Inspection of local authority arrangements for the protection of children

Kent County Council

Inspection dates: **26 November – 5 December 2012**
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Age group: All

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The inspection judgements and what they mean

1. All inspection judgements are made using the following four point scale.

Outstanding	a service that significantly exceeds minimum requirements
Good	a service that exceeds minimum requirements
Adequate	a service that meets minimum requirements
Inadequate	a service that does not meet minimum requirements

Overall effectiveness

2. The overall effectiveness of the arrangements to protect children in Kent County Council is judged to be **adequate**.

Areas for improvement

3. In order to improve the quality of help and protection given to children and young people in Kent, the local authority and its partners should take the following action.

Immediately:

- audit child in need cases to ensure that purposeful work is taking place and there are no unidentified risks

- the Kent Safeguarding Children Board should ensure that the audit that was underway at the time of the inspection under section 11 of the Children Act (2004) is completed, analysed robustly and used to support improvements.

Within three months:

- ensure that all child in need cases have an up to date assessment of need and a plan which addresses identified needs and contains specific and measurable objectives with timescales

- ensure that children removed from child protection plans are provided effective continuing support that addresses identified needs and that these are formulated within a specific and measurable child in need plan with clear contingency arrangements

- review the current approach to conducting child protection conferences so that they are not unduly long for parents and that

they enable the full contribution to risk assessment and planning of all participants

- clarify decision-making processes within the central duty team (CDT) to eliminate the scope for confusion and duplication that currently exists.

- take action to improve the quality of assessments and plans carried out under the common assessment framework (CAF) so that interventions are focused on achieving specific and measurable objectives

- take action to improve the quality of supervision and management oversight and direction in casework.

Within six months:

- ensure that children in need referrals requiring assessment are promptly transferred from the CDT to the family support teams as soon as there is sufficient information to determine that an assessment is required

- ensure that partner agencies understand and carry out their shared responsibilities for supporting children in need and their families.

About this inspection

4. This inspection was unannounced.

5. This inspection considered key aspects of a child's journey through the child protection system, focusing on the experiences of the child or young person, and the effectiveness of the help and protection that they are offered. Inspectors have scrutinised case files, observed practice and discussed the help and protection given to these children and young people with social workers, managers and other professionals including members of the Local Safeguarding Children Board. Wherever possible, they have talked to children, young people and their families. In addition the inspectors have analysed performance data, reports and management information that the local authority holds to inform its work with children and young people.

6. This inspection focused on the effectiveness of multi-agency arrangements for identifying children who are suffering, or likely to suffer, harm from abuse or neglect; and for the provision of early help where it is needed. It also considered the effectiveness of the local authority and its partners in protecting these children if the risk remains or intensifies.

7. The inspection team consisted of five of Her Majesty's Inspectors (HMI) and a Seconded Inspector.

8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

Service information

9. Kent has approximately 323,000 children and young people under the age of 18 years. This is 22% of the total population. Some 17% of those under 18 are living in poverty. The proportion of children and young people entitled to free school meals is below the national average. Children and young people from minority ethnic groups account for 9.4% of the total population, compared with 16.3% in the country as a whole. The proportion of pupils with English as an additional language (10%) is below the national figure of 16%. Kent's population is largely of white ethnic origin, with approximately 6.3% estimated to be of minority ethnic origin. The largest minority ethnic group is formed by people of Indian origin at about 1.5% of the total population. In addition there are significant local populations of Roma people of East European origin.

10. The council and its partners have refocused the arrangements for providing early help to children, young people and families. This is now delivered through 97 children's centres and a very recently commissioned range of services delivered largely by private and voluntary sector organisations. These include family advice workers, an intensive family support service, intensive adolescent support, the healthy minds project and a domestic abuse service to support children. A recent reorganisation has brought together the coordination of early help and children's social care services under common management structures in order to improve responsiveness.

11. Initial contacts with children's social care services are managed by the council's central duty team (CDT) which is located within the multi-agency contact and referral unit (CRU). Those children identified as requiring further social care assessment are transferred to a locally based assessment and intervention team (AIT). Children who need a period of continuing social work intervention, for example through a child protection or child in need plan, subsequently transfer to a family support team. An emergency duty team, located in the CRU, responds to children and young people who require support or protection out of normal office hours.

