

# Inspection of local authority arrangements for the protection of children **Cornwall**

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**Inspection dates:** 4 February to 13 February 2013  
**Lead inspector** Pat O'Brien HMI

**Age group:** All

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# Inspection of local authority arrangements for the protection of children

## 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 Cornwall 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 Cornwall, the local authority and its partners should take the following action.

### Immediately:

- ensure that all children who are subject to child protection plans are seen within expected timescales and seen regularly at home
- review children in need cases to ensure that every child in need has an up to date plan
- ensure that where appropriate the individual needs of each child in a family are assessed and that the assessment informs their individual plan.

### Within three months:

- ensure that plans relating to children set out more clearly what specific outcomes they seek to achieve and how progress will be measured and include clear contingency plans with timescales
- ensure that progress on all plans relating to children is systematically monitored
- ensure that timely and decisive action is taken when plans relating to children are not progressing and identified risks are not being reduced, particularly in cases of child neglect.

- strengthen the quality and consistency of peer and core audits and ensure that themes and issues from these audits and from the multi-agency audits are used to provide a more comprehensive picture of the quality of practice and the impact of the work on keeping children safe
- strengthen auditing of children in need work to enable a full picture of the impact of this work in reducing risks to children
- ensure that assessments and plans take full account of the impact of ethnicity and diversity in working with families
- embed the use of the new supervision framework to further improve the quality and consistency of supervision and ensure that all management decisions are supported by clear rationale.

**Within six months:**

- ensure that all cases have appropriate chronologies in place
- extend the use of the multi-agency audit to examine and assess the child protection practice of other agencies.

## 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 four of Her Majesty's Inspectors (HMI) and two seconded inspectors. A newly appointed HMI shadowed the inspection.
8. This inspection was carried out under section 136 of the Education and Inspections Act 2006.

## Service information

9. Cornwall has approximately 117,000 children and young people under the age of 19 years. This is 22% of the total population. The proportion entitled to free school meals is below the national average. Children and young people from minority ethnic groups account for just over 4% of the total population, compared with 16.3% in the country as a whole. The largest minority ethnic groups are Asian and British Asian, Mixed White and Asian, and Mixed White and Black Caribbean. The proportion of pupils with English as an additional language is below the national figure.
10. Referrals to children's social care services are now managed through the multi-agency referral unit (MARU). This was initially established in September 2012 and became fully operational in January 2013. It is managed and staffed by social workers with support from administrative staff and includes staff from the police, education, housing and drug and alcohol services. There are well developed plans for community health services to join the unit. The MARU provides a county wide service. Its work is coordinated closely with locality teams to identify families who

need early support. Initial and core assessments and section 47 enquiries are carried out by four assessment teams based in different local areas across the county. Following assessment, cases can transfer to one of eight locality teams for early help, to one of six children in need teams or to one of six child protection teams. These teams are located throughout the county to enable easier access for families. The children in need service was established in April 2012. In addition there are three children with disabilities teams. They undertake assessments and section 47 enquiries and hold both child in need and child protection cases. There are 18 children's centres spread throughout the county and a family assessment centre.

## Overall effectiveness

11. The overall effectiveness of local authority arrangements to protect children in Cornwall is adequate. Significant progress has been made by the local authority and its partners in tackling the deep rooted problems which led to safeguarding arrangements being judged inadequate by Ofsted in the safeguarding and looked after children inspections in 2009 and 2011.
12. The Director of Children's Services and the Head of Service provide ambitious, resolute, energetic and very visible leadership. They have driven improvement effectively through a sound analysis of the problems and a detailed improvement plan which is progressing well. There is a clear and realistic understanding of what has been achieved and what still remains to be done to ensure that practice standards are consistently embedded and high quality services delivered. Staff have confidence in senior managers and are working hard to improve their practice in an increasingly strong culture of challenge, support and learning. Morale is high.
13. A good range of early help is available. This supports children effectively and helps to resolve problems early. However not enough children benefit from this coordinated support as not all agencies participate fully in taking responsibility for assessments through the common assessment framework (CAF). The needs assessment of children in Cornwall (Kernow Matters) presents comprehensive information and analysis of the profile of children and families, identifying areas of highest need and key risks. This is well used to plan services and target resources.
14. No children were identified during the inspection as being at immediate risk of harm. The new multi-agency referral unit (MARU) operates effectively and ensures that concerns are responded to appropriately. Timely and appropriate advice is provided for professionals who have concerns. Management decisions are sound. Concerns about children are appropriately assessed and strategy discussions and child protection enquiries are undertaken jointly with the police without delay.

