Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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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 Tameside

This report outlines the findings of the recent SQS inspection, conducted during 28th-30th October 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 Tameside 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 that Tameside YOS was performing very well. There had been significant improvements in many areas of work since our last inspection in 2009. Practitioners had a high level of professional knowledge and were committed to their work. We found particular strengths in how case managers recognised and responded to a range of diversity issues. We saw positive working relationships with children and young people and their parents/carers. Pre-sentence reports were generally of a high standard, and initial assessments and plans were timely and comprehensive. Good attention was paid to safeguarding issues. There is scope for further improvement in public protection work, including planning to manage specific risks to identifiable individuals. We also found that the effectiveness of improvement actions could be increased by more robust management oversight.

Commentary on the inspection in Tameside:

1. Reducing the likelihood of reoffending

1.1. We expect to see a timely and sufficient initial assessment of the factors linked to offending, and we found that in all the cases we looked at. The initial assessments included information from a wide range of relevant sources.

1.2. Assessments led to good quality plans that outlined how factors related to offending would be addressed.

1.3. In all relevant cases we found that reviews of the likelihood of reoffending assessment had been completed when required and were of a good standard.

1.4. It was clear that case managers had a sound understanding of the principles of effective practice, and made good use of these in planning and delivering the work with children and young people. This area showed a substantial improvement since our previous inspection.

2. Protecting the public

2.1. We look for a detailed assessment of the risk of harm a child or young person poses to others. In over three-quarters of relevant cases, we found that this had been done well enough - a significant improvement since the last inspection. Where assessments were judged to be insufficient, this was because they were not completed promptly, or did not fully analyse factors related to risks to actual or potential victims.

2.2. Three-quarters of cases where a review of the risk of harm to others was deemed necessary had a review completed to a sufficient standard. In the cases where reviews were not good enough this was because information relating to new offences or other behaviour was not clearly explained and analysed.

2.3. Following an assessment of risk of harm issues, we would expect the YOS to put in place plans to manage any risky behaviour and try to prevent it taking place. In 9 out of 13 cases we found that the plans were clear. In the remaining four cases we found that risks to identifiable victims, including family members and staff, were not being sufficiently well managed. For example, internal 'risk management' meetings were not always clear about specific actions needed to prevent the child or young person causing harm.

2.4. In two out of the three cases where the child or young person was in custody, we found that plans to manage the risks they presented were not good enough. The plans did not make clear how risks to staff and other prisoners would be managed either during the custodial phase of the sentence or after release.

2.5. Management oversight was recorded on the case file in almost all cases, but we felt it did not always identify the shortcomings in assessment and planning. We did not see any evidence of systematic follow up by managers to ensure that the remedial actions they had identified had then taken place.

3. Protecting the child or young person

3.1. In many cases, children and young people who have offended are also vulnerable themselves, and we expect to see that this has been taken into account. We found that in 17 out of 20 cases there was a sufficient initial assessment of vulnerability and safeguarding issues. For those that had not met the benchmark, in one case the assessment was not completed on time, and in two we felt that the assessment had underestimated the level of vulnerability.

3.2. All pre-sentence reports contained a clear and thorough assessment of vulnerability.

3.3. In all cases where it was necessary we found sufficient plans in place to manage safeguarding and vulnerability issues. This included the three cases where the child or young person was in custody.

3.4. We expect to see a regular review of vulnerability issues because children and young people's lives can change very quickly. In 9 out of the 13 relevant cases we found that this was completed when required. In three cases a review had not been completed following a significant change in the child or young person's circumstances.

3.5. Management oversight of vulnerability and safeguarding issues was effective in three-quarters of cases. Where it was not, the reasons were the same as above.

3.6. We found that all staff were aware of local safeguarding children policies. In one case we found an example of good work jointly with another agency in escalating a referral to children's social care, which resulted in the child or young person becoming subject to a Child Protection plan. We also saw a case where there was excellent joint working with the leaving care team to ensure a safe and structured release plan was in place for a young person being released from custody.

4. Ensuring that the sentence is served

4.1. There was a thorough assessment of a wide range of diversity factors and possible barriers to engagement in all of the cases we looked at. The availability of a seconded speech and language therapist in the team meant that this area of need was particularly well covered. We saw an excellent example where the case manager had addressed complex cultural, language and religious issues to jointly manage a high risk of harm case with colleagues in education and social care. The outcome was that the young person was enabled to return to live at home safely and to participate in full-time education.

4.2. All YOS case managers put a great deal of effort into engaging the parents/carers of children and young people. We found evidence in several cases of excellent practice where parents/carers who were initially reluctant to engage were encouraged to work in a positive way with the YOS. In almost all cases we found that children and young people and their parents/carers were effectively engaged in their planning for supervision.

4.3. In all of the cases where there had been non-compliance we found the response of the YOS was appropriate, balancing the need to engage children and young people with the need to take enforcement action if they did not cooperate.

Operational management

We interviewed six practitioners who all spoke positively about operational management in Tameside YOS. All felt supported in their work and viewed their managers as skilled and knowledgeable. All felt that their training and development needs were fully or partially met. We found that all practitioners understood the principles of effective practice and were familiar with local policies relating to safeguarding, risk of harm, engagement and compliance.

Management oversight had improved since our last inspection. There was a formal quality assurance process in place to review cases shortly after they had started. However, managers needed to develop their skills to better identify shortcomings in assessments and plans and then ensure that case managers implemented the actions identified. There are plans in place to link up with another Youth Offending Service to undertake joint peer review and managers recognise that as a good opportunity to develop this work.

Key strengths

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

- strong and positive working relationships with all children and young people and their carers, which incorporated the recognition a wide variety of diversity factors
- access to speech and language therapy via a seconded specialist, to support staff in finding the most appropriate way to communicate with children and young people
- excellent working relationships with a range of co-located service providers including the leaving care team, substance misuse service and careers service. This maximised the access of children and young people to services that met their needs.

Areas requiring improvement

The most significant areas for improvement were:

i. fuller analysis of all factors related to risk of harm to others

ii. ensuring that all risk management plans follow from and address issues raised in assessments, and contain specific actions to manage risks to identifiable victims including other children and young people and staff

iii. further development of the quality assurance process to ensure that all shortcomings in assessments and planning are identified and that actions required by managers are followed up by case managers.

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 Tameside Youth Offending Service 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 Liz Smith. She can be contacted on 07827 663397 or by email at liz.smith@hmiprobation.gsi.gov.uk.

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