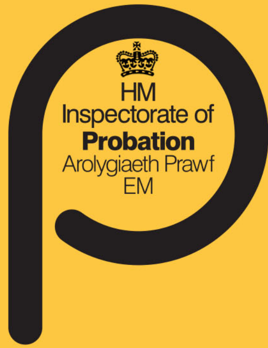

Full Joint Inspection of Youth Offending Work in **Cambridgeshire**

An inspection led by HMI Probation

independent inspection of youth offending work

February 2017

Foreword

This inspection of youth offending work in Cambridgeshire 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 Cambridgeshire primarily because it was performing well on each of the national youth justice outcome indicators. Outcomes of work to reduce reoffending, reduce first-time entrants to the youth justice system and reduce custodial sentences had been consistently strong for a number of years. Staff understood the importance of forming positive relationships with children and young people in order to influence change in their lives, and achieved this well.

The local authority commitment to youth offending work was strong and Cambridgeshire Youth Offending Service (YOS) was well regarded. Progress on making sure that all those subject to court orders received suitable education, training or employment had been stubbornly slow. Not all partners were effectively engaged with the work of the YOS at a strategic level. The YOS had encountered some difficulties over the past year, which had an impact on the delivery of some core practice. Cambridgeshire YOS expected high standards of its personnel, and it was pleasing to see the commitment of staff and managers to high quality work that made a positive difference to the lives of those affected by offending.

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

Dame Glenys Stacey
HM Chief Inspector of Probation
February 2017

Key judgements

Summary

Reducing reoffending

Overall work to reduce reoffending was satisfactory. Staff and managers were committed to the delivery of high quality work to make a positive difference to those affected by offending. Managers and staff should be commended for maintaining their services over a difficult period, although some attention was needed to return aspects of practice to the levels they expected. Good attention was given to the quality of engagement with children and young people. A broader range of approved interventions was needed. Work in the courts was strong and custodial sentences were used only in the most serious cases. There was a strong Intensive Surveillance and Supervision scheme in place.

Protecting the public

Overall work to protect the public and actual or potential victims was satisfactory. Assessment of the risk of harm to others was generally good. Planning, and making effective use of AssetPlus to support it, required improvement. Multi-Agency Public Protection Arrangements were not understood well, and partnership work was not effective. There were good examples of restorative justice, although more attention needed to be given to the needs of victims. Oversight by managers was not always effective. Police intelligence sharing needed to be more comprehensive. Children and young people were able to describe work undertaken with them to reduce their risk of harm.

Protecting children and young people

Overall work to protect children and young people and reduce their vulnerability was satisfactory. Work carried out to safeguard or reduce the vulnerability of children and young people was often good. Joint work and information sharing with children's services was not always effective. Both planning and management oversight required some improvement. The sexually harmful behaviour service was well integrated with the YOS and Multisystemic Therapy was used well.

Making sure the sentence is served

Overall work to make sure the sentence was served was good. Staff were good at understanding and then seeking to address those factors in the lives of children and young people that were likely to affect their engagement with the YOS. Where children and young people did not comply with the sentence appropriate action was taken to encourage future compliance or, when necessary, to return the order to court. Good attention was given to health and well-being factors.

Governance and partnerships

Overall, the effectiveness of governance and partnership arrangements was satisfactory. Outcomes against national criminal justice system indicators were consistently among the best in England and Wales. There were important gaps in attendance at the Management Board. The partnership had not been effective in improving education, training and employment outcomes for those known to the YOS post-16. The YOS was highly valued by partners. It was well led by a respected YOS manager. Cambridgeshire County Council had shown a high degree of commitment to the work of the YOS and to maintaining a unique identity for youth offending work. Difficulties with IT systems had a substantial impact on the work of the YOS.

Recommendations

Post-inspection improvement work should focus particularly on achieving the following outcomes within 12 months following publication of this report (lead responsibility in brackets):

1. young people aged 16 years or over should be in receipt of suitable education, training or employment; with monitoring in place to make sure this issue is addressed in a timely manner (Chief Executive of Cambridgeshire County Council and the YOS Management Board)
2. the YOS Management Board should include appropriate senior representatives of all statutory partners, who attend regularly and make effective strategic and operational contributions. This should include children's services, those with specialist knowledge of post-16 education, training or employment; and representation from the health service that recognises the range and complexity of local health organisations, particularly the role of the Clinical Commissioning Group (Chair of YOS Management Board and statutory partners)
3. IT systems should be reliable and support effective and timely case work and information sharing (Chief Executive of Cambridgeshire County Council)
4. routine intelligence sharing between the police and the YOS should make sure that caseworkers receive timely information about all children and young people who are arrested (Cambridgeshire Constabulary and YOS manager)
5. there should be a consistent and appropriate understanding of Multi-Agency Public Protection Arrangements among staff, managers and partners. Partnership arrangements should be clear and work well. Senior management should have clear oversight of Multi-Agency Public Protection Arrangements cases (YOS manager)
6. joint working with children's services and information sharing at case level should be consistently effective (YOS manager and Interim Director – children's social care)
7. case management practice should be of consistently good quality and reap the benefits of the AssetPlus assessment and planning system (YOS manager)
8. planning for work to protect others, reduce the vulnerability of children and young people, and reduce offending should be of good quality (YOS manager)
9. there should be a structured and consistent approach, based on good practice, to the provision and use of interventions intended to reduce offending (YOS manager).

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

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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 71% of work to reduce reoffending was done well enough.

Key Findings

1. Assessment for work to reduce offending was good. Staff understood the complexity of their cases. Staff had a clear focus on understanding the perspective of the child or young person.
2. Work with the courts was good. Pre-sentence reports (PSRs) were of good quality and presented robust but credible proposals in which sentencers had confidence.
3. Not enough work was done during the custodial phase of sentences to reduce offending.
4. Priority was given to cases with the highest likelihood of reoffending.
5. There was a strong Intensive Supervision and Surveillance (ISS) scheme in place that provided a credible alternative to custody.
6. The menu of recommended interventions available to caseworkers for work to reduce offending needed to be improved and expanded.
7. Understanding of restorative justice was good. There were examples of positive outcomes from it.
8. Police made a positive contribution to the work of the YOS, particularly in cases requiring the most intensive input, but information sharing needed to be more comprehensive.
9. Positive relationships were developed with children and young people and their parents/ carers. These were important to effective work to reduce offending
10. Many children and young people were able to explain why they were less likely to reoffend following their work with the YOS.

Explanation of findings

1. It is essential, in order to lay foundations for future work, that sufficient effort is made at the start of the sentence to understand why the child or young person offended and what may help reduce that. This was done well enough in all except four cases, with generally clear explanations of why children and young people had offended. Workers understanding and analysis of the complexity of their cases was often better than their records showed.
2. Caseworkers had a clear focus on trying to understand the situation from the perspective of the child or young person. Not enough effort was always made to gather information from partners such as children's social care services and probation service providers, for example where parents/carers were involved with the criminal justice system or domestic abuse may have been a factor in the family. This was needed to understand the child or young person's behaviour and responses, as well as to keep

them safe. We were pleased that the recently seconded probation officer recognised that information sharing was an important part of her role and had plans to improve it. This was a positive development.

3. Work on the inspected cases had coincided with early use of the AssetPlus assessment and planning tool. It was encouraging that caseworkers had developed a good understanding of how to use this to support assessment, but further work was required to make sure that records were comprehensive and that its potential was fully realised.
4. PSRs are the main method by which the court is informed about offending and other factors to assist in sentencing, particularly in more serious cases. The quality of PSRs and the appropriateness of recommendations are particularly important when considering cases on the threshold of custody. All except one inspected PSR was good enough. Proposals were clear, appropriate, credible and well argued. Attention to the potential impact of custody was individualised to the specific circumstances of each case. PSRs were considered to have made an important contribution to the low custodial rates.
5. Referral order reports were good, providing valuable information to inform deliberations at youth offender panels. Panel members said reports had recently improved considerably.
6. Planning for work to reduce offending was good enough in over three-quarters of cases, generally providing a strong basis for future work. Work to address education, training or employment (ETE); thinking and behaviour and attitudes to offending was identified in almost all plans where this was required. More attention needed to be given to planning to address relationships (family and personal), emotional or mental health, perception of self or others and motivation to change. The role of partners sometimes needed to be clearer.

Example of notable practice: Bail - showing that Lee could be managed in the community

Lee was on a referral order and then convicted of a drugs offence. He was on the threshold of a custodial sentence. The caseworker worked with Lee during the bail period to motivate him. He explained how good engagement with the YOS could provide evidence to the court of his suitability for a community sentence. Work was undertaken with Lee to help develop his self-esteem and overcome educational difficulties. The PSR described how Lee behaved while on bail. It presented a robust proposal including ISS and other conditions. Lee was sentenced to a community sentence. The sentencer referred to the combination of the package of support proposed, and the way Lee had engaged with the work and demonstrated his ability to comply with an intensive package during the bail period, as being influential in his decision.

