HM Inspectorate of Probation management oversight

Key principles for effective management oversight of cases

Introduction

Effective management oversight is much more than countersigning. It includes elements of quality assurance, staff supervision, dealing with developing areas of concern in individual cases and facilitating improvements in practice. It is particularly focused on ensuring that actual or potential victims and children or adult service users themselves are sufficiently protected from harm.

In particular, management oversight should focus on cases that have been assessed in YOTs as medium or higher risk of harm to others or as medium safety and wellbeing, and for adults as high or very high risk of harm to others. However, managers should also be aware of, and actively monitoring, those cases that, are not currently assessed at these levels of risk of harm or safety and wellbeing, but have the potential to increase.

This document outlines the principles of effective management oversight and provides examples of where management oversight would be considered sufficient and where it would be considered insufficient. The document should be read alongside the Case Assessment Rules and Guidance (CARaG) and the domain one Rules and Guidance (R&G) which can be found within the Documentation area of our website.

The importance of management oversight

Oversight of risk of harm and safety and wellbeing is different from regular staff supervision and the general oversight of practice; although it may sometimes be undertaken at the same time, and discussions in supervision may support identification of the need for management oversight.

Effective management oversight takes into account the unique demands of an individual case, and the skills, knowledge and experience of the case manager or responsible officer. A skilled manager, taking a fresh look at a case and exercising professional curiosity, can encourage practitioners to exercise respectful uncertainty and critical thinking, address any misplaced professional optimism and take a balanced and informed view of a case. This promotes defensible decision-making and enables the case manager or responsible officer to feel confident and supported to manage risk and identify appropriate interventions and responses.

Professional Curiosity

Professional curiosity is a term generally deployed in relation to the safeguarding of children and vulnerable adults, especially in the assessment and management of risk of serious harm.

Professional curiosity is defined by HMPPS as follows: *"being professionally curious is a process of always questioning and seeking verification for the information you are given rather than making assumptions or accepting things at face value"* (HMPPS, 2020).

Professional curiosity, from both practitioners and managers is an important part of effective management oversight. Questions to consider are:

- Has the case manager or responsible officer exercised sufficient professional curiosity?
- Has the line manager exercised sufficient professional curiosity?
- Has the presence/absence of professional curiosity impacted on the quality of work undertaken within the case?

Three categories of oversight

This document refers to three levels of management oversight; quality assurance of processes, management oversight through supervision and management oversight of immediate risk of harm and risk to safety and wellbeing.

Level 1 - quality assurance of processes

This is normally an audit-type exercise completed on most or all cases. It is usually undertaken to ensure that processes have been followed and action taken that is timely and in line with national standards, contractual requirements or local and national policies. For example, that allocation is undertaken according to the local policy or that assessment is timely.

This type of oversight in individual cases should be clearly recorded in the case record. This includes ensuring that an explanation is recorded as to why a particular action has been agreed and followed, and if not why not, along with reasons for any variance from national or local procedures where they exist.

Level 2 - management oversight through supervision

The Inspectorate considers that managers are accountable for ensuring the quality of work where they were, or should reasonably have been aware of the raised risk of harm or safety and wellbeing.

Oversight of risk of harm, safety and wellbeing is different from regular staff supervision and the general oversight of practice, although it may sometimes be undertaken at the same time, and discussions in supervision may support identification of the need for management oversight. In all cases, but particularly those of raised risk of harm and safety and wellbeing, supervision should be regular, purposeful, clearly recorded and contribute to the management of the case. It is important to acknowledge that the case manager or responsible officer's perception can sometimes be inconsistent with an inspector's view of the quality of supervision or management oversight.

To be considered sufficient, management oversight should assess the quality of practice, identify where there are deficits, ensure that remedial actions are identified, and confirm that required actions have been taken. However, the precise nature of confirmation may vary depending on the skills or experience of the practitioner. Simply asking for tasks to be undertaken, without ensuring they have been done, is not enough.

In order to provide effective management oversight, managers should themselves have sufficient underpinning knowledge about risk of harm, safeguarding and safety and wellbeing; understand the assessment, planning and management processes, be able to recognise indicators of raised risk of harm and safety and wellbeing and be able to distinguish both good and insufficient practice.

