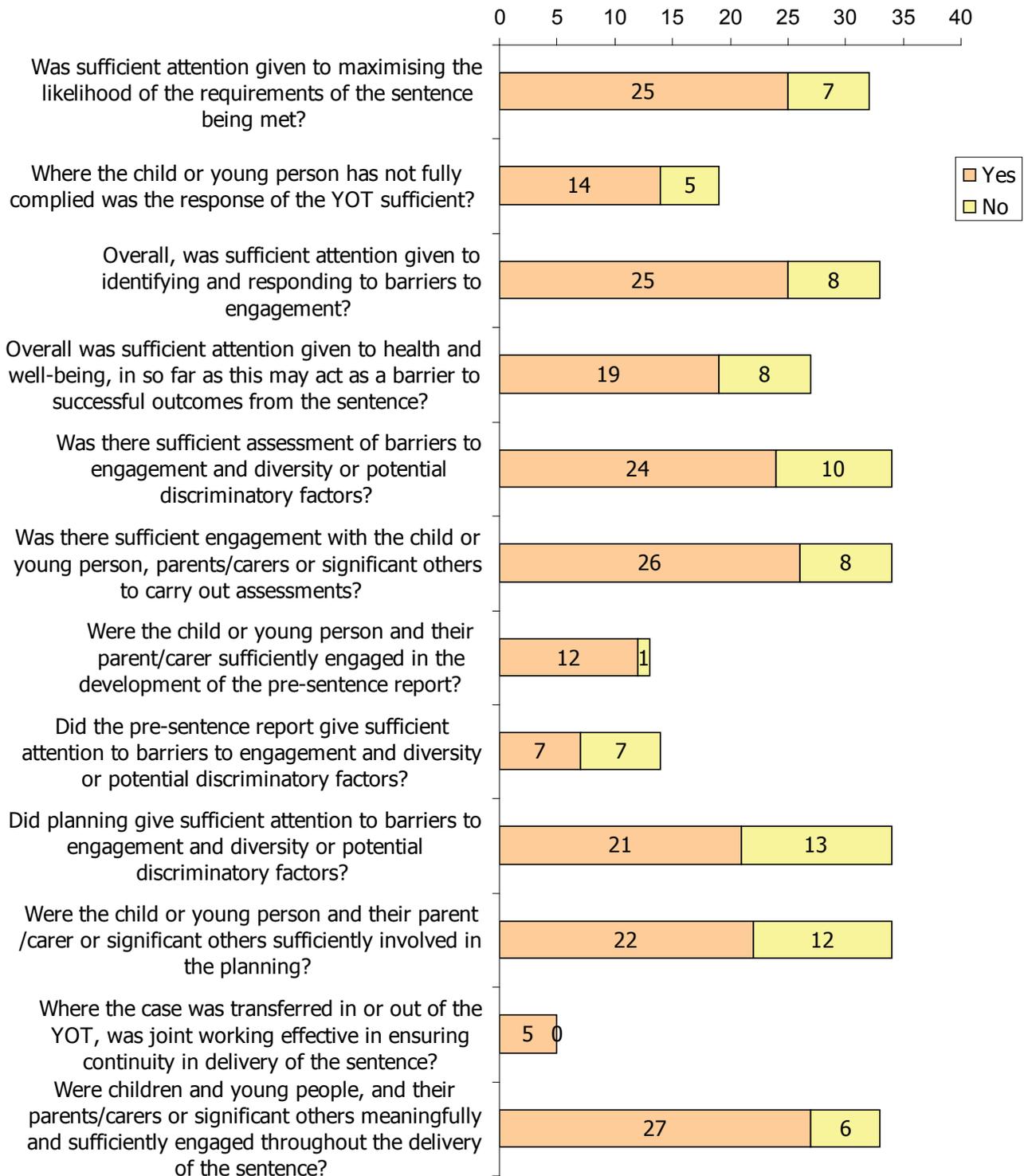
### Summary

*Overall, work to ensure that the sentence was served was good.* Engagement with children and young people was good and was valued by them and their parents/carers. The children and young people and their parents/carers were usually involved in both the assessment and planning processes. Attention needed to be focused on identifying the barriers to compliance and planning how to address these before they become an issue. Good efforts were made to ensure that the children and young person cooperated with the order of the court and, where necessary, enforcement was generally carried out promptly.