15. The quality of assessments is adequate. In almost all cases children are seen regularly but in a small number of cases inspectors identified significant delays in children being seen and not all children are seen sufficiently regularly in their homes, leading to delays in plans progressing. There are many examples of good direct work with children and young people by targeted youth workers and family support workers as well as social workers. Some assessments show clearly how children's views are taken account of but this is not consistent in all assessments. Most assessments do not consider matters of equality or diversity within families.
16. In most cases the help and protection provided to children and their families effectively reduces risks. Most parents, children and young people seen by inspectors felt that they had been helped effectively. Children subject to a child protection plan have up to date plans but not all children in need have plans. Risks are identified well in child protection plans but not all plans are sufficiently outcome focused. Reviews are held regularly and chairs engage well with parents, though progress on plans is not always systematically reviewed in a structured way at reviews. The approach to neglect is inconsistent. In some cases children suffering neglect are left too long before timely and robust action is taken. The local authority has recognised this issue. They are auditing cases of neglect to ensure that timely and appropriate actions are now being taken on all cases.
17. The Cornwall and Isles of Scilly Local Safeguarding Children Board (LSCB) meets its statutory requirements adequately. It has made a useful contribution to ensuring thresholds for services are agreed and well understood across agencies and to the development of the multi-agency referral unit.
18. Management oversight and supervision has improved though the quality is still variable. Practice is increasingly centred on the child's experience and this approach is well supported by the new supervision template but this is not consistently used across all teams.
19. A clear quality assurance and performance management framework is in place with good analysis of practice informed by a wide range of data and audits against key practice standards. Managers and staff across services, including locality teams, are held to account for their performance when audits identify practice shortfalls. However there is limited auditing of children in need work and the quality of core and peer audits is variable. While comprehensive multi-agency audits are undertaken effectively to explore areas of concern, themes and issues are not consistently drawn out from all the audits to provide a fuller picture of the quality of practice.
20. There has been a considerable investment in training to develop core competencies amongst social work staff with a strong emphasis on

evidence based practice. The training is valued by staff and there is evidence of it improving the quality of practice.

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

### **Adequate**

21. The effectiveness of help and protection for children, young people and their families and carers is adequate. Children and young people who are at risk of actual or likely significant harm, are being appropriately identified. The response to concerns and the provision of services is timely and appropriate and in most cases risk is being reduced. Developments in the co-location of the police within children's services in some local areas is assisting in the early identification of children and young people who may be at risk of harm and in the subsequent effective planning of protection and support. Arrangements for identifying and responding to risks for disabled children have been strengthened in the children with disabilities service; as a result disabled children are effectively protected.
22. A range of accessible early help and support services, aided by a good electronic information service directory, are available to children, young people and their families. Local teams offering the range of provision from early help to child in need and child protection demonstrate good awareness of the needs of their communities. The quality of communication between professionals and partner agencies, including voluntary sector providers, is generally good. Arrangements for the provision of early help and support are being actively developed to ensure there is a range of services to prevent family breakdown and to support families in the care of their children and young people. However, not all services are setting clear outcome measures in ways that enable them to assess the effectiveness of help and support over time.
23. The co-ordination of early help services between locality based family support and targeted youth support, children's centres and health partners is improving. This is particularly the case where professionals are co-located. For example, health visitors based in children's centres and specialist workers within schools are extending the reach of services to facilitate more effective work with children and parents. Youth support workers are being deployed effectively across all services and use their specific skills well to provide targeted services to young people and their families. In an increasing number of cases early help is preventing an escalation of problems within families and reducing the risk of harm to children and young people. Several projects, such as those helping adults and young people who are mis-using substances, the family intervention project supporting challenging families with complex needs and work with young people at risk of offending, are providing more intensive and

targeted services. However, the overall impact of these services is not yet well understood by the local authority and partners.

