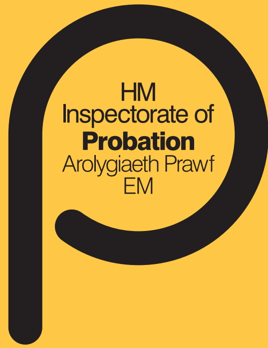

Full Joint Inspection of Youth Offending Work in **Portsmouth**

An inspection led by HMI Probation

independent inspection of youth offending work

February 2014

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 majority of the Youth Offending Teams (YOTs) selected for these inspections are those whose performance – based on the three National Youth Justice Outcome Indicators 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.

Published data on first time entrants to the criminal justice system in Portsmouth had showed substantial improvement. However, we chose to inspect in Portsmouth primarily because of concerns arising from the core case inspection of Wessex YOT (of which Portsmouth formed a part) in 2011, which had identified particular weaknesses in Portsmouth, together with higher than average rates of reoffending.

Portsmouth YOT was formed in April 2012 following the disaggregation of Wessex YOT into its constituent local authorities. Formation of the YOT was preceded by a period of shadow board and other preparatory arrangements. The new YOT Management Board has been far too slow to address the previous inadequate performance and to ensure that the required structures and resources were in place to enable improvement to take place. As a result, the YOT continued to be beset by staffing difficulties that had a direct impact on the quality of practice. Further work is required to ensure that the Board and its leadership through the Chair are effective.

We found some positive developments in Portsmouth and signs of encouragement in the developing YOT management and staff groups. Work with children and young people assessed as posing the highest Risk of Serious Harm to others or assessed as being very vulnerable, was given priority and was generally undertaken well enough. Case managers engaged with children and young people well. Overall, however, work to reduce the likelihood of reoffending and work to manage the risk of harm to others were worryingly poor and suffered particularly from the longstanding staffing difficulties as cited above.

The recommendations made in this report are intended to assist Portsmouth YOT and its partners in their improvement by focusing on specific key areas. Due to the poor performance identified in this inspection we will return to undertake a further full joint inspection which is likely to occur 12 to 24 months from the publication of this report.

Paul McDowell

HM Chief Inspector of Probation

February 2014

Summary

Reducing the likelihood of reoffending

Overall, work to reduce reoffending was poor. It continued to suffer from longstanding individual performance problems and gaps in the establishment of competent case managers. When interventions were delivered they were done well. However, they were not delivered often enough, largely due to poor assessment and planning and staff shortages. Work to address education, training and employment needs was positive, but remained at risk due to a key post being vacant. Health work was not well integrated into the YOT, although health workers delivered some good interventions. The role of the YOT police officer was not yet being used to best effect.

Protecting the public

Overall, work to protect the public and actual or potential victims was poor. As with other work, it continued to suffer from longstanding individual performance problems and gaps in the establishment of competent case managers. Assessment was poor and the impact of this was felt throughout the work. Priority was given to those cases with a high risk of serious harm to others that needed management under Multi-Agency Public Protection Arrangements. This work was done well. Not enough consideration was given to victims when planning and undertaking work.

Protecting children and young people

Overall, work to protect children and young people and reduce their vulnerability was unsatisfactory. Work in the more serious cases, such as those close to child protection thresholds was good. However, work in other cases was weak and suffered from the same longstanding staffing problems as other aspects of the YOT's work. There was good joint work with staff in children's services, with whom the YOT was co-located; however, health workers had not been well integrated into the work. There was not a systematic approach to ensuring that all staff had received appropriate training in child protection.

Ensuring the sentence is served

Overall, work to ensure that the sentence was served was satisfactory. The YOT had a good understanding of where it needed to improve the engagement of children and young people in assessment and planning for their sentences. Assessment and planning to address diversity factors needed improvement, including where speech, language or communication needs may be present. Case managers maintained positive, but professional, relationships with children and young people, but sometimes had to use unsuitable facilities in the Civic Offices for meetings with them. Enforcement action was taken when children and young people did not comply with their sentence.

Governance arrangements

Overall, the effectiveness of governance and partnership arrangements in ensuring that the quality of core practice improved as required was poor. In particular, insufficient urgency had been given by the YOT Management Board to timely resolution of the staff and management structures that were critical to improving performance. Staffing difficulties continued to be problematic. Further work was required to

ensure that the Board and its leadership through the Chair was effective, to ensure that its role and that of members were well understood and to hold partners to account for their contribution. Attention was given to the development of partnership approaches and the work of the YOT was well linked into local strategic objectives. Performance management and the use of data by managers and the Board needed to be improved.

Recommendations

Post-inspection improvement work should focus particularly on achieving the following:

1. The Management Board provides effective leadership. It holds the YOT and its partners to account to ensure high quality practice and achieve successful outcomes (Chair and members of the YOT Management Board).
2. All partners contribute actively to effective leadership, including through regular attendance at, and contribution to, the work of the YOT Management Board (All YOT Partners).
3. As a matter of urgency, the YOT has a full complement of competent case managers and other specialist staff in place. This includes a suitably skilled education officer to maintain the effectiveness of this work and to develop the range of training opportunities and links with employers (Chair of the YOT Management Board).
4. Data on appropriate local outcome measures, including health; education, training and employment; diversity; and safeguarding are received, scrutinised by the YOT Management Board and used to improve services (Chair of the YOT Management Board).
5. Work to reduce the likelihood of reoffending, protect the public and protect the child or young person is consistently good. It is based on high quality assessment and planning, includes delivery of appropriate interventions and achieves positive outcomes (YOT Manager).
6. Children and young people, and their parents/carers are fully and appropriately involved in all relevant aspects of the sentence in order to maximise the likelihood of their effective engagement and, thereby, increasing the likelihood of positive outcomes (YOT Manager).
7. Case managers have a good understanding of effective practice and YOT expectations upon them, and are subject to effective performance management (YOT Manager).
8. All staff have up to date training in local child protection and safeguarding procedures (YOT Manager).
9. Effective and appropriate training, supervision and oversight are provided to staff to support them to develop their skills and deliver consistent, high quality practice (YOT Manager).
10. Facilities used to undertake work with children and young people are private and appropriate to their needs (Chair of the YOT Management Board).
11. Priority is given to the needs of victims when undertaking risk of harm work (YOT Manager).
12. Work between health partners and the YOT is well integrated. This should include active involvement in assessment and planning; shared plans; improved formal communication and information sharing; and linked reviews, where appropriate (YOT Manager).

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Reducing the likelihood of reoffending

1

Theme 1: Reducing the likelihood of 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 38% of work to reduce reoffending was done well enough.

Key Findings

1. The quality of work to reduce reoffending continued to suffer from longstanding individual performance concerns and staff shortages.
2. Assessment and planning were poor.
3. The quality of pre-sentence reports (PSRs) needed to be improved.
4. Planning in custodial cases did not sufficiently reflect the Youth Offending Team assessment of the causes of offending, and both halves of the sentence.
5. Work to address education, training and employment (ETE) needs was good, but was at risk due to a key position remaining vacant. A wider range of provision was required.
6. Health workers delivered positive work; however, they were not integrated well into the YOT.
7. Little work had been delivered to address key factors related to offending. However, when interventions were delivered they were good.
8. The role of YOT police officer was not yet being used to best effect.
9. The Portsmouth Priority Young Person (PYP) scheme was a positive development focused on those at highest likelihood of reoffending.

Explanation of findings

1. Assessment

1.1. The quality of assessments of likelihood of reoffending was poor. Evidence was often unclear, insufficient or not analytical. Those factors most closely linked to offending were not always recognised and there was insufficient assessment of emotional or mental health. Links between vulnerability and the likelihood of reoffending were not always recognised, and links between the evidence and the likelihood of reoffending often were not clear. In too many cases, relevant available information was not included in the assessment. However, most initial assessments were timely to meet the needs of the case. The great majority of reviews were not good enough. In many cases this was due to shortcomings in the initial assessment not having been addressed and a lack of effort to ensure that the assessment remained current.

1.2. A new or recent PSR had been used to inform the sentencing court in half of the inspected cases. However, there were too many cases where there was not enough information available to explain what advice had been provided to the court, nor what comments had been made in court that may

inform work with the child or young person. The local youth court sat in Fareham, which was within the boundaries of Hampshire YOT. Portsmouth case managers would attend, but on occasions cover was provided by Hampshire staff. Staff did not make use of the information technology (IT) facilities that had been provided to them for work in the court at Fareham, meaning that it was more difficult to ensure that records were completed and ad hoc information requests responded to at short notice. Some remand work was undertaken at Portsmouth magistrates' court. We were concerned that there was no access to IT systems from there, despite requests to address that.

1.3. Half of the PSRs that we inspected were not good enough. Many needed to be more analytical, concise and focused on the most important things that the sentencer needed to know. Where a custodial sentence was a possibility, we considered that not enough consideration was given to robust options in the community. This aspect of a PSR is particularly important to the outcome. We found inappropriate terminology and careless use of language that could have inadvertently increased the likelihood of a custodial sentence. We were encouraged that the YOT had recently completed a quality assurance exercise for PSRs, had identified a similar range of concerns and had begun work to source appropriate training.

Case illustration

Luke received a custodial sentence for burglary. He had refused to meet his case manager to undertake an assessment to inform the PSR. However, she persevered and saw Luke in the court cells on the morning of his hearing. She was able to use this to complete an assessment and write a full and comprehensive PSR that was detailed, concise and analytical. It was presented to the court later that day. This meant that the court did not have to delay the court hearing and was able to sentence Luke in full knowledge of all relevant information. It also ensured that sentence planning was fully informed by Luke's circumstances.

1.4. Staff understood the ETE needs of those with whom they worked. Initial assessment included information gained through accessing the local authority's education database. Local authority personnel located in the same office aided access to information for assessments. For those who had not been in prior learning, an initial assessment of literacy and numeracy was not routinely undertaken to inform how work should be undertaken. However, once referral had been made to the ETE officer this was undertaken. Good internal links with the local authority inclusion and support panel ensured that detailed assessments were carried out to make sure that children and young people of school age were placed in appropriate provision.

1.5. There was general acknowledgement that health professionals were not being well used by case managers, including in assessments. Therefore, assessments of substance misuse, emotional or mental health and physical health were not rigorous and were often insufficient, with health concerns not clearly identified and referral pathways unclear. To date there had been no routine dip sampling on cases to check the accuracy of the assessments. There was a perception that the most chaotic cases were the ones likely to get referred, rather than as a consequence of good assessment. Support and advice was available for lower level of need cases but this was not generally taken up by case managers.