Overall effectiveness

12. The overall effectiveness of arrangements to protect children in Kent is judged to be adequate. Senior leaders within the council, supported by strong and well-informed political leadership, have delivered a significantly improved response at the point of referral to children's social care services

from an earlier low baseline. In consequence, children who are at risk of harm are protected by effective initial screening and prompt subsequent action by the council and police services. Children are almost always seen and seen alone in child protection investigations and both initial and core assessments. A workforce development strategy has reduced vacancy rates through a range of initiatives including overseas recruitment and a 'grow our own' policy. While there remain significant difficulties in recruiting suitably qualified and experienced staff to some posts and some areas, the council has adopted an appropriately determined stance, preferring to employ good locum staff rather than appointing weak candidates to permanent posts. It has also taken a robust stance on poorly performing staff, a number of whom have now moved on from their posts. Children requiring protection receive a more assured initial response than previously, with risk identified in a timely and effective way. However, child protection planning and review need further improvement. Children on child protection plans are seen and seen alone, but plans too often lack specific and measurable improvement goals. This leads to unfocused interventions and makes progress hard to evidence. A significant number of child protection plans end after three to six months before improvements are seen to be embedded and sustainable. No children were seen to be exposed to immediate risk as a result but remaining welfare needs are not always fully mitigated by effective step-down planning and intervention and there is a high rate of children experiencing repeat child protection plans.

13. A recently introduced new approach to conducting child protection conferences aims at improving the extent to which parents, children and young people contribute to and influence their own plans. The council's own survey suggests some success, with parents and children reporting that they understand the reason for the concerns and have helped shape plans. However, a small number of conferences seen by inspectors were excessively long and did not consider sufficiently the views of the full range of professionals in evaluating risk.

14. Planning for children in need is weak, characterised by superficial assessments and a lack of specific and measurable objectives and contingency plans. This means that too often interventions lack focus and there is drift and delay. Inspectors saw child in need cases where visits were not made, children were not seen for long periods and reviews were not held in a timely way.

15. There has been a recent reconfiguration of early help services. A range of services has been commissioned and council early intervention teams including common assessment framework (CAF) coordinators are now located within the same management structures as children's social care services. This has improved the accessibility and responsiveness of help and is leading to improvements in communications between agencies, the coordination of help and the use of the CAF to identify and respond to

need. However, there are still weaknesses in the quality of too many CAFs which often lack effective analysis and objective-setting.

16. The council has a good understanding of its strengths and areas for improvement. It has used the improvement plan that followed the notice to improve issued in 2010 to prioritise and focus improvement activities. It has a comprehensive approach to gathering and analysing performance data and has used this to drive improvements, for example in the timeliness of assessments. It has also conducted a wide range of practice audits, for example of child protection enquiries that do not progress to initial child protection conferences. However, the overall programme of audits is unfocused and not clearly guided by any overarching priority framework, and there is only very limited evidence that their findings are used systematically to drive progress. Complaints are analysed in detail and discussed in the annual report, with lessons learnt explicitly identified.

17. Kent Safeguarding Children Board (KSCB) has historically been weak and has not secured sufficient commitment from some partner agencies in key aspects of its business. These include the failure of some agencies to complete individual management reviews in serious case reviews, which has compromised the partnership's capacity to learn and respond to lessons that arise from them. While recent improvements are in evidence, such as stronger challenge to partners over their level of engagement and the fact that KSCB is now meeting its obligations under statutory guidance, it is not yet fully effective. For example, it has not yet completed a recent audit of partner agencies' safeguarding measures.

The effectiveness of the help and protection provided to children, young people, families and carers

Adequate

18. The effectiveness of the help and protection provided is adequate. During the inspection no children were identified who were left at risk of, or suffering from, significant harm as a result of systemic weaknesses in management or action.

19. The establishment in May 2012 of a multi-agency CRU that includes the children's social care CDT has improved communication and information sharing. As a result, responses and decision-making for new contacts and referrals are now sounder and more consistent than previously. Strategy discussions in most cases are timely with the involvement of relevant partner agencies and effective decision-making and action planning. This leads, where necessary, to prompt child protection enquiries and means that children referred with child protection concerns now receive an assured response.

20. A well-established out of hours service that provides emergency intervention is located within the CRU. This enables prompt communication and information sharing with day services and immediate access to the children's electronic case records. Staff schedules overlap with day time services which facilitates effective information sharing between them.

