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 **Lewisham**

An inspection led by HMI Probation

independent inspection of youth offending work

December 2016

Foreword

This inspection of youth offending work in Lewisham 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 Lewisham primarily because of high rates of reoffending and custodial sentence in the area.

Lewisham Youth Offending Service (YOS) works with children and young people with complex needs. They live in a challenging environment, and safeguarding and risk of harm issues are all too common. The YOS was delivering some satisfactory operational work which was supported by plenty of partnership activity. Attendance figures for education, training and employment were impressive and the YOS engaged well with children and young people.

Despite committed and determined work, however, there was a lack of cohesion in the delivery of services and we did not see the impact of the YOS's work in enough cases. Better outcomes will be achieved by more consistent case management underpinned by more sharply focused partnership work.

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

Dame Glenys Stacey
HM Chief Inspector of Probation
December 2016

Key judgements

Reducing reoffending	
Protecting the public	
Protecting children and young people	
Making sure the sentence is served	
Governance and partnerships	
Interventions to reduce reoffending	

Summary

Reducing reoffending

Overall work to reduce reoffending was unsatisfactory. Although the majority of initial assessments were sufficient the lack of consistency in planning and review was unsatisfactory. Integrated action planning was not embedded into the YOS. Without effective planning, the impact on reoffending was limited. We saw good arrangements for information sharing with establishments when children and young people were in custody.

Protecting the public

Overall work to protect the public and actual or potential victims was unsatisfactory. We found some good work by case managers to protect the public underpinned by strong assessments. As with work to reduce reoffending, however, plans were not always meaningful for the child or young person and lacked measurable objectives. This was a missed opportunity which meant that interventions to address risk of harm did not always address the specific risks posed.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was unsatisfactory. There was some good safeguarding work undertaken by individual case managers. Assessments usually included a coherent analysis of the risk to the child or young person, but planning and review did not always reflect this. The immediate sharing of information between the YOS and children's social care services about missing children and young people was not sufficiently robust. The provision of mental health services was good but physical health and speech, language and communication needs were not being adequately met.

Making sure the sentence is served

Overall work to make sure the sentence was served was good. The YOS made consistently good efforts to understand and respond to barriers to engagement. Engagement with parents/carers at the assessment stages was particularly good. Compliance work was carried out effectively with some good examples of professional discretion to manage the sentence as a whole.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was ineffective. There was a lot of partnership activity in Lewisham and a sense of energy around the delivery of services. This was not always cohesive and the impact of this considerable effort for children and young people who had offended was inconsistent. The YOS was willing to try innovative approaches but these were not always reviewed or evaluated. Management oversight was largely process driven and information sharing with some partners needed to improve.

Interventions to reduce reoffending

Overall work to deliver interventions was unsatisfactory. A range of interventions was available for YOS case managers and partners but further work needed to be done to better engage with children and young people. Interventions were not evaluated routinely so it was difficult for the YOS to understand what was effective with children and young people, to develop that further and to demonstrate impact.

Recommendations

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

The local authority Chief Executive should make sure that:

1. the Youth Justice Management Board focuses on improving outcomes for children and young people with all partners being accountable for a reduction in reoffending rates, better management of risk of harm to others and the more effective protection of vulnerable children and young people who have offended.

The YOS Head of Service should make sure that:

2. the Youth Justice Management Board considers a broader range of performance information to enable a consistent focus on outcomes for children and young people
3. planning for work with children and young people is carried out in all cases and is regularly and meaningfully reviewed
4. interventions are planned, address the areas identified in assessment, delivered with integrity and evaluated
5. quality assurance and management oversight in all case management work is conducted to a good standard, including the delivery of interventions and review of work
6. the risk and vulnerability management panel is functioning effectively given the pace of work and volume of cases that it deals with

7. education, training and employment providers have sufficient information about the circumstances of children and young people before placements begin
8. the delivery of health services to YOS children and young people reflects the needs identified in The Joint Strategic Needs Assessment 2014: Young People In Contact With The Criminal Justice System including physical health, and speech, language and communication needs
9. information sharing with health, substance misuse and social care partners is improved.

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

Contents

Foreword 1

Key judgements 2

Summary 2

Recommendations 3

Theme 1: Reducing reoffending 7

Theme 2: Protecting the public 12

Theme 3: Protecting the child or young person 16

Theme 4: Making sure the sentence is served 20

Theme 5: Governance and partnerships 24

Theme 6: Interventions to reduce reoffending 29

Appendix 1 - Background to the inspection 32

Appendix 2 - Acknowledgements 34

Reducing reoffending

1

Theme 1: Reducing reoffending

What we expect to see

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

Case assessment score

Within the case assessment, overall 60% of work to reduce reoffending was done well enough.

Key Findings

1. There was some good work done by case managers with individual children and young people.
2. Assessments of the likelihood of reoffending were done well enough in most cases.
3. Planning for work with children and young people was not done consistently well and plans were not always reviewed.
4. Interventions to reduce reoffending were consistent with assessed needs in only half of the cases that we looked at.
5. There were good arrangements for sharing information between the YOS and custodial provider when children and young people were in custody.
6. There was insufficient restorative justice and victim work.

Explanation of findings

1. Good assessment of the reasons for offending underpins a YOS's ability to work effectively with children and young people. In Lewisham, we saw comprehensive assessments demonstrating case managers' understanding of the reasons for offending. A small number of assessments were overly descriptive and lacked analysis.
2. Pre-sentence reports (PSRs) were of a consistently good quality and were effective in advising the court of sentencing options. PSRs contained clear and thorough assessments of risk of harm, likelihood of reoffending and vulnerability factors in almost all cases. Sufficient attention was paid to the alternatives to and impact of custody in all but one case. Good efforts were made to engage children and young people and their parents/carers in the PSR process.

Example of notable practice

The report provided a clear proposal, a good argument against custody. There was good engagement with the parent from the outset despite the fact that she refused to discuss the offence and was in the process of an appeal. The parent was fully involved.

