Inspection of Youth Offending Work
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Report of Short Quality Screening (SQS) of youth offending work in Newcastle

This report outlines the findings of the recent SQS inspection, conducted during 4th-6th November 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 34 recent cases supervised by the Newcastle upon Tyne Youth Offending Team. 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

Overall, we found a dedicated staff team working conscientiously with a range of children and young people presenting complex needs. Staff consistently involved and engaged the child or young person and their families in assessments. Every case manager reported that they received excellent supervisory support. However, we did not find that management oversight in the quality of risk of harm issues, safeguarding and vulnerability was always effective. Plans were often not completed. Enforcement decisions were taken appropriately.

Commentary on the inspection in Newcastle:

1. Reducing the likelihood of reoffending

1.1. In almost four-fifths of the cases we found that good quality pre-sentence reports (PSRs) were provided to the court. There were effective quality assurance systems in place and the reports proposed a range of realistic and robust alternatives to a custodial sentence.

1.2. In nine-tenths of the cases, we concluded that there was a timely and sufficient assessment of likelihood of reoffending. An inspector noted "*In one case, the documentation provided a very detailed and comprehensive assessment of the young person, his background, history and the offending related factors. Additionally the case manager had sourced information from a number of professionals*".

1.3. The personal situations of children and young people can change very quickly. It is therefore necessary to review assessments accordingly. In four-fifths of the cases we examined, reviews were completed appropriately and on time. However, there were several reviews that were not timely, not undertaken following a change in circumstances or were not of good enough quality.

1.4. In 14 out of the 34 cases we found that the planning in place for work to reduce the likelihood of reoffending was deficient. This was due to a range of reasons including insufficient inclusion of substance misuse and/or education and training needs; objectives not being clear; and not enough focus on reducing the likelihood of reoffending. Plans needed to be sequenced so that *how* the work would be delivered during the sentence was communicated to whoever may need to know it. As an example of good practice in a community case, the case manager agreed a focused initial plan with three Specific, Measurable, Attainable, Relevant and Time-bounded (SMART) objectives about establishing engagement and motivation whilst education and training needs were assessed. These were then reviewed in consultation with the child or young person and specific objectives set.

1.5. Where the child or young person was serving a custodial sentence we found sufficient planning during the custodial period of the sentence to reduce the likelihood of reoffending in six out of the seven relevant cases.

2. Protecting the public

2.1. This is an area of work that requires further attention. We found that in 14 out of the 34 cases there was insufficient assessment of the risk of harm to others. In one case we noted that *"the risk of harm at the commencement of the order was under assessed".* The understanding of what comprises good planning to manage the risk of harm to others was inconsistent and management oversight of work in individual cases was not always clear and effective. However, once a case had been assessed as having a high risk of harm to others then the quality of the interventions and level of management engagement was much improved and helpfully supported by a risk management forum.

2.2. We found inconsistencies in a number of the risk of harm classifications and when challenged we were advised that no matter what the classification, the case manager would take the same action. We do not agree with this as the classification system is there to aid professional decisions about the threat a young person may pose to others, and the action that may be needed to avoid this happening.

2.3. In one-third of the cases, planning and subsequent reviews in managing the risk of harm to others was insufficient. This was due to risk management plans not being completed and the reviews not being of a sufficient quality.

2.4. Case managers had appropriate awareness of the potential of Multi-Agency Public Protection Arrangements (MAPPA) in contributing to the management of risk of harm to others and engagement with MAPPA where necessary. In one case we noted some very good practice in relation to close multi-agency working. The case manager used the Care Team and Looked After Children reviews to inform the child or young person's risk and vulnerability assessments. These were actively shared with relevant professionals in order to ensure joined-up working and holding all practitioners to account.

2.5. In three-quarters of the cases we found that the risk of harm to victims or identifiable victims had been effectively managed. As an example of good practice, the victim liaison worker had completed some useful work with the young person and this had culminated in a face-to-face conference with the victim of the child or young person's last offence.

2.6. As with assessments of the likelihood of reoffending, reviews of assessment and plans to manage risk of harm to others were not completed in almost one-third of the relevant cases.

2.7. When providing oversight to this area of work there was clear evidence that managers had good knowledge of the case, but their input did not always provide consistently clear advice on how the risk of harm to others could and should be managed. We found that over half of the cases lacked effective management input into risk of harm work. This was primarily due to deficiencies in assessment and planning not being addressed.

