

# Inspection of local authority arrangements for the protection of children

Metropolitan Borough of Rotherham

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**Inspection dates:** 2 July to 11 July 2012  
**Lead inspector:** Nicholas McMullen 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 Rotherham 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 Rotherham, the local authority and its partners should take the following action.

### Immediately:

- undertake a multi-agency review of cases of serious neglect where children's social care services have been involved for a significant period of time
- ensure all strategy discussions meet statutory requirements, are clearly and fully recorded and signed off by a manager
- ensure the outcomes and rationale for all Section 47 enquiries are clearly recorded and signed off by a manager.

### Within three months:

- improve the consistency and quality of referrals from partner agencies to the contact and referral team
- ensure that domestic violence notifications from the police are timely and include a child focused risk assessment
- improve the quality and consistency of child protection and children in need plans, ensuring they are appropriately focused on key risks

and the actions required to reduce risks and set clear, specific and measurable outcomes

- ensure that core groups, children in need meetings and supervision sessions focus on the progress made to reduce the risks identified in plans
- take action to reduce the caseloads of the busiest teams and workers, ensure all newly qualified social workers have a caseload appropriate to their skills and experience and review the overall social work capacity needs of the service
- ensure that full consideration is always given as to how children and young people's views are represented in child protection conferences including, when appropriate, enabling access to advocacy support
- ensure all social workers and managers in duty and children in need teams understand the requirements for identifying, assessing and monitoring private fostering arrangements.

**Within six months:**

- develop and implement systems to collate and evaluate feedback from children and families subject to child protection processes and use this feedback to inform service development
- strengthen the degree of independent challenge in the child protection system by, for example, creating direct links between the manager of the child protection chairs, the Strategic Director of Children's Services and the chair of Rotherham Local Safeguarding Children Board (RLSCB)
- fully implement the proposed quality assurance framework. Include in this the regular collation of practice issues noted by child protection chairs and ensure that findings from all quality assurance work undertaken by partner agencies are reported to RLSCB.

## 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 73 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 an Additional Inspector.
8. This inspection was carried out under Section 136 of the Education and Inspections Act 2006.

### Service information

9. Rotherham has approximately 56,000 children and young people under the age of 18 years. This represents 22% of the total population. Overall deprivation is significant and increasing, with Rotherham ranked as the 53<sup>rd</sup> most deprived local authority area in the 2010 Index of Multiple Deprivation, placing it amongst the top 20% most deprived areas. Rotherham's minority ethnic population is relatively small but growing in size and diversity. The Kashmiri and Pakistani communities are the largest minority ethnic groups in the borough, but other newer communities are growing, including a growing Slovak and Czech Roma community of around 3,700.
10. Referrals to children's social care services are now managed through the contact and referral team (CART), which was established in January 2012 and provides a Borough wide service. Its work is coordinated with the parent support service and common assessment framework (CAF) coordinators to support the swift diversion of appropriate cases into early intervention services. Initial and core assessments and Section 47 enquiries are carried out by four duty teams. Following assessment, cases

requiring child protection or children in need support are transferred to one of eight local children in need teams. Assessments for children in court proceedings are undertaken by a specialist family assessment team (FAT) and there is also a developing specialist multi-agency team to support children at risk of sexual exploitation. Referrals of disabled children are screened by the CART, with assessments and support provided by a specialist disabled children's service. A range of services provides early intervention, including 23 children's centres and multi-disciplinary teams structured around Rotherham's local learning communities. A family recovery project provides intensive support for children on the cusp of care.