24. The use of the common assessment framework (CAF) across the county and partnership to secure single or multi-agency support is improving. However, not all children and families who could benefit from this approach are being offered this service because some settings and services are not always prepared to use this model or assume lead professional roles. In some instances different processes have been used to undertake assessments resulting in unnecessary duplication of effort. Steps are now being taken to establish a single early help assessment process supported by a shared electronic data base to replace the CAF. Where a range of professionals and agencies are working with children, young people and their families team around the child (TAC) meetings provide good opportunities to review the needs of the family, share information and clarify the impact of the support provided. The views of parents, children and young people are being taken into consideration in assessments and meetings are mostly conducted well to enable service users to have a voice. However, action plans are not routinely tracked from one meeting to the next and this makes them less effective in helping children.
25. In most cases actions are proportionate to risk and need and this ensures that children and young people are not drawn unnecessarily into child protection systems. Where concerns are raised about children and young people, risks are identified and assessed appropriately and in most cases this leads to the right levels of service. However, in some cases of neglect there are unnecessary delays in taking decisive action, including service escalation or use of legal powers to reduce risks. This was identified in audits and senior managers have put measures in place to tackle this; as a result the number of repeat child protection plans has fallen. There are many examples of purposeful work within children in need services which are having a positive impact on their lives. However because not all children in need cases have plans it is difficult to measure the purpose and progress of all this work. Inspectors saw positive examples of well-formed relationships between social workers, children and parents in relation to direct work undertaken in respect of domestic abuse. Direct work by targeted youth workers and family support workers is also supporting children effectively in some cases including, for example, one to one work to raise self-esteem and raise awareness around keeping safe.
26. The arrangements to respond to the needs of children and young people who go missing have been strengthened and an adequate protocol is in place to ensure that debriefing interviews are conducted when missing children and young people are found. The rate of recovery of missing children and young people is good. Positive steps are also being taken to raise awareness of the risks of child sexual exploitation and the council and LSCB are actively engaged in joint work on child sexual exploitation

with neighbouring authorities. They have developed and introduced a joint strategy but it is too early to measure the impact of this work. There is recognition that more work is needed to tailor the strategy to the specific demographic needs of the county. Data on children who go missing is not being routinely collated and shared across agencies or fully utilised to evaluate the full impact of current strategies.

27. Basic information relating to ethnicity, race, religion, culture and language is recorded on case files. However, assessments are not always using this information to best effect to tailor plans to specific needs. Insufficient consideration is also being given in assessment and planning about the way diversity may impact on the ability of parents to protect their children from harm.
28. Children, young people, parents and carers are, in the main, positive about the help and support they receive. They indicate they are usually aware of the reasons for interventions and the aims of services. Surveys are conducted by the council on a quarterly basis to obtain the views of parents, carers and professionals on the services received or provided. In the last quarter 69% of service users who responded to the survey said they were fairly or very satisfied with the services they had received and a high proportion indicated that they understood the reasons for interventions and felt their situation had improved as the result. However, some parents seen in the course of this inspection have shown frustration with perceived delays in planning, changes of support workers and the length time it has taken to reach firm conclusions about aspects of plans.

