

Northumberland County Council

Inspection of services for children in need of help and protection, children looked after and care leavers

and

Review of the effectiveness of the Local Safeguarding Children Board¹

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Children's services in Northumberland require improvement to be good	
1. Children who need help and protection	Requires improvement
2. Children looked after and achieving permanence	Requires improvement
2.1 Adoption performance	Good
2.2 Experiences and progress of care leavers	Requires improvement
3. Leadership, management and governance	Requires improvement

¹ Ofsted produces this report under its power to combine reports in accordance with section 152 of the Education and Inspections Act 2006. This report includes the report of the inspection of local authority functions carried out under section 136 of the Education and Inspections Act 2006 and the report of the review of the Local Safeguarding Children Board carried out under the Local Safeguarding Children Boards (Review) Regulations 2013.

Executive summary

Children's services in Northumberland require improvement to be good. Since the last inspection in 2012 some services have deteriorated. There have been significant changes of senior personnel in the last year, including the appointment of a new head of service for children's social care. This means stability is relatively recent. Senior leaders recognised the scope of this role was too large and acknowledged during inspection the reduction of additional performance management capacity to the post was withdrawn too soon. This adversely impacted on the effectiveness of management oversight.

The local authority's corporate vision and service priorities are appropriately ambitious and well aligned with those of other strategic bodies. This has not yet resulted in consistently good services for children. There is a gap between high-level strategy and ambition, which are good, and practice on the ground, which remains too variable. The pace of change has been slow although there are examples of more recent and rapid progress. There is an appropriate emphasis on early help, but the recent development of early help hubs is not yet fully effective in diverting children from statutory services. The threshold for access to statutory services is not yet fully understood or applied across the partnership or within children's social care. Too many children are referred to children's social care when a lower level response would be more appropriate.

The local authority has been slow to take effective action to reduce social workers' caseloads. Their range and complexity have not been understood by senior managers. Caseload allocation is not always proportionate to social workers' capacity and experience. Inconsistencies in management oversight and high caseloads in three teams have led to poor decision-making and delay for some children in having their needs identified. Inspectors did not however identify any children at risk of immediate harm during the inspection. As recently as December 2015, significant delay in one locality in responding to referrals, including Section 47 child protection enquiries, left children potentially at risk of significant harm. There have been delays in holding strategy meetings and failures by key agencies to attend them. There are some weaknesses in the analysis of information in assessments and the resultant plans are insufficiently outcome-focused. Private fostering arrangements are underdeveloped. The local authority has recognised some of these deficits through its performance management arrangements and has very recently introduced improvement measures. Assessments and plans completed by the disabled children's team (DCT) are of consistently good quality. Disabled children and their families have access to a wide range of services and support.

Despite shortcomings in strategy meeting participation, partnership working is generally good and resources are used well. Good joint work between voluntary and statutory agencies offers a comprehensive response to domestic abuse that reduces risk to victims and their children. Multi-agency arrangements to identify and meet the needs of children missing from home, education or care are good. Arrangements to identify and support children at risk of sexual exploitation and radicalisation are

robust and lead to timely actions to safeguard children in most cases.

Where children need to be looked after by the local authority, a range of appropriate placement options is available. Many looked after children receive good quality services but practice is not consistent across the county. The local authority takes too long to achieve legal permanence for children who need it. The quality of care applications is not consistently good. Pre-proceedings work is underdeveloped and there is insufficient legal capacity to meet the demands of the service. Independent reviewing officers' caseloads are too high, so they are not always able to provide enough oversight of progress in implementing children's care plans.

Adoption is an area of strength. Children identified as needing adoption receive good quality planning and support from the adoption service. The quality of life story work is outstanding. Prospective adopters are assessed, trained and supported well and the quality of post-adoption support is good. There have been no fostering to adopt placements in the past 12 months. The local authority recognises this as an area that requires further development.

Children looked after receive good education support. This has contributed to improving educational outcomes, which show that most children make consistently good progress, often from low starting points. However, too many older care leavers are not in education or training and fail to secure employment. Pathway plans are of poor quality and do not always provide care leavers with a clear statement of their needs and how they will be met.

Current arrangements for the independent scrutiny of children's services through the corporate parenting advisory cabinet and children's scrutiny committee do not provide effective challenge. The corporate parenting panel is not thorough enough in prioritising the needs of children looked after and care leavers. Performance information is generally good but reporting to senior managers and elected members on the progress of care leavers is too limited. Effective quality assurance of practice is not embedded. Quality assurance systems, including supervision, do not always identify practice deficits or challenge delay when children's plans have not progressed. While there is some evidence that children and young people are involved in planning services at both strategic and operational levels, some children looked after and care leavers feel their views are not taken into account.

The local authority's commissioning arrangements are effective, based on a sound understanding of local need. The local authority works well with partner agencies through the health and wellbeing board. As a result of this collaboration, services for children who have emotional health needs have significantly improved. Support for care leavers, including managing their accommodation, is good. The service has some important strengths for care leavers up to 18 years who remain at school, as well as those in apprenticeships and further education. However, during the course of the inspection, senior managers have recognised that more needs to be done to help care leavers address their emotional and mental health needs and ensure that they all understand and have access to their health history.

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The local authority

Information about this local authority area²

Previous Ofsted inspections

- The local authority operates five children's homes, including one secure home that provides support to young people from across the country. All five were judged to be good or outstanding in their most recent Ofsted inspection.
- The previous inspection of the local authority's safeguarding arrangements and arrangements for the protection of children was in March 2012. The local authority was judged to be outstanding.
- The previous inspection of the local authority's services for looked after children was in March 2012. The local authority was judged to be good.

Local leadership

- The director of children's services (DCS) has been in post since January 2014.
- The DCS is also in the role of the deputy chief executive.
- The chair of the Northumberland Safeguarding Children Board (NSCB) has been in post since April 2015.

Children living in this area

- Approximately 59,794 children and young people under the age of 18 years live in Northumberland. This is 19% of the total population in the area.
- Approximately 17% of the local authority's children live in poverty.
- The proportion of children entitled to free school meals:
 - In primary schools is 13% (the national average is 16%)
 - In secondary schools is 12%% (the national average is 14%)
- Children and young people (0–17) from minority ethnic groups account for 3% of all children living in the area compared with 22% in the country as a whole.
- The largest minority ethnic groups of children and young people in the area are Mixed and Asian or Asian British.
- The proportion of children and young people with English as an additional language:

² The local authority was given the opportunity to review this section of the report and has updated it with local unvalidated data where they were available.

- In primary schools is 2% (the national average is 19%)
 - In secondary schools is 2% (the national average is 15%).
- Within the context of the relatively low numbers from minority ethnic groups, there is a relatively large Traveller and Eastern European population who seek seasonal agricultural work in parts of the county.

Child protection in this area

- At 30 November 2015, 2,462 children had been identified through assessment as being formally in need of a specialist children's service. This is a reduction from 3,364 at 31 March 2015.
- At 30 November 2015, 386 children and young people were the subject of a child protection plan. This is an increase from 355 at 31 March 2015.
- At December 2015, three children were living in a privately arranged fostering placement. This is a reduction from eight at 31 March 2015.
- Since the last inspection, six serious incident notifications have been submitted to Ofsted, one serious case review has been completed and one is underway at the time of the inspection. Publication of the report is awaiting completion of police proceedings.

Children looked after in this area

- At 30 November 2015, 354 children are being looked after by the local authority (a rate of 59 per 10,000 children). This is a reduction from 370 (62 per 10,000) at 31 March 2015. Of this number:
 - 93 (or 27%) live outside the local authority area
 - 22 live in residential children's homes, of whom seven (32%) live out of the authority area
 - 11 live in residential special schools,³ of whom all (100%) live out of the authority area
 - 267 live with foster families, of whom 63 (24%) live out of the authority area
 - 13 live with parents, of whom none lives out of the authority area
 - one child lives in secure residential housing within Northumberland county
 - there are no children who are unaccompanied asylum-seeking children
- In the last 12 months:

³ These are residential special schools that look after children for 295 days or less per year.

- there have been 36 adoptions
 - 23 children became subject of special guardianship orders
 - 167 children ceased to be looked after, of whom 1% subsequently returned to be looked after
 - seven children and young people ceased to be looked after and moved on to independent living
 - there are no young people living in houses of multiple occupation.

The casework model used in this area

- Signs of Safety

Recommendations

1. Improve agencies' understanding and application of thresholds for access to children's social care so that children and families receive coordinated support appropriate to their level of need in a timely way.
2. Reduce social workers' caseloads and ensure that all staff have workloads that are manageable and commensurate with their level of knowledge and experience.
3. Improve the quality of social work assessments for all children and young people, including care leavers, and robustly analyse risks to individual children and young people within their family.
4. Ensure that all children's and young people's plans, including pathway plans, identify necessary outcomes and how they will be achieved and monitored. In addition, ensure that children and young people contribute to their own plans and that plans identify contingency arrangements, in particular the action to be taken if change is not achieved within the child's timescale.
5. Ensure that management capacity and oversight is sufficient and robust across the service and provides the critical challenge that drives timely progress in individual children's cases.
6. Ensure sufficient capacity for independent reviewing officers and child protection chairs so that they meet their statutory responsibilities. In addition, raise their profile to enable them to challenge and impact positively on plans that are not progressing in the child's timescale.
7. Ensure that early permanence options are considered by a child's second review and that all staff understand and respond to the importance of early permanence.
8. Review the arrangements of the risk management group and ensure, where risks to adolescents are discussed as an alternative to an initial child protection conference, that this decision is proportionate to the perceived level of risk. In addition, ensure that young people and their parents have an opportunity to participate in the discussion and the development of safety plans and reviews.
9. Improve the quality and timeliness of public law applications, including work before proceedings to ensure that viability assessments of family members and connected persons are undertaken in a timely way and have satisfied statutory requirements before children are placed.
10. Increase the capacity of legal services to ensure the timely progression of children's cases through care proceedings to legal permanence.

