HM Inspectorate of Probation
Arolygiaeth Prawf EM

Inspection of Youth Offending Work
Arolygiad o Waith Troseddu Ieuenctid

Full Joint Reinspection of Youth Offending Work in **Portsmouth**

An inspection led by HMI Probation

independent inspection of youth offending work

August 2015

Foreword

This inspection of youth offending work in Portsmouth is one of a small number of full joint inspections that we are undertaking annually with colleagues from the criminal justice, social care, health and learning and skills inspectorates.

The inspection in Portsmouth was a reinspection given that performance had shown poor outcomes for children and young people in 2013.

The number of children and young people entering the youth justice system in Portsmouth had continued to rise. Custody rates had fallen. The published reoffending rate[1] for children and young people in Portsmouth at the time of inspection was 45.6%. This remained worse than the average performance for England and Wales (36.6%) but showed an improvement on previous reoffending rates.

We found that over the past 18 months Portsmouth YOT and its partners had worked hard to raise performance standards. The improvements achieved were significant and in every criterion that was inspected, progress had been made. The YOT Management Board had set an ambitious improvement plan following the last inspection and this had required the full engagement of YOT staff and stakeholders. All had effectively risen to the challenge. The resilience shown was impressive and the platform for achieving better outcomes for children and young people had been laid.

The recommendations made in this report are intended to assist Portsmouth in its continuing improvement by focusing on specific key areas.

Paul Wilson CBE
HM Chief Inspector of Probation

August 2015

1 Published April 2015 based on binary reoffending rates after 12 months for the July 2012 - June 2013 cohort. Source: Ministry of Justice.

Key judgements

Summary

Reducing reoffending

Work to reduce reoffending was satisfactory. Case managers provided relevant information to the courts, assessments demonstrated that they understood the reasons why children and young people offended and the frequency and seriousness of offending had decreased. Planning for work to support desistance was inconsistent and some education and training programmes were under-utilised.

Protecting the public

Work to protect the public and actual or potential victims was satisfactory. Multi-agency arrangements were largely effective in the management of risk of harm work. The sharing of intelligence between the YOT police officer and case managers was progressive. Required interventions were often not delivered and health services were not systematically considered in the assessment of risk of harm.

Protecting children and young people

Work to protect children and young people and reduce their vulnerability was good. Assessments and reviews were done well. Relationships with children's social care services and the YOT were much improved. Work with health issues was not yet embedded but was progressing. Management oversight had improved and interventions to manage assessed needs were mainly being delivered well.

Ensuring that the sentence is served

Work to ensure that the sentence was served was good. The YOT and its partners worked effectively to achieve positive outcomes for children and young people. Enforcement was managed well. Children and young people and their parents/carers were not always actively involved in planning work to reduce reoffending. Case managers gave good attention to addressing barriers that were affecting progress.

Governance and partnerships

The effectiveness of governance and partnership arrangements was satisfactory. The YOT Management Board had acted decisively to address the findings of the joint inspection in 2013. Performance data was being used to inform service delivery. Child sexual exploitation did not appear as a regular item on the Board's agenda although the YOT was represented on both Portsmouth Safeguarding Children's Board and operational child sexual exploitation forums. Police analysis of crime data was not systematically presented to the Board. YOT representation at crucial forums was good and quality assurance systems had had an impact on improving services.

Interventions to reduce reoffending

The management and delivery of interventions to reduce reoffending was satisfactory. The variety of reparation activities was not always meaningful to children and young people. Outcomes were not fully measured. The Civic Centre setting for the delivery of some interventions was problematic. The 'triage' arrangements to determine interventions showed promise. One-to-one delivery of supervision with children and young people was impressive.

Recommendations

Post-inspection improvement work should focus particularly on achieving the following outcomes within 12 months following publication of this report:

1. The YOT should ensure that planning for work to reduce reoffending is effective and children and young people and parents/carers have a greater input into these plans. (YOT manager)
2. Attention should be given to increase the numbers of children and young people attending and engaging in education, training and employment. (Chair of the YOT Management Board/YOT manager)
3. Child sexual exploitation should be covered as a standing item on the YOT Management Board agenda. (Chair of the YOT Management Board)
4. Health services should be integrated into assessments, planning, reviews and service delivery. (YOT manager)
5. Reparation activities should be meaningful to children and young people; the effectiveness of interventions should be measured and suitable alternative settings to the Civic Centre to deliver interventions should be considered. (YOT manager)

Please note – throughout this report all names referred to in the practice examples have been amended to protect the individual's identity.

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Reducing reoffending

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Theme 1: Reducing reoffending

What we expect to see

As the purpose of the youth justice system is to prevent offending by children and young people we expect youth justice partners to increase the likelihood of successful outcomes by undertaking good quality assessment and planning, deliver appropriate interventions and demonstrate both positive leadership and effective management.

Case assessment score

Within the case assessment, overall 70% of work to reduce reoffending was done well enough.

Key Findings

1. The vast majority of pre-sentence reports (PSRs) submitted to courts provided relevant information to support sentencing proposals.
2. Assessments and reviews were done well but planning for work to reduce reoffending was done less well.
3. Work undertaken to reduce reoffending was carried out well.
4. Case managers provided some support to children and young people to maximise school and college attendance.
5. Portsmouth Craft and Manufacturing Industries (PCMI) programmes had been under-utilised by the YOT.
6. The frequency and seriousness of offending had decreased.

Explanation of findings

1. It was clear that case managers had a good grasp of the reasons why children and young people had offended. We saw evidence of creative working to better understand these reasons. The standard of reports to the courts was generally good although some reports were not always concise and analytical. On some occasions key information around vulnerability and risk of harm had been left out.
2. Formal health assessments and referrals were inconsistent and not all case managers fully understood the role of health practitioners. Here, we found that there was an absence of joint working in the preparation of work that would impact on offending behaviour.
3. The reviewing of assessments throughout the sentence was good. We were particularly pleased to find that reviews had also been undertaken following a significant change in circumstances. We consider this to be good practice. Planning for work to reduce reoffending was done less well and during the custodial phase there were several cases where plans had not been produced. When planning was done well it was highly effective. In these instances, the case manager had used a forensic approach in identifying the root causes of the offending behaviour before agreeing the actions that needed to be taken. These were specific and achievable with realistic timescales. In one particular case, we found evidence of how a case manager had inherited a chaotic case and had worked effectively to reduce reoffending.

Example of notable practice

The case manager had inherited the case of a chaotic young person. The previous case manager had exercised little authority and the young person was 'managing' the order. While progress had been slow, the current case manager had re-engaged the young person by appropriately challenging him, agreeing a plan and placing a greater onus on him to take responsibility. The outcomes achieved were impressive: no offending for six months; good preparation to support a college placement; now engaging with the substance misuse worker; motivational work being undertaken; fewer breaches[2] (only one in six months); compliance with curfew; increased confidence and reparation work was completed.

4. The resources and materials available in the community for work to reduce reoffending were of good quality. In case files, we saw several examples of exercises which had enabled children and young people to make better choices. In particular, case managers were skilled in reinforcing positive factors which supported desistance. We saw examples of 'road maps' which plotted the offending journey of children and young people. These pictorial images were then used as a tool to determine the type of interventions that would affect change.

Quotes from children and young people

"She [YOT worker] told me about a visit I could do to Winchester prison where you get to speak to certain prisoners… Some were murderers and some had been letting drugs into the port… And yes, I did go on the visit, it was alright. You get to hear from the prisoners first hand, and get to ask them about what they'd done and how they felt about prison… It does make you think, I wouldn't want to go there. It's wasting your life. Personally I'd rather go in the Army. If you're in prison rotting away you may as well do something worthwhile."

"Basically they just kept me positive. They told me to get a job and advised me that I needed not to offend… I'm never gonna offend again but the YOT helped me to keep that attitude. They kept telling me how well I was doing. No one had said that to me before. My dad was in prison for years and I don't want to end up like that."