7. Caseworkers were encouraged to be creative in the way they developed written plans of work with children and young people. We saw many positive examples of plans presented and agreed in formats that were engaging and meaningful to children and young people.
8. The custodial phase of sentences should include planning for work to reduce offending. This should explain what work will be undertaken during both the custodial phase and following release. Three of seven inspected cases did not have a plan that met this standard. As a result, custodial sentences were not always delivered as a single integrated sentence. Insufficient work to reduce offending was undertaken during the custodial phase in three cases. This finding was confirmed in interviews with children and young people.
9. Inspectors formed their own judgements about the priorities that should have applied in each case, and whether sufficient work had been undertaken to address these. We found this was so when work was required to deal with living arrangements, substance misuse, and emotional or mental health. It reflected the strong partnership arrangements in those areas. Sufficient work had been undertaken in less than two-thirds of cases where it was required to deal with family and personal relationships, lifestyle, attitudes to offending and motivation to change.

10. Priority was given to identification and delivery of appropriate interventions in those cases with the highest likelihood of reoffending; including Multisystemic Therapy (MST), use of ISS and active work with the police in the Deter scheme. The range of interventions available and used in lower risk cases, however, was less strong. Much of the work relied on face-to-face discussions in the family home; although these were effective in establishing relationships. In part this was understandable due to the challenges of a rural county with limited public transport, but it did not always progress to structured evidence-based work. Some children and young people and their parents/carers we met also commented that this was so. In those instances where caseworkers delivered a structured intervention, in which they were well trained, they delivered it well.
11. Caseworkers sometimes described reliance on internet or other research to find suitable intervention work, rather than having a coherent set of recommended options available. They should be applauded for their creativity in seeking to identify appropriate work to match the individual cases, but this should be grounded in a core set of evidence-based interventions. Caseworkers understood the broad principles of effective practice with children and young people, but they did not always have a good understanding of what interventions would work best, nor how to evaluate their effectiveness.
12. Sufficient attention was given to reinforcing positive factors in work to reduce offending in almost all cases. Such work is important and is consistent with the latest theories about what causes people to stop offending. Attention was then given to making sure that positive outcomes were sustainable in all (except two) cases that were close enough to the end of their sentence to assess this.

Comments from children and young people

"*I was a prolific offender and the police have stopped me to check on me. For a . . . period I committed a lot of offences, but I have stopped that now*".

"*I meet weekly with the [YOS] police officer . . . he would talk to me about my offending and told me the police . . . will tell the YOS if there is any intelligence*".

13. Assessments included information about health and substance misuse needs and their impact on offending behaviour and on safety and well-being. Children and young people did not routinely attend an initial physical health assessment with the nurse, which was a missed opportunity to make full use of the time and skills of this valuable resource and to make sure that these needs were clearly identified. Caseworkers reported they were confident when conducting health screenings; although we found examples of unmet health needs where referrals had not been made. Information was provided at the start of an order that included a letter from the nurse about the services they offered as well as information about local health services.
14. The YOS health and substance misuse team was made up of clinical psychologists, substance misuse workers and a physical health nurse. These staff were knowledgeable, motivated and dedicated to help improve the outcomes of the children and young people they worked with. There was good work carried out by the whole team. YOS staff and managers spoke highly of them, acknowledging the flexibility of their approach and seeing children and young people at a variety of venues which helped increase their engagement. There was clear information for caseworkers about emotional and mental health services and who should be contacted if a clinical psychologist was not available.
15. Partnership links to make sure children and young people of statutory school age accessed the most appropriate education, training or alternative provision were strong; leading to good outcomes. Schools worked closely with alternative provision and the virtual school to make sure the YOS was alerted if problems were experienced, enabling them to take swift action. Integration with the locality teams was good and provided continuity between the school, the pupil referral unit and other partners. Careers advice was flexible and focused on maintaining children and young people in an environment where they could best achieve GCSEs.

16. Conversely, outcomes for those post-16 were poor. The number not in ETE had remained too high. It was 50% on the latest local information available. These children or young people had received limited support to find and access training or work, due to the previous lack of appropriately trained advisers to support them. More recently, education and training needs were effectively assessed early in meetings with locality team Transition Advisors. This was a positive development; however, they had only been in post for six weeks and hence the support they provided was not yet systematic. There was often a greater focus on accommodation or managing substance misuse rather than identifying appropriate work or training to meet their individual needs. Access to careers information, advice and guidance for this group was less effective. Sometimes there was too much focus on further education as the best route, with few opportunities to access, or knowledge about, alternative traineeships or apprenticeships, meaning that work or college were the only options promoted for most. For those excluded from college there were few options that did not involve extensive travel and more generally, the training provision for those post-16 was often too geographically dispersed.
17. Where individuals wanted to attend further education, the YOS worked closely with colleges to develop an appropriate strategy and procedures to manage them. This was done especially well when the offence may have been a concern for the college.
18. Some children and young people accessed a weekly programme of activities which included Duke of Edinburgh Bronze Awards, cycle repair, climbing and adventure training. These helped develop communication, interpersonal and other skills to prepare them for employment and other activities. They also helped develop literacy and numeracy skills. These were important for those not engaged in formal education or employment.
19. The YOS actively managed the education or training needs of children and young people on release from custody. Staff would attend review meetings in custody. Plans were often limited by the availability of training courses at the time of release.
20. There was no systematic monitoring of progress made by children or young people while in ETE. Records about this were sometimes limited. Neither was there a mechanism to analyse the impact of specific ETE activities on reoffending rates.
21. The seconded police officers made a positive contribution to the work of the YOS, including providing interventions and conducting home and prison visits, primarily for those being supervised under the Deter strand of the Integrated Offender Management scheme.
22. We found some evidence of two-way intelligence sharing. This was not systematic and was often shared in an informal way, with no record of this having been done. Consideration could be given to police officers putting information onto the case record themselves. This would allow caseworkers to see the information in its totality, help avoid oversights and save time. There was some evidence that police intelligence contributed to PSRs and reports where the background behaviour may have been pertinent. This was not routine, again being more focused on those on the Deter cohort.
23. Information exchange between the police and the YOS did not comply with National Standards for Youth Justice Services. These advocate the use of the Police Early Notification to YOTs system for all children and young people who have been arrested. We found that Police Early Notification to YOTs system in use in Cambridgeshire was more akin to referral to a disposal decision-making panel. This meant the YOS would either not be directly informed of some arrests (for instance, where no further action was taken), or there would be a delay in notification, leading to significant gaps in intelligence sharing. We found occasions where caseworkers were unaware of vital information about those they were working with. For example, a child or young person on a referral order was victim of an alleged assault by his girlfriend’s father. This information was not passed to the caseworker.
24. The YOS had maintained a strong ISS scheme. It provided examples of how it successfully managed complex cases safely in the community. Expectations for children and young people were clear and effort was made to make sure these were understood as part of the assessment of suitability for

ISS. Children and young people were met face-to-face by an ISS worker seven days a week, which was positive and stood apart from the practice that we sometimes find. Telephone tracking was only undertaken using a landline, which was appropriate but again not the practice always found elsewhere. Timetables focused on the development of positive activities and life skills that may help children and young people succeed and help develop their self-esteem. They were responsive to the child or young person's needs and aspirations, and included regular contact with YOS police officers. Timetables were clear and well presented, and included key contact details for use during the day, evenings and at weekends. When asked to describe why the scheme was successful, workers recognised the importance of involvement and positive relationships with the family and with family support workers.

25. The local youth court expressed confidence in the YOS, and described good communication between the YOS and sentencers. This included regular attendance at youth panel meetings at which, for example, useful statistics would be presented or new developments and resource changes explained. This helped sentencers understand what lay behind the sentences available to them, when responding to YOS proposals. The Cambridgeshire approach to YOS staff presence in the youth court was commended as making sure those who provided advice were knowledgeable and experienced. When an alternative to custody was proposed it was robust and credible, with clear details about what it would entail.

26. There was a good understanding of restorative justice. We saw some valuable examples of this work. In some cases not enough attention had been given by caseworkers to the possibility of this. Insufficient attention was given to making sure that referral order panels heard and understood the voice of the victim. These findings were surprising, since there was evidence that restorative justice workers achieved verbal contact with over two-thirds of known victims and met about one-third – both of which were encouraging outcomes.

27. It was pleasing to find that, overall, there appeared to have been a reduction in the frequency of reoffending since the start of the sentence in 80% of those cases where there was sufficient evidence to assess this, and a reduction in the seriousness of offending in three-quarters. Inspectors judged that almost half of children and young people were less likely to reoffend than they had been at the start of the sentence.