3. Referral order panel reports were well-written and provided comprehensive information to panel members.

4. The quality of planning was not as good as the quality of assessment. We saw too many plans that did not relate to assessed needs and we saw others that did not include measurable targets. Children and young people were not fully engaged and did not always understand or own their plans. This limited the opportunity to impact on reoffending.
5. Custodial planning was insufficient in one-third of cases. In half of these this was because a plan had not been produced that covered the whole sentence, rather than just the custodial element. This meant that too often the plan that was produced did not reflect the YOS's assessment of a child or young person's needs. Plans did not clearly outline the interventions that were to be delivered. Planning for resettlement after a period in custody was sometimes done too close to the date of release.
6. Reviews of the reasons for offending were completed sufficiently in just over half of inspected cases. There were too many instances where reviews should have been triggered by a change in circumstances and were not. This was a missed opportunity to evaluate and assess progress made, to reinforce positive achievements and to build motivation and aspiration.
7. Delivery of interventions was consistent with the identified reasons for reoffending in only half of the cases. In many of these either no plan was produced or the interventions that were delivered were not consistent with the plan. Subsequently, the reviews of interventions to reduce reoffending in these cases were not meaningful and could not demonstrate any impact on reducing reoffending. We found insufficient progress in reducing offence related factors. Evidence of a reduction in either the frequency or seriousness of reoffending by children and young people was demonstrated in only two-fifths of cases.
8. Over 80% of children and young people had an education, training or employment (ETE) place at the end of their order. It was not clear how frequently these children and young people attended this provision and this information was not reported to the Board or collected regularly by the YOS.
9. We saw examples where case managers, the local authority and partner agencies provided good practical support. Some partners visited children and young people at the YOS to deliver their provision. The local authority's leaving care team made bridging payments and paid travel expenses to a young person to tide them over while they were awaiting their first apprenticeship wage. Other positive work included good communication between partners and the YOS where, for example, a tutor at the pupil referral unit (PRU) reminded a young person of pending appointments at the YOS and the importance of keeping these.
10. For children and young people in custody we saw good arrangements for information sharing between the YOS and custodial provider. This was evident throughout the custodial period.

Example of notable practice

In one case, as a result of good advocacy by the YOS, an education place was maintained while the young person served his custodial sentence. On release he rejoined a familiar environment and his tutor regularly updated his case manager on attendance and progress at school. On completing year 11, the young person successfully began a course at a local college.

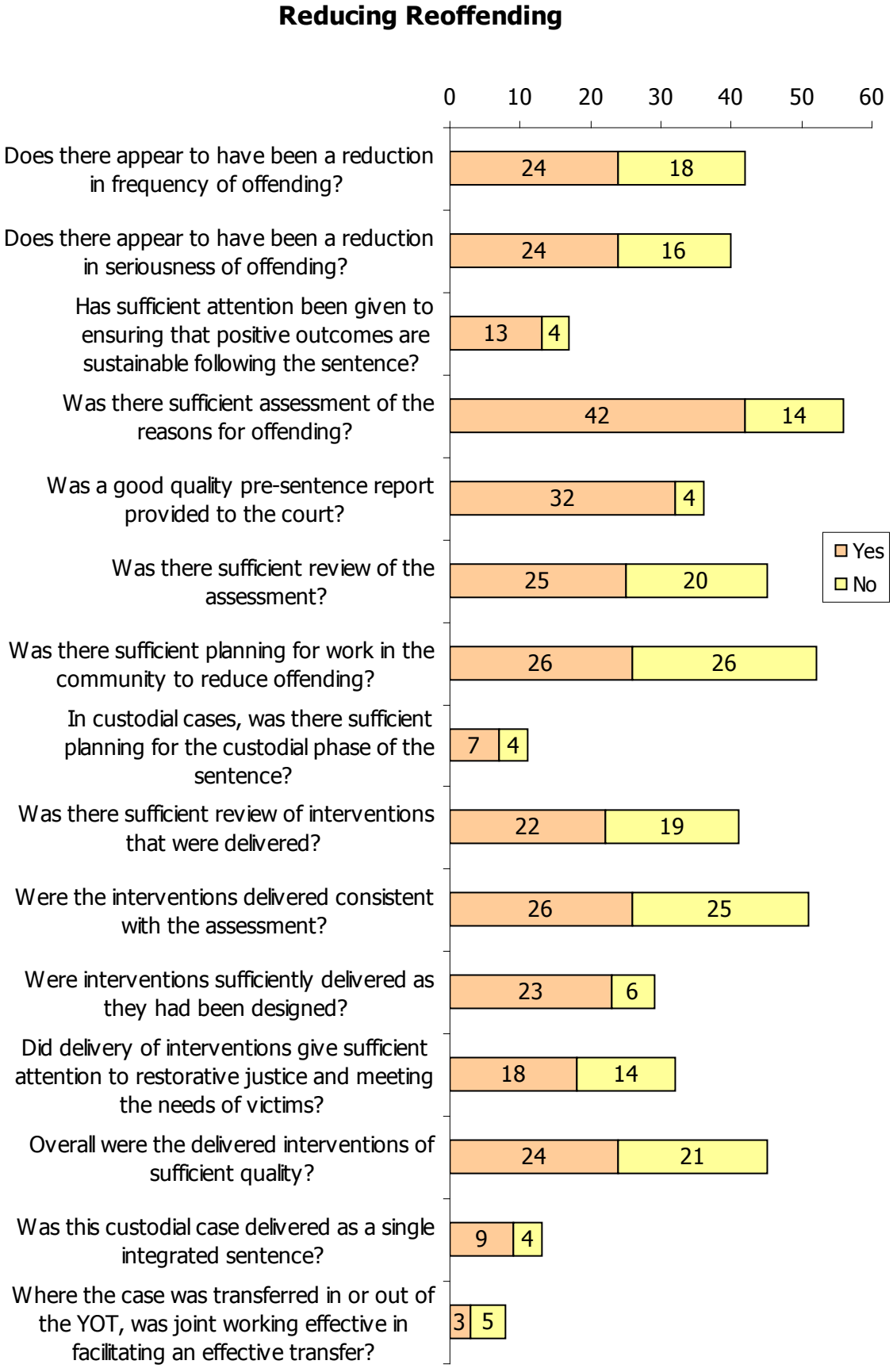
11. While information sharing with partners was usually good this was not always the case. In a minority of cases outcomes for children and young people deteriorated. When children and young people started provision, education and training providers did not always have enough information on circumstances, background or aspirations when placements began. We saw instances where this hindered planning and impacted on a child or young person settling quickly into provision.
12. Information from the speech, language and communication needs (SLCN) provision Kaleidoscope indicated there had been no referrals from the YOS to SLCN services in the borough for the period 2015/2016. Other speech and language needs were reportedly addressed via schools who commission

provision. Schools, however were unable to capture, however, all those children and young people with SLCN difficulties, often due to attendance issues. Given the correlation between speech and language needs and offending in children and young people this was a cause for concern.

