



Inspection of Youth Offending Work

Arolygiad o Waith Troseddu Ieuenctid

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Report of Short Quality Screening (SQS) of youth offending work in Manchester

This report outlines the findings of the recent SQS inspection, conducted during 17th-19th June 2013. We carried this out as part of our programme of inspection of youth offending work. This report will be published on the HMI Probation website. A copy will be provided to partner inspectorates to inform their inspections, and to the Youth Justice Board (YJB).

Context

As an independent inspectorate, HMI Probation provides assurance to Ministers and the public on the effectiveness of work with those who have offended or are likely to offend, promotes continuous improvement by the organisations that we inspect and contributes to the effectiveness of the criminal justice system.

Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. The purpose of the SQS inspection is to assess the quality and effectiveness of casework with children and young people who have offended, at the start of a sample of 47 recent cases supervised by the Manchester Youth Offending Service. Wherever possible this is undertaken in conjunction with the allocated case manager, thereby increasing the effectiveness as a learning opportunity for staff.

We gather evidence against the SQS criteria, which are available on the HMI Probation website - <http://www.justice.gov.uk/about/hmi-probation>.

Summary

Manchester Youth Offending Service has, over the past year, undertaken a range of actions intended to assess and improve the quality of work. Their willingness to respond positively is encouraging and has led to some performance improvement. This inspection has highlighted areas of work where substantial improvement is still required. In particular the Management Board should ensure that middle managers take more proactive ownership of practice to ensure that the knowledge of staff and quality of practice meets the required standard.

Commentary on the inspection in Manchester:

1. Reducing the likelihood of reoffending

- 1.1. Pre-sentence reports (PSR) were generally of good quality. This meant that the court was provided with valuable information to assist them in making a fully informed decision

about the sentence. In cases where a PSR was not requested by the court, but may have been appropriate because custody was being considered, we were often unable to find evidence of why it was not requested, nor whether the YOS had challenged it. Some PSRs needed to be more concise, and to be analytical rather than descriptive. An example of good practice was where a young person and their parent/carer's opinions on the causes of offending were very different. The PSR writer acknowledged this, analysed the reasons for it and provided valuable advice on how the likelihood of reoffending could be reduced.

- 1.2. The quality of initial assessments of likelihood of reoffending was mixed. We saw some that were of a high standard, including where links were made between the different elements of the assessment. In one we found a helpful appraisal of the lack of progress on a previous order. Overall just over half were good enough. In many, the evidence was insufficient or unclear. Sometimes important information that was known or available at the time was not included; in others the evidence conflicted with the overall assessment, and in a few the evidence applied to a different case. Some assessments were a copy of a previous one with little effort made to update them.
- 1.3. Reviews of the assessment often appeared to be undertaken as a technical exercise (i.e. so that the case record showed a review assessment on file), with insufficient effort made to update them. There were too few effective reviews following significant changes such as at the start of a sentence. Sometimes the initial assessment, along with the PSR, had been undertaken by a different member of staff. The review was undertaken by the case manager immediately following sentence - before they had had a substantive meeting with the child or young person and without reconciling their knowledge of the case with that of the PSR writer. In doing this case managers missed the opportunity to take full ownership of the case, and shortcomings remained in place to inform planning.
- 1.4. Planning for work to reduce likelihood of reoffending was variable, with just under two-thirds being of a sufficient standard. Some plans had Specific, Measurable, Achievable, Realistic and Time-bounded (SMART) objectives that would have been meaningful to all readers including children and young people, however this was not common. Plans needed to be sequenced so that the case manager's thinking on how they would deliver the work over the course of the sentence was communicated to whoever may need to know it. Sometimes the link between the assessment and the objectives in the plan was unclear. For referral orders, the initial youth offender panel meeting to agree a contract was often late, meaning that the sentence did not start in a timely manner and sometimes with limited contact with the child or young person in the interim. As an example of good practice in a community case, the case manager agreed a short initial plan with two objectives about building engagement and motivation whilst emotional and mental health and the level of motivation were assessed, then reviewed this and agreed a substantive plan after a few weeks once the assessments were undertaken. We were encouraged to see this and other plans with a specific objective to build motivation.
- 1.5. When children and young people receive custodial sentences, planning during the custodial phase of the sentence is a joint responsibility between the YOS and the secure estate. It should reflect the YOS assessment of likelihood of reoffending and both elements of the sentence. It should also reflect the views of the child or young person on how their offending can be reduced and give early attention to resettlement. Just under half of the custodial sentence plans met this standard.

2. Protecting the public

- 2.1. This was the weakest area of work in the YOS. Assessments of the risk of harm to others a child or young person may pose needed substantial improvement. The understanding

of what constitutes good planning to manage risk of harm to others was limited, and oversight by immediate line managers of work in individual cases was ineffective.

