Report into Children's Services in Sandwell following inspection

Report for the Secretary of State for Education by Eleanor Brazil, Commissioner for Children's Services in Sandwell

April 2016

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1. Introduction and context

I was appointed by the Secretary of State for Education as Commissioner in January 2016, included in the Direction to Sandwell Metropolitan Council in relation to children's social care. My responsibilities required me to support the improvement of children's social care, review leadership and management capacity and, within three months, make recommendations on future delivery arrangements.

The Council have been extremely welcoming and co-operative, and have sought to provide full support to enable me to undertake this task. I am very grateful for this.

The political and officer leadership of Sandwell Council have impressed on me that they are keen to succeed in improving the quality of its children's social care services to a good standard, but have struggled to do so for over 10 years. Over that time, they have not been complacent, have made changes and invested time and resources, but progress has been intermittent and not sustained. Recently, the momentum of change has not resulted in the impact that was hoped for.

External inspection of services over the past 10 years has judged the quality to be at best adequate, and all too often inadequate. Whilst the framework for inspection has changed over this period, with new requirements and standards being introduced, those judgements demonstrate a pattern of improvement followed by setback. Since 2010, there have been five Ofsted inspections, of which four have resulted in a judgement of inadequate.

This report focuses particularly on the steps taken since 2013, the impact this has had, how services currently are performing and how best to drive and sustain improvement going forward.

Regulator	Date	Overall outcome	Additional comments
Commission for Social Care Inspection (CSCI)	January 2005	inadequate	Staying safe and leadership not robust or reliable
Joint review	2005	adequate	Progress in addressing recommendations from previous inspection
Annual performance assessment (APR)	2007	adequate	
APR	2008	adequate	
Ofsted	2010	inadequate	Three-yearly inspection of safeguarding and looked after children
Ofsted	2011		Unannounced – no priority areas for action
Ofsted	January 2012	adequate	Safeguarding follow up inspection
Ofsted	February 2013	inadequate	Safeguarding inspection
Ofsted	June 2013	inadequate	Looked after children inspection
Ofsted	2015	inadequate	Single inspection – safeguarding inadequate, looked after children adequate

Table 1 – Inspection History – Sandwell Metropolitan Borough Council

2. Terms of Reference

The January 2016 Direction states that:

> *The Secretary of State has carefully considered the 2015 Ofsted report and the findings of the independent diagnostic report conducted by Malcolm Newsam. Both reports found that the Council's delivery of children's services, particularly in relation to child protection, continues to be 'inadequate''.*
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> *In line with the recommendations set out in the Ofsted report of children's social care published on 5 June 2015, the Children's Services Commissioner is expected to take the following steps:*
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> 1. *To direct and support the improvement of children's social care;*
> 2. *To review the Council's leadership and management capacity and capability to drive forward the changes necessary to achieve the required standard; and*
> 3. *To make a recommendation to the Secretary of State as to whether alternative delivery arrangements are the most effective way of securing and sustaining improvement.*
>
> *The Commissioner will provide her report to the Secretary of State by 31 March 2016.*

3. Process

In the three months leading up to delivery of this report I have sought to use existing forums and observation of practice, and, as far as possible, not to put additional pressure on the service to attend meetings or gather information that they would not otherwise be doing. There is a significant amount of information already available, from previous inspections and reviews, and from the work of the Safeguarding Children Board and the Performance Accountability Board (PAB).

I have worked with the Director of Children's Services (DCS) and the Director of Children and Families to identify areas for improvement and development during this period and advised them on how best to address those.

4. How Sandwell children's services are currently organised and staffed

The DCS joined Sandwell in autumn 2013 as Director of Children and Families (responsible for all children's social care) and became DCS in early 2015. The previous DCS had been part of the iMPOWER contract, and he was retained by the local authority until June 2015, after the Ofsted inspection, to oversee challenging the outcome. The Director of Children and Families took up post in April 2015.

Six group heads report to the Director of Children and Families. Two were internal promotions of managers undertaking other roles, three joined Sandwell in September 2013, and one joined in April 2014. The Principal Social Worker (PSW) joined in July 2015.

The group heads are responsible for:

1. The multi-agency safeguarding hub (MASH) and the multi- agency enquiry team (MAET) dealing with initial enquiries and Section 47 investigations, and two Single

Assessment teams (the second team staffed by agency workers was established in September 2015);

2. Early help teams organised into six geographical community operational groups (COGs), which now, following a re-structure in July 2015, include a COG manager, and team of co-ordinator, social worker and eight family support workers;

3. Care management and child protection teams;

4. Looked after children teams;

5. Safeguarding and quality assurance including Independent Reviewing Officers (IROs) who also chair child protection case conferences;

6. New initiatives (includes child sexual exploitation (CSE), disabled children, family group conference, multi-systemic therapy); and

7. The PSW, who manages five Assistant PSWs, and Youth Offending manager also report to the Director of Children and Families.

In March 2016, there were 11 IROs, 23 team managers, 53 senior social workers (SSWs) and 85 social workers in the structure. In addition, 20 agency SSWs and 6 agency team managers and a further 297 non social work staff were working in the service.

The lead member for children's services has been in this role since 2013. He chairs the corporate parenting board, attends the local safeguarding children board (LSCB), has held monthly performance meetings with the Director of Children and Families, meets with partners and undertakes visits to front line services.