3. Protecting the child or young person

3.1. The assessment of vulnerability and safeguarding was sufficient in two-thirds of the inspected cases. Where this was lacking, vulnerability assessments or full risk of harm assessments had not been undertaken. In some of the cases, additional attention was required to pull together all relevant behaviours, including previous convictions, rather than limiting the assessment on the current issues. One inspector commented "*the case manager had failed to draw together historical and current vulnerability factors and combine them within a contemporaneous and coherent vulnerability assessment*".

3.2. Planning for work to address safeguarding and vulnerability met the needs of the case in three-fifths of those where it was required. While a formal vulnerability plan had not been produced in virtually all the cases where we considered one was required, in some of these inspectors observed that the appropriate actions were being taken. Clearly, this is preferable to no action, but the advantage of a plan is that proposed work by the case manager to protect the child or young person is easily shared with other practitioners who may also contribute to it. In one case, where the offending behaviour was placing the child or young person in danger, we noted "*despite insufficiencies in assessment and planning the case manager had undertaken some very good work in terms of facilitating desistance and the beginnings of behavioural change by the young person*". In other cases, the links between the assessment and the plan were unclear. As with managing risk of harm to others, these plans would benefit from increased understanding of their intention and how to use them effectively. In custodial cases, planning for work to address safeguarding and vulnerability was good in almost all the cases.

3.3. Management oversight in ensuring that the quality of work to address safeguarding and vulnerability was sufficient in just over half the relevant cases. In the other half we found that deficiencies in assessment and planning were not adequately addressed. This could account for one-third of case managers not demonstrating to inspectors that they had a sufficient understanding of local policies and procedures for the management of safeguarding.

3.4. One-third of the PSRs inspected did not have a clear and thorough assessment of vulnerability and safeguarding needs, which may offer an explanation for why these deficits continued in planning and reviews.

4. Ensuring that the sentence is served

4.1. This area of work was a major strength in the YOT. In almost nine-tenths of the cases we found that diversity factors and barriers to engagement had been sufficiently assessed. One inspector reported "*The case manager had recognised diversity issues and had*

clearly considered the best way to try and facilitate an effective working relationship with a difficult and uncommunicative young person, who had a history of poor compliance".

4.2. We were pleased to find that in almost every case, case managers had engaged well with the child or young person and their parent/carer to both carry out the assessment and develop the PSR.

4.3. Every PSR we assessed included consideration of diversity factors and possible barriers to engagement. It was, therefore, disappointing to find that these factors had not seamlessly been introduced into the initial intervention plan. One-quarter of the cases did not include clear plans. Speech, language or communication needs were not explicitly identified, disability issues were lost and the needs of Looked After Children were not always considered.

4.4. In almost all of the cases the YOT had appropriately given sufficient attention to the health and well-being outcomes for the child or young person as far as these factors may have acted as a barrier to achieving favourable outcomes.

4.5. We were pleased to learn that an 'appreciative enquiry' approach was often used in dealing with complex cases. In one case a number of key professionals and family members had come together to address some challenging behaviours that were being exhibited by a young person. Following a full review of the case and consideration of views from the family, themes were identified and further action agreed.

4.6. We were satisfied that virtually all of the case managers interviewed had a sufficient level of understanding of local policies and procedures to support effective engagement and appropriately respond to enforcement. This ensured that the sentence was served.

Operational management

Every case manager interviewed reported that in their opinion their line manager had the skills and knowledge to assess the quality of their work; support them in their duties; actively help them to develop their practice; and provide them with effective and appropriate supervision. However, we judged that staff supervision had made a positive difference in 19 of the cases. The inspection team concluded that whilst there was clear evidence of management accountability its effectiveness was not consistent.

Three-quarters of case managers felt that their training and skills development had been met. One-third believed that their future developmental needs were only partially being met. Almost half reported that they would like more training to improve their ability to recognise speech, language, communication needs of children and young people. Diversity training was also identified as requiring additional attention.

The vast majority of case managers expressed the view that the organisation positively promoted learning and development but half stated that they did not fully understand organisational priorities.

Key strengths

The best aspects of work that we found in the Newcastle YOT included:

- the engagement of case managers with young people to build positive and trusting relationships in order to ensure that the sentence is served
- the timely and sufficient completion of initial assessments of likelihood of reoffending
- the positive supervisory relationship between the case and line manager.

Areas requiring improvement

The most significant areas for improvement were:

i. consistent oversight by middle managers to ensure the quality of work to manage risk of harm to others, safeguarding and vulnerability

ii. planning and reviewing of the work to manage risk of harm to others and reduce vulnerability

iii. high quality assessments of risk of harm to others must be undertaken when necessary.

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 Newcastle YOT to facilitate and engage 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 Avtar Singh. He can be contacted on 077969 48325 or by email at avtar.singh@hmiprobation.gsi.gov.uk.

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