13. The YOS had good access to accommodation services. Housing providers were well engaged and there was a proactive approach to accessing suitable and sustainable provision for children and young people who had offended.

Data summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 57 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]



Protecting the public

2

Theme 2: Protecting the public

What we expect to see

Victims, and potential victims, of crime have the right to expect that everything reasonable is done to manage the risk of harm posed by children and young people who have offended. We expect to see good quality assessment and planning with the delivery of appropriate interventions, and positive leadership, effective management and partnership work which reduces the risk of harm to others.

Case assessment score

Within the case assessment, overall 60% of work to protect the public was done well enough.

Key Findings

1. The majority of PSRs contained a clear and thorough assessment of the risk of harm to others.
2. Planning to manage the risk of harm posed to others was not good enough in over half of community cases and the same proportion of custodial cases.
3. Work to address the risk of harm to others was not delivered consistently well across the YOS. Interventions to address the risk of harm did not always address the type of risk posed.
4. Risk of harm to others work was not always reviewed as it should have been.
5. The pace and volume of cases at the monthly risk and vulnerability management panel (RVMP) was limiting its efficacy.
6. Management oversight of work to manage the risk of harm to others was not demonstrating a consistent impact.

Explanation of findings

1. To protect actual and potential victims and the wider public, the YOS should first assess what a child or young person might do, in what circumstances and when, who the victim might be and what might trigger the event. We saw a sufficient assessment of the risk of harm to others in almost all cases.
2. Once an assessment has been completed, the task of the YOS is to work with the child or young person to devise a plan to prevent the circumstances or triggers occurring. In both community and custodial cases, we judged plans to be sufficient in less than half of the cases that we saw. Where planning was insufficient, this was because a written plan had not been completed. Planning did not always cover actions to address individual need including gang membership and entrenched offending behaviour. We saw too few examples of contingency planning, in particular with other agencies.
3. Reviews of plans to manage the risk of harm to others were not always carried out or were not always carried out well. In some cases, the review did not include new information and in others a review had not taken place in response to a change in circumstances.
4. In order to reduce the risk of harm to others, interventions delivered to children and young people must be consistent with their assessed need. We saw that this was case in only half of the interventions that were delivered. We saw limited evaluation of interventions
5. Effective work with the police is vital to reducing the risk of harm to others. Such work must be underpinned by good information sharing processes. The RVMP demonstrated evidence of information sharing between the police and the YOS.

6. We saw only a small number of cases that had been referred to Multi-Agency Public Protection Arrangements. We understand that the RVMP is the multi-agency approach that Lewisham YOS has taken to managing some of the most vulnerable and risky children and young people. Under these arrangements, we saw examples of actions not being followed through from one meeting to the next resulting in unacceptable lapses of time in actions being taken. The sheer pace and volume of cases going through this process meant that further work needs to be done to make sure that it is functioning as effectively as possible.
7. The police ran a weekly serious youth violence multi-agency panel that was attended by the YOS, where children and young people were discussed. We observed the meeting and saw good evidence of partnership working to address offending behaviour. There was a good understanding of the risks of radicalisation and there was a coordinator embedded within the YOS who provided guidance to children and young people and staff.
8. We saw a limited number of restorative justice interventions and little evidence of any victim work. We observed a session of the reparation group. The group provided an opportunity to motivate children and young people and encourage their contribution to developments in Lewisham. The lack of engagement through the session that we observed was notable and insufficient efforts were made to address this.