**Data Summary**

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]

**Ensuring that the Sentence is Served**



# Governance

# 5

# Theme 5: Governance

## What we expect to see

The YOT<sup>1</sup> partnership and YOT Management Board<sup>2</sup>, provide sufficient governance to meet national and local criminal justice objectives, and delivers effective outcomes for children and young people who offend or who are likely to offend and the local community. Equality of opportunity and wider diversity issues are prioritised throughout. The YOT has developed partnerships, which work together to ensure effective outcomes for children and young people who offend or who are likely to offend and the local community. The YOT has, in place, workforce management that enables staff to deliver quality engagement and effective outcomes for children and young people who offend or who are likely to offend, and the local community.

## Outcome

Overall, we found that the governance provided by the Board was unsatisfactory.

## Key Findings

1. The YOT Management Board did not provide sufficient strategic leadership or governance to meet criminal justice objectives, and deliver effective outcomes for children and young people who offend and the local community.
2. The Board did not ensure that partnership working was effective. The lack of strategic planning had led to a lack of integration of multi-agency workers within the YOT, for example, health, education and police, and there were no plans to focus their full and effective use within the YOT.
3. Performance management within the YOT was underdeveloped, such that the Board was unable to challenge effectively or drive performance improvement.
4. Workforce management and policy development were work in progress, with some internal and pan-Lancashire draft policies, but they were not yet fully embedded within the work of the YOT.
5. Staff were not supervised regularly but were positive about the quality of supervision.
6. The current changes both in the organisation of the YOT and the membership of the Board, whilst also work in progress, gave hope that this will enable the improvement in performance to continue.

## Explanation of findings

### 1. National and local criminal justice objectives are met

- 1.1. Blackpool YOT is one of three YOTs (Blackpool, Blackburn with Darwen and Lancashire), located within the areas of responsibility of Lancashire Constabulary and Lancashire Probation Trust. This adds additional challenges to multi-agency working, since local agreements in one YOT can differ from those in another YOT. Commendable efforts had been made to address this through the creation of a number of pan-Lancashire agreements, such as the procedure for children and young people who display sexually harmful behaviour; however, this work was ongoing.
- 1.2. The Director of Children's Services had assumed responsibility for chairing the Board in mid-2012.

<sup>1</sup> We use the term YOT as this is in the legislation but this refers to all partnerships delivering services to children and young people who have offended or who are likely to offend.

<sup>2</sup> This is likely to be broader than stated as it also relates to any strategic body which has responsibility for work with children and young people who have offended and/or those who are likely to offend. In legislation, the overall responsible person is the local authority Chief Executive.

It had been recognised that there needed to be some progress in the process of reinvigorating the Board, with invitations to new members. The Board had representatives from statutory partners, but some of these were not senior enough to make decisions to effectively support the YOT, and not all had fully understood their role. For example, we observed that there was no Health Commissioner on the Board.

- 1.3. For the police, the Head of Criminal Justice for Lancashire Constabulary had only recently joined and was yet to attend a meeting, although a local Chief Inspector had been present. Wider agency representatives such as accommodation providers or the Crown Prosecution Service were not involved.
- 1.4. The frequency of meetings held in 2012 did not enable the Board to be effective and there was little evidence of the members contributing significantly to its work. Current Board members accepted that individually they should see their role as including the responsibility to appropriately challenge each other, and work as a partnership, as well as representing their own organisation. This had not happened much in the recent past. The Director of Children's Services was committed to improving the effectiveness of the Board and this was welcomed by the YOT manager.
- 1.5. Managers and Board members were represented appropriately on the relevant Boards and panels in the area, such as the Blackpool and Lancashire Local Safeguarding Children Boards (LSCBs). Commendably, the YOT had undertaken joint activity with the police and other Lancashire YOTs to create a pan-Lancashire agreement on the retention of Police and Criminal Evidence Act 1984 beds<sup>3</sup>, to minimise the length of time children and young people were held in cells.