11. Ensure that the local authority rapidly progresses fostering to adopt arrangements where this is in the best interests of children.
12. Ensure that managers and staff understand and comply with statutory guidance relating to private fostering, and that all necessary steps are taken to protect and support children who are privately fostered.
13. Ensure that elected members, including corporate parenting and scrutiny chairs, are suitably trained so that their challenge and scrutiny of officers and partners is robust. In addition, review the effectiveness of current corporate parenting arrangements and improve the engagement of elected members with children looked after and care leavers.
14. Ensure that performance management information reported to managers and senior leaders includes sufficient accurate reporting on care leavers so that their experiences are effectively monitored.
15. Improve the provision of support to care leavers once they reach adulthood to meet emotional and mental health needs and improve participation in education, employment and training (EET).

Summary for children and young people

- Not all children who need help and protection in Northumberland get the support they need at the right time. Senior managers know this and are working hard to develop early help hubs around the county where children and their families can get help and advice when they need it.
- Some social workers have too many children and families on their caseloads. This means they cannot always spend the time required to understand children's needs well enough.
- Professionals work well together to make children safe when they go missing from home or school and help children learn about the dangers of child sexual exploitation.
- Children who are looked after by the council generally live in good homes. Foster carers and staff who work in children's homes are very committed to making children feel safe. They look after children very well.
- When children become looked after, wherever possible they live with their brothers and sisters. The council however, takes too long to decide whether or not a child can return to their parents.
- Once the court has decided that a child needs an adoptive family, the council acts quickly to find one. Children who are adopted get very good support.
- Children who are looked after get good support to attend school. Senior managers at the council want children to do well in school but they need to do more to help young people find a job or go into further or higher education when they are no longer looked after.
- Social workers and senior managers need to make sure that when young people are no longer looked after, they have all the information they need about their health history. When care leavers need help with emotional problems and worries, they do not always get the right help when they need it. Senior managers need to make sure this support is available.
- Social workers and senior managers do not listen enough to the voices of children and young people. Social workers need to help children contribute to their assessments and the plans that affect their lives. Senior managers need to ask children and young people what they think of the services they receive and use this information to improve children's experiences.

The experiences and progress of children who need help and protection

Requires improvement

Summary

Early help hubs are not yet always effective in diverting children from statutory services whose needs can be met at a lower level. In parts of the county where they are well established, the hubs coordinate a robust multi-agency approach to family support. In other localities, the hubs are relatively new and are yet to have a demonstrable impact on reducing unnecessary referrals to children’s social care. Schools and children’s centres play an important role in delivering effective targeted early help, and this is benefiting many children. The threshold for access to statutory services is not yet fully understood or applied across the partnership or within children’s social care. This contributes to high numbers of inappropriate contacts and delays for children in receiving services at an appropriate level. Strategy meetings do not always involve other agencies in discussing and making decisions for children. In one locality, there have been significant delays in responding to referrals, including those requiring a section 47 investigation. This has left children at potential risk.

Social workers’ caseloads remain too high on some teams. This means that they sometimes struggle to provide a good quality service to all children. Many social workers carry out good direct work with children and develop plans that lead to improved outcomes, but this is not a consistent picture across the service. Management oversight does not consistently provide enough scrutiny and challenge to social workers.

The quality of social work assessments and planning for children in need of help and protection is not consistently good. Despite evidence of some good quality assessments, case recording does not always capture the child’s voice and assessments do not focus well enough on individual children. Plans are not updated often enough and do not always set out the desired outcome or how it will be achieved. Not all social workers are sufficiently skilled in recognising and responding to children who experience neglect and there are currently no agreed tools or models to work with families where neglect is a concern. Private fostering arrangements are not well understood by practitioners and the potential risks to children living in these arrangements are not well considered. Work carried out by the disabled children’s team is of a consistently good standard. Assessments and plans on this team are thorough and clearly capture the voice and experience of children and those within the family.

There are highly effective mechanisms in place to respond to and safeguard children and young people who go missing from home or education or who are at risk of being sexually exploited. Timely action is taken to keep them safe. The work of the risk management group helps to reduce risk to vulnerable young people and adults.

Inspection findings

16. Early help hubs have been developed across the local authority to strengthen and coordinate the multi-agency response to children when problems first emerge. The pace of development has been slow. The model was first approved by the Northumberland Safeguarding Children Board (NSCB) in July 2014, but in some areas of the county early help hubs have only recently been introduced and these are not yet always effective in diverting children from statutory services where appropriate. Where hubs are better established, there is evidence of positive impact, for example in the shared understanding and application of thresholds for statutory services. The quality of early help assessments seen during the inspection is good. Children, young people and their families are fully engaged in assessments and their views inform planning. There is evidence of significant partner involvement both in taking the lead professional role and in team around the child processes.
17. There is a growing range of targeted early help available. Children's centres are at the heart of this work, delivering good-quality evidence-based parenting programmes and focused work with fathers. This includes support for military families and children living in rural locations. Effective and well-established services are available to support children in households where parents suffer from mental ill health or where adult substance misuse is an issue. There is a good range of interventions and wrap around support available to children exposed to domestic abuse and to adult victims. Multi-Agency Risk Assessment Conferences (MARAC) effectively coordinate information-sharing and responses to domestic abuse across agencies. Currently, some of these early help services are not available in all parts of Northumberland, for example adult perpetrator programmes and the family nurse partnership. This means that not all vulnerable children and their families benefit from a full range of support.
18. A shared outcomes framework for all early help services helps professionals link what they are doing to what they want to achieve. The Intensive Family Support Programme has replaced the Troubled Families Programme and is a good example of this outcome-focused approach. The programme encourages information-sharing, discussion and collaborative working. Northumberland identified 650 families for the 'troubled families' programme in 2012–15 and could evidence positive outcomes to varying degrees for all of them.
19. The threshold for access to statutory services is not yet fully understood or applied across the partnership or within children's social care. Northumberland receives more contacts than its statistical neighbours. In the three months leading up to the inspection, 2,117 contacts were made to children's social care. Only 50% (1,109) met the threshold for referral. Consequently, some children and families have experienced delay in receiving the service they need at the right time. This is compounded by having several points of access to statutory services across the county. Senior managers recognise this issue and are working towards a single point of contact within their current transformation programme. (Recommendation)

20. Contacts to children's social care are screened by experienced social workers and dealt with promptly. Information-sharing between agencies and professionals is effective. There is an equally effective response to contacts and referrals out of hours. Referrals on unborn babies are accepted at 18 weeks' gestation to enable the pre-birth assessment to be completed at the earliest opportunity. Management oversight of decisions is in evidence, but the rationale for decision-making and management challenge is not always clearly recorded.
21. Robust multi-agency arrangements are in place to receive referrals relating to children and adults at risk of radicalisation into a single point of contact. Effective training and awareness-raising through the NSCB have resulted in three referrals in recent months. All were from schools and were of children at perceived risk of radicalisation. While none of these progressed to Channel meetings, robust section 47 enquiries were undertaken in all cases and the children were appropriately safeguarded and supported.
22. Appropriate arrangements are in place to enable the effective identification of female genital mutilation. There are currently no reported cases in Northumberland. The local authority provides training to all staff covering, female genital mutilation, honour-based violence and forced marriage. Staff have access to e-learning programmes and clear referral pathways are in place across all partner agencies in Northumberland. These are linked to locality social work teams.
23. When child protection concerns are identified social workers undertaking section 47 enquiries are suitably experienced. However, not all strategy discussions include key professionals. Too many involve only a social worker and social work team manager. This means not all decisions to progress to Section 47 enquiries are made with the benefit of multi-agency information and perspective. Information from police and health partners is usually added to children's files as progress on enquiries. During the inspection the local authority responded positively to this finding, and immediately issued new guidance to staff that all decisions to initiate a section 47 enquiry must be discussed with police and one other agency as a minimum requirement. The process of recording section 47 enquiries was also changed, which was adding to the problem. Senior managers and police were already in consultation with the NSCB to agree thresholds to initiate section 47 enquiries and new guidance was being drafted through the NSCB during the inspection.
24. While Inspectors did not identify any child who was at risk of immediate harm at the time of the inspection, in one locality, there were significant delays in responding to referrals, including section 47 enquiries, as recently as December 2015. This left children potentially at risk of significant harm. The local authority had recognised these deficits prior to the inspection through its own audit process. Senior managers took robust action to reassess every child's circumstances within that team and introduced measures to improve practice. Inspectors found social workers in some teams with caseloads in excess of 35.