Example of notable practice

Connor was a complex young person who had not engaged in education for some time and had a number of welfare and vulnerability issues. Despite the potential for this case to become 'chaotic', the case manager engaged with Connor, worked through what was bothering him, motivated him and supported him to internalise the offending behaviour work that he was doing. This led to good compliance and no further convictions over the course of the order.

5. When done well, we saw some highly effective work with children and young people to support attendance at school and college. In these instances, case managers were proactive, offered practical support and help to children and young people and their families, and worked well with schools. This led to improvements in attendance and participation in education, training and employment (ETE).

2 Breaches – non compliance with court order requirements

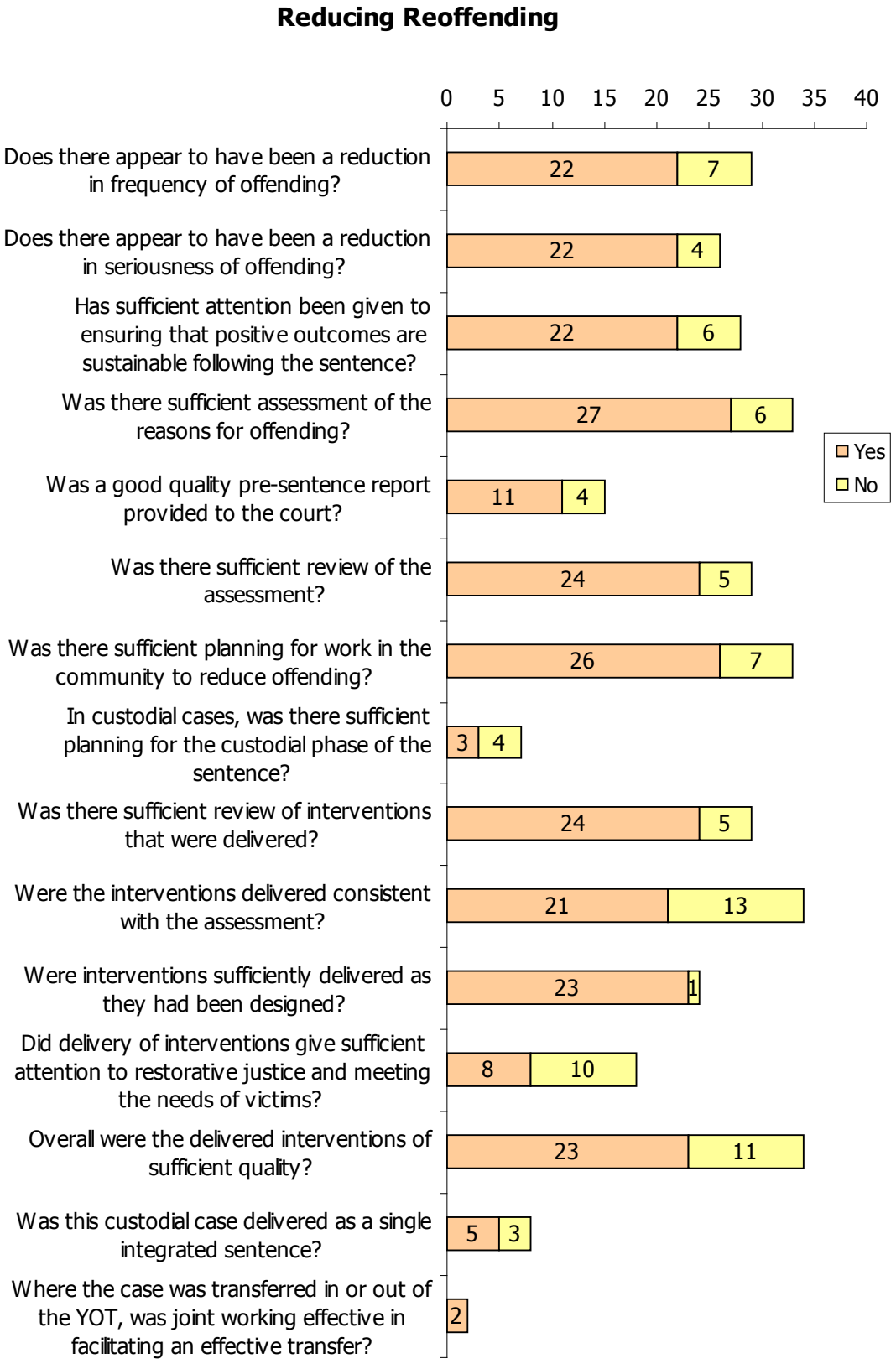
Example of notable practice

Latif, a year 11 pupil, had been on a carefully considered part-time timetable. The local authority had monitored this well to ensure that he was gaining the maximum education he could at this time. The case manager initiated meetings with Latif's school and made sure that his mother was involved. This ensured that there was a close eye on Latif's progress. Latif's attendance at school improved. The school then arranged a careers interview with Latif to plan his next steps after year 11. Staff from the school accompanied Latif to his interview at a local college. As a result, he secured a college place for September studying multi-skills.

6. There had been several changes in personnel to support ETE since the previous inspection. ETE case workers were no longer in place. However, an education link in the YOT had been developed. This role focused on liaison and advice to case managers, schools, education providers and education services within the local authority. We saw very little evidence of direct work in this role with children and young people to support their ETE participation and aspirations. We were pleased to learn that this arrangement was under review.
7. We found that education and training opportunities for children and young people supervised by the YOT were changing. PCMI had provided flexible vocational training programmes for vulnerable children and young people, including those supervised by the YOT. Children and young people had benefited from short vocational courses in construction, health and safety, manual handling and had been able to obtain their Construction Skills Certificate Scheme card. They had also been able to undertake work experience and volunteering. Nevertheless, PCMI programmes had been under-utilised by the YOT.
8. We were pleased to see in a number of cases that there had been a reduction in the frequency and seriousness of offending. The cases inspected represented just over one-third of the total YOT caseload. Additionally, we concluded that the work carried out by case managers was likely to reduce reoffending in at least half of the cases. This figure could have been significantly greater had focus been given to the signposting of community services, the completion of additional motivational work and the delivery of interventions that were consistent with the assessment and the formulation of a planned exit strategy.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the Public

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Theme 2: Protecting the public

What we expect to see

Victims, and potential victims, of crime have the right to expect that everything reasonable is done to manage the risk of harm posed by children and young people who have offended. We expect to see good quality assessment and planning with the delivery of appropriate interventions, and positive leadership, effective management and partnership work which reduces the risk of harm to others.

Case assessment score

Within the case assessment, overall 76% of work to protect the public was done well enough.

Key Findings

1. Multi-agency arrangements were largely effective in the management of risk of harm work.
2. Assessments and reviews of risk of harm were appropriately carried out in most of the cases.
3. Systems and procedures for restorative justice work had recently been put in place.
4. Required interventions were not delivered in far too many cases.
5. Planning for work to manage the risk of harm to others was not consistent.
6. Health services had not been systematically considered in the assessment of risk of harm.
7. Sharing of intelligence between the YOT police officer and case managers was progressing well.

Explanation of findings

1. We found a strong partnership between the YOT and Multi-Agency Public Protection Arrangements (MAPPA) in Portsmouth. In every case we examined where the procedures were necessary, we concluded that the YOT had engaged fully. However, it was not always clear whether the discussions that had taken place at these panels to determine the level of MAPPA intervention for a child or young person had formally been recorded and referenced in case work. We were pleased to discover that the mental health practitioner had made relevant contributions at MAPPA meetings on several occasions.
2. It is critical in public protection work that case managers fully understand the risk of harm to others in each case and appropriately review assessments when circumstances change. We were pleased to find that this had been done well in the vast majority of cases. Assessments and reviews had been undertaken, MAPPA processes had been followed and there was evidence of work to keep victims safe. In some cases, reviews were often replicated from previous assessments and case managers had not taken account of both static and dynamic factors. In one case for example, the homelessness of a young person had not triggered a review.
3. We were pleased to find that restorative work was beginning to have a higher profile in case work. Systems, processes and schedules had been developed and staff delivering theses services fully understood their role in this work. The YOT had developed guidance information to support the preparation of letters of apology. It was encouraging to find that these letters were not systematically forced on to children and young people. As an illustration of this, in one case we spoke to a case manager who took an informed decision not to prepare an apology letter with the young person she was supervising because the young person was not sorry for what he had done. Instead, she undertook some preparatory work to enable him to recognise the impact of his aggressive behaviour on others.