21. In some cases where children do not meet the threshold for a child protection response, inspectors saw unnecessary delay in the CDT in reaching decisions about whether further assessment was needed. This means that children in need of help short of protection can experience delays in transfer to the assessment and intervention teams and in the provision of services to meet their needs. The CDT is still in development and has yet to be fully embedded. Systems for management oversight of cases lack clarity, and in some cases several senior practitioners or managers are involved in case direction or oversight of the same case and this is confusing and contributes to delay.

22. The KSCB has recently introduced new processes for conducting child protection conferences and core groups and report that partner agencies feel that this has improved information exchange and the involvement of parents. The new structures for conducting child protection conferences were informed by consultation with parents and have brought an increased focus on their active involvement. The council's own surveys suggest that parents say they have been able to influence their child protection plans and know what needs to change. However, child protection conferences observed by inspectors were not effectively managed or focused and were repetitive. They were longer than the circumstances of the cases required and did not sufficiently engage all professionals present. As a result, child protection plans were not drawn up in a way that reflects analysis of a full range of views and they lacked specific and measurable goals.

23. Inspectors examined a number of cases where child protection plans had recently ended. While no children were left at risk as a result of the plans ending, in some cases there was a lack of analysis of risk in conference reports and minutes and in consequence the rationale for concluding that reductions in risk were embedded and sustainable was not always clear. This was particularly evident in some cases where child protection plans had been in place for a long period. In almost all cases seen where a child protection plan ended, subsequent child in need plans were not sufficiently specific and measurable and did not always address the continuing needs identified at the final conference. Contingency plans were superficial and formulaic, for example simply indicating that a further conference should be considered if new concerns arose. These weaknesses are evident in the rate of children being made the subject of repeat child protection plans. According to the council's own data, this has increased in a year from 14.7% in September 2011 to 26.2% in

September 2012, which is considerably higher than comparable authorities.

24. Interventions aimed at protecting and supporting children on child protection plans are proportionate and sufficient to reduce risks identified. Agencies work together appropriately to provide support to children and families subject to child protection plans. However, their effectiveness is reduced by a lack of specific and measurable goals. Parents told inspectors that recent improvements in the services they receive mean they now feel well supported by their social workers.

25. Interventions and support for children on child in need plans are not as effectively supported. A significant number of such cases seen by inspectors lacked coherent child-focused assessments and clear planning and this led to drift and delay in achieving desired outcomes for the welfare and support of children. In a small number of open child in need cases seen by inspectors, a lack of rigour in intervention, re-assessment and review meant that emerging problems of neglect were not identified as potential child protection concerns early enough. As a result, children continued to live in potentially harmful environments for too long.

26. A range of new early help services has been commissioned very recently. Early intervention teams have been established in each of the 12 districts in September 2012 and each team has early intervention workers who act as CAF lead professionals and deliver parenting programmes. CAF coordinators have been placed within each of the teams and have regular contact with CAF coordinators located within the CRU and this ensures prompt notification and tracking of cases where a CAF is required.

27. The restructuring of early intervention has led to some improvements in the way the CAF is used to identify the needs of children and families. Emerging evidence of the impact of the re-structuring indicates that the quality of services is beginning to improve. Staff told inspectors that there is now clarity about roles and responsibilities, communication with children's social care is better and there is increasing understanding about the CAF. Parents spoken to by inspectors were positive about the early help they have received and the use of the CAF to identify their needs. They felt that they had been promptly referred to a range of services which met their needs. Young parents told inspectors that they are provided with access to a range of valued services through the Young Able Parents early intervention programme and that this has helped to improve their parenting skills. Staff in this service are readily available to give support and advice and signpost them to other services. However, the quality of CAFs seen during the inspection is only just adequate overall. Many lack depth and pay insufficient attention to identifying strengths and needs. As a result, priorities and action plans are not specific enough about desired outcomes and how and when they should be achieved. The

council and KSCB are aware of these weaknesses and they are being tackled, but substantial further work is needed.