1.6. The substance misuse worker had been proactive in chasing up referrals from case managers, based on the assessment score for that section. It was a good idea for the substance misuse worker to confirm that she was aware of cases that should have been discussed with her; however, it served to highlight the shortcomings in the assessments.

1.7. The Child and Adolescent Mental Health Service (CAMHS) worker also actively reviewed the accuracy of referrals and pursued those which she felt had been missed. There was acknowledgement that more recent assessments were more accurate. Whilst use of the Screening Questionnaire Interview for Adolescents (SQIfA) screening tool was encouraged, this had been inconsistent and little evidence was found of this, even though case managers were aware of the correct process. Some cases had been referred to mainstream CAMHS without input from the YOT CAMHS worker.

1.8. While there was some evidence of self-assessments being completed by children and young people, the information was not used well to inform the assessment or subsequent planning. For example self-identified concerns with sleep and alcohol did not feature in one assessment, intervention plan or health referral even though the case manager recognised that these were relevant.

2. Planning for interventions

2.1. Planning for work to reduce the likelihood of reoffending was poor. Plans often did not reflect the assessed needs. They were not sufficiently focused on reducing the likelihood of reoffending, their objectives were not clear and they were not sequenced appropriately. While the great majority of cases had a plan on file, too many appeared to have been produced to satisfy process requirements rather than as considered attempts to plan what work needed to be done, agree this with all who were involved and ensure that it was communicated to anyone who needed to know it. Partners had not been involved in the planning, as required, to ensure that it was consistent and integrated. Reviews of plans were insufficient, primarily because they did not resolve the shortcomings in initial plans, and did not reflect progress made or other changes.

2.2. National standards require that custodial sentence plans are agreed jointly by the YOT case manager and secure estate staff, even though they are completed in the secure estate. Planning during the custodial phase of sentences for work to reduce the likelihood of reoffending was insufficient in more than half the cases. There were three common reasons. Firstly the plan did not reflect the YOT assessment, secondly it did not reflect the whole sentence and thirdly it was unclear which aspects were to be delivered in custody and the community. A Detention and Training Order is a single sentence served in two parts and it is important that a clear message is presented from the beginning of what progress needs to be made throughout the whole sentence, and the opportunity to begin that work during the custodial phase is maximised. Where plans do not meet the required standards case managers should be empowered to escalate this.

Comment from a child or young person

"...I didn't get much of a say. They already had a list when they came and I just agreed to make it easier".

"It was like a discussion thing. I got choice and then he told me what he thought was best for me and why. I could have said no to them, but he explained how it would help and stuff".

2.3. Where a complex ETE intervention was required, the case managers and ETE officer arranged appropriate meetings with the school, parent/carer and child or young person to organise this. ETE featured regularly in planning, but progress on an ETE intervention was not always reflected well in reviews.

2.4. Planning to address health needs was insufficient in just over half of the cases. Emotional and mental health was the most problematic area. Plans were often developed without reference to health workers and omitted health concerns. Health workers were often left to work in isolation from other work to reduce reoffending. The YOT acknowledged that there were problems using the pathways into health work effectively and health workers did not use the case management system as required. Case managers had a range of referral options available, including informal discussions, but often none were used unless a high level of need was apparent.

2.5. Physical health needs were not always appropriately considered, assessed or addressed and referral pathways were not clear. More helpfully, waiting lists for sexual health support could be bypassed using the nearby one-stop shop.

2.6. In referral order cases it was unclear whether the reasons for offending had been explored sufficiently at the youth offender panel. Similarly, it was unclear if there was sufficient engagement with the child or young person to consider and agree the contents of their contract prior to signing

it. Contracts did not clearly state what interventions the child or young person had agreed to undertake. Reparation was not always included on contracts, in contravention of statutory guidance.

3. Delivery of interventions

3.1. Interventions delivered were consistent with the plan in only just over one-third of cases. Often it was unclear what, if any, interventions had been delivered, and in others the planned interventions had not been delivered and/or there was no clear link between the interventions that were delivered and the assessment or plan. There was little evidence of the effectiveness of interventions being reviewed.

3.2. While ETE interventions were clearly delivered in about three-quarters of the cases, where these were required, the frequency with which interventions were delivered to address thinking and behaviour, attitudes to offending and motivation to change was poor. It was consistently reported to us that, due to staffing difficulties, low priority had been given for a period to interventions to reduce offending behaviour. Restorative justice featured sufficiently well in only 4 out of the 26 cases where this was required, even though making use of the available time to undertake this had been cited as a reason by the YOT for not focusing on offending behaviour interventions.

3.3. However, in the small number of cases where we did find that offending behaviour work had been undertaken, it had often been done well, with appropriate resources used that were delivered as intended. Case managers now have a consistently positive relationship with children and young people and their parents/carers; however it was apparent that this had not been the case during the whole sentence for many of the cases we inspected.

Comment from a child or young person

"[She] comes to my house and speaks to my mum. She gets on my case too, reminding me about stuff like appointments and college. There's no escape from them both. But it's all fine...[She] makes me feel like I'm not alone – we're all in it together".

3.4. Less than half of the cases examined included evidence of the required health interventions being delivered, with evidence of substance misuse interventions being most commonly absent. It was generally accepted that the health workers were well qualified, skilled and experienced, but there was a lack of understanding from case managers of the range of interventions used by them or of the outcomes from those interventions. Health workers were rarely asked for updates by case managers. Both health workers tried to be proactive by cutting and pasting some information from their own systems into the Youth Offending Information System (YOIS+) but this was not an effective way of working together.

3.5. Victims spoke positively about their relationship with the YOT; but they felt that restorative processes such as reparation took too long to complete, and that by the time they happened it was too late for the child or young person to recognise the link between their offending and the reparation. There was also the risk that leaving actions for too long could re-victimise the victim.

3.6. An appropriate balance was struck between delivery of interventions to manage risk of harm, reduce the likelihood of reoffending and address vulnerability in only just over one-third of cases.

Comment from a victim

"Things happened really slowly, I had almost forgotten about it when the letter of apology arrived".

4. Initial outcomes

4.1. We judged that reasonable and sufficient progress had been made as at the date of inspection in only 19% of cases where we had assessed that attitude to offending was a priority, 21% of cases where motivation or lifestyle was a priority, and 24% of cases where thinking and behaviour was a priority.

Comment from a young person who made a direct apology to their victim

"It's right I should do it, I was in the wrong. I'm no coward. You do feel ashamed. [The YOT] have made me see what I did".

4.2. The area where improvements were most commonly made was in ETE, where initial outcomes for children and young people known to the YOT were good but fluctuated. Staff worked hard to use their limited time to maintain the well established links with local schools and colleges, and some positive examples were identified to illustrate how the YOT had successfully helped children and young people make good progress in their engagement with ETE provision. For example, supporting and encouraging children and young people who started to attend part-time provision to increase their number of hours. In another example, a structured programme of activities correlated with a reduction in offending.

4.3. The provision available through the main providers and colleges to which young people were referred was generally good and flexible. Courses provided opportunities to develop independent living skills and skills to enable young people to progress into training or employment, and to gain accredited qualifications. The availability of courses to develop English and mathematics was good. However, the range and variety of providers and options was not sufficient. Volunteer opportunities were available, but links needed to be made, in particular with employers in order to develop opportunities for work experience.

4.4. While attendance at suitable provision was monitored, data analysing the effectiveness of provision and the success rates or achievement for children and young people known to the YOT was not available.

4.5. Case managers tried to work with children and young people and their parents/carers to encourage sustainability of engagement with the provision following the end of the sentence. When this was done it was done well. However, workload and other priorities often meant that this was not undertaken.

Comment from a young person

"I don't want to get back with the old crowd and that's how I always got into trouble...[He] respects that and we meet at different times so I don't bump into them".

Comment from a young person

"You wouldn't want it done to you, [the victim awareness work] made me realise you've gotta work for your own money. Need to work to buy stuff for yourself; you can't just keep robbing it".

4.6. Insufficient overall progress was demonstrated in relation to identified health concerns in a high percentage of the cases, in particular in relation to substance misuse. The concerns were twofold. Firstly, there had been a lack of information exchanged in relation to outcomes (NB: the service was based elsewhere, i.e. not co-located with YOT staff). Secondly, little progress was seen to have been made in some cases to demonstrate a reduction in the substance misuse and the impact this had on offending behaviour. Independent outcome monitoring had been done by the worker within the substance misuse service, but this was not used by the YOT. The lack of integration with the health services and lack of outcome monitoring in relation to emotional and mental health work contributed to the lack of evidence of progress.

4.7. Reductions in the frequency and seriousness of offending were seen in just over half of the cases where there was sufficient evidence to assess this.

4.8. Insufficient attention had been given to ensuring that positive outcomes were sustainable beyond the end of the sentence in over half of the cases. We were encouraged by work within 'Priority D' of

the Portsmouth Children's Plan to develop step-down support. If implemented well, and with a good understanding of the particular needs of children and young people who have offended, this has the potential to make a positive difference to the likelihood of children and young people remaining free of offending once they have finished their sentence.

Lack of appropriate engagement with health workers

The lack of appropriate engagement with health workers was illustrated by a recent case that had included a drug treatment order. This relied on the efforts of the substance misuse worker to engage the young person, assess and plan for the sentence without this being integrated with the rest of the offending behaviour assessment and plan. There was insufficient understanding within the YOT of the requirements of the order in terms of responsibilities to ensure compliance, deal with enforcement and the necessity of consent.

5. Leadership, management and partnership

5.1. The level of understanding among case managers, of the principles of effective practice with children and young people who have offended, was mixed. It is, therefore, no surprise that the quality of assessment and planning to inform the delivery of appropriate interventions was insufficient in some cases.

5.2. The deployment of a police officer to the YOT was now broadly in line with that suggested in national guidance. This was a positive development. However, case managers had limited mutual understanding of the police officer role and potential contribution to the work. Consequently, the specific skills, knowledge and experience that a police officer could bring to the team were less likely to be used effectively. For example, there was little evidence of attempts being made by case managers to make links through the YOT police officer with local policing, such as safer neighbourhood teams, police custody staff, or officers involved in policing the misuse of drugs.