5. Background to the involvement of the Commissioner

The Council was originally issued with an improvement notice in March 2010, as a result of the 'inadequate' rating following an Ofsted inspection published in January 2010. Although the follow up inspection of safeguarding in January 2012 rated services adequate, subsequent inspections (February and June 2013) found that child protection services were again 'inadequate' and that the service for looked after children service was also 'inadequate'.

In 2013, Ofsted noted that:

> *"Senior management arrangements in Sandwell have been changeable and inconsistent, with several variations in senior leadership over the years. In order to address the known service deficits and to promote sustained improvement, the council took the innovative decision to enter into a strategic partnership to achieve sustainable improvement, clarity, drive and consistency in the functioning of services to children.*
>
> *Following a procurement process, the council established a strategic partnership with two private providers, (iMPOWER and Penna), who were commissioned through a three-year contract to 'lift' Sandwell out of inadequacy and to improve services to a good standard. The contract commenced in January 2013, led by an experienced DCS. A revised comprehensive improvement plan was augmented by the findings and recommendations of an Ofsted inspection in April 2013."*

Following the two 'inadequate' inspection results, Ministers issued Sandwell with a Statutory Direction in October 2013. The Direction put in place an advisor, Professor Ray Jones, to support and challenge the Authority. He set up and chaired the PAB to oversee and drive improvement.

In July 2014, the Government issued a further Direction, directing the Council to:

a) *execute the improvement actions set out in the improvement plan, including implementing Ofsted recommendations where further improvement is required within six months of the date on which this Direction is signed;*

b) *continue to engage Professor Ray Jones (Professor of Social Work, Kingston University) as an independent child protection expert to act as a children's social services advisor to the Council and to chair the Performance Accountability Board established pursuant to the October 2013 direction;*

c) *facilitate Professor Jones to spend sufficient time visiting staff, attending Sandwell Safeguarding Children Board, meeting Council officers, members, leaders and partners, in order to enable him to make an independent assessment of the Council's progress; and*

d) *maintain and support the PAB to hold the Council to account for any failure to deliver the required improvements.*

6. Performance Accountability Board (PAB)

The Board initially met monthly from September 2013, until part way through 2014, then bi-monthly. Its final meeting was in December 2015. The arrival in August 2014 of the new chair of Sandwell Safeguarding Children Board (SSCB) was very significant as he quickly brought much needed leadership to the partnership. The PAB chair had confidence that he was appropriately challenging and supported his taking over some of the areas that he felt the PAB had needed to focus on.

The PAB received detailed reports on the process of implementing new early help and front door arrangements, and on social care performance data. The Board was attended by the DCS and Director of Children and Families but group heads were not asked to attend to report directly on their service areas. The PAB also received feedback from the Council's auditing of cases. This is likely to have contributed to the positive view described below reached by the chair as the Council's assessment of cases was deemed to be far more positive than independent reviews in 2014 and 2015 found.

The PAB also considered some partner service issues such as NHS staffing, and child and adolescent mental health service data.

By the time Ofsted came to undertake the February 2015 inspection, the Independent Chair of the PAB was confident that the service was no longer inadequate and compared it favourably with other authorities he had closely worked with. As PAB chair, he considered that there were three main elements that would demonstrate to him that the service was progressing adequately. These were a) a stable workforce managed by a stable management team; b) partners pulling their weight; and c) an appropriate structure to deliver services to vulnerable children. He cited the increasing stability of the workforce, the new structure, reasonable workloads and the multi-agency arrangements of the MASH and MAET as evidence for his view and he is on public record as have expressed his criticism of Ofsted's inspection and his continued confidence in the Council's services.

Sandwell's children's services have improved significantly over the past two years. All agencies are working well to help families and protect children. Workloads are in control and a stable workforce with experienced and wise managers has been created.

(Chair of PAB, June 2015)

7. Appointment of new Sandwell Safeguarding Children Board (SSCB) chair

The independent chair of the LSCB has been universally recognised by partners and the Council as having had a major impact since his appointment as chair in August 2014. This view was also reinforced by the Ofsted inspection. The chair's view was that Ofsted had identified issues of real substance including the operation of thresholds within the MASH, the inappropriate use of early help to manage risk and responses to CSE.

Partners were universal in their agreement that the SSCB had dramatically developed under the leadership of the independent chair, who has driven the improvement agenda effectively. He was seen as having brought pace and focus and a knowledge of what was needed. Since the Ofsted inspection, he had commissioned three major reviews of practice: on thresholds, CSE and early help. These reviews are consistent with the findings of Malcolm Newsam's diagnostic and raise similar issues about the quality of social work practice that was identified in the external evaluations commissioned by the Council during 2014.

8. West Midland peer review challenge 'auditing the auditors' – April 2014

This was a two-day review by three heads of service from other local authorities in the region to evaluate the effectiveness of Sandwell's auditing process. The review team looked at the consistency and robustness of audit practice , testing whether auditors are being too optimistic in their judgements, analysing how embedded is auditing and the audit process in frontline practice and management and, how fit for purpose is the tool being used. The team looked at 10 cases across the service and rated them: five, poor; four, satisfactory; and one, good; compared with Sandwell's ratings of the same cases: eight, satisfactory; and two, good. 60% were therefore downgraded. The team's main findings were:

- difficulty understanding how audit practice is improving outcomes for children;
- finding little evidence that the voice of the child is heard;
- too much focus on activity not analysis;
- auditing is not used to inform learning and practice development;
- there was no evidence of senior management oversight — audits were completed by line managers;
- ratings were overly optimistic; and
- there was no evidence of a sense of urgency — that is, too little drive to move plans forward and consequently leading to drift.

