Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

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John Long
Chair of Management Board
Bristol Youth Offending Team

9th January 2013

Dear John Long,

Report of Short Quality Screening (SQS) of youth offending work in Bristol

This report outlines the findings of the recent SQS inspection, conducted during 3rd - 5th December 2012. 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 Ofsted 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 33 recent cases supervised by the Youth Offending Team. 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

Bristol YOT was committed to continually improving the quality of its work. A recent self-assessment showed that it was able to critically and effectively review its practice. Case managers engaged well with the children and young people with whom they worked, and recognised what was required to reduce their likelihood of reoffending. However, significant improvement was needed to assessment and planning for work to protect others from harm and to reduce the vulnerability of children and young people. In particular, oversight of this work by immediate line managers was not effective in ensuring the quality of practice.

Commentary on the inspection in Bristol:

1. Reducing the likelihood of reoffending

1.1. The sentencing court made use of a full pre-sentence report (PSR) in about two-thirds of cases. Almost three-quarters of PSRs were good enough; giving the court valuable information about the circumstances of the child or young person to inform the sentence.

In one-quarter of PSRs the assessment of risk of harm to others was insufficient, and assessment of vulnerability often focused too narrowly on risk of self-harm.

1.2. More than three-quarters of initial assessments of the likelihood of reoffending were good enough. The understanding gained through these assessments formed a solid basis on which planning for work to address offending behaviour could be undertaken. The most common area for improvement was that offending-related vulnerability, such as learning or behavioural difficulties, had not been recognised. More broadly, the link between evidence and conclusions in individual sections of the assessment could often be clearer; and the clarity was sometimes confused by too much historical information being left in as a chronology rather than brought together into a clear and current summary.

1.3. Just over one-third of assessments had not been reviewed as required. The need for this was sometimes not recognised following a significant change, including after sentence in appropriate cases. Also assessments recorded as a review were too often largely, or sometimes entirely, a copy of a previous assessment with insufficient updating.

1.4. All except four cases included an initial plan for work to address the likelihood of reoffending that linked appropriately to the outcomes from the assessment. However, in almost half of the relevant cases there had been insufficient review of the plan. The most significant learning points for plans are that they should clearly communicate the sequence in which interventions would be delivered, and objectives should be more precise about the outcomes that are sought and the methods to achieve that.

2. Protecting the public

2.1. Oversight, by immediate line managers, of work to manage the risk of harm to others was sufficient in only 4 out of the 21 cases where this was required. In most cases deficiencies in assessment and/or planning had not been identified and addressed, with managers countersigning work that was not good enough. Sometimes, managers had not become actively involved, even though information available to the YOT (for example, type of offence) should have identified the need for this. Some assessments and plans had not been countersigned. Our expectation is that management oversight actively focuses on ensuring the underlying quality of practice.

2.2. Assessment of risk of harm to others was good enough in just over half of the cases, providing a robust basis for work to manage and seek to reduce this. In most of the assessments that were insufficient the initial screening did not identify all the relevant indicators (including from previous offences and other relevant behaviour) that existed in the case, sometimes because the importance of bringing the information together before making the assessment was not recognised. Therefore, the requirement for a full assessment of risk of harm to others was also not always recognised.

2.3. Only one-third of relevant cases then included sufficient planning to manage the risk of harm to others. In many cases the main problem was that the importance of specific planning had not been identified during the assessment. In others, the planning was not sufficiently timely. The needs of victims were not always recognised sufficiently in both assessments and plans. In some custodial cases there was insufficient consideration of early work that could be undertaken in preparation for release.

2.4. Plans to manage risk of harm to others often did not provide a clear, concise and accessible picture to others of the actions required to manage risk of harm; how and when they would be undertaken; how joint work with others would be managed; and the contingency if circumstances were to change.

2.5. As the inspection progressed we were pleased to see some revised assessments and plans for work to manage risk of harm that indicated that staff could produce these to good quality once they were clear what that was, and were expected to achieve it.