## **The quality of practice**

### **Adequate**

29. The quality of practice is adequate. Thresholds are known and understood across the partnership and agencies know how and when to make referrals. The local authority has introduced, and successfully encouraged, the widespread use of a standard multi-agency referral form, which has helped to ensure that comprehensive information is generally available at the point of referral. Partner agencies make referrals to social care in a timely manner and have access to the expertise and advice of social workers working in the MARU to support them in determining whether a referral to social care is appropriate. Professionals report that this is helpful and they have seen an improvement in the response from children's services to their concerns. Assessments completed under the CAF in locality teams are detailed and appropriately focused on children's needs and professionals recognise when thresholds for child protection are met.
30. The co-location of police, education, housing and drug and alcohol services within the MARU promotes effective sharing of information and a prompt screening system for referrals. Well developed plans are in place

to extend those arrangements by including community health services within the MARU. The response to initial referrals is prompt and timely and is supported by a clear protocol. Management decisions about the outcome of referrals are sound and are routinely recorded. However, the rationale for those decisions is not always evident. There is an appropriate and timely transfer of referrals to the assessment service and referrers receive appropriate feedback on the decisions made. Signposting of families to other sources of help, including the locality teams, is appropriate.

31. Referrals received by Cornwall out of hours team are handled effectively. Communication with day time services, including the MARU, is sound. An additional service (the crisis team) is available at evenings and weekends and provides valuable additional monitoring and support to ensure that children are well supported and protected.
32. All section 47 child protection enquires are carried out by qualified social workers and are overseen appropriately by managers. Risks to children with disabilities are identified and addressed appropriately and are assessed, investigated and escalated in a timely way by social workers working in the children with disabilities teams. Strategy discussions between social care, police and other agencies are prompt but the records do not always indicate that strategy discussions are being used effectively to plan child protection enquires.
33. In almost all cases examined children and young people are seen regularly by social workers and are seen alone, with due consideration being given to the children's presentation and the home environment. Where children are subject to child protection plans most children are seen regularly by way of announced and unannounced visits, though not all children are being seen in their own homes sufficiently regularly. Inspectors also identified a small number of children who, although subject to a child protection plan, had not been seen for a significant period of time. There was no evidence of systemic failures in relation to children being seen and inspectors were satisfied that these children were not at immediate risk.
34. In the majority of cases recording is timely and up to date. Although the quality of case recording is variable, inspectors saw some good examples of recording which included detailed observations of children's presentation and development with clear evidence of the progress of the case. However, in some cases the recording was too brief and lacked detail. For example, evidence of challenge to parents about the quality of their parenting was not always sufficiently recorded and the rationale for visits was not always evident.
35. The practice of only allocating the youngest or most vulnerable child within a sibling group has resulted in the individual needs of some children not always being given sufficient consideration. The individual records of

sibling children are not always clear as the record of one child is often populated across sibling groups and therefore does not reflect each child's needs. This was evident both in CAF, child in need and child protection work.

36. The quality of initial and core assessments is adequate overall. Some are comprehensive. Good use is made of genograms and family history is generally taken into account within assessments. However, the quality of chronologies is variable: they are not always up to date or focused on significant events; some are not comprehensive; others record the activity rather than the actual concern.
37. Some assessments give good consideration to children's wishes and feelings. The use of 'the lived experience of children' section within the assessment framework is encouraging social workers to focus on children and prompting them to fully consider what it is actually like to be a child living in the family. However, this is not yet fully embedded within social work practice and consequently not all assessments present a picture of life for the child, describe their day to day experience or explain how parenting difficulties are impacting on them. Social workers are receiving helpful training and support to improve their practice in this area. Partner agencies contribute to the assessment and planning process by providing timely information about the child or parents/carers.
38. The assessment tool used by social workers requires them to identify, analyse and develop plans to manage risk. Inspectors saw some good examples of well-considered risk management plans. However, the way in which risks are described is not always clear and concise and as a result most of the plans seen were not outcome focused or measurable. The timeliness of initial and core assessments are generally good but the quality of analysis within assessments is variable. Core assessments are not always updated and therefore do not reflect the changing circumstances of children and young people.
39. Initial and review child protection conferences are timely. Most are chaired by experienced managers with good engagement of parents. However, the structure of the meeting is not always clear and does not consistently make it easy for parents to understand what the meeting is trying to achieve. There was also a lack of rigour in tracking progress against decisions taken and actions agreed at the last meeting leading to a loss of focus and lack of momentum in some cases. Most core groups are timely and are well attended by partner agencies.
40. Children and young people do not routinely attend child protection conferences. However, in one child protection conference observed, which the child did attend, the meeting was sensitively chaired and structured to enable the child to give their views and participate well. Independent advocates are available to children and young people involved in child