#### **Comment by an inspector**

*The YOT manager had worked extremely hard to improve the rate of transfer of children and young people charged and detained in police custody into local authority accommodation. A permanent bed placement had been obtained for such a purpose and work done in partnership with the police to ensure custody sergeants understood the legal obligation to use the facility provided. Each case of a child or young person who was not transferred was scrutinised by the YOT management and, if appropriate, an explanation was sought from the police. This was a better service than we had seen anywhere else in England and Wales.*

- 1.6. Performance management within the YOT was underdeveloped. Core performance management information included the key national youth justice outcome measures and some local indicators. Effective work had been undertaken to ensure that performance information was accurate following the previous YOT Core Case Inspection in 2009. However, the systems were insufficiently established to enable managers or the Board to fully understand the service strengths and areas for development, or the quality of the work undertaken. There was no evidence of Board members holding the YOT Manager to account, or commissioning work on performance to identify and achieve improvements. No strategic needs analysis had taken place and, therefore, the Board were not able to identify whether resources were being utilised effectively or how they might plan services in the future.
- 1.7. Data from partners was underutilised. For example, the health worker completed work returns detailing her cases but failed to capture children and young people's progress, and these returns had not been used to inform service delivery, such as the prioritisation of high risk cases. For ETE, the data was not used sufficiently to monitor the outcomes for the children and young people engaged in ETE. The YOT collected insufficient information on the quality of outcomes such as qualifications

<sup>3</sup> Once a child or young person is charged with an offence, the custody officer may decide that it is necessary to deny them bail and then they must be placed in the care of a local authority pending an appearance in court, unless it is impracticable or there is a risk to public of serious harm, and no secure accommodation is available. The duty on the police to transfer a child or young person to local authority care is reciprocal in that, under Section 21 of the Children's Act 1989, the local authority must accept that child or young person when they receive a request from police.

and development of skill and progression, attained by the children and young people under their supervision, particularly in the post-16 provision. Some providers did not gather this information relating to YOT children and young people separately from their overall provision.

- 1.8. The YOT did not apply enough scrutiny to the quality of provision delivered by the learning providers. For example, not all providers made effective use of the initial assessment and learning plans to ensure children and young people progressed and achieved well.
- 1.9. A youth justice plan was in place which sought to anticipate future needs and priorities; however, the performance management system provided insufficient information to allow the Board to make clear, cohesive plans to ensure each partner's strategic aims would be fulfilled and their resources within the YOT used fully and effectively. The plan was not fully integrated with other relevant plans for children and young people to maximise the likelihood of local and national objectives being met.
- 1.10. As such, the leadership provided through the Management Board and other governance arrangements was ineffective in ensuring that local and national criminal justice objectives were met; in particular that children and young people were less likely to offend, victims were protected, and children and young people who had offended were kept safe. Overarching strategies to get the best from partnership working with the different agencies did not exist. For example, there was no formalised strategy highlighting the vision, ambition, goals and targets for the children and young people they referred to ETE services. The needs and interests of the children and young people had not been fully ascertained and integrated in the ETE provision and there was a need to offer more vocational and employability-focused learning programmes. Partnerships with several community agencies, such as fire and rescue, were working well and increasing children and young peoples' awareness with regards to fire safety. However, not enough work had taken place with some partners in the community, such as employers, to influence and represent the ETE needs of the children and young people.

#### **Comment by an inspector**

*The percentage of children and young people, known to the YOT, participating in full-time ETE had, overall, remained virtually the same since the last inspection. In particular, the percentage of children and young people above school age had improved from 56% in 2009/2010 to 76% in 2011/2012. However, the trend of performance in the current year so far, was one of decline for this group. In contrast, the percentage of school age children attending education had declined, from 73% to 52%, however, this had greatly improved in the current year.*

- 1.11. The YOT Board had not, therefore, provided sufficient challenge to the ETE area to bring about improvement quickly. Actions for improvement identified by the previous 2009 inspection had only been briefly reviewed by the Board after a considerable period of time. The Board had failed to constructively challenge performance regarding the number of children and young people who were engaging in ETE in the last three years.

