Inspection of Youth Offending Work
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To:	Charlotte Ramsden, Chair of Salford Youth Offending Service Management Board and Director of Children's Services
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From:	Alan MacDonald, Assistant Chief Inspector (Youth Justice)
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Report of Short Quality Screening (SQS) of youth offending work in Salford

The inspection was conducted from 29 February-02 March 2016 as part of our programme of inspection of youth offending work. This report is 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

The aim of the youth justice system is to prevent offending by children and young people. Good quality assessment and planning at the start of a sentence is critical to increasing the likelihood of positive outcomes. We examined 20 cases of children and young people who had recently offended and were supervised by Salford Youth Offending Service (YOS). Wherever possible, this was undertaken in conjunction with the allocated case manager, thereby offering a learning opportunity for staff.

Summary

The published reoffending rate[1] for Salford was 35.6%. This was better than the previous year and the England and Wales average of 38.0%.

Overall, we found that practice had improved since the last SQS in February 2013. The YOS had a group of committed case managers and specialist workers who demonstrated tenacity in their work with children and young people. There was a clear approach to compliance which enabled case managers to use discretion appropriately while satisfying the statutory requirements of each case. Staff worked hard to maximise the impact of their relationships with children and young people and their parents/carers. Management oversight arrangements had improved but were onerous and not consistently effective. The quality of assessment and management of all aspects of risk was variable and in need of further development and strengthening. Despite much good quality work, the YOS faced challenges in trying to impact on the entrenched offending behaviour and complex needs of many of the children and young people under their supervision. The YOS needed further support from a range of partner agencies in order to maximise the impact of their work.

[1] The reoffending rate that was available during the fieldwork was published January 2016, and was based on binary reoffending rates after 12 months for the April 2013 – March 2014 cohort. Source: Ministry of Justice

Commentary on the inspection in Salford:

1. Reducing reoffending

1.1. In just under half of the cases inspected, children and young people were less likely to reoffend than at the start of the sentence. Assessments of the reasons why children and young people had offended were of variable quality. Case managers had, for the most part, taken time to fully understand the reasons behind offending but this was not always accurately recorded.

1.2. Case managers were adept at working holistically with children and young people and we saw some evidence of plans being sequenced effectively. YOS staff demonstrated particular resilience in supporting children and young people to access education, training and employment and there were good lines of regular communication between the YOS and children and young people's education placements.

1.3. Planning for work to reduce the likelihood of reoffending was stronger in community rather than in custody cases. Plans of community cases were largely accessible to children and young people and there was evidence of them contributing to their plans. Plans from custody cases did not sufficiently address resettlement needs at an early enough stage and in most cases were too heavily weighted towards behaviour and activity in custody.

1.4. Just over half of reviews were carried out thoroughly and in a timely fashion. Not enough reviews were carried out when there was a significant change in the circumstances of the child or young person.

1.5. Staff across the YOS demonstrated a good understanding of the principles of effective practice and factors contributing to desistance.

2. Protecting the public

2.1. The sources of information that the YOS used in preparing pre-sentence reports was impressive and provided a wealth of information. This did lead, however, to some particularly lengthy reports. Although robust alternatives to custody were provided where relevant, the structure and language of many of the pre-sentence reports could better focus on these alternatives.

2.2. We expect to see a meaningful and detailed assessment of the risk of harm a child or young person presents to others. Not all the assessments that we saw achieved this, with too many demonstrating a limited understanding of risk of harm. We saw assessments of risk of harm and risk of reoffending based only on the nature of the offence, and that insufficiently considered the individual risk and protective factors of the child or young person. This resulted in some risk management planning that did not appropriately address the underlying issues.

2.3. Planning to manage the risk of harm to others should be based upon the careful assessment of risk of harm posed by the child or young person. While we saw this clear link in most cases, the limited assessments of risk of harm and risk of reoffending in some instances meant that the resulting plans did not always address the key risk factors. Plans were completed, for the most part, on time.

2.4. The personal circumstances of children and young people can change very quickly and purposeful case reviews need to take place in order to ensure that the risk of harm to others is managed effectively. Where reviews of risk of harm were insufficient this was because they either lacked analysis or did not include a review of the plan.