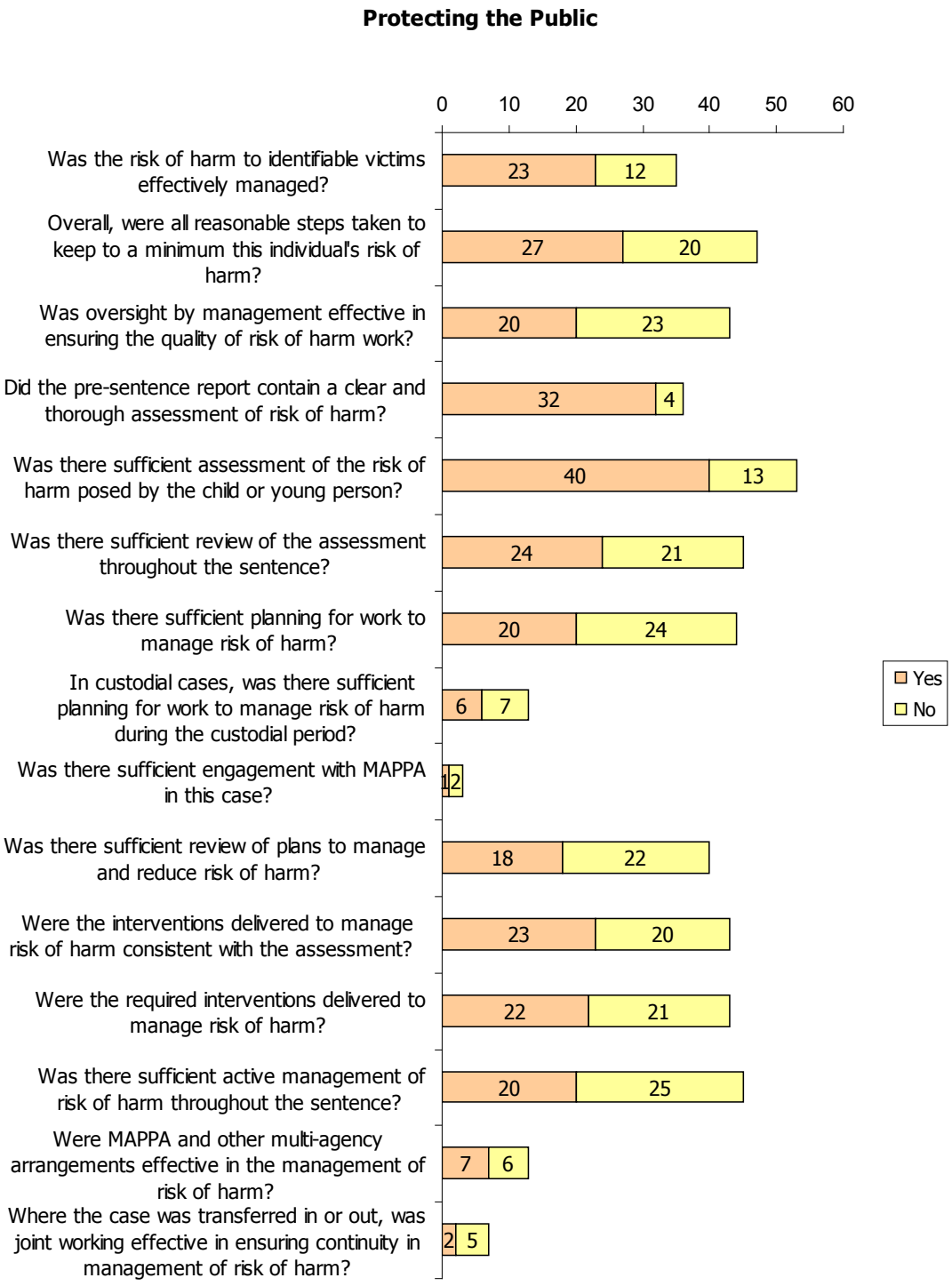
Comment from a young person

"*Someone came in and sat down and was explaining to us about victim awareness and gave a little talk and police came in and done it as well.*"

9. Management oversight of risk of harm work was evident but this was process driven. As such it had not had a sufficient impact on improving outcomes in this area.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 57 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]



Protecting the child or young person

3

Theme 3: Protecting the child or young person

What we expect to see

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

Case assessment score

Within the case assessment, overall 62% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Efforts had been made to understand, assess and explain the safeguarding and vulnerability needs that applied in most inspected cases.
2. The lack of a robust planning process meant that interventions to address safeguarding and vulnerability were too often not linked to assessed need.
3. The effectiveness of joint work between the YOS and children's social care services was variable.
4. The YOS made sure remanded children and young people who were eligible received a full leaving care service with access to appropriate support.
5. The amount of strategic activity to protect children and young people had a limited impact for children and young people.
6. Provision of mental health services was good but physical health and speech, language and communication needs were not being met.

Explanation of findings

1. We found some good safeguarding work by individual case managers. We saw cases where complex vulnerability issues had been recognised and supportive action had been taken. Efforts had been made to understand, assess and explain the safeguarding and vulnerability needs that applied in four-fifths of cases. Assessments usually included a coherent and joined-up analysis of the risk of harm to the child or young person. Where this had not happened it was because the links between mental health, substance misuse and care arrangements in relation to vulnerability had not been made.
2. The YOS had recently adopted an approach whereby plans to address vulnerability were included in the integrated action plan. We saw an inconsistent use of this process to effectively manage the vulnerability of children and young people. Too often plans were muddled, nonspecific, not meaningful to the child or young person and had limited 'buy in' from them.
3. The lack of a robust planning process meant that interventions to address safeguarding and vulnerability were too often not linked to assessed need. It was not surprising therefore, that 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.
4. The effectiveness of joint work between the YOS and children's social care services was variable. In

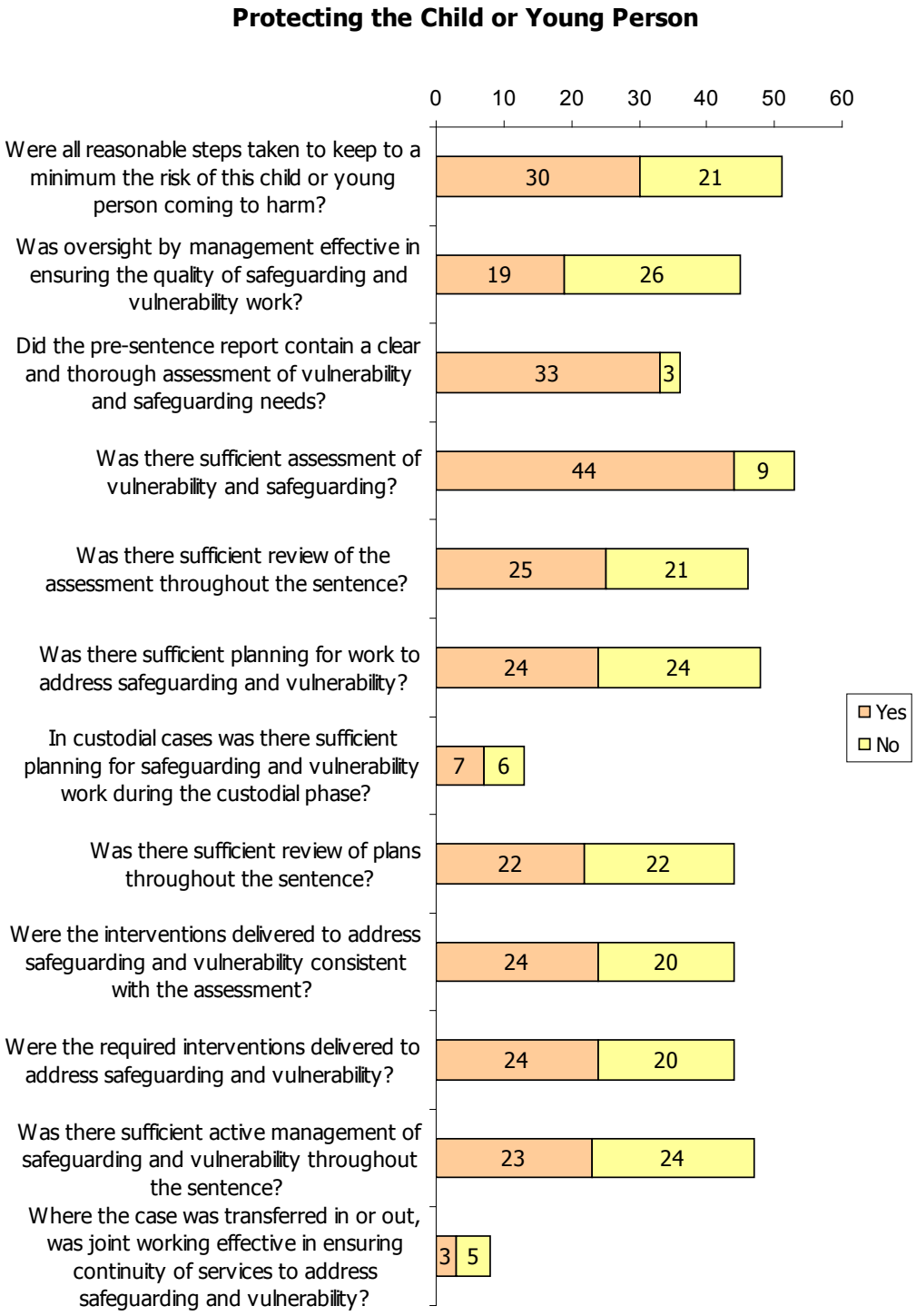
some cases, work was not of a sufficient quality to reduce vulnerability either because children and young people were not referred to social care in a timely way or because the response from social care was unsatisfactory. Two of the three most recent critical learning reviews[1] have identified the need for the YOS and children's social care services to develop more effective communication.