## **2. Effective partnerships make a difference**

- 2.1. The YOT Manager had worked hard to establish and improve relationships with the wider local authority and other criminal justice agencies from what had been a low base. The YOT was viewed as proactive in local partnerships such as MAPPA and some other multi-agency forums; for example, it was fully engaged with the Lancashire Criminal Justice Board at various levels.
- 2.2. We did not find evidence of commissioned work to be delivered by partners based on assessed needs (including diversity needs). An internal review of the interventions available at the YOT had been completed, but this had not led to the measurement of their effectiveness, or the identification of any gaps in provision.

- 2.3. We did not find evidence that plans had been agreed jointly by the YOT and key partners, although, the Youth Justice Plan was due for review in 2013. Plans from partners to provide for the needs of children and young people who had offended were spoken of, but were due to be published after the inspection.
- 2.4. The underdeveloped nature of performance management meant that the YOT Management Board were unable to identify when they should be undertaking joint work with partner agencies to tackle underperformance, and ensure improvements in service delivery were evidenced. For example, there was an absence of evaluative data on the performance of health services operating within the YOT and no outcome measures agreed between the health services and YOT to capture how they contribute to reducing reoffending by children and young people.
- 2.5. Joint initiatives from partner agencies were undertaken, such as the movement by police to increase the utilisation of pre-court disposals, but there was no sense that this had grown from a joint strategic commitment underpinned by the Board, despite the YOT manager's long term commitment to increasing the use of pre-court disposals. Blackpool had a triage<sup>4</sup> scheme in operation; whilst numbers of children and young people being dealt by triage had increased and the numbers entering the criminal justice system had fallen, it was acknowledged that more could be done to increase its uptake. There is sometimes reluctance on the part of the police to use triage, because currently a reprimand or final warning issued to a child or young person results in a 'sanction detection' for the police, and that merits higher reward against police detection targets. Changes due to be implemented in the near future by the Home Office will mean that triage and other restorative outcomes for children and young people will be given equal status to 'sanction detections'. However, what this demonstrated was that the partners had not explored how their conflicting targets could still be achieved and services improved to keep children and young people out of the criminal justice system.
- 2.6. We did not find evidence that the YOT worked effectively and efficiently with partners to coordinate and share resources, including, for example, human resources, structural arrangements, information sharing, and delivery of services. However, some use had been seen of the police's performance management tool, which provided up to date information on arrests and disposals across Lancashire.
- 2.7. Whilst there was evidence of good liaison at a strategic level between the YOT Manager and the police Chief Inspector, the relationship between the YOT and police was more variable at an operational level. Expressed negative perceptions by two key criminal justice partners caused concern to us. Whilst a challenging culture is healthy in one sense, these perceived differences fostered mistrust and can impact on the ability to work closely together for the benefit of all so should be addressed by the Board.
- 2.8. It was confirmed that the YOT worked appropriately with the courts to assist in the efficient and effective administration of justice for children and young people who have offended. The relevant representatives from HM Courts and Tribunals Service were Board members and the YOT had welcomed magistrates for a recent visit, in addition to training.

### **3. Effective workforce management supports quality service delivery**

- 3.1. Although interviewed staff understood the importance of the YOT's role in delivering positive outcomes for the children and young people they worked with and their role in achieving that vision, the YOT's overarching vision was not clear and well communicated, nor driven by the Board.
- 3.2. We did not consider that staff were appropriately supervised and appraised within a performance management framework in accordance with their role and identified development needs. The existing supervision policy was not applied consistently and actions given during supervision were not always followed up. Little evidence was seen of the appraisal system being used to identify

<sup>4</sup> Triage schemes are based in police stations and aim to identify the needs of young people as they enter the youth justice system. A key objective of the schemes is to divert young people who have committed less serious crimes away from the formal youth justice system.

development needs or marry up the needs expressed with national and local priorities or the needs of the YOT as a whole, so that whilst records showed a variety of training taking place, it was not clear how this met the strategic needs of the YOT. Additionally, there was no formal system to recognise, celebrate and reward outstanding work, and to share best practice throughout the YOT.