## Overall effectiveness

### Adequate

11. The overall effectiveness of local authority arrangements to protect children in Rotherham is adequate. Significant improvements have been made since 2009, when services were failing to adequately protect children. These improvements have been driven by clear and resilient leadership and informed by a sound and realistic understanding of the needs of the local community. However, further work is required to consolidate this improvement, address current weaknesses and provide services of a consistently good quality.
12. A good range of family support and early intervention services is in place and these are promoting improved outcomes for children, supported in many cases by appropriate use of the CAF. The local authority has a clear early intervention strategy and operational plan although these are at a relatively early stage of implementation, and inconsistencies remain in the accessibility and quality of early support.
13. The creation of the CART and duty teams in January 2012 has improved the consistency and timeliness of responses to contacts and referrals. Contacts are swiftly and usually appropriately categorised as requiring a social care assessment or being suitable for early help support. However, more work is needed by partner agencies to improve the timeliness and quality of some referrals, including domestic violence notifications.
14. In all cases seen by inspectors, children at immediate risk were identified and received a robust response to ensure their safety. In a few cases where risk was less immediate, the response was less assured. The planning, recording and management oversight of Section 47 enquiries are also too variable.
15. Children with multi-agency child protection plans are visited and seen regularly. Examples were seen of intervention achieving improved outcomes for children through effective family support, sound social work practice and good collaborative partnership working. However, too many

child protection plans lacked a clear focus on risk and how this was to be reduced, and generally plans were not functioning as effective tools to assist the development and monitoring of work to protect children. Where difficulties were more entrenched, inspectors found evidence of inconsistency in decision making in determining when situations required escalating into legal proceedings. In some cases this was timely and appropriate; in other, seemingly similar, cases children were maintained in unsatisfactory circumstances for too long with little evidence or prospect of improvement.

16. Performance management has focused effectively on national performance indicators and compliance issues but there has been insufficient attention and action on assessing and improving the quality of practice, which is too variable. The local authority recognises this and has developed and piloted a new comprehensive quality assurance framework and is now planning its implementation with the aim of addressing this deficit.
17. RLSCB has recently completed and published a serious case review concerning the murder of a teenage girl. This clearly identified important lessons to be learned for example concerning the risk assessment of vulnerable young people and the quality assurance of safeguarding work. The local authority and its partners are developing a programme for disseminating this learning. However, it is too early to see impact in some key areas. RLSCB has not been sufficiently focused or challenging in some core areas of child protection activity such as the quality of child protection planning and ensuring the appropriate application of service and care thresholds. Senior managers are knowledgeable and clear about their responsibilities but there is only limited evidence of professional challenge holding senior managers to account for their management of child protection services.
18. Workforce planning has been effective in reducing vacancies, turnover and dependence on agency workers. Social workers report feeling well supported and show a strong commitment to the children on their caseloads and to working for Rotherham. However, despite some progress, caseloads in some teams, including those of newly qualified social workers (NQSWs), remain too high. As a result supervision, whilst happening, is not consistently effective in evaluating and challenging the progress of child protection and children in need plans and some workers, despite working long hours, do not have enough time to give appropriate attention to all their cases or to their own professional development.

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

### **Adequate**



19. The effectiveness of help and protection provided to children, young people, and their families and carers is adequate. The common assessment framework (CAF) is often used well; its use is increasing across agencies and more children and young people are getting the support they need at an early stage. There are many examples of children and their families benefiting from the practical and timely support available. Local community and school resources include individualised support for parenting, practical support in the home or access to courses such as hygiene or safety in the home. Outcomes for children receiving early support are generally good and some children and families are being effectively diverted from requiring more targeted provision.
20. Concerns about children and young people are identified appropriately by a wide range of professionals, agencies and the public. When children are receiving early help, agencies are alert to where action is needed to protect children and make timely referrals to children's social care services. When children are identified as being at immediate risk of harm, risks are investigated and assessed and appropriate and prompt steps are taken to ensure that children are protected. In a few cases where risk was less immediate inspectors noted delays in initiating appropriate enquiries.
21. In the majority of cases, risks to children subject to child protection plans are tackled successfully. Effective multi-agency support is put in place and key risks are reduced. There is clear evidence in these cases that children are safe and are making satisfactory and often good progress overall. The Family Recovery Project is a valuable resource in helping to tackle entrenched parenting problems, though it does not currently have sufficient capacity to support all families who require such intensive support. As a result some children are waiting too long to have their basic needs met. Steps have already been taken to increase this resource. In most cases seen when children are no longer at risk of significant harm but need continued support, this continues to be provided through children in need services or the CAF process.
22. Child protection plans are not consistently effective. In some cases this is because there is insufficient focus on the key risks. In other cases, particularly where neglect is the key concern, progress is limited, often despite considerable support, persistence and appropriate challenge by social workers and other staff. Decision making on these cases is inconsistent. Sometimes prompt and appropriate decisions are taken to instigate care proceedings when children can no longer remain safely at home and there are no other appropriate family carers available. In other cases timely decisions are not always made to escalate concerns, even when it is agreed that the threshold for legal proceedings is met and there is a considerable weight of evidence that the parents are unable to make or sustain improvements. As a result some children are left too long at continuing risk of harm with parents who cannot meet their needs.