Caseload management systems are ineffective. New referrals are not always allocated in accordance with caseload capacity. Social workers in their first Assessed Year in Employment (ASYE) have caseloads that are not always commensurate with their level of knowledge and experience. Social work teams are generic and provide assessment and intervention from the initial point of contact throughout a child's journey to achieving permanence. While this does provide continuity of social worker for some children, the volume of work means social workers are not always able to produce the quality of assessment required. In addition ASYEs do not always receive the support and protection they need to develop the competence, knowledge and skill to practice good quality social work. (Recommendation)

25. Ninety three percent of assessments are completed within the local authority's own target of 45 working days. Team manager checkpoints at 10, 20 and 30 working days respectively are applied to ensure that the assessment is completed within the child's timescale but these are not always well evidenced and do not always address the quality of the assessment. In the vast majority of cases seen during the inspection, obvious risks were identified well. However, not all assessments used the signs of safety framework to its full advantage in order to explore wider risks and the impact on children of their experiences. Too many assessments do not focus sufficiently on individual children's needs, particularly when they are part of a sibling group. Assessments do not consider well enough the wider impact of equality and diversity issues within families on children's experiences. The presence of fathers and other adults are not given enough consideration despite this being a key learning point from the most recent serious case review (SCR). (Recommendation)
26. The absence of chronologies on some children's files makes it more difficult to gain a full picture of children's histories and significant events to inform analysis of need and risk. This contributes to the delay in decisive action being taken for some children where neglect is a concern. Currently, there is no use of a recognised tool, training or agreed approach to help social workers identify neglect and its impact on children. The local authority has recognised this as an issue and has recently commissioned specialist training for staff, including a toolkit to address neglect, as part of its response to the neglect strategy launched in January 2016.
27. Not all children in need plans seen by inspectors were clear about what change was to be achieved or how this would be supported, and not all plans were reviewed in a timely way. This makes it difficult to see how progress is measured against the child's plan or identify where change is not being achieved. (Recommendation)
28. The vast majority of children in need cases are managed at the appropriate level by suitably experienced and qualified staff. Inspectors identified two statutory cases that were managed by family support workers. At the request of inspectors, senior managers reviewed all children in need cases being held

by support workers. This review satisfied inspectors that this role was appropriate to the status of the case and that no statutory assessments or reviews were being undertaken by these staff. Appropriate systems are in place to step cases down to universal services. When cases step down, this is usually supported by a family support worker.

29. The local authority's own data show timeliness of initial child protection conferences (ICPC) from the point of the initial section 47 enquiry has deteriorated slightly in recent months. Conferences are mostly well attended by an appropriate range of professionals who provide written reports. Core groups are less well attended. The local authority has recognised this issue and is working with the NSCB to ensure that progressing plans for children through core groups is prioritised. Core groups do not always monitor effectively any progress made under child protection plans. Most plans are task-focused and lack evidence of contingency planning or the likely consequences for parents and carers if change is not achieved within the child's timescale. Child protection conference chairs do challenge social workers and managers when children's plans do not progress on timely but there is little evidence of impact. (Recommendation)
30. The participation of children and young people in child protection conferences is still at an early stage of development. Very few children and young people participate in conferences or core groups or contribute directly to their plan. However, child protection conference chairs make good efforts to see young people before and after conferences, where appropriate, to ensure that their views are expressed and taken account of. Some individual workers are very skilled in direct work with children. Inspectors saw some good examples of social workers using creative tools and practice to tell children's stories and hear their views, but this is not the case for all children. The exception to this is within the disabled children's team (DCT) who consistently demonstrate sensitive and bespoke work, listening to children and gaining their views. As a result, the child's lived experience shines through the assessments and plans in this team.
31. There are highly effective mechanisms in place to respond to and safeguard children and young people who go missing from home or education or who are at risk of being sexually exploited. There is good communication between education professionals and children's social care who monitor when children are missing from school. All children and young people who go missing from home benefit from a return home interview. Where appropriate, a vulnerability checklist is completed. This considers a wide range of risk and protective factors and includes all children who have suffered or who are at risk of suffering sexual exploitation.
32. Where appropriate, children's cases are escalated to a weekly risk management group (RMG) that is chaired by a senior manager from the local authority and benefits from a high level of commitment and participation by agency partners. The RMG provides a clear, multi-agency focus on risk and need. Vulnerable

adults are also discussed in the group with good input from adult services. This ensures a good read-across between children and adult issues and if required expedites interventions from adult services for parents and carers and transitions for older young people into adult services.

33. Effective information-sharing and analysis from vulnerability checklists and return home interviews identify patterns and trends of risk and concern. This feeds well into multi agency strategic planning and actions. Good information-sharing and well-coordinated agency responses are reducing risks for many children and ensure that children and young people receive individually targeted interventions and support to keep them safe.
34. Not all children who meet the threshold of significant harm are discussed at an initial child protection conference (ICPC). The local authority accepts for some older children who have reached the threshold for a strategy discussion some children's needs have been discussed at the RMG as an alternative to an ICPC. This would explain in part why only 34% (195) of 573 section 47 enquiries progressed to ICPC in 2014–2015. While this may be appropriate if the risk is not directly attributable to the care they are receiving from parents or carers, the RMG meeting does not involve the child or their family to make decisions about the child's future safety. (Recommendation)
35. Policies and procedures for private fostering are clear but not understood or applied by front-line social workers and managers. Assessments in the three cases where children are currently in private fostering arrangements have not been undertaken within statutory timescales. There are significant gaps in visits to children from their social workers. The local authority recognised private fostering has not been given enough attention. In September 2015, senior managers began a programme of auditing cases but there is no evidence that practice has improved or that outstanding actions have been followed up or challenged. (Recommendation)
36. The designated officer role is taken very seriously. Allegations of abuse, mistreatment and poor practice by professionals and foster carers are robustly investigated to ensure children and young people are safeguarded.

The experiences and progress of children looked after and achieving permanence

Requires improvement

Summary

Children do not become looked after unless it is necessary. Decision-making is appropriate although not always timely. Many looked after children receive good quality services but practice is not consistent across the county. There have been delays for some children in achieving permanence. Some children still wait too long for safe, stable and permanent parenting to be achieved for them. Not all children placed with family and friends carers are formally recognised as children looked after and they and their carers have not received the assessments and support stipulated in statutory guidance. Other children remain looked after under voluntary agreements for too long when court applications should have been made. The quality of care applications requires improvement.

The majority of children looked after live in foster placements and benefit from the experience of family life this affords. Most children live in stable placements, with educational and health care provision that is appropriate to their needs. Children and young people who offend or misuse substances, and those who are at risk of sexual exploitation receive effective help that reduces risk and increases their life chances. Children’s views, experiences and needs are not always clearly at the heart of assessments, plans and other work. Social workers’ caseloads are too high in some teams, which impacts on their ability to undertake good quality assessments for all children. Case records do not consistently demonstrate clear direction and decision making from managers. The current workloads of the Independent Reviewing Officers (IROs) are too high so they cannot always carry out their quality assurance role effectively. Challenge from IROs is not consistently heard or responded to and the robustness of their review and testing of plans need to be strengthened.

Adoption is an area of strength and children identified as needing adoption receive good quality planning and support. The quality of life story work is outstanding. Prospective adopters are assessed, trained and supported well and the quality of post adoption support is consistently good.

Support for care leavers, including living on their own and managing their accommodation, is good. The service has some important strengths for care leavers up to 18 years who remain at school, as well as those in apprenticeships and further education. However, too many older care leavers are not in education or training and who fail to secure employment. Support needs to be improved, particularly in relation to helping care leavers address their mental health needs and ensuring that they all understand and have a copy of their health history.

Inspection findings

37. At the time of the inspection 362 children and young people were looked after by Northumberland County Council. This was one third higher than in 2011–12. From being considerably below the national average, Northumberland is now just above it. Services aimed at preventing children becoming looked after are increasingly coordinated through a wide range of early help provision through targeted family and child support teams across the county. These provide bespoke responses and intensive work to meet the assessed needs of children and their families, and they help some families resolve their problems. Children do not become looked after unless it is necessary. Decision-making is appropriate, although not always timely. Some children experience neglectful parenting for too long before they are safeguarded through becoming looked after. In some instances children were known to social care for lengthy periods before decisions were made that they needed to become looked after. For those who are very young and those about to be born there is a consistently, timely focus on assessing and planning for their futures, resulting in clear decision-making.
38. Legal planning and public law outline (PLO) arrangements do not always ensure an early enough focus on assessment and progressing plans for permanence. The recently implemented PLO panel is beginning to have a positive impact in managing pre-proceedings work and ensuring action to progress care proceedings in a more timely way. However, the local authority has been slow to implement these arrangements. At a duration of 34 weeks, care proceedings in Northumberland take considerably longer than the expected average of 26 weeks. The result is that children wait longer to achieve legal permanence. Too many children spend long periods being looked after under voluntary agreements before proceedings are commenced. (Recommendation)
39. Where Northumberland intervenes through the use of public law, it is supported by good legal advice and guidance, although there have been capacity difficulties within legal services. These are seen by court agencies as having a negative effect in some cases on the thorough and timely preparation for applications and presentation at hearings. (Recommendation)
40. Where looked after children experience significant changes in their circumstances, a thorough reassessment of their needs does not always take place. Not all assessments and plans seen by inspectors are clear enough about the child's timescale for stability and permanence. Case records are not always up to date. For example, important information, such as the outcomes of looked after reviews, updated plans and new placement information, have not always been added promptly or signed by those responsible. High caseloads in some social work teams impact on the capacity of social workers to undertake good quality work in some children's cases. While the early adoption of the signs of safety approach has generally provided a positive framework, it is not fully applied to children looked after. The views of children are also not always clear at the outset or reflected in their plans, although this improves the longer

a child is looked after. Sometimes the circumstances and needs of individual children are lost among those of their brothers and sisters. (Recommendation)