protection processes, but the take up of advocacy support is too low. Having recognised this, the council has implemented an 'opt out' system in order to encourage and promote the use of the advocacy service.

41. Child protection and child in need plans are not always sufficiently detailed in setting specific and achievable objectives and as a consequence progress is not easy to measure. Outcomes are frequently too general and some plans are unnecessarily long, making it difficult for parents and professionals to focus on the key changes needed to reduce the risks. Contingency planning is not sufficiently robust and whilst continuity of care is addressed, timescales for alternative courses of action were not evident. Child in need plans are regularly reviewed but only by the allocated worker which means there is no critical challenge to the progress of plans.
42. Managers, social workers and other staff receive regular supervision but while the quality has improved it is still not consistent. The introduction of a supervision framework designed to enable and promote critical reflection, challenge to social work practice and focus on the child's experience is a very positive development. Inspectors saw examples of the framework being used effectively but it is not yet consistently being applied.

## **Leadership and governance**

### **Adequate**

43. Leadership and governance are adequate. Senior leaders are ambitious; they are strongly committed to delivering high quality services to ensure children are helped and protected and they have a clear vision of how to achieve this. Council leaders and senior managers display a good knowledge of the strengths and weaknesses of early help and intervention and child protection services. The strategic leadership team demonstrates a firm and resilient resolve to addressing previous failures within children's services in a systematic, coherent and planned way to ensure that improvements made can be sustained. Good use has been made of peer review to help target priority areas for improvement. A clear and detailed improvement plan is well monitored and progressing well. Some services have been re-structured and new services developed, alongside new processes and systems and this has made a significant contribution to ensuring that child protection concerns are responded to promptly and that children in Cornwall get help and protection when they need it. The pace and momentum of change continues and well developed plans are in place to develop a specialist pre-birth assessment team and to further strengthen partnership arrangements by co-locating child and adolescent mental health services (CAMHS) and including community health services in the MARU. However council leaders and senior managers recognise that

it will take more time to embed quality standards and achieve a greater consistency in social work practice.

44. The Children and Young People's Plan 2012-13 sets out the council's aspirations for improving outcomes for children and young people with clear and ambitious priorities that reflect the overall improvement agenda. A comprehensive strategic needs assessment with detailed information and analysis on areas of high deprivation and vulnerable children is used effectively to inform the allocation of resources and service delivery. For example this has informed the commissioning of services through the voluntary sector and the resources allocated to locality teams. An overarching early help strategy is being developed.
45. Accountabilities between the DCS and Lead Member are clear and appropriate. The Lead Member is confident, committed and takes his responsibilities seriously. He ensures that members are well briefed through regular attendance at scrutiny committee meetings enhancing further their understanding and commitment to child protection services.
46. The LSCB is meeting its statutory responsibilities satisfactorily. The scale of the challenge faced by the LSCB following previous inspection findings was substantial. Progress made against these findings has been significant since the last inspection in January 2011. The Board has reviewed its membership and governance arrangements and through this work re-structured and re-focused their energies.
47. The work of the LSCB is now more focused on core child protection activity and this is reflected in the Board's current business plan. Better performance and quality assurance monitoring information enables them to understand and challenge safeguarding activity across the partnership more confidently. At the time of this inspection section 11 audits have been undertaken across the partnership but the findings have yet to be analysed and reported on. The Board has commissioned a thematic review on neglect in response to delays in some cases in effectively tackling neglect identified through case file audits. Serious incidents are appropriately identified and reported to Ofsted and consideration is given as to whether the criteria for a serious case review are met. However records do not always show clearly the rationale for recommendations to the Chair and the relevant agencies have not always been involved in these discussions. These arrangements have now been strengthened. At present one serious case review is being undertaken.
48. Board members are sufficiently senior within their own organisation to hold others to account, effect change and commit their agency to resources to support the work of the Board. An attendance register and robust reporting on this means that partner agencies are held to account for non-attendance. The recent appointment of two lay members further enhances the progress made and re-naming the three sub groups,