Example of notable practice: YOS presence in the youth court

The youth court was attended by both a YOS admin worker and a caseworker. The same caseworker attended the weekly court over a number of months. This helped to make sure that they were skilled and confident in working with and advising the court, and delivering a consistent approach. Both the admin worker and caseworker had laptops in the court room, which meant they could quickly access information from the case record that the court may need. The admin officer made sure that everything was organised and, for example, prepared first appointment letters and other paperwork and made sure these were recorded into the case record.

28. We spoke to 12 children and young people from the cases that we inspected. Eleven of the twelve felt that they were less likely to offend compared to when they were first subject to YOS supervision, and were able to explain why they thought that was the case. The other one said that he was being more open with the YOS on the current order than he had been previously. Most could identify their individual risk factors and said these were discussed in supervision sessions. One said: "*[my caseworker] has been supportive and helped me. She has also had difficult conversations . . . about things I don't like to talk about . . . that has really helped*".

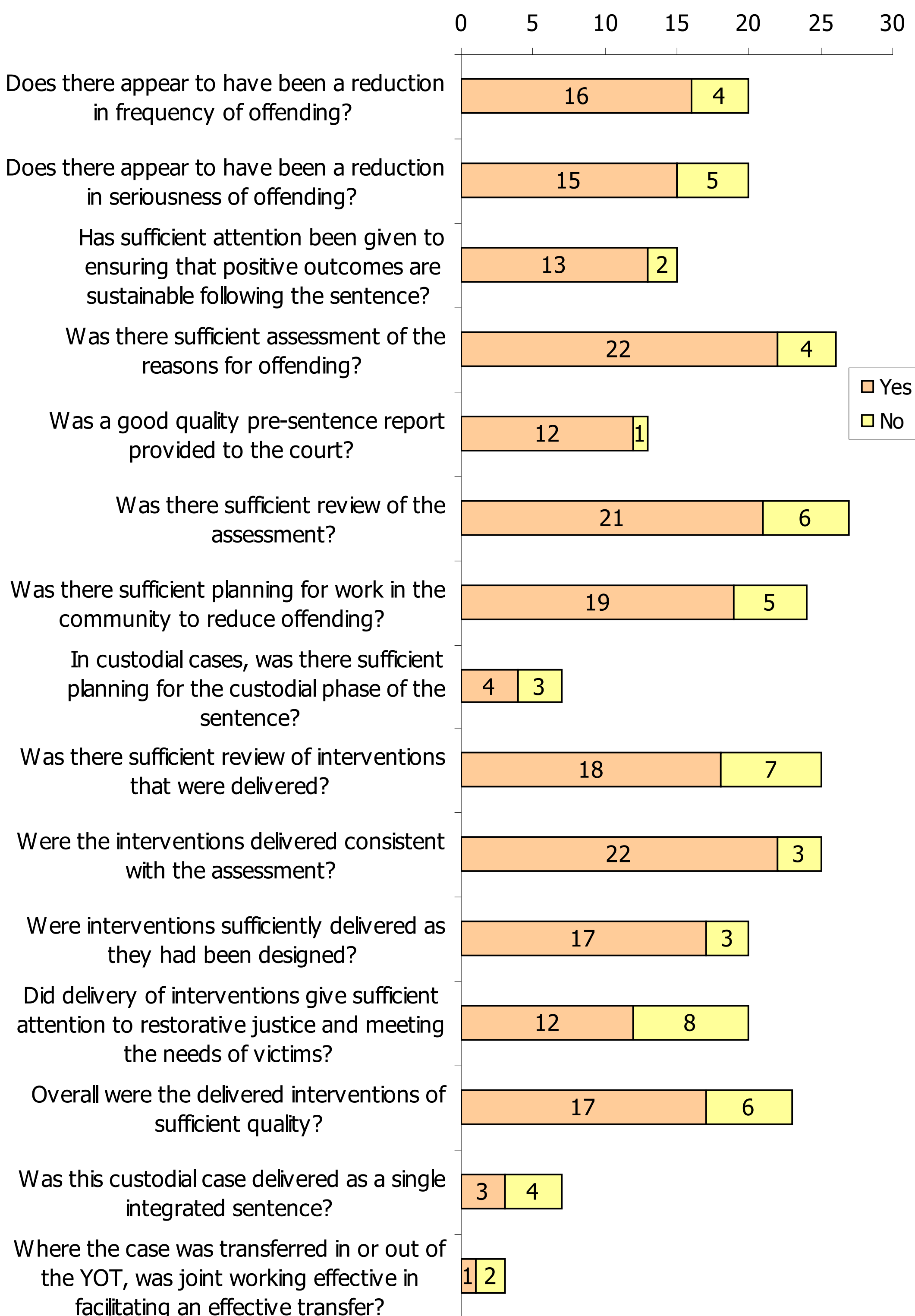
Comment from a parent

"From what he was a year ago, he is a different fella. I believe he's not yet turned the corner, but he is standing on the edge of it . . . he is beginning to understand the consequences, the knock-on effects of his behaviour."

29. These findings, and those in the subsequent chapters on core case practice, should be understood in the context of a difficult combination of circumstances, including substantial unpredictable staff shortages that affected the YOS, primarily during the first part of 2016. This was the period in which the majority of the inspected cases commenced. It was apparent from our previous inspection and from other information that Cambridgeshire YOS traditionally had high expectations for the quality of its practice and had delivered it well. Both managers and staff were ambitious to return to those standards. These inspection findings are not as strong as the YOS would have wished; even so managers and staff should be commended for maintaining their services over a difficult period.
30. The key objective of inspecting in Cambridgeshire was to try and understand how it achieved consistently low reoffending rates and use of custody. A range of factors have contributed to this. The quality of engagement between caseworkers and both children and young people and their parents/carers has stood out. Children and young people highly valued their relationships with caseworkers and the interest shown by them. This was consistent with theoretical knowledge about why children and young people stop offending. The YOS gave specific attention to the delivery of interventions, including MST, in more complex cases that were more likely to reoffend. There were effective operational partnerships; particularly those addressing emotional and mental health, accommodation and substance misuse. There were strong links with locality services that could provide continuing support when the YOS order ended.
31. The quality of work with the courts, including the service in court, Saturday cover, good communications for problem solving, and the quality of PSRs appeared to be key factors in the low custodial rates. The courts had a high degree of confidence in the YOS. The YOS had a strong ISS scheme, worked hard with children and young people to make sure they completed their sentence, and provided robust but credible proposals, particularly in custody threshold cases, that sentencers had confidence in. There were strong systems in place to monitor or deal with those children and young people at greatest risk, including a positive alternative to care scheme, reliable access to an overnight bed for those who might otherwise have been detained in police custody, and an effective Integrated Offender Management scheme for the most prolific offenders.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of 27 cases. [NB: The total answers, however, 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, 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 70% of work to protect the public was done well enough.

Key Findings

1. Almost all PSRs contained a clear and appropriate assessment of risk of harm to others.
2. Assessment of risk of harm to others was usually good.
3. Planning for work to manage or reduce risk of harm required some improvement.
4. Multi-Agency Public Protection Arrangements (MAPPA) were not understood and joint working did not work well.
5. More attention needed to be given to the needs of victims.
6. Oversight by managers was not effective in enough cases.
7. The sharing of intelligence by the police was not sufficiently comprehensive.
8. Children and young people described work being undertaken with them that was intended to reduce their risk of harm to others.

Explanation of findings

1. To protect victims and the wider public from harm it is important that work is informed by good assessment, at an early stage, of what harmful behaviour the child or young person may become involved in, the circumstances in which that might occur (including targeting of victims) and what may trigger that. That was done well enough in most cases although there were a few where other relevant behaviour, including behaviour that had not led to conviction, had not been taken sufficient account of, and one where the assessment had not been done and it was not picked up by a manager in a timely manner.
2. The assessment should, where required, be followed by a clear plan designed to prevent the circumstances occurring. Plans should also explain what actions need to be taken if the harm does occur. One-third of cases did not have a sufficient plan in place at or near the start of sentence for work to manage risk of harm to others. Usually this was because the caseworker had not recognised the need to plan to manage risk of harm. In another example the offence related to domestic abuse but there was nothing linked to this in the planning. In custodial cases a risk management plan was always in place but was not always sufficiently comprehensive to cover both the custodial and community phases. In general, caseworkers did not yet understand how to produce risk management plans in AssetPlus with the clarity, comprehensiveness and precision that is needed.

Comment from a young person

"The YOS helped me be calmer, it's stupid to fight, now I think about my family, my girlfriend . . . I think I am maturing . . . I used to get angry all the time, but I don't so much now."