- 2.2. However, once a case had been identified as having a high risk of serious harm to others and a manager made aware, then the quality of work and level of management engagement was generally much better, helpfully supported by a case planning forum.
- 2.3. Case managers had good awareness of the potential of Multi-Agency Public Protection Arrangements (MAPPA) in contributing to the management of risk of harm, and there was effective engagement with MAPPA where it was appropriate. There was also good joint work with Greater Manchester Police to share information and protect the public.
- 2.4. We found confusion amongst some staff and managers about the circumstances in which a full assessment of risk of harm to others could be undertaken. In a number of cases the risk of serious harm to others was classified as medium, but the assessor had avoided the requirement to undertake a full assessment of this. Guidance clearly states that a full assessment must be completed before a case can be classified as medium or higher risk of serious harm to others. They had not answered 'yes' to any of the indicators of serious harm in the screening section of Asset, including to the question about other intuitive feelings, that would automatically prompt the requirement for a full assessment, and also held the mistaken belief that a full assessment could not be undertaken in this situation. In some of these cases a risk management plan had been developed and received managerial oversight but the current case manager was unaware that this existed.
- 2.5. In other cases, the need for a full assessment was recognised, but it had not been undertaken until the gap was identified by a manager immediately prior to the inspection. Where a full assessment had been undertaken, the main opportunities for improvement were to ensure that the nature of the potential harm is clear, to clearly state who is at risk and to ensure that sufficient account is taken of known and potential victims.
- 2.6. Where it is identified that a child or young person may pose a risk of harm to others we expect to see planning to minimise the likelihood of this happening. This was good enough in only half of the cases where it was required. Sometimes this was because a formal risk management plan (i.e. a plan which details what the risks are, to whom, and how they can be reduced) had not been completed in a case where it was required. Where a plan was completed there were large numbers of areas of potential improvement which, in combination and following discussions with staff, indicated that some staff and managers did not understand how to use the planning tools effectively. Clear planning to manage victims' issues was also a common area for improvement. Conversely, there were some encouraging examples where a precise contingency plan had been clearly recorded in case this was needed. In custodial cases the sentence plan developed during the custodial phase often did not include sufficient interventions designed to address the YOS assessment of risk of harm to others.
- 2.7. As with assessments of the likelihood of reoffending, reviews of assessment and plans to manage risk of harm often appeared to be a technical exercise with insufficient updating.
- 2.8. When providing oversight to this area of work there was positive evidence that managers often required improvements before they would countersign assessments and plans. But too many countersigned assessments and plans were still not sufficient, reinforcing our concerns about understanding of good quality practice. In some cases it was clear that oversight of an assessment or plan had occurred in isolation from the rest of the case, since even a cursory scan could have identified unaddressed shortcomings. In other cases oversight had not been provided, because it had not been requested by the case manager even where a raised risk of serious harm had been recorded, a full assessment completed or a risk management plan produced. The system for identifying where oversight was

needed placed too much reliance on case managers telling their manager that it was required, without an effective means of checking that this was happening. Effective use of information systems could support a rapid improvement of this.

3. Protecting the child or young person

- 3.1. The assessment of vulnerability and safeguarding was sufficient in three-quarters of the inspected cases. This provided a strong basis in those cases for work by the YOS to manage and reduce the vulnerability of those with whom they worked. We were pleased to find examples of a good understanding of potential child sexual exploitation. In some cases more attention needed to be given to bring together all relevant behaviours, rather than restrict the assessment to the immediate presenting issue, and to make full use of information or assessments held by other agencies.
- 3.2. Planning for work to manage and reduce vulnerability met the needs of the case in just over half of those where it was required. The most significant area for improvement was that a formal vulnerability management plan had not been produced in all cases where we considered it was required. In some of these cases inspectors observed that the right actions were being taken, but the lack of a plan meant that this work by the case manager to protect the child or young person was not communicated sufficiently to anyone else who may have needed it, and was not subjected to oversight. In other cases there was insufficient congruence between the assessment and the plan. As with managing risk of harm to others, these plans would benefit from increased understanding of their purpose and how to use them effectively. In custodial cases staff sometimes needed to be more effectively involved with the custodial institution in planning to address vulnerability.
- 3.3. Reviews of assessment and plans to safeguard the child or young person and reduce their vulnerability were often a technical exercise with insufficient updating. This reinforces the comments made within the previous two inspection themes.
- 3.4. Similarly, whilst being slightly more effective, oversight by managers suffered from the same problems as in work to manage risk of harm to others.
- 3.5. Case managers reported significantly improved joint work with allocated social workers for children who were looked after. The YOS had instituted a single point of contact in each team for work with children who were looked after. Staff commented that this was a positive development. Whilst largely outside the scope of this inspection, inspectors saw evidence within case files of this improved working.