5. The sharing of information by children's social care services about missing children and young people who were under YOS supervision was not sufficiently robust. The missing children liaison officer did not have access to the YOS system and did not routinely check whether or not a missing person was known to the YOS. In cases where a social worker was allocated the YOS did not receive automatic alerts. If accurate and timely information about the number and frequency of missing episodes, is not reliably and routinely passed to YOS case managers, their assessments of vulnerability will be incomplete and safeguarding plans ineffective.
6. YOS case managers responded promptly and comprehensively to safeguarding concerns in secure accommodation and provided confidential opportunities for children and young people to speak freely about whether they had experienced abuse. One young person was appropriately supported to make a disclosure of physical abuse. Children and young people in secure accommodation always had an opportunity to talk privately to their YOS case manager after review meetings.
7. The RVMP accepted referrals of children and young people who were assessed to be at a high level of vulnerability. Children's social care services were represented at this panel and we saw an example of a safeguarding concern which had been appropriately escalated. Actions were often carried over however, which meant that plans to safeguard children and young people were not always being carried out with appropriate urgency.
8. A subgroup of the Local Safeguarding Children's Board, the Missing, Exploited and Trafficked (MET) Board, had been established to provide strategic oversight of MET children and young people. This group had multi-agency representation and was responsible for the policy and performance of the work to improve practice.
9. Completion of 'return home' interviews was inconsistent. This meant that the reasons why children and young people went missing were not always explored in sufficient depth and did not inform planning. Children in care to other local authorities who went missing were referred to the MET forum.
10. The YOS made sure remanded children and young people who were eligible received a full leaving care service which included provision of housing, setting up home grants, and university support. The YOS remand social workers received professional support from an experienced senior colleague. This made sure they were knowledgeable about available services for children and young people in care and could support children and young people to access the virtual school and children in care council. Their work had to be recorded on two different case management systems which was not the most efficient use of their time. Closer links, supported by a written protocol, were being developed between the YOS based remand social workers and the children in care team social workers.
11. Case managers were responsible for the initial health and well-being assessments of all cases as contained in their Asset or Assetplus assessments. Appropriate referrals were made to the Adolescent Resource and Therapy Service (ARTS) and the substance misuse service, Lifeline, but none were sent to SLCN services or physical health services. The YOS based ARTS team provided a flexible approach. Clinicians had smaller caseloads and discretionary leeway was given to non attendances as appointments with the ARTS were not statutory.
12. A large number of multi-agency forums existed to support the YOS in safeguarding children and young people. The complexity of the YOS cohort and the volume and pace of activity meant that actions to safeguard children and young people frequently focused on immediate and short-term actions and there was limited opportunity for longer-term planning and reflection.

1 Critical Learning Reviews are completed by a YOS and submitted to the YJB in the case of a community safety or public protection incident. The purpose is to determine whether supervision was appropriate and sufficient for the young person's needs.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 57 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]



Making sure the sentence is served

4

Theme 4: Making sure the sentence is served

What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the YOS 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 76% of work to make sure the sentence was served was done well enough.

Key Findings

1. Case managers engaged well with children and young people.
2. Case managers were creative in building compliance from children and young people although the rationale behind decision-making processes was not always evidenced.
3. Intervention plans were not sufficiently 'owned by' or meaningful to children and young people.
4. Children and young people had good access to mental health services.
5. Better use could be made of mentors to support and build the resilience of children and young people.

Explanation of findings

1. Lewisham YOS made consistently good efforts to understand and respond to barriers to engagement in the early stages of their work with children and young people. We saw an appropriate balance in assessments between factors that affect reoffending, risk of harm and vulnerability. In almost all assessments, sufficient attention was given to identifying and responding to barriers to engagement. The picture was similar with PSRs as three-quarters of reports gave sufficient attention to barriers to engagement and diversity.

Example of notable practice

A real strength of the case management in Yaneck's case was the attitude of the individual practitioner and his value base. He was firmly of the view that in order to make any meaningful difference, the order had to include elements that Yaneck was motivated to work on and could be sustained once the order had ended. The work in this case was a thoughtful example of a collaborative approach.

2. At the planning stages engagement was not as good and children and young people reported a lack of input to or ownership of their plans. Parents/carers were not consistently involved in planning and review. Effective engagement with parents/carers during an order is a significant opportunity to reinforce the YOS's work and increase its impact.

Comments from a young person

"*I have the odd phone call every now and again, but sometimes they're [the YOS] not easy to get hold of 'cause they're quite wrapped up in their work.*"

"*They [the YOS] looked at meeting his needs and stuff and they did take that into consideration. He was treated as an individual.*"

3. Reviews of the delivery of interventions were completed in just over half of relevant cases. These reviews were not always of a sufficient quality. Where we did see reviews, more should have been done to address attitudes, motivation and barriers to engagement.
4. Compliance work, making sure that the child or young person carries out the sentence of the court, was delivered in a timely and appropriate fashion. In order to help compliance, case managers were skilled at identifying potential barriers to engagement. Case managers regularly thought creatively in terms of where meetings could take place, addressing any safety issues, considering language and cultural differences and making time to develop trusting relationships.
5. We saw some good examples of the use of professional discretion to manage a sentence as a whole and to best engage with children and young people. We also saw a small number of cases where compliance work and breach proceedings should have taken place and had not with no clear rationale for this. This had caused some tension with the police.