3. There was a lack of understanding about MAPPA, and about how and when to engage with them. Processes were unclear and so joint working was not always effective. MAPPA involvement in the initial assessment and planning did not always meet the needs of the case. We were told that 14 cases on the YOS caseload were currently eligible to be managed under MAPPA. YOS-wide monitoring or recording of MAPPA cases, to make sure that they were regularly reviewed if circumstances changed and the possibility of referral back to MAPPA needed to be considered, did not work well. It was unclear whether all appropriate staff had received training about MAPPA.
4. Reviews of assessments and plans for work to manage risk of harm to others were not always undertaken or done well enough. Sometimes this was because the progress made or any changes had not been included. The YOS had clear and appropriate local standards for reviews in cases where the risk of serious harm classification was medium or above, however, these were not always adhered to.
5. In order to reduce the risk of harm to others, interventions delivered with children and young people must be consistent with both the assessed need and the plan. This was achieved in almost three-quarters of cases. The main issue was that required interventions had sometimes not been delivered, and it was unclear why that had been the case.
6. In about one-quarter of cases the right balance had not been struck between reduction in offending, managing risk of harm to others and addressing vulnerability. The most common reason was insufficient attention being given to risk of harm interventions.

Example of notable ractice: Positive victim contact

Jane was victim of a violent offence that led to a custodial sentence. The restorative justice worker visited Jane and her family to discuss the young person’s imminent release from custody. He had developed a good working relationship with the family, who were open and honest with him. They appreciated being kept informed. They were able to give their views about release and licence conditions. They felt reassured that their concerns were considered at that important time.

7. Sufficient attention was given to managing the risk of harm to known or potential victims in about two-thirds of relevant cases. Where this had not been the case the main cause was gaps in planning, specifically related to known victims. In general, caseworkers were not focused on the needs of known victims. For example, in a custodial case specific attention needed to be given to monitoring any reference to the victim in the child or young person’s communications, but this was not included in the planning. There were a number of cases where the parent/carer was also a victim, but this had not been recognised in the work done. Some parents/carers we met also pointed this out to us. In one positive example the family were involved in sessions with the ISS team. The mother said: “*I can tell them what he has done and they can back me up, I find them supportive*”. All victims we spoke to felt supported by the YOS, were kept informed and, where appropriate, were able to make a contribution to the consideration of licence conditions.
8. Oversight by managers of risk of harm work had been effective in less than two-thirds of the inspected cases where this was required. Reasons for this included important deficiencies in assessment and planning not having been addressed. For example, one assessment was countersigned with positive comments by the manager, even though it had not reflected the specific harm related offence that the current order related to.
9. The YOS used a Risk and Vulnerability Management meeting as a forum to provide broader oversight of risk of harm work, but cases were not always referred to these meetings as required, even though the YOS had a clear and appropriate policy which caseworkers understood. There were no simple reporting or other monitoring processes in place to make sure this happened. We observed some of these meetings and considered that, while the sharing of information and perspectives that occurred was positive and valuable, not enough structure or focus was given to making sure that the risks were

clearly identified, agreed and recorded. Neither was enough attention given to putting in place robust but proportionate plans to address risks, nor to contingency planning. In one example, poor recording of the discussion meant that actions agreed earlier in a meeting were not then picked up when it was summarised and actions confirmed.

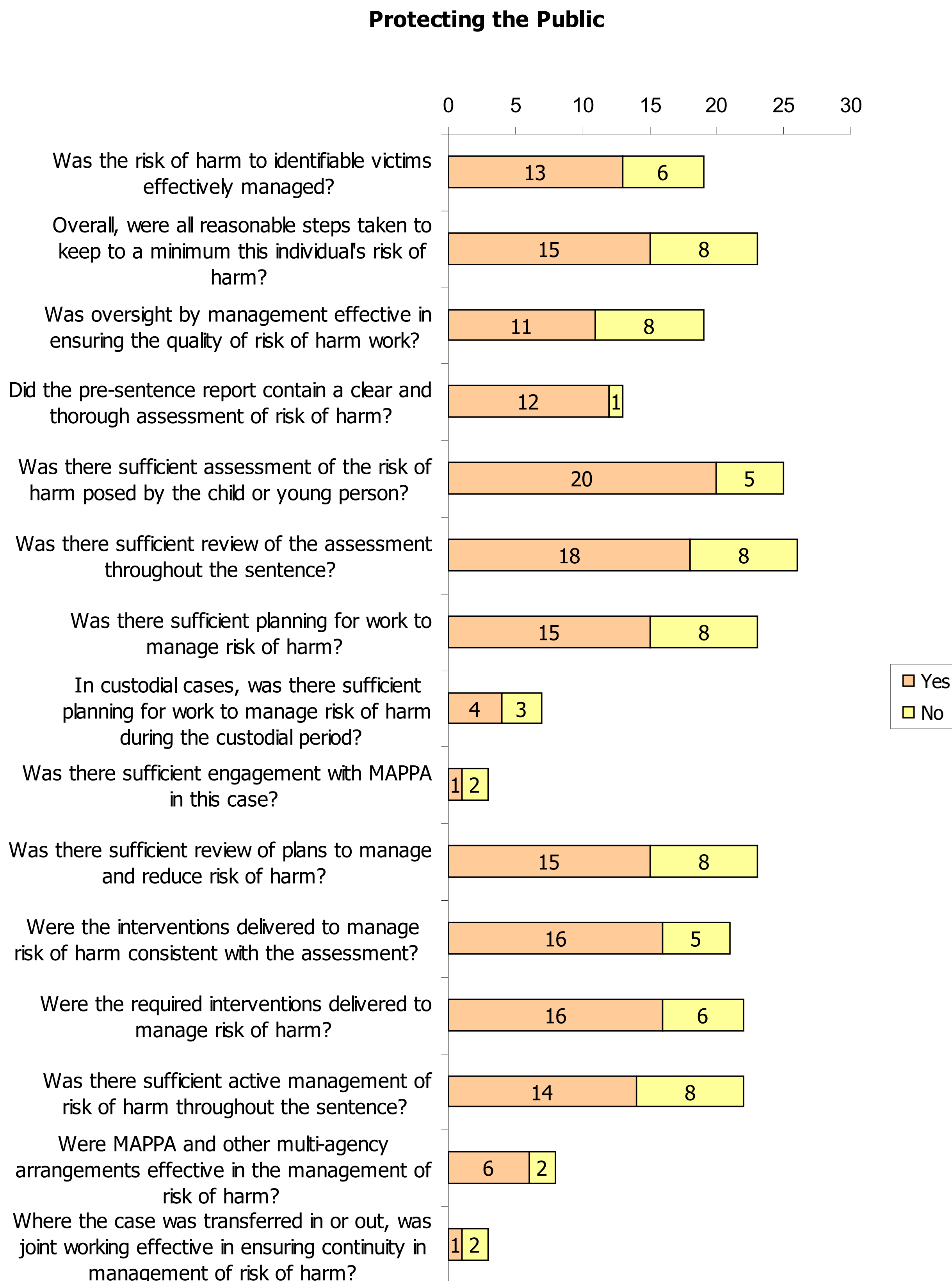
Quotation indicating a positive outcome from a restorative conference

"*I wanted to meet the boy who burgled my property, at home. The restorative justice worker explained it didn't work quite that like, so I had two meetings with the worker who explained it carefully. [the YOS worker] explained how he might react, so I wouldn't be disappointed if he didn't say anything helpful. We then met in a neutral place and it went very well. He recognised he had done a bad thing and we had a sense that he was trying to put it right. I said that he can do community service with me, helping clear my rubble. That went very well. The boy I thought it was – it wasn't him. He was just a boy and nothing to be afraid of, whereas I had imagined a big strapping lad. He came and worked and had a worker with him, he worked very hard. The worker also worked, so we got two for the price of one. I wanted to put a face to the name. It was a really positive experience*."

10. The core role of a police officer in a YOS is intelligence sharing. There was a system in place for the police officers to identify when children or young people known to the YOS came to police attention. This was not used for all those on the YOS caseload, but merely the small number on the Deter cohort. This, therefore, may have often excluded those who were being managed under MAPPA.
11. Many of the children and young people we met did not specifically recognise elements of their intervention as relating to the protection of the public, which is quite common. Even so, when they described the work that had been undertaken it was apparent that this was often intended to address their risk of harm to others. Other children and young people were aware of plans in place to protect the public. Some of these were unhappy about the plans and apparently did not understand why they needed to be in place, whereas others understood them and explained how they were complying with restrictions.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of 27 cases. [NB: 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 74% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Good work was often carried out to safeguard children and young people.
2. There were examples of good joint work with children's social care to keep children and young people safe, but also examples where this was not sufficiently joined up.
3. Information sharing and communication between the YOS and children's social care was not robust.
4. There was insufficient review of safeguarding and vulnerability factors.
5. Planning required improvement, although planning in custodial cases was good.
6. Staff developed positive relationships with children and young people, which were valuable in helping keep children and young people safe.
7. MST was a valuable service and was well integrated into the YOS.