The main conclusions and recommendations were:

- concern that new audit tool will not in itself lead to improved practice;
- outcomes for children need to be at the heart of the audit process;

- senior managers must be involved in the audit process; setting the standards for audit practice;

- need to develop a culture of learning from audits, individually and organisationally; and

- ensure that the new audit tool is outcome focussed, adaptable to themes and encourages analytical considerations.

9. Local Government Association (LGA) diagnostic – November 2014

The LGA team of six peers, led by a very experienced ex-DCS, undertook a week long diagnostic with the objectives of providing the Council with an external perspective on the quality of social care case work and an assessment of the effectiveness of Sandwell's quality assurance framework and processes. The diagnostic included a desk top audit of 77 cases, an in-depth review of 25 cases from the sample of 77, and an 'Auditing the Auditors' exercise, re-auditing 20 cases audited by the Council. The team, as requested by the Council, focused on the last 12 months and were not asked to look at any early help cases or CAFs, or the use of thresholds.

Key Findings of the LGA Diagnostic in 2014

- Practice is largely driven by process and monitoring activity and it is hard to see what the unique professional contribution of social work is.

- Current practice looks more robust and is becoming more consistent. There are still variable levels of management oversight and direction and quality of social work interventions, assessments and care planning.

- The ICS system is ineffective and inefficient, which is significant as it does not allow the journey of the child to be recorded adequately. Information is hard to find and often missing.

- The quality of practice in the 25 cases that we followed through further was in many cases significantly better than the case records led us to believe. Recording is generally poor – not up to date, with gaps and limited detail and little reflection and analysis.

- Plans are mainly an identification of actions required with insufficient emphasis on desired outcomes/aims.

- No evidence of a clear model of social work intervention being used to inform and support good social work practice and decision making.

- Out of the 21 case audits reviewed the LGA team agreed with the 11 of the Sandwell auditors' ratings. Of the 10 cases where there was disagreement, the LGA ratings were all less positive than the Sandwell auditors' ratings. The key areas of disagreement were about the rigour with which the quality of assessments and plans were considered, quality of case recording, quality of analysis and how well the voice of the child was considered.

In summary, the team concluded that:

"*Good progress has been made in many areas over the last year. Of significance has been a strong and stable senior leadership team with a permanent middle management team in place and an increasingly stable social work workforce. We saw evidence of a lot of unpicking and taking apart and rebuilding firm foundations for moving forward. This is reflected in your policies, structures and processes. Those we spoke to all highlighted these as significant achievements and making a difference to the development of safer practice.*

You have committed staff that understand and support the changes and want to do well.

We read and heard about a number of proposals and plans that were not in place yet, such as the recruitment to the PSW role, the ICS replacement and the Sandwell Gateway, but which were said to be happening soon. We would strongly suggest that you ensure you have plans for the implementation of these plans with clear timelines."

Recommendations included:

- Setting practice improvement and quality assurance within a learning framework;

- Creating a staff development plan that is targeted at individual needs as well as the business of social care and learning areas identified through audit activity and performance management; and

- Developing a model of social work practice in Sandwell and making it explicit so that it is clear to see what it is that social work brings to improving outcomes for children and young people – to include a range of tools to help guide and support social work practice, for example, risk assessments, parenting assessments, direct work with children and young people and, the voice of the child.

10. Ofsted Inspection and its aftermath in 2015

Ofsted undertook an inspection of child protection and looked after children's services under the Single Inspection Framework from January to February 2015. Their report was published on 5 June 2015 and the judgements for children who need help and protection, and leadership, management and governance were rated as 'inadequate'. The judgement for children looked after and achieving permanence was rated as 'requires improvement'. The overall performance of children's services was judged as 'inadequate'. The LSCB was also found to be 'inadequate' by Ofsted. The Ofsted report outlines a lack of progress in addressing issues, many of which were identified in previous inspections, and in the two reviews undertaken in 2014. Main findings of the inspection were:

Key strengths: Political commitment to improvement, MASH model strengthening partnerships and multi-agency arrangements.

Key areas for improvement:

1. Thresholds, in particular between early help and concerns that warrant a statutory social work response – senior leaders do not have full understanding of strengths and weaknesses of frontline practice;

2. Decision-making, professional curiosity and management oversight – no evidence of impact from acting on audit findings;

3. Awareness, identification and management of CSE;

Prior to publication of the report, the Council robustly complained about the judgements, arguing that Ofsted had failed to understand the Sandwell model. The complaint went through three stages and was finally concluded in July 2015.

11. Diagnostic commissioned by the Department for Education (DfE) in 2015

In August 2015, the DfE commissioned Malcolm Newsam, a very experienced DCS and national expert on diagnosing and improving failing services, to lead a 'diagnostic' of Sandwell's progress. His task was to:

> *"Examine Sandwell's capability and capacity to improve with the aim of providing a recommendation to Ministers as to what arrangements will secure and sustain the required improvement in performance. To conduct the diagnostic the advisor would need to consult with the Council, Ofsted, the LSCB, key partners (both in Sandwell and across the West Midlands) and the Chair of the Performance Accountability Board."*

The following areas of work were undertaken: a detailed analysis and desk-top review of the Council's performance management arrangements, quality assurance processes and progress since the last Ofsted Improvement Plan; meetings with key personnel within the Council; analysis of the Ofsted 2015 inspection and consideration of the representations made by the Council; discussions with Ofsted to consider both the inspection findings and representations made by the Council; analysis of partnership capacity; analysis of Sandwell LSCB through consideration of meeting minutes and performance and quality arrangements and on-site field work which included the following key elements:

- review of 20 social care case files randomly selected by the diagnostic lead and audited in advance by the authority;
- review of 20 early help files randomly selected by the diagnostic lead and audited in advance by the Authority; and
- interviews with the social worker and team manager responsible for the cases selected for further scrutiny.

