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To:	Curtis Ashton, Chair of YJS Management Board and Head of Families and Adolescent Services
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From:	Julie Fox, Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Merton

This report outlines the findings of the recent SQS inspection, conducted during 16th-18th September 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 20 recent cases supervised by the Merton Youth Justice Service (YJS). 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

Merton YJS had made important changes to practice since our inspection in 2011. These had led to the delivery of improved services. Case practitioners used a thoughtful, investigative approach, working well with specialist colleagues and other agencies. Despite encouraging developments to management oversight there was more to be done to ensure assessments and planning were effective.

Commentary on the inspection in Merton:

1. Reducing the likelihood of reoffending

1.1. We look to see if the assessment as to why a child or young person has offended is good enough. In over two-thirds of the cases we looked at, it was. In most instances, case practitioners used an investigative approach to assess the factors most closely linked to a

child or young person's offending behaviour and gave due consideration to identifying diversity issues, for example, any cultural or gang-related issues. However, in too many instances evidence pointed to an undue delay between the time of sentence and completion of the assessment, which adversely affected the overall quality of the case.

1.2. In the large majority of cases, a report had been prepared by the YJS to help the courts with their sentencing decisions. With effective oversight by managers, almost all of these were of good quality.

1.3. In three-quarters of the cases we looked at there had been sufficient planning to reduce the likelihood that the child or young person would reoffend. Timeliness, again, was an issue in some. While, in the main, objectives in plans were relevant and addressed areas identified in the assessment, many needed more detail to enable the children and young people to identify exactly what was expected from them. Two cases had no initial plan.

1.4. Planning for work to reduce the likelihood that children and young people would reoffend was good enough in every custodial case.

1.5. Children and young people's lives can change rapidly, with the subsequent need to review and update their assessments and plans. Almost three-quarters of the initial assessments were reviewed well enough. However, there were cases where reviews had not been undertaken as needed, for instance after a significant change in the child or young person's life. The assessments in custodial cases had not been reviewed sufficiently.

1.6. Just over one-third of plans were not reviewed as well as they should have been. Case practitioners often identified promptly when there was a need to alter the order of tasks or the direction of their work to meet the changing needs of a case. However, they were less likely to reflect these changes in the written plans.

1.7. Case practitioners recorded monthly summaries of their cases, some of which set out the future direction of work and next steps to be taken. The YJS is to be commended for this practice as it provides the opportunity to reflect on the progress in a case and anticipate and plan for further work. However, it is not an acceptable alternative for reviewing and updating assessments and plans as these are the tools that provide for all relevant information to be brought together, which is particularly important in complex cases.

2. Protecting the public

2.1. We expect to see a clear, relevant and comprehensive assessment at the time of sentence of the risk of harm children and young people pose to others. We found that this had happened in three-quarters of the cases where a pre-sentence report (PSR) had been prepared for the court, but less often where the assessment had been prepared after sentence. Some case practitioners failed to consider previous offending and other relevant behaviours. In a small number of cases a full analysis had not been undertaken when it should have been.

2.2. Where it is assessed that a child or young person could cause harm to others we expect to see a plan identifying the work that needs to be carried out to reduce or manage relevant risks. Merton YJS needs to make considerable improvement in this area of work. The quality of planning was good enough in just over half of the cases that needed it. Case practitioners had not set out all of the work that needed to be done to manage risks, were not giving enough consideration to potential changes in risk and contingencies to address these, or providing enough detail about how information pertaining to risk of harm would be shared with relevant partners. A small number of plans were completed late and, in two cases, one involving a young person in custody, there was no plan to manage the risks he posed.

2.3. Risk of harm to others is dynamic in nature and needs to be continuously reviewed. The majority of case practitioners were actively reassessing factors linked to risk of harm, but had recorded this sufficiently on their assessment in less than half the cases we looked at. A small number had not been reviewed at all after a significant event in the life of the child or young person. There were considerable gaps in work to review plans to manage the risks identified. Many were not updated with progress against previous objectives or to reflect changes in the direction in the case. Some were reviewed late.

2.4. Taking account of the needs of victims is crucial in helping to keep them safe. It also plays an important role in reducing the risk of harm children and young people pose. We were pleased to see that in almost three-quarters of cases where there was a victim to protect, there was evidence that the risk of harm to them was being managed effectively.

3. Protecting the child or young person

3.1. There was evidence that the YJS gave priority to assessing the vulnerability and safeguarding needs of children and young people. Initial assessments had been completed well enough in the large majority of cases and three-quarters of PSRs. The main areas for improvement related to ensuring the nature and level of vulnerability were accurately and clearly recorded on the assessment.

