HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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

An inspection led by HMI Probation

independent inspection of youth offending work

May 2015

Foreword

This inspection of youth offending work in Bromley is one of a small number of full joint inspections that we are undertaking annually with colleagues from the criminal justice, social care, health and learning and skills inspectorates.

We chose to inspect in Bromley primarily because reoffending rates had been rising for some time and were worse than the national average. Custody rates had also risen, bucking the national trend and offending by Looked After Children was higher than average.

Bromley had achieved a reduction in the number of children and young people entering the youth justice system and the most recent published data showed a reduction in reoffending, however, the numbers reoffending remained higher than the average in England and Wales at 43.6% compared with 35.7%. The use of custody had showed a steady rise, month on month for over a year; the most recent figure being 0.61 per 1000 of the population of 10-17 year olds compared with 0.47 across England and Wales.

The strategic and operational management of Bromley YOS had been separated and was the responsibility of different people. This was not working effectively. There were two management boards in place as a result of an historic decision, one executive, one operational. This arrangement was not working effectively either and resulted in little strategic partnership work. The YOS was well resourced operationally but specialist workers and case managers did not integrate their work. There was some good work to improve physical health and to access education, training and employment. Engagement with children and young people was also good although this needed to improve with parents/carers. Children and young people were not assessed properly for interventions and generally had to 'fit in' with what was being delivered at any one time.

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

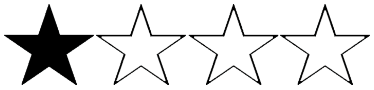
Paul Wilson

HM Chief Inspector of Probation

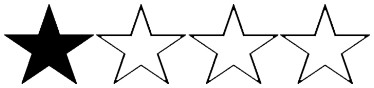
May 2015

Key judgements

Reducing reoffending



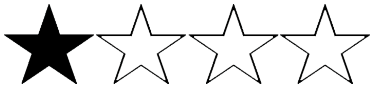
Protecting the public



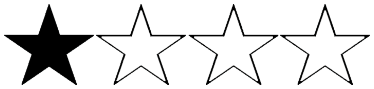
Protecting children and young people

Ensuring the sentence is served

Governance and partnerships



Interventions to reduce reoffending



Summary

Reducing reoffending

Overall work to reduce reoffending was poor. Information to courts to help with sentencing was generally good and efforts were made to understand why children and young people were offending. Planning often did not reflect those reasons and neither assessments nor plans were reviewed well or frequently enough. Outcomes related to education, training or employment were generally good but there was not enough progress made by children and young people towards stopping offending.

Protecting the public

Overall work to protect the public and actual or potential victims was poor. Neither the assessment of the risk that children and young people posed to others, or the planning to manage that risk and protect the public, was done well enough. Too often, the work to protect the public was judged to be not good enough and management oversight was not considered effective in many cases. Where there was an identified victim, however, work to protect them was generally considered to be satisfactory.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was unsatisfactory. Too often, case managers did not recognise what needed to be done to protect a child or young person. The assessment, planning and work to safeguard was not always done well enough and management oversight had not rectified this. Children's social care services withdrew services from children and young people involved with the Youth Offending Service (YOS) when there were still welfare needs.

Ensuring the sentence is served

Overall work to ensure that the sentence was served was satisfactory. Case managers and other YOS staff identified and recognised the diversity needs of children and young people and engaged well with them. Inspectors commented on a number of cases that case managers had a clear understanding of the issues for the child or young person and that they had worked hard to establish good working relationships. Where necessary, the YOS also responded appropriately to a lack of compliance. Involvement with, and engagement of, parents/carers was carried out less routinely.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was poor. The separation of the YOS management into operational and strategic levels was not working effectively. Neither of the two management boards, one operational and one strategic, had supported or held the YOS to account effectively. Data and other information had not been used to scrutinise, monitor or support performance. There was insufficient, effective strategic partnership working yet the YOS was well resourced by partnership agencies.

Interventions to reduce reoffending

Overall, the delivery and management of interventions to reduce reoffending was poor. Children and young people had to 'fit in' to a group work schedule whether it was the right time to deliver the work to them or not. Their suitability or ability to carry out a programme was not assessed. There was little integration of the work that children and young people were undergoing with different workers. The effectiveness of programmes of intervention was not evaluated.

Contents

Recommendations

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

The Chair of the YOS Management Board should ensure that:

- reoffending is reduced and, in particular, reoffending by Looked After Children
- the number of children and young people receiving custodial sentences is reduced to the national average or below
- data is commissioned, scrutinised and used to evaluate and improve outcomes for children and young people who have offended
- partners are involved at an appropriate level of seniority and work together effectively
- links between the strategic and operational work of the YOS work effectively
- the YOS makes an effective, strategic contribution to wider partnerships including the Bromley Safeguarding Children Board and the Safer Bromley Partnership
- children's social care services continue to work with children and young people involved with the YOS where there are outstanding welfare needs
- the variety of the education, training and employment provision is increased.

The Head of Youth Support should ensure that:

- early help services target those children and young people who are already offending and work with the YOS to prevent offending behaviour becoming entrenched
- the standard of assessment, planning and work in the YOS to reduce offending is of good quality and positive outcomes are achieved across all types of interventions
- information is shared and all work with children and young people is coordinated and integrated
- recording of YOS work takes place routinely and expeditiously
- management oversight is effective.

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

Reducing reoffending

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Theme 1: Reducing reoffending

What we expect to see

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

Case assessment score

Within the case assessment, overall 39% of work to reduce reoffending was done well enough.

Key Findings

1. Efforts were made to understand the reasons that a child or young person was offending but the assessments were not reviewed well or regularly enough.
2. Planning was not judged to be good enough and, again, was not always reviewed during the period of supervision.
3. Overall there was not enough progress by children and young people towards stopping offending.
4. Information to the courts, pre-sentence reports, were generally of good quality.
5. Education, training or employment (ETE) outcomes were largely good, however, post-16 year old outcomes did not match those of the under 16 years age group.

Explanation of findings

1. Generally, sufficient effort had been made to understand the reasons that children and young people were offending; where this was not the case, it was due to unclear or insufficient information. Reviews of those reasons, and what might reduce them, were either not carried out or were not of good enough quality in too many cases. We found some duplication of effort where both case managers and intensive supervision and surveillance workers were carrying out separate assessments – some of which contradicted each other. Intelligence sharing with the police was not as effective as it should have been.
2. Conversely, pre-sentence reports to assist courts with sentencing were generally of good quality; those that were not judged good enough lacked assessment of vulnerability or the risk of harm posed, or were not sufficiently analytical.
3. Planning in both community and custody cases was not judged to be of good enough quality; nor were plans reviewed sufficiently well. We found insufficient progress in reducing offending-related factors and no identifiable evidence that children and young people were less likely to offend.