Key Findings of DfE-Commissioned Diagnostic in 2015

Malcolm Newsam concluded:

"My diagnostic work has established that the quality of social work practice remains poor in Sandwell. Although I had been told by managers at every level within the Council that case work had improved and that they were no longer inadequate as a service, the evidence from my case file analysis did not support this. I undertook a detailed audit of 40 cases; 20 from social care and 20 from early help and graded them as follows:

	Unsatisfactory	*Satisfactory*	*Good*
Social Care:	*11*	*8*	*1*
Early help:	*10*	*7*	*3*
Total:	*21*	*15*	*4*
Percentage:	*52.5%*	*37.5%*	*10%*

There were also cases which were indicative of very poor multi-agency practice

The results of this audit exercise are remarkable on a number of counts:

- *The very high level of unsatisfactory work the sample has revealed and the high proportion of work where risk was poorly managed; and*
- *The similarity of these findings with the Ofsted judgements following their inspection of Sandwell Council in January 2015.*

The contrast between the statements I have heard almost universally across the Council and the partnership that Sandwell was no longer "inadequate" and the evidence within this sample of a widespread failure to adequately protect children."

12. SSCB-initiated reviews and Serious Case Reviews (SCRs)

During 2015, following the outcome of the Ofsted inspection, the chair of the SSCB, with the DCS, commissioned three separate reviews on thresholds, early help and finally on CSE. Whilst all of the reviews are helpful in identifying where action is needed to improve practice, there are also common themes. The process of the reviews themselves is inevitably an additional pressure on managers and staff, and many of the issues identified are similar to those identified by the LGA, Ofsted, and the DFE commissioned diagnostic.

Review of the Multi-Agency Strategic Hub (MASH) and Child Sexual Exploitation (CSE) Services – June 2015

The Review focused on the referral taking and referral making practices and assessed frontline practice in respect of contacts, safeguarding referrals and early help referrals. It included an evaluation of the effectiveness of the SSCB Thresholds Document. The Review focussed primarily on work of the MASH and other access points that exist.

Key conclusions included:

- There was a comprehensive MASH in place, which operated effectively. A Police-led Domestic Violence Triage Team was also working effectively. Referral rates had fallen significantly since the advent of these services. Auditors found threshold decision-making to be in line with policy;

- MAET was under considerable operational pressure and there were concerns over the quality of some of the assessments;

- The step up and step down processes were said to work well. However, there were concerns that in some cases stepped down early help services had struggled and there were long periods when a case was open but little or no effective work was being undertaken;

- The CSE service was still in the process of forming. The team manager had only been in post for four weeks;

- The quality of the work in children's services was variable. Some of the assessments were light and lacked sufficient child focus. Case planning needed strengthening;

- The work was often poorly evidenced and the lack of good chronologies and regular case summaries exacerbated the problem; and

- Morale in the teams appeared to be high especially in the MASH. Both managers and practitioners spontaneously spoke of the huge strides made in the services provided over the last two years and were convinced the service was travelling in the right direction. The direction of travel was positive and that there were managers in place able to drive the quality of the service upwards.

Early help

One of the recommendations from the review of the understanding and application of thresholds was that a more detailed review of early help should be undertaken. The same external team carried out a review of early help in October 2015. Key findings were:

- There has been a considerable amount of case auditing and challenge, and the recent introduction of weekly COG cases discussions, including care management team managers, have all contributed to enabling the step up and step down process;

- The recent changes to and strengthening of the COG/Targeted Help service are yet to be fully bedded down;

- At present the impact of early help within universal services is somewhat uneven;

- The almost complete absence of health practitioners as lead professionals is the biggest challenge to the development of early years services and will require thought on how best to move things forward;

- The quality of the work in the cases audited was variable and some of the weaknesses seen last May, as might be expected, were still apparent; and

- There remains a perception among many staff in partner agencies that the thresholds to social care remain high in Sandwell. However, the evidence does indicate that thresholds have clearly softened since the Ofsted inspection.

Review of CSE

SSCB and the Council jointly commissioned a CSE Assurance Review in response to key issues identified in the Ofsted inspection report. The review was completed in November 2015 and considered ten key CSE assurance questions, through interviews and an audit of a representative sample of 20 CSE cases. 5 of those cases were escalated to senior managers.

The findings were reported against SSCB's ten key questions:

1. How well does Sandwell understand the nature and scale of CSE?
2. How reliable is the data?
3. How effective is preventative work with children and families?
4. How far are services providing timely, appropriate and effective support to victims and those at risk?
5. How far do partner agencies have the capability and capacity to respond to CSE?
6. How effective is work in disrupting and prosecuting perpetrators?
7. How effective is information sharing?
8. How effective is multi-agency training for responding to CSE?
9. How effective are quality assurance arrangements?
10. How effective is the strategic leadership of Sandwell's response to CSE?

The report found evidence of strong commitment from all partner agencies to tackle CSE, with some evidence of progress. Nevertheless, there were significant improvements required across all 10 of the areas for assurance.

There are now agreed action plans in place to progress the recommendations from all three reviews.