41. Some good examples of assessments were seen, particularly those undertaken by the disabled children team. These were of a high quality, with the child at the heart of all assessment and planning. Communication needs and those arising from disability, culture and ethnicity were addressed well. However, assessments overall are too variable in quality and content and do not sufficiently identify the impact of ethnicity and diversity on children's experiences and needs.
42. The local authority attaches a high priority to finding local foster placements for children who need to be looked after. Matching is effective and together with good support to carers, contributes to good placement stability. There is a sufficient range of placement options, including high quality residential provision. At the time of the inspection, a high proportion (79%) of children looked after were placed within the area. In many cases this enables children to remain at their school and, where appropriate, maintain contact with families and friends. Over 88% of children are placed with foster families within Northumberland. When children are placed out of the area, it is almost always due to their complex needs and the specialist services required. Wherever possible, brothers and sisters are placed together. The very large majority of children and young people live in good quality placements that meet their needs and the majority of carers are highly positive about the support they receive.
43. When children become looked after, their carers are not always given written information needed to support their care. In some cases (two) where children became looked after under section 20 of the Children Act 1989, records did not include evidence of parental consent. Where a child is placed with extended family members or connected persons, care planning regulations are not always complied with. Inspectors identified eight cases where children had been placed by the local authority in such placements. These had not been appropriately assessed or formalised. The result is that children are placed in potentially unsafe arrangements without the support and safeguards afforded to children who are placed in foster care. In addition, family or connected person carers do not receive the same training, financial and practical support as provided to other carers. As a result of this finding, senior managers took action during the inspection to review all cases where children have been placed with extended family or connected persons. (Recommendation)
44. Social workers know children well, particularly in the disabled children team. They visit children and spend time alone with them, although several children and carers identified the turnover of social workers as a problem. Where the likely plan is for the child to live away from their birth family permanently, effective life story materials and direct work are used to support the child's understanding. While social workers were able to tell the child's story, outline their plan and their own actions and those of others, these were not fully

reflected in written records. Children's care plans are not always updated when things change or when they reach significant milestones. The history and experiences of children are not always clear as chronologies are not routinely used to document the key life events. Instead they tend to be a history of agency activity. There is still some way to go for Northumberland to achieve consistently high quality outcome-focused care plans for a safe, stable future for children who are looked after. (Recommendation)

45. Too few children looked after have a permanence plan by their second review. Almost half children looked after (24%) had been looked after in voluntary arrangements for more than two years and nearly 6% for more than five years. There is not enough routine management oversight of cases to ensure consistently high performance in achieving early permanence. While managers comment on case records, this does not often include guidance, direction or reflection. Similarly, there is only limited evidence of intervention by IROs to challenge lack of progress in cases. Even where they do challenge, it is not always acted upon by practitioners and managers. Some IROs have caseloads that are significantly higher than the figures indicated by guidance. This reduces their capacity to provide the necessary comprehensive and assertive service to all their allocated children. While capacity is now being increased, their authority and the effectiveness of their scrutiny and challenge need substantial improvement. (Recommendation)
46. For those few children with a plan for rehabilitation, active and appropriate support services are offered. When children are returned home, very few return to be looked after for a second or subsequent time (only five of the current looked after population). In the vast majority of cases, when children return home, they are well supported and improved circumstances are evidenced. Children's records do not, however, show that decisions for children to return home from looked after care are agreed by a senior manager and ratified through a looked after review, which is a legal requirement.
47. Permanence through special guardianship orders (SGOs) has increased in recent years, improving the chances for some children to remain within their extended families or have permanence with their foster carers. Almost one child in eight ceases to be looked after through such an order. A high proportion of children (six of the 32) who ceased to be looked after in the three months prior to the inspection did so through a SGO within their extended family. Families with this outcome receive the same valued offer of support as that for adoptive families. However, these arrangements are not considered early enough or supported through timely assessments or family group meetings. For some children, this positive outcome could have been achieved earlier. (Recommendation)
48. While there are challenges in recruiting in-house carers, this has not prevented Northumberland from procuring good quality placements for children and young people. Children are supported to remain in independent-sector foster placements if that placement meets their long-term identified needs. Effective

arrangements are made to identify foster care or children's home placements that take account of the child's needs, contact and proximity to school. The geographical area covered by the local authority is extremely large and the distance from home is routinely considered, minimising school disruption and distance from family. There are good levels of placement stability, with 77% of children looked after having no placement moves in the previous year.

49. Foster carers spoken to felt that they were a part of the professional team supporting the child. They spoke positively about the training they received, the care taken in planning for the child and arrangements for supervised contact. All eligible foster carers had received regular training and completed the mandatory training. Carers considered that the high levels of placement stability are supported by effective matching and accessible and responsive workers, including those working out of hours. After a period of change when the number of foster carers declined, recruitment has improved significantly with a 25% increase in capacity (to 122 placements) from mid-2014. While not yet meeting its own high target, when family and friends carers are included, there have been 35 additional foster carer households recruited in the past year, with an increase of almost one-third in the number of enquiries.
50. Assessing and mitigating risk for older children looked after are high priorities. Practitioners and placement providers are appropriately trained and able to evaluate risks from child sexual exploitation, offending and substance misuse. In the large majority of cases when children go missing, they receive a return home interview which addresses issues of concern. These are timely and undertaken in line with the level of perceived risk and complexity. Effective work by social workers is delivered alongside the commissioned service through risk assessment and arrangements to monitor, inform and adapt safety plans. Senior manager involvement across the key statutory agencies, through the multi-agency RMG, is particularly useful in ensuring that protective action is coordinated where necessary. The RMG ensures targeted actions are taken for those most at risk of harm within the community and from their own behaviours. Similarly, there is a strong coordination of effort with the youth offending team and specialist services for substance misuse, achieving significant reductions in offending as well self-harm.
51. When children become looked after, the vast majority experience improved health and educational outcomes. Almost all initial and review health assessments are completed in a timely way and identify children's needs well. Most children make progress where a need for sexual health services, substance misuse services or therapeutic assistance is identified. More than three quarters of all children looked after have an up to date emotional health survey (SDQ). Where these lead to concerns for a child, there are frequent clinical reviews with necessary action taken when indicated.
52. Advocacy and independent visiting are available for children looked after, although the take up is not high. In the 20 months prior to the inspection, there were just 34 referrals for advocacy. An online self-advocacy 'app', Mind of My

- Own (MOMO), has been developed although its use and impact are not sufficiently well evaluated.
53. There is a good range of age-appropriate resources and support available to children and young people to represent the collective views of children looked after. Voices Making Choices groups have been supported and consulted on some matters. They have undertaken project work on identified issues, including promoting priorities for service improvement. While there have been some changes, for example around bullying, exploitation and in training for professionals, there is no clear routine input into corporate parenting or service improvement. Young people spoken to during the inspection said that while they were consulted on some things, they do not always feel their voices are heard. (Recommendation)
 54. The council and its partners have worked closely together to ensure that children looked after, and the families with whom they live have access to a range of social and leisure activities. Children looked after are well supported to pursue their individual ambitions, talents and skills. Events celebrating achievements of all children looked after take place annually. These are welcomed by the children as well as their carers and parents.
 55. There is an effective education support team for looked after children (ESLAC) supporting the educational attainment of the 244 school-aged children. A multi-agency looked after partnership (MALAP) provides effective support and challenge as the governing body. Virtual school staff, alongside designated teachers in schools, thoroughly track, monitor and support the progress of children looked after. In addition there is good use of pupil premium funds through personal education plans (PEP). The vast majority of PEPs are thoroughly prepared, accurate and up to date and include details of achievements. Pupil premium funding enhances the education opportunities for children looked after, positively rewarding pupils for excellent school attendance. However, despite these incentives, current attendance rates for all children looked after are not good enough at 85% and need to improve. Currently only 18% of young people have experienced an additional school move, a low figure that matches with the high placement stability
 56. The vast majority of current pupils make at least expected levels of progress from their starting points. The expected progress for pupils at Key Stage 1 is good and the gap between children looked after and all children is narrower than that nationally. Virtually all children looked after made expected levels of progress between Key Stage 2 and Key Stage 4 in maths, reading, and writing, where their progress rates were above those of similar pupils, nationally. The gap in educational progress between children looked after and their peers has narrowed by 2015 in both Key Stage 1 and Key Stage 2, and narrowed at Key Stage 4 in 2014, before widening significantly in 2015.
 57. The steady improvement in attainment for children looked after over the past few years was not maintained in 2015, when results dipped, although cohorts

were small, increasing the volatility of results. There are high numbers of children with additional needs. The positive upward trend, particularly for those gaining five good GCSEs A* to C including English and mathematics, fell in 2015. The gap in educational progress between children looked after and their peers has narrowed by 2015 in both key stage 1 and key stage 2, and narrowed at KS4 in 2014, before widening significantly in 2015. However, 19 out of the 23 from this year group have continued to engage in further education, training or employment. The current cohort's progress is positive with 30% on track to achieve five A* to C including English and mathematics. In contrast to the previous year, the vast majority of the current pupils are in good or outstanding schools.