Management oversight through supervision should enable both supervisor and supervisee to reflect on, scrutinise and evaluate the work being undertaken and assess the strengths and weaknesses of the practice and interventions being carried out with the child or service user. For this reason, those providing supervision should be trained in supervision skills and have current knowledge of the legislation, policy and research relevant to YOS or probation practice. The practitioner should also have the insight as to when to bring matters to the attention of their own line manager.

Level 3 - management oversight of immediate risk

This level of management oversight applies where there is an immediate risk of harm of immediate safeguarding issues.

Managers should be able to respond and be clearly involved, in supporting their staff to make defensible decisions and prioritise those cases of the most immediate risk of harm and safeguarding concerns. This ensures that risk management becomes a shared organisational responsibility, rather than the sole responsibility of the individual staff member.

Managers should ensure that there are systems in place for them to identify cases with raised risk of harm and safeguarding. These systems should include ensuring that all staff are aware and clear about their responsibility to raise these cases with their manager. If information systems could reasonably have identified to the manager the need to provide oversight, then lack of referral to the manager is not sufficient to excuse the gap in oversight.

Examples to illustrate where information systems may be helpful include: information from the police regarding arrests, charges and call outs (for example, for domestic violence), monitoring of any further appearances in court for new offences, monitoring cases where indicators of raised risk of harm or safeguarding have been identified in the initial screening, and identifying cases where the classification of risk of harm or safety and wellbeing would, under current guidance, require formal management involvement.

Managers should assure themselves that:

- the risk of harm is managed in such a way that actual or potential victims are protected
- as a minimum, assessment and planning is effective and appropriate to the needs of the case
- work undertaken is timely, undertaken as planned and responsive to changing circumstances
- escalation or other action is taken as appropriate to ensure that required services are delivered.

In general, a lack of immediate action in cases where there is a new, immediate risk of harm to others, or a new immediate safeguarding risk, this is likely to indicate that management oversight was not effective in that case.

Evidence of management oversight

In domain one, evidence from inspected cases, structured meetings with staff and managers, reading of the inspected organisation's evidence in advance including key policies, guidance and frameworks, and information obtained from case manager or responsible officer interviews, should triangulate to allow overall judgements to be made on the quality and effectiveness of management oversight within domain one.

In domains two and three, insufficient assessment and planning for cases where there is a recognised raised risk of harm to others, or raised safety and wellbeing risks, is likely to indicate that management oversight was not effective in that case. Similarly, where there is evidence of insufficient action to address gaps in provision of relevant services, or where the deficits have not been addressed in a timely manner, this is likely to lead to a negative judgement on the quality of management oversight.

Evidence of management oversight in individual cases may be gathered a number of places including:

- in the case management system/records (for example, NDelius, CareDirector, CorePlus)
- countersigned documents (PSRs, OASys, Asset plus, MAPPA referrals)
- within minutes of meetings (for example: MAPPA, CP, s47 Strategy meetings, oral hearings etc)
- discussions with the case manager/responsible officer
- audit documentation attached to case records
- assessments and plans being rolled back and improved
- evidence of case discussions between the line manager and the case manager
- records of direct observation of work
- communications (emails, phone calls, letters etc) between the manager and other agencies involved in the case.

Inspectors will judge whether the overall quality of management oversight meets the needs of the case. Inspectors need to take into account the available evidence and weigh up whether the strengths outweigh the deficiencies. We are not looking for perfection, but for a sufficient level of management oversight; particularly in cases where there are indicators of a raised risk of harm to others, safeguarding or safety and wellbeing.

Where there are deficits, inspectors will consider their impact in the context of the case. So, in some circumstances a particular omission may be enough to lend a judgement of insufficient. For example, there may be evidence of brief management entries on the case record, but overall quality assurance and countersigning was not sufficiently defensible.

Summary

Whichever level management oversight is at, the quality of assurance of process, supervisory oversight or the management of immediate risk, effective management oversight should produce sufficient assurance in relevant cases that all that should be done is being done.

The key questions for inspectors of management oversight across all three levels are:

- Is there sufficient evidence of management oversight?
- Was management oversight effective?
- Did management oversight make a difference to the quality of work undertaken in the case?