Example of notable practice

Good liaison with an out of area YOT had resulted in tight supervision while Lennie was being supervised. When Lennie tried to cut short a supervision session and threatened the YOT case manager, he was promptly given a final warning by the Portsmouth case manager. Since that incident there were no compliance issues. Plans for transition to adult probation services were being actively considered. MAPPA in both out of area and Portsmouth were involved. This was a hugely complicated case which was very well and tightly managed by the Portsmouth YOT case manager in close collaboration with the local authority children's social care services. An example of excellent resettlement work balancing both individual vulnerability and the risk of harm to others.

4. The number of restorative conference meetings that had taken place were small but the notes we read from the ones that had taken place showed that they were having an impact on children and young people. Victims spoke positively about the service they received from the YOT. In one particular example the restorative justice workers had set up a meeting with two police community support officers (PCSOs – the victims), the young person and his mother. In the incident that led to a conviction the young person had said to the PCSO *'I hope you die of cancer'*. On arrival, the PCSOs were in their uniform but were asked if they would be willing to remove what they could to make the meeting less formal. To this they agreed. The meeting began with full introductions and clarifications were sought from all present about their expectations from the meeting. The pace of the discussion was consistent with the learning needs of the young person. The outcome of the meeting led to the young person better understanding the impact of his behaviour on others.

Quotes from victims

"We went to a restorative justice conference; we were invited along. It gave us the opportunity to meet the lad who had caused the damage and we let him know how his behaviour had proved difficult at the centre but we made it clear he was welcome on site to work with us and that we wanted to build a relationship with him and give him another chance. He was also open enough to admit that he thought he had got away with it, and hadn't realised just how much harm he'd caused. The workers were very good."

"To tell you the truth it was 100% satisfaction for the job the workers have done… I've suffered routine criminal damages with tenants over the years. I can say that this team have done an excellent job at supporting me and making me feel safe, it's all been dealt with properly."

Quotes from children and young people

"I met with [X] the police officer. He said about how him getting assaulted really affects his life, but he's not like the other police officers I've met, the others all have massive power trips and try to control you, he's different, he's actually okay. I can now see what I did messed him up. I'm sorry yeah."

"I did victim empathy with my YOT worker but I think it was called something else, I think it was victim awareness… It makes you think how you would feel if someone beat you up."

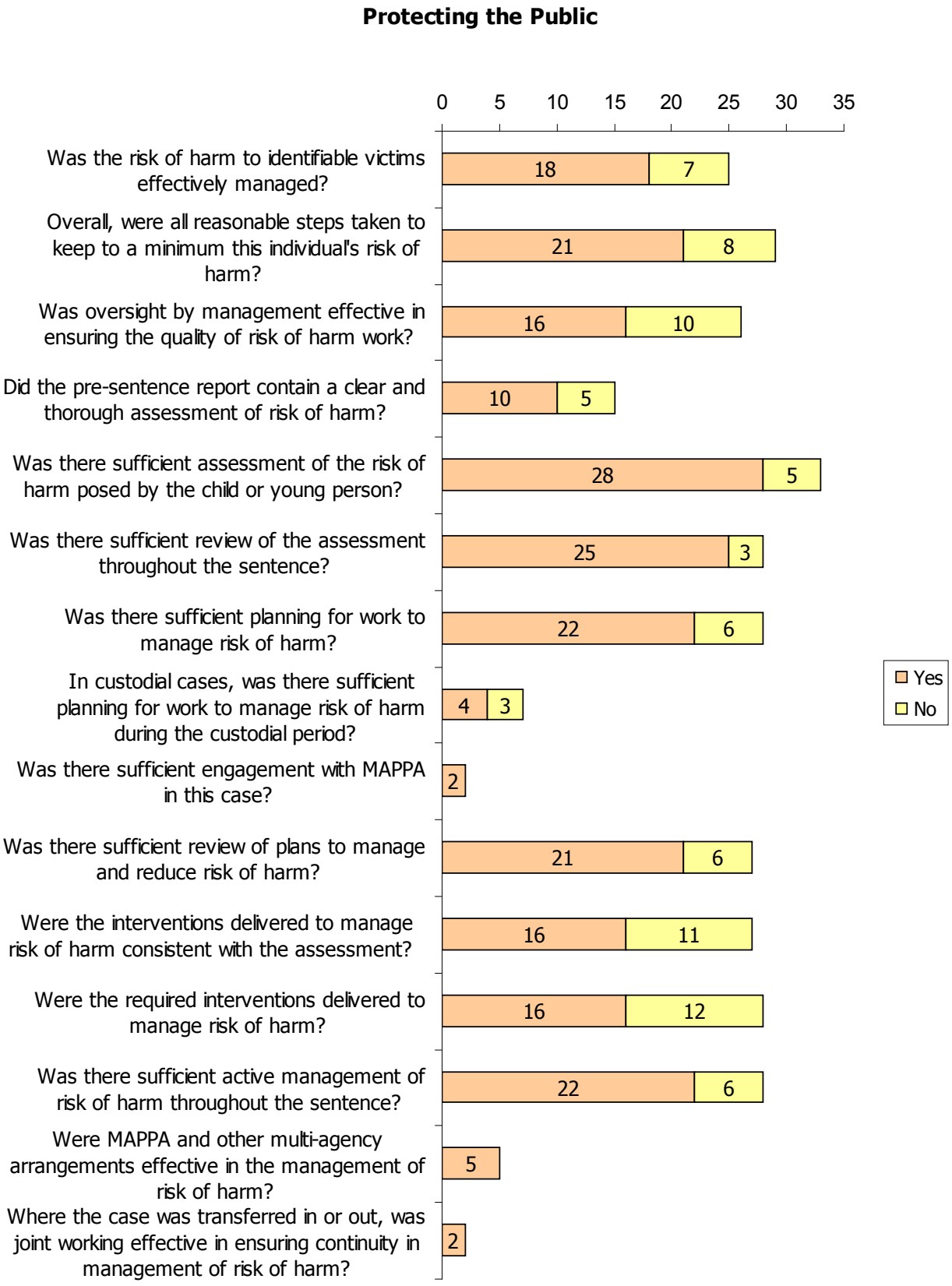
5. In just under half of the cases we inspected, we were disappointed to find that while the need for interventions to manage the risk of harm had been identified, these interventions had not been delivered. Furthermore, preparatory and motivational work was lacking. On the contrary, interventions

delivered by health practitioners were of a good standard although records did not always truly reflect the contents of the sessions. Health practitioners were able to offer aftercare once the YOT aspect of any order or licence had been completed. This was good practice as it enabled some continuity.

6. Initial planning for work to manage risk of harm to others was not done well in one-fifth of community cases. This deficit was equally present in custodial cases. It was not clear how and what work needed to be done to reduce the risk of harm. In one custodial case of a young person sentenced for a violent offence, no plan had been produced and in one community case there was no inclusion of victim work in the plan. Conversely, we saw several cases where case managers had appropriately identified interventions to mitigate against harm being caused. Sequencing of work was good and information sharing arrangements were clearly identified and agreed.
7. Health services had not always been well considered in the assessment of risk of harm although good use had been made of existing external health reports, such as psychological reports prepared as addendums for courts. Case managers did not routinely seek the views of health practitioners to inform their assessments.
8. There was a robust and effective flagging system in place for the YOT police officer to identify when children and young people on the YOT caseload came to police attention. We found clear evidence of two-way intelligence sharing, with relevant police intelligence being recorded on the YOT casework system. Information from YOT case managers was also found on the police intelligence system. However, the system for the transfer of information between the police officer and YOT was time consuming and cumbersome. There was no designated police administrative support worker updating information and intelligence directly onto the casework system.
9. There were good links between the YOT and local neighbourhood policing teams, facilitated by the YOT police officer. This was especially the case in relation to the higher risk Priority Young Persons. Operation Goldstone, an initiative to provide support to victims of child sexual exploitation, was notable. However, at the time of the inspection it was too early to report on the way in which the operation interacted with the YOT and how effective it was.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Protecting the child or young person

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Theme 3: Protecting the child or young person

What we expect to see

Whether the vulnerability of children and young people is due to the consequences of their own behaviour or the behaviour of others, we expect to see that they are kept safe and their vulnerability is reduced. This should be through good quality assessment and planning with the delivery of appropriate interventions, positive leadership and management, and an effective contribution to multi-agency child protection arrangements.