- 3.3. There was a lack of understanding at every organisational tier (health commissioners, YOT Board members, YOT managers, health/specialist professionals and caseworkers) of the roles, responsibilities and the interventions being delivered by the emotional well-being workers and health nurse. Case managers had only received training in alcohol and cannabis awareness including the recognition of substance misuse, the effects, risks, and harm reduction strategies and no training on physical or emotional mental health. The lack of understanding of the roles and responsibilities of the health professionals was further complicated by a duplication of roles with low tiered interventions designed at addressing self-esteem and anger management being delivered by the health nurse and emotional and mental workers. This conflict had not been identified by the YOT or health worker supervisors, who were unaware of the interventions being delivered to children and young people specifically in relation to anger management.

### Case illustration

Jim was given a YRO for possession of cannabis and antisocial behaviour (ASB) and had disclosed he had "paranoia and hearing voices". The caseworker conducted a Screening Questionnaire Interview for Adolescents (SQIFA) and referred Jim to the YOT emotional and mental health worker (EMH) for 'special support linked to his diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and health needs'. Jim would not take his medication, smoked cannabis daily, was blacking out, had an uncle with schizophrenia and his offending was escalating. The EMH worker attempted to conduct a further assessment, but Jim disengaged from the service. The significance of these disclosures was not identified or understood by the YOT staff, no referral was made to CAMHS or followed up with Jim, his family or his GP to ensure that he was accessing appropriate health services. No one had captured Jim's potential unaddressed health need and secured him the services he required.

- 3.4. Specialist health oversight of the health workers was inconsistent. The partnership agreement between the YOT and the NHS stipulated two hours of clinical supervision was to be provided each month to the emotional and mental health worker, but this was actually provided every six weeks. The Hub<sup>5</sup> also provided annual leave, sickness cover and training to the YOT substance misuse worker. However, this supervision was not subject to a formal agreement, despite it being necessary to ensure the substance misuse worker could practice safely and effectively at Tier 3.
- 3.5. However, it was the lack of involvement by CAMHS management to ensure appropriate cases were referred/retained that exposed the greatest risks for the children and young people and wider public.
- 3.6. Since the last inspection there had been considerable change and improvement and it is commendable that managers had brought the staff with them, such that they still responded positively to the upcoming organisational changes. Staff were clear that the YOT supported and valued continual training and development, even in the current straitened times.

## 4. Positive outcomes are achieved and sustained

- 4.1. As has previously been stated, the performance management system was underdeveloped and did not provide sufficient information, including reference to performance of disadvantaged and overrepresented groups in order to improve practice. Nor were plans, interventions and outcomes regularly monitored and reviewed to assess improvement.

<sup>5</sup> The Hub is a substance misuse service providing advice to children and young people, their families and friends, and professionals in Blackpool.

- 4.2. The YOT has yet to engage with higher education, pilot programmes and other bodies to help independently evaluate the effectiveness of work undertaken.

### **Summary**

*Overall, governance in Blackpool was unsatisfactory. A previously supportive but ineffectual Board was gradually changing to one populated by suitably senior representatives from partner agencies, but at the point of the inspection did not provide sufficient strategic leadership or ensure the delivery of effective outcomes. They also did not ensure partnership working was effective, partly due to the lack of information from the performance management system. Internal operational procedures were insufficiently robust and inconsistently applied, although they were being developed and implemented. Managers had worked hard to improve performance and had also ensured that the staff were travelling with them on this journey.*

# Appendices

# Appendix 1

## Contextual information about the area inspected

Blackpool had a population of 142,100 as measured in the Census 2011. The youth population (those aged between 10-17 years old) accounted for 9.6% of the population. This was about the same as the average for England and Wales as a whole, which was 9.4%.

The percentage of the youth population with a black and minority ethnic heritage was 5.3% (ONS, mid-year estimate 10-17 year olds, black and minority ethnic 2009). This was lower than the average for England and Wales, which was 14.1%.

Reported offences for which children and young people aged 10-17 years old received a pre-court disposal or a court disposal in 2010/2011, at 92 per 1,000, were much higher than the average for England and Wales of 33 (YJB 2010-2011).