4. Ensuring that the sentence is served

- 4.1. Assessment of diversity factors and barriers to engagement was often good. However, more attention needed to be given to assessing the impact of learning styles and speech, language or communication needs. The great majority of PSRs gave sufficient attention to relevant diversity factors and barriers to engagement.
- 4.2. Having identified relevant diversity factors or barriers to engagement the plan to manage these needed to be clearly communicated with all others for whom it may have been relevant. While case managers articulated appropriate plans to inspectors, that thinking was often not apparent within the recorded plan.
- 4.3. Effective engagement with the child or young person and their parents/carers is essential to a robust assessment of how to reduce the likelihood of reoffending and to maximise their ownership of the work being undertaken. More attention was needed to ensure that

parents/carers contributed effectively to the assessment, and that they and their child understood what was said in a PSR before going to court.

- 4.4. Engagement of both children and young people and their parents/carers in the development of plans needed substantial improvement. Plans must be discussed with children and young people, written in language that is meaningful to them and, where appropriate, reflect their views on how to reduce their offending behaviour. Parents/carers need sufficient understanding and ownership of the plan in order to support and reinforce the work of the YOS with their children and young people.
- 4.5. Sufficient attention was given to health or well-being factors in the great majority of cases where this was needed. This included referrals for work to address substance misuse, monitoring of contacts with other agencies and liaison with leaving care services.
- 4.6. Two-thirds of children and young people complied sufficiently well with the requirements of their sentence. Where they did not comply, the YOS response was appropriate in well over three-quarters of cases. There were some good examples of a clearly recorded and defensible decision, with management support, to adopt an alternate strategy rather than return the order to court for breach. Equally, the YOS would instigate breach action when it was appropriate. On occasions a more robust approach was needed to poor behaviour and more attention could have been given to understanding the causes as soon as indicators of likely non-compliance appeared.
- 4.7. The YOS had introduced compliance panels. These were a meeting between a YOT manager, case manager and other relevant staff, and the child or young person and their parents/carers, to discuss the reasons for non-cooperation and to seek to agree strategies to improve behaviour and attendance. By meeting after the second failure to comply these panels had the opportunity to influence behaviour before breach proceedings needed to be considered. Training had recently been provided to case managers, and all clearly understood YOS expectations for addressing non-compliance. Together these had a positive effect on work to ensure that the sentence was delivered as the court intended.

Operational management

Many staff spoke positively about their managers. However, views on the quality of supervision they received and how actively their managers helped them improve the quality of their work were mixed. In particular they reported limited evidence of random sampling of cases and general discussion about improving practice. We found few entries into the case record by managers, as evidence of their active involvement, other than where formal countersigning was undertaken. Where managers had been involved it was often left to case managers to record this. The YOS had developed helpful local standards and a self-audit tool to be used by case managers and checked by managers, but the self-audit was not yet being used effectively. Some relatively inexperienced staff had only infrequent supervision and felt that they had been left to get on with the job without sufficient support and training. Staff also commented that they would value more formal opportunities to discuss practice with their peers. Their perception of training opportunities available to them was broadly positive.

Key strengths

The best aspects of work that we found in Manchester included:

- Willingness of YOS management to seek to understand and address areas for improvement.
- Compliance panels and the YOS approach to ensuring that the sentence is served as the court expects it.
- Overall quality of pre-sentence reports provided to the sentencing court.

- Effective engagement with MAPPA and Greater Manchester Police.

Areas requiring improvement

The most significant areas for improvement were:

- i. Middle managers need to be effective, including through the provision of oversight, in ensuring the quality of work to manage risk of harm to others and to reduce vulnerability, and in quality assuring and developing the work of their staff.
- ii. Staff and managers need to have a common understanding of how to use the YJB assessment and planning tools effectively to aid consistent and good quality work.
- iii. Planning for work to manage risk of harm to others and reduce vulnerability needs to be improved.
- iv. Full assessment of risk of harm to others must be undertaken where required and be of good quality.
- v. Planning in custodial cases should reflect the YOS assessment, and both phases of the sentence.
- vi. Reviews of assessments and plans should be meaningful.
- vii. Children and young people and their parents/carers should be more effectively involved in assessment and planning. Plans must be understood by and meaningful to them and, wherever appropriate, agreed with them.

We strongly recommend that you focus your post-inspection improvement work on these particular aspects of practice.

We are grateful for the support that we received from staff in the YOS and for their positive and enthusiastic engagement with this inspection. Please pass on our thanks, and ensure that they are made fully aware of these inspection findings.

If you have any further questions about the inspection please contact the lead inspector, who was Ian Menary. He can be contacted on 07917 183197 or by email at ian.menary@hmiprobation.gsi.gov.uk.

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