5.3. The police officer reported difficulties with effective sharing of information, particularly the inability to access information using IT when working away from the YOT office. This had an impact on the effectiveness of the role.

5.4. The YOT should be alerted when children and young people have come to the notice of the police. We were unable to confirm that there was a systematic approach in place to ensure that this happened in every case.

Portsmouth Priority Young Person Scheme

The Portsmouth PYP Scheme targeted those who posed the highest likelihood of reoffending. It was a partnership between the police, YOT, local authority and voluntary sector agencies. Its objectives included being a framework for joint management of these children and young people and sharing of information in order to reduce the likelihood of reoffending and the risk of harm. Children and young people were referred through a broad range of routes including YOT assessment, frequency of arrest and conviction, concern identified by a 'step-down' agency, police intelligence or assessment as being a high Risk of Serious Harm to others. A second strand focused on those in the YOT with specific characteristics. These children and young people were discussed at a monthly strategy meeting which allocated a lead professional and ensured that appropriate resources were put in place. Initial outcomes appeared to be positive and children and young people were targeted for intensive intervention earlier than would have otherwise been the case.

5.5. The education officer post was vacant and the complement of ETE officers had been reduced. Responsibility for maintaining links with providers and developing the provision was unclear. Staff were concerned about the capacity to continue to ensure that their referrals resulted in positive and timely interventions.

5.6. Advice and guidance for those post-16 was available within the YOT. Links with the integrated targeted youth service and the Portsmouth craft and manufacturing industries provided additional information and guidance services. Opportunities were available to develop job search skills, build CVs and complete applications.

5.7. Partnership working between the YOT and its key ETE partners was good with providers having a good understanding of the needs of children and young people who had offended. The YOT linked effectively with the local authority education systems. There were clear protocols for work with those of school age.

5.8. Health workers had not been used as effectively as they should be. Operational oversight, referral processes, the level of interaction and information exchange and case manager awareness all needed improvement. The relevant health information recorded within the YOT case management system was very limited. Given the lack of good quality health needs information, referred to elsewhere in this report, it is impossible to be confident that there were effective arrangements to address those needs. In relation to physical health, it was clear that these needs were not being met since little had been done to identify them and ascertain how they were linked to offending behaviour.

5.9. Recording of the key aspects of contacts with children and young people was, at best, inconsistent and sometimes poor. An adequate record of each contact, including an assessment of its impact, is essential to informing ongoing work and effective communication with all those who may need to be involved in the case.

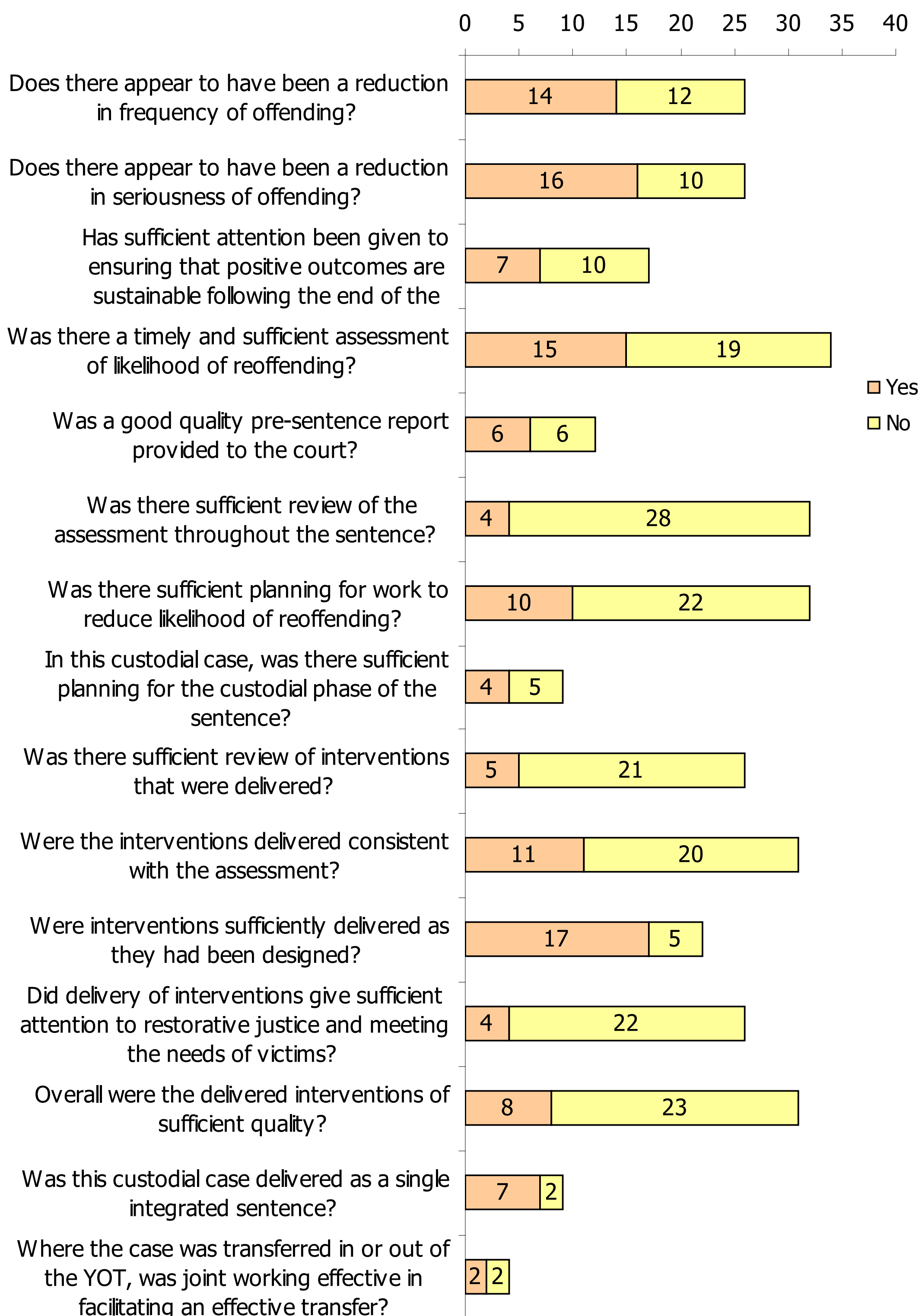
5.10. A helpful Children’s Services internal audit of assessment and planning work had recently been completed. It mirrored many of the findings from this inspection.

Summary

Overall, work to reduce reoffending was poor. It continued to suffer from longstanding individual performance problems and gaps in the establishment of competent case managers. When interventions were delivered they were done well. However, they were not delivered often enough, largely due to poor assessment and planning and staff shortages. Work to address employment, training and education needs was positive but remained at risk due to a key post being vacant. Health work was not well integrated into the YOT, although health workers delivered some good interventions. The role of the YOT police officer was not yet being used to best effect.

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

2

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 43% of work to protect the public was done well enough.

Key Findings

1. The quality of work to manage risk of harm to others continued to suffer from longstanding individual performance problems and staff shortages.
2. Assessment was poor and planning required substantial improvement. Neither gave sufficient attention to health concerns and the involvement of health workers.
3. Not enough consideration was given to the needs of victims.
4. Priority was appropriately given to cases that needed to be managed within multi-agency public protection arrangements (MAPPA). This work was done well.
5. Interventions to manage risk of harm to others were often not delivered as required.
6. Management oversight of risk of harm work had not been effective.
7. Insufficient priority was sometimes given to work to reduce the risk of harm to others.

Explanation of findings

1. Assessment

1.1. Assessment of the risk of harm to others was not good enough in just over half of the cases. In two-thirds of these, the initial screening was inadequate so that it had not properly informed the need for a full assessment. When a full assessment had been completed, insufficient consideration was often given to actual or potential victims, and other relevant offences or behaviour were sometimes ignored. Only one-quarter of reviews of assessment of risk of harm to others were good enough, primarily because they gave insufficient consideration to changes that had occurred and had not corrected deficits in the initial assessments.

1.2. Health needs were not considered sufficiently, although good use had been made of existing external reports, such as psychological reports prepared for court. Even so, the impact of health-related needs on risk of harm to others was better understood than was its impact on vulnerability, for example the risk posed to others by excessive alcohol misuse rather than the risk to self and vulnerability.

2. Planning for interventions

2.1. Planning for work to manage risk of harm to others was good enough in only just over half of the cases where this was required. We were pleased to find that risk management plans were

normally completed when required and were timely. However, their quality was often insufficient. We expect plans to be clear, with precise actions that clearly articulate the plan to everyone who needs to know about it. Plans should not normally be cluttered with unnecessary repetition of the assessment. We rarely saw plans that met these standards. In particular the precise nature of the plan (i.e. the planned response) was often unclear or not good enough and victims' issues were not always addressed sufficiently. On some occasions there was inadequate linkage between the plan to manage the risk of harm and the overall intervention plan that should have been driving the work with children and young people to reduce the likelihood of them reoffending. In a substantial number of cases, reviews had not been undertaken as required, and in others they were not timely to meet the needs of the case. For example, where the risk of harm is higher, then assessments and plans should normally be reviewed more frequently. The review should also be undertaken within the timescale that was determined when the plan was created.

Case illustration

Lee received a youth rehabilitation order (YRO) for an assault. Insufficient attempts had been made to overcome family difficulties to enable a full assessment to be made. No intervention plan was created and neither of the plans to manage the risk of harm or vulnerability presented clear actions, instead containing mainly narrative background. The case was taken over by a new case manager. She used a range of methods to ensure that a full assessment was completed, rather than just expect Lee to attend the office. She produced new plans that included specific clear actions to manage risk of harm and vulnerability, including actions to build on his strength and resilience. They clearly defined the role of other agencies and the arrangements for information sharing. Contingency plans were also included in case circumstances changed. In doing these, the case manager took full ownership of the case, addressed the previous deficits and increased the likelihood of the risk of harm and vulnerability being managed well.

2.2. We were pleased that priority was given to those few children and young people whose risk of harm to others was such that it needed to be managed under MAPPA. Engagement with MAPPA in the assessment and planning was good in both cases where this was required.

2.3. Managing the risk of harm to others posed by those who had health needs was often undertaken without the clear involvement of health workers. The CAMHS worker sometimes prepared her own risk management plans to ensure that all of the agencies she worked with were aware of the risks and could take appropriate action. There was no link made between the YOT risk management plan and these other plans.