SCRs

In the past few months, two SCRs have been completed by the SSCB, and one intensive management review. Whilst inevitably they relate to historic poor practice, the partnership will need to respond to all the recommendations and ensure that the learning from the reviews informs current practice. The cases came to light during 2014 and 2015, and were in respect of the severe neglect of a six year old child, the involvement in CSE of a 15-16 year old looked after girl, and an eight year old child with complex special needs who was known to health and housing agencies but not to education or social care prior to an anonymous phone call in 2014.

13. Information from Council activity and Commissioner's observations

As can be seen from the previous sections in this report, there has been constant review, inspection and auditing work undertaken within Sandwell since 2013, and particularly during 2014 and 2015. Since January, I have reviewed documentation, attended and observed a range of meetings, discussed progress with staff, managers and politicians within the Council, and talked to partners. I have also talked to a number of individuals who were part of the process during the past three years, including the LGA lead on the LGA diagnostic, the PAB independent chair and Malcolm Newsam.

My observations are consistent with the findings from reviews described above. Similar themes in relation to quality of practice are still evident in the service. Despite those issues being evident since 2013, much of the activity to address this is quite recent, and yet to show impact.

A. Impact of actions in the improvement plan

There is insufficient evidence of positive impact of the improvement plan and associated activity on the quality of practice, nor is there a clear understanding of the importance of this to ensure improvement of outcomes for vulnerable children.

The independent chair of the SSCB is noted in the minutes of the December 2015 meeting as saying '*that the report as presented did not provide any evidence of the impact of the LA's improvement plan. A number of related aspects of this plan were off track, including aspects of practice development and management development'*

The DCS report on performance to the PAB in Sept 2015 *notes 'The service demands have reduced with the reduction in CP plans and the consistent levels of LAC numbers reducing caseloads to below national average. The service focus is now on improving quality and plans and support is being provided to the team to improve their role in driving this agenda.*
The service will be focussing on increasing the contact to young people and obtaining their views to feed into the plans.'

The performance report to the PAB in December 2015 notes *'The reviews undertaken in the service in addition to the work carried out by the DfE diagnostic has identified further areas of work which are currently being addressed. It has also raised challenges across the partnership and discussions are underway to address the issues raised, along with immediate changes and support to the service to manage the additional activity generated.*
The service has run a series of workshops for all staff to discuss the issues raised within the reviews that have occurred. The message has been clearly presented that quality of practice, impact on outcomes across the system is not yet adequate and this is the focus of the improvement plan.'

B. Children's services' performance management and quality assurance

The service receives regular detailed performance data and information from audits. The data continues to reflect the challenges the service is facing in improving performance to an adequate standard.

Most recent data shows an improving picture in respect of some indicators but from a very low base so in many instances performance is well below what is needed. For example:

- Only 75.3% of child protection plans updated in the last six months;
- 89.7% of children subject to child protection plans visited in last six weeks and only 76.1% seen alone;
- 68.7% of core groups undertaken within six weeks of previous core group; and
- 63.7% of single assessments completed within 35-day timescale.

The Director of Children and Families meets with all Group Heads and Team Managers monthly to re-inforce the messages around performance. Each Group Head now runs a monthly quality surgery to look at performance information and issues in their service. This is a relatively recent initiative in the past few months, but is encouraging managers to take much more responsibility for their own team's performance. The surgeries would benefit from more independent challenge from senior managers.

Children's services have recently agreed a new programme of case file audits and themed audits, managed by the Group Head responsible for Safeguarding and QA. The case file audit framework has been revised and simplified in the past few months. Previously team managers were not completing their required number of audits, but compliance has improved with the new framework, which has also reduced the numbers to be completed. The process of monitoring and evaluating the lessons from auditing and using this to inform training and practice improvement is still not well developed.

Since May 2015, the service has undertaken a themed audit approximately monthly. The themed audit completed in January covered management oversight and supervision. The overall findings were that evidence of management oversight is patchy, with only 17.2% of cases looked at evidencing good oversight, and a clear drive to progress the child's plan. In relation to supervision, on the majority of files looked at, there was little evidence of reflective discussions and analysis of the case.

The Director of Children and Families has recently appointed an interim very experienced senior manager to help address the performance and quality assurance issues. She has initially audited a number of Single Assessments and found the same picture of little management oversight and no evidence of supervision during the assessment process. This links to a significant performance issue that is evident from P.I data and from discussions with the IROs. The policy in MASH / MAET is to book a child protection conference at the time of a strategy discussion to ensure compliance with the 15-day requirement. This often means that conferences take place with insufficient information and 25% of children placed on a child protection plan are no longer considered to be in need of a child protection plan within three months, once further assessment has been done. This is a very high proportion and would indicate that some families may be being brought into the child protection system unnecessarily.

However, there are no feedback mechanisms in place for parents, so their views are not captured. There is no practice in place requiring social worker reports for initial conferences. Instead, single assessment documentation is being used. This is a long document, up to 21 pages, and is likely to be confusing for parents and not a good tool for making it clear what the concerns are and why.

C. Staff morale and motivation

During the past six months, children's services, in partnership with the HR service, have undertaken a number of activities to monitor morale and motivation within the service. These activities included an annual health check, as recommended in the Munro report and a survey undertaken by independent consultants. The survey was followed up by a series of commissioned interviews and focus groups with staff and managers from across the service, which highlighted a number of issues. There was a strong consensus on areas for improvement such as office workspace and tools, ways of working and policies, general communication processes, and performance management and development opportunities.