28. The council and its partners have recognised the need to meet the needs of an increasingly diverse population. Where required, appropriate use is made of interpreters and key documents are translated into the user's first language. Appropriate steps have been taken to ensure that the Equality Act 2010 is met. There is a range of support for different minority ethnic groups. For example, targeting has led to increased access to early help among groups from Traveller and Eastern European communities, with an increase in one year from 500 to 3000 families from minority ethnic groups taking up early help services in one part of the county. In children's social care and CAF assessments, basic information about diversity, including ethnicity, disability and communication needs, is routinely recorded. In some cases there is sensitive assessment and intervention that reflects and responds to diversity factors. However, this was not the norm and in most cases, needs in relation to culture and ethnicity were superficially considered and not addressed adequately in planning and interventions.

The quality of practice

29. The quality of practice is adequate. Clear written thresholds for referral are in place and screening at the central referral unit ensures that the right children are getting services. Decision making at this stage is consistent and there are examples of effective and systematic multi agency processes, which safeguard and protect children at risk of significant harm. Transfer to assessment and intervention teams (AIT) works well. The timeliness of initial and core assessments has improved, and all children in child protection processes have an allocated social worker. Children in need services are insufficiently developed to ensure effective action in all cases and the council has recognised this though remedial action is not yet fully implemented. Early help services are not yet fully embedded but are beginning to show an impact for children whose needs can be met by the common assessment framework (CAF) process.

30. The route to escalate cases from the CAF is effectively applied in most cases, and where there are child protection concerns these are recognised and addressed. Professionals are able to consult with qualified social workers to discuss and consider whether to make a referral. In most cases partner agencies communicate and exchange information or concerns appropriately and have established close working relationships. However a small number of examples were seen where partner agencies did not take prompt and appropriate action in response to potential risk to children. These included a delay of two weeks in the referral of domestic abuse where there were young children in the household; and the failure by acute health services to refer a very young child with suspicious injuries.

Children's social care services took appropriate action once they were made aware of these cases.

31. All new referrals are dealt with promptly by the CDT. New contacts, including re-referrals, are screened and appropriately addressed or redirected with a minimum of delay in most cases. Domestic abuse referrals are initially screened by the police, and where they are high priority they are immediately addressed. However, some domestic abuse cases were seen where there had been a delay in their being passed to the CDT for action. In some child in need work, inspectors saw delays in engaging both adult and children's mental health services where these services were needed.

32. Managers and staff understand the need to focus on children and young people, to ensure that interventions are timely, effective and avoid drift. The extent to which children and families understand the role of social workers is not routinely evident from the case records, but in some offices information packs for families are provided. In almost all initial assessments and child protection cases children and young people are seen and seen alone and their wishes and feelings are considered and reflected in casework. In child in need cases the picture is more mixed. There are some examples of direct work where effective relationships have been developed which have influenced the child's plan. However inspectors have seen cases in which the level of engagement with children and young people was less robust. Some examples of child in need cases were reviewed where children and young people had not been seen by social workers for several months. While children were not exposed to risk of significant harm in these cases, their welfare needs were not fully assessed and met. Overall the quality and effectiveness of assessments and interventions to support children and to minimise risk is too variable, and the quality of practice is just adequate.

33. Social workers regularly and appropriately seek advice and guidance from managers and seniors, who are visible and accessible to staff. In some cases managers chair child in need meetings and core groups. Decisions made by managers are regularly recorded on case files. However managers' effectiveness in driving forward casework by monitoring action taken and progress made is too variable. Inspectors saw cases where weak planning and a lack of rigour in management oversight led to drift and delay in meeting the welfare needs of children in need.

34. Most supervision records show evidence of monthly meetings. Although some contained a staff appraisal on file, these were limited and there is little evidence of how the professional development needs of staff are being met. Most supervision records seen are brief, with little evidence of reflective discussion and challenge and little rationale for decisions made, though a minority of records were good and did include these elements. Children's files do include supervision discussions and decisions and some

of these include a rationale for decisions. There is evidence of formal quality assurance feedback from child protection conference chairs on some supervision files and these are discussed with staff to inform professional development.

35. Enquiries made under section 47 of the Children Act 1989 are undertaken by suitably qualified social workers. Background checks are carried out and in most cases assessments and outcomes of enquiries clearly recorded. In the CDT, findings and actions from initial strategy discussions are clear. However while child protection enquiries are triggered effectively in new cases referred via the CDT, emerging child protection concerns in open child in need cases do not always receive a sufficiently prompt response.