Explanation of findings

1. We saw some good work carried out intended to safeguard or reduce the vulnerability of children and young people. There were some examples of effective joint work with social workers, but this was inconsistent.
2. Sufficient effort had been made to understand, analyse and explain the safeguarding and vulnerability needs that applied in three-quarters of cases. Assessments normally gave sufficient attention to emotional or mental health, physical health, substance misuse, care arrangements and ETE, in so far as these related to the vulnerability of the child or young person.
3. There were too many cases where there were gaps in information sharing. This issue was two-way. Caseworkers needed to be more investigative in requests for information. Police and children's social care services needed to be more aware of the importance of the YOS knowing relevant information, and to share this routinely. For example, where a child or young person was either at risk of or vulnerable to child sexual exploitation the exact nature was not always known to YOS workers, the consequence being that assessments and plans were sometimes limited. There was a lack of clarity about the use of child sexual exploitation screening, for example when the offending may have been an indicator of child sexual exploitation.
4. Communication and information sharing between YOS staff and social workers was variable and insufficiently robust. For example, in one case the absence of information sharing meant that a young

woman's increased level of vulnerability was not identified in a timely manner, leading to delay in safeguarding activity. In another, YOS staff did not respond to a request for information. This was compounded by the social worker's failure to follow it up.

5. Three-quarters of PSRs included a clear and sufficient explanation of the safeguarding and vulnerability needs that applied in the case.

6. There was insufficient review of safeguarding and vulnerability. Some reviews were a copy of a previous assessment, even though relevant additional information was known. The need for review following a significant change was not always recognised. The YOS had produced helpful guidance about the additional circumstances in which reviews would be required. It was disappointing to find that this was not always followed.

Example of notable practice: Helping to keep a young person safe

Jake sometimes self-harmed. The YOS, Jake and his mum developed a code for his bedroom door. He had a range of different faces, which he would put on the outside of his door to indicate his mood. This system meant his mother knew when to leave him alone and when to enter his room to check him. It gave her permission to enter his room when necessary, while also preserving his privacy.

7. Planning for work in the community to address safeguarding and vulnerability needs was variable. There were seven cases that did not have adequate plans, in three of which a plan was missing. It was unclear whether caseworkers understood how to use the new AssetPlus tools effectively when planning. Positively, six of the seven cases in custody included sufficient planning to address safeguarding and vulnerability.

8. Inspectors were encouraged to find that, once the need for intervention to address safeguarding or vulnerability needs had been identified, it had then been delivered in all except one case. Overall, the YOS had done enough to keep the child or young person safe in about two-thirds of the cases. While there were deficits in assessment and planning, no child or young person had been left unsafe as a direct result of these.

9. Management oversight of safeguarding and vulnerability work was sufficient in only half the relevant cases, primarily due to deficiencies in assessment and planning that the manager should have been aware of not having been addressed. Sometimes assessments and plans had been countersigned without sufficient consideration given to their quality. This was in spite of a clear and appropriate policy in place for management oversight.

10. YOS staff understood the importance of children and young people having someone they could trust and speak to. The quality of those relationships helped children and young people understand how they would be helped and kept safe. Children and young people we spoke to were aware of work being undertaken to help address vulnerability.

11. All children and young people in custody reported regular visits from and contact with their caseworker, who always attended sentence planning meetings. Staff understood the impact of custody and took action to try and lessen this. Children and young people in custody did not always have the opportunity to speak to their caseworker alone, which meant it was less likely they would voice any concerns or make disclosures.

12. All heath staff had received safeguarding and child sexual exploitation training at the appropriate level and had a good understanding of the issues. The physical health nurse also received specific safeguarding supervision.

13. Health and substance misuse practitioners contributed to the Risk and Vulnerability Management meetings which helped to make sure that a multi-disciplinary approach was taken. Staff considered it was sometimes hard to get others to understand the clinical issues, in particular when these may impact how offending related needs are addressed. It was positive that the child or young person was the centre of these meetings and they helped to manage their vulnerability. Workload issues for social workers sometimes limited their ability to participate in the meetings.

14. All health staff recorded information directly onto the case management system, which helped to make sure that it was shared. The clinical psychologists also had access to external health systems which meant they could assist caseworkers in identifying if a child or young person was known to Child and Adolescent Mental Health Services (CAMHS).

15. The YOS had recognised an emerging gang problem in part of the county. Children's social care had responded cooperatively, acknowledging that this was also a safeguarding concern. Together they helped steer an integrated approach to tackle the issues. The child sexual exploitation operating protocol was being updated to cover gang exploitation and radicalisation.

16. Partners had identified that information about children and young people who were missing or were vulnerable to child sexual exploitation was not always reliably reaching the YOS. These children and young people now benefited from their return home interviews being conducted by their YOS caseworker, which had enhanced the quality and breadth of information obtained.

Example of notable practice: Work to reduce the risk of child sexual exploitation

Carly was on a referral order. She was working with a YOS clinical psychologist to explore and manage her emotional difficulties following a violent assault in the family home. She was not in school and was deemed a difficult young person, but she wanted to be back at school. The psychologist recognised that Carly was at greater risk of child sexual exploitation if she remained out of school. She liaised with the school to help them understand about trauma and how a person experiencing this can present. She also worked with teachers to give them strategies about how to manage Carly's behaviour. As a result Carly had returned to education.

17. We saw cases where joined up work by the YOS and children's social care services had been effective in safeguarding vulnerable children and young people. There were also cases where there was an absence of joined up assessment; for example, where triggers and changes of circumstances which heightened a young woman's vulnerability and increased the risk of child sexual exploitation had not been recognised in a timely way due to poor communications. Two Critical Learning Reviews had identified that information available from children's social care or the prevention services about vulnerability was not always comprehensively incorporated into the YOS's assessment. The effect was that the level of vulnerability was assessed too low and, therefore, the necessary management processes were not triggered.

18. Children and young people benefited from strong and positive relationships with staff from both the YOS and children's social care. We saw examples of practice which was reflective, child-centred and supported by clinical case discussion. We also saw other examples of effective joint work between the YOS and children's social care. One example we noted was a young person and his father who benefited from intensive support provided by the Alternative to Care team which resulted in sufficiently improved family relationships for successful reunification and return home. This enabled him to reduce his cannabis use, gain employment and establish a new and positive friendship group.

19. Helpfully, the YOS had some access to the children's social care case management system and caseworkers made use of this to inform their assessments. Even so, limitations on access meant

relevant information was not always easily available. An additional obstacle was that the system did not pull through information about others in the family. This was particularly unhelpful where domestic abuse was present, which affected the whole family. Information sharing about domestic abuse was also sometimes restricted by issues of consistency, proportionality and consent but this was being addressed through the redesign of the Multi-Agency Safeguarding Hub, which had YOS involvement.
20. YOS staff did not always attend Looked After Children reviews, and were not always informed about them.

20. Children and young people who had been arrested and were unable to return home but did not require a secure placement, benefited by avoiding overnight detention in police custody through the provision of a locally commissioned bed which was always available.