There was also a consistent sentiment, which echoed the past few uncertain years, which could be summarised as a general scepticism about change initiatives and concerns around constant redirection of service developments. However, motivation to do a good job, to serve the children and families of Sandwell, and to see Sandwell through to an improved Ofsted rating, were strongly communicated by both staff and managers.

The activity identified a number of recommendations to be taken forward as part of the improvement plan:

- improve physical working tools and conditions;
- develop an effective communication strategy and roll-out;
- promote leadership and management development opportunities;
- re-design and roll out a new induction programme;
- embed a culture of performance management;
- create a talent management strategy; and
- design and roll-out an onboarding (retention) programme.

The one to one meetings I had with frontline staff and managers were consistent with these findings. The full report by the independent consultant includes some strong messages from staff:

> *"feeling that feedback is given but not listened to"* (team manager);
>
> *"physical nature of building has a negative impact on staff – makes children's feel like poor relation compared to other Council staff"* (team manager);
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> *"Feels like there is little acknowledgement and recognition of the effort and hard work staff put in"* (team manager);
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> *"Tools are inadequate – old laptops, can take up to 20 minutes to start up in the morning"* (social worker);
>
> *"Induction process is unclear, inconsistent"* (social worker);
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> *"We are not having formal supervision regularly though informal supervision is very good"* (newly qualified social worker); and
>
> *"Agile working doesn't work because we don't have the right tools"* (senior social worker).

D. Workforce data

The service has had a policy of continuous recruitment of social workers. Sandwell, like other local authorities, faces a very difficult task to recruit experienced social workers and it is not surprising that almost all the social workers recruited over the past two years have been newly qualified, known ASYEs (assessed and supported year of practice), reflecting that their first year of employment requires a reduced caseload, and specific training and development. Through this recruitment process, Sandwell has been successful in reducing reliance on agency staff and filling their establishment with permanent employees. There are now only 1.5 vacancies against core establishment though there are 28 agency staff retained to support the service due to the level of inexperience of so many of the social workers.

Malcolm Newsam in his diagnostic commented that almost 50% of the social workers in many of the teams were ASYEs and that in the cases he had audited a number where he had concerns were allocated to a social worker with too little experience to deal with the complexities of the case. This is still true five months on, particularly in the care management teams who hold the cases of children subject to child protection plans.

I am concerned about the level of support being given to ASYEs given that their recruitment and retention is of such importance to the development of the service. The findings of the audits in relation to management oversight and supervision, and the concerns from the morale and motivation reviews, particularly on induction, are not reassuring in this respect.

It is also the case that retention of key staff is not as good as has been described to me. Of particular concern is the data from April 2014 to March 2015, which shows that of seven team managers appointed in that period, three have already left Sandwell, and 16 out of 27 ASYEs appointed have also left. This pattern has not been repeated from April 2015 to March 2016, with overall a total of 54 social work staff recruited and 46 still with the authority (although 13 are still to start).

What this also shows is a continuing degree of turnover, which will inevitably have an impact on continuity for service users and the development of expertise in the service. 58 out of 85 social workers have worked in Sandwell for less than two years. There is a real risk that ASYEs once they have gained one or two years' experience will move on to another authority.

This is in sharp contrast to the senior social work group – of 53 in post 38 have worked for Sandwell for over four years. Many of those are among the most positive and committed to Sandwell. It is important that this group see themselves as supportive and important for the ASYEs but there is no clear evidence of this.

E. New initiatives

There is evidence of some renewed pace and increased action in recent months. Many initiatives were described to me as fairly recently implemented or still being developed.

This includes:

a) In January, the Council approved the IMPRESS project – to replace the case management system in children's and adults' services. Whilst it is clear that the current system hampers the ability of social workers to do their job efficiently, the implementation of a new system is inevitably an additional pressure for the service. Such a project is very complex, involving mapping of processes, building and

checking the new system, data cleansing and migration, training and development in the use of the new system. Implementation of the system is not likely before January 2017;

b) Since January 2016, weekly early help COGs being held in the six towns. These are multi-agency, led by the COG manager, and in recent weeks now attended by a care management team manager covering the same town. I attended two meetings in different towns and whilst they felt that they were still developing their way of working, they were effective forums for professional sharing of concern about individual children and families and productive discussion on whether early help could continue to hold the case or it needed to be transferred to social care;

c) Aspirant team manager programme, a development programme with monthly sessions over 12 months, which was launched in February;

d) Programme of training on 'outcomes-focussed plans' for all social work staff started in last few months by the PSW;

e) Monthly group supervision sessions for team managers led by the PSW, started in past two months;

f) Signs of Safety approach being rolled out until May, beginning to be used by MASH and MAET and by the COGs in past two months;

g) Quality assurance (QA) framework recently launched and disseminated;

h) New audit framework introduced in January; and

i) Mentoring programme planned to start in May.

One of the assistant PSWs made the following comment to me:

> "*didn't see much happening until past year, now lot of things happening at once, it's hard to keep track*".

When I met with 11 members of the IRO teams, they felt that insufficient attention is paid to consolidating new ways of working, or considering the impact of one initiative on another. They are concerned that this may be happening in relation to the separate Signs of Safety project and the Impress project. They also commented on the recruitment initiative:

> *'Sandwell attracts young, enthusiastic staff but don't hang on to them'.*

F Partnership working

The SSCB is now a forum that has a clear business plan, is well attended and is ensuring key partnership issues are identified through reviews and are acted upon. Partners attend regularly and contribute to the discussions. The development of the MASH is seen as a major partnership success with both the Police and NHS clinical commissioning groups (CCG) representative expressing their satisfaction in having successfully overseen the development and implementation. Less obvious is an explicit demonstration of strategic leadership of the whole children's system with a visible expression of an ambition to improve outcomes for children and young people in Sandwell. This is now being addressed in the revised improvement plan.