The graded judgement for adoption performance is that it is good.

58. Managers and staff ensure that achieving permanent placements for children who need adoption is a priority and strength in Northumberland and, as a result, the percentage of children who cease to be looked after as a result of adoption is increasing. In the year up to December 2015, 48 children were matched and placed for adoption, with 37 adoption orders made; this compares with 22 adoption orders in 2013 and 25 in 2014.
59. The family placement service provides adoption and fostering services. It is stable, experienced and well led. It robustly monitors and tracks individual progress of children through meetings held every three weeks and sends regular updates to the agency decision maker (ADM) who monitors progress effectively as part of their quality assurance role. This means managers in the service are familiar with the circumstances of all children who are waiting for permanent placements. The progress of adopter assessments is also considered in these meetings. These tracking and monitoring systems are making a positive impact, with children who have become looked after in the last two years being placed for adoption in line with government timescales.
60. Child permanence workers complete reports on all children that require an adoptive placement, and take a lead role in family finding. This leads to greater continuity since the child permanence workers already know the child when family finding commences. Because they work alongside social workers in carrying out adoption assessments, they also know about prospective adopter profiles prior to approval. This leads to more timely matching. Adopters spoken to by inspectors all said that they received comprehensive information about their children and were fully involved in discussions about matches and introductions. All of the child permanence reports sampled by inspectors were good, with child-centred and reflective assessments.
61. Children are prepared well for adoption. Adoption support plans are completed with care and sensitivity. They provide good information to adopters about children and support carefully planned introductions involving foster carers. Life

story work is outstanding. It is carried out with children to a very high standard, with care, attention and time taken to complete child-centred accounts of adopted children's stories. There is no child in an adoptive placement without a life story book. Later life letters are written in a clear and honest way, with a sensitive account of the child's history. The family placement service has an established system for coordinating the post box for indirect contact. Inspectors saw examples of birth parents meeting prospective adopters. This is described in a positive way in children's life story books and helps children understand their story as they get older.

62. All children who required adoption placements with their brothers or sisters were placed together last year. In 2015, five sibling groups were placed together for adoption including a sibling group of three across a very wide age range. Since January 2015, one child had their adoption care plan changed to long-term fostering following a second adoption disruption. This was an appropriate decision. The service has worked with the adoption panel to learn from disruptions through reflective workshops and made changes to practice, such as introducing post-approval training for adopters. Initial indications suggest that the changes to practice are making a positive impact.
63. At the time of the inspection, 11 children had a placement order without a match. Active family finding was taking place for all these children. The longest a child had waited was over two years. This was due to the child's complex needs, but the child was in a stable foster placement and the agency was pursuing further avenues to find a suitable adoptive family. Social workers do not give up on children. They are tenacious in finding the right match.
64. Using the national adoption scorecard measure of the average length of time between children becoming looked after and being placed for adoption, the three-year average at the end of 2013–14 was 601 days, compared with the national average of 628 days. The local authority's reported performance against this measure has deteriorated in the past year and the rolling three-year average is now at 637 days. This is below the national average in the latest published figures and the government target of 547 days. This is due to the local authority continuing to find families for older children and those who have complex needs where adoption is the plan. Inspectors saw many examples of these children being successfully placed for adoption.
65. Adopters are recruited, prepared and trained to a high standard, and inspectors saw evidence of good quality recruitment and assessment practice. This was confirmed by adopters who spoke positively about the standard of communication, preparation, training and support. Timescales for the assessment of adopters and the time between approval and matching are not always met. In most cases, this was for unavoidable reasons but in the past there was avoidable delay in a small number of cases, meaning some children waited longer than necessary for an adoptive placement. The local authority recognised this and strengthened tracking and monitoring, with discernible improvement.

66. The local authority's recruitment strategy for adopters is coherent and based on an analysis of predicted numbers, needs and profiles of children. At the time of the inspection, 17 adopters were approved, three of whom were going through the matching process. The authority actively promotes the Adoption Register and Links Matters once adopters have been approved at panel if they are unable to immediately identify a child for matching. The time adopters wait for a match is variable and there are four adopters who have been waiting for up to 12 months. In one case, this was because an adopter had been approved for a second child and was waiting for the right match; in other cases this was either due to adopters' narrow age range preference or because they lived too near the birth families of those children requiring adoption. There have been no fostering to adopt placements made in the past 12 months and the authority recognises this as an area that requires further development.
(Recommendation)
67. The quality of post-adoption support is good with a range of effective services for those adopters and children who need them. Following requests for support an adoption support worker carries out an initial assessment. In all cases seen by inspectors, these were of a good standard and included the views of adopted children. Assessments resulted in the provision of helpful support, ranging from adopters getting involved in adoption support groups to therapeutic intervention. In almost all cases seen by inspectors, assessments leading to interventions were timely. Post-adoption support is provided through a commissioned organisation that provides a range of good support services from advice and guidance to therapeutic packages.
68. The adoption panel is properly constituted and well managed. It demonstrates effective oversight of adoption decisions and the approval of adopters. Feedback from adopters who have attended the panel is positive. The head of service for children's social care acts as the agency decision maker and makes timely decisions. Where required, she pursues additional information to ensure well-considered decisions about children. The chair of the panel and the agency decision maker meet periodically but the panel does not routinely provide written reports on its quality assurance of the service. This is an omission as it means that the local authority does not receive a coherent overview of performance about practice in the service.

The graded judgement about the experience and progress of care leavers is that it requires improvement

69. Care leavers told inspectors that they feel safe where they live. Effective risk assessments are undertaken and reviewed through a weekly multi-agency risk panel that considers accommodation. Care leavers receive advice and guidance from their social workers about keeping themselves safe from sexual exploitation, online risks and other dangers they may face. When safeguarding concerns are identified, care leavers' needs are robustly assessed. Where

necessary, they are discussed at the weekly panel and individual safety plans developed.

70. The panel also provides effective and well-coordinated support to potentially homeless young people age 16–17 who are not care leavers. Timely mediation work enables young people to remain with their families where possible and, when this cannot happen, emergency accommodation is provided while social workers within the adolescent support team complete an assessment. If young people are vulnerable, they will become looked after under section 20 of the Children Act 1989. Fifteen young people were discussed at the panel in 2015. The resulting multi-agency support enabled five young people to return home. The remainder were found suitable alternative supported accommodation.
71. The service is in touch with all but two of their 172 care leavers, and is diligent in its efforts to maintain contact with the others. Twenty two percent of care leavers have benefited from 'staying put' arrangements, remaining with their carers after the age of 18. No care leavers live in houses of multiple occupation and none are placed in bed and breakfast accommodation.
72. Services are structured so that children looked after have the same social worker wherever possible from the age of 14 to 21. This provides continuity and the opportunity for some young people to develop a long-term relationship with a trusted adult who knows them well. However, a small number of care leavers spoken to by inspectors did not have a positive experience of these arrangements, finding it hard to make contact with their social worker when they needed them.
73. Pathway planning is weak. Care leavers spoken to by inspectors were not always sure that they had completed one with their social worker. While a small number of care leavers said their pathway plan had been helpful, many of the plans reviewed by inspectors were out of date and did not identify how care leavers' needs would be addressed as their circumstances changed. The vast majority showed too little evidence of the young person's involvement. Plans were also unclear in how they would support progress towards successful independent adulthood. These shortcomings were particularly evident in the education, training and employment part of pathway plans, with the next steps poorly considered. (Recommendation)
74. For those care leavers with a disability, pathway plans are of much better quality. Transition to adult services is carefully mapped out, effectively planned and executed so that they can continue to receive the level of care and support, which they need through to adulthood and beyond. This careful approach results in good, well-supported transition to adult social care.
75. The physical health needs of the majority of care leavers are suitably addressed. Positive work with care leavers helps them take increasing responsibility for meeting their own health needs. Care leavers are provided with good information and support in relation to their sexual health needs.

However, while there is a guarantee that all care leavers receive their health histories, none of those spoken to by inspectors could recall receiving this information.