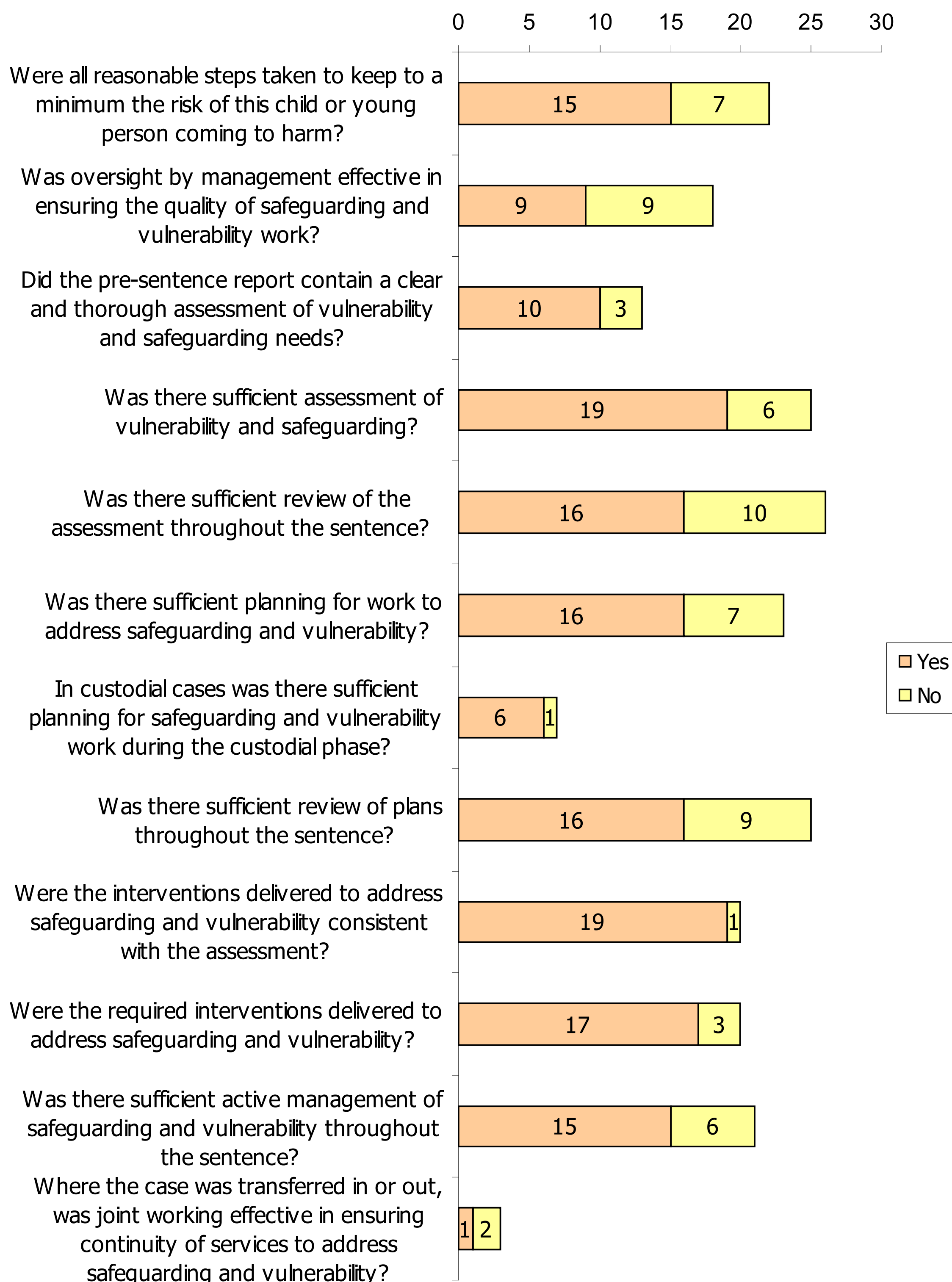
Example of notable practice: Positive joint work with children's social care

Jack was on an order with the YOS. His girlfriend, Tracey, was known to children's social care. Tracey was considered to be vulnerable in the relationship. Jack, Tracey, the YOS and children's social care worked together to develop a comprehensive safety plan for Tracey. Both Jack and Tracey were adhering to it.

21. MST was a well-established and evidence-based intensive programme which was meeting the needs of those who displayed sexual or harmful behaviour. The local sexually harmful behaviour service was located and managed within the YOS. This meant that children and young people could be assessed quickly, be allocated to a worker who was well trained, and receive the interventions needed to manage their risk. This service had credibility with sentencers and worked with PSR authors to propose strong and credible support and management packages. This was likely to have had a positive impact on the rates of custodial sentences.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of 27 cases. [NB: 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 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 84% of work to make sure the sentence was served was done well enough.

Key Findings

1. Good attention was given to diversity factors and to responding to the individual needs of children and young people throughout the work of the YOS.
2. Children and young people and their parents/carers were involved well in the development of both assessments and PSRs.
3. Staff built positive relationships with children and young people.
4. Attention was usually given to making sure children and young people met the requirements of their sentence.
5. When children and young people did not comply with the sentence the response was usually appropriate.
6. Good attention was given to health and well-being factors, in particular where these may affect the likelihood of a positive outcome from the sentence.

Explanation of findings

1. Considering and responding to the individual needs of children and young people was an important strength of Cambridgeshire YOS. The individual needs and circumstances of children and young people and their families, including diversity factors and other barriers to engagement, were usually assessed and understood well. All the children and young people we met reported that any diversity factors that applied in their cases were met.

Example of notable practice: Positive impact of attention to diversity factors

Ahmed considered that he was victimised and alienated by those in authority. He was likely to receive a custodial sentence. His case manager would change on sentence. The new case manager attended Crown Court and conducted a handover meeting with Ahmed and his father while awaiting sentencing. Ahmed was a practising Muslim, but for safety reasons needed to be kept separate from associates and could miss Friday prayers. This could have further alienated him. The case manager worked with Ahmed's father so that he understood why this was necessary. He was then able to work with the Imam to explain the situation to Ahmed and encourage him to pray separately. They worked together so that plans were in place to enable Ahmed to observe Ramadan. These were important steps contributing to a substantial change in attitude towards those working with Ahmed, helped convince him of his case manager's commitment and led to early indications of progress in his attitudes to offending.

2. Children and young people, and their parents/carers were usually well engaged in the development of assessments. This meant that assessments reflected their actual experiences as these had been presented to the caseworker. The need for continued care was shown by two cases where the child or young person or their parents/carers had clearly expressed views that had not been reflected in the assessment.
3. It is particularly important that children or young people and their parents/carers understand what is likely to be said about them in PSRs, since this can have an impact on the progress of the sentence once it is underway. In Cambridgeshire, the child or young person and their parents/carers had been sufficiently involved in the preparation of the PSR in every relevant case that we inspected.
4. Over three-quarters of PSRs gave sufficient attention to diversity factors and potential barriers to engagement. Attention to this during the planning was also good enough in the great majority of cases. The child or young person and their parents/carers or significant others had been sufficiently involved in the planning in just over three-quarters of cases; although there were some cases where their parents/carers should have been more involved.

Example of notable practice: A creative approach to developing engagement and achieving a positive outcome

Jasmine's offending was escalating in both frequency and seriousness. She had complex needs and had disrupted family circumstances. She was difficult to engage and would not meet her caseworker directly. The caseworker recognised that, in order to reduce future offending, she first needed to form a positive relationship with Jasmine so she would be willing to do the work needed. She undertook sessions with Jasmine speaking to each other through the letterbox, until she gained her trust and was then able to meet properly. Jasmine worked with the YOS for about two years, taking part in a range of interventions. These included a psychological intervention overseen by the YOS psychologist but delivered by the caseworker, due to the positive relationship that had been achieved. The persistence and creativity led to positive outcomes for Jasmine. Her vulnerability and risk of harm reduced considerably. She had not reoffended for over a year since the order ended, had returned to the family home, took part in positive activities and was attending college.

5. Staff were persistent and skilled in building positive relationships with children and young people, and recognised that sometimes this took time. Their actions gave clear messages to children and young people that they mattered. This was consistent with what is known about the factors that may support children and young people in moving away from offending. We saw numerous positive examples of how caseworkers showed their understanding of children and young people's situations, two of which are highlighted in this section.

Example of notable practice:

Raj was in custody and due in court the next day. The case manager was told that a close relation had just died and was concerned Raj might hear about this from his codefendants before suitable support was in place. She made arrangements for him to be seen on his own at court, rather than with his codefendants, and then liaised with the secure estate for an Imam to speak to him and break the news immediately on his return. This meant that Raj was able to hear the news in a sensitive and private way, with support immediately available to him.

6. Overall, sufficient attention was given to making sure that the child or young person engaged with the YOS and that the requirements of the sentence were met in almost all cases. Parents/carers that we met explained how the YOS kept them informed about their child or young person's meetings, which helped them support the work of the YOS. All the children and young people we spoke to were aware

of the importance of keeping appointments. Some provided examples of caseworkers demonstrating flexibility in order to facilitate attendance.

7. The geography and limited public transport links in Cambridgeshire meant that caseworkers understandably undertook a higher proportion of their work through home visits than would often be the case. It is essential that caseworkers regularly visit the family home, as this is important to maintaining an understanding of the child or young person's circumstances and how these may change over time. Children and young people should also, where appropriate, take responsibility for their own compliance. This is particularly the case with older children and young people, for whom this can be used as an opportunity to help develop the self-discipline and self-organisation they will need when starting work or when re-engaging with formal education or training. In our judgement, caseworkers did not always strike the right balance. This view was also expressed by some parents/carers who considered their children and young people should be encouraged by the YOS to take greater responsibility.
8. There were ten cases where the child or young person had not complied fully with the requirements of their sentence. The response of the YOS to this was appropriate in all except two, where they needed to be more timely. The YOS operated a compliance panel process in cases of continued non-compliance. This had a clear focus on understanding and putting in place actions to address the problems in a way that would enable the work on the sentence to reduce offending and protect the public to continue. If these actions failed the YOS would return cases to court. Caseworkers understood the YOS approach to supporting effective engagement and responding to non-compliance.
9. A child or young person's involvement with health services was voluntary; although substance misuse interventions were statutory if explicit within an order.
10. Staff had received training by the Communication Trust around speech, language and communication needs and staff were aware of how to make any necessary referrals.
11. There were monthly health and substance misuse meetings which looked at new referrals and existing cases, which helped to promote a holistic approach to health needs. They gave practitioners support and advice to help meet children and young people's needs. There were clear guidelines about who should hold cases where a dual diagnosis had been made. Support could also be received from a psychiatrist.