Case assessment score

Within the case assessment, overall 85% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Assessments and reviews of safeguarding and vulnerability were done well in the vast majority of cases.
2. Plans were better in community cases compared with custodial cases.
3. Relationships with children's social care services and the YOT were much improved.
4. Social workers in the YOT were hard working and generally had good knowledge of policies and procedures to protect children and young people from harm.
5. Work with health issues was not yet integrated, but was developing.
6. Reflective practice was becoming embedded and was leading to appropriate decision making to protect children and young people.
7. Interventions to manage assessed needs were largely delivered well.
8. Management oversight had improved and was effective in most of the cases.

Explanation of findings

1. We were pleased to find that assessments and reviews of safeguarding and vulnerability had been given a key priority. Information relating to vulnerability had been pulled through from other sources and this provided good integrated assessments. In particular the attention given to mental health, impact of drugs and alcohol on vulnerability was impressive. Screening was consistently carried out and reviews were timely and appropriately triggered by a change in circumstances.

Quote from a carer

"He took part in SWITCH meetings, which is support with drug-related stuff… It really helped him. My grandson has been using legal highs for some time but since he's moved back here his attitude to drugs has changed. I suppose you could say he's realised he can get by without them and as far as I know once you've been assessed, you can carry on with SWITCH, but his YOT worker explained that we can't force him to carry on with the support but that it's down to him to continue with it. The worker's been great. She's taken time to understand my grandson and has tried to help him to look after himself better."

2. Planning for work to manage safeguarding and vulnerability at the start of community orders was generally good. Case managers had considered the information that was available to them and identified meaningful actions that would keep children and young people safe. Planning activity in custodial cases was markedly worse. In some of these instances, case managers had not actively responded to the lack of information from institutions. This meant that plans to address vulnerability were not properly informed.

Example of notable practice

The YOT became aware of a specific individual who was posing a risk to children and young people. Information about him was sparse and it was difficult to understand which children and young people he was linked with. Based on snippets of information, their knowledge of individuals and the city, case managers drew up a chart which helped them to map, identify and monitor associations and links between two adults and numerous children. They coded children and young people who were Looked After[3] and those known to the YOT. This gave them a far greater understanding of who was at risk and how children and young people could be drawn into the web. This work was impressive as it was, but not satisfied with that, the case managers were now plotting with a worker, on a city map, the picture of drug use, location of children's homes and where adults of concern were located. This was enabling all of the YOT staff (and others within the authority) to quickly and discretely identify and respond if children and young people were going into risky places or associating with people who might harm them.

3. YOT case managers were making a positive contribution to plans for children and young people who were Looked After and/or in need of protection. Action taken in response to the findings of a safeguarding audit of youth offending had resulted in risk management plans being more effectively cross-referenced to Child Protection plans and vice versa. This was helping to improve coordination and reduce duplication in a way that was benefitting children and young people and their families.

4. Relationships with children's social care services and the YOT were much improved. The co-location of the YOT with the young people's support team, plus the development of a joint working protocol, had helped to raise the YOT's profile within children's social care services. Improvements were found in communication and information-sharing. This had contributed to a more joined-up approach.

5. Social workers in the YOT were conscientious, committed, intelligent and analytical. They knew children and young people under their supervision well and had easy access to high quality Child Protection policies and procedures. They were well supported by an experienced advanced practitioner. They had regular monthly supervision and this was more frequent in the case of newly qualified social workers. They spoke very positively about the recent introduction of group clinical supervision sessions involving a consultant from forensic child mental health services, not least because of the opportunity they offered for reflection and shared learning. This all contributed to appropriate decisions being made about safeguarding and vulnerability.

6. YOT social workers were able to identify risks and strengths and understood the thresholds for referral to children's social care services. They demonstrated good awareness of child sexual exploitation, the missing persons protocol and the role of the local authority delegated officer. They and their managers had no hesitation in escalating issues or concerns as and when appropriate. However, not all of the YOT social workers had completed training on the missing person and trafficking protocol or the online child sexual exploitation training module, albeit for those that had not attended this had been booked. When talking to inspectors, none of them made reference to the child sexual abuse training which also covered child sexual exploitation.

3 Looked After (Children) – children and young people who are in the care of the local authority

7. We found that some case managers had mixed views about the confidence they felt around assessing the health needs of the children and young people they were supervising. Case evidence suggested that some case managers were less able to make in-depth assessments in the absence of a primary health professional and did not make use of the public health link worker for advice or guidance. The absence of the mental health worker, who was on maternity leave until March 2015, was suggested as a reason why there were fewer referrals despite members of the Child and Adolescent Mental Health Service team providing cover. The Looked After Children's nurse provided effective liaison with some case managers who supervised Looked After Children but relationships were tenuous and 'developing'.
8. Practice standards had improved. Case managers welcomed the constructive critical feedback they received as a result of the monthly quality assurance process, which was helping them to be more reflective and improve their assessment and planning skills. However, we found some evidence to suggest that different managers within the YOT appeared to have different expectations and standards. This resulted in some confusion and frustrations.
9. Increased cross-referencing between the police, YOT and children's social care services data systems had led to the YOT police officer being able to alert his YOT colleagues immediately about any children or young people known to them who were missing.

Example of notable practice

By ensuring that the new IT system included both sets of unique ID numbers (those used by the YOT and those used by children's social care services) it had reduced the risk of duplication and/or of professionals working in parallel rather than in a joined-up way.

10. Interventions specifically aimed at addressing safeguarding and reducing vulnerability had been delivered well in the vast majority of inspected cases. There were a small number of cases where referrals to specialist provision had not been made. In one particular case an inspector noted that there had been evidence of self-harm, but this had not triggered a referral to the mental health team. In another example, insufficient motivational work had been carried out with a young person who denied being vulnerable despite an escalation in alcohol use and non-attendance at school.
11. We saw evidence of active management oversight in work relating to safeguarding and vulnerability. Immediate action was mostly directed when necessary and there was good engagement with other agencies when there was a need for escalation. There were occasions when some managers did not identify deficits in plans and provide clear explanations about why and how certain actions should be carried out.

Example of notable practice

Ralph was 16 years old and sentenced to a 4 month detention training order while in year 11 of school. He immediately expressed that he felt scared in the jail where he was placed and refused to leave his cell for much of the day or engage in education. The YOT case manager made significant efforts to raise the placement decision with the Youth Justice Board (YJB) and to encourage the custodial environment to try to engage with Ralph beyond talking to him through his cell door. While he was not moved out of the jail, progress was made with the jail starting to offer education in his cell.

Lucas had recently been released from custody and immediately suffered serious reprisals in relation to his sexual offence. Lucas and his father were placed on a train from his home YOT before Portsmouth YOT was informed that they were coming. There was very little information and the assessment of Lucas' risk was not sufficient. Portsmouth YOT responded pragmatically, ensuring that the external controls in relation to Lucas' risk were well managed. They established MAPPA and public protection links rapidly, liaised with housing and made appropriate disclosures and dealt with Lucas and his father's immediate health and welfare needs.

12. Overall, we concluded that the YOT had done enough to keep children and young people safe either from themselves or from others.

Quote from a parent

"I once had a big issue with my son's self harming behaviour so I came to speak to his YOT worker and basically told him what I thought we needed to do. He always listens and yes, I'd say he took my advice and came up with what needed to be done. My mind was put to ease."