Good practice example

Pam was subject to a Youth Rehabilitation Order (YRO) for stealing from her mother. At 16 years old, Pam had been in care for several years. She had a very difficult relationship with her mother and felt that she was not as good, or as loved, as her siblings. The case manager recognised this and one of the actions on Pam's intervention plan was to remind her that she was a capable young woman who could achieve. As a result of the support and guidance given by the case manager, Pam's self-worth had increased and she was better able to deal with her emotions. She had not reoffended and was actively looking to become involved in training and education.

4. In custodial cases, there was not always sufficient focus on resettlement. For example, we were told that substance misuse work was put on hold while children and young people were in custody and that they would be offered an appointment on the day they were released. ETE provision was frequently not in place at release and plans for constructive activity while children and young people were waiting to start college courses were often not carried through.
5. The level of reoffending by Looked After Children had reduced since 2013, at which time a significant proportion of them were reoffending (13.4% compared with the national average which was 6.2%). It was not possible to attribute this reduction to any targeted work streams across the local authority's children's social care services or the YOS.
6. Overall, ETE outcomes for children and young people working with the YOS were good, with most being referred successfully into some form of ETE. YOS information indicated that approximately 74% were in ETE at the end of their order during the period 2013/2014. Within that figure, outcomes were better for the pre-16 year old group at around 88%.

Quotes from children and young people about help they had received from the YOS

"*They've given me loads of support. They've got me into college, they've got me a CSCS card [Construction Skills Certification Scheme], training thing in February. They've done a lot for me. The education man at YOT got me into college. I just asked the man and he said 'are you interested in getting into college?' and I said 'yeh, I'd love to do that' and he said ' what are you interested in?' and I said 'something physical like construction or something' and he went away and a couple of weeks later he said 'I've got you a starting date'. So I started. I started attending college and obviously I was attending regular so he decided to pick me to go on this course because I was like a trusted person who'd actually attend, so I did that. He even said, when I've finished I could go up and sit with him in the jobcentre; that's where he's based, and he'd help me next to him on the computers, so I could revise next to him and he'd help me.*"

"*It would be cool if it was stuff that was actually going to help me; they help me to not reoffend but then I need stuff that is going to help me get a job, stuff that is actually good for me when I finish here.*"

7. The local authority education team worked with the YOS to intervene quickly to develop strategies where children and young people were in danger of being excluded. They worked with the school to maintain their learning and, where this was not possible, other options were found.
8. For those children and young people who were not in ETE or were in danger of becoming so, the youth support worker carried out an assessment of the barriers and produced an action plan which focused on the steps that were necessary to progress. Case managers and the youth support worker worked hard to find alternative placements.
9. The recording of education and training interventions was generally very good by the education welfare officer and the youth support worker within their own respective systems. It was clear in these systems what progress has been made by the child or young person and whether the original objectives were achieved. However, the same level of information was not sufficiently well communicated to all YOS staff working with the child or young person.
10. Health workers generally worked well with children and young people. There was evidence that they had built professional relationships and offered both one-to-one and group interventions. We observed that children and young people felt able to ask questions about sensitive areas in a safe environment and that staff dealt with these questions in a professional and open manner. A counsellor was employed to carry out anger management sessions.

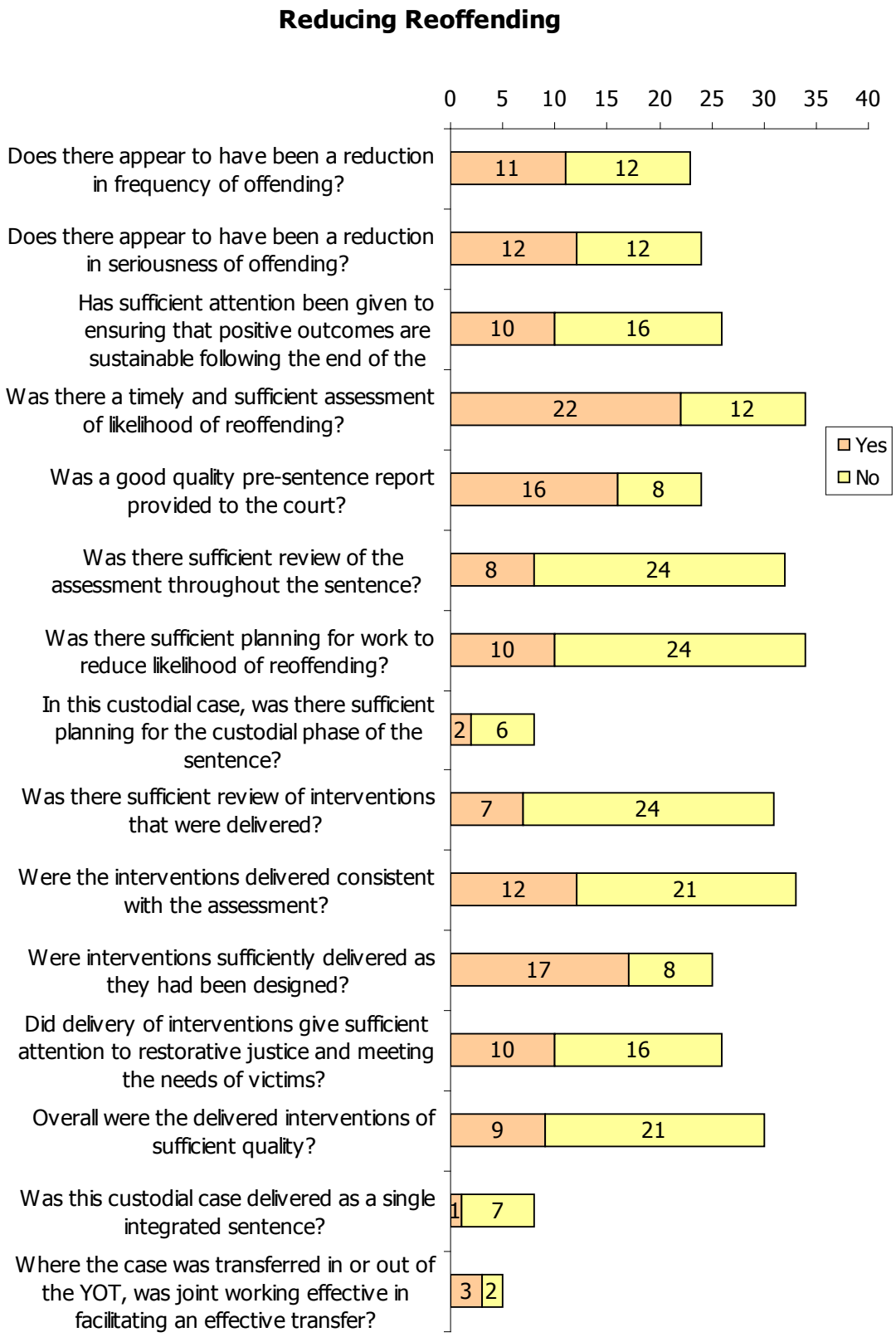
11. There was confusion between health staff and case managers about when health referrals should be made. Very recent changes in the health screening process meant that all children and young people would now be subject to a physical and mental health screening at pre-sentence stage.

