Inspection of Youth Offending
Archwilio Rhaglen Troseddwyr Ifanc

Criminal Justice Joint Inspection
Arolygiad ar y Cyd Cyfiawnder Troseddol

Core Case Inspection of youth offending work in England and Wales

Report on youth offending work in:

Cheshire

ISBN: 978-1-84099-254-0

2009

Foreword

This Core Case Inspection of youth offending work in Cheshire took place as part of the Inspection of Youth Offending programme. We have examined a representative sample of youth offending cases from the area, and have judged how often the Public Protection and the Safeguarding aspects of the work were done to a sufficiently high level of quality. Our findings will also feed into the wider annual Comprehensive Area Assessment process.

Over the area as a whole, we judged that the Safeguarding aspects of the work were done well enough 69% of the time. With the Public Protection aspects, work to keep to a minimum each individual's *Risk of Harm to others* was done well enough 69% of the time, and the work to make each individual less likely to reoffend was done well enough 77% of the time. A more detailed analysis of our findings is provided in the main body of this report, and summarised in a table in Appendix 1. We also provide there the separate analyses of the case samples from the constituent areas, for feeding into their separate Comprehensive Area Assessment processes.

Overall, we consider this an encouraging set of findings. A recent change of senior management in the YOS had already resulted in greater stability and the prospect for the authority to make improvements. This was evident during the inspection. Recent changes in Local Authority boundaries and consequences for the YOS have yet to have an impact. The commitment of staff to make a difference to the lives of the children and young people under their supervision will ensure a continuing commitment to develop the service.

Andrew Bridges
HM Chief Inspector of Probation

October 2009

Acknowledgements

We would like to thank all the staff from the YOS, members of the Management Board and partner organisations for their assistance in ensuring the smooth running of this inspection.

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Scoring – and Summary Table

This report provides percentage scores for each of the 'practice criteria' essentially indicating how often each aspect of work met the level of quality we were looking for. In these inspections we focus principally on the Public Protection and Safeguarding aspects of the work in each case sample.

Accordingly, we are able to provide a score that represents how often the *Public Protection* and *Safeguarding* aspects of the cases we assessed met the level of quality we were looking for, which we summarise here.

We also provide a headline 'Comment' by each score, to indicate whether we consider that this aspect of work now requires either **MINIMUM, MODERATE, SUBSTANTIAL** or **DRASTIC** improvement in the immediate future.

***Safeguarding* score:**	
This score indicates the percentage of *Safeguarding* work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
Score:	***Comment:***
69%	***MODERATE improvement required***

Public Protection – Risk of Harm score:	
This score indicates the percentage of *Risk of Harm* work that we judged to have met a sufficiently high level of quality. This score is significant in helping us to decide whether an early further inspection is needed.	
Score:	***Comment:***
69%	***MODERATE improvement required***

***Public Protection - Likelihood of Reoffending* score:**	
This score indicates the percentage of *Likelihood of Reoffending* work that we judged to have met a sufficiently high level of quality.	
Score:	***Comment:***
77%	***MINIMUM improvement required***

We advise readers of reports not to attempt close comparisons of scores between individual areas. Such comparisons are not necessarily valid as the sizes of samples vary slightly, as does the profile of cases included in each area's sample. We believe the scoring is best seen as a headline summary of what we have found in an individual area, and providing a focus for future improvement work within that area.

Recommendations (primary responsibility is indicated in brackets)

Changes are necessary to ensure that, in a higher proportion of cases:

(1) The vulnerability and Safeguarding needs of children and young people are correctly identified and addressed. (YOS Head of Service)

(2) A timely and good quality assessment of the individual's *Risk of Harm to others* is completed at the start of an intervention, as appropriate to the specific case (YOS Head of Service)

(3) As a consequence of the assessment, the record of the intervention plan is specific about what will now be done in order to safeguard the child or young person's well-being, to make them less likely to reoffend, and to minimise any identified *Risk of Harm to others* (YOS Head of Service)

(4) Management oversight of work to address Safeguarding and *the Risk of Harm to others* can be seen to support improvements in practice (YOS Head of Service).

Next steps

An improvement plan addressing the recommendations should be submitted to HM Inspectorate of Probation four weeks after the publication of this inspection report. Once finalised, the plan will be forwarded to the Youth Justice Board to monitor its implementation.

Service users' perspective

Children and young people

Eighteen children and young people completed a questionnaire for the inspection.

- All the children and young people who responded to our questionnaire knew why they were involved with the YOS and what they could expect when they attended for appointments. They all thought that the staff were interested in helping them.
- Sixteen thought that they were listened to and that staff took action in relation to issues raised by them.
- Fourteen had been asked to complete the *What do YOU think?* form.
- Seventeen of the children and young people were able to identify ways in which the YOS had helped them. The highest scores were for 'making better decisions' (12) and 'understanding your offending' (12), followed by 'decision making' (nine), 'drug use' (eight) and 'feeling less stressed' (eight).
- Thirteen thought they were less likely to commit offences through their work with the YOS.
- On a scale of one to four (four being completely satisfied), 15 children and young people rated the service provided by the YOS as three or four.