23. In most cases timely pre-birth risk assessments are completed and appropriate steps are taken to support parents and monitor their baby's well-being. However, there are delays in completing pre-birth assessments in a small number of cases. Decisions are made appropriately to initiate care proceedings and remove babies at birth when that is the only safe course of action. Social workers make good efforts to place children and young people within their extended family or with family friends when they cannot be cared for safely by their parents. Arrangements to identify and monitor private fostering placements are not robust and as a result the local authority cannot assure itself that private foster carers are able to meet the needs of the children and young people in their care.
24. Parents who met with inspectors and whose children received early help were very positive about the difference this had made, particularly in helping them to parent more effectively. An evaluation of outcomes from the CAF and 'team around the child' work highlighted the positive impact on the ability of parents and carers to look after their children. Parents' evaluations of early support parent workshops record a wide range of positive comments about the impact of the workshops on improving family life and gaining confidence in managing challenging behaviour. Social workers engage well with parents. Most parents who met with inspectors understood what the risks and concerns were, though some had difficulty in understanding or accepting the changes that were needed. Most parents were happy with the support they were receiving and were positive about the progress their children had made. However, the extent to which children and young people feel they have been effectively helped is not clear as recording of children's views is inconsistent at all stages of help and intervention.
25. A wide range of early help is available and easily accessible in local communities to families. Effective work has been carried out to improve take up of early support services by newly arrived families and by the Roma community. Sensitivity to cultural and ethnic backgrounds of European migrants has had a positive impact on stabilising the community and helping parents to understand the procedures required to enrol their child at school. Assessments, support and intervention take appropriate account of children's ethnicity, culture, religion, language and disability. Interpreters are accessed and used appropriately.
26. Agencies, including voluntary and community groups based in local communities, work well together to identify children and families who may need additional help. They work closely together to offer support and tackle concerns with individual children and their families. Information on children who go missing and young people at risk of sexual exploitation is shared effectively at an early stage and work is well coordinated to support these children and young people.

27. Professionals' attendance and involvement in meetings are generally good. Multi-agency meetings are held regularly and are used effectively to share information. However, this work is not always well focused on assessing the progress and impact of child protection plans and children in need plans. In many cases the discussion focuses on the activity undertaken rather than on outcomes for the children. Some children on child protection plans have to wait too long for assessment and support with their therapeutic needs by the child and adolescent mental health services (CAMHS), but the local authority is seeking to address this with health services.
28. Decisions to make children and young people subject to child protection plans are usually appropriate, and child protection plans are ended when the threshold for child protection is no longer met. However, the thresholds between children in need and child protection are not consistently applied and understood. Some children are supported as children in need when the levels of concern indicate that thresholds for child protection may be met.

## **The quality of practice**

### **Adequate**

29. The quality of practice is adequate. In most cases considered by inspectors, children were being seen regularly and seen alone, with careful consideration of the children's presentation and the home environment. Children subject to child protection plans are seen in accordance with the requirements of the plan both at home and at school, with an appropriate balance between announced and unannounced visits. Practice is generally focused on understanding and improving the daily experiences of children and young people, although in a small number of cases this focus had been lost or is not sufficiently clear. Case records show that social workers are talking with and listening to children but the representation of their views in assessments (including those undertaken using the CAF and reports to child protection conferences) is too inconsistent and often indistinct. Very few children or young people attend their child protection conferences and whilst some very good examples were seen of work to present children's views to conferences, this was not consistent or routinely expected and so is dependent on the initiative of individual social workers. Children and young people involved in child protection processes do not have clear access to advocacy services.
30. The quality of referrals from some partner agencies to children's social care services is inconsistent. A clear, thorough and appropriate guidance document on service thresholds is in place, as is a multi-agency referral form, but neither are being used consistently by referrers. A number of referrals seen contained scant information and no evidence that the referrer had given appropriate consideration as to whether the service