Performance, Practice and Learning aligns the work of the LSCB more closely to the main work strands of the council and the improvement agenda. The current independent Chair's tenure is drawing to a close and the transfer to a new Chair is being managed effectively to ensure that momentum for improvement is not lost.

49. Stronger partnership arrangements are being achieved through safeguarding training and the re-launched thresholds guidance. Safeguarding is now increasingly being recognised across the partnership as everybody's business. Joint working across the South West Peninsular LSCB has seen the development of a coherent child sexual exploitation strategy. Appropriate governance arrangements are in place between the LSCB and the Children's Trust. The Safeguarding Annual Report is presented to the Trust which further strengthens the mechanisms for appropriate challenge at a strategic level.
50. The senior leadership has been successful in creating a culture of learning, support and challenge. Good attention has been paid to developing performance management and quality assurance. A clear and detailed framework is in place providing appropriate scrutiny of performance against a range of key indicators and the auditing of practice against key quality standards. Shortfalls in practice are identified and staff are routinely held to account for their practice. The council is developing this further to include reports on all aspects of child protection activity including the frequency of statutory visits, the quoracy of child protection conferences and the attendance at conferences by partner agencies so that any repeat absences can be challenged through the LSCB. Managers across locality teams and child protection teams receive monthly quality assurance and management reports and have to account for progress. The quarterly conferences for staff led by senior managers ensure that staff are kept well informed and understand the importance of performance management and their individual responsibilities.
51. The safeguarding standards unit established in Sept 2011, has strengthened the audit and quality assurance role of child protection chairs. Good quality multi-agency audits are undertaken on cases and provide good challenge to social care staff. Whilst detailed, audits are based on social care records, which means the work of other agencies does not have the same level of scrutiny. Core audits, undertaken by child protection review chairs and peer audits, undertaken by line managers and senior managers are undertaken regularly on case work but the quality is variable and they do not always accurately reflect the quality of practice. Themes and issues arising from all the audits are not drawn together and this prevents senior managers from having a broader understanding of the quality of practice across the service and to further enhance their ability to identify areas for improvement. Auditing of children in need cases is limited to peer audits and these do not provide sufficient insight into the overall quality of children in need work.

52. An effective workforce strategy is in place with a significant investment in the training and development of front line social workers, managers and other social care staff. The creation of Principal Social Worker (PSWs) posts working alongside team managers has increased the management and supervisory capacity available to teams and enhanced the quality of professional practice. Through learning from best practice, lessons learnt from serious case reviews and establishing specific learning sets on core social work activity the senior leadership team is developing and strengthening professional practice and ensuring compliance with statutory child protection guidance. Managers at all levels are enthusiastic about the changes that have been introduced and this has led to tangible improvements in practice.
53. The recent development of the Foundation for Social Work in Cornwall provides an effective approach to recruiting newly qualified social workers. The quality of practice, supervision and support for newly qualified social workers is impressive. While there remain some staffing pressures most teams are fully staffed and case loads are generally manageable.
54. Feedback is routinely collected from parents and professionals about their experiences providing a helpful insight into performance. Key themes and issues from this are identified but subsequent actions to tackle areas of development are not always clear. Overall feedback from parents about the service they receive is positive. However there is no process in place to systematically gather the views of children and young people involved in the child protection process.

## 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