Data Summary

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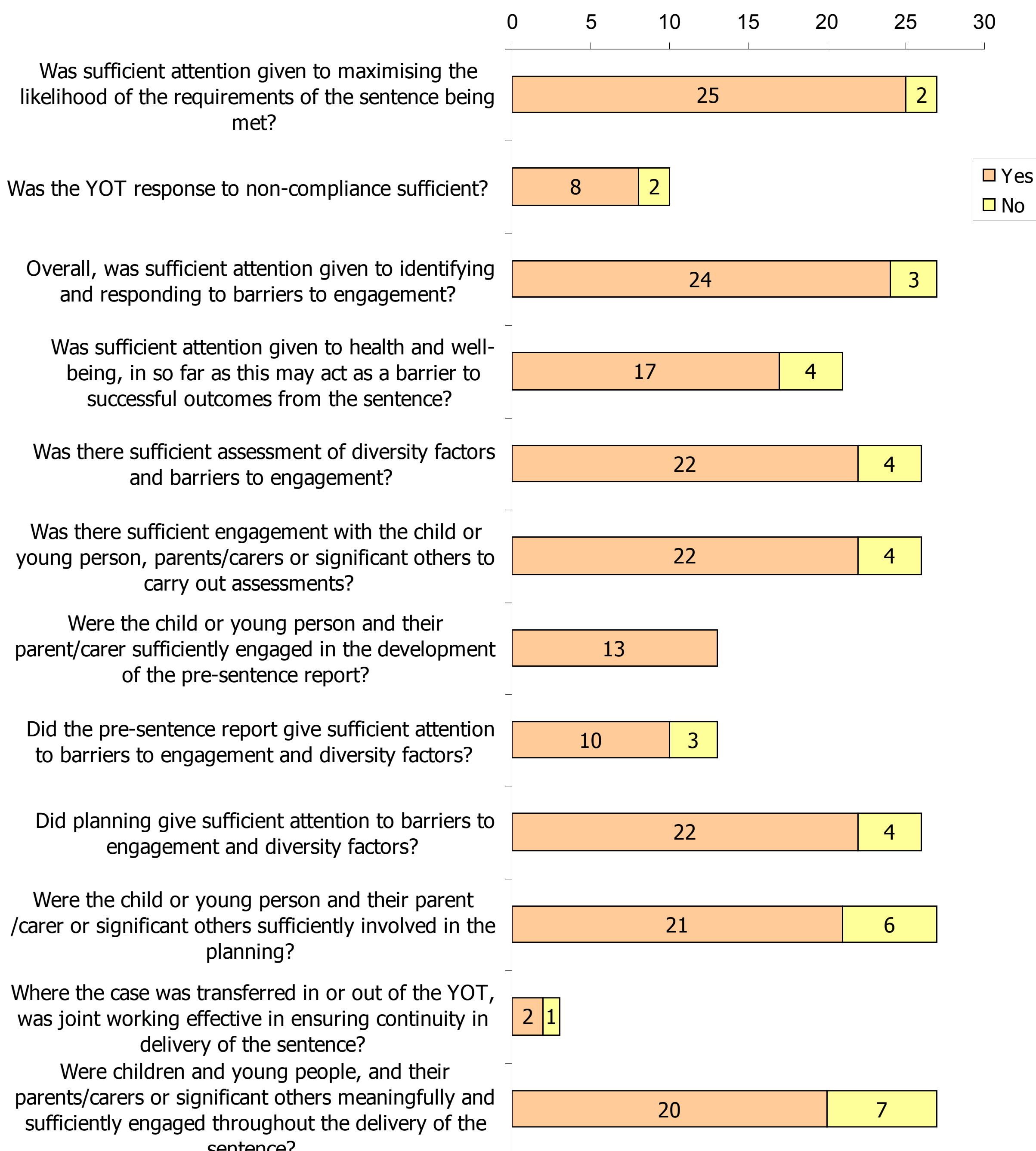

Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

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

Key Findings

1. Cambridgeshire's performance on meeting national criminal justice system objectives had been consistently good.
2. There was good commitment to the work of the YOS within the local authority and some strong partnerships, particularly at an operational level.
3. There were substantial gaps in the contribution of some statutory partners to the work of the YOS Management Board.
4. The new joint Management Board with Peterborough YOS was a positive step to support improved strategic oversight.
5. The partnership had not been effective in meeting targets for the involvement of older children and young people in ETE.
6. The YOS had a set of appropriate standards and procedures in place. These indicated high expectations for the quality of work.
7. Difficulties with IT systems had a substantial impact on the work of the YOS.
8. The YOS and Management Board were both ambitious to improve services.
9. Staff and managers worked together well.

Explanation of findings

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

1.1. Reoffending rates and the number of offences committed per offender had been consistently among the best in England and Wales for over two years. Reoffending rates had improved consistently over that period. The use of custody was also among the lowest in England and Wales. The number of first-time entrants to the youth justice system had also reduced consistently.

1.2. The YOS had a high degree of visibility and commitment within the local authority, including at lead member and Chief Executive level. Examples of this were a decision to fully cover a shortfall in the expected central grant to the YOS, and an intent to maintain a strong YOS identity within the restructure taking place in children's services, intended to improve the quality of services. The new structure, once fully implemented, had the potential to improve joint work and information sharing substantially, and to address barriers that had prevented achievement of ETE outcomes for post-school age children and young people known to the YOS.

1.3. Cambridgeshire YOS and YOS Management Board had high expectations for the services they provided, and were ambitious to further improve these. They had requested a sector led peer review earlier in 2016, in order to help maintain the YOS profile, refresh the work of the Board, make sure the YOS was fit for purpose and assist in areas the YOS was concerned about. There was a positive

response to the findings, including reporting them to the local authority Children and Young People Committee. This led to further visibility for the work of the YOS and a greater understanding of the challenges faced by it.

1.4. There were important gaps in the contribution of statutory partners to the work of the Board. The health representative had not attended for the past year and the second NHS Trust that provided services locally had not been invited. The arrangements did not adequately represent the range and complexity of local health partners, including the local Clinical Commissioning Group. As a result, strategic oversight and challenge about the health services was not provided. Neither had the Board included suitably knowledgeable representation able to address ETE problems for those aged 16 years and over. This was particularly important in view of the continued failure to achieving ETE targets for those working with the YOS. Representation by children's social care services had been inconsistent.

1.5. The Board had very recently formed a joint board with Peterborough YOS. This was a positive step. It recognised that some key partners, such as the police and health services, operated across both areas. It should support better partner engagement and a more strategic approach to YOS oversight. A representative of the Police and Crime Commissioner (PCC) was a Board member. The joint Board now reported directly to the Community Safety Strategic Board, chaired by the PCC. This helped to make sure that PCC and YOS objectives were linked.

1.6. The Board had not had a clear focus on victims. It was encouraging that, as part of the new arrangements, a strategic vision had been developed which recognised the importance of work with victims.

1.7. Board meetings alternated between a joint meeting and a Cambridgeshire meeting. Cambridgeshire agendas included a greater focus on understanding practice than is often the case. At each meeting the Board examined one case in detail. This helped members understand the work of the YOS and the obstacles and challenges of case practice. It had been beneficial in highlighting issues which needed resolving at the YOS/social care interface.

1.8. The Board received a broad range of performance information. This included additional local indicators that they had chosen to monitor, covering suitability of accommodation and access to ETE. These did not enable the Board to conduct regular in-depth analyses of, for instance, the impact of training or education on specific groups or those from specific parts of the county. Oversight of this critical area had not been effective. It had not influenced other partners to widen provision where needed.

1.9. The Board and the YOS had identified clear and appropriate development priorities. The latest youth justice plan indicated that they broadly understand changing local needs and risks to the service.

1.10. There was a joint strategic needs assessment in place; although this did not explicitly consider the health needs of children and young people known to the YOS. Coupled with the lack of Clinical Commissioning Group oversight, this meant that the Board could not be assured that the health needs of this group were met.

1.11. There was good attendance at Board meetings and a strong commitment to the partnership by Cambridgeshire Constabulary. It was positive to note that the YOS police officers were in the Protecting Vulnerable People section of Cambridgeshire Constabulary, in recognition of the safeguarding needs of children and young people working with the YOS. Analysis of crime trend data was not presented to the Board to help understand offending patterns and emerging trends, and react accordingly. For example, local data suggested there had been a recent increase in the number of first-time entrants to the youth justice system. The Board was, positively, aware of this increase, but it had not yet analysed the causes.

1.12. The YOS had identified, in advance of national indicators, a change in reoffending rates and the use of custody. From these it had identified a particular hot-spot and a change in offending

characteristics. At the time of the inspection the YOS was planning how to respond. While it was too early to see the impact, it was encouraging that the YOS was able to identify these itself, rather than rely on national data.