Victims

Three questionnaires were completed by victims of offending by children and young people.

- All three victims were clear about what the YOS had to offer them. Two were satisfied with the work undertaken by the YOS. One thought they had benefited from it.
- There was satisfaction from all that the YOS had paid sufficient attention to their safety.

Sharing good practice

Below are examples of good practice we found in the YOS.

Assessment and Sentence Planning **General Criterion: 3.1**	An intervention planning meeting was used to good effect. A dynamic start to supervision was ensured when all of the key participants were gathered together to plan. This was particularly effective when the child or young person themselves and their parent/ carer were able to be there. Everyone was clear what the purpose of the order was, who was going to do what and what was expected of the individual subject to the order. The child or young person was able to meet the workers involved in their plan, which lessened any fears and all left with dates in diaries and a clear understanding about expectations.
Delivery and Review of Interventions **General Criterion: 2.1**	Multi-agency arrangements to protect the public were used effectively in Sean's case. His case manager showed an impressive approach to managing the *RoH* posed and understanding that a potentially dangerous young man was also vulnerable; whilst he needed to be restricted using the resources available to the multi-agency team, Sean also needed help. Sean was confined to home by means of technology, his victims were actively protected by the police and he was referred to the health worker to address his emotional needs, tackling his offending from all sides.
Outcomes **General Criterion: 3.1**	Tom was on licence following a serious assault that had left the victim badly injured and too afraid to go out alone. Jane, the case manager, made contact with him but found that he did not want to pursue reparation due to his fears. She felt that neither Tom nor his parents understood the impact of Tom's offence. She was a trusted worker in the family and used her position to make a powerful statement to them about the impact during a home visit. It was clear from the subsequent attitudes of all the family that her very strong statements had hit home and had a positive effect on Tom's behaviour.

1. ASSESSMENT AND SENTENCE PLANNING

1.1 Risk of Harm to others:	
General Criterion: *The assessment of RoH is comprehensive, accurate and timely, takes victims' issues into account and uses Asset and other relevant assessment tools. Plans are in place to manage RoH.*	
Score: ***71%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) An Asset RoSH screening was completed in all but five (6%) cases in the sample. They were completed on time in 76% of cases and 74% were considered to be accurate. We found that the RoSH screening indicated the need for a full analysis in 38 cases which was completed in 31 (82%). Children and young people's diversity issues were well addressed in the analyses.

(2) Classification of the RoSH was accurate in 87% of cases. There was evidence that details of RoSH were communicated to all relevant staff in 71%.

(3) Notwithstanding the areas for improvement noted below, there were children and young people in the sample whose circumstances and needs were complex and who posed a clear *RoH to others*; in some of these cases we saw some very thorough and confident approaches to multi-agency *RoH* assessment and planning.

(4) Referral to MAPPA was undertaken in a timely manner in 89% of relevant cases. There was one case that was judged to require a referral that had not been made. The MAPPA categories and levels were appropriate in the referred cases.

Areas for improvement:

(1) The full RoSH analysis was completed on time in 57% of cases and was of sufficient quality in 55%. In a number of cases this was because an existing analysis was being used that did not adequately address new information or offences. The *RoH* to victims was not adequately addressed in approximately one-third of the analyses so it followed that it would not be addressed in the subsequent plan.

(2) In custody cases the RoSH was sent to the establishment within 24 hours in 63% of cases.

(3) Whilst there was routine checking with children's social care services and the police in particular, to inform RoSH assessments, there was a lack of clarity amongst some workers about what should be included. The use of information from other agencies was satisfactory in 68% of cases which meant that in ten cases it was not.

(4) A RMP was completed in 73% of the cases where one was needed. However, only 45% of them were on time and of sufficient quality. We saw examples, in two cases, where information about worrying behaviour and reoffending was known but not used in the plan because there had been no conviction in court. In approximately one-third of cases the roles and responsibilities of all staff involved were not clear. There was also no indication in one-third of what action was planned, should there have been a change in circumstances that indicated an escalation in the RoSH posed to potential victims. Several plans mixed up *RoH to others* and the vulnerability of the child or young person were therefore inevitably muddled.

(5) There was clear evidence of management oversight in most cases and specific direction in some. Indeed all but two of the RMPs had been countersigned. However, this was not always effective as the inadequate assessments and plans were countersigned; we found that management oversight was effective in just over half of the assessments of RoSH in the sample. Some staff expressed confusion about whom to approach for guidance and we saw inconsistencies between managers recorded on files. This was being actively addressed at the time of the inspection.