Case illustration

Jack was a 16 year old sentenced to a 12 month YRO for theft from a shop. The case manager identified early in the order that Jack had some difficulties engaging with her. She met with the Speech and Language Therapist (SALT) to gain a better understanding of his special educational need (SEN) statement and language difficulties. As a result the case manager was better able to plan her sessions and use different approaches where appropriate. This resulted in Jack retaining more of the information that was discussed.

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

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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 51% of work to protect the public was done well enough.

Key Findings

1. The risk of harm that children and young people posed to others was not always sufficiently well assessed or regularly and thoroughly reviewed.
2. The planning to protect other people was not good enough in too many cases and often did not reflect the assessed risk of harm.
3. Work to protect the public was not carried out well enough overall although it was better where there was an identified victim.
4. Management oversight of this area of work was generally not effective.
5. Information and intelligence was not always shared or effectively used.

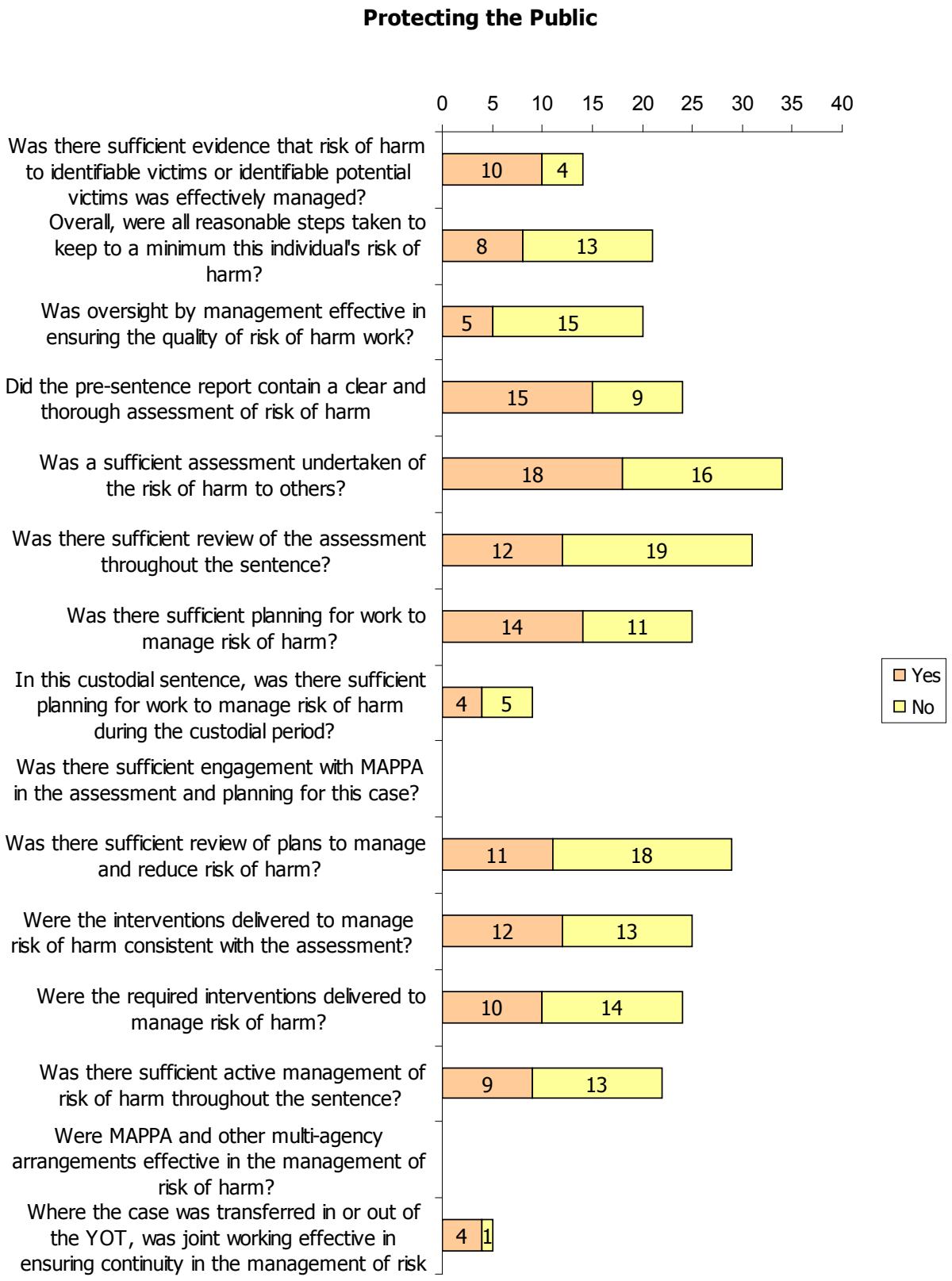
Explanation of findings

1. The risk of harm posed to other people was not sufficiently well understood, nor was it reviewed well enough. Planning to manage the risk of harm was not timely or good enough in many cases and, too often, planned interventions to manage or reduce the risk of harm were not consistent with the assessment or were not delivered.
2. Where there was an identified victim, the risk of harm had been effectively managed. Overall however, the work to effectively manage the risk of harm posed by children and young people was not carried out well enough and management oversight was not effective in ensuring that good quality work was delivered.
3. Bromley was not officially designated as a 'gangs area', although it was surrounded by boroughs that were, and as such it had a multi-agency panel including representatives from education, housing, YOS and mental health services, that met monthly to discuss emerging youth gang issues. This was primarily an intelligence sharing meeting. Recently, a bid had been submitted for funding to conduct an education programme in schools to prevent children and young people being drawn into gangs.
4. We saw evidence that health staff attended multi-agency meetings including those under the Deter Young Offender (DYO)[1] scheme and internal risk panel meetings. This helped to ensure there was a health perspective offered.
5. Although we were told that police intelligence was easily accessible, we saw a number of cases where intelligence had not been accessed or used effectively by case managers.