Generally, partners feel that there has been significant improvement in social care in the past two years, but from a very low base. All are very clear that there is still much to be done. This is supported by the findings of recent SSCB multi- agency audit, which looked at 28 children from 19 families who were subject to a child protection plan and there were requests for transfers either in or out of the borough between September 2014 and August 2015. This was in response to issues raised in one of the recent SCRs. The auditors judged one graded as outstanding, nine as good, 15 as Requires Improvement, two inadequate and one unable to grade as the child moved out of the country. The audit found that there were some concerns with full compliance with the protocol; in particular, meeting the required timescales for the transfers. The audit did highlight some good multi-agency work and clear risk assessments and plans. However, there were some key learning points where the quality of communication and work with families was not good enough.

G. Trade unions

The trade unions are active in Sandwell and during the three months leading up to this report, they organised a branch meeting to raise very strong concerns about any possibility of Sandwell's social care services transferring to a Trust. They told me that they have wanted to support the improvement of the service over past years but feel that they have not been listened to when they have raised issues with senior managers. From minutes of meetings held with managers it is clear that concerns have been raised by the unions, but not clear what resulted from those discussions, or what if any, active steps were taken by the unions to positively impact on the quality of the service.

H. Views from practitioners and managers I spoke to

Many of the comments I heard are consistent with the picture I found of a service that has struggled to improve over a long period of time, which was in a particularly poor state in 2013, which has tried hard to implement positive change but is still not delivering the quality of service needed. In particular, people reflected on the impact of introducing the MASH and early help model, and expressed disappointment that this was not matched with appropriate focus on social care:

"NQSWs come in good, then lose it";

"lack of consequences – particularly with team managers";

"audited to death, but so what?"

"focus on individual children, not what's needed to sort the system";

"Two years ago: lack of policy, procedures, staff, knowledge. Now: much better";

"Early help should have gone live before MASH but didn't until June 2014";

"Front door has been the answer and would sort all our problems, but didn't";

"In a much better place now"; and

"'Real battle to keep morale going".

14. Analysis of progress since January 2013 and what went wrong

The evidence from Ofsted inspections in 2013, and from the views of those who came to work in Sandwell during 2013 including senior managers, partners and the PAB chair, is that the service was in a very fragile state. The PAB chair described it to me as 'in total disarray, with a backlog of about 600 cases, children not being assessed appropriately, no permanent middle or senior managers, 40-50% agency social workers, plus an ineffective chair of SSCB lacking in child protection experience. By November 2013, the current group heads were all but one recruited and in post with a new Director of Children and Families. The group heads describe their first year in post as very difficult, dealing with significant performance and recruitment issues.

The DCS and iMPOWER embarked on a major re-structure of the system, with much of their focus on the development of early help, the COGs and the MASH and MAET. The explicit objective was to address concerns early and reduce work coming into children's social care.

In November 2014, the LGA commented:

> *"Sandwell has been on a long journey of improvement, periods of which have been difficult and required leaders to hold their nerve. Many we talked to felt solid foundations have now been laid; a lot of taking apart and rebuilding has happened, but there are now good policies, structures, strategies and processes and staff in place with good morale."*

It is clear that the emphasis of improvement work was on developing the framework for structural and system change and implementing the new model. At the same time, not enough attention was paid to what was happening in other parts of the service. Issues and recommendations identified by Ofsted in 2013 and subsequently in the external reviews in 2014 were not acted upon. In summary:

1. focus on the model with not enough attention paid to the quality of social work; and

2. insufficient attention to consequences of some key initiatives, in particular the successful recruitment of newly-qualified social workers (NQSWs) without sufficient steps in place to ensure that enough experience and support was in place to allow them time to develop and to improve the quality of work on complex cases.

The PAB should perhaps have identified this but focussed mainly on data and received too little information on quality. It is also very likely given the findings of the reviews in 2014, and in the DFE diagnostic, that the Council continued to present an over optimistic picture.

However, in the context of the investment of time and resources in implementing the new model, the disappointment created by the Ofsted outcome of February 2015 was enormous. This was whole system change led by the council not a tinkering round the edges but it did not achieve the required improvements in quality of practice.

Malcolm Newsam's diagnostic showed that eight months after the Ofsted inspection very little seemed to have changed at the front door. He found similar issues of poor assessment of risk, inappropriate application of thresholds and children not receiving a timely or appropriate response. There was an ongoing issue of cases that should have been passed to social care remaining in early help and little understanding of the importance of social care in providing rigour, risk assessment and planning of intervention.

He also reviewed all the Ofsted Annex H entries (these are cases causing concern referred back to the authority), had a telephone conversation with the Lead Inspector and considered the correspondence between the Council and Ofsted subsequent to the inspection. I too

reviewed those cases, and the comments in the diagnostic, and concur with those comments. In summary, the inspection team found widespread and serious failures that left children at risk of harm.

They found a significant number of children and families referred into early help services and a significant number of children at risk of CSE held in early help services. A dispassionate observer would view the Council's response to these findings as combative and bordering on the vexatious. Rather than accepting the evidence of very clear failure to address their statutory responsibilities, the Council attacked both Ofsted's understanding of the "Sandwell model" and also the conduct of the inspection.