Comments from young people and a parent

"*They [the YOS] help me with stuff. Like if I wanted to change my day they would help me out and think of a day that I can actually come in. Just stuff like that.*"

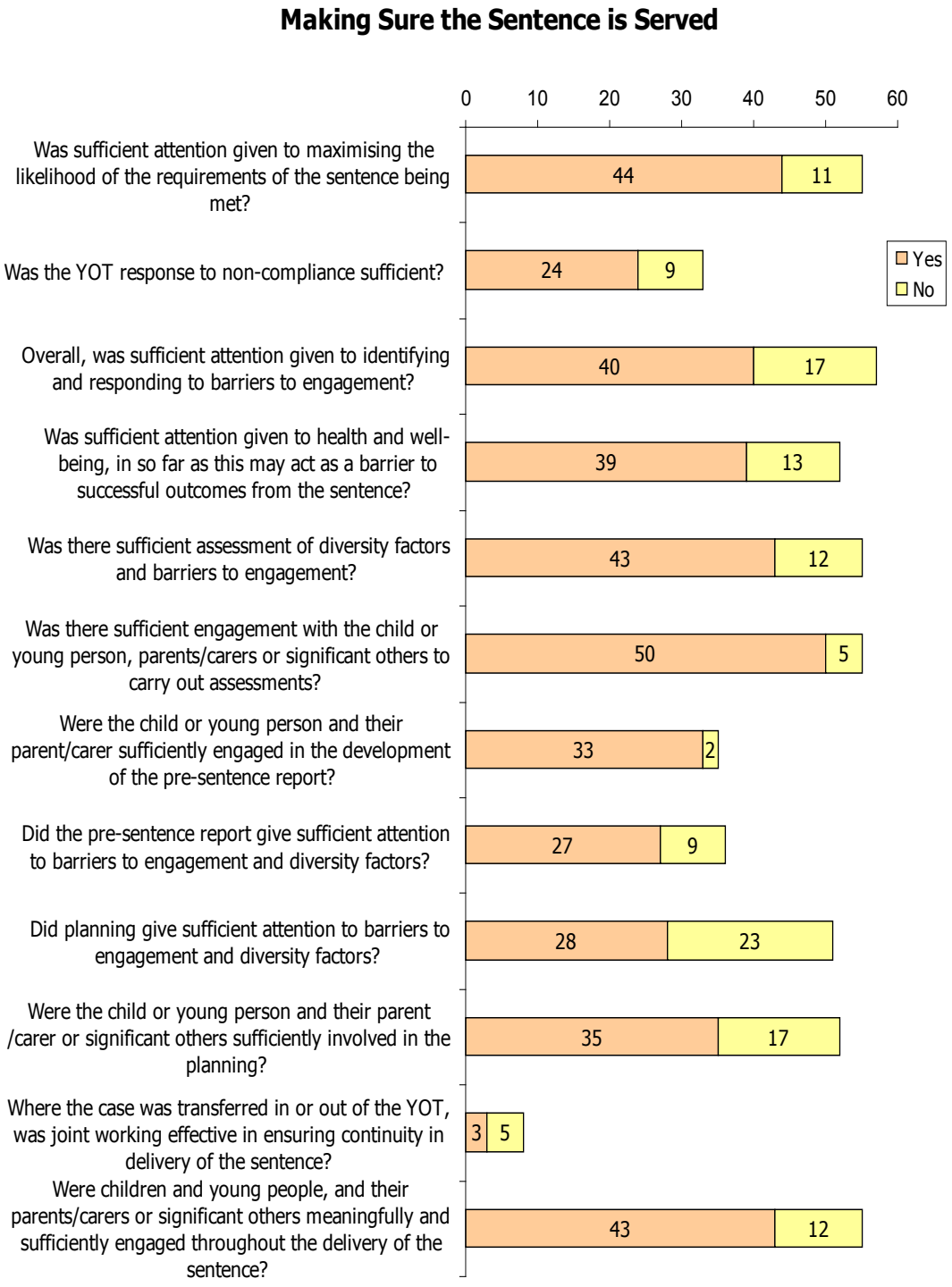
"*When I didn't have my Oyster [card], like obviously I was running late for school and that, like my attendance was getting bad...and then [YOS worker] sorted out my Oyster and that and she gave me bus tokens for when I didn't have an Oyster... and then they got me my Oyster ordered... so yeah they helped me out.*"

"*He [the young person] doesn't want to comply because there is no deterrent for him not to stick with it.*"

6. Children and young people had good access to YOS mental health services. There were no waiting lists and this was strengthened by having Lifeline substance misuse services, ARTS and Liaison and Diversion co-located with the team. Health professionals engaged well with the parents/carers of the children and young people working with the YOS. The ARTS clinical psychologist and the Lifeline workers conducted home visits.
7. Lewisham had a large number of children and young people who, because of entrenched attitudes to offending or gang issues, were particularly difficult to engage with. These needed a different and bespoke approach. We were surprised that although mentoring provision was available, case managers did not access this in all relevant cases.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 57 cases were inspected. The total answers, however, may not equal this, since some questions may not have been applicable to every case]



Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

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

Key Findings

1. The Youth Justice Management Board did not contribute sufficiently to the delivery of effective youth justice outcomes.
2. The Youth Justice Management Board was neither provided with the right data or effectively scrutinised data enough to inform delivery and impact on outcomes for children and young people.
3. Although the YOS was located in the community safety directorate the strategic links with children's social care services were good.
4. There was a lot of activity and energy around partnerships in Lewisham.
5. The YOS quality assurance systems were largely driven by process rather than quality and impact.

Explanation of findings

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

1.1. The Safer Lewisham Partnership Plan 2016/2017 set out the local authority's commitment to reducing offending. It identified four priority strands of work as: peer on peer abuse, 'violence against women and girls', work in relation to identified geographical hotspots, premises/people of interest and hate crime. The Lewisham youth justice plan references these four priorities. The youth justice plan sets out six performance measures against which it will measure its performance and lists nine operational priorities.

1.2. Although the Youth Justice Management Board was scheduled to meet quarterly there have been gaps in engagement from statutory partners. The Police Superintendent had been the chair of the Board but this had changed in the last three months to the National Probation Service Assistant Chief Officer. Representation and engagement was not consistent enough either to make sure the partnership gave contributions or provided sufficient accountability.