1 The Youth Justice Board define DYOs as being those that are likely to cause the most harm to communities and pose a high risk of reoffending. Local authorities should have arrangements in place to identify, and work with, those children and young people who meet the criteria.

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

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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 55% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. The work to assess, plan and deliver work to keep the child or young person safe was not carried out well enough. Case managers often did not identify what needed to be done.
2. Management oversight of this work was judged to be ineffective.
3. The contribution of physical health work to promote well-being was a strength.
4. Children's social care services too often withdrew services from children and young people involved with the YOS when welfare needs remained outstanding.

Explanation of findings

1. In too many cases, sufficient effort to understand and explain vulnerability and safeguarding needs was not made. Although assessments were carried out, there was no coherent, joined-up analysis of what risk the child or young person was at as a result of the various factors identified. It was not surprising therefore, that the planning to protect was also not done sufficiently well; case managers, too often, did not recognise what interventions were required. Reviews of both the needs of the child or young person and the plans were not carried out regularly or well enough.
2. The work carried out to safeguard the child or young person was often not consistent with the assessment of need or the plans; there was no clear link between what was needed and what was carried out. In too many cases there was not sufficient active or effective work to safeguard the child or young person. In particular, we judged that work to address emotional or mental health issues and alcohol abuse had not been delivered effectively in enough cases. This was, in some instances, as a result of a lack of referral to those specialist services.

Case illustration

Brian is 15 years old and had been sentenced to an 18 month YRO for burglary and driving offences. The case manager had worked with Brian for over 12 months and had developed a good relationship with him. As a result of a number of physical health concerns, the case manager challenged his father about Brian's reluctance to access medical help. Following a hospital visit for a broken foot the case manager realised that Brian's reluctance was actually a direct result of his father's fear of medical interventions. The case manager encouraged Brian to have further health assessments and also involved children's social care services regarding his father's lack of care for Brian's health. As a result, Brian accessed help and his anxiety about receiving medical intervention was reduced.

3. In the small number of custodial cases that we inspected, we judged that the transition from custody to community was generally managed well in regard to vulnerability and safeguarding need. Overall, we judged that the YOS had too often not done enough to keep the child or young person safe and that management oversight of this area of work had not been effective.
4. YOS staff were routinely invited to, and attended, planning meetings with partner agencies. These included regular involvement in child protection conferences and core groups. Invitations to YOS and attendance by YOS staff at Looked After Children and care leaver reviews and planning meetings were more variable. Information was routinely exchanged at these meetings however the action plans did not set specific tasks for YOS staff over and above their general monitoring role. This seldom added value or maximised the likelihood of children and young people being protected or their welfare needs being met. YOS staff did work collaboratively alongside staff from partner agencies although joint work and joint visits, where these would have been beneficial, were seldom evident.
5. Communication between YOS staff and partner agencies did take place at key events, but most case files seen did not show regular information sharing between agencies outside of key planning meetings. For example, YOS staff reported that often they were not kept sufficiently up to date with what was happening with Looked After Children with whom they were working and relied more on residential placements or carers than social workers for information.
6. Clear information was provided by YOS staff to support referrals to children's social care services, although not all staff understood the thresholds and, where they had referred concerns, they did not routinely know the outcome.
7. Health staff did not routinely attend planning and review meetings; there were limited integrated health targets within plans and a lack of clarity about whether health outcomes had been achieved. Not withstanding this, work to promote physical health, where it had been identified as necessary, was delivered well. Amongst other things, the nurse was able to supply and administer some medicines to children and young people promptly without the need for a doctor's authorisation. These included immunizations and antibiotics for sexually transmitted infections.
8. It was of concern that there were a number of examples where health staff had not felt that it was appropriate, due to confidentiality, to share information with case managers. These included misuse of Class A drugs and low level self-harm. There was little recognition that this information was needed to help assess overall vulnerability and protect the child or young person. Case managers reported that they felt that they did not always receive sufficient or timely information about the interventions delivered and that the approach was "*disjointed*".

Data Summary

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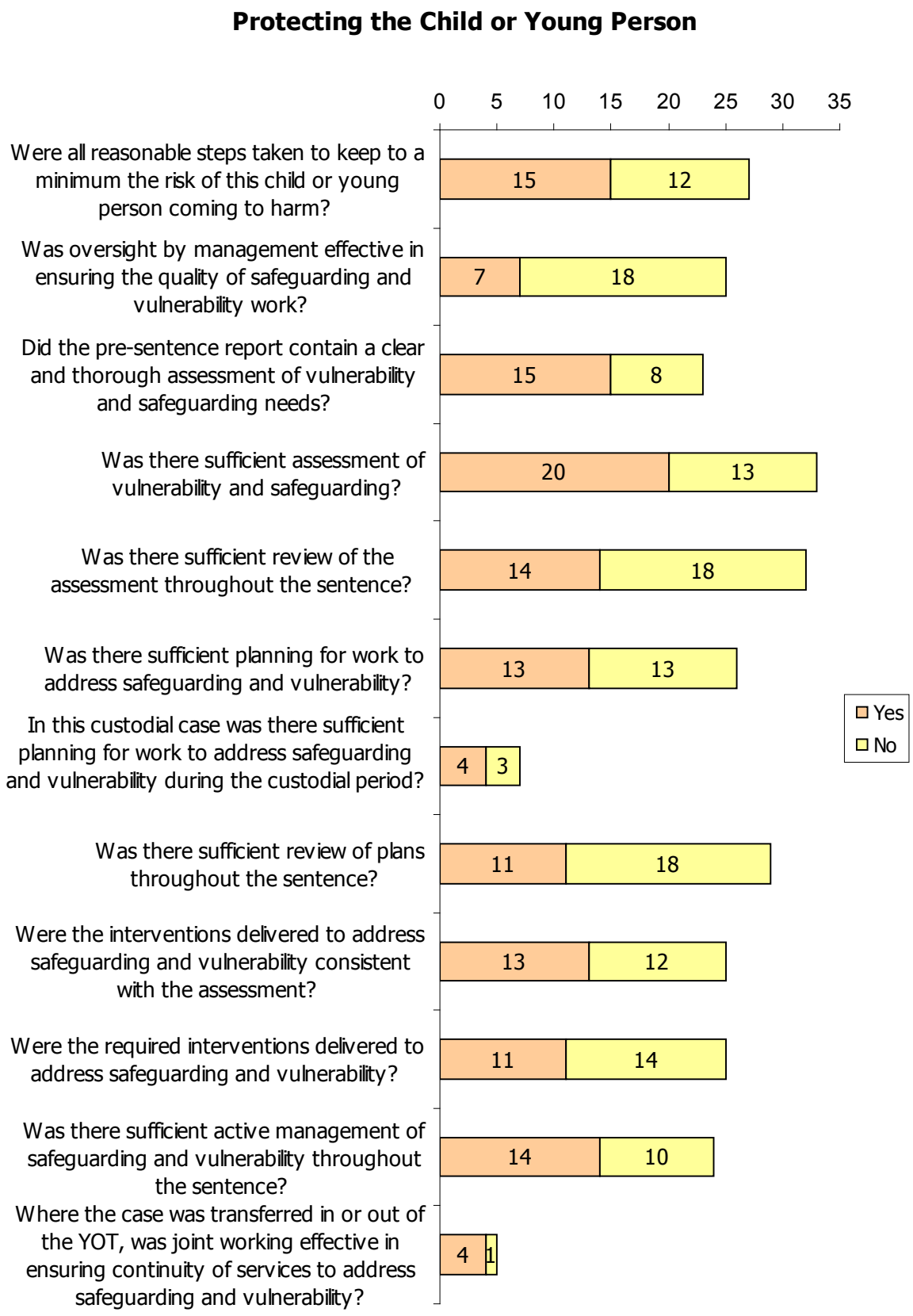