36. Most core assessments identify risk and protective factors and reflect relevant historical information about children and families. Some demonstrate effective analysis to inform future planning but too many do not explicitly identify the actual or potential impact on children of the relevant risk factors. Reports for child protection conferences also reflect a tendency to list risks rather than analyse or weigh them. In most cases, social workers share their reports with families in advance of the child protection conference. A majority of CAF assessments are timely, and families understand the reasons for agency involvement but not all assessments identify clear priorities. This has a detrimental effect on the planning process, with outcomes not always spelt out sufficiently clearly and progress measures often ill-defined.

37. Most child protection and child in need plans seen by inspectors are too general and are insufficiently explicit about how the actions will reduce risk and improve outcomes for children. Few include timescales for improvement. Actions are not often prioritised or differentiated. Too many child in need plans in particular are poorly formulated, and some are not routinely reviewed, leaving children without purposeful involvement to meet their assessed needs.

38. The electronic social care record has been improved over the past year, enabling social workers to identify quickly relevant records and have access to key decisions made. However significant limitations remain and this results in social workers keeping documents on parallel files. This is being addressed by the council, which has procured and is due to launch a new electronic social care system in May 2013.

39. Case recording on child protection files is generally up to date, although the rationale for decisions is not always clearly identified on case records. In many cases seen the purpose of the work in relation to plans is not clear. On child in need cases, plans and meeting records are not stored on children's electronic files, making it more difficult for managers to audit and assure the quality of the work. The quality of chronologies is variable.

Although the transfer protocol requires every case to have a chronology at the point of transfer, some are too detailed to be of value. The council has recognised this and action is being taken, but it is too early to see significant impact.

40. In the majority of cases reviewed, multi-agency conferences, strategy meetings and core groups include a range of professional participants. Records of these meetings show that while risks and protective factors are identified sufficiently to lead to appropriate decision-making, they are not always fully evaluated to assist planning. This reduces the quality of child protection plans. Compliance with child protection plans is monitored, but it is not clear how outcomes for children are changed or improved. In one core group observation, there was insufficient challenge to parents and professional agencies to address the lack of improvement in meeting the objectives of the plan. Agencies were not held to account, and this lack of transparency presented a confusing message to the parents. Some children and young people attend their child protection conferences, though this is a small minority of cases. Although good examples were seen of the use of advocates to support children with disabilities in attending their conferences, advocacy services are not yet routinely available. The council has very recently recognised this and is beginning to take action to remedy this weakness.

Leadership and governance

Adequate

41. The judgment for leadership and governance is adequate. Elected members and senior managers have consistently given a high level of strategic priority to protecting and improving services to Kent's most vulnerable children. Following judgments of inadequate in a safeguarding and looked after children inspection in October 2010, Kent was given a notice to improve in March 2011. The council has taken an appropriate phased and prioritised approach to the improvement task. In the first 12 months up till October 2011 remedial work focused on successfully clearing the backlog of unallocated and incomplete assessments. A development programme was introduced to bring control over referral levels and workflow. Work to reduce high caseloads was initiated along with a programme of auditing to develop an understanding of strengths and deficits in casework practice. The council also launched its workforce strategy to deal with high staff turnover and identified weaknesses in the capability of some staff.

42. A second, consolidation, phase followed between October 2011 and August 2012 and was marked by the appointment of a new Director of Children's Services and two reorganisations to develop clearer lines of accountability and responsiveness. This included the establishment of the

CRU as a multi-agency single point of access, and within it, the CRT as well as in-house early intervention teams. An early intervention strategy was launched including a quality assurance framework as well as further work to improve the CAF process through a rolling programme of training. There has been significant investment in early help services. Similarly, and because of an unsatisfactory child and adolescent mental health service (CAMHS), robust action was taken to terminate the existing contract and re-let the contract. The new range of CAMHS provision started in September 2012 and is now becoming established. A new electronic social care record system has been procured to replace the current inefficient system and is due to be launched in May 2013. During this phase there have been significant performance improvements around the responsiveness to initial referrals as well as child protection enquiries. However, the council acknowledges that the pace of improvement and prioritisation in the consistent application of appropriate thresholds, assessment, planning, multi-agency engagement and supervision for children in need remains insufficient.

