Inspection of Youth Offending Work
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To:	Mike Batty, Chair of Stockton-on-Tees Youth Offending Service Management Board
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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 Stockton-on-Tees.

This report outlines the findings of the recent SQS inspection, conducted during 25th-27th 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 20 recent cases supervised by the Stockton-on-Tees Youth Offending Service (YOS). 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 really positive picture in Stockton-on-Tees. The YOS can be proud of the progress made since our last inspection in 2010. Staff delivered high quality reports and assessments of reoffending, harm and vulnerability. They were well supported by their management team through robust quality assurance procedures. There is scope for further improvement by ensuring that reviews are timely and completed in response to significant changes in the circumstances of children and young people.

Commentary on the inspection in Stockton-on-Tees:

1. Reducing the likelihood of reoffending

1.1. There was a timely and sufficient assessment of the likelihood of reoffending in all 20 of the cases inspected.

1.2. Pre-sentence reports (PSRs) were completed in ten cases and were of good quality in nine of these. There was evidence of effective management oversight in eight cases. Information in other forms, such as verbal updates provided by case managers, offered enough information for the purposes of sentencing. An Inspector noted in one case that there was a "*Good quality, succinct panel report, informed by a well-evidenced initial assessment. This helped to inform some strong management plans and Initial Sentence Plans, meaning that the case was targeting the key risk factors from the outset and allocating resources efficiently*."

1.3. Planning to reduce the likelihood of reoffending was sufficient in 17 out of the 19 relevant cases. Five of these related to custodial sentences and four of these cases were of sufficient quality. One Inspector noted: "*The sentence plan is of an excellent standard. It is written in a way that encourages ownership by the young person without undermining its importance and specific management of re-offending risk. It incorporates the outcomes of the learning skills and What Do You Think questionnaires and keeps the plan to three pertinent targets, with future targets highlighted but kept separate to be considered on review. This plan feels like it finds the balance between young person engagement and acknowledging that there are risks to be addressed*."

1.4. All 15 cases that required a review of the likelihood of reoffending were reviewed to a good standard. In the 11 cases where the plan to reduce reoffending was reviewed, all but one was of the required standard.

2. Protecting the public

2.1. There was a clear and thorough assessment of the risk of harm to others in eight of the ten cases where there had been a PSR. A good quality assessment of risk of harm to others was seen in 19 out of the 20 cases. These assessments were adequately reviewed in 11 of the 13 relevant cases. One was not timely, the other of insufficient quality.

2.2. Planning to address the risk of harm to others had been done well in 14 out of the 16 relevant cases. In one case a plan had not been completed, in another it was not timely. The quality of planning was generally good and in one case an Inspector noted: *"The Initial Sentence Plan was of very good quality, targeting the key risk areas, in young person friendly terms, specific to the individual, with a clear idea of what would be done and by whom, making measurement of progress potentially much easier. Planning for risk of harm and vulnerability flowed from the screenings and plans were well-compiled, workable, stand alone documents fit for purpose in terms of risk management/ safeguarding".*

2.3. The risk of harm to identifiable victims had been effectively managed in all 12 relevant cases.

2.4. Management oversight was effective in ensuring the quality of risk of harm assessments, and planning in all but two cases.

3. Protecting the child or young person

3.1. We were pleased to see that vulnerability issues were accurately assessed in the vast majority of cases. Where it had not been, in one case an assessment had not been done, in another it was not timely. All PSRs had sufficient safeguarding and vulnerability assessments. Planning to address safeguarding and vulnerability issues was of a sufficient standard in 17 out of 19 relevant cases. However, plans had only been reviewed sufficiently in 12 out of 15 cases. In two cases plans were not reviewed despite significant changes in the children and young people's circumstances. In one case the review was not timely.

3.2. Management oversight was effective in the vast majority of cases. There was an effective process to ensure case managers were regularly quality assessed, coupled with a well established management countersigning procedure. This approach was well received by staff who felt supported by the management team.

3.3. The staff had a good understanding of safeguarding and vulnerability issues. They were able to apply this knowledge to produce accurate assessments that allowed the effective management of safeguarding and vulnerability. In one case we noted: "*The Initial Sentence Plan covered the relevant risk factors with objectives appropriate to the young person and in language they would likely be able to follow. The risk and vulnerability plans were generally very good with relevant information in each section and even a level of contingency, although this had room to be more specific and directive. All plans were reviewed at the appropriate time and, in terms of the Risk Management Plan, reflected the level of risk change and slightly different issues and required approach*".

4. Ensuring that the sentence is served

4.1. We found that the assessment of diversity factors and barriers to engagement was an area of strength for the YOS. All PSRs and Initial Sentence Plans were of good quality. Engagement with the child or young person, or parent/carer occurred in all but one instance. Plans incorporated identified diversity issues sufficiently well in 18 out of 20 cases. Health issues were particularly well addressed, with all 18 relevant cases giving sufficient attention to this area. The identification of diversity issues and the potential barriers to engagement were well addressed by staff and solutions were effectively built into plans. An Inspector noted: "*The case manager did an in depth assessment of the diversity issues in this case. The importance given to this area was demonstrated through a meeting with college staff to brief them on the behavioural issues associated with the young person's diagnosis which led to them constructing a management plan that built in adjustments and options for the young person if they became aggressive or could not cope in a lesson. A breakout room was made available with teacher support to allow a cool down period*."

4.2. We found well established and effectively used procedures to address non-compliance. Fifteen out of the twenty children and young people complied with their sentence. Nine of these required the use of compliance procedures. The YOS operated a 'Back on Track' process which was effective in re-engaging the child or young person and promoting compliance. There was evidence in the case files of persistence and dedication among the staff group to successfully complete the sentence of the court. When necessary, the YOS used enforcement appropriately and returned the order to court. The YOS approach was sufficient in all these instances.

Operational management

We found that Stockton-on-Tees YOS had responded well to the recommendations made in the last inspection of 2010. They had focused on the quality of risk and vulnerability management plans and established an effective management oversight strategy. Clear guidance had been put in place with regular reviews and updates. It was clear to us that staff were aware of the risk and safeguarding procedures and understood them.

Staff were well trained and felt equipped to do the work, although there was some anxiety concerning the resources that might be available for future training. The principles of effective practice were understood and evident in the plans which we saw.

Arrangements for management oversight were improved; we saw evidence of regular oversight in all cases and in most cases this had a positive impact on the quality of the work done. Oversight

was valued by staff who felt that their managers were skilled and capable of developing their practice to a higher level. We felt that achieving this positive view among the staff of a high level of management oversight was a particular success of the management team.

Key strengths

The best aspects of work that we found in Stockton-on-Tees included:

- excellent engagement with children and young people and their parents/carers in carrying out initial assessments and intervention plans
- the identification of diversity issues and what needed to be done to overcome barriers to change
- high quality assessments of the likelihood of reoffending, risk of harm and vulnerability both at report and initial assessment stage.

Area requiring improvement

The most significant area for improvement is that:

i. in all cases, reviews of assessments and plans to tackle the risk of harm to others and vulnerability should be timely and completed quickly in the event of a significant change in circumstances.

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

We are grateful for the support that we received from staff in the YOS 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 Jonathan Nason. He can be contacted on 07768 073286 or by email at jonathan.nason@hmiprobation.gsi.gov.uk.

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