threshold might be met. However, the CART is effective in screening these referrals and provides sound professional advice to assist referrers in making appropriate referrals. This service is valued by school staff, who report improvements in the communication with social workers and in feedback on the outcomes of referrals.

31. The response to contacts and referrals by the CART is well managed and timely. Close monitoring of activity by the CART manager ensures appropriate decisions are made on nearly all contacts within 24 hours. Diligent practice is evident within the CART whereby social workers focus not just on the presenting issue and the named children in the contact but, through robust checking, identify other children within the family whose welfare need to be considered. Good consideration is also given to past history, which promotes well informed decision making.
32. The volume of police notifications of domestic abuse is high. Cases assessed as high risk by the police are referred promptly but situations assessed as medium risk which can involve significant potential risk to children are not always being notified in a timely fashion. The children's service out of hours team provides a sound response to referrals. The team has access to children's social care records and liaises well with both duty and long term teams.
33. Strategy discussions are routinely held by social workers with the police over the telephone and other agencies are rarely involved in these discussions. The content of the discussions, actions agreed, individual responsibilities and timescales are not clearly recorded and it was often therefore not clear whether and how these discussions met statutory requirements. Section 47 enquiries are undertaken by suitably qualified social workers and in recent cases seen by inspectors enquiries appeared thorough with appropriate decision making. However, the recording of the outcomes of Section 47 enquiries is inconsistent and therefore findings in relation to significant harm are sometimes unclear or not clearly evidenced. Multi-agency strategy meetings for complex cases are chaired by a manager and are recorded appropriately.
34. The timeliness of assessments has improved significantly, with most now completed within expected timescales. The quality of assessments seen by inspectors is variable. Some include extensive information, are supported by a detailed chronology and pay good attention to past history and the individual needs of children. However, some assessments do not analyse the available information well enough to provide a clear risk assessment and so determine the focus of support and monitoring. Partner agencies are generally well engaged in assessments although information sharing and engagement from the probation service are not always evident. Assessments seen of Roma Slovak children gave good attention to the cultural context and needs of these children. In child protection cases considered by inspectors, most reports for review case conferences did

not clearly present progress made in relation to the child protection plan. The quality of most CAFs seen was good, albeit with the proviso that most did not reflect the child's views and wishes. These assessments informed purposeful and effective action planning.

35. The quality and format of child protection plans and children in need plans vary across the service, with few being of good quality. In some cases, the social worker has written their own version of the plan for parents to understand. Outcomes are often not clearly specified or measurable and some plans lack clarity about the key needs and risks to be addressed in work with the family. Contingency arrangements within plans are not included in many cases. Core groups are held regularly, are well attended and recorded and in most cases promote good information sharing, with attention given to the individual needs of each child. However, it was much less clear how core groups were monitoring and evaluating the overall progress of the child protection plans, and the current content of most plans did not assist in this. Where review child protection conferences have decided that the child protection threshold is no longer met, children in need plans are appropriately used to support sustained progress and improved outcomes. Conference chairs clearly set out the detailed actions for the children in need plan, for this to be further developed at a child in need meeting. In most cases, the child in need meeting is held within an appropriate timescale. However, in a number of children in need cases, including some which have been stepped down from child protection, there was no evidence of a children in need plan being in place.
36. Child protection conferences are chaired confidently and professionally with appropriate sensitivity to parental anxieties. This helps parents and relatives to actively contribute and share their views. In most cases there is good attendance and participation from all relevant agencies. Reports are consistently provided to parents prior to the meeting and agencies are challenged by the chair if this has not happened. Actions from previous conferences are followed up; incidents of concern and also positive progress receive appropriate focus.
37. In the majority of cases seen by inspectors there was evidence of regular supervision and management oversight. Social workers spoken to confirmed this and reported that they could access management support and advice. However, the quality of oversight and supervision was too variable between teams and managers. Supervision at the point of allocation in duty teams is regular, with clear evidence of discussions about cases, risk factors and required actions. Examples were also seen in the children in need teams of good quality, reflective and challenging supervision. However, most supervision records were primarily task focused, with limited evidence of supervision being used to evaluate progress in child protection and children in need plans or to ensure actions are being completed.