1.2 Likelihood of Reoffending:	
General Criterion: *The assessment of the LoR is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to reduce LoR*.	
Score: ***71%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) There was a timely assessment of factors linked to offending in relation to individual children and young people in 92% of the cases inspected. We saw evidence of active engagement with the child or young person themselves, 90% of the time and with parents/ carers in 86% of relevant cases.

(2) The initial assessment of the LoR was satisfactory in 75% of cases. They routinely included positive and protective factors and addressed diversity needs. Workers made good use of the information available from other agencies including education providers, the ASB team and substance misuse workers. Assessments were forwarded to custodial establishments within 24 hours in 83% of the relevant cases.

(3) The YOS had developed an intervention planning meeting that included all workers in a case and potentially the child or young person and their parents/ carers. We found plans in all but three cases and that three-quarters of them addressed the LoR to a satisfactory standard. The meetings made planning a dynamic activity, with the potential to sign all relevant agencies up to meet the needs identified in the plan. We found that the Connexions workers were particularly active in making use of this process.

(4) Intervention plans were good on structure: 93% reflected the sentencing purpose, whilst 75% gave a clear shape to the order and focused on achievable change. There were relevant goals in 67% of plans. They were weaker on timescales, however, with realistic ones set in only 31% of the cases.

(5) It was apparent that 84% of the children and young people were actively and meaningfully involved in the planning process as were 78% of their parents/ carers. A range of other agencies were appropriately involved in contributing to plans with routine involvement from custodial establishments, education providers and those addressing physical health and substance misuse needs. Case managers were less likely to involve children's social care services or mental health services in compiling plans.

(6) In spite of the comment below, about the room for improvement in taking learning style into account, there was some imaginative work planned that included adapting materials to suit the diverse needs of individuals e.g. the use of pictures for someone with limited literacy skills. Addressing diversity in intervention plans was satisfactory in 68% of cases. Other plans made good use of available material to address specific types of offending e.g. an accredited scheme 'Changing Places' to address domestic abuse from the perspective of the child or young person to the parents/ carers as well as parents/ carers to parents/ carers. 'Against human dignity' was used to address racist behaviour.

(7) Reviews of Asset and the intervention plan were undertaken at appropriate intervals in 71% of cases.

Areas for improvement:

(1) Whilst there was active engagement with children and young people to complete the assessment, the *What do YOU think?* form was completed in only 46% of cases. Their learning style was not taken into account in 44% of assessments and plans, although staff had undertaken training in this issue.

(2) Gaps in initial plans were sometimes significant and included the child or young person's motivation to change; their emotional or mental health; their living arrangements and potential impact of their family; and personal

relationships on their LoR. Case managers were much better at planning to address concrete needs e.g. ETE and substance misuse.

(3) Whilst plans tended to include positive factors (79%), most were not written in a way that would make sense to a child or young person. We did find an exception to this where the plan was written simply as 'I will..'. RMPs, Safeguarding and VMPs were integrated into the overall plan in less than half of the relevant cases.

(4) Activities identified in intervention plans and contracts were sequenced according to offending behaviour related need in 48% of cases. They addressed victims' issues in 58%.

1.3 Safeguarding:	
General Criterion: *The assessment of Safeguarding needs is comprehensive, accurate and timely and uses Asset and other relevant assessment tools. Plans are in place to manage Safeguarding and reduce vulnerability.*	
Score: ***65 %***	***Comment:*** ***SUBSTANTIAL improvement required***

Strengths:

(1) Screening for vulnerability and Safeguarding needs was undertaken in 94% of cases in the sample. They were completed in a timely manner in 75% and were of a satisfactory quality in 68% of the cases. In 69% of cases the needs were reviewed on time.

(2) Vulnerability assessments were informed by contributions from other agencies. In most cases there was evidence of relevant information being sent to and received from secure establishments to inform staff about vulnerability and Safeguarding issues.

Areas for improvement:

(1) There was a pattern in the cases we read of staff not recognising factors that indicated vulnerability or a Safeguarding need. In discussion it was clear that some staff had insufficient knowledge or understanding in this area. Examples were that staff were aware in different cases of alcohol misuse, a diagnosis of Attention Deficit Hyperactivity Disorder, the incidence of unprotected sex or previous threats of suicide but did not make a link with present vulnerability. In several cases the significance of violence within the home between parents/ carers or between parents/ carers and children and

young people was not understood.

(2) A VMP was produced in 52% of the cases that required one. Of these, one-third were completed on time. Less than half of these (44%) were found to be completed to a sufficient standard. Where the VMP was done it did contribute to the intervention plan as intended.

(3) The contribution by the case manager to other assessments designed to safeguard children was low and found in only six cases of the 16 where it was deemed to be appropriate. There was a lack of knowledge amongst some case managers about their role in relation to the CAF and the appropriateness of sharing information as part of the process.

(4) The quality of management oversight of the assessment of vulnerability was satisfactory in just over half of the cases in the sample.