Data Summary

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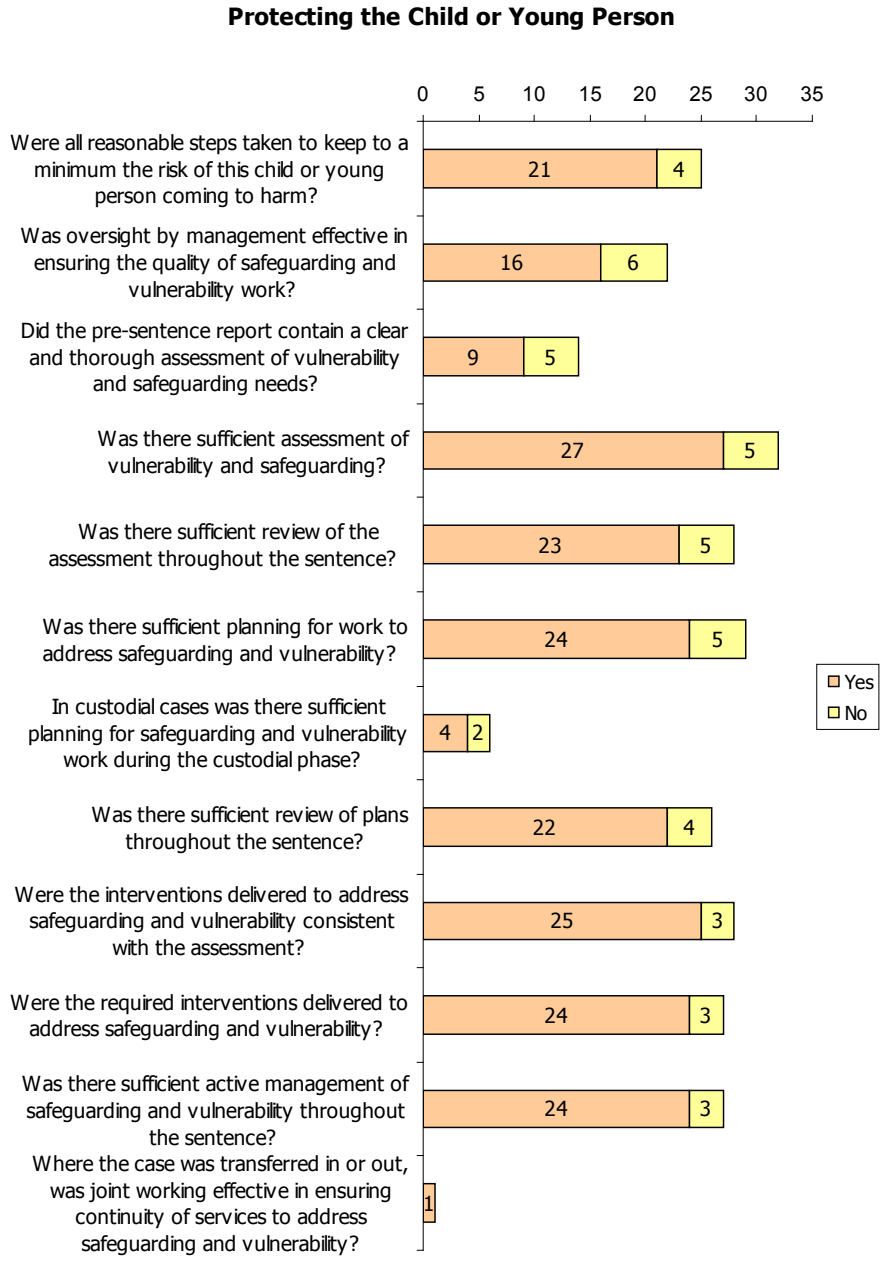

Ensuring that the sentence is served

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Theme 4: Ensuring that the sentence is served

What we expect to see

Children and young people should serve their sentences as the court intends. We expect that the YOT will maximise the likelihood of successful outcomes by effective engagement with them and their families, responding to relevant diversity factors including paying attention to their health and well-being, and taking appropriate action if they do not comply.

Case assessment score

Within the case assessment overall 86% of work to ensure the sentence was served was done well enough.

Key Findings

1. The YOT and its partners worked effectively to achieve positive outcomes for children and young people.
2. Engagement with children and young people and parents/carers was good.
3. Non-compliance was managed very well.
4. Children and young people and their parents/carers were not always involved in sentence planning.
5. Attention to health needs was developing but did not always lead to specialist referrals.
6. Good focus was given to assessing and overcoming barriers to successful engagement.

Explanation of findings

1. The YOT's commitment to active engagement with children and young people and their parents/carers to ensure that sentences were served was outstanding. We consistently saw evidence of case managers building constructive relationships with children and young people to bring about lasting change. Office and home visiting was appropriately determined and members of the extended family were given opportunities to support assessments and reviews. Children and young people were ruthlessly but appropriately held to account for non-compliance. This facilitated an improvement in engagement levels by the children and young people.

Quotes from case managers about enforcement

"I'm not going to dance around the subject. I will be blunt when I have to be. His compliance has improved and he has now started a college course."

"He knows where he stands with me. I'm fair but won't put up with being messed around. He needs to know that there are consequences for bad decisions and I do want to help him make better choices. He gets that because he calls me if he's going to be five minutes late."

2. It was disappointing to see that despite all the investment in building positive relationships case managers did not always seek the full views of children and young people and their parents/carers to formulate plans. However, when this was done well, it was done so extremely well.

Quotes from children and young people

"If I don't give my YOT worker a good reason why I'm not attending you get a warning. I've had one. Once you've had three then you get sent back to court. I think they call it a breach."

"My two years at YOT haven't been rubbish, I've got nothing bad to say, they've all really helped me a lot …. they talk to you like a friend, they never treat me like a criminal. My YOT worker says everyone makes mistakes and there's no point looking down at anyone."

"When I arrived here the YOT didn't have any paperwork on me and they had to start from scratch. They gave me a warm welcome as soon as I came in. The staff here were really nice, they had a good chat with me and told me I'd be on intensive five-day week supervision. They asked me what I liked and found out all about my offence. They got me to do a CV with my YOT worker. She's really nice, she helped me with temporary accommodation and got me a flat and told me I wouldn't be in it for very long. The YOT rang up different charities for furniture. It was a goodwill thing… staff from the YOT came every day to see me at my flat. I was new to the place so that help was great."

Example of notable practice

The recent introduction of a screening tool to identify Looked After Children who were at risk of offending had increased the opportunity to develop a proactive, coordinated multi-agency response to reduce those risks.

3. Case managers consistently took account of health and well-being issues in their supervision of children and young people but did not always make the necessary referrals to specialist provision.

Quotes from parents/carers

"The YOT do what they can for me. I have suffered with Parkinson's [Disease] for many years. I've also had two strokes within two weeks… I think people with disabilities or illnesses who want to attend their child's appointments should be supported more - such as taxis to and from appointments or even help with fuel costs as I'm on disability benefit."

"The main thing is I get so much support from them, it's good because I feel that I can let it all out and know you have all that support around you."

"Since his involvement with the youth offending team he is now studying maths and English and much of it is IT-based. It's the first time in his life that he's had any educational certificates …He's actually coming up for the end of his first year and that has all been arranged through the youth offending team. Once again they have excelled with regards to his education, quite simply because they've maintained good communication with the college on a regular basis."

"I have a lot of contact with the YOT. They come to visit as well. Sometime they spend more time talking to my son and don't really ask me what I think. I'm with my son a lot of the time and I know him, his moods, what he does, what he gets up to but they don't always ask me for my thoughts. What they're doing with him is really good – they should ask him why he does what he does and get him talking more."

4. Appointments, when necessary, with the substance misuse worker and the mental health practitioner were not systematically made by case managers. We found that half of the children and young people in our sample were not involved with health interventions. General health screening by a nurse was not

part of the process for children and young people involved with the YOT. This potentially meant that some physical health needs were missed for example; immunisations and vaccinations, sexual health and weight management.

5. Case managers were able to identify and address barriers to engagement presented by children and young people. The manner in which this was done was both skilful and considered. A notable number of cases we inspected involved children and young people with specific learning needs. We were delighted to find that assessments which informed the learning preferences and diversity needs of the children and young people had been consistently carried out. Equally encouraging was the identification of these barriers in plans.