Ensuring that the sentence is served

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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 65% of work to ensure the sentence was served was done well enough.

Key Findings

1. Engagement of children and young people by case managers and other YOS staff was a strength and diverse, individual needs were recognised.
2. The involvement of parents/carers was not given sufficient attention.
3. Overall the YOS responded appropriately to lack of compliance.

Explanation of findings

1. We judged that efforts to understand the diverse and individual needs of children and young people, and to engage with them, were a strength.

Case illustration

Ben is 15 years old and received a YRO for burglary offences. He had a history of similar offending linked with funding the use of cannabis. He had been diagnosed as suffering from Attention Deficit Hyperactivity Disorder and social isolation. The YOT case manager recognised that Ben had worked with a lot of different case managers and had not always complied with his orders. To try to better engage Ben, the case manager included an objective in his intervention plan:

'*to establish a working relationship with Ben as he has had a lot of change in regards to YOS officers and appears to be unhappy that he has to disclose all of the information about himself again*'.

As a result of being seen both at home and at the YOS office to further this objective, Ben's compliance improved and he was able to work with his new case manager.

Quotes from children and young people about their case managers

"*I think I get on well with her… I can ask her things and she knows the answers…she gives me good advice.*"

"*She talks to me with respect. She treats me how she'd want to be treated, so I respect that. So then that's why I respect her.*"

"*I just know that there is someone always there to support me if you know I ever feel like I might go and do something that I shouldn't do.*"

Comments from inspectors about case managers' efforts to engage children and young people

"*The case manager inherited the case making him the young person's third case manager. He appeared to build a relationship quite quickly with the young person, meeting the family and establishing the needs of the young person quickly.*"

"*The case manager has a clear understanding of the issues relating to the young person and his needs. Her relationship with the young person is also clearly supportive and engaging.*"

"*The case manager built a good relationship with the young person and tried to work in a responsive and flexible way.*"

2. In particular, it was evident that children and young people were involved in the preparation of their pre-sentence report which largely paid good attention to their individual needs.
3. This did not always follow through into the planning unfortunately. The involvement of parents/carers also needed to increase; assessments did not reflect their views and they were not sufficiently involved in planning or reviews.

Views of parents/carers about the work of the YOS

"*Yeah, very supportive. I think my opinion was taken on board quite a lot.*"

"*I just think they've really helped him in terms of keeping focused, given him a lot of support, a lot of time.*"

"*They are doing all they can at the moment and they have done a good job.*"

"*In my honest opinion, they've done more than enough for him, they've got him back into mainstream education. I'm very happy, they couldn't have done anymore. He's been out of school, when he was in pupil referral unit he never went there, you know they got him in college. Oh it's brilliant, different kid, different kid, it feels like I've got my old child back.*"

And conversely

"*There ain't no support for family. There needs to be more support for family.*"

"*It was a complete waste of time. They didn't offer him nothing. I think they made him do a few written pages here and there but he didn't come out with nothing new from there.*"

"*I asked them to help him to get to college and they gave him something to fill out and send off. He hasn't been at school since he was 11 years old. He needed help with that, that's what I requested from them and they never got round to it. Then he got this 4 months thingy [order] I said 'well while he's got this can we make some use of it and try to help him get back into education. They did nothing.*"

4. There was good attention paid to health and well-being outcomes and, where this was not the case, it was generally because referrals had not been made or the work was not well coordinated.
5. Where children and young people did not comply with their order, the response of the YOS was generally active and sufficient to get them back on track. Where this was not the case, it was largely because unacceptable misses had not been recognised as such or acted upon.

Inspector's comments about work while the young person was in custody

It was evident that the case manager was a strong advocate for Kyle. This involved liaison with a Barnados advocate while he was in custody. The case manager had tried to be flexible in her approach with Kyle and was creative in ways to get him to comply and engage. She had recognised the importance of understanding Kyle in relation to the community in which he lived and was keen to see him at venues away from YOS as this helped with compliance and engagement. The case manager had also developed links with Kyle's significant others in an attempt to secure better compliance.