38. Decision making on cases is undertaken by suitably qualified and experienced social work staff. Decision making at child protection conferences is largely appropriate but conference chairs are not consistently providing clear and authoritative guidance to partner agencies when there is uncertainty about whether the threshold for a child protection plan is met. The local authority has established a multi-agency support panel to consider cases which require high intensity multi-agency resource packages and this is also used as the gateway for commencing legal proceedings. Whilst appropriate decisions are made in most cases considered by the panel, cases of long standing neglect are not consistently managed and in some cases decisions lead to significant further delays in both considering and in initiating care proceedings.
39. Case recording is clear and generally up to date. Some good examples were seen of chronologies being compiled and used to inform case planning and decision making, but up to date chronologies of a good standard were not present in the majority of case files. Child protection visits are well recorded and clearly evidence whether a child was seen and spoken to. This recording also shows that the visits are well focused on risk factors and concerns are appropriately raised with parents. In some of the more comprehensive recording, examples of reflection and an analysis of the situation are documented.

## **Leadership and governance**

### **Adequate**

40. Leadership and governance are adequate. The local authority has established and resourced a clear focus on the provision of child protection services and delivered some key priorities, such as improving the consistency and timeliness of responses to referrals and facilitating access to support services for children who do not meet thresholds for statutory services. In order to reduce pressure on child protection services, and improve the outcomes for children, an early help and support strategy, based on a detailed analysis of need, has been developed with partners. The operational framework to deliver this includes clear thresholds for accessing services but its implementation is at an early stage.
41. The level of partner agency support is variable. Despite extensive efforts by the local authority there are not, as yet, multi-agency arrangements to screen the incidents of domestic abuse. However, good collaborative working between the police and the local authority has resulted in a targeted and successful approach to tackling child sexual exploitation, which is being further strengthened by a commitment to creating a team of qualified social workers based within the police protection unit.
42. The relationship between the Children's Trust, the RLSCB and the new Health and Wellbeing Board has been unclear, leading to confusion and

lack of effectiveness. Clarification about the accountabilities of the RLSCB and the Children's Trust has now been agreed but it is too early to assess the impact of this and to determine whether the RLSCB chair is empowered to provide robust challenge. There are regular meetings between the independent RLSCB chair, the Strategic Director of Children's Services and the Lead Member for Children's Services, but the chair has no regular access to the Chief Executive or Leader of the Council.

43. The RLSCB is becoming more effective in carrying out its statutory duties. It is led by an independent chair and has appropriate membership, including lay members. The chair has been instrumental in establishing multi-agency sub groups that have delivered some constructive improvement work, for example to protect children at risk of sexual exploitation, and has overseen the recent completion of a serious case review, evaluated by Ofsted as outstanding. However, the work of the board has not been sufficiently well focused on core child protection and safeguarding activity, nor has it provided a strong enough challenge in some key areas. Much of its consideration of performance has been based on the national data set for stay safe outcomes, and it has lacked initiative in instigating its own areas of enquiry. Plans are now in place to improve this through commissioning multi-agency case audits, and the current RLSCB business plan shows a clearer sense of priorities.
44. The local authority has effective business planning processes in place. The Children and Young People's Service has a business plan that supports the delivery of the Children and Young People's Plan and is in turn supported by individual service and team plans.
45. Performance monitoring systems are in place and are producing increasingly accurate, relevant and analysed data. An improvement panel has overseen the delivery of the key actions following the government improvement notice in 2009, and following the termination of this notice has continued to meet to address recommendations from subsequent inspections. The 2011 peer review of safeguarding also produced some helpful recommendations. In response, the local authority developed a detailed action plan and addressed some of the identified priorities, for example the development of a quality assurance framework and an early help strategy. However, other issues have not been sufficiently progressed such as avoiding drift, improving the quality of child protection planning and supervision, reducing caseloads, and improving screening of domestic abuse notifications.
46. Senior managers receive regular information on performance and use this to determine the agenda for the performance clinics that interrogate practice more closely. Front line managers have access to, and use, reports on a range of workload and performance issues. This has enabled them, together with the performance clinics, to improve some aspects of practice such as the timeliness of initial and core assessments, the number of children who are made the subject of a child protection plan for a second time, the number of children on a plan for more than two years