2.5. Management oversight was present in all cases. All assessments were countersigned and we were told, and saw evidence of all cases being discussed at every supervision meeting. This level of management oversight has led to some improvements in quality but has created too strong a focus on process rather than reflective practice.

3. Protecting the child or young person

3.1. Case managers understood the factors that made a child or young person vulnerable, and had made sufficient assessments of safeguarding and vulnerability in most cases.

3.2. We saw some good and detailed work being done by case managers to keep children and young people safe, and in some cases effective multi-agency work was evident. We saw evidence of YOS staff working with children's social care services to keep children and young people safe, but communication between the two organisations was not always good enough.

3.3. When children and young people are vulnerable, reviews are an important way of identifying changes and of adapting plans to respond to any new issues. When we interviewed staff they were able to tell us about changes and what they had done in response. This demonstrated a good awareness of what was happening to children and young people. There was a lack of formal reviews, however, in response to such changes and this meant that plans did not always reflect a child or young person's different circumstances.

4. Ensuring that the sentence is served

4.1. Ensuring that the sentence is served was a strong area of practice for the YOS. Case managers worked hard to secure compliance, and when enforcement action was necessary it was taken swiftly and appropriately. We saw evidence of case managers supporting children and young people to fully understand the requirements of their sentences and explaining the consequences of non-compliance to them. The YOS had achieved a good balance between working with the individual needs of children and young people at the same time as meeting its statutory duties in supervising court orders. There was an appropriate use of professional discretion.

4.2. Efforts were made at the start of the sentence to understand and identify how the individual needs of the child or young person may affect their engagement. This resulted in case managers adapting how they worked to suit communication difficulties and differing levels of maturity.

4.3. YOS staff had developed purposeful relationships with the children and young people they were working with. Most demonstrated a detailed knowledge of those they supervised and we saw evidence of creative approaches. For example, one Looked After Child (by the local authority) had multiple individuals working with him. The case manager provided photographs to the residential home so that they could produce a pictorial map to enable him to understand who each person was and how they could help him.

4.4. In most cases, engagement with parents/carers was excellent. Home visits were used regularly and effectively and we saw some creative ways of staff building relationships with parents/carers to reinforce the work of the YOS and to ultimately strengthen the family unit. There was evidence that this effective work was pivotal to achieving compliance in a number of cases.

Operational management

The staff that we interviewed had a good level of confidence in their management, received regular professional supervision and felt supported to access relevant training and develop their skills. Staff generally felt that their managers had the knowledge and skills necessary to support them in their work. Case managers were enthusiastic about the benefits of peer supervision and we saw some good examples of where this enhanced service delivery in individual cases. Management oversight had achieved a demonstrable improvement in the quality of practice in the YOS since our last inspection. The approach to management oversight had necessarily been an arduous and resource intensive one which was largely driven by process. The YOS would now benefit from a review of its management oversight arrangements in order to further develop practice.

Key strengths

- The YOS had tenacious and resilient case managers and specialist workers who had ambitions for the children and young people.
- Peer supervision was a useful opportunity for professional reflection, challenge and problem solving and added value to a number of cases.
- Good efforts were consistently made to engage and sustain relationships with parents/carers.
- Links with education placements were mostly strong and in a number of cases ensured a wrap around level of support that ensured placements could be sustained.

Areas requiring improvement

- The assessment and management of all aspects of risk needs to be further developed and strengthened.
- Management oversight should be streamlined and better targeted to develop the quality of assessment, planning and review.
- The length and focus of pre-sentence reports should be reviewed.
- More consistent communication with children's social care services at a case level needs to be achieved.

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 Helen Mercer. She can be contacted at helen.mercer@hmiprobation.gsi.gov.uk or on 07825 420104.

Copy to:

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Note 1: 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.

Note 2: We gather evidence against the SQS criteria, which are available on the HMI Probation website - http://www.justiceinspectorates.gov.uk/hmiprobation.

Note 3: To request a paper copy of this report, please contact HMI Probation Communications at communications@hmiprobation.gsi.gov.uk or on 0161 240 5336.