1.3. We saw limited follow-up of actions from one Management Board meeting to the next. As a consequence the Board had been unable to effectively direct, challenge and scrutinize the delivery of youth justice outcomes. The energy and activity of partners was evident but without effective leadership, provided by a discrete Youth Justice Management Board, the outcomes achieved from all of this activity represented a poor return.

1.4. We saw evidence of performance reporting to the Management Board but there was not a strong enough link between this and improved outcomes. The performance reporting consisted of national indicators and national standards measures with insufficient attention paid to how the best outcomes for children and young people could be achieved. The Management Board did not consider any performance information about interventions.

1.5. The Director of Children's Social Care Services attended Management Board meetings and was an appropriate senior representative able to make decisions and allocate resources. This was encouraging but a detailed analysis of outcomes for the cohort of children and young people in care who were known to the YOS had not been undertaken. This scrutiny would help YOS staff and managers both to assess the effectiveness of work to reduce reoffending by this vulnerable cohort and to inform the design of future services.

1.6. The Management Board also included a representative from the children's services education directorate. The Board routinely received data on the proportion of children and young people who had an ETE place at the conclusion of their order. This data provided limited insight into the effectiveness of ETE in reducing reoffending and had not been used to analyse the strengths or areas for improvement in relation to ETE. Other data that could provide a more complete picture of ETE performance, such as whether attendance at school or college has improved, had not been considered. The lack of more meaningful performance reporting limited the insight that the Management Board had about the effectiveness of ETE provision.

1.7. Health partners attended the Management Board. The *Joint Strategic Needs Assessment 2014; Young People In Contact With The Criminal Justice System*, was a comprehensive document which made recommendations around sexual health, speech and language, and physical health provision. The YOS had not made use of the recommendations and was not able to say what their response to it was. There was a gap in terms of access to physical health resources despite the strategic needs assessment highlighting this area. This had not been considered by the Management Board.

2. Partnerships – effective partnerships make a positive difference

2.1. Although the YOS was located in the community safety directorate it had good strategic links with children's social care services. There were strong local networks and support existed for senior managers from their peers. There was a lot of activity and a real sense of energy around partnerships in Lewisham.

2.2. The serious youth violence team worked closely with schools to raise awareness of the issues around gang associations. Members from the unit also visited children and young people in custody to deter them from gang association. This included seeking education, employment and accommodation, and also placed conditions on children and young people upon release. The partnerships created by the South London Resettlement Consortium were impressive

2.3. We found that those children and young people without an ETE placement were effectively prioritised by the education lead in the YOS. There was good liaison between the YOS and key partners such as the PRU and the virtual school. This enabled the YOS to be alerted in a timely way when children and young people had problems such as deteriorating attendance.

2.4. The education lead advocated effectively with education providers, professionals and groups, such as the fair access panel, to make sure that children and young people had an ETE place that best met their needs. The role of the education lead was valued highly by case managers and partners alike, including those at the PRU, the local authority and at Cookham Wood Young Offenders Institution.

2.5. The YOS had effective links with specialist ETE partners. These links added to the breadth of help that was available to children and young people. A partnership with the St Giles Trust[2] for example provided additional support including CV writing, promoting apprenticeship and employment opportunities and offering mentoring support. The Not in Education, Employment or Training traineeship programme has had some success in helping children and young people to gain sustainable education or training placements. 54% of children and young people supervised by the YOS and participating in the programme achieved sustainable placements in the last year.

2 St Giles Trust is a mid-sized UK based charity that works primarily with ex-offenders helping them with training and equipping them for life beyond prison.

2.6. The MET arrangements were newly developed and it was too early to assess their impact. The new weekly meeting attended by the YOS was fast paced and was described by staff as being more focused and effective than previous arrangements. The MET strategic forum had met twice and the YOS had responded in a timely manner to a mapping exercise.

2.7. There was an ambitious and challenging improvement programme for the Multi-Agency Safeguarding Hub (MASH) and early help, which together with the YOS restructure, was not yet implemented. Nonetheless, the plans demonstrated a clear commitment by the YOS to increased partnership working with children's social care services through a dedicated link worker to be located in the MASH. The proposed location of the YOS in school hubs should increase the likelihood that children and young people at risk of vulnerability through gang activity will be identified and helped at the earliest opportunity.

2.8. A jointly developed innovation bid had been submitted by the YOS and children's social care services to develop bespoke resources and a joined-up response to serious youth violence and child sexual exploitation. Although the outcome was unknown at the time of inspection the bid demonstrated a clear intention to jointly find solutions to address the risks faced by children and young people known to both services.

2.9. The RVMP accepted referrals of children and young people who were assessed to be at a high level of vulnerability. Children's social care services were represented at this forum and we saw an example of a safeguarding concern which had been escalated appropriately. Often actions were carried over from meeting to meeting meaning that plans to safeguard children and young people had not always been carried out with appropriate urgency.

2.10. Lewisham has been a leading local authority in developing a national 'county lines'[3] approach to drug dealing as well as in the delivery of trauma informed approaches to case work. It is the lead local authority for the South London Resettlement Consortium. The YOS has been part of some local authority wide work with the University of Bedfordshire to develop its work on safeguarding and managing risk of harm.

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

3.1. Workforce management is an important component of a well managed YOS. In Lewisham we found that YOS operational managers had the required level of knowledge and skills to assess the quality of practice.

3.2. Some, but not all, case managers at the YOS felt that they had been provided with sufficient training both to enable them to do their job and to meet their future development needs. We saw a forward facing workforce development plan but records of training already undertaken by YOS staff was limited. This made it difficult to correlate the impact of staff training and development on service delivery.

3.3. The YOS quality assurance systems were thorough and process driven and this provided a level of reassurance to managers. There was scope for a greater focus on quality and consistency in order to maximise the impact of management oversight in individual cases.

3.4. Supervision of YOS staff was regular and on the whole staff valued the support that they received. Performance management was in evidence but the follow-up in individual cases where issues had been identified was not always robust enough. This meant that the value added by quality assurance processes was limited.

3 County Lines is a national issue involving the use of mobile phone 'lines' by groups to extend their drug dealing business into new locations outside of their home areas.

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

4.1. In Lewisham there was a commitment to trialling innovation and this was something of which the YOS was proud. The 'trauma-based' approach to case work was an example of this. Such work now needs to become better embedded into operational delivery in order for the impact on outcomes to be demonstrated.