Case examples

Case example one

The inspector found that:

> *"Management oversight was consistently evident throughout the case record. This was in the form of monthly case supervision discussions and updates, within swift QA and feedback activity (including follow-up where the AssetPlus had been rejected for further amendments). This was a high risk and highly vulnerable child being supervised by the YOT, but there was a shared responsibility across a number of manager oversight meetings. The child was managed within an additional risk management panel process, with copies of minutes and actions on the case record. Management oversight and guidance was also delivered to the specific specialist workers who were supporting the child, again evidenced in the contact log. Actions were set and followed up to reduce drift. In addition, the case manager was complimentary about level of management oversight and support, citing a supportive culture which challenges practice appropriately".*

This case demonstrates 'sufficient' management oversight. There is because there is consistent evidence throughout the case record, which contains oversight entries, case supervision discussions and evidence of impact from swift QA (including follow-up to improve the quality of the work) Risk management policies and procedures were followed, and the manager advocated within multi-agency processes.

Case example two

The inspector found that:

> *"The AssetPlus assessment is quality assured by the senior practitioner at the initial assessment stage, but there are deficits in the quality of information and subsequent countersignature of an insufficient assessment and plan. However, as the case progresses, there is very regular management oversight and commitment from the manager, who made telephone calls and held meetings with other agencies, to advocate in response to the case being escalated and successfully remove barriers. I am assured by the case worker in interview that the appropriate discussions have taken place with managers, and there are sufficient mechanisms in place (Risk Panel, Review meeting, MACE meeting) to manage the risks. There is partial evidence of this on the case record, although there is a detailed review assessment, which captures the raised risk of harm and safeguarding issues. This assessment is well-informed, countersigned and contains clear managerial feedback given through the quality assurance process".*

This case demonstrates 'sufficient' management oversight. This is because the initial shortfalls in QA are later outweighed by the activity and oversight from the manager. This includes, advocacy to remove barriers and involvement within risk management arenas. The

impact is that risk management practice improves, with better quality assessment and planning, clear feedback and more robust quality assurance.

Case example three

The inspector found that:

> *"This case is assessed as high risk at PSR stage, however there is a three-month delay in completion of the assessment following sentence. When it is completed, there is no management countersignature for four months after that. The assessment was countersigned with a number of significant deficits. Risk of Harm to others was underestimated, key information from other agencies was not included and there was confusion around classifications relating to risk of harm and safety and wellbeing. The management oversight entries are threadbare with no content. They fail to identify key omissions in the management of the case. When this was discussed with the case manager his response was to pass full responsibility to the line manager, with minimal acceptance of his own role as a practitioner. He expressed a view that, within the organisation, there is no room for reflective practice and a lack of clinical supervision for these types of cases".*

This case demonstrates 'insufficient' management oversight. There is because there is an absence of management scrutiny of both process and the quality of practice, which is poor. Limited entries are contained on the case management system and there is no support, supervision or guidance for the case manager (who himself shows insufficient responsibility in relation to his own role and lacks insight into the actions required to effectively manage raised risk of harm and safety and wellbeing.

Case example four

The inspector found that:

> *"Overall the management comment is frequent and evident within the case record, but it is superficial and mainly a general discussion, rather than an analysis of the risk factors. However, the case manager's assessment of safety and wellbeing is underestimated, and this is not picked up (or remedied) by the manager who quality assures the assessment. The case manager advises that the case has been discussed in formal supervision with her line manager. This leads to a review being completed and the case is correctly re-assessed as high risk of harm. However, there is a delay in QA and countersignature and thereafter, no formal no risk management meeting (as per local policy) takes place and the case ends up drifting. The practitioner explained that because she is experienced, her manager usually adopts a 'light touch' approach and that she was happy with the management oversight".*

This case demonstrates 'insufficient' management oversight. This is because, although there is evidence of management 'footprint' within the case record, it is not of sufficient quality. The initial assessment is countersigned with deficits and shortfalls are not addressed through the initial QA process. There is evidence of formal supervision, which leads to an updated review assessment. However, the subsequent delay in QA and countersignature, coupled with a lack of action or follow-up to adhere to local risk management policy/guidance, causes drift in the case. Application of professional curiosity from the line manager is inconsistent, both within the case inspected and as part of the broader supervision of the case manager.