Data Summary

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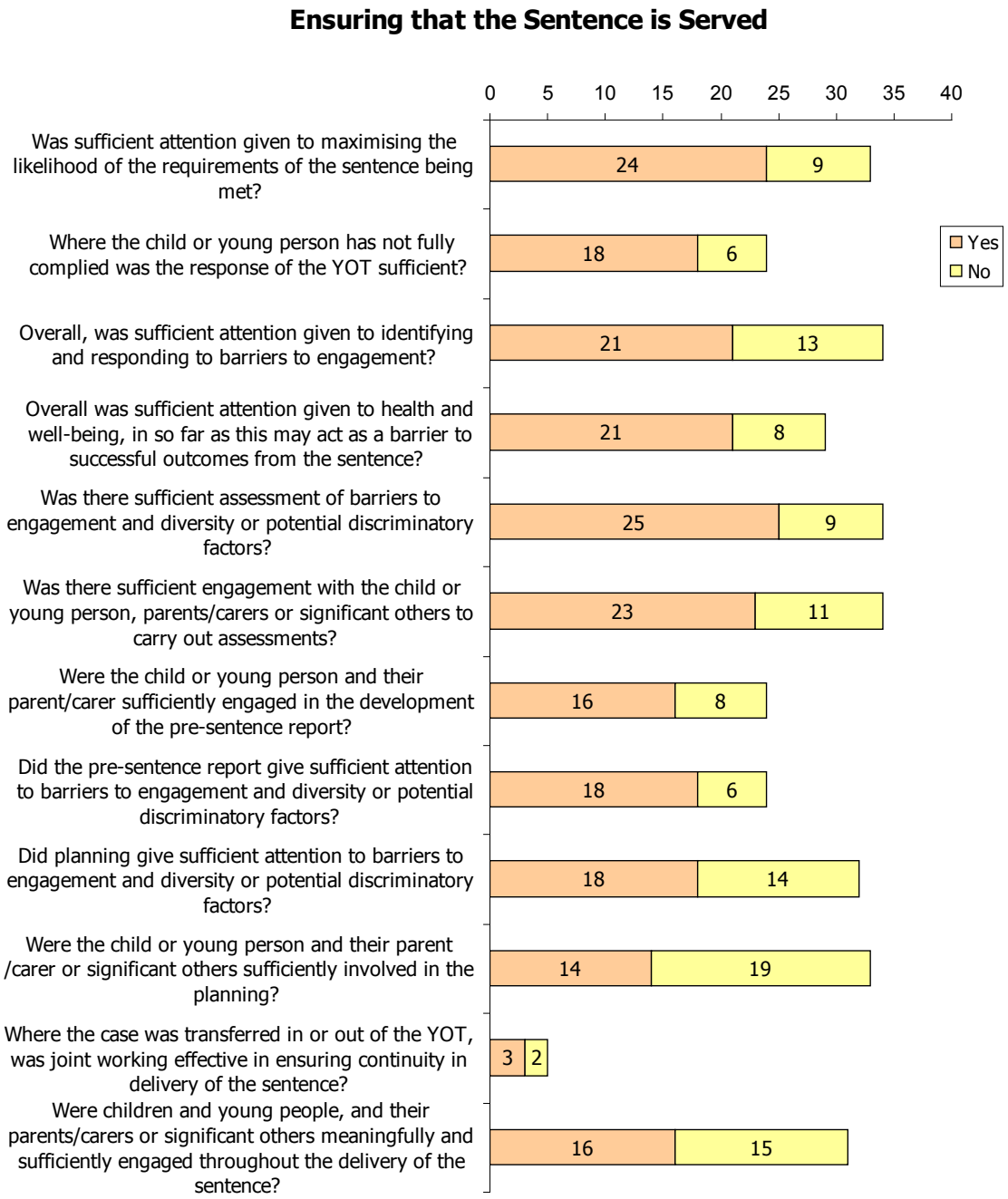

Governance and partnerships

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Theme 5: Governance and partnerships

What we expect to see

Effective governance, partnership and management arrangements are in place. These enable the YOT to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

Key Findings

1. The management of the YOS was separated into operational and strategic levels and was not working effectively.
2. There were two management boards, one operational and one strategic. Neither had supported or held the YOS to account effectively. This had been recognised and changes were already taking place.
3. Data and other information had not been used to scrutinise, monitor or support performance. This had been recognised and plans were in place to improve it.
4. There was insufficient, effective strategic partnership working; agencies tended to operate independently of each other.
5. The YOS was well resourced by partnership agencies and there was some excellent work but it was not always well integrated.

Explanation of findings

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

1.1. The strategic and operational management of Bromley YOS had been separated. The overall, and strategic, management of the YOS sat with the Head of Youth Support while the operational management sat with a group manager. This was not working effectively. Communication links were insufficient and role boundaries were blurred.

1.2. There were two management boards in place as a result of an historic decision. One, the executive board, was chaired by the local authority chief executive and the senior, strategic representatives from the partner agencies sat on this board. With the exception of a briefing about the forthcoming inspection, it had not met for over a year. The second, known as the operational board, was chaired by the Assistant Director, Safeguarding & Social Care and comprised mainly operational managers. The Head of Youth Support attended the operational board.

1.3. Health professionals sat on both boards; attendance, particularly at the operational board, was poor and those in attendance were not able to make the decisions needed. Attendance by the police representative was regular, but again, she was not able to make strategic decisions or commit resources. The problem of seniority had been recognised recently and was being addressed. The board member for ETE, who was of appropriate seniority, had held the position for around five months.

1.4. The level and quality of information to the operational board was insufficient in all areas including ETE, health, accommodation and offending behaviour and had not been challenged. This had recently been recognised and change was planned.

1.5. We could see that some changes had occurred as a result of the operational board, such as the engagement of a SALT worker, albeit at a slow pace.

1.6. The YOS was not sufficiently engaged in the strategic leadership of safeguarding or corporate parenting across the local authority. The Head of Youth Support was not a member of the Bromley Safeguarding Children Board (BSCB); there was representation on some of the sub-groups. YOS issues had been brought to the BSCB at the board's request, rather than being instigated by the YOS. No formal links had been established between the BSCB and the YOS, and although some representatives sat on both boards, there was little evidence to demonstrate that the YOS influenced safeguarding work across the partnership or that the specific needs of children and young people who had offended were being routinely considered.

1.7. Offending by Looked After Children had not been fully considered within the local authority corporate parenting strategic management and while the data showed that offending by this group had reduced, there was no evidence that this was as a result of strategic efforts by the local authority.

2. Partnerships – effective partnerships make a positive difference

2.1. Strategic links across the partnership were fragmented and ineffective in supporting and challenging the YOS. We saw very little joined-up, solution-focused strategic partnership work.

2.2. As an example, we were told that, in Bromley, there was a small but significant number of children and young people responsible for committing a large number of theft and burglary offences. While each organisation appeared committed to working on this, there was no coordinated partnership plan at either a tactical or operational level to address it. While operational DYO meetings took place in the YOS, involving a number of operational partners, these arrangements had clearly been ineffective at preventing the children and young people in this cohort from reoffending.

