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 Stoke-on-Trent

This report outlines the findings of the recent SQS inspection, conducted during 22nd-24th July 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 Stoke-on-Trent 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

Overall, we found a positive picture in Stoke-on-Trent. The Youth Offending Service (YOS) can be rightly proud of the improvements in the quality of practice since our previous inspection in November 2010. These improvements have been achieved despite a reduction in resources since then. Case managers had a detailed knowledge of the children and young people they supervised. They produced good quality pre-sentence reports (PSRs) assessments and plans. There was scope for further improving the quality of work, mainly in relation to plans taking into account previous relevant behaviour and offending of the child or young person, their diversity needs and victims' safety issues. The YOS had undertaken a mini inspection based on our SQS methodology earlier in the year and had created an SQS Delivery Plan for 2013/2014, which was being implemented and will be amended based on the findings of this inspection.

Commentary on the inspection in Stoke-on-Trent:

Reducing the likelihood of reoffending

1.1. Most initial assessments of what was likely to make the child or young person offend were on time and of a good enough quality. Because children and young people's lives can change rapidly, we expect to see regular reviews of the work being done. In just over two-thirds of cases we looked at, this had been done well enough but leaving in historical information, which was not relevant to the period under review, was unhelpful.

1.2. In the 15 cases where a PSR had been requested, a high quality report was provided for the court in all but one case. Reports outlined all of the relevant information that the court needed to take into account and, where appropriate, offered intensive alternatives to a custodial sentence. Management oversight of the quality of reports was effective.

1.3. Following on from assessment, we expect to see a plan of work to help reduce the likelihood of reoffending. Just over half of the plans in the community were 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. More plans needed to contain objectives that were sequenced so that the case manager's thinking about what should be delivered and completed first were clear to all those involved in the case.

1.4. We would have liked to have seen more custodial plans reflecting the assessed needs of the child or young person and covering the whole sentence rather than being restricted to interventions that were available in the institution. In two custodial cases we found 'Post Custody Support Plans' prepared by the post-custody worker. One inspector commented that the plan "*detailed the support on offer both in custody and on licence and helped to promote the whole sentence approach so necessary for custodial sentences to have a chance to be effective. It was SMART and broken down in to sections and the language was understandable for the young person, with roles and responsibilities made clear and was pertinent to their particular needs*".

1.5. Overall, we found that case managers had a good understanding of what was likely to be effective in working with children and young people to help them stop offending and improve the quality of their lives.

2. Protecting the public

2.1. The PSR contained a clear and thorough assessment of whether the child or young person was likely to harm others in 13 out of 15 cases. There were good quality assessments of risk of serious harm to others at the start of supervision in 17 out of 20 cases. In one example we noted that a risk of harm assessment "*highlighted key events and behaviours and used this information to provide a realistic view of potential future behaviour*". Previous offences or behaviour were not always taken into account. In 16 cases where a review was required, 11 were good enough. Sometimes a review had not been undertaken when a significant change had taken place in a child or young person's life.

2.2. Where it was 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. We saw a mixed picture. A number of plans covered the main issues in the case and provided a strong contingency plan if the risk of serious harm increased. We would have liked to have seen more plans including contact names and telephone numbers of those involved. In just under one-third of the 16 relevant cases there had not been enough attention given to planning. For example, in three cases a plan had not been completed and one was not

timely. Plans did not sufficiently cover victims' issues and information sharing arrangements were unclear.

2.3. Half of the custodial plans were not good enough because the plan did not follow from the assessment or potential changes in risk of harm were not anticipated; although it was pleasing to see that there was a sufficient review, throughout the sentence, of plans to manage and reduce the risk of harm in the majority of cases. The policy of reviewing high risk of serious harm cases every month and discussions at the internal Management of Risk Forum (MORF) contributed to this finding. An inspector noted a case manager's thoughts about the MORF "*Specialist staff and police officers attended the meeting. The case manager thought the guidance from colleagues at the meeting was useful*". A number of staff were positive about MORF meetings, which they found supportive.

2.4. Where there was an identifiable victim or potential victim the risk of harm they faced was not effectively managed in four out of nine cases. This was mainly because the previous assessment and plans were insufficient. It was unclear in some cases where the victim lived in relation to the child or young person, whether it was likely they would meet or what the relationship was between them.

2.5. Managers were not effective in ensuring the quality of risk of harm work in half of the 14 relevant cases. This was mainly due to them countersigning either assessments or plans which contained important deficiencies that had not been addressed.

2.6. All staff understood local policies and procedures for the management of risk of harm, in particular the local Risk Management Strategy.