3. Delivery of interventions

3.1. In almost two-thirds of cases work undertaken to manage the risk of harm to others was not consistent with the assessment or plan, and in almost three-quarters interventions were not delivered as required. There was often no clear link between the assessment or plan and the interventions actually delivered.

3.2. In almost half of the cases where the required interventions were not delivered, the need for them had not been recognised by the case manager. Half those interventions planned were not then delivered. No clear or appropriate reason was given for this. The focus seemed to be on completing a form to meet process standards, rather than on ensuring the right actions were taken to minimise risk of harm to others.

4. Initial outcomes

4.1. MAPPA and other multi-agency arrangements were effective in managing risk of harm to others in each of the few cases where this was required.

4.2. Overall, we judged that the YOT had done enough to manage the risk of harm posed by the child or young person in less than half of the cases inspected. This was primarily because the required interventions had not been delivered, itself partially a consequence of shortfalls in assessment and planning. In almost one-third of cases we assessed that work to manage risk of harm had not been accorded sufficient priority relative to other work in the case. While it can be difficult to strike the right balance between managing the risk of harm, delivering work to reduce the likelihood of reoffending and addressing the welfare or vulnerability of the child or young person, it is not an either/or. Risk of harm work and reducing reoffending work done well reduce the vulnerability of the child or young person; and it is not in their best interests to leave their risk of harm to others unaddressed.

4.3. Where an actual victim or potential victim could be identified there was sufficient evidence that the risk of harm to them had been well managed in only just over one-quarter of cases. Just because a child or young person has been assessed as being a raised risk of harm to others does not necessarily mean that they will go on to cause harm; however, victims in particular have the right to expect that the right things are done to reduce the likelihood of this happening.

5. Leadership, management and partnership

5.1. Management oversight had not been effective in ensuring the quality of work to manage risk of harm to others in almost three-quarters of the cases where this was required. There were too many cases, particularly earlier in 2013, where oversight had been required but had not been provided, or where insufficient work had been countersigned before shortcomings were addressed.

5.2. Involvement with MAPPA was positive, and priority was given within the YOT to these cases with the highest risk of harm to others. However, a systemised approach to their management had not been clearly adopted. We were informed that a single point of contact (SPOC) for MAPPA issues existed within the YOT, but it was not clear that the role was adequately recognised or developed. An effective SPOC is widely regarded as necessary to support a consistent and appropriate approach to what is normally a small number of often complex cases. We saw positive and constructive engagement of YOT police officers in MAPPA meetings involving children and young people.

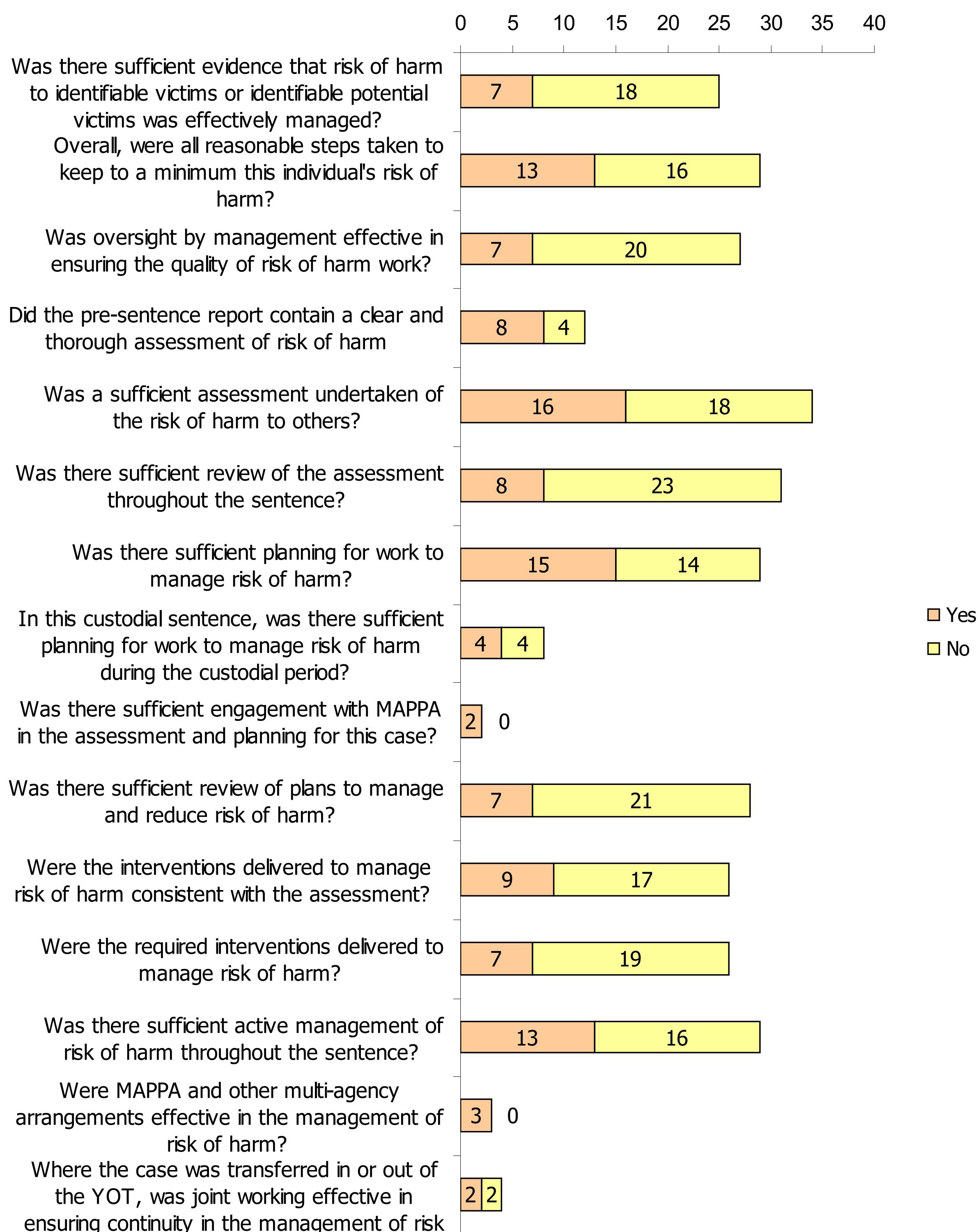
5.3. Only half of the case managers that we met had a clear and appropriate understanding of local policies and procedures for risk of harm work. The YOT still worked to many Wessex YOT policies and procedures, but was replacing these with Portsmouth procedures. However, we noted that none of the documents provided a clear expectation of what management oversight would provide.

Summary

Overall, work to protect the public and actual or potential victims was poor. As with other work it continued to suffer from longstanding individual performance problems and gaps in the establishment of competent case managers. Assessment was poor and the impact of this was felt throughout the work. Priority was given to those cases with a high risk of serious harm to others that needed management under MAPPA. This work was done well. Not enough consideration was given to victims when planning and undertaking work.

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

3

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 55% of work to protect children and young people and reduce their vulnerability was done well enough.

Key Findings

1. Work in more complex cases such as those close to child protection thresholds was good.
2. Beyond that, work was weaker, assessments were of variable quality, planning was not sufficient and as a result required interventions were not always delivered.
3. Health workers were not well linked into this work. Their interventions to reduce vulnerability were often undertaken in isolation from other work.
4. There was good communication between YOT staff and those in children's services, with whom there were good working relationships.
5. Delays in completing the new management and team structures, staffing and individual performance difficulties had affected the pace of improvement of this work, although there were early signs of improvement in practice.
6. Clear priority was given to keeping children and young people safe.
7. Management oversight of work in individual cases had not been effective.
8. There was not a systematic approach to ensuring that all staff had received appropriate training in child protection.

Explanation of findings

1. Assessment

1.1. The timeliness of assessments of vulnerability and the risk of children and young people coming to harm was good. However, the quality of these was too variable and less than half were good enough. The most common concerns were that the breadth of vulnerability factors that existed in a case had not been recognised. In some cases the need to review all of the factors in a full assessment had not been recognised.

1.2. We were encouraged that most YOT assessments seen, in relation to children and young people subject to child protection plans or looked after plans, were at least sufficient. They appropriately considered the information and assessments from other services, in particular children's social care services.

1.3. Health workers were not always included, as required, in contributing to assessments of vulnerability, nor in the creation of plans to manage vulnerability. Therefore, their views had not informed the assessment.

1.4. Information was not well shared between the YOT and health professionals, who had limited opportunities to access the YOT case management system.

2. Planning for interventions

2.1. Planning for work to safeguard and reduce the vulnerability of children and young people at the start of the sentence was sufficient in just under half of the cases where this was required. Earlier comments about the quality of plans to manage risk of harm apply equally to vulnerability management plans.

2.2. However, we were pleased that planning in more complex cases, such as when there were child protection concerns or children and young people were looked after, was good enough. During custodial sentences there was planning in place throughout the custodial period for work to address safeguarding and reduce vulnerability in all except one case. Assessment and planning work with unaccompanied asylum seeking children and young people was appropriate for their needs.

2.3. Individual plans were created by health workers, which would often contribute to the management or reduction of vulnerability. However, these were done independently and not well integrated with overall YOT plans.

2.4. Reviews of assessment and plans for work to safeguard and reduce the vulnerability of children and young people generally suffered from the same problems as in work to manage risk of harm to others.

3. Delivery of interventions

3.1. YOT staff worked well with partner agencies to protect children and young people in those cases seen by inspectors that were close to the child protection threshold or who were looked after. Case managers routinely attended planning meetings and contributed to formulating multi-agency plans, including those related to child sexual exploitation, missing children and young people, child protection conferences and Looked After Children reviews. However, there was little evidence of YOT staff challenging decisions of other agencies, nor of such challenge being responded to positively. For example, the transfer of accommodation of a young unaccompanied asylum seeker, against YOT advice, resulted in increased offending. Where multi-agency meetings took place, there had usually been health representatives and their contribution had been both welcomed and effective.

Case illustration – help to return home to dad

Charlie's relationship with his dad had broken down and he was living in a hostel. The case manager helped them rebuild their relationship by meeting with them both regularly, discussing the issues they had previously and helping them develop strategies to improve the situation. As a result, Charlie was able to successfully return to living at home.

3.2. The required interventions to reduce vulnerability had been delivered in just over half of the cases. There was often no clear link between the assessment or plan and the actual interventions delivered, and the required interventions had often not been recognised by the case manager due to shortcomings in the assessment or planning.