The proportion of young people in Blackpool aged 16-18 who were not in education, training or employment is estimated at 7.8%. This is higher than the average for England which is estimated at 6.1% (Department for Education 2012).

### Youth Justice Board indicators

The YJB indicators are national measures of YOT work and performance:

#### Reoffending measures:

(i) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a class A drug on arrest, the proportion who reoffend within a 12 month reporting period. This reoffending proportion for Blackpool was 39.3 %, worse than the 35.8% for England and Wales as a whole.

(ii) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a Class A drug on arrest, the average number of reoffences within 12 months, per 100 such children and young people. For Blackpool, there were 1.47 offences per child or young person who reoffends, much worse than the 1.03 for England and Wales as a whole.

(Data based on April 2010 to March 2011 cohort.)

#### First time entrants measure:

The number of children and young people who received their first reprimand, final warning or court conviction (and thus entered the youth justice system) in a 12 month period, as a proportion per 100,000 10-17 year olds in the general local population. The figure for Blackpool is 965, compared to 595 for England and Wales as a whole.

(Data based on October 2011 to September 2012 cohort.)

## Appendix 2

### Contextual information about the inspected case sample

In the first fieldwork week we look at a representative sample of 34 individual cases up to 12 months old, some current, others terminated. These are made up of first tier cases (referral orders and reparation orders), youth rehabilitation orders (mainly those with supervision requirements), detention and training orders and other custodial sentences.

The sample seeks to reflect the make up of the whole caseload and will include a number of those who are a high risk of harm to others, are particularly vulnerable, are young women or are black & minority ethnic children and young people.

## Appendix 3

### Acknowledgements

<b>Lead Inspector</b>	Caroline Nicklin, <i>HMI Probation</i>
<b>Deputy Lead Inspector</b>	Bobbie Jones, <i>HMI Probation</i>
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<b>HMI Probation Support Services</b>	Stephen Hunt, <i>Support Service Officer</i> Oliver Kenton, <i>Assistant Research Officer</i> Alex Pentecost, <i>Publications Manager</i> Christopher Reeves, <i>Proof Reader</i> Rob Turner, <i>Support Service Manager</i>
<b>Assistant Chief Inspector</b>	Julie Fox, <i>HMI Probation</i>

## Appendix 4

### Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work in a small number of local authority areas each year. It focuses predominantly on the quality of work in statutory community and custodial cases during the sentence up to the date of inspection. Its objective is to seek assurance that work is being done well enough to achieve the right outcomes. The four core themes for this inspection are:

- Reducing the likelihood of reoffending
- Protecting the public
- Protecting the child or young person
- Ensuring the sentence is served

#### Methodology

YOTs are informed 11 working days prior to the inspection taking place. Fieldwork is undertaken over two weeks with a week in between. The primary focus is the quality of work undertaken with children and young people who offend, whoever is delivering it. Cases are assessed by a team of inspection staff with local assessors (peer assessors from another Youth Offending Team). They examine these with case managers who are invited to discuss their work in depth, are asked to explain their thinking and to identify supporting evidence in the record.

Prior to or during this first week, we receive copies of relevant local documents. During the week in between, the data from the case assessments are collated and a picture about the quality of the work of the youth offending team emerges.

The second fieldwork week is the joint element of the inspection – HMI Probation are joined by colleague inspectors from the police, health, social care and education to explore in greater detail the themes which have emerged from the case assessments. In particular, the leadership, management and partnership elements of the inspection are explored, in so far as they contribute, or otherwise, to the quality of the work delivered.

During this week we also gather the views of others including strategic managers, staff and service users – children and young people, parents/carers and victims, and where possible observe work taking place. From April 2013 we will also gather the views of children and young people through a questionnaire.

At the end of the second fieldwork week we present our findings to local strategic managers, the YOT management team and other interested parties.

#### 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 Youth Justice Board. 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*'.

## Appendix 5

### Scoring approach

This describes the methodology for assigning scores to each of the core themes:

- Reducing the likelihood of reoffending
- Protecting the public
- Protecting the child or young person
- Ensuring that the sentence is served

Inspector staff examine how well the work was done across the case - from assessment and planning to interventions and outcomes, focusing on how often each aspect of the work was done well enough. This brings together performance on related elements of practice from all inspected cases.