1.13. The extensive programme of structural change in children's services included a redesign of the Multi-Agency Safeguarding Hub and review of the current threshold document. The Board had considered whether YOS referrals should be given priority access and a working protocol was in place but not yet fully implemented.

1.14. Many Board members had, unusually, a good understanding of the latest theories about how children and young people may stop offending. This knowledge was helpful in, for example, understanding the importance of supporting the work of the accommodation worker in the YOS.

2. Partnerships – effective partnerships make a positive difference

2.1. The YOS and the YOS manager in particular were highly regarded by partners, with some effective partnerships in place.

2.2. The YOS had a good range of health and substance misuse staff, including both a physical health nurse and clinical psychologists. There was very good interagency working between substance misuse staff, YOS health workers and the County Substance Misuse Service. A working protocol had been developed between the YOS and CAMHS, and also adult mental health services for those aged 18 years and over. The inclusion of psychologists was valuable as it enabled emotional and mental health needs to be addressed within the context of the YOS and without the delays and other difficulties often experienced when individuals need to be referred to specialist services. They also provided direct support to caseworkers when that was the most appropriate way to work with those with lower level needs, including when the child or young person refused to engage with them.

2.3. Internal health review meetings were normally held twice a year. They enabled the YOS to monitor trends to help make sure the services they provided were appropriate. Information from these had been passed to the Management Board. The opportunity to respond was limited by the lack of health representation. Quarterly meetings were held with the substance misuse team and the drug and alcohol team to monitor the contract with the YOS. The commissioners reported that the YOS met targets and performed well. Specific monitoring of the impact of health and substance misuse interventions on reoffending needed further development.

2.4. For those of statutory school age the work of the YOS was well integrated with local authority services for education and the provision for alternative education. Arrangements enabled collaborative work in supporting vulnerable children and young people known to the YOS. This was not the case for those aged 16 years and over. The transfer of responsibilities to locality teams had not worked well. This had resulted in one manager in the YOS looking after post-16 provision and dealing with all new cases, while also engaging with training and work providers. They provided adequate support in individual cases, but this was restricted to those of the highest priority. Positively, two new transition advisors had recently been appointed. Both had a good understanding of the depth and range of available provision. These appointments did not match the previous provision and remained insufficient to cover the breadth of need across the county.

2.5. There were two full-time police officers which was positive and an appropriate contribution. They were co-located in the YOS, which should bring benefits, particularly in relation to intelligence sharing. There were good relationships between the officers and other YOS staff. The officers had been appropriately trained, including, for example, safeguarding. There was a limited understanding of MAPPA. This was important considering their involvement in public protection work. The officers made a positive contribution to the YOS, including providing interventions and conducting home and prison visits, albeit primarily for those being supervised under the Deter strand of the Integrated Offender Management scheme. They also undertook assessments as part of the out-of-court

disposal process. The time taken in doing this detracted from what should be their core role of sharing intelligence about the whole YOS cohort.

2.6. A new seconded probation officer had recently been appointed. The secondee had a good understanding of their role. There was agreement that the provision would be increased by another half post.

2.7. The YOS also included an accommodation worker. This was a valuable resource.

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

3.1. The YOS had clear and appropriate internal procedures in place, including local standards for practice delivery and procedures to support quality assurance and oversight. These helped demonstrate the high standards of case practice that managers and staff aspired to. The YOS was understandably disappointed that practice found in this inspection did not always meet these standards. The cause could be explained at least in part by staffing and other difficulties experienced, particularly in early 2016. These meant that, for a period of time, it was delivering its services with a substantially reduced workforce. This also affected the opportunity for managers to provide effective oversight.

3.2. All case managers spoke positively about their managers. It was apparent that staff and managers worked together well. Staff, without exception, considered that managers were skilled at assessing their work; supporting them and helping them improve. All said that they received effective and appropriate supervision.

Example of notable practice: Together for families group supervision

This fortnightly group supervision for case holders and seconded staff was led by a clinical lead in work with challenging families, who was not linked to the YOS. It provided an opportunity outside of formal supervision to take a reflective look at cases. Due to the independent and impartial approach participants treated the forum as a safe space to reflect, consider alternative points of view and identify constructive ways to move forward. It was also sometimes used as a space into which other concerns could be brought for support.

3.3. Substance misuse and health staff reported regular supervision and felt well supported. They could also access specialist advice from the county substance misuse service and CAMHS. Not all clinical supervisors looked at YOS cases to make sure that work was appropriate and clinically sound. Not all areas of substance misuse and health had three-way meetings involving a YOS manager and clinical supervisors, meaning the YOS could not have full confidence that any issues or concerns had been fully addressed. Health staff had good access to training; although it was felt that enhanced training was needed around gangs.

3.4. The effective work of the YOS was heavily dependant on reliable IT systems. This applied during normal office hours and also out of hours as much YOS work was undertaken in the evenings or at weekends. Reliable IT was essential for day-to-day access to case record systems that contained the information about the risks and needs in individual cases on which the whole work of the YOS depended. It was also critical to effective communication with other agencies, for example to help keep victims or children or young people safe, with the custodial estate and for communication with courts. Difficulties with IT systems were an unusually frequent cause of frustration among staff and managers. Inspectors themselves experienced these problems. There had been an ongoing impediment to the work of the YOS and caused considerable anxiety when caseworkers had to undertake their work without access to key information.

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

4.1. Case managers were generally positive about their training in the YOS. Most considered that their immediate skills development needs were met; although some whose role had changed more recently would benefit from further support. They were less positive about training for future development. While there were examples of the YOS supporting this, there was also an undercurrent of frustration that staffing difficulties meant that they sometimes had not had time to undertake training that was available. Most staff said the YOS promoted learning and development, with some saying that lack of time was the main impediment.

4.2. When asked about their ability to deliver a range of suitable interventions, only slightly over half said skills development needs in this area had been fully met.

4.3. Volunteers on referral order panels understood their roles well. They valued their support and training. Further work to support them in engaging well with children and young people would be helpful.

4.4. Staff were complimentary about the way that the YOS kept them informed about and involved in local priorities and developments. They found the periodic YOS staff meeting particularly valuable in providing an opportunity to hear about and comment on developments.

4.5. The YOS was party to a local authority service user participation strategy and had its own participation policy. We were disappointed to find that, in spite of these, insufficient attention was given to engagement with service users to help improve services. The comments provided elsewhere in this report help illustrate the value of a focused approach to gaining the service users perspective.

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 published reoffending rate[1] for Cambridgeshire was 26.5% (with an average number of previous offences per offender of 0.86), compared to 37.8% for all England and Wales (average number of previous offences of 1.21). Use of custody in Cambridgeshire was 0.11 episodes per 1000 in the 10-17 population, compared to 0.37 for all England and Wales.

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

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

Fieldwork for this inspection was undertaken on the weeks commencing:

07 November 2016 and 21 November 2016.

In the first fieldwork week we looked at a representative sample of individual cases up to 12 months old, some current, others terminated. Following an assurance and moderation exercise, 27 cases were used for the inspection findings, from an original selected sample of 34 cases. 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, explain their thinking and identify supporting evidence in the record. We gathered the views of children and young people, parents/carers and victims linked to the cases we inspected.

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, and observed work taking place.

1 The reoffending rate that was available throughout the inspection was published July 2016, and was based on binary reoffending rates after 12 months for the October 2013–September 2014 cohort, and use of custody in the year to March 2016. Source: Ministry of Justice.

At the end of the second fieldwork week we presented our findings to local strategic managers, the YOS Management Team, 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 shortly 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	Ian Menary, *HMI Probation*
Deputy Lead Inspector	Yvonne McGuckian, *HMI Probation*
Inspection Team	Jane Attwood, *HMI Probation* Jo Dowling, *HMI Probation* Tracy Green, *HMI Probation (user engagement)* Caroline Nicklin, *HMI Probation* Jan Fooks-Bale, *Care Quality Commission* Cat Raycraft, *Care Quality Commission* Haylex Cox, *HMI Constabulary (observer)* Ian Elliott, *HMI Constabulary* Tony Gallagher, *Ofsted (observer)* Martin Hughes, *Ofsted Further Education and Skills* Kate Malleson, *Ofsted Social Care*
	Marie Turner, *West Mercia YOS, Local Assessor*
HMI Probation Support Services	Pippa Bennett, *Support Services Manager* Stephen Hunt, *Communications Manager* Oliver Kenton, *Research Officer* Alex Pentecost, *Head of Operations and Communications*
	Amy Williams, *Support Services Officer*
Assistant Chief Inspector (Youth Justice)	Alan MacDonald, *HMI Probation*

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

ISBN: 978-1-84099-774-3