76. The waiting times for those with emotional health needs have reduced but more needs to be done to meet the emotional and mental health needs of care leavers. This includes some young people with high levels of anxiety and stress-related disorders. One example of the impact on young people is that 22% of care leavers aged 19 and over are not in employment, education or training because of their mental and emotional health problems. (Recommendation)
77. A lack of performance reporting limits managers' overview of the service and means gaps are not readily identifiable. For example, managers do not know whether poorly completed pathway plans adversely impact on those care leavers over the age of 19 who are not in employment, education or training (NEET). In contrast, there is good support for care leavers aged 16–18 who remain in their school. PEPs are completed by the education services for looked after children (ESLAC) team. There is a strong focus on the education, employment and training needs of young people. Care leavers confirm that they value the work of the ESLAC team. One young person said 'ESLAC are mint, they really helped with my English and maths'. This results in the majority of 16–18-year-old care leavers remaining in education, with 8% continuing in school and 53% attending local further education provision. (Recommendation)
78. The local authority provides appropriate support for those care leavers attending university and higher education. There are 11 care leavers in university. Support is tailored to their individual needs. Some of these young people remain with their foster carers, others have housing costs paid for during the holidays. All are supported with accommodation, a bursary, a book allowance and transport costs to keep contact with family and friends. There are also 12 care leavers currently being well supported in completing apprenticeships. For those who choose not to continue in school or college, a specialist advice and guidance worker provides an effectively targeted service supporting them in deciding on next steps and possible career goals. Action plans are detailed, comprehensive and helpful in setting out realistic options and contingency plans if choices are unavailable. These plans are not, however, regularly reviewed, which makes it difficult to identify clear outcomes of this active support. (Recommendation)

Leadership, management and governance	Requires improvement
<p>Summary</p> <p>Children’s services in Northumberland require improvement. Good quality standards set by senior leaders supported by clear procedures are often not fully achieved in practice and do not result in consistently good services for children. Although the local authority has taken some action to ensure social workers’ caseloads are manageable, the pace of change has been too slow. Some staff, including newly qualified workers, continue to have caseloads that are too high for their skills and level of experience which impact on the timeliness and quality of work. There have been significant changes of senior personnel in the local authority in the last year, which includes the appointment of a new head of service for children’s social care. This means its stability is relatively recent. Senior leaders recognise the scope of this role is too large and acknowledge additional performance management capacity to the new head of service was withdrawn too soon.</p> <p>The local authority’s commissioning arrangements are effective and based on a sound understanding of local need. The local authority works well with partner agencies through the health and wellbeing board. As a result of this collaboration, services for children who have emotional health needs have significantly improved. The quality of performance management information is generally good and it is being used to drive up performance. However, performance information on the progress of care leavers provided to senior managers is too limited. This has been recognised and recently more detailed reports are being provided.</p> <p>Current arrangements for the independent scrutiny of children’s services through the corporate parenting advisory cabinet and children’s scrutiny committee are insufficient to assure effective challenge. Children’s files show challenge from IROs to poor practice, but, this does not always lead to positive change because of ineffective and rarely used escalation procedures. This limits senior leaders’ overview of how well children are being cared for, helped and protected. While the DCS, chief executive and lead member all have a good understanding of the quality of most service areas for children and families, they did not know the extent of improvement required in some areas of practice highlighted in this inspection.</p> <p>Front-line managers who met with inspectors were knowledgeable and committed. Social workers report that they receive good quality guidance and support from managers and senior managers. Managerial oversight on children’s files did not reflect this level of support, often lacking analysis. In a small number of cases oversight was not regular enough. In a minority of cases managers had failed to ensure compliance with regulation and statutory guidance.</p>	

Inspection findings

79. The local authority's corporate vision and priorities are well aligned with those of other strategic bodies such as the health and wellbeing board, families and children's trust and NSCB. Strategic plans demonstrate a 'golden thread' and the needs of vulnerable young people, looked after children and care leavers are given appropriate priority. Strategic plans are well informed by up-to-date, detailed knowledge of current and projected future need. This high level strategic vision is underpinned by good, clear quality standards and procedures. They have not yet resulted in consistently good services for children.
80. Until October 2015, the DCS had overarching responsibility as director of adult social services, public health and children's services and was employed jointly by the county council and NHS foundation trust as executive director for wellbeing and community health services. Following a management restructure and test of assurance, she was formally designated deputy chief executive and additional capacity was added through appointment of a director of adult services. As such, the DCS has overall managerial responsibility for community health services, oversees the work of the directors of adult services and public health as well as having overarching responsibility for children's services. This remains a demanding span of control but early indications are that it is resulting in better collaboration across services.
81. There have been significant changes of senior personnel in the local authority in the last year, which includes the appointment of a new head of service for children's social care. This means its move towards stability is relatively recent. The head of service for children's social care has been in post since April 2015. Senior Leaders recognised the scope of the role was too large and acknowledged during inspection the reduction of additional performance management capacity to the post was withdrawn too soon. This adversely impacted on the effectiveness of management oversight across the service.
82. The pace of positive change has only increased in recent months, including the period inspectors were on site. The local authority identified in 2014 that increasing social work caseloads were having a detrimental impact on the timeliness of assessments and services for children and their families. This was further highlighted by findings from a local government association peer review in April 2015. Throughout 2015–16 it prioritised reducing social work caseloads through a range of short- and long-term measures. These included social work recruitment drives; increased establishment by 17.4 full time equivalent posts including use of agency staff; regular reporting of the top 10 caseloads to the DCS; and the very recent creation of a transformation team of experienced workers. The team can be drafted in as a short-term support measure to areas that are struggling. These measures, combined with a longer term strategy based on the roll-out of early help, are showing very recent positive impact in some areas of the county. Senior managers, however, have not considered the range of work undertaken by individual social workers in some teams. Inspectors found some social workers with caseloads in excess of 35, which

prevents social workers undertaking good quality work with children and their families. (Recommendation)

83. While action has been taken to monitor practice and quality assure work, progress has been slow. As recently as December 2015, in one locality there were significant delays in children receiving an assessment, including some of those requiring a section 47 enquiry. In some cases, delays were of a number of months. This meant that some children and young people were left in situations of unassessed risk for unacceptable lengths of time. By the time of the inspection, all these children and families had been visited and assessments completed through the effective deployment of the transformation team and oversight of team managers. However, some social workers spoken to by inspectors, including newly qualified staff, continued to report workloads impacting negatively on the quality and timeliness of the work they do with children. (Recommendation)
84. This legacy of drift and delay due to excessive workloads was apparent in a significant minority of the cases tracked and sampled by inspectors during the inspection. In some cases, very recent action had started to complete overdue pieces of work such as risk assessments and legal planning meetings. These included some incomplete actions that were identified as a result of the inspection audit process itself. Case audits completed by the authority for the purposes of the inspection had, in some instances, an unduly positive view of the case. The local authority's overview report of the areas of improvement identified during the audit process did not recognise delay as a theme although it was a feature in over a third of the cases tracked by inspectors. This indicates a lack of understanding of the extent of delay in casework and the impact it has had on individual outcomes for children.
85. The quality of performance management information is generally good but its use does not yet have enough impact on the quality of practice. Reporting on the progress of care leavers is too limited and reliant on often partial and inaccurate data.
86. The Performance related documents are adapted to the needs of the user. Elected members and senior leaders, for example, receive regular written commentary and some benchmarking information against regional and national performance that provides a useful context, while team managers receive a regular dashboard of key performance information. Regular performance clinics chaired by the head of service address identified areas for improvement such as timeliness of assessments or the frequency of statutory visits to children on child protection plans.
87. The local authority's approach to driving up performance in this and other activities including auditing activity is largely compliance focused. While compliance is a necessary component of any improvement framework, the local authority recognises that more needs to be done to ensure qualitative as well as quantitative measures are used. It has appropriately identified a key action

for 2015–16 to embed a quality approach that concentrates on outcomes for children and young people.

88. Current arrangements for the external scrutiny of children’s services by the corporate parenting advisory cabinet and children’s scrutiny committee are not strong enough. They do not enable members to gain a detailed enough understanding of the quality of service children receive and this limits the extent to which they are able to hold officers to account. Both are over-reliant on reporting by officers. For example, as an efficiency, members of the scrutiny committee receive performance information in advance and bring any queries or concerns to the meeting. Performance is not discussed as a set agenda item. This system is too dependent on committee members having a good grasp of the right questions to ask and being proactive in adding matters to the agenda. The local authority recognised during this inspection that arrangements for scrutiny by these bodies require strengthening and has made it a priority action for 2016–17. (Recommendation)
89. The lead member, DCS and chief executive have a good grasp of most, but not all, of the key challenges within the service. They have frequent formal and informal contact with each other and the chair of NSCB to scrutinise performance through mutual constructive challenge. These meetings are not always recorded and this is a missed opportunity to provide an audit trail of issues discussed and outcomes. The role IROs have in quality assurance lacks impact. Themes arising from their activity are not regularly reported and escalation processes are rarely used, limiting senior leaders’ and elected members’ understanding of some of the depth and breadth of areas for improvement identified in this inspection. They did not know, for example, that some children remain with family members in placements that are not compliant with regulations or how some children’s cases had experienced delay and drift, despite these being identified by IROs. (Recommendation)
90. Front-line managers’ workloads are challenging due to high caseloads and in some localities a high proportion of newly qualified staff who require more frequent guidance and support. Over a third of the workforce has been qualified for less than two years and 22% of the workforce is newly qualified. There is significant variation across teams ranging from Alnwick and the disabled children’s team, which have no newly qualified workers, to Ashington where all three teams have over 40% newly qualified staff and in one team 64% of the workforce are less than two years qualified. (Recommendation)
91. These capacity issues affect the quality of oversight given. Although social workers have told inspectors managers, including senior managers, offer good personal and professional support, this is not strongly reflected on case records or in supervision files. Supervision is generally regular but brief and often lacks reflection. Many recorded decisions on case files lack analysis and rationale. A minority of records seen had significant gaps in recording of decisions. In a small number of cases, the quality of decisions was poor, contravening regulation or statutory guidance. Inspectors saw eight cases where children had

been placed with relatives by the local authority without being afforded looked after status and the level of support and oversight this entails. This was despite the local authority recognising it as an area for improvement in 2014 and issuing staff with guidance. Although strategic understanding of the local authority's responsibilities in relation to children and young people, who are privately fostered, is clear, practice on the ground is poor. These examples are illustrative of the gap between high-level strategy and ambition, which are good, and practice on the ground, which remains too variable. (Recommendation)