OVERALL SCORE for quality of Assessment and Sentence Planning work: 70%

COMMENTARY on Assessment and Sentence Planning as a whole:

The completion rates for assessments and plans indicated a YOS where systems were in place to ensure that they were done. This was supported by an auditing process that included feedback to case managers about the quality of their work and suggesting where improvements were necessary. Case managers were positive about the support provided to them. That there was a need to introduce more consistency into the quality of planning and management oversight was already understood by the new management team.

Whilst assessment and planning in relation both to the *RoH* and Safeguarding was a weakness for the service overall, this did not include all staff. We met some outstanding case managers who were working imaginatively and with confidence with potentially dangerous and damaged children and young people to protect them and the public from harm. They made excellent use of the multi-agency resources available to them to plan for the best service possible.

2. DELIVERY AND REVIEW OF INTERVENTIONS

2.1 Protecting the public by minimising Risk of Harm to others:	
General Criterion: *All reasonable actions have been taken to protect the public by keeping to a minimum the child or young person's RoH to others.*	
Score: ***71%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) The approach to managing the *RoH to others* followed a similar pattern to that at the assessment stage. Plans were reviewed at three month intervals in the community in two-thirds of cases. In custody they were reviewed at appropriate intervals in 80% of relevant cases.

(2) Within the case sample there were several children and young people who posed a significant *RoH to others*. Some were being managed as PPOs and some within MAPPA. Specific interventions to manage the *RoH* were found in 76% of plans and most of these were delivered as planned. We found good use of additional restrictive requirements in licences e.g. an exclusion zone to protect specific victims and prohibitions on contacting certain people as well as use of the curfew.

(3) MAPPA were found to be used effectively in all but one case. The contribution of case managers to MAPPA and PPO management was active and positive in the community and custodial settings.

(4) Purposeful home visits were carried out during the course of the sentence in 78% of the cases where *RoH* was an issue. Some case managers routinely and appropriately included other family members and other carers in their work rather than just operating from their office base.

(5) An appropriate level of resources in line with the assessed *RoH* was allocated to 88% of cases in the sample. This included case managers with the right level of experience and resources from elsewhere in the YOS and from other agencies.

Areas for improvement:

(1) In approximately half of the cases in the sample there were significant changes that could have indicated a change in the level of *RoH* posed to the

public. In only half of these cases were reviews undertaken in response. We found that change was not anticipated and planned for in half of the cases where it could have been. In 69% of these, the changes were identified swiftly and acted on appropriately in 63% of them.

(2) There was an inconsistent approach to the safety of victims. In 47 cases there were known or potential victims. A full assessment of their safety was carried out in 57% of these and plans to address victim safety put in place in 61%.

2.2 Reducing the Likelihood of Reoffending:	
General Criterion: *The case manager coordinates and facilitates the structured delivery of all elements of the intervention plan.*	
Score: ***83%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) The enthusiasm and commitment of staff to work with children and young people was very clear. They actively motivated and supported them throughout their sentence, whether in the community or custody, and reinforced positive behaviour. There was a slightly lower rate of engaging with parents/ carers but this was still evident in 90% of relevant cases.

(2) In all but one case, interventions were delivered that were designed to reduce the LoR. In 86% they reflected what was included in the plan and 80% of the interventions were found to be of good quality. In all of the custody cases plans were reviewed on time.

(3) Attention to the learning style of children and young people was stronger in delivery than in planning as 79% of the interventions were appropriate in this regard and 72% took account of the factors that might prevent them from benefiting from supervision. A reflective diary to evaluate work undertaken by children and young people was used in several cases as a pilot exercise; we judged that this was good practice.

(4) There was an impressive range of resources for workers to draw on; we also found there was an appropriate level of resources deployed in 90% of the cases. Gaps were identified in appropriate housing in two cases and timely access to substance misuse resources for two children and young people due to an internal vacancy that was subsequently filled.

(5) The approach to delivering offending behaviour programmes was flexible and

met the needs of most of the cases. Two workers undertook a needs analysis on a quarterly basis and delivered programmes accordingly across the three teams. There were plans to increase this resource. We saw good examples of programmes being customised to meet the needs of individuals e.g. an individual anger management programme for a young person with Attention Deficit Hyperactivity Disorder. A fire officer delivered a driving offences programme.

(6) Connexions staff worked actively across the caseload. We saw cases where they were involved in planning in custody and in ensuring that children and young people were referred into appropriate provision on release. The Drug and Alcohol Action Team was seen to be responsive to needs and provided resources in a number of the cases to children and young people with tier three and four substance misuse problems.

(7) A number of case managers routinely included the victim perspective in their work to reduce the LoR, either directly or via the victim's worker. We saw examples of where children and young people reflected on what they heard or read of the victim's point of view; this prompted them to want to apologise, whilst earlier they had not understood the impact of their offending. There was a good level of reparation routinely expected by some case managers.