4.2. YOS staff told us they annually attended good quality mandatory training provided by Lewisham Children's Safeguarding Board. Training included learning from serious case reviews and examining current safeguarding concerns such as online grooming, child sexual exploitation, and female genital mutilation. This made sure that YOS staff had current information about new and emerging risks of harm facing children and young people.

4.3. Interventions were not evaluated sufficiently and this was a significant missed opportunity for learning across the YOS. Without such evaluation the YOS cannot know whether its work has been effective or not.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

What we expect to see

There should be a broad range of quality interventions being delivered well and as their design intended. We expect to see that these are based on assessed needs with appropriate planning to maximise the likelihood of sustainable outcomes being achieved. Where children and young people are working with more than one agency partnership working should be integrated.

Case assessment score

Within the case assessment, overall 64% of work on interventions was done well enough.

Key Findings

1. Assessments of the suitability of children and young people for specific interventions had been considered well enough in most cases.
2. Restorative justice did not feature sufficiently in delivered interventions.
3. The delivery of interventions by practitioners within the YOS or between the YOS and partner agencies was not always joined-up or consistent with assessed need.
4. The effectiveness of interventions was not evaluated.

Explanation of findings

1. There was a good range of interventions available to children and young people. Some of these were delivered by partner agencies, for example the police stop & search programme. Most were delivered by YOS practitioners, not all of whom had received training on their delivery.
2. There were some strengths in the way that interventions were being delivered. The Them and Us programme was well delivered encouraging reflection and testing out the views of those less confident to speak up.

Example of notable practice

In the Them and Us programme, discussion and debate was generated with good humour. The tutors worked well together, encouraging reflection and how different people are assigned power and status, for example celebrities, politicians , police, and 'the rest of us'. Skills versus status were examined. The YOS worker encouraged empowerment and children and young people's voices and views were important and valued.

3. Case managers selected aspects of interventions to deliver on a one-to-one basis with children and young people, to suit their needs. Some interventions were delivered as group work programmes, such as Double Edge (a knife/weapon awareness programme) and Them & Us (self-awareness and negative social influences). The YOS had a Restorative Victim Awareness Programme, though we saw little evidence of victim awareness work.

Example of notable practice

Cynthia was initially assessed as shy, quiet and reluctant to work in a group. It was also her first conviction, with no other issues or concerns to indicate a high level of risk. In this context the case manager assessed that interventions, usually delivered in a group setting, would be better undertaken on either a one-to-one basis, or along with her co-defendant only, in order to avoid the young person mixing with more sophisticated and high-risk young offenders. This approach led to a far better level of engagement in the work than might have been expected in a group programme, where the young person would not have been able to contribute and express themselves as fully.

4. Assessments of the suitability of children and young people for specific interventions had been considered well enough in the majority of cases. There were, however, notable gaps in the delivery of interventions, where only half of those within the case sample matched the identified reasons for offending. This was mostly because no plan was produced or there was no clear link between planning and interventions or actual delivery was not recorded.
5. It was not always clear how interventions contained in plans were linked or sequenced in accordance with assessed need. For example, some plans did not include learning styles, issues around age or maturity or barriers to engagement. Parents/carers were not meaningfully engaged in planning for interventions in enough cases. Reviews of interventions being delivered to reduce reoffending were also insufficient in almost half of the cases we examined. We found that either reviews had not been completed, or were of a poor quality.
6. The standard of one-to-one delivery with children and young people was inconsistent and such interventions were not always systematically delivered. We saw examples of missed opportunities to address reoffending particularly in the delivery of groupwork.
7. Restorative justice did not feature sufficiently in delivered interventions, nor did the support for positive factors in the child or young person's life.
8. Intelligence gathered 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 or between the YOS and partner agencies.
9. There was little evidence of interventions being quality assured. We found no monitoring of the quality of delivery, for example through practice observation. While managers had developed a quality assurance framework for the YOS over the course of the last year, this did not include interventions, and the absence of analysis made it difficult to make judgements about positive outcomes for children and young people being achieved. It was not clear how the YOS evaluated the quality of delivery or effectiveness locally on outcomes.

Appendices

Appendix 1 - Background to the inspection

Inspection arrangements

The Full Joint Inspection 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 published reoffending rate[4] for Lewisham was 46% (with an average number of previous offences per offender of 1.48), compared to 43.9% for the previous year (average number of previous offences of 1.24) and 37.8% for all England and Wales (average number of previous offences of 1.21.

The primary purpose of the youth justice system is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, making sure the sentence is served and governance and partnerships.

Criteria

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

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

Methodology

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

Fieldwork for this inspection was undertaken on the weeks commencing:

12 September 2016 and 26 September 2016.

In the first fieldwork week we looked at a representative sample of 57 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 YOS developed.

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

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

4 The reoffending rate that was available during the fieldwork was published in July 2016, and was based on binary reoffending rates after 12 months for the October 2013- September 2014 cohort. Source: Ministry of Justice.

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

Scoring Approach

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

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

Publication arrangements

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

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

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

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

Role of HMI Probation and Code of Practice

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

www.justiceinspectorates.gov.uk/hmiprobation

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

HM Chief Inspector of Probation

1st Floor, Manchester Civil Justice Centre

1 Bridge Street West

Manchester

M3 3FX

Appendix 2 - Acknowledgements

Lead Inspector	Helen Mercer, *HMI Probation*
Deputy Lead Inspector	Sue McGrath, *HMI Probation*
Inspection Team	Andy Griffiths, *HMI Probation* Yvette Howson, *HMI Probation* Nicola McCloskey, *HMI Probation* Tessa Webb OBE, *HMI Probation* Robert Smith, *HMI Probation* Rebecca Clift, *Local Assessor* Amit Nath, *Local Assessor* Andrea Crosby-Josephs, *Care Quality Commission* Andrew Reed, *HMI Constabulary* Jon Bowman, *Ofsted Further Education and Skills* Kate Malleson, *Ofsted Social care*
	Greg Barton, *User Voice*
HMI Probation Support Services	Amy Williams, *Support Services Officer* Adam Harvey, *Support Services Manager* Claire Fallows, *Data Officer* Stephen Hunt, *Communications Manager*
Assistant Chief Inspector (Youth Justice)	Alan MacDonald, *HMI Probation*

Criminal Justice Joint Inspection

Arolygiad ar y Cyd Cyfiawnder Troseddol

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

ISBN: 978-1-84099-768-2