92. The local authority demonstrates appropriate commitment to obtaining a quality workforce. It has taken a number of steps to recruit and retain staff, including forging good links with local higher education institutions, the 'Step up to social work programme' and more recent collaboration with 'Frontline', which will result in an influx of trainees in January 2017. Staff spoken to during this inspection, while acknowledging recent challenges, were almost uniformly positive in identifying Northumberland as a good place to work.
93. The local authority is committed to supporting and developing newly qualified staff through the Assessed and Supported Year in Employment programme (ASYE). Staff receive clear guidelines outlining the levels of support they should receive. The local authority has struggled to meet the required standards in practice. This was an area for development identified in the peer review of April 2015 and ASYEs spoken to during the inspection continued to experience levels of support that fell short of the standards required. For example, three ASYE social workers with less than five weeks' post-qualification experience variously reported caseloads of 24, 25 and 27 children and did not yet have a named mentor. Two other ASYE social workers reported delays in completing the ASYE programme due to their own or supervisors' workload pressures. The local authority recognises established mechanisms for assuring ASYEs are supported well need to be strengthened. (Recommendation)
94. The range of training available to social workers is of good quality overall. The local authority has a clear competence framework for ASYE but has not yet extended this to the rest of the workforce. This limits the scope for effective analysis of training needs and targeting. It has recently introduced mandatory online courses. It is about to launch a mandatory training card to monitor that all workers, including agency staff, have received relevant training to meet basic requirements. These are positive developments. The local authority recognised prior to the inspection that, while some scoping of training needs has been undertaken by NSCB, further analysis is required that is role-specific to ensure that social workers and managers have the training necessary for the range of work they cover. This analysis is yet to be completed and the current range of training extended.
95. The local authority's commissioning strategy is based on sound theoretical principles. It is informed by key corporate and service priorities as outlined in the corporate plan, strategic statements and children's services priorities. All are

well aligned to health and wellbeing board priorities. Commissioning activity draws on the Joint Strategic Needs Assessment (JSNA), which is comprehensive and regularly updated. As a result, the local authority has a current strategic overview of the needs of the population. The JSNA includes information in relation to the prevalence and impact of domestic abuse, parental mental health and parental substance misuse and detailed information on the current cohort of looked after children, with outcomes benchmarked against national and regional performance.

96. Effective, robust commissioning and compliance monitoring of external placements for looked after children are supported by a clear framework in collaboration with neighbouring authorities. The local authority takes authoritative action when providers fall below required standards and almost all children live in placements judged good or better. Development of joint commissioning arrangements is in the early stages. An integrated commissioning hub between children's social care, clinical commissioning group (CCG) and public health has been created which the local authority anticipates will lead to effective joint commissioning arrangements in the future, but none has taken place to date. In the meantime, good collaboration by all partner agencies through the health and wellbeing board has resulted in improved services for children with emotional health needs commissioned through the CCG. However, during the course of the inspection, senior managers recognised that more needs to be done to help care leavers address their emotional and mental health needs. (Recommendation)
97. The local authority has developed effective strategic partnerships with other agencies in relation to the exploitation of children. These have benefited from national and local learning. As a result, responses to children and young people who go missing from home or care or are at risk of child sexual exploitation are robust. Local intelligence is used well to analyse any emerging patterns or trends. A multi-agency risk management group meets regularly and considers wider risks to children and young people, such as substance misuse and risk of radicalisation. While largely concerned with responses to individual children, the group's experience of what works well is used to improve practice and inform strategic planning and commissioning of specialist services. For example, auditing of return home interviews as a result of concerns raised at the group resulted in improvements to the template used and in identifying child sexual exploitation champions in each locality to cascade learning. Multi-agency commitment is good and elected members attend the group regularly as observers.
98. Liaison with Cafcass and the local family justice board, while regular, has not led to a shared understanding of the underlying causes of the local authority's continued failure to meet expected timescales within court proceedings. The local authority recognised during the inspection that this needs to be addressed as a matter of urgency in order to inform shared improvement planning. (Recommendation)

99. Mechanisms for learning from complaints are well established and learning from a peer review in April 2015 has informed improvement planning. The participation and positive activities team undertakes a wide range of activities to encourage children and young peoples' involvement with service development. This includes regular consultation with Voices Making Choices. This strategic commitment to listening to children is not yet embedded in individual casework or communicated effectively to the young people themselves. Young people spoken to by inspectors, including some members of Voices Making Choices, do not always feel listened to or that they have influence. More needs to be done to ensure that young people are assured that what they have to say matters. (Recommendation)

The Local Safeguarding Children Board (LSCB)

The Local Safeguarding Children Board is good

Executive summary

The NSCB plays an active and often dynamic leadership role in monitoring and shaping services for children. Its Annual Report 2014–15 provides detailed information about the Board’s achievements and priorities for 2015–16. It does not provide an analysis of the quality of services responsible for safeguarding children in the county, but this is planned for the next report.

Governance is a strength and partnerships across adults and children’s service are well established. Partners challenge each other constructively and hold each other to account. The Board has played a key role in driving and monitoring strategic developments, such as sexual exploitation, radicalisation, early help and neglect. Sub-committees, such as the sexual exploitation sub-committee, the prevent strategy group and child death overview panel (CDOP) have joint accountabilities. This has further promoted a joined up approach with partners and neighbouring local authorities.

The Board collects and scrutinises a range of data from key partners, such as social care, education, police and health. A key indicator set and dashboard are in place to enable the Board to monitor effectively the delivery of its priorities. This needs some further refinement to ensure that the Board fully captures all necessary information concerning neglect, early help and the application of thresholds. It does not consider reports concerning outcomes for children looked after, particularly those placed out of county. However, it uses other reporting mechanisms to understand the needs of this group of young people.

Reports concerning outcomes for children looked after, particularly those placed out of county are not provided to the Board as part of the bi-monthly performance data, which would support the Board to understand how their needs and outcomes are met. However, the needs of children looked after are considered by the Board within other reporting mechanisms such as reports from a consortium of six Local Authorities regarding residential placements for children looked after, the independent reviewing service report and adoption and fostering data.

The NSCB’s Governance Framework for 2015–16 provides a clear framework for its multi-agency auditing activity. It describes priorities and details the 2015–16 audit programme. It lacks, though, a systematic audit methodology so that the Board can be confident of the accuracy of the findings. The Learning and Improvement Framework encompasses learning from serious case reviews (SCRs), multi-agency and single-agency audits, performance data and section 11 audits. Learning from SCRs impacts positively on service development and informs training. The multi-

agency training plan is comprehensive and is responsive to emerging issues. Multi-agency attendance on training courses is good and e-learning courses are widely available. Evaluation includes a rolling programme of telephone surveys amongst different groups of practitioners and managers.

The Board consults with a range of youth groups. Access to an advocacy service has recently been extended by the local authority to children attending child protection conferences. It is too early for the NSCB to know whether this is making a difference.

Recommendations

100. Ensure that the Annual Report 2015–16 includes an analysis of the quality of services responsible for safeguarding children.
101. Ensure that performance information gathered through audit and data provides both qualitative and quantitative information about the impact of the neglect and early help strategies, including the consistent application of thresholds.
102. Ensure that the governance framework incorporates a robust audit methodology to strengthen the accuracy of findings.

Inspection findings – the Local Safeguarding Children Board

103. The Northumberland Safeguarding Children Board (NSCB) Annual Report 2014–15 provides detailed information about the full range of the Board’s activities and achievements. It also establishes an appropriate set of priorities for 2015–16. However, it lacks a rigorous and transparent analysis of the quality of services responsible for safeguarding children in the county. This is planned for inclusion in the next and subsequent reports. In all other respects, the NSCB complies well with the guidance set out in ‘Working Together to Safeguard Children’ (2015). (Recommendation)
104. Governance arrangements between the Board and other strategic partnership boards are clear and well-established. Protocols are in place between the health and wellbeing board (H&WBB), the safeguarding adults board and the families and children’s trust (FACT) that clearly set out the relationship between these groups. Many of the senior managers from partner agencies are members of a number of different boards. This facilitates communication and ensures that children’s issues are considered. Key strategic reports and action plans are submitted to some or all of these key strategic groups as appropriate. Some sub-committees have joint accountabilities. These include the sexual exploitation sub-committee and the prevent strategy sub-committees, which are accountable to both safeguarding boards and to the Safer Northumberland partnership. This ensures a strategically strong approach to the coordination

and oversight of multi-agency practice in protecting children and young people from sexual exploitation, going missing or radicalisation.