3. Protecting the child or young person

3.1. Very similar themes applied to assessment and planning for work to protect the child or young person and to reduce their vulnerability, as are described in the section above; although the effectiveness of management oversight was very slightly better.

3.2. There was sufficient assessment of the child or young person's vulnerability in just over half of the cases. The most common concern was that the understanding of vulnerability was too narrow – its focus being limited to child protection concerns and risk of self-harm.

3.3. The significance of broader vulnerability factors such as living arrangements, reckless behaviour, lifestyle, substance misuse and the needs of children and young people who are looked after were often not recognised and brought together into a robust assessment. The significance of changes to these factors, such as a child or young person being evicted by their parents/carers or moving locality, was not always recognised and did not lead to a review.

3.4. One-third of case managers with whom this was discussed were not able to clearly explain the YOTs approach to the management of vulnerability.

3.5. These problems had a knock-on effect on the quality of plans to manage and reduce vulnerability, half of which were not good enough. The main reasons for this have been explained in the previous paragraphs and in the section on work to protect the public, including custodial cases which needed early planning to reduce vulnerability on release.

3.6. Conversely, we found a small number of cases where the multi-agency work to protect the child or young person and reduce their vulnerability was very good, and similarly for work to protect others. In general, multi-agency work undertaken in Bristol was strong.

4. Ensuring that the sentence is served

4.1. Work to ensure that the sentence was served as the court intended it, and work to maximise the likelihood of positive outcomes through effective engagement with children and young people and parents/carers, were both very good.

4.2. Assessment of diversity factors and barriers to engagement was sufficient in almost all cases. Children and young people, their parents/carers and significant others had been sufficiently involved in the assessment in all except two cases, and in the development of PSRs. In combination these created a solid basis for ownership by children and young people of the work that would be undertaken by the YOT.

4.3. Planning gave sufficient attention to the outcomes from these assessments in the great majority of cases. However, the understanding gained from the assessments, including of relevant diversity factors, was not always clearly recorded in the plan, thereby reducing the likelihood that other workers who might become involved in the case would be aware of, and could act on, these things. In some cases, identified speech, language or communication difficulties, or the particular needs of children and young people who were looked after were not reflected in the planning.

4.4. Children and young people and their parents/carers were sufficiently involved in the planning in over three-quarters of cases. There were a small number of cases where their views were not appropriately reflected in the plan. In general, plans were not written in language that made clear to the child or young person what they were expected to achieve and the actions planned to achieve that, thereby limiting the opportunity for them to own their plan and for their parents/carers to support the work.

4.5. Case managers gave sufficient attention to health and well-being factors, particularly insofar as they may act as a barrier to successful outcomes, in almost all cases.

4.6. The actions taken by the YOT to enforce the sentence or support compliance were appropriate in all cases where the child or young person had not fully complied, and over half of these children and young people had then gone on to comply.

Operational management

Case managers were generally positive about their managers, the quality of supervision that they received and the training available to them. However, when supervision methods were examined more closely it was clear that most would welcome more opportunities to reflect on the *quality* of their practice. Staff said that supervision of casework often focused on caseloads, and whether tasks were completed, with little review of practice. Staff considered that the YOT had a positive approach to learning and development, and fully engaged them in understanding its priorities.

Areas requiring improvement

The most significant areas for improvement were:

i. Management oversight should ensure the quality of practice, in particular for work to protect the public and to reduce the vulnerability of children and young people.

ii. The quality of assessment and planning, including at reviews, for work to protect the public and to reduce the vulnerability of children and young people needs to be improved.

iii. Work to reduce the vulnerability of children and young people needs to recognise and respond to the breadth of vulnerability factors, in addition to child protection and risks of self-harm.

iv. Plans should be produced in language and a format that is outcome-focused and makes clear to children and young people what they are expected to achieve, and their role in doing so.

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 YOT 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 Ian Menary. He can be contacted on 07917 183197 or by email at ian.menary@hmiprobation.gsi.gov.uk.

Yours sincerely,

Julie Fox
HM Assistant Chief Inspector of Probation

Copy to:
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James Clynch, Business Area Manager YJB
YJB link staff with HMI Probation
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