Each scoring question in the inspection tool contributes to the score for the relevant section in the report. In this way the core themes focus on the key outcomes.

This approach enables us to say how often each aspect of work was done well enough, and provides the inspected YOT with a clear focus for their improvement activities. Each core theme is assigned a percentage (quantitative) score, which along with a descriptor is then given a provisional star rating.

Case assessment score	Descriptor	Star rating
80% +	Very good	★★★★
65% - 79%	Good	★★★☆☆
50-64%	Unsatisfactory	★★☆☆☆
< 50%	Poor	★☆☆☆☆

Each of these themes contains elements of leadership, management and partnership which cannot be evidenced through the scoring system for individual cases, and which are a particular focus of the work of partner inspectorates. A moderation process then takes account of these elements to determine the final descriptor.

Additional modules are scored on a similar basis.

If there are serious and unaddressed shortcomings, in individual cases, relating to the risk of suffering harm either to or from the child or young person, that have left someone at risk, then this may constitute a limiting factor to the star rating.

Further details of this process can be found on our website: [Inspection of Youth Offending Work](#)

## Appendix 6

### Criteria

The aspects of work youth offending work that were covered in the core themes in this inspection are defined in the Inspection Criteria for Full Joint Inspection. A copy of the inspection criteria is available on the HMI Probation web-site at the following address:

<http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work>

Separate criteria are published for each additional module inspected, which are available from the same address.

## Appendix 7

### Role of HMI Probation and Code of Practice

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

[www.justice.gsi.gov.uk/about/hmi-probation](http://www.justice.gsi.gov.uk/about/hmi-probation)

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 8

## Glossary

ASB/ASBO	Antisocial behaviour/antisocial behaviour order
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the child or young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
CJS	Criminal justice system. Involves any or all of the agencies involved in upholding and implementing the law – police, courts, Youth Offending Teams, probation and prisons
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
FTE	Full-time equivalent
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
Interventions; <i>constructive</i> and <i>restrictive</i> interventions	<p>Work with an individual that is designed to change their offending behaviour and/or to support public protection.</p> <p>A <i>constructive</i> intervention is where the primary purpose is to reduce the likelihood of reoffending.</p> <p>A <i>restrictive</i> intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others.</p> <p>Example: with a sex offender, a <i>constructive intervention</i> might be to put them through an accredited sex offender programme; a <i>restrictive intervention</i> (to minimise their risk of harm) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case.</p> <p>NB. Both types of intervention are important</p>
Likelihood of reoffending	See also <i>constructive</i> Interventions
LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
MAPP	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others
Ofsted	Office for Standards in Education, Children's Services and Skills: the inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
PSR	Pre-sentence report: for a court
RMM/VMM	Risk Management Meeting/Vulnerability Management Meeting
<i>Risk of harm to others</i>	See also <i>restrictive</i> Interventions

'Risk of harm to others work', or 'Risk of Harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using <i>restrictive interventions</i> , to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others
RoSH	Risk of Serious Harm: a term used in Asset. HMI Probation prefers not to use this term as it does not help to clarify the distinction between the <i>probability</i> of an event occurring and the <i>impact/severity</i> of the event. The term <i>Risk of Serious Harm</i> only incorporates 'serious' impact, whereas using 'risk of harm' enables the necessary attention to be given to those offenders for whom lower <i>impact/severity</i> harmful behaviour is <i>probable</i>
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm
STC	Secure training centre
SIFA	Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers
SQIFA	Screening Questionnaire Interview for Adolescents: Youth Justice Board approved mental health screening tool for Youth Offending Team workers
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution: a Prison Service institution for children and young people remanded in custody or sentenced to custody
YOIS+	Youth Offending Information System: one of the two electronic case management systems for youth offending work currently in use in England and Wales
YOS/YOT/YJS	Youth Offending Service/Youth Offending Team/Youth Justice Service. These are common titles for the bodies commonly referred to as YOTs
YRO	The youth rehabilitation order is a generic community sentence used with children and young people who offend



Arolygiad ar y Cyd Cyfiawnder Troseddol

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