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To:	Chris Palmer, Chair of Solihull Youth Offending Service Management Board
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From:	Julie Fox, HM Assistant Chief Inspector
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Report of Short Quality Screening (SQS) of youth offending work in Solihull

This report outlines the findings of the recent SQS inspection, conducted from 24th-26th February 2014. 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 this inspection was to assess the quality and effectiveness of recent casework with children and young people who had offended. In order to do this, we examined 14 cases supervised by Solihull Youth Offending Service (YOS). Wherever possible this was 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 and committed staff group working hard to deliver services. We saw good engagement with children and young people and parents/carers, an understanding of the diversity issues they faced and the subsequent challenges they had to overcome. The YOS was undergoing a significant change programme that included a team restructure, a large proportion of relatively new managers and a staff group still adapting to changes in ways of working and new assessment tools. We saw some good assessments of risk of harm in pre-sentence reports (PSRs). However, the quality of planning concerning risk of harm and vulnerability had fallen since the last inspection in 2011 and needs to be improved. Management oversight in ensuring the quality of risk of harm, safeguarding and vulnerability work was not always effective.

Commentary on the inspection in Solihull

1. Reducing the likelihood of reoffending

1.1. We saw a timely and sufficient assessment of the likelihood of reoffending in a large majority of the cases inspected.

1.2. PSRs had been written in six cases. Four of these were of good quality and contained a thorough analysis of the reasons for offending. All six provided the courts with constructive alternatives to custody. Two, however, did not provide a sufficient assessment of vulnerability to the court.

1.3. Planning to reduce the likelihood of reoffending was sufficient in 10 out of the 14 relevant cases. Three of these related to custody cases and all of these were of sufficient quality. An inspector noted in one case there was a "*good detailed assessment of his health and mental health situation which informed the risk assessment and led to a well structured sentence plan*".

1.4. The assessment of the likelihood of reoffending was reviewed to a good standard in 10 out of 11 cases. In nine cases, plans to address the likelihood of reoffending were reviewed to a sufficient standard. In two cases, the planning review was not good enough.

2. Protecting the public

2.1. We were pleased to see a clear and thorough assessment of the risk of harm to others in all six of the cases where there had been a PSR. A good quality assessment of risk of harm to others was seen in 11 out of the 13 relevant cases. One assessment was not timely and one ignored relevant behaviour.

2.2. These assessments were adequately reviewed in 7 out of the 11 relevant cases. In three cases, reviews were of insufficient quality; in one case the review had not been undertaken.

2.3. The risk of harm to identifiable victims had been managed effectively in all but one of the eight relevant cases.

2.4. Planning to address the risk of harm to others had been done well in nearly half of the 12 relevant cases. Where it was not, in two cases a risk management plan had not been completed and, in four, the plans were of insufficient quality. In three cases, planned responses were unclear and four cases had contingency plans that were insufficient. Planning for work in custody was sufficient in one out of the three relevant cases.

2.5. We expect to see that managers identify and ensure that where work is not good enough it is remedied. While we saw evidence of management oversight in the great majority of cases, we found that in the quality of risk of harm work this was mostly ineffective. Despite management involvement with a case, deficiencies were rarely identified or acted upon.

2.6. Staff we interviewed were aware of local managing risk of harm to others policy and procedure, but there was evidence that this was not always applied in all cases.

3. Protecting the child or young person

3.1. The assessment of vulnerability and safeguarding was satisfactory in 10 out of 13 cases. Two vulnerability assessments had not been done and one was not timely. Two-thirds of PSRs contained a sufficient vulnerability assessment.

3.2. We saw good quality reviews of assessments in the vast majority of cases. Where they were not, one had not been done in response to significant change and the other was late.

3.3. Planning for work to address safeguarding and vulnerability was done well in 6 out of 13 cases. Two of the three custodial cases had sufficient plans. Two cases did not have, but needed, vulnerability management plans. In five cases, planned responses were insufficient. In four cases, the contingency planning was not of the required standard.

3.4. Plans were reviewed sufficiently in half of the cases where a review was required. In three cases the reviews were of insufficient quality; in one case the review was not undertaken when required.

3.5. We saw evidence of management oversight in most cases. However, this was effective in only one-third of the cases. Deficiencies in reviews of assessment and planning were not always identified and, consequently, we saw several cases where assessments and plans were not good enough.

3.6. The staff interviewed were aware of local procedures concerning vulnerability and safeguarding.

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. Twelve out of thirteen cases had good quality assessments of diversity and barriers to engagement. In one instance an inspector found that: "*The health assessment was top quality and captured all the relevant information. There was clear evidence of liaison with a variety of health professionals. The supervision regime was adjusted to facilitate compliance with the order and enable the young person to remain engaged and continue with the good progress they had made to date with offending behaviour work*". The staff were effective in engaging the children and young people, their parents/carers or significant others in carrying out assessments. In 10 out of the 13 relevant cases, health and well-being had been addressed sufficiently.

4.2. All six PSRs had good quality assessments of diversity and barriers to engagement.

4.3. The identification of diversity issues and the potential barriers to engagement were addressed well by staff and solutions were effectively built into plans. There was clear evidence of the involvement of the child or young person and their parent/carer in the planning process in all but one of the cases inspected.

4.4. We found well established and effectively used procedures to address non-compliance. In the eight cases where action was required, the YOS response was sufficient every time. Staff worked hard to engage children and young people and were successful at building good relationships with those they supervised.

Operational management

Three-quarters of staff felt that their manager had the skills to assess the quality of their work and actively supported them to improve the quality of their work. Half considered that management supervision was appropriate and effective. Countersigning and management oversight was felt to be effective by half of the staff group interviewed. Training and staff development needs were assessed as being satisfactorily addressed half of the time. The principles of effective practice were understood and evident in the work that we saw.

We judged that staff supervision or other quality assurance arrangements had made a positive difference in 4 out of the 14 cases inspected. While there was clear evidence of management oversight and accountability, it was not usually effective.

Key strengths

- Good quality risk of harm assessments in PSRs.
- High quality engagement with children and young people and parents/carers, and understanding of diversity issues.
- Established and effective approaches to achieving compliance.

Areas requiring improvement

- Improve the quality of risk management plans in order to protect the public.
- Improve the quality of vulnerability assessments and plans in order to protect the child or young person.
- A robust management oversight and quality assurance process that would ensure good quality assessment and planning.

We are grateful for the support that we received from staff in the Solihull 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 at Jonathan.nason@hmiprobation.gsi.gov.uk or on 07768 073286.

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