3. Protecting the child or young person

3.1. In 9 out of 14 PSRs there was a clear and thorough assessment of vulnerability and safeguarding needs. In the sample overall, all but four had sufficiently assessed safeguarding and vulnerability needs of the children and young people. The factors that detracted from these four cases were that the screening was of insufficient quality or, in custodial cases, the assessment was unclear about the risk that applied separately during the custodial and community parts of a sentence. We felt that, in some cases, vulnerability was not always recognised or was underestimated. Most cases had a sufficient review where required.

3.2. Sufficient planning was in place to address safeguarding and vulnerability in 9 out of 13 cases. Planning was insufficient in four cases either because potential changes in vulnerability were not anticipated or contingency arrangements, if vulnerability increased, were inadequate. In two out of five relevant custodial cases planning to address safeguarding and vulnerability throughout the custodial period was not good enough. In one case, there was information from the institution that clearly indicated the child or young person was vulnerable but this was not reflected in the plan. Some plans were not sufficiently individualised. In two cases, plans had been completed using a checklist, which we felt discouraged the use of professional judgement and the analytical skills of the case manager. In the majority of cases there had been a sufficient review of plans to address safeguarding and vulnerability.

3.3. In just under three-quarters of the relevant cases, management oversight was effective in ensuring the quality of work to address safeguarding and vulnerability. Deficiencies in management oversight were again related to the countersigning of assessments and plans that were not of good enough quality.

3.4. In our view, case managers had sufficient experience, knowledge and support to enable them to effectively address vulnerability issues in their work with children and young people.

4. Ensuring that the sentence is served

4.1. At the pre-sentence stage and at the start of supervision, attention was routinely being paid to assessing the child or young person's diverse needs and identifying issues that might get in the way of them engaging with the YOS. There was evidence of high levels of involvement of children and young people, and their parents/carers, in assessment and in planning for interventions.

4.2. We were pleased to find that all children and young people and their parents/carers had been involved in the development of the reports submitted to court.

4.3. However, in 12 out of 20 initial plans, not enough attention had been given to exploring what might get in the way of engagement with the YOS. For example, diversity factors such as being a Looked After Child, being a girl or young women or having a speech, language or communication need had not been addressed in the plan of work.

4.4. In all relevant cases we reviewed, sufficient attention had been given to the health and well-being of the child or young person.

4.5. Thirteen of the children and young people had complied with the requirements of their sentence. Some of the children and young people presented with complex issues and demonstrated challenging behaviour. We noted that, in a number of cases, case managers and other workers had used different methods to encourage compliance and maintain engagement. For those children and young people who had not complied with the requirements of their sentence, even after steps had been taken to address this, the response of the YOS was good enough in all except one case.

Operational management

We found that staff supervision and other quality assurance arrangements had made a positive difference in just over two-thirds of relevant cases inspected. Case managers, themselves, were confident in the abilities of their managers to both assess and improve the quality of their work. The majority of staff said they received appropriate and effective supervision. All staff thought management oversight was effective, although as outlined above we found this was not always the case. Most case managers thought their training, skills and development needs were addressed to do their job and for their future development. However, several case managers would have liked more training to develop their skills to deliver interventions and improve their ability to recognise the speech, language and communication needs of children and young people. Not all case managers were clear about the priorities of the organisation and how those priorities affected their role.

Key strengths

The best aspects of work that we found in Stoke-on-Trent included:

- Monthly reviews of assessments and plans for high risk of serious harm and vulnerability cases. In addition these cases were discussed regularly at MORF. This risk led approach meant that resources were appropriately targeted, there was management and specialist worker involvement in the case through MORF and the case manager was given support and guidance.
- Overall quality of PSRs provided to the court.
- There was a focus on protecting and safeguarding children and young people who were vulnerable or in crisis by facilitating engagement and actively monitoring their situation using

all the specialist skills of staff within the YOS, for example the police, mental health workers and others. In one case a child or young person was given a mobile phone so they could receive calls from the YOS and a sessional worker was employed to see them at weekends.

Areas requiring improvement

The most significant areas for improvement were:

i. Although initial assessments were usually thorough, in every case they included too much historical information. Case managers were often worried about taking this information out. However, for the assessment to be dynamic, they should contain only relevant information relating to the child or young person's current situation.

ii. Assessments and plans for the management of risk of harm should address the safety of any identified victims or potential victims.

iii. Assessments of risk of harm should take into account relevant previous behaviour and offences.

iv. Plans should note any diversity factors and barriers to engagement and describe how case managers and others will address them when delivering interventions.

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 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 Nigel Scarff. He can be contacted on 07766 422290 or by email at nigel.scarff@hmiprobation.gsi.gov.uk.

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