4. Initial outcomes

4.1. Where children and young people were subject to child protection plans or other plans, interventions to protect them and to reduce their vulnerability were delivered as required.

4.2. YOT staff knew their cases well and routinely communicated with children's services staff who

provided support to the young people and their families. Where children and young people, known to the YOT, were engaged in other support programmes, such as the troubled families, Multi-Systemic Therapy or the Family Intervention Project, close partnerships had been established.

4.3. Overall, the YOT had done enough to keep the child or young person safe and to reduce their vulnerability in just under two-thirds of cases. Where this had not been sufficient, it was due to shortcomings in the planning in all except one case.

5. Leadership, management and partnership

5.1. Managers had worked hard to achieve some improvement in the quality of work, although this was not yet consistent or sustained across the team. Their ability to make rapid and substantial progress had been hampered by the performance of some staff, staff turnover, delays in confirming and then filling the new team structure.

5.2. Staff and managers recognised that protecting children and young people was a priority for the YOT. However, oversight had not been effective in ensuring the quality of work to address safeguarding and reduce vulnerability in three-quarters of the cases where this was required. This was primarily because deficits in assessment and planning had not been addressed.

5.3. The Local Safeguarding Children Board (LSCB) appropriately oversaw safeguarding work within the YOT and had received progress reports on safeguarding concerns. However, these reports did not provide sufficient critical analysis of work within the YOT. The LSCB needs to increase its scrutiny of this aspect of work to protect children and young people and reduce their vulnerability.

5.4. Active and effective contribution had been made by the YOT to the development of some local child protection arrangements, in particular to the enhancement of multi-agency procedures and practices in relation to child sexual exploitation, missing children and young people and unaccompanied asylum seekers.

5.5. Co-location of the YOT with children's services had resulted in improvements in joint working and communication across the services, facilitating information and advice exchange between practitioners, joint planning and engagement in joint meetings. The contrast between this and engagement with health workers who were located in different locations was noticeable.

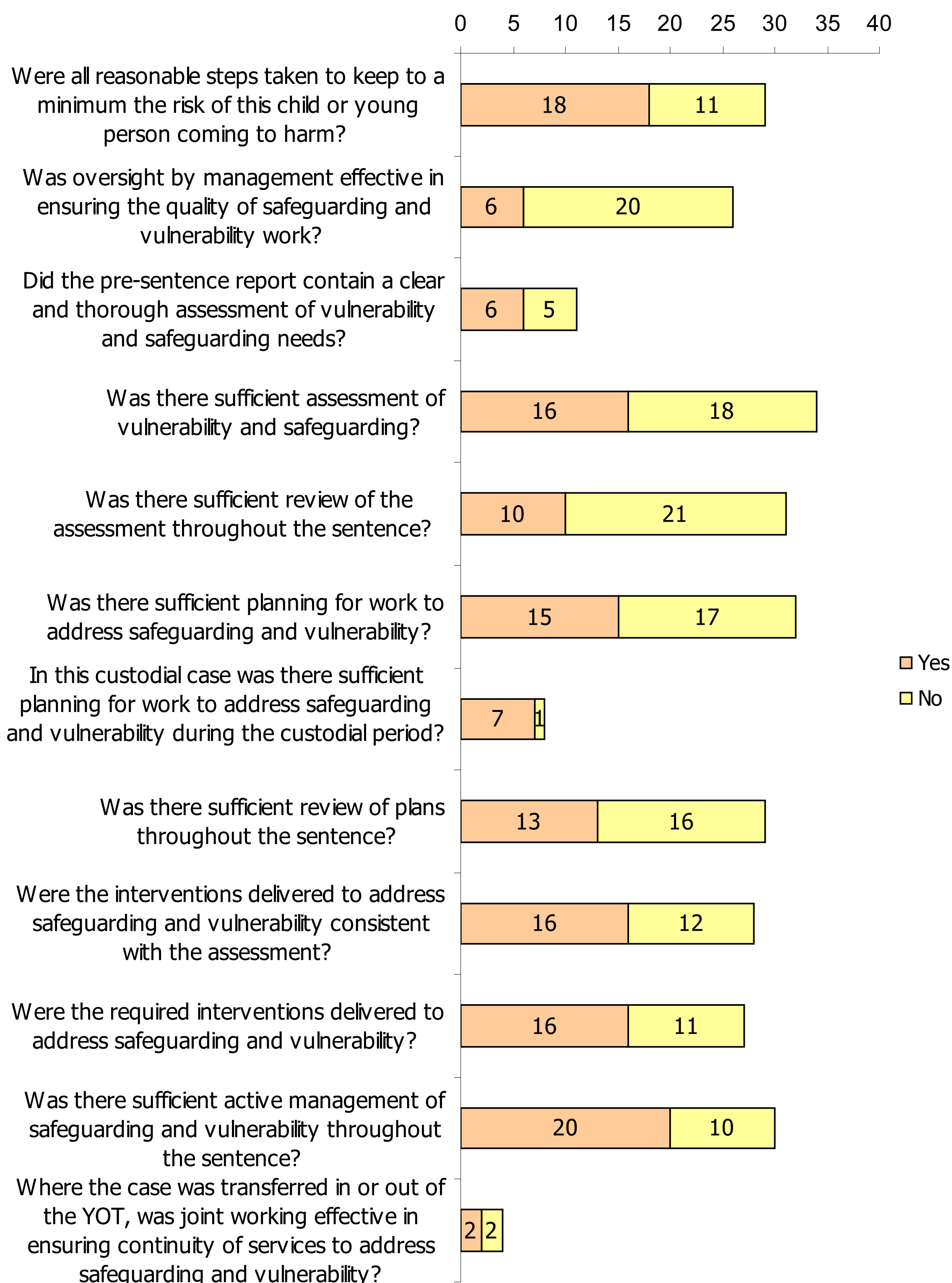
5.6. YOT staff demonstrated commitment to keeping children and young people safe and a willingness to develop safeguarding skills and experience. However, not all staff had systematically received appropriate training to understand and recognise child protection and safeguarding concerns and issues that may affect the welfare of children. Such training is essential to enhance their skills in identifying and assessing the needs of children and young people, and their families.

Summary

Overall, work to protect children and young people and reduce their vulnerability was unsatisfactory. Work in the more serious cases such as those close to child protection thresholds was good. However, work in other cases was weak and suffered from the same longstanding staffing problems as other aspects of the YOT's work. There was good joint work with staff in children's services, with whom the YOT was co-located; however health workers had not been well integrated into the work. There was not a systematic approach to ensuring that all staff had received appropriate training in child protection.

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]



Ensuring that the sentence is served

4

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 67% of work to ensure the sentence was served was done well enough.

Key Findings

1. When children and young people had not complied with the requirements of their sentence, the YOT response was normally appropriate and enforcement action was taken if required.
2. There was good engagement with children and young people and their parents/carers to carry out assessments. But, not enough attention was given to ensuring their views, as expressed in self-assessments, were recognised.
3. Insufficient attention was given to ensuring that children and young people were effectively involved in developing plans.
4. Assessment and planning to understand and address diversity factors needed improvement.
5. Inappropriate facilities were sometimes used in the Civic Offices for work with children and young people who have offended.
6. The quality of engagement and professional relationships between children and young people and case managers were good.
7. The YOT had a clear understanding of where it needed to improve the involvement of children and young people in arrangements for delivery of their sentences.

Explanation of findings

1. Assessment

1.1. Assessment of diversity factors and potential barriers to engagement was sufficient in slightly more than half the cases. Three-quarters of PSRs gave sufficient attention to these. There were many cases where there had not been an assessment of the child or young person's learning style, although generally that was done at an early stage. In some others, there was an indicator of speech, language or communication needs that had not been followed up with a full assessment. In a small number of cases, the impact of being looked after, or being an unaccompanied asylum seeker, had not been sufficiently recognised at the start of the sentence. In one particular example the case manager had continued with their assessment, even when the interpreter had not turned up, assuming a facility in use of English that was not supported by the other facts in the case.

1.2. Whilst there was generally good engagement with children and young people and their parents/carers to carry out assessments, there were a number of occasions where the assessment did not appropriately reflect views that they had expressed, and effective use was not being made of self-

assessments. More needed to be done to ensure that children and young people understood the contents of PSRs in advance of court hearings.

1.3. Children and young people reported that, on occasion, other people were present during meetings with their case manager, particularly during assessments. They were unsure why they were there and sometimes nobody had introduced them.

1.4. Good efforts had been made by health workers to engage with children and young people when undertaking assessments and also to support and encourage their ongoing engagement. Children and young people were encouraged to participate fully in health assessments.

1.5. Health workers shared information well with each other where there was a dual diagnosis and intervened appropriately, while also working jointly where required. They had developed a supportive and productive relationship.

Comment from a young person

"there was a couple of others there, but I didn't know why. Nobody explained it. Think I was supposed to see them again, but I didn't go 'cos I never knew them".

2. Planning for interventions

2.1. Children and young people and their parents/carers were sufficiently involved in planning in less than half of the cases. Primarily, this was because case managers had not recognised the need for the plan to be agreed and owned by the child or young person wherever possible, with their priorities reflected as appropriate, in order to facilitate their engagement in the work and their commitment to make changes in their behaviour.

Case illustration

Young unaccompanied asylum seekers often arrived in Portsmouth, in particular from North Africa. The YOT had been proactive in identifying that these children and young people required specific support with their use of English language. Existing well established links between the education, training and employment officer and local colleges were used to develop an English for Speakers of Other Languages (ESOL) course specifically tailored to their needs. Children and young people attended regularly and made good progress. Additional activities also were introduced that promoted training opportunities.

2.2. Planning to address diversity factors and potential barriers to engagement was good enough in more than half of the cases. The most significant areas for improvement were the need to plan to address speech, language and communication needs, and the need to sometimes undertake specific planning to recognise the impact of being looked after on engagement with the YOT.

3. Delivery of interventions

3.1. Children and young people and their parents/carers were meaningfully engaged throughout delivery of the sentence in almost three-quarters of cases. However, there was sometimes insufficient evidence of motivation being provided to children and young people to engage with the YOT and sometimes insufficient support was provided to enable them to do so.

Comment from a young person

"I went to live with my mum...she lives further away...it takes me an hour. It would be fairer if they offered to meet me half way, not all the time just sometimes, or come to my home".