Areas for improvement:

(1) The delivery of interventions in custody was disappointing. There was little work available to address offending behaviour and none in some cases. Children and young people with a history of serious offending were unlikely to undertake anything other than vocational education work and possibly a victims' awareness course.

(2) Reviews of intervention plans in community cases were undertaken on time in 63% of cases. Sequencing of interventions was appropriate in only 53% of cases.

2.3 Safeguarding the child or young person:	
General Criterion: *All reasonable actions have been taken to safeguard and reduce the vulnerability of the child or young person.*	
Score: ***78%***	***Comment:*** ***MODERATE improvement required***

Strengths:

(1) All necessary immediate action was taken to protect all but two of the children and young people in the sample in custody.

(2) Purposeful home visits were carried out during the course of the sentence in 73% of the cases where Safeguarding or vulnerability was an issue. There were other cases where home visiting ought to have taken place.

(3) In custody cases planning and reviews were managed tightly with few gaps; where there was a VMP, interventions were delivered accordingly. In secure establishments there was only one case where there ought to have been a referral to children's social care services. There were few gaps in services to support children and young people who were vulnerable; the main one appeared to be for mental health services in four cases. In most custody cases there was continuity between provision in the establishment through to supervision on licence; gaps were again identified in mental health and this time in four cases of substance misuse.

Areas for improvement:

(1) Planning and reviews did not consistently identify Safeguarding needs. Whilst 70% of plans did, that meant that they were not identified in 17 cases where issues were present. In five cases, interventions identified were not included in a VMP and in 14 cases, actions identified in the VMP were not implemented.

(2) Whilst the action necessary to protect 73% of the children and young people in the community, who were seen to be vulnerable had been taken, that still meant that action had not been sufficient in 13 cases. Case managers tended to underplay the significance of what they saw. Examples included the children and young people of parents/ carers with severe alcohol problems, leading to neglect or vulnerability due to their inability to protect them, or who themselves had a significant problem with alcohol. There were seven cases where no action was taken to protect children and young people, other than the one under supervision. Examples included a case where there was action to protect the child or young person under supervision from violence in the home, but no consideration was given to the safety of younger children and young people in the same home.

(3) There were 11 cases where we considered that referrals to other agencies should have been made in relation to Safeguarding. Agencies were responsive to referrals in most of the cases where it did happen and worked together with the YOS to promote the Safeguarding and well-being of the child or young person. Connexions, statutory education and substance misuse providers were most likely to be involved in these cases. There were clearly community order cases, where referrals to children's social care services ought to have been made. In two cases we had concerns about the responsiveness of children's social care services to vulnerability needs. The other significant gap in referrals was for mental health services.

(4) Management oversight was satisfactory in 54% of community cases and 64% of custody cases.

(5) There were two custody cases and 17 community cases where it was considered that staff did not promote the well-being of the child or young person.

OVERALL SCORE for quality of Delivery and Review of Interventions work: 77%

COMMENTARY on Delivery and Review of Interventions as a whole:

Case managers were clear that their role was to manage the case and to pull in resources, from elsewhere within the YOS or other agencies, to achieve plans to manage the LoR. Attention to offending behaviour was encouraging; case managers engaged positively with this issue themselves and made appropriate referrals. The levels of resources available internally for delivering interventions appeared to be appropriate with some external gaps noted above. Children and young people with many needs could appropriately find themselves very busy, which was often a form of positive containment, particularly for those not in education or training.

3. OUTCOMES

3.1 Achievement of outcomes:

General Criterion:

Outcomes are achieved in relation to RoH, LoR and Safeguarding.

Score:	***Comment:***
59%	***MODERATE improvement required***

Strengths:

(1) All reasonable action to keep to a minimum the individual's *RoH to others* was taken in 72% of cases. The assessed level of *RoH* was seen to be reduced in 35%.

(2) Work to motivate children and young people under supervision led to compliance with an order in 66% of cases.

(3) The most significant improvements in factors linked to offending were in motivation to change (74%); living arrangements (71%); thinking and behaviour (66%); and substance misuse (64%).

(4) There appeared to have been a reduction in the frequency of offending for 64% of those in the sample and a reduction of 61% in the seriousness of offences committed where children and young people had reoffended.

(5) There was a reduction in risk factors linked to Safeguarding in 47% of cases.

Areas for improvement:

(1) There was room for improvement in enforcement practice in most of the cases where this was required.

(2) In 26% of the cases we thought more could have been done to keep the child or young person safe.

3.2 Sustaining outcomes:	
General Criterion: *Outcomes are sustained in relation to RoH, LoR and Safeguarding*	
Score: ***80%***	***Comment:*** ***MINIMUM improvement required***

Strengths:

(1) Full attention was given to community integration issues in 72% of the custody sample. Activity and progress were assessed to be sustainable in 80% of cases. Case managers and Connexions staff worked to maintain links with the children and young people in secure establishments and to foster work e.g. on substance misuse and education.