2.3. Similarly, we were advised that a significant number of repeat offenders, known to other agencies, were not known to the YOS until their offending became entrenched and more difficult to address. The partnership links at the operational board had not resulted in a multi-agency approach to this being considered.

2.4. The YOS had access to the local authority children's social care services electronic case file system. This enabled case managers to see what work was being undertaken by social workers. However, information held on this system was not always readily accessible, with some information not recorded or easy to locate.

2.5. In cases where the child or young person had resisted engaging with professionals from other agencies, YOS staff were often left with little effective support from partners. Children's social care services 'step down' processes, from child protection to children in need and then to universal services, were sometimes implemented at too fast a rate, without adequately addressing the ongoing issues of concern, or ensuring that any improvements had been sustained. In these cases YOS staff were left to tackle longstanding welfare issues for those children and young people in addition to the offending issues. Partner agencies were sometimes reluctant to become re-involved with those young people, even where they had been very recently involved. This negatively impacted on the welfare of those particular children and young people, sometimes resulting in homelessness, substance misuse and repeat offending. While YOS staff did challenge other services, no use had been made of local authority formal escalation procedures, to ensure that the needs of these children and young people were properly addressed.

2.6. The provision for further education within the Bromley area was not extensive although the colleges and training providers were generally good. Bromley College had recently started to provide more flexible provision, better tailored to the individual needs of children and young people working with the YOS. Courses provided opportunities to develop skills to enable them to progress into training or employment. Opportunities for children and young people to improve their English and mathematics were generally good but more flexible courses were needed.

2.7. The variety of opportunities outside the main college provision to develop employability skills was insufficient. The pupil referral unit had been found to require improvement by Ofsted in July 2014. This provision was now part of the Bromley Academy Alternative Trust with a clear improvement plan in place. It was recognised by the board that the suitability of the provision was the main problem. Plans were in place to develop a multi-skills course for hard to engage YOS children and young people (pre-16) that will be put in place during 2016.

2.8. Links made by the YOS with the local college were developing and were benefiting children and young people by helping to identify the type of support that they needed to attend college courses. The youth support worker had started to build partnerships with local organisations to help develop and extend the provision. For example, a link with an housing association (Affinity Sutton) had led to developing Construction Skills Certification Scheme training for children and young people from the YOS; this was due to start imminently, and was to take place at the YOS premises. A recent link developed with the local jobcentre had led to a scheme using local employers to undertake mock interviews and offer opportunities for work experience; again, this was due to start over the next few months.

2.9. The YOS panel which considered children and young people not in ETE, met monthly. It was working well to develop an understanding of the characteristics of those in this group. A good level of information on individual progress identified what was proving successful. The panel provided good opportunities to develop internal partnership working, linking the youth support programme, 16-19 Education Commissioner, Bromley Mentoring Programme and the Bromley Education Business Partnership. The information from these meetings was starting to be used to with providers to shape provision.

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

3.1. All practitioners interviewed said that they felt that their supervisors had the skills and knowledge to assess their work and to supervise, support and help them improve their practice. Most thought that the management oversight/countersigning process was adequate. It was our judgement however, that supervision and other quality assurance processes had not made a positive difference to most of the cases we inspected.

3.2. YOS staff understood their roles and responsibilities in relation to identifying and referring concerns about vulnerable children and young people to partner agencies. They had attended a range of safeguarding training courses, which enabled them to identify concerns. They routinely discussed concerns with their managers and other colleagues, many of whom were social work trained. This was enhanced by workers from other agencies, such as social workers, routinely visiting the YOS as part of their induction to better understand respective roles and responsibilities. YOS staff had received training on, and were familiar with, issues of child sexual exploitation. They had also received *AIM 2* training which focuses on children and young people who have carried out sexually harmful behaviour.

3.3. The police officers in the YOS were not co-located with other YOS staff; they worked from Bromley police station. There was a sense from existing YOS staff that police work was not fully embedded and a corresponding view from the police officers that the provision of information to them from the YOS was not as good as it should be. We heard reference during staff interviews to "*council YOS*" and "*police YOS*".

3.4. A vast amount of police time was spent carrying out administration, which included searching the custody recording system for details of children and young people arrested in the borough; checking, updating and forwarding notifications of incidents to other agencies, and updating records. While these processes were useful, they did not seem to us to be tasks that needed to be carried out by police officers and were not the best use of their time. More useful, in our view, was their attendance at risk panels and DYO meetings.

3.5. Generally, the police officers' role and tasks complied with official guidance. The exception was managing the interface between Integrated Offender Management and the YOS where children and young people were approaching 18 years old. The new model of policing in the Metropolitan Police area is intended to bring IOM and YOS police officers closer together under a common management structure spanning all aspects of offender management.

Good practice example

The YOS police officers attended quarterly forums (along with the other YOS police officers from across the London Metropolitan Police Service). These meetings were used to share information relevant to the role and best practice.

3.6. Bromley was a well-resourced YOS in regard to health services. The health team comprised a substance misuse worker, a part-time nurse, a part-time counsellor and a dedicated Child and Adolescent Mental Health Service (CAMHS) worker based at the YOS for three days per week. Bromley Young Persons Alcohol and Substance Service (BYPASS) was the local drug and alcohol service for children and young people. They dealt with the cases that required Tier 3 services (structured community-based treatment) and pathways were in place for the YOS to refer.

Good practice example

The YOS had a pilot involving a SALT worker. Part of this pilot included delivering training to staff to increase their awareness of speech and language difficulties and help them identify when a child or young person needed an assessment or extra support. It was evident that case managers had used the SALT worker to gain advice to allow them to adapt their practice with individual children and young people.

3.7. The working agreements and protocols between the YOS and health agencies were out of date, some by several years, and two were not signed by both organisations. They had not been reviewed to ensure that the correct level of service and support for staff was being provided. As an example of this, the CAMHS nurse was based at the YOS three days a week and two days at the wider CAMHS service dealing with mainly emergency cases. These emergency cases often needed follow-up appointments in the week and therefore impacted on the time at the YOS. The managers of both CAMHS and the YOS were aware of this but had not resolved the issue.

3.8. Managerial supervision for health staff did not always occur on a monthly basis. The health practitioners, with the exception of the substance misuse worker, received clinical supervision. It was of concern that the substance misuse worker did not. We were informed by the commissioner that procedures were in place for it to be carried out by BYPASS; this conflicted with information from BYPASS. The substance misuse worker had not accessed any recent role specific training or attended team meetings with BYPASS for approximately 18 months.