3.2. The YOT was based in the Civic Offices and much of its work with children and young people was undertaken there. It did not have a dedicated room available for work with children and young people who had offended. Most YOTs have guidance materials

and leaflets readily available adjacent, or in a room specifically arranged to suit work with children and young people, but this was not the case in Portsmouth. Rooms were accessed from a public area, with a clear glass panel in part of the door enabling the public to look in and see what was happening. If a room was not available then contacts would sometimes be undertaken on chairs in the open public area, where conversations could be overheard. Because the Civic Offices were a busy public access area it also increased the risk of children and young people who had offended being identified as such by members of the public. The open area in particular was not a safe and appropriate environment in which to conduct sensitive and private work and was likely to have a significant impact on effective engagement with them. Children and young people made a number of negative comments about this.

Comments from children and young person

"...children and stuff running around. It does put you off...".

"It's not very private, I'm sure people listen to what you are saying. You wanna tell them not to be so F&%INg nosey".*

3.3. We were able to observe a small number of sessions undertaken with children and young people. In each of these there was evidence of the case manager being well prepared, with a clear objective for the session, and of a positive but professional working relationship with the child or young person.

3.4. Liaison between custodial placements and the YOT regarding education and then planning for ETE provision on release was good. For children and young people under-16 the education inclusion and support panel worked well with the YOT to ensure that appropriate provision was available on release. For post-16 young people steps were taken to try and arrange ETE placements prior to release.

4. Initial outcomes

4.1. Overall, the YOT paid sufficient attention to the health and well-being of the children and young people, particularly insofar as these may act as a barrier to a successful outcome from the sentence, in three-quarters of cases. However, case managers and health professionals had not worked together to promote health and well-being in an integrated way and appropriate referrals were not always made for health interventions.

4.2. Sufficient attention was given to ensuring that the child or young person met the requirements of the sentence in over three-quarters of cases. Children and young people reported that case managers reminded them regularly of the need to comply with their sentences and often phoned to remind them about appointments and question where they were if they were late. Children and young people found this helpful.

4.3. Just over half of the children and young people complied with the requirements of their sentence by attending their appointments, behaving appropriately and engaging with their case managers. When this had not happened, the response of the YOT had been appropriate in almost all cases.

Comments from children and young person

"[They] changed the group time so I could come, 'cos I've got a curfew and it was meaning I had to leave early. I really enjoyed that. They're good like that."

"The relationships good. I know I can call anytime."

"[She] says it how it is, I like that."

Enforcement action had been taken appropriately and this included consideration of attendance at arranged health sessions that the case manager was aware of.

4.4. However, there was no routine referral of enforcement cases to the YOT police officer to support or progress. Case managers lacked awareness of the mutual benefits that this could bring.

5. Leadership, management and partnership

5.1. Case managers had a good and consistent understanding of the expectations of the YOT for supporting effective engagement and responding to non-compliance.

5.2. The YOT had recently undertaken an audit of the participation of children and young people in assessment, planning and PSRs. This was a useful piece of work that had been reported to the Management Board. It reinforced findings from this inspection and also spoke positively to the core knowledge of the new Management Team.

Comment from a young person

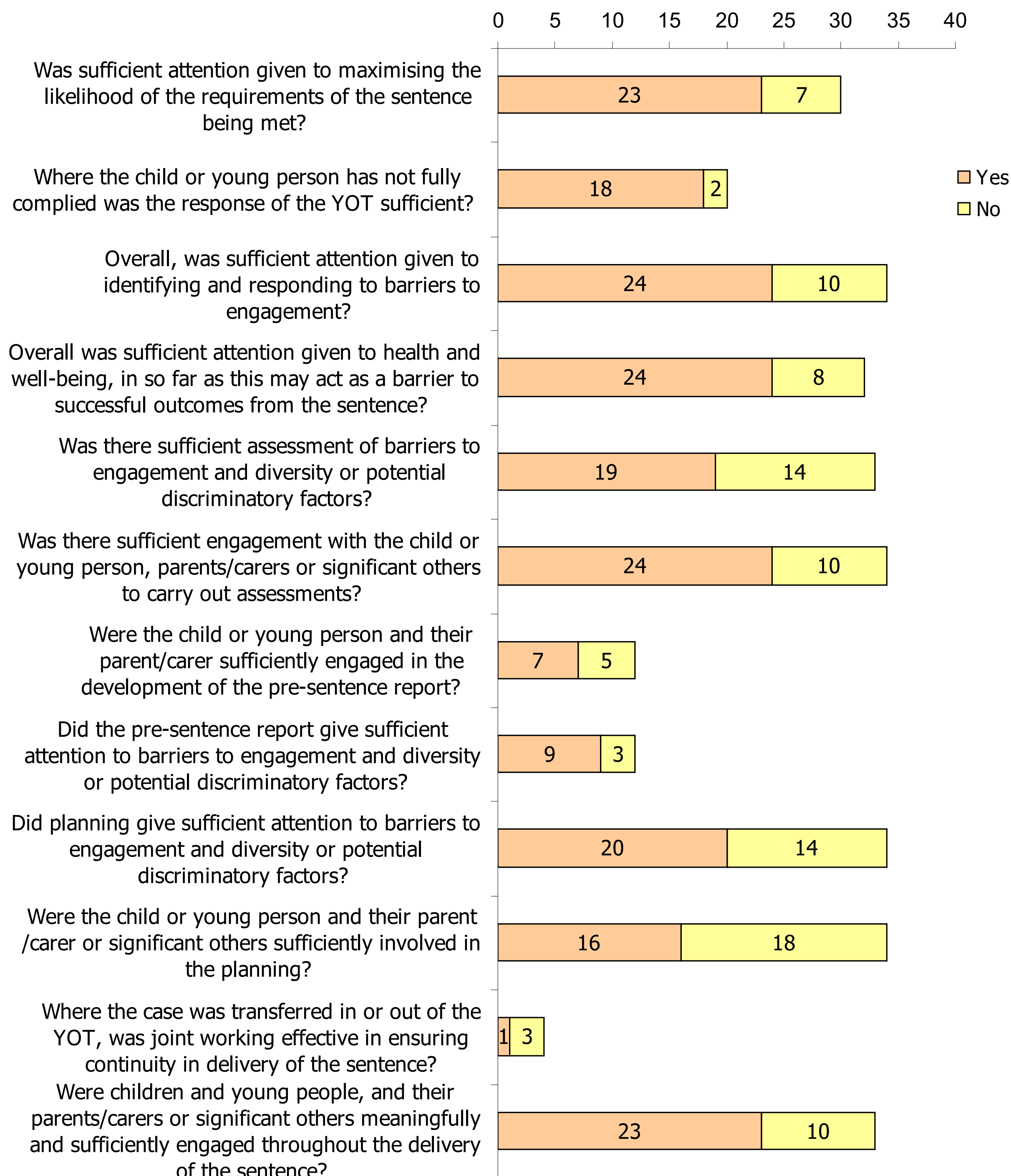
"[He] checks I am coming, phones if I'm late. He always reminds me what will happen if I forget to meet him. I don't want that so try my hardest to get there".

Summary

Overall, work to ensure that the sentence was served was satisfactory. The YOT had a good understanding of where it needed to improve the engagement of children and young people in assessment and planning for their sentences. Assessment and planning to address diversity factors needed improvement, including where speech, language or communication needs may be present. Case managers maintained positive but professional relationships with children and young people, but sometimes had to use unsuitable facilities in the Civic Offices for meetings with them. Enforcement action was taken when children and young people did not comply with their sentence.

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

5

Theme 5: Governance and partnerships

What we expect to see

Effective governance, partnership and management arrangements are 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 Board had been slow to fully recognise and act on the performance challenges that applied at the time of disaggregation from Wessex YOT, and ensure these were addressed.
2. It had not shown effective leadership to ensure that appropriate management and staff structures were in place in a timely manner, and barriers to their implementation overcome.
3. There had been three Chairs of the Board in 20 months and many Board meetings where the Chair had not attended, detrimentally impacting on their ability to drive the development of the Board and YOT, along with significant gaps in attendance at the Board by some key partners.
4. The work of the YOT was linked into wider strategic objectives in Portsmouth and the Board had given attention to the development of partnership approaches, such as the PYP Scheme.
5. The YOT Management Team was in post, but the opportunities for substantial improvement continued to be limited by ongoing staffing difficulties.
6. Staff that had been recruited in recent months were of a good calibre.
7. The views of service users were not routinely sought to inform improvement in services.
8. Performance management was underdeveloped, although a quality assurance manager had recently taken up post. The Board needed to routinely receive and consider a wider range of information about the quality of practice, effectiveness of provision and scale of needs, including the impact of diversity factors.

Explanation of findings

1. Leadership and governance – criminal justice and related objectives are met

1.1. The Management Board had stated that the focus of the YOT should be specifically to work with children and young people who were within the youth justice system. Reoffending by children and young people and the proportion of children and young people who received a custodial sentence remained substantially above those of national and comparator averages.

1.2. Serious concerns about the quality of work being undertaken in the Portsmouth team within Wessex YOT were recognised in advance of disaggregation, in particular through the inspection carried out in the summer of 2011; and there were discussions about the quality of performance on a number of subsequent occasions, along with recognition of individual performance concerns and the development of a local post-inspection improvement plan.

1.3. The scale of these problems and the urgency of addressing them were not recognised quickly enough and effective actions were not taken soon enough. In particular, the Board had been too slow to ensure that there was sufficient management and case manager capacity to improve the quality of practice. Insufficient attention was given to identifying and addressing barriers to timely

resolution of these problems. At the time of the inspection, gaps remained in the establishment of competent case managers, such that it remained a significant barrier to improvement in the quality of practice.

1.4. A number of Board members and other senior partners recognised that the Board had been too slow to act on the challenges, both immediately before and after the YOT was formed in April 2012. We were pleased that the Board had recognised the need for support from the Youth Justice Board (YJB) during its development; however, over-reliance on this had served to further delay the urgent work.

1.5. The Board was chaired by the police District Commander. Unfortunately, this was a post which, for police operational reasons, had changed hands with some frequency. There were three Chairs of the Board over the previous 20 months, the designated Chair had attended only four out of ten meetings and there was a period of four meetings, prior to October 2013, when the previous Chair did not attend any meetings. Some continuity was provided by the Director of Children's and Adults' Services, who attended most meetings and chaired meetings when the designated Chair was absent.