3.2. We expect to see effective planning to address vulnerability and keep children and young people safe. We were disappointed to find that this was happening in less than two-thirds of the cases that merited it. As with plans to manage risk of harm to others, we found that in one case there was no plan and in two the plan was completed late. In some cases, the links with other agencies and their plans were unclear and case practitioners had not included important aspects of work to be done or covered contingencies.

3.3. There were two custody cases where issues of vulnerability and safeguarding had been identified. We were satisfied that there was enough planning in place in both of these.

3.4. The quality of reviews of vulnerability and safeguarding varied. Case practitioners were actively reflecting on the changing needs of a case and altering work accordingly but had recorded this sufficiently in just over half the assessments and half the plans we looked at. Some reviews did not reflect progress and changes in the case. A number had been completed late or not at all, for example after a significant change in the child or young person's life. Many plans were not revised to reflect new work to be done.

4. Ensuring that the sentence is served

4.1. This was an area of strength for Merton YJS. We found case practitioners committed to doing the best for children and young people and to ensuring they achieved the best possible outcomes.

4.2. In a large majority of cases there was sufficient assessment of children and young people's individual needs and potential barriers to their engaging with the YJS. In most, planning reflected the issues identified.

4.3. The YJS worked hard to build and sustain relationships with the children and young people and their parents/carers and, in most cases, they were encouraged to be meaningfully involved in assessments and planning. Some plans were written from the perspective of the child or young person; however, in a small number of cases it was difficult to see how the plan reflected their or their parents/carers' views or priorities.

4.4. In a large percentage of cases, the children and young people were initially reluctant to comply with the requirements of their sentence. For the most part the YJS responded appropriately to this and compliance improved. Few cases had to be returned to court.

5. Operational management

5.1 Merton had introduced a number of changes to practice since our inspection in 2011 and there was an evident improvement in service delivery. Most notably, the YJS was managing risk of harm to others, vulnerability and safeguarding considerably better than they had been. Action to encourage compliance was also more effective. We found, however, that some of the areas for improvement identified in 2011 remained issues for the YJS. One of these related to the timeliness of assessments, plans and reviews. We were pleased to learn that the YJS has an improvement plan in place to help sustain its positive journey and is developing a system to address timeliness issues.

5.2 Extensive developments in the YJS's management oversight arrangements will, undoubtedly, have helped to achieve recent improvements. A range of processes for quality assuring assessment and planning were in place, and these had made a difference to a large majority of the cases we looked at. Managers had a thorough understanding of cases and openly recorded their views and suggestions for improvement. The YJS had issued an updated Quality Practice Framework (QPF) which provided guidance on many of their assessment and planning processes. We were unable to identify why, despite these mechanisms, there were still areas of work that required considerable improvement.

5.3 The YJS had adopted the use of an Integrated Action Plan (IAP) which replaced the separate intervention plan, and risk and vulnerability management plans. In principle, this approach was a positive step. The IAP should have set out a comprehensive, clear and coordinated course of action for a sentence, with the YJS's QPF providing guidance for its effective completion. However, we did not see many instances where case practitioners were making effective use of the template.

5.4 Case practitioners had strong links with YJS specialists and partner agencies that benefited children and young people, and their families. There were a number of opportunities to discuss cases at internal and multi-agency meetings and evidence of a collaborative and effective approach to assessment and planning.

5.5 Without exception, the case practitioners understood local policies and procedures for managing risk of harm, vulnerability, safeguarding, engagement and compliance. Most felt they had received the right training to do their jobs and for their development to other roles. Some were keen to attend further training in areas of diversity such as speech, language and communication.

Key strengths

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

- in almost all cases, PSRs provided the courts with good quality advice to help inform sentencing
- the willingness of YJS management to seek to understand and address areas for improvement and its holistic approach to management oversight that had led to considerable improvements in case management
- the case practitioners' enthusiasm and determination to build positive, trusting relationships with the children and young people and their parents/carers
- the case practitioners' exploration of the diverse needs of children and young people - for instance, relating to learning styles, culture or links with gangs - and constant reflection on the changing needs of the case that had helped to achieve positive outcomes.

Areas requiring improvement

The most significant areas for improvement were ensuring:

i. a full and thorough analysis of the risk of harm children and young people pose to others is completed where necessary; to include an assessment of circumstances and behaviours - past, present and potential - that are relevant to the case

ii. there is a timely and effective plan in place to manage and reduce the risk of harm children and young people pose to others and to address their vulnerability and safeguarding needs; that plans contain sufficient detail, and provide for contingencies

iii. that assessments and plans are meaningfully reviewed and updated where necessary, especially after a change in circumstances for the child or young person.

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 YJS 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 Vivienne Clarke. She can be contacted on 07872 485611 or by email at vivienne.clarke@hmiprobation.gsi.gov.uk.

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