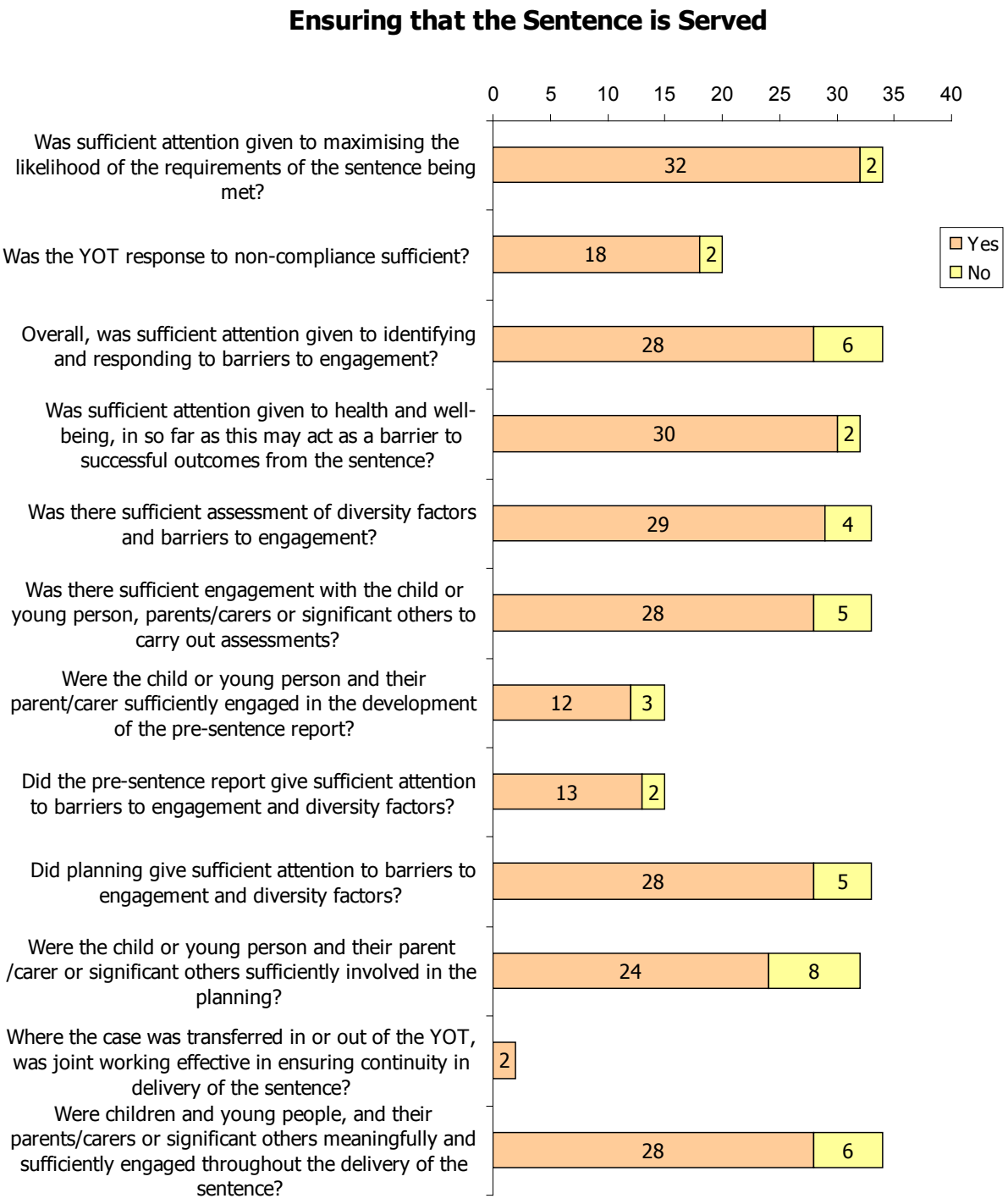
Example of notable practice

Julian (18 years old) was a Looked After Child at the time of sentencing. He had had numerous placements around the country and was well known to the YOT. He had a good relationship with the YOT drugs worker. As a result of his drug use increasing the YOT had decided to continue supervising him for a period of additional time to prepare him for transfer to adult probation. The YOT pursued a psychological assessment (which should have been carried out years ago) and it transpired that Julian had a low IQ score and the speech and language ability of a 7 year old. Prior to transferring him to probation, he was referred to the learning disabilities team (and was accepted).

6. We were pleased to hear about the quarterly 'meet the YOT manager' opportunity that was given to all children and young people being supervised by the YOT. This was held during the half-term school holidays. Feedback from these meetings was directly shared with case managers and themes considered at staff meetings. This provided an effective tool in receiving regular feedback.

Data Summary

The following chart summarises data from some of the key questions assessed during the inspection of cases. [NB: 34 cases were inspected. However, the total answers may not equal this, since some questions may not have been applicable to every case]



Governance and partnerships

5

Theme 5: Governance and partnerships

What we expect to see

Effective governance, partnership and management arrangements should be in place. These enable the YOT to meet national and local criminal justice and related objectives, and to deliver and maintain good quality services.

Key Findings

1. The YOT Management Board (Board) had set an ambitious improvement plan since the last inspection and partnership working was evolving well.
2. Child sexual exploitation did not appear as a regular agenda item on the Board's agenda.
3. The effectiveness of the Missing, Exploitation and Trafficked (MET) meeting needed to be reviewed.
4. Overall, performance data was being used to inform service delivery.
5. Police analysis of crime data was not systematically presented to the Board.
6. Promising signs were becoming evident in the integration of health services and the YOT but progress had been slow.
7. YOT representation at key forums was good.
8. Quality assurance systems and auditing of work were having a positive impact on improving services.
9. Clinical and direct supervision had led to greater reflection and learning for practitioners.

Explanation of findings

1. Leadership and governance – offending is reduced and other criminal justice and related objectives are met

1.1. In order to ensure that objectives were achieved as quickly as possible, the YOT Management Board had scheduled monthly meetings. There was a clear recognition of the significant improvement that was necessary at all levels and a clear understanding of what needed to be done. As a result, we found that substantial improvement had been achieved.

1.2. Attendance at the Board had been good despite the significant level of commitment required. There was evidence that the meetings were focused and effective and those discussions had driven the improvement plan forward. Membership of the Board had been reviewed and consequently a number of the current Board members had not been in place for long. The Chair had taken an active role in renewing the momentum of the Board, helping to equip new members and ensuring that all were clear about their role and responsibilities. Where necessary, there had been meetings outside the main Board to address issues specific to individual agencies. Overall, Board members were committed, engaged and increasingly knowledgeable.

1.3. The Board had established theme 'champions' from within the group to promote partnership working and to monitor the delivery of outcomes with the YOT manager. We were pleased to find that the champion role had been clearly defined and was at a level that could make the greatest impact.

1.4. Overall, performance data was used to monitor progress and to better understand what needed to be changed. There was evidence that Board members had sought to fully interrogate and understand statistical information. Where issues were raised, there had been action to resolve or further explore the problem.

1.5. The performance management framework was evolving. The YOT did not yet have a team scorecard similar to the ones used elsewhere in children's social care services. The performance management report that was presented to the YOT Management Board on a quarterly basis did not include any information about new entrants to the youth justice system who were Looked After, or those who became Looked After as a result of having been remanded. The same quarterly report did not include any information about child sexual exploitation, missing children and young people or safeguarding issues.

1.6. More recently, with the implementation of a new YOT database, the performance team within children's social care services had started to extract and collate the YOT data. This was a promising development as the team was proactive, informed and actively considered whether individual statistics were useful or not. The Board had commissioned a review of the data and, at the time of inspection, was about to consider the proposals. The performance data team had made several useful suggestions for improvement and we found a stated intention to make the data more outcomes focused.

2. Partnerships – effective partnerships make a positive difference

2.1. Processes and procedures had been improved and actions were being delivered more consistently. We were particularly impressed to see the implementation of a process to improve joint working between the YOT and children's social care services.