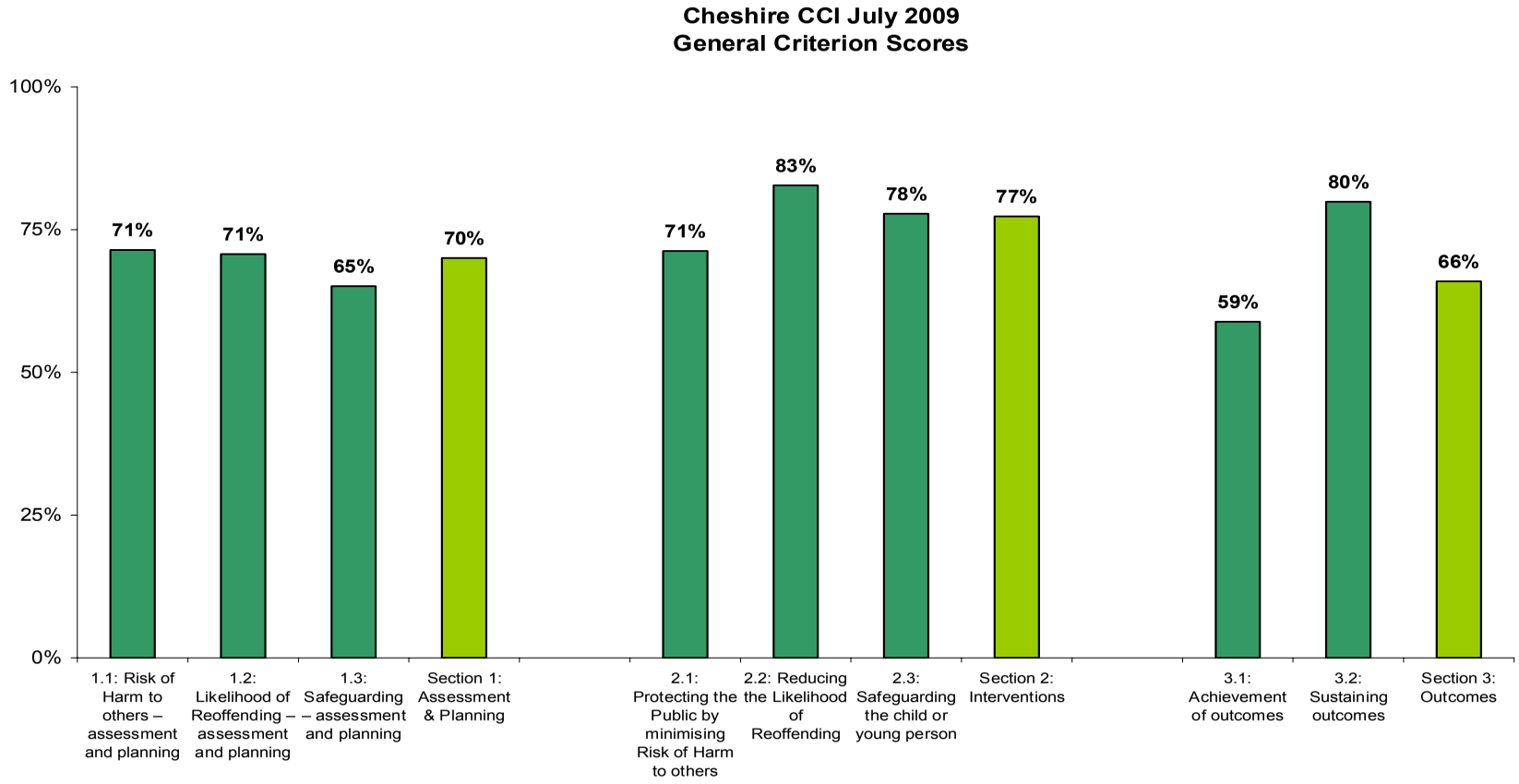
(2) We saw a similar positive approach in 80% of community order cases, of which progress was judged to be sustainable in 82%. We saw positive examples where a child or young person's living arrangements improved, which gave them the support to get on in education or employment. In a number of cases coming to a close, or that had actually finished, we saw appropriate referrals to address factors linked to past offending to sustain young people in the future.

SCORE for quality of Outcomes work: 66%

COMMENTARY on Outcomes as a whole:

It was encouraging to see that progress in relation to factors linked to offending was almost as positive in the custody sample as with those children and young people subject to community orders. Despite the lack of offending behaviour work in secure establishments, there were resources to address linked needs e.g. substance misuse. Enforcement practice needed a more consistent approach. In the community it was encouraging seeing the consideration of an exit strategy that might sustain the child or young person in the future, rather than just drawing a line under supervision.