3.9. The educational welfare service provided an experienced education welfare officer to work within the YOS. The priority was to work with children and young people of school age without an educational placement. The YOS and the education welfare officer worked well together to reintegrate children and young people back into education. The targeted youth support worker was seconded in to work with post 16 year old children and young people who were not in ETE. The post of teacher at the YOS was vacant.

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

4.1. Not all staff thought that the YOS had a culture of learning and continual improvement.

4.2. We saw no evidence that the YOS or the Management Board used performance data or other information such as feedback from children and young people to improve practice or outcomes. There were no partnerships with local universities or other research or management facilities to evaluate and aid the work of the YOS.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

What we expect to see

The work with children and young people to reduce reoffending should include a broad range of good quality interventions. They should take into account individual need and ability, be delivered well and be monitored and evaluated to ensure their effectiveness. Where children and young people are working with more than one agency, partnership work should be integrated.

Case assessment score

Within the case assessment overall 43% of interventions to reduce reoffending were done well enough.

Key Findings

1. Programmes were delivered sporadically and children and young people had to 'fit in' to the schedule.
2. The effectiveness of programmes was not evaluated.
3. There was no assessment of the suitability and ability of a child or young person to carry out particular programmes.
4. Work being carried out with individual children and young people by different practitioners was not integrated.
5. The delivery of programmes by different agencies was fragmented and, as a result, resources were wasted.

Explanation of findings

1. The YOS produced a menu of programmes to be delivered over the forthcoming quarter. The programmes included health work such as 'Healthier Living', offending behaviour work, 'Victim Awareness' and life skills such as 'First Aid' and 'Streetlife' which focused on stop and search powers. Other programmes such as 'Weapons Awareness' ran at different intervals. There was some confusion, during the inspection, about who was running the 'Weapons Awareness' course. We observed a session run by the YOS. This was a surprise to the police who thought that theirs was the agency that ran this programme.
2. The 'Healthier Living' group was reported to be a positive intervention by case managers. It had been carried out on a 'one off' basis and had covered emotional and mental health, sexual health and substance misuse. There were concerns however, that health staff did not always have sufficient information about the children and young people in the group, including the nature of their offence. The nurse was also trained to offer smoking cessation, however no children and young people had taken up this programme.
3. The targeted youth support worker ran a structured employability course 'Future prospects' at the YOS which provided opportunities to discuss future employment objectives. Children and young people received good support in helping them develop employability skills, such as curriculum vitae building, job search, college applications and interview techniques. Those who lacked confidence were accompanied to college interviews.
4. Bromley Police ran a cadet scheme for those aged between 11 and 17, who lived or studied in the borough. The YOS was able to refer children and young people to the cadets as an intervention.

5. Some of the recording of individual interventions was so poor that it was impossible to say what work had been carried out with children and young people. Where we could determine what had been delivered, the interventions were, too often, not consistent with the reasons for offending.

6. As far as we could ascertain, less than half of the interventions planned were actually delivered; it was unclear why this was the case. They were not reviewed, so that no account was taken of whether the work was making a difference, whether the child or young person's circumstances had changed or just whether they were responding. Too few took account of the need to manage risk of harm and only slightly more took account of vulnerability factors. Restorative justice did not feature sufficiently in delivered interventions, nor did the support for positive factors in the child or young person's life. The delivery of interventions in custody was particularly lacking.

Quotes from children and young people about offending behaviour work

"*It made me aware of other people's feelings, made me aware that not everyone is the same that you shouldn't treat everyone on the basis of how you think they should be, you should treat them on how they are.*"

"*I had to write a letter to the woman, to the victim and then we were just talking about how crime or being a victim can change people like. Say someone got robbed and how they'd be scared to do certain things or paranoid and what not and we just had conversations about what I could do to help and that stuff. I got an understanding of what it feels like to be a victim.*"

7. Between practitioners, interventions were not well integrated. Information was not always shared by the various people that were working with a child or young person, meaning that risk or vulnerability were not always fully understood. Interventions overlapped and not all specialists focused on their remit; practitioners were doing some of the same things with individual children and young people. Intelligence was not always known or used effectively. Individual interventions and programmes did not inform each other. We got little sense of coherent, joint working between practitioners within the YOS.

8. We found that children and young people were, too often, referred to programmes as a matter of course, without their suitability for the particular programme being assessed. For example we saw a group work session which involved considerable reading of programme material but the participants' literacy was not known. The decision about when a child or young person undertook a particular piece of work (sequencing) appeared to be a matter of what was available when, rather than being delivered when it would be most suitable and useful. None of the programmes had been evaluated to determine their effectiveness.

Appendices

Appendix 1 - Background to the inspection

Inspection arrangements

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

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

The primary purpose of the Youth Justice System is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, ensuring the sentence is served and governance and partnerships.

Criteria

A copy of the inspection criteria is available on the HMI Probation website:

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

Methodology

YOTs are informed approximately 11 working days prior to the inspection taking place.

Fieldwork for this inspection was undertaken on the weeks commencing:

19 January 2015 and 2 February 2015.

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

We also received copies of relevant local documents.

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

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

We also gathered the views of others, including strategic managers, staff and service users – children and young people, parents/carers and victims, and observed work taking place.

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

Uservoice[2] undertook a total of 20 one to one interviews for the purpose of this report. These interviews were semi-structured in nature and digitally recorded, transcribed and analysed.

Children and young people

- 7 children and young people currently engaging with Bromley YOS were interviewed.
- The age range of the children and young people was from 15 to 18 years old; 4 were 16 years of age with one 15, 17 and 18 year old respectively.
- 6 of the children and young people interviewed were male and one was female.
- 4 of the interviewees were from a White British background, with 1 coming from a Black African, Black British and Dual Heritage background.

Parents/carers

12 parents/carers were interviewed.

- 8 parents/carers were female, 4 were male.
- All the 8 were mothers, 3 of the males were fathers and 1 was a brother.
- 4 of the parents/carers were from a White British background, 2 from a British Caribbean background, 2 chose not to disclose, while 1 was from a Black African, Oriental, Middle Eastern and Dual Heritage background respectively.

Scoring Approach

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

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

Publication arrangements

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

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

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

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

2 User Voice is a charity, led by majority ex-offenders, which aims to reduce offending by presenting the voice of the people in the criminal justice system: www.uservoice.org

Role of HMI Probation and Code of Practice

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

www.justiceinspectorates.gov.uk/hmiprobation

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

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Appendix 2

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Criminal Justice Joint Inspection

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