1.6. National guidance suggests that, to be successful and effective, the Chair should, amongst a range of characteristics, provide consistency over a substantial period of the partnership's operation and provide leadership to integrate the efforts of the youth justice partnership. The frequent change of Chair was not conducive to that individual being able to lead the work of the Board effectively during a critical period for the fledgling YOT. We were pleased that the new district commander indicated that he expected to remain in Portsmouth for a substantial period.

1.7. Portsmouth City Council officers and the probation member attended Board meetings regularly. Until April 2013, a Public Health representative had been expected to attend the YOT management board but attendance at meetings had been poor. An additional Board member representing health commissioning through the Clinical Commissioning Group (CCG) had then been established and planning was in evidence for the health contribution to the YOT. However, strong links between the health Board members and the operational health providers needed to be clearly evident. Lack of attendance by partners makes it very difficult for the Board to act as an effective lead for the YOT partnership.

1.8. Not all Board members clearly understood their individual role or the role of the Board and the YJB yet. The Board had taken part in two YJB facilitated development workshops. More recently, plans to undertake further work to support the Board to function better had been delayed. There was insufficient supportive challenge to the YOT and in our view the Board did not drive the performance and development of the YOT. However, discussion at a recent review of the PYP strategy made a positive difference.

1.9. We were concerned that the role and professional judgement of the YOT Manager, as head of service for the youth offending partnership, were not always sufficiently respected. In the best YOTs the YOT Manager often has a direct relationship with the Board and Board Chair that is independent of local management structures. While there were clear advantages to being physically co-located within children's services we were also concerned that the specific priorities and specialist skills of the YOT as a youth offending service were not sufficiently recognised.

1.10. A youth justice plan was in place as required, and this had recently been reviewed. A number of other practice development plans were also in place; however targets in these did not recognise the impact of the continuing staffing difficulties on their likelihood of being achieved.

2. Partnerships – effective partnerships make a positive difference

2.1. We were pleased to find a multi-agency partnership approach to developing services across Portsmouth, with a focus on meeting the holistic needs of the vulnerable group of children and

young people who had offended or were at risk of offending. The Board had given attention to developing partnership approaches and links into the Safer Portsmouth Partnership and Children's Plan objectives.

2.2. The PYP scheme was a recent positive and potentially valuable example of partnership working. Managed by the YOT, it linked into a Safer Portsmouth Partnership target to reduce the number of children and young people who offend frequently. Unfortunately, its effectiveness was limited by one or more key partners not being present at the monthly strategy meeting, meaning that it was unable to create and implement robust plans in all cases.

2.3. Senior police managers with responsibility for YOT work presented a clear vision of how their service could contribute to multi-agency arrangements, to partners' mutual benefit and to the benefit of children and young people and the wider community. This included a clear articulation of how police officers in the YOT could act as a 'hub', facilitating the work of YOT colleagues with the wider policing community. Had this been effectively shared with, and understood by all partners, it would have helped to ensure that the benefits of partnership were fully realised.

2.4. The valuable information that can be provided by YOT police officers can be sensitive, touching on criminal investigations, police intelligence or third parties who are not working with the YOT. We were concerned that the open plan office was not a suitable venue for these matters to be discussed. YOT staff did not appear to fully appreciate the sensitivities of such information. Better practical arrangements were needed for how such information is shared.

2.5. Key ETE performance targets were in place and were monitored. The priority to improve the quality of interventions, to develop more partnership links to extend the range and variety of provision, and the need to make links with employers to develop work experience opportunities were all recognised; as was the impact of not currently having an education officer in place and the potential impact on the service. It is a concern that such a key post remained vacant.

2.6. The Health Needs Assessment (HNA) presented to the Board in October 2013 was useful in that it identified areas which needed to be strengthened. The YOT had, however, frequently needed to elicit support from a variety of community based sources, rather than seek to consolidate what was delivered within the YOT itself. The HNA was completed without discussion with the substance misuse service and neither was the resulting paper shared with them.

2.7. Physical health needs, including speech, language and communication needs (SLCN), have not been well identified or met in the YOT although these had been considered more fully in the recent HNA. Health members of the Board indicated that some additional health funding to the YOT was likely to be used to provide training to case managers to support the identification of SLCN, which would then be met by strengthened community services. Training for case managers would be particularly valued as they recognised they had a deficit in this area.

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

3.1. We were pleased that a revised structure for the delivery of core case management had been approved, along with recognition of the need for a robust YOT management structure. The urgency of this was reflected in the fact that, due to workload pressures, there was sufficient evidence in under one-third of cases that staff supervision or quality assurance had made a positive difference.

3.2. It was also pleasing to see that the full management team had been recruited and was in place with effect from September 2013. Initial indications were that this would provide the management skills and resource to support improvement in the quality of work, once current staffing difficulties had been overcome.

3.3. The opportunity to achieve substantial improvement continued to be limited by the difficulties in recruiting the staff required under the new structure and establishing a fully competent group of case managers.

3.4. Staff reported that disproportionate time was spent doing administrative tasks, that could be undertaken more efficiently if sufficient and effective administrative systems were in place. They believed that the particular needs of YOT work, including knowledgeable cover and ensuring that working hours were fully covered, were not understood by those who managed the administrative staff. The current administrative worker had only recently started work; however, it was unclear whether this level of resource would be sufficient to provide an efficient and effective service. We were encouraged that some staff had begun to consider how systems could be improved.

3.5. It was also reported that the continuing shortfall in the number of competent case managers in post meant that staff were often required to cover other work at short notice, in which they may have insufficient experience or training. Sometimes this resulted in meetings with children and young people being cancelled and it continued to impact their ability to deliver work to the standard that was required.

Comment from a young person

"Their communication is s&!t – I got a letter about a court date that had already gone – what's that about? It's me that gets in trouble not them".

3.6. Regular supervision and case direction was provided to staff, although recording of management oversight of case practice was basic and rarely demonstrated detailed consideration of the work undertaken or actions required. Staff recognised that they now received a higher level of challenge than previously, but considered that this should be balanced better with supported development.

3.7. For much of the life of the YOT, to date, the then senior practitioner, who was new to the role, had an unacceptable workload. We are pleased that the situation has improved following implementation of the current management structure, although managers still had to focus too much on the delivery of casework, due to the continuing staff shortages and remaining performance concerns. It was therefore no surprise that that the quality of casework and oversight provided, in particular up to implementation of the new structure, was insufficient.

3.8. Staff were keen to engage in team development and training opportunities to enable them to enhance their knowledge, skills and understanding and to develop the work of the service. However, work demands and staffing problems had resulted in development opportunities, including reflective group discussions, not being systematically progressed.

3.9. The post of education worker had remained vacant resulting in the overall management of ETE in the YOT being unclear. Case managers were uncertain as to the extent of the work they were expected to do. They were concerned about being able to maintain the level and quality of ETE interventions, and effective links with schools, colleges and external providers. Additional training to prepare case managers for the more complex aspects of education training and employment had not yet taken place.

3.10. The lack of management capacity within the YOT until recently meant that the links made with the line management and clinical supervision of the health staff were insufficient, which had restricted the level of shared operational oversight and ownership of the YOT based work. There were no proper contingency plans in place relating to the CAMHS and substance misuse workers used by the YOT to ensure continuity of service if the allocated worker was absent.

3.11. A number of case managers had been recruited during the current year. We were encouraged that these new staff had the potential to produce work to a high standard and this indicated to us that managers clearly understood the type of staff required to deliver good practice.

4. Learning organisation – learning and improvement increases the likelihood that positive outcomes are achieved and sustained

4.1. Performance management was underdeveloped. This had recently been enhanced by the positive appointment of a practice lead for quality assurance, but it was too early to assess the impact of this

role. Performance management and audit systems across children's social care services had included the YOT. There was now an opportunity to make more effective use of the IT systems to support managers and the oversight of practice.

4.2. A detailed quarterly report was produced for the Board that provided a reasonable level of information and data on the performance against key priorities. However, the report was insufficiently focused on the quality of provision and on giving a clear indication of achievement or outcomes. Targets were not sufficiently focused on the quality of the provision. Further attention needed to be given to ensuring that the impact of diversity factors on the work of the YOT was recognised and addressed.

4.3. The monitoring of ETE progress of children and young people was not sufficient. There were no protocols with providers to provide information on the effectiveness of their work.

4.4. The effectiveness of the health contribution to the YOT had not been evaluated, although there was an expectation in the recent HNA that this would now happen. Attempts had been made to evaluate the timeliness and accuracy of health assessments but due to referrals having not been recorded correctly on the IT systems this had to be interrogated manually. This was inefficient and would not have been necessary if the assessments were completed well and referrals to health practitioners properly recorded.

4.5. The YOT did not seek the views of its services users about the quality of services that they had received, in order to inform improvement of these. However, we were pleased that it had already recognised the need to do this.

4.6. When asked whether their training and skills development needs were being met sufficiently to undertake their current roles, and whether the culture of the YOT positively promoted learning and development, staff said that these were only partially the case. However, staff consistently said that, whilst things had been very difficult, there were signs that the YOT was moving in a positive direction.

Summary

Overall, the effectiveness of governance and partnership arrangements in ensuring that the quality of core practice improved as required was poor. In particular, insufficient urgency had been given by the YOT Management Board to timely resolution of the staff and management structures that were critical to improving performance. Staffing difficulties continued to be problematic. Further work was required to ensure that the Board and its leadership through the Chair was effective, to ensure that its role and that of members were well understood and to hold partners to account for their contribution. Attention was given to the development of partnership approaches and the work of the YOT was well linked into local strategic objectives. Performance management and the use of data by managers and the Board needed to be improved.

Appendices

Appendices

Appendix 1
Contextual information about the area inspected

Portsmouth had a population of 205,056 as measured in the Census 2011. The youth population (those aged between 10 and 17 years old) accounted for 8.7% of the population. This was lower than the average for England and Wales as a whole, which was 9.5%.

The percentage of the youth population with a black and minority ethnic heritage was 13.9% (Census 2011). This was lower than the average for England and Wales, which was 18.3%.

Reported offences for which children and young people aged 10 to 17 years old received a pre-court disposal or a court disposal in 2011/2012, at 55 per 1,000, were higher than the average for England and Wales of 26 (Youth Justice Board 2011-2012).