and the timeliness of conferences and reviews. The local authority recognises that its focus has been too much on monitoring performance indicators and compliance and it is now beginning to consider quality. A comprehensive file auditing framework, which assesses quality as well as process compliance, is about to be delivered.

47. At a senior management level the responsibility and accountability for child protection are insufficiently shared and there is a lack of effective professional challenge to senior management on operational and practice issues by the RLSCB and others, including child protection conference chairs. However, the Lead Member for children's services provides effective challenge within a supportive and collaborative political framework. It has been recognised that the base children's services budget was insufficient to meet the demands placed on it and, within a challenging resource climate, appropriate action has been taken to address this imbalance. As a result, children's social care services have received much needed additional investment, although it is not yet clear whether the current budget is sufficient to provide the necessary capacity to deliver the core requirements of the service.
48. Social workers, including NQSWs, have high morale and they report feeling well supported by their colleagues, managers and, in the case of NQSWs, consultant practitioners. Their access to supervision and training is good. They feel positive about the recent re-structuring of the contact and referral service and children in need teams, which they report has helped to improve services for children and families by reducing the number of changes of social workers and enabling better quality assessments. Schools describe good training and support from the CAF team to help them improve practice and increase the number of families supported by the CAF process and there is widespread praise for the safeguarding training provided through the RLSCB and individual agencies.
49. The RLSCB is considering how best to capture the views of children and young people about safeguarding but this is at a very early stage. However, the views of parents who met inspectors, and Ofsted inspections of Rotherham children's centres, consistently report high levels of satisfaction with local early help services. Support from health visitors, family support workers and parenting support advisers provide practical help that improves their confidence and parenting skills. Parents and carers feel that the quality of their family life has improved because of the care, guidance and support they have received from these family support services and which are based on strong parental engagement and responding positively to parental feedback. However, there are no processes in place for gathering and evaluating feedback from families who receive child protection services.
50. The findings from the very recently published serious case review have been effectively shared with team managers but not across the partnership or with social workers, although there are plans to do so. As a result, most practitioners are not yet fully aware of the learning from the



review and so have not been able to use it to influence their practice. There is evidence of some good learning from individual complaints, though there is less evidence of learning from complaints informing service wide improvements in practice.

51. Workforce planning, recruitment and development are good. Standards for recruitment are high and meet the needs of the authority. For example all NQSWs are required to have had previous experience in a statutory setting. The workforce broadly reflects the diversity of the communities it serves. Creative arrangements have been made to ensure that workers have access to specialist knowledge of the culture of the newly arrived eastern European families. The council has effectively reduced the number of vacant posts and the use of agency staff. The few currently vacant posts will be filled within the next three months by qualified social workers who were supported by the council in gaining their social work qualifications. This has reduced social work turnover and so is providing more stability for children and families. However, case loads in some teams and for some workers are too high and this impacts on their ability to progress lower priority work (which includes children with significant needs and vulnerabilities), work reflectively and attend to their own professional development.
52. Managers at all levels are visible and accessible. Staff report positively on their access to formal and informal supervision and training. Due to the level of demand, NQSWs undertake statutory work at an early stage but in recognition of this the council ensures frequent supervision by team managers and has employed consultant practitioners to work with NQSWs and support their case management and development. However, the volume of work currently being managed limits managers' capacity to provide sufficiently focused and reflective supervision on all cases.

## 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