105. The Board is attended by all relevant partner agencies, who demonstrate an evident commitment to effective multi-agency working. The business sub-group, which sets the Board's agenda and drives its work, is chaired by the NSCB chair. All sub-committee chairs attend. The safeguarding board business manager attends all the meetings and so has a good overview of board activity. This structure helps to identify gaps and avoid duplication. Each sub-committee works to agreed work plans aligned to the delivery of the Board's priorities. The work of the Board and its sub-groups is supported by a small but efficient business unit.
106. The chair of the NSCB has been in post since May 2015 and is well-respected by colleagues from partner agencies. She also chairs the Safeguarding Adults Board and is a member of the H&WBB. She works closely with the local authority chief executive, the director of children's services and the council's elected members to ensure that safeguarding children and adults is afforded the highest priority. The chair appropriately raises issues, exerts challenge and enables partners to do so. Since November, she has ensured that the minutes of the Board meetings record challenges made. These are followed through until resolution. For example, the police have been subject to a challenge concerning attendance at strategy meetings and initial child protection conferences (ICPCs). Attendance at ICPCs has been resolved through the new post of police safeguarding advisor and criteria for attendance at strategy meetings have been agreed. Their implementation will be monitored by the Board. Another challenge led to a more efficient and accurate system of inviting and recording attendance at child protection conferences.
107. The Board collects a wide range of data from partner agencies, and this is scrutinised by the Quality Improvement and Performance sub-committee. A set of key performance indicators has been agreed by the Board. Scrutiny of data is taken very seriously by the Board and it is clearly informing strategic developments and challenge to partners. It is not as yet sufficient to enable the Board to identify drift and delay in cases involving neglect and the consistent application of thresholds, both of which have been identified as areas for improvement during the inspection. Similarly, the Board would improve its ability to hold partners to account for their contribution to the safety and protection of children if they received reports concerning the well-being of children looked after, particularly those placed out of county.
(Recommendation)
108. The Board agreed its current Learning and Improvement Framework in July 2014 and it was subject to review in December 2015. It is a comprehensive document encompassing learning from SCRs, case reviews, multi-agency and single-agency audits, performance data and section 11 audits and is consistent with statutory guidance. A thorough approach is taken to learning from SCRs and child deaths and this is disseminated through training, videos, posters,

leaflets and briefings. The 'Eve' SCR action plan is monitored by the Board and implementation is on track. Action has already been taken to commence work in response to the as yet unpublished 'Kirsty' SCR with regard to improving procedures when bruising is identified on immobile babies.

109. The Board delivers a well-regarded programme of face-to-face training and e-learning opportunities and this is supported by partners who provide the trainers. Practitioners and managers spoken to across a range of agencies, including schools, confirmed that training is of a high standard and improved their practice. A telephone survey of children's services managers was undertaken in 2015 that provided some very positive feedback. This will be extended to other groups on a rolling programme, with general practitioners to be the next group to be surveyed.
110. The LCSB's governance framework for 2015–16 provides a clear framework for the Board's multi-agency auditing activity. It describes auditing priorities and details the 2015–16 audit programme, which includes s11 audits (s175 for schools) as well as audits of core groups, return interviews, policies and procedures, NSCB challenge, early help assessments and early help good practice. There is an expectation that partner agencies submit reports and details of specific internal auditing activity.
111. The NSCB has ensured that safeguarding is a priority for all its partners, through a range of s11 self-assessment audits. The areas addressed by the audits are informed by the learning from SCRs and this year, for example, included a question about the inclusion of fathers in assessments and a question about radicalisation. The format of the audit has enabled extensive engagement of agencies and practitioners, including a high level of involvement from GPs and schools. The s11 submissions are subject to a challenge event, which this year will involve a focus on the inclusion of the voice of the child in decisions that affect them and in influencing service development. The audit findings will form part of the discussion that takes place in the annual challenge meeting attended by all involved agencies.
112. The child death overview panel (CDOP) is a well-regarded, independently chaired joint panel with North Tyneside and Newcastle. Operating in this way is efficient and brings the benefits of additional expertise, such as that located within the North East Ambulance Service and the Great North Children's Hospital. Child death reviews considered by CDOP have led to focused work on safe sleeping, and this issue must now be considered at all ICPCs concerning unborn and new born babies. Midwives are routinely using a 'crying baby' video with first-time parents and there has been a recent campaign on the dangers of nappy sacks. Reviews have also led to improvements in the way parents are supported to contribute to reviews; strengthened pathways to alcohol and substance misuse support services; and ensured that communities in which high numbers of first cousins marry are given information about the genetic risks to children such marriages may incur. The recent deaths of four 17-year-old, newly qualified drivers led to a risk awareness campaign in schools and

alteration to roads and road signs. Holding meetings on a bi-monthly basis contributes to some delay in completing reviews and the CDOP chair is keeping this under review by monitoring impact.

113. In order to extend its reach into schools and other education providers, the Board has expanded its head teacher membership and established an Education Reference Group chaired by the Virtual Head, with representation from all educational provision in the county. A new team manager post has been established to provide a support service to education settings and a half-termly bulletin for education settings – Safe to Learn – has been introduced as part of the Board’s communication strategy. School governing bodies have received training on safeguarding roles and responsibilities.
114. The Board has successfully engaged with GPs across the county, initially through a GP conference and now through regular GP network meetings, which have forged better connections with other professional groups. This has led to the development and distribution of a safeguarding toolkit and delivery of training, for example, about domestic violence.
115. The sexual exploitation action plan for 2015–16 is a comprehensive strategic and operational document routinely monitored by the sexual exploitation sub-group. The plan is priority-rated and evidence of progress is clearly detailed. Significant work has been undertaken through the Board to target the education of teachers and children in rural schools. Packages of training, including the video Chelsea’s Choice, have been rolled out across all year 11 groups. In addition, a drama project has just completed a video to raise awareness of the risks of sexual exploitation and trafficking among local young people in all high schools. A webinar is under development by the sexual exploitation sub-group and will be made available to all staff across the partnership when complete. This has the potential to enhance significantly professional understanding of the risks and issues. Work has been undertaken with all GP practices across Northumberland about the complex abuse process and this has been specifically adapted for GPs in rural areas. The Board has also worked with the taxi-licensing authorities and secured an agreement that a key licensing condition for taxi drivers is the completion of training on trafficking and child sexual exploitation.
116. Since August 2015, the Board has benefited from a dedicated Business Manager who has conducted a comprehensive review of policies and procedures. The revised procedures went live in December 2015 and have been updated to ensure that they reflect national guidance, local policy and learning from the last two SCRs. This includes a new procedure to ensure that all child protection plans considering babies routinely consider their sleeping arrangements to ensure that they are safe, and a new procedure concerning immobile babies with identified bruising.
117. Clear and detailed threshold procedures have been widely published. Overall, these are well understood by partner agencies though they are not always

consistently applied. They require that children identified as being at risk of child sexual exploitation or female genital mutilation are immediately referred for a social work assessment.

118. The Board has been instrumental in developing and driving the neglect and early help strategies. The Multi- Agency Neglect Strategy 2015–18 refreshed an existing strategy and is informed by findings from data and audits. It focuses on the role of early help services in the identification and response to neglect. A neglect toolkit is to be piloted in the north of the county. The Early Help and Early Intervention Strategy has led to the roll-out of four early help hubs across the county supported by two newly appointed early help coordinators. The hubs consider all early help assessments at multi-agency meetings, which determine next steps. The outcomes of multi-agency audits considering the quality of early help assessments and the impact of early intervention upon referrals to social care have been reported to the Board. The Board does not as yet receive reports about the impact of early help services or about equality of access to the early help offer, which is a challenge for rural communities.
119. Improving its consultative processes with young people is a Board priority. Currently the Board consults with a range of youth groups including the Youth Advisors Group that has taken on some of the functions of a shadow board. Access to an advocacy service has recently been extended to include children attending case conferences although the impact upon participation by children/young people at child protection conferences is not yet subject to board scrutiny.

Information about this inspection

Inspectors have looked closely at the experiences of children and young people who have needed or still need help and/or protection. This also includes children and young people who are looked after and young people who are leaving care and starting their lives as young adults.

Inspectors considered the quality of work and the difference adults make to the lives of children, young people and families. They read case files, watched how professional staff work with families and each other and discussed the effectiveness of help and care given to children and young people. Wherever possible, they talked to children, young people and their families. In addition the inspectors have tried to understand what the local authority knows about how well it is performing, how well it is doing and what difference it is making for the people who it is trying to help, protect and look after.

The inspection of the local authority was carried out under section 136 of the Education and Inspections Act 2006.

The review of the Local Safeguarding Children Board was carried out under section 15A of the Children Act 2004.

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The inspection team consisted of six of Her Majesty's Inspectors (HMI) from Ofsted and two Associate Inspectors.

The inspection team

Lead inspector: Tracey Metcalfe HMI

Deputy lead inspector: Shirley Bailey HMI

Team inspectors: HMI Susan Myers, Fiona Millns, Pamela Blackman, Carolyn Spray.

Associate inspectors: Andy Smith and Jo Pymont

Senior data analyst: Clare Atkinson

Quality assurance manager: Simon Rushall

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Piccadilly Gate
Store St
Manchester
M1 2WD
T: 0300 123 4234
Textphone: 0161 618 8524
E: enquiries@ofsted.gov.uk
W: www.gov.uk
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