Appendix 1a: Summary



Appendix 1b: Breakdown of Scores by Local Authority Area

CCI Scorecard	Cheshire (n=79)	CHESHIRE EAST (n=40)	CHESHIRE WEST & CHESTER (n=39)
1.1: Risk of Harm to others – assessment and planning	71%	65%	77%
1.2: Likelihood of Reoffending – assessment and planning	71%	72%	70%
1.3: Safeguarding – assessment and planning	65%	60%	70%
Section 1: Assessment & Planning	**70%**	**69%**	**71%**
2.1: Protecting the Public by minimising Risk of Harm to others	71%	66%	76%
2.2: Reducing the Likelihood of Reoffending	83%	83%	83%
2.3: Safeguarding the child or young person	78%	72%	84%
Section 2: Interventions	**77%**	**74%**	**81%**
3.1: Achievement of outcomes	59%	52%	65%
3.2: Sustaining outcomes	80%	68%	93%
Section 3: Outcomes	**66%**	**58%**	**74%**
Safeguarding Score	69%	66%	72%
Risk of Harm Score	69%	64%	73%
Likelihood of Reoffending Score	77%	75%	79%

Appendix 2: Contextual information

Cheshire YOS was located in the North-West region.

The area had a population of 673,788 as measured in the Census 2001, 10.2% of which were aged ten to 17 years old. This was slightly lower than the average for England/ Wales, which was 10.4%.

The population of Cheshire was predominantly white British (98.4%). The population with a black and minority ethnic heritage (1.6%) was below the average for England/ Wales of 8.7%.

Reported crime levels for children and young people aged ten to 17 years old across the area, at 47 per 1,000, were below the average for England/ Wales of 46.

YOS

The YOS boundaries were within those of the Cheshire police and probation areas. The NHS Western Cheshire PCT and the Central and Eastern Cheshire PCT covered the area.

The YOS was located within the Services for Children's and Families of Cheshire East Council. It was managed by the Head of Services for Children and Families.

The YOS Management Board was chaired by the Chief Executive of Cheshire East Council. All statutory partners attended regularly.

The YOS Headquarters was in the Cheshire town of Northwich. The operational work of the YOS was based in Ellesmere Port, Crewe and Macclesfield. ISSP was provided by an internally managed service.

