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 Cheshire East

This report outlines the findings of the recent SQS inspection, conducted during 3rd-5th June 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 Cheshire East Youth Offending Service (YOS). 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

Although the structure of Cheshire East YOS was relatively new, following its disaggregation from Cheshire West and Chester Council in 2012, we found an enthusiastic team of managers and staff working closely with their colleagues in children's social care services and other partners. Overall, we found a high standard of service being delivered, with case managers having a detailed knowledge of the children and young people they supervised, offering them both support and challenge where appropriate.

Commentary on the inspection in East Cheshire:

1. Reducing the likelihood of reoffending

1.1. In all but one case, we found timely and sufficient assessment of the factors associated with why the child or young person had committed the offence.

1.2. In the 11 cases where a new pre-sentence report (PSR) had been requested, a high quality report was provided for the court in all but two cases. Management oversight of the quality of reports was effective. In cases where a report had not been requested, there was evidence of the YOS providing information in the form of breach reports or verbal updates.

1.3. Following on from assessments we expect to see a plan of work to help reduce the likelihood of reoffending. These were in place and of good quality in the vast majority of cases. The YOS had introduced an intervention planning form, *My Change Plan, w*ritten jointly by the case manager and the child or young person. This was an excellent initiative to get children and young people to recognise and take ownership of the work they needed to do to stop reoffending.

1.4. In almost all cases the assessment and plan to reduce the likelihood of reoffending had been appropriately reviewed, taking into account changes in the child or young person's circumstances. *My Change Plan* was also used when reviewing plans to enable the child or young person to see what progress had been made and what work still needed to be done.

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. There was a sufficient assessment of the risk of harm to others posed by the child or young person in all but four of the cases we inspected. Comments from inspectors included "*There was evidence of good communication with specialist staff and other agencies in making assessments"* and "*Assessments of risk of harm outlined the issues in relation to young people's risky behaviour and demonstrated good practice".* In the four cases that we judged not good enough, we found that the initial screening was not of a sufficient quality.

2.2. The vast majority of PSRs contained a clear and thorough assessment of the risk of harm to others.

2.3. The risk of harm a child or young person poses to others often changes; it can be reduced as well as heightened. There are certain significant changes that are associated with an increase in risk of harm, for example increased substance misuse or reoffending. As lives change it is useful to review these issues. In Cheshire East, reviews of risk of harm were, in all cases, done on time, and in all but three relevant cases completed to a high standard.

2.4. There was sufficient planning to address issues of the risk of harm to others in 13 out of the 15 relevant cases. We saw positive examples of joint working in complex cases where children and young people had mental health, learning disabilities and accommodation needs. In the two cases judged to be insufficient we found that the plans either did not contain the required intervention or did not follow on from the assessment.

2.5. In all but one case, plans to address the risk of harm to others had been reviewed sufficiently well. Intervention plans were, in the vast majority of cases, clearly linked to the risk management plan. As a result, the interventions delivered had the desired outcome of reducing risk of harm, and reviews also clearly recorded progress made.

2.6. Where there was an identifiable victim or potential victim, the risk of harm they faced had been effectively managed in almost all cases. In many cases we found that the victim or

potential victim was related to the child or young person. The YOS had made good use of local multi-agency risk assessment conferences in the management of these cases.

2.7. There was effective management oversight in all but one relevant case. The YOS had a robust quality assurance process which was clearly understood and valued by case managers. All staff understood local policies and procedures for the management of risk of harm and how this would be undertaken in partnership, where necessary.

3. Protecting the child or young person

3.1. In the majority of cases, vulnerability and safeguarding needs were sufficiently assessed, and these aspects were fully covered in all but three PSRs examined. In four cases, where we judged the initial assessment of vulnerability and safeguarding to be insufficient, this was because of the quality or timeliness of the screening and assessment. The precise nature of the vulnerability was not always clear, or we judged that the vulnerability classification was inaccurate.

3.2. Reviews of safeguarding and vulnerability throughout the sentence were of a similar standard to the initial assessments. In three cases we judged the review to be insufficient; this was because it was either not timely or not of sufficient quality.

3.3. Planning to address vulnerability and safeguarding issues was of a good standard in all but one of the five custody cases and two of the community cases.

3.4. Reviews of plans to address safeguarding and vulnerability issues had been undertaken to a good standard in all but three relevant cases. All three cases were found to be of insufficient standard because they had not been reviewed as required.

3.5. We found that management oversight of vulnerability and safeguarding was effective in all relevant cases. As with the management of risk of harm, the YOS had a good quality assurance process in place. All staff understood local policies and procedures for the management of safeguarding issues. There was good liaison with children's social care services and other partner agencies in almost all cases.