Example of notable practice

A 'YOT/Social Care Interface Audit' had been carried out where managers from the YOT and children's social care services met with practitioners from both services to review the integration of planning and practice. In total, 19 cases had been reviewed and recommendations made for improving joint work on individual cases. It was intended to repeat the exercise on a quarterly basis.

2.2. Police analysis of crime data was not presented to the YOT Management Board to enable the group to understand offending patterns and emerging trends and react accordingly. The most recent data suggested that there had been a significant increase in the number of first time entrants. While the Board appeared to have been aware of this increase, at the time of inspection it had not taken action to analyse the causes of this increase. This was surprising considering the likely impact on the workload of the YOT (including the triage system). Child sexual exploitation did not appear as an agenda item in Board meetings. This information would have assisted the Board to focus on those children and young people at greatest risk of harm.

2.3. The police strategic lead chaired the YOT Management Board and was also a member of the Safer Portsmouth Partnership Board. This provided a good link between the two boards.

2.4. There were transition protocols in place for the transfer of cases to the National Probation Service and the Community Rehabilitation Companies as children and young people became adults. Regular meetings took place to ensure that slippage was avoided.

2.5. The integration of health services into the YOT was becoming visible although progress had been slow. The YOT Development Day (May 2014), the Health Needs Assessment (October 2014), the Audit to Assess Identified Health Needs in Young Offenders (April 2015) and the Health Actions Stock Take (May 2015) all provided good evidence to show that there was significant cooperation and joint working between commissioners, Solent NHS Trust, the YOT and Public Health at a strategic level. Robust contract monitoring was in place for the Clinical Commissioning Group, Public Health and Solent NHS Trust. This had recently been reviewed. There was still some way to go

before frameworks and referral pathways were consolidated, but the YOT Management Board was clear about its plans and was actively pursuing the goals they had set themselves and the YOT.

2.6. The YOT Management Board had two health representatives; one from the Integrated Commissioning Unit and one from Public Health. They were both at senior levels which allowed them to make strategic decisions regarding the YOT. YOT Management Board minutes showed that health had become a regular agenda item with clear actions and outcomes required. The health representatives were active members of the group.

2.7. Recognising that in 2013/2014 9 of the 10 children and young people in Portsmouth who received custodial sentences were Looked After Children, the YOT and its partners were taking decisive action to reduce the over-representation of Looked After Children in both the youth justice and custodial systems. A detailed multi-agency action plan had been developed and was being implemented. Performance targets had been agreed and a screening tool had been introduced to help identify Looked After Children who were at risk of offending. It was, however, too soon to evaluate the impact of this initiative.

2.8. The YOT was well represented on a number of key decision-making forums including the placement panel, the supported young person's housing panel and the monthly MET meeting. This ensured that the needs of children and young people who offend were given appropriate priority.

2.9. The MET meetings were a work in progress. While they provided an opportunity to discuss children and young people who were missing and/or at risk of child sexual exploitation and to share operational information and intelligence, the size of the membership, the number of children and young people being discussed and the scope of the meetings suggested that there was a need to review their impact and effectiveness. The interface with a number of multi-agency strategy meetings that were in place for all high risk children and young people was good.

2.10. Although the local authority and its partners had established a single database which covered children and young people who were missing from home and care as well as those who were identified as being at risk of child sexual exploitation, the fact that it did not include children missing from education represented a significant omission. This limited the ability of the MET to identify children and young people who may be at risk of child sexual exploitation but who never went missing from home or care.

2.11. Well-established links between the Safer Portsmouth Partnership Board and the YOT Management Board ensured that there was an appropriate level of scrutiny and critical challenge of the work of the YOT.

2.12. We found that education services were now well represented on the YOT Management Board and there was increased information available on ETE at Board meetings. This was not the case at the time of the last inspection. The Board had routinely considered education information and data with the education representative reporting at each Board meeting. Data had started to be used to inform the Board of the YOT's performance in this area, but this remained an area for further development. Some performance measures had not been fully developed and data over time had not been collated or used fully to help analyse performance. The usefulness of some data such as the extent to which children and young people make the progress expected of them had been considered by the Board. However, this had not helped inform the Board of the effectiveness of the YOT's work to improve ETE outcomes for children and young people.

3. Workforce management – effective workforce management supports quality service delivery

3.1. There had been some delay in ensuring the full staffing of the YOT, in particular, the education and health provision. These were now in place although the use of health staff was underdeveloped. Extra resources had been made available where necessary, for example, the funding of an extra post to facilitate data analysis.

3.2. Internal management oversight had improved considerably and had been bolstered by a quality assurance system and additional effective resource approved by the Board. This had made a significant impact on contributing to improved practice. Staff were supervised regularly and further support had been provided through regular clinical supervision. Case managers were more confident about the processes they needed to follow but did not always demonstrate the confidence to use professional discretion. Separate support was available for those supervising children and young people who had committed sexual offences. Training in assessment and planning had been provided to staff and there was more training planned to raise awareness of child sexual exploitation. All managers had also received development training and this had improved their impact on service delivery. Staff were extremely motivated and keen to improve their own learning and skills.

3.3. By providing funding for an additional member of staff based in the performance development team, the YOT Management Board had made it possible for the activities of the YOT to be monitored through children's social care service's existing performance management and quality assurance systems. This was increasing the opportunities to carry out thematic examinations, collate information on outcomes, identify learning from successful interventions and capture feedback from children and young people and their parents/carers.

3.4. The YOT had a current workforce development plan to cover the period 2014-2015. The team training plan however was less developed.

4. Learning organisation – learning and improvement leads to positive outcomes

4.1. Around half of case managers interviewed reported that there was a healthy culture in the YOT to promote learning and development. A significant number felt that it was a mixed picture and a number were not clear about the priorities of the organisation as they related to their own role. The training records we examined showed case managers had attended various events including; 'engaging young people with speech language and communication difficulties within the youth offending system'; 'making every contact count' and 'MAPPA awareness training'.

4.2. The YOT had an impressive set of quality assurance systems in place which were used well to inform developments. We saw evidence of peer reviews and all staff in the YOT were active in wanting to reduce reoffending and make a lasting difference.

4.3. Auditing of work was a regular feature. This informed improvement plans.

4.4. The Business Support Team was knowledgeable about youth justice, well integrated into the YOT and contributing to service improvements.

Example of notable practice

The Business Support Team was proactive and had consulted practitioners about what worked well and what needed to improve. They had taken action as a result. An example of this was the breach procedure which they had streamlined. The administrative part of the process, which had previously been carried out by practitioners was now, appropriately, being carried out work by business support staff.

The YOT Management Board had suggested and facilitated joint development days where the YOT team and Board members had met together; these had improved knowledge and understanding and had contributed to better morale within the YOT team.

Interventions to reduce reoffending

6

Theme 6: Interventions to reduce reoffending

What we expect to see

This module focuses specifically on interventions intended to reduce reoffending. We expect to see a broad range of quality interventions delivered well, coupled with appropriate assessments and plans which maximise the likelihood of sustainable outcomes being achieved. Effective leadership and partnership work needs to be evident in the delivery of interventions.

Case assessment score

Within the case assessment, overall 75% of work on interventions to reduce reoffending was done well enough.

Key Findings

1. The range of interventions available to the YOT was under review.
2. The standard of one-to-one delivery of supervision with children and young people was very good.
3. Outcomes from interventions had not been fully measured.
4. The 'triage' arrangements to determine interventions showed promise.
5. There was good information sharing between those delivering interventions and case managers.
6. Interventions delivered at the Civic Centre were less effective.
7. The range of reparation activities was often not meaningful to children and young people.