The proportion of young people in Portsmouth aged 16 to 18 years old who were not in education, training or employment is estimated at 7.8%. This is higher than the average for England which is estimated at 5.7% (Department for Education 2013).

Youth Justice Board indicators

The Youth Justice Board indicators are national measures of YOT work and performance:

Reoffending measures:

(i) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a class A drug on arrest, the proportion who reoffend within a 12 month reporting period. This reoffending proportion for Portsmouth was 49.0%, worse than the 35.9% for England and Wales as a whole.

(ii) Of those children and young people who received a reprimand, final warning, court conviction or who were released from custody or tested positive for a Class A drug on arrest, the average number of reoffences within 12 months, per 100 such children and young people. For Portsmouth, there were 1.90 offences per child or young person who reoffends, worse than the 1.04 for England and Wales as a whole.

(Data based on January 2011 to December 2011 cohort)

First time entrants measure:

The number of children and young people who received their first reprimand, final warning or court conviction (and thus entered the youth justice system) in a 12 month period, as a proportion per 100,000 10 to 17 year olds in the general local population. The figure for Portsmouth is 494, compared to 484 for England and Wales as a whole.

(Data based on July 2012 to June 2013 cohort)

Use of Custody measure:

The number of children and young people receiving a conviction in court who are sentenced to custody in a 12 month period, as a proportion per 1,000 10 to 17 year olds in the general local population. The figure for Portsmouth is 1.27, compared to 0.52 for England and Wales as a whole.

(Data based on October 2012 to September 2013 cohort)

Appendix 2
Contextual information about the inspected case sample

In the first fieldwork week we looked at a representative sample of 34 individual cases up to 12 months old, some current, others terminated. These were made up of first tier cases (referral orders and reparation orders), youth rehabilitation orders (mainly those with supervision requirements), detention and training orders and other custodial sentences.

The sample sought to reflect the make up of the whole caseload and 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.

Appendix 3
Acknowledgements

Lead Inspector	Ian Menary, *HMI Probation*
Deputy Lead Inspector	Avtar Singh, *HMI Probation*
Inspection Team	Colin Barnes, *HMI Probation* Lisa Clarke, *HMI Probation* Fergus Currie, *Care Quality Commission* David Thompson, *HM Inspectorate of Constabulary* Pietro Battista, *Ofsted* Stephen Miller, *Ofsted* Clare Probert, *User Engagement Officer* Joe Coleshill*, Local Assessor*
HMI Probation Support Services	Stephen Hunt*, Support Services Officer* Oliver Kenton, *Assistant Research Officer* Alex Pentecost, *Publications Manager* Christopher Reeves, *Proof Reader* Rob Turner, *Support Services Manager*
Assistant Chief Inspector	Julie Fox, *HMI Probation*

Appendix 4
Inspection arrangements

The Full Joint Inspection (FJI) programme inspects youth offending work in a small number of local authority areas each year. It focuses predominantly on the quality of work in statutory community and custodial cases during the sentence up to the date of inspection. Its objective is to seek assurance that work is being done well enough to achieve the right outcomes. The four core themes for this inspection are:

- reducing the likelihood of reoffending
- protecting the public
- protecting the child or young person
- ensuring the sentence is served.

Methodology

Fieldwork for this inspection was undertaken on the weeks commencing:

18 November 2013 and 02 December 2013.

YOTs are informed 11 working days prior to the inspection taking place. The primary focus is the quality of work undertaken with children and young people who have offended, whoever is delivering it. Cases are assessed by a team of inspection staff with local assessors (peer assessors from another YOT). They examine these with case managers, who are invited to discuss their work in depth, are asked to explain their thinking and to identify supporting evidence in the record.

Prior to, or during, this first week we receive copies of relevant local documents. During the week in between, the data from the case assessments are collated and a picture about the quality of the work of the YOT emerges.

The second fieldwork week is the joint element of the inspection – HMI Probation are joined by colleague inspectors from the police, health, social care and education to explore in greater detail the themes which have emerged from the case assessments. In particular, the leadership, management and partnership elements of the inspection are explored, insofar as they contribute, or otherwise, to the quality of the work delivered.

During this week we also gather the views of others, including strategic managers, staff and service users – children and young people, parents/carers and victims, and where possible observe work taking place.

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

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 Youth Justice Board. 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.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work

Appendix 5
Scoring approach

This describes the methodology for assigning scores to each of the core themes:

- Reducing the likelihood of reoffending.
- Protecting the public.
- Protecting the child or young person.
- Ensuring that the sentence is served.

Inspection staff examine how well the work was done across the case - from assessment and planning to interventions and outcomes, focusing on how often each aspect of the work was done well enough. This brings together performance on related elements of practice from all inspected cases.

Each scoring question in the inspection tool contributes to the score for the relevant section in the report. In this way the core themes focus on the key outcomes.

This approach enables us to say how often each aspect of work was done well enough, and provides the inspected YOT with a clear focus for their improvement activities. Each core theme is assigned a percentage (quantitative) score which, along with a descriptor, is then given a provisional star rating.

Case assessment score	Descriptor	Star rating
80% +	Good	★★★★
65% - 79%	Satisfactory	★★★☆
50-64%	Unsatisfactory	★★☆☆
< 50%	Poor	★☆☆☆

Each of these themes contains elements of leadership, management and partnership which cannot be evidenced through the scoring system for individual cases, and which are a particular focus of the work of partner inspectorates. A moderation process then takes account of these elements to determine the final descriptor.

Additional modules are scored on a similar basis.

If there are serious and unaddressed shortcomings, in individual cases, relating to the risk of the child or young person suffering or inflicting harm that leaves someone at risk, then this may constitute a limiting factor to the star rating.

Further details of this process can be found on our website.

http://www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work

Appendix 6
Criteria

The aspects of youth offending work that are covered in the core themes in this inspection are defined in the Inspection Criteria for Full Joint Inspection. A copy of the inspection criteria is available on the HMI Probation website at the following address:

www.justice.gov.uk/about/hmi-probation/inspection-programmes-youth/full-joint-inspection-fji-of-youth-offending-work

Separate criteria are published for each additional module inspected, which are available from the same address.

Appendix 7
Glossary

ASB/ASBO	Antisocial behaviour/antisocial behaviour order
Asset	A structured assessment tool based on research and developed by the Youth Justice Board looking at the child or young person's offence, personal circumstances, attitudes and beliefs which have contributed to their offending behaviour
CAF	Common Assessment Framework: a standardised assessment of a child or young person's needs and of how those needs can be met. It is undertaken by the lead professional in a case, with contributions from all others involved with that individual
CAMHS	Child and Adolescent Mental Health Services: part of the National Health Service, providing specialist mental health and behavioural services to children and young people up to at least 16 years of age
CCG	Clinical Commissioning Group
DTO	Detention and training order: a custodial sentence for the young
ESOL	English for Speakers of Other Languages
Estyn	HM Inspectorate for Education and Training in Wales
ETE	Education, training and employment: work to improve an individual's learning, and to increase their employment prospects
FTE	Full-time equivalent
HM	Her Majesty's
HMI Probation	HM Inspectorate of Probation
HNA	Health Needs Assessment
Interventions; *constructive* and *restrictive* interventions	Work with an individual that is designed to change their offending behaviour and/or to support public protection. A *constructive* intervention is where the primary purpose is to reduce the likelihood of reoffending. A *restrictive* intervention is where the primary purpose is to keep to a minimum the individual's risk of harm to others. Example: with a sex offender, a *constructive intervention* might be to put them through an accredited sex offender programme; a *restrictive intervention* (to minimise their risk of harm) might be to monitor regularly and meticulously their accommodation, their employment and the places they frequent, imposing and enforcing clear restrictions as appropriate to each case. NB. Both types of intervention are important
ISS	Intensive Surveillance and Supervision: this intervention is attached to the start of some orders and licences and provides initially at least 25 hours programme contact including a substantial proportion of employment, training and education
Likelihood of reoffending	See also *constructive* Interventions
LSC	Learning and Skills Council

LSCB	Local Safeguarding Children Board: set up in each local authority (as a result of the Children Act 2004) to coordinate and ensure the effectiveness of the multi-agency work to safeguard and promote the welfare of children in that locality
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others
Ofsted	Office for Standards in Education, Children's Services and Skills: the inspectorate for those services in England (not Wales, for which see Estyn)
PCT	Primary Care Trust
Pre-CAF	This is a simple 'Request for Service' in those instances when a Common Assessment Framework may not be required. It can be used for requesting one or two additional services, for example health, social care or educational
PYP	Priority Young Person: a scheme in Portsmouth targeting children and young people who pose the highest likelihood of reoffending
Risk of harm to others	See also *restrictive* Interventions
'Risk of harm to others work', or 'Risk of Harm work'	This is the term generally used by HMI Probation to describe work to protect the public, primarily using *restrictive interventions,* to keep to a minimum the individual's opportunity to behave in a way that is a risk of harm to others
RoSH	Risk of Serious Harm: a term used in Asset. HMI Probation prefers not to use this term as it does not help to clarify the distinction between the *probability* of an event occurring and the *impact/severity* of the event. The term *Risk of Serious Harm* only incorporates 'serious' impact, whereas using 'risk of harm' enables the necessary attention to be given to those offenders for whom lower *impact/severity* harmful behaviour is *probable*
Safeguarding	The ability to demonstrate that all reasonable action has been taken to keep to a minimum the risk of a child or young person coming to harm
Scaled Approach	The means by which Youth Offending Teams determine the frequency of contact with a child or young person, based on their RoSH and likelihood of reoffending
SIFA	Screening Interview for Adolescents: Youth Justice Board approved mental health screening tool for specialist workers
SLCN	Speech, communication and learning needs
SPOC	Single point of contact
SQIfa	Screening Questionnaire Interview for Adolescents: Youth Justice Board approved mental health screening tool for Youth Offending Team workers
YJB	Youth Justice Board for England and Wales
YOI	Young Offenders Institution: a Prison Service institution for children and young people remanded in custody or sentenced to custody
YOIS+	Youth Offending Information System: one of the two electronic case management systems for youth offending work currently in use in England and Wales
YOS/YOT/YJS	Youth Offending Service/Youth Offending Team/Youth Justice Service. These are common titles for the bodies commonly referred to as YOTs
YRO	The youth rehabilitation order is a generic community sentence used with children and young people who offend

Appendix 8
Role of HMI Probation and Code of Practice

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

www.justice.gov.uk/about/hmi-probation

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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