43. The council has a range of strategies and initiatives to improve services and help and protect children. These include the Practice Improvement Programme (PIP) which has used performance and audit data to identify areas for improvement and has focused on raising supervision, increasing consistency in the quality of practice and improving managerial oversight and leadership across the county. The council has achieved a high level of awareness of this programme among first line managers and practitioners as well as a strong commitment to it. While this has contributed to clear improvements in important aspects of services, the council itself acknowledges that much work remains to be done. The council's governance structure has recently changed with the removal of the Chief Executive role. However, there are clear accountabilities and responsibilities between the KSCB, the Children's Joint Commissioning Board, the Improvement Board, the Lead Member for children's services and the Council Leader.

44. The KSCB largely meets its statutory responsibilities and has established a generally adequate business and training plan although it is not as yet clearly able to demonstrate the impact of its work. KSCB members acknowledge that it has delivered insufficient challenge, due in part to a longstanding variation in the commitment of partner agencies to the importance of the Board's work. The Board has only recently commenced a section 11 audit which was scheduled for completion shortly after the end of the inspection. There is duplication and confusion between the roles of various sub groups and task and finish groups.

45. Performance management information is routinely collated and analysed at all levels. A scorecard of key performance data is effectively scrutinised and reported to senior managers, the KSCB and council members. Performance scorecards indicate wide variations for some indicators

between the best and worst performing districts. One example of this is the high level of children who are subject to a child protection plan for a second or subsequent time. The council acknowledges that some child in need planning for those removed from child protection plans was not sufficiently outcome focused and has taken steps to improve this. It recognises that although there has been a high level of qualitative auditing, this has not always been well focused with clear pathways from lessons learnt to action. Work has very recently begun to develop a more effective model with a clearer improvement focus.

46. Senior and middle managers have been largely effective in ensuring robust oversight and tackling weaknesses in child protection practice and systemic barriers to improvement. For example a number of staff have been subject to formal performance and capability measures and a significant number have moved out of the service when they have not met required standards. However, the consistency and quality of work remains a significant issue and the council accepts that much more in particular is required to be done to improve the quality of assessment, planning and provision for children in need.

47. Some analysis has taken place of user feedback on services provided. An externally commissioned survey of staff engagement in March 2012 which sampled 67% of staff in children's social care services found the majority of staff felt enabled and supported with high job satisfaction scores but that only 44% felt confident in senior management. However, the inspection found consistently good morale among social workers, based on confidence that managers understand the front line and have introduced safer systems of casework management. Social workers report that formal supervision occurs regularly and newly qualified social workers report positively on the support and protection they receive in their first year. Despite this the inspection has found significant inconsistency in the quality and recording of supervision. The council recognises this and has already started to deliver a programme of reflective supervision training which will be concluded for all relevant managers by mid-2013.

48. There is some evidence in reports of an active approach to seeking the views of children, young people and parents about child protection and early help services. Changes made reflect to some extent the views obtained, for example a report format for parents to present their views to meetings is now in use. Feedback suggests some progress in ensuring parents are clearer about what needs to change in child protection cases, although casework examined during the inspection shows this is limited. It also suggests that most children and young people feel that child protection conference chairs help them express their views and that social workers explain to them why people are concerned. Staff report that they have opportunities to express their views about the improvement agenda.

49. There is evidence of the use of a range of sources to create an active learning environment. This is particularly evident in the council's commissioning of a peer review in September 2012 and acceptance of its findings as well as the consideration and review of information from complaints. However, the inspection has not found evidence that learning from serious case reviews or research is established in casework practice.

50. Workforce planning is adequate. Kent has some significant and difficult challenges in relation to workforce development. It has reduced its social worker vacancy levels and pursues a 'grow your own' policy as well as recruiting social workers from abroad. There remains variation in the balance between experienced and less experienced workers in teams across the county. There are also specific recruitment problems related to some geographical locations. The council has invested in ensuring the recruitment of good quality staff with additional pay incentives in place to address particular staff shortages, and has also deployed staff in a flexible manner to cover gaps. There remain key first line manager and social worker posts that are not filled by permanent staff. However, the council does not compromise on the calibre of staff and retains good quality locum staff rather than appoint social workers who do not met the required standard. In some cases, supernumerary locum staff have been engaged to help respond to peaks of demand. As a result of these activities, social workers' caseloads are maintained at a manageable level.

Record of main findings

Local authority arrangements for the protection of children	
Overall effectiveness	Adequate
The effectiveness of the help and protection provided to children, young people, families and carers	Adequate
The quality of practice	Adequate
Leadership and governance	Adequate