3.6. The YOS was supervising a number of Looked After Children placed in their area by other local authorities. We saw some excellent examples of the case managers employing an investigative approach in order to gain information about the child or young person, to help understand their needs and put in place plans that would better safeguard them. Unfortunately, we also saw some cases where the external local authority placing the child or young person in Cheshire East, did not appear to have fulfilled their full responsibility to that individual. In one case a vulnerable 17 year old, placed in Cheshire East by a neighbouring authority, was not receiving appropriate support from his home area. The YOS escalated concerns appropriately to the home YOT and within their own children's social care services department. The Independent Reviewing Officer then escalated the concerns to the child or young person's home area children's social care service. At the time of the inspection the matter had still not been resolved. The YOS also had the option to escalate the matter to the YJB.

4. Ensuring that the sentence is served

4.1. High quality assessments of diversity factors and barriers to engagement were undertaken in all cases that had an initial assessment. Effective use had been made of a speech and language therapist, who provided guidance to the YOS managers and case managers about how best to engage with the child or young person. As a result, the YOS had some excellent working methods and tools to use with children and young people with a wide range of diversity needs.

4.2. We found a strong culture in the YOS of engaging well with the child or young person and their parents/carers to inform the initial assessment. This was evident in all but one of the PSRs written, and nearly all the cases inspected.

4.3. There was evidence of excellent involvement of the child or young person and their parents/carers in the assessment and planning of interventions. Case managers often arranged text reminders to the child or young person or worked with parents/carers to ensure that their child or young person got the most out of their work with the YOS and complied with their order. This resulted in good compliance in the majority of cases inspected.

4.4. Where there were issues connected to the health and well-being of the child or young person, case managers were able to identify these and include them in the plans. A wide range of partner agencies, both in and outside the YOS, worked actively with case managers to improve the health and well-being of those they supervised. These included the forensic learning disabilities team, substance misuse agencies and youth services. One inspector commented "*A significant strength of the YOS is its co-ordinated approach to working with the young person on issues relating to their emotional well-being and family/lifestyle issues that may have a significant part to play in the likelihood of further offending*".

4.5. Overall, we found that good use was made of multi-agency working both within the YOS and in the wider children and young people's service. Effective practice emphasises the importance of the quality of the relationship between the case manager and the child or young person. Developing this working relationship takes time but positive change is more likely. There was clear evidence of positive outcomes for children and young people as the result of multi-agency working and the use of effective practice delivered by professionally qualified workers across the YOS.

4.6. Cheshire East YOS and Cheshire Probation Trust had developed a transitions project (*Project-17*) to support the successful transition of young people from youth justice to adult probation supervision. During the inspection we saw some excellent examples of joint working between YOS case managers and probation officers, with young people between the ages of 17 and 21, which helped them move successfully to the adult criminal justice system.

Operational management

We found that case supervision, direct observation of practice and other quality assurance measures had made a positive contribution in all relevant cases inspected. Case managers themselves were confident in the abilities of their managers to both assess and help to improve the quality of their work. All said that they received appropriate supervision and thought that management oversight was effective. All believed that Cheshire East YOS had a culture that actively promoted learning and development. They were all clear about organisational priorities, and this was supported by the evidence we saw.

Since the disaggregation of the YOS from Cheshire West and Chester Council, the interim Management Board had ensured that the YOS remained a multi-agency service, within the Early Interventions and Prevention structure. In our view, employing qualified staff from all partner agencies had contributed to the high quality of service and successful outcomes we saw during this inspection.

Key strengths

The best aspects of work that we found in Cheshire East YOS included:

- The use of an investigative approach when undertaking assessments, ensuring that information was checked thoroughly and acted upon. An example included the case of a young person who had moved to Crewe from Manchester. The case manager undertook a thorough investigation looking at all records and past reports, including those from childrens services, the young offender institution, police and the home YOS. This gave her a clear overview of all the issues. She then referred her findings to Cheshire East Children's Services who carried out their own investigation, leading to a case conference and child protection proceedings.
- The YOS managers ensured that the case managers had the right tools to engage with the child or young person and help them successfully complete their sentence. This included the *My Change Plan* and *Project-17*, as well as a wide range of partnership agencies actively involved with the children and young people throughout their order.
- All YOS staff worked hard to help children and young people comply with their court orders. They were particularly good at building relationships with the child or young person and undertaking home visits to help understand issues thoroughly.

Area requiring improvement

The most significant area for improvement was:

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

We strongly recommend that you focus your post-inspection improvement work on this particular aspect 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 Les Smith. He can be contacted on 07798 607828 or by email at les.smith@hmiprobation.gsi.gov.uk.

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