Explanation of findings

1. The range of interventions available to help children and young people stop offending was under review. The management team had a clear view of the interventions that were needed to meet assessed needs.
2. Good analysis of data and information had enabled the YOT manager to identify gaps in provision. Active steps were being taken to increase the range and type of interventions. It was pleasing to see that the YOT was thinking about the different needs of girls and younger children.
3. The quality of one-to-one supervision with children and young people was very good. Case managers were well prepared for the sessions, had a clear idea of what they wanted to achieve and importantly knew how they needed to engage the child or young person. During the course of the sessions we observed, case managers knew when to break and change pace and focus. They were able to provide appropriate and effective challenge to help children and young people reflect and consolidate on previous sessions. Children and young people were observed to relax after a period of time and then started to talk freely with case managers.
4. As in many YOTs, identifying which interventions are making a difference can be difficult. Strategically, the outcomes of interventions had not been fully measured. However, it was good to see that case managers were able to identify some of the discrete and subtle changes that children and young people had made.
5. The triage process which brought together a number of professionals to determine the type of interventions to use had only recently been established and this was 'a positive work in progress'.

While it currently diverted children and young people away from the criminal justice system it did not easily direct them to support services which would reduce the chances of them offending in the future. However, the involvement of the Community Safety Team and Joint Action Team in this process had resulted in some restorative interventions being proposed.

Example of notable practice

Avery was a 17 year old, on a youth rehabilitation order. He did not think a lot of himself, was depressed and talking to people, even those he knew and trusted, was a struggle. He became angry and frustrated when he was unable to resolve his problems by himself. This was the main cause of his convictions. The case manager knew him well and in preparation for the session she was to have with him, she had brought some food and drinks for him. She knew that due to his situation he would be hungry and that this would affect his engagement. When Avery first came in, he was very withdrawn, answering the case manager's questions about how he was with shrugs and keeping his head down, not looking at the case manager. The case manager was calm and reassuring. She paced her questions very well, giving Avery time to respond. This he began to do. Once he had started to talk, she subtly changed her body position so that she could look at his face. He gradually made eye contact with her. By the end of the session he had a clear plan of what he needed to do the following day to enable him to claim benefits so that he could be housed. He was clear about where to meet the case manager the following day, how he needed to behave in order to take a step closer to being housed and how he needed to keep his emotions under control to reduce the chances of him getting into trouble again. In this case the detailed and sensitive approach taken by the case manager restored some dignity to Avery and gave him some much needed hope that his life could change. When he left, he smiled.

6. Case managers were creative and skilful when working with children and young people, carefully selecting appropriate interventions for each child or young person and adapting them to suit each individual. The use of volunteers in supporting the delivery of interventions was encouraging.
7. We sometimes find that when interventions are delivered by partner agencies, case managers are not clear about what work has been done or how the child or young person is responding. It was very pleasing to find that this was not the case in Portsmouth. We found that discussions between case managers and other workers meant that those involved in the case were clear about their roles. They also knew how the specific work they were doing complimented offending behaviour work that was being done by the case manager. This enabled case managers to consolidate and reinforce key lessons.

Quotes from a young person

"This building is a council building, my appointments should be in another building. Sometimes there's shouting outside which is distracting. There are always people crying outside in the waiting area … I always have to come here."

8. The location of the delivery of interventions made a significant difference to the sessions. Children and young people were noticeably more distracted when they were at the Civic Centre. Case managers seemed to be anticipating being disturbed and were very obviously 'watching the clock' as they knew that someone would be waiting for the room. This limited the flexibility case managers had to allow the child or young person to be more reflective about their needs and situation.

Quotes from a parent

"I've always come here [civic centre] to attend my son's appointments, but I think they could do more home visits as this place is open to the public and there is no privacy. We've had to wait out there in the waiting rooms and we've even had to have appointments in the waiting area with the YOT worker. I didn't moan, but I didn't agree with that, the civic offices are so open planned so you don't know who's listening into the conversation."

Example of notable practice

One 12 year old boy came into a session with a case manager. He was being distracted by two things. Firstly the noise coming from outside the room in the Civic Centre and secondly he was uncomfortable making eye contact with the case manager. There was little else in the room for him to focus on. Like other young people of his age, establishing and making eye contact is not a natural skill but is being developed. This made it hard for him to really listen to what the case manager was talking about. The case manager gave him a blob of 'blue tack', which he immediately started to play with. This drew his attention away from what was going on outside of the room and his difficulty of where to look. His engagement quickly improved and a snail, snake and body later, he was talking openly about how to avoid getting into trouble again.

9. The range of reparation activities varied, and was being developed. Some of the children and young people that we spoke to could not see how what they were doing benefited or paid back to the community. One of the new projects, which involved refurbishing bikes, showed good promise. On a positive note, there was a good link within the reparation projects and community wardens, who were able to support projects and who knew the children and young people. This had resulted in effective information sharing that enabled case managers to know what children and young people were doing in the community. Community wardens were then able to redirect children and young people into other more beneficial activities.

Quotes from children and young people

"I'm not sure how many hours it was, but I know it was eight sessions… I had to make cups of tea and coffee in a church. It was quite boring, but if it benefits me I may as well do it. I also had to clean scooters. That wasn't as bad but they were already clean so it was a bit pointless… I was speaking to somebody from the referral order panel who mentioned pit bikes. I would prefer to do that as I've got a pit bike myself, I want to ride bikes - that's more interesting to me."

"We do all sorts really, we've done an intervention at a cafe where I helped to wash up, and today I've been to the Salvation Army where I folded clothes and sorted them into men's, women's and kids….. I suppose it's good because it keeps me out of the house and pays back to the community what I've done….. My sessions usually last about two hours, which is enough for me."

Appendices

Appendix 1 - Background to the inspection

Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work, predominantly in statutory community and custodial cases, in a small number of local authority areas each year.

The majority of the Youth Offending Teams selected for these inspections are those whose performance – based on reoffending rates, National Youth Justice Outcome Indicators and supported by other information, such as recent inspections – is of significant concern. Periodically, we also include high performing areas to establish a benchmark of good practice.

The primary purpose of the Youth Justice System is to reduce offending. This is the main theme of the inspection. The other core themes are protecting the public, protecting the child or young person, ensuring the sentence is served and governance and partnerships.

Criteria

A copy of the inspection criteria is available on the HMI Probation website:

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

Methodology

YOTs are informed approximately 11 working days prior to the inspection taking place.

Fieldwork for this inspection was undertaken on the weeks commencing:

11 May 2015 and 01 June 2015.

In the first fieldwork week we looked at a representative sample of 34 individual cases up to 12 months old, some current, others terminated. The sample included a number of those who are a high risk of harm to others, are particularly vulnerable, are young women, or are black and minority ethnic children and young people. Cases were assessed by a team of inspection staff. They examined these wherever possible with case managers, who were invited to discuss their work in depth, explain their thinking and identify supporting evidence in the record.

We also received copies of relevant local documents.

During the weeks in between, the data from the case inspections was collated and a picture about the quality of the work of the YOT developed.

The second fieldwork week is the joint element of the inspection. HMI Probation was joined by colleague inspectors from police, health, social care and education. We explored the lines of enquiry which emerged from the case inspections. The leadership, management and partnership elements of the inspection were assessed, with a particular focus on reducing offending.

We also gathered the views of others, including strategic managers, staff and service users – children and young people, parents/carers and victims, and observed work taking place.

At the end of the second fieldwork week we presented our findings to local strategic managers, the YOT Management Team, YOT staff and other interested parties.

Scoring Approach

Details of how our inspection judgements are made can be found on our website.

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

Publication arrangements

A draft report is sent to the YOT for comment three weeks after the inspection, with publication approximately six weeks later. In addition, a copy goes to the relevant Ministers, other inspectorates, the Ministry of Justice Policy Group and the YJB. Copies are made available to the press and placed on our website.

FJI reports in Wales are published in both Welsh and English.

Further details about how these inspections are conducted can be found on our website in the document '*Framework for FJI Inspection Programme*' at:

http://www.justiceinspectorates.gov.uk/hmiprobation/about-our-inspections/youth-inspection-programmes/inspecting-youth-offending-work/full-joint-inspection/

Role of HMI Probation and Code of Practice

Information on the role of HMI Probation and our Code of Practice can be found on our website:

www.justiceinspectorates.gov.uk/hmiprobation

The Inspectorate is a public body. Anyone wishing to comment on an inspection, a report or any other matter falling within its remit should write to:

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Criminal Justice Joint Inspection

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