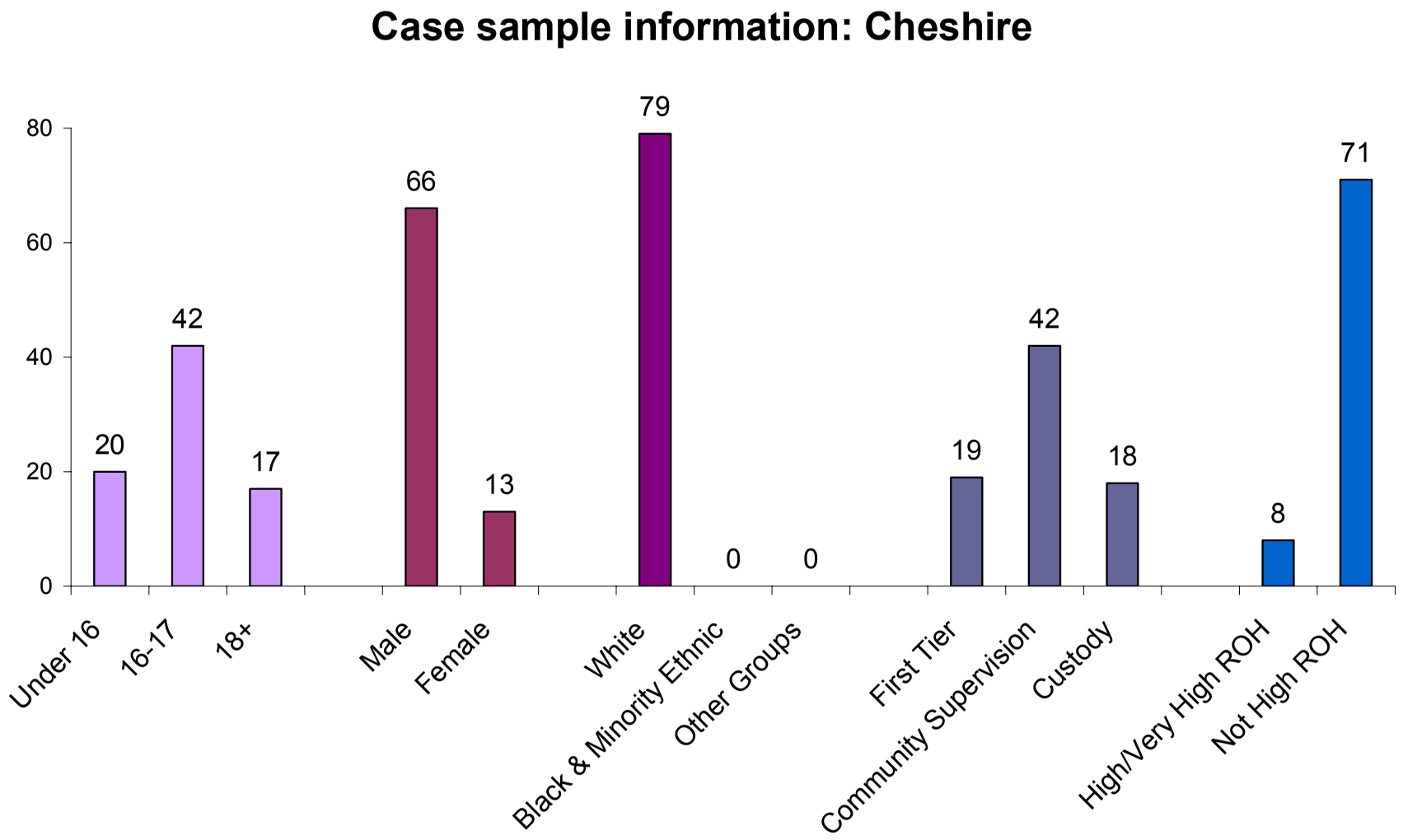
YJB Performance Data

The YJB summary of national indicators available at the time of the inspection was for the period April 2008 to March 2009.

Cheshire's performance on ensuring children and young people known to the YOS were in suitable education, training or employment was 66.3%. This was worse than the previous year but below the England average of 72.4%.

Performance on ensuring suitable accommodation by the end of the sentence was 99.7%. This was lower than the previous year, but better than the England average of 95.3%.

Appendix 3a: Inspection data chart



Appendix 3b: Inspection data

Fieldwork for this inspection was undertaken in July 2009.

The inspection consisted of:

- examination of practice in a sample of cases, normally in conjunction with the case manager or other representative
- evidence in advance
- questionnaire responses from children and young people, and victims

We have also seen YJB performance data and assessments relating to this YOS.

Appendix 4: 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:

http://www.justice.gov.uk/inspectorates/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:

HM Chief Inspector of Probation
2nd Floor, Ashley House
2 Monck Street
London, SW1P 2BQ

Appendix 5: 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 young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAF	Common Assessment Framework: A standardised assessment of a child or young person's needs, and of how those needs can be met . It is undertaken by the lead professional in a case, with contributions from all others involved with that individual
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
Careworks	One of the two electronic case management systems for youth offending work currently in use in England and Wales. See also YOIS+
CRB	Criminal Records Bureau
DTO	Detention and Training Order, a custodial sentence for the young
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Employment, training and education. Work to improve an individual's learning, and to increase their employment prospects
FTE	Full-time equivalent
HM	Her Majesty's
HMIC	HM Inspectorate of Constabulary
HMI Prisons	HM Inspectorate of Prisons
HMI Probation	HM Inspectorate of Probation
Interventions; *constructive* and *restrictive* interventions	Work with an individual that is designed to change their offending behaviour and/ or to support public protection. A *constructive* intervention is where the primary purpose is to reduce Likelihood of Reoffending. A *restrictive* intervention is where the primary purpose is to keep to a minimum the individual's *Risk of Harm to others*. Example: with a sex offender, a *constructive intervention* might be to put them through an accredited sex offender programme; a *restrictive intervention* (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. NB. Both types of intervention are important
ISSP	Intensive Supervision and Surveillance Programme – this intervention is attached to the start of some orders and licences and provides initially at least 25 hours programme contact including a substantial proportion of employment, training and education
LoR	Likelihood of Reoffending. See also *constructive* Interventions
LSC	Learning and Skills Council
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.

MAPPA	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
PPO	'Prolific and other Priority Offender' – designated offenders, adult or young, who receive extra attention from the Criminal Justice System agencies
Pre-CAF	This is a simple 'Request for Service' in those instances when a Common Assessment Framework may not be required. It can be used for requesting one or two additional services, e.g. health, social care or educational
PSR	Pre-sentence report – for a court
"Reoffending rate after 9 months"	A measure used by the Youth Justice Board. It indicates how many further offences are recorded as having been committed in a 9-month period by individuals under current supervision of the relevant YOT, and it can be either more or less than 100%. "110%" would therefore mean that exactly 110 further offences have been counted as having been committed 'per 100 individuals under supervision' in that period. The quoted national average rate for England in early 2009 was 85%
RMP	Risk management plan. A plan to minimise the individual's *Risk of Harm*
RoH	*Risk of Harm to others.* See also *restrictive* Interventions
'RoH work', or 'Risk of Harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using *restrictive interventions,* 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 *probability* of an event occurring and the *impact/ severity* of the event. The term *Risk of Serious Harm* only incorporates 'serious' impact, whereas using *'Risk of Harm'* enables the necessary attention to be given to those offenders for whom lower *impact/ severity* harmful behaviour is *probable*
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 YOT workers)
VMP	Vulnerability management plan. A plan to safeguard the well-being of the individual under supervision
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution. A Prison Service institution for 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. See also Careworks.
YOS/ T	Youth Offending Service/ Team