Unfortunately this approach was also communicated to the workforce, the Members and partners. In March 2015, senior officers presented to the Children's Scrutiny Board the findings of the inspection and in the slides delivered to the Board the following is stated:

- *Inspection entirely driven by thresholds issue*
- *The model and application of thresholds are clearly visible to partners*
- *Did not understand MASH*
- *Did not agree or engage with our model*
- *Assessment of Leadership, Governance and LCSB dominated by their concerns*
- *LA challenging during moderation, and will pursue to JR if there is no movement*
- *Impasse might lead to re-inspection or action by SoS.*

The inadequate judgement did not relate to Sandwell's operating model but that the application of the model was not consistently robust and did not ensure appropriate assessment and management of risk.

The argument with Ofsted has been damaging for the service, and impacted negatively on the improvement journey. The prolonged period from February to June when the report was finally published must have created further confusion about the actual state of the service and in that period no steps seem to have been taken to address the findings. The argument hinged on front door issues and whether cases reached the threshold for social care or could be appropriately managed in early help. The role of social work assessments seems to have been poorly understood and little valued. Group heads with significant social care experience seem to have been overruled or ignored when they raised concerns about the approach and my sense is that there was no room for an alternative view about the Ofsted findings with such powerful and robust denial from the DCS, supported publicly and firmly by the chair of the Performance Accountability Board, the Chief Executive and the Leader.

During his on-site work, Malcolm Newsam found many examples of this misinterpretation still being held by senior Members and officers and reflected in the opinions and understanding of management and staff throughout the organisation. While he did believe the new DCS has helpfully tried to re-position some of this narrative, he considered that there needs to be a much clearer acceptance of what went wrong and what now needs to be fixed if the Council is to successfully move forward. Five months on from the diagnostic, I did find that there was greater acceptance and awareness. However, the ambiguity and confusion created by the response to Ofsted, then challenged by the diagnostic and the SSCB reviews, has created an environment where staff and managers have lost confidence and in many cases are very bruised by the past months.

A lot of time and money was invested in iMPOWER. Understandably, it was shocking for all that all that that investment did not seem to have shifted the quality of the service from being inadequate. There was clearly a lot at stake. The model depended on early help being central to the council's response to families, and a view that the balance of work should shift to 70% in early help and 30% in social care. I have not been able to find any detail about how that assumption was arrived at.

Since the conclusion of the diagnostic in November 2015, efforts have been made to address the ongoing failings as is demonstrated by the number of initiatives progressed in recent months. It is difficult to find a coherent description of all the activity underway and how it all interacts. Communication was raised by staff as a significant issue and it is not surprising that they may feel overwhelmed by all the new demands and opportunities.

In my view, the service is lacking in confidence and this is impacting on decision-making and creating an environment of over-cautiousness, which in itself is likely to affect the efforts to improve the quality of practice. The service has recognised that this needs to be addressed and have undertaken a lean review of MASH /MAIT as a first step. There are many strengths in those arrangements, and in particular the impressive collaboration and contribution from partners. Twelve agencies contribute to the work in that service. However, as the review, which has just concluded, has demonstrated, some of the processes are overly complicated, cumbersome and time consuming; for example, each case can take up to 50 minutes and involve up to 12 professionals from different agencies. In addition, the quality of the social care single assessments is not good enough, and recent auditing has shown that the gaps in management oversight and supervision prevalent in other parts of the service, are present here. The partners have now agreed to work with the Council to address these issues with changes planned to be completed by September 2016.

This lack of confidence is seen in other ways. For example, one of the group heads suggested that Ofsted would not accept cases remaining open in early help if they had been stepped up to social care. I have confirmed with Ofsted that this would not be the case. They agree with my view that early help support where appropriate can rightly continue alongside social work intervention. In practice, this is what is happening in Sandwell, but it is notable that there is this degree of uncertainty.

15. Capacity for improvement within the current arrangements

Improving children's social care services is not an easy task and it takes time. Above all, it requires strong and clear leadership and direction, with a coherent plan of action that is flexible in responding to new factors, and unforeseen consequences. It is also a relentless pursuit, as without momentum there is a risk of falling back. It requires an absolute focus on the objective of improving the experience and the outcomes for the most vulnerable children and young people in the authority.

This report has described the events leading up to today. This is a Council that has, particularly since 2013, invested in resources, which they believed would provide that much needed step change. They took a courageous decision in 2012 to take a very different approach and to bring in a strategic partner to transform the system with an ambition to achieve long term change, aimed at better supporting children in their families through developing and investing in substantial early help provision.

However, in focussing on one element of the system model, they failed to explicitly address other failings, which were clearly evident from the 2013 Ofsted inspections, and from the reviews in 2014 and in 2015. Investing in iMPOWER is likely to have further delayed the much needed replacement of the electronic case management system, which has only recently been agreed. It is unfortunate that both those initiatives could not have been proceeded with at the same time.

The strengths of good social work practice are poorly understood and until very recently have not received sufficient attention. The failure to ensure consistent good assessments, with robust attention to the management of risk, alongside rigorous intervention, care planning and direct work with children is a constant theme. It is this that protects and supports the most vulnerable children the service is working with, and this is why the experience of individual children is so critical. Whilst there has been some progress over the past two years, it has not been fast enough nor has it had the impact on the quality of practice needed. Too many children are still in receipt of an inadequate service.

The PAB chair expressed confidence in the achievement of a stable management group. However, the process around the changes to the DCS and Director of Children and Families roles in this period have not helped in ensuring the absolute clarity around leadership and direction which is needed. After the Ofsted inspection, the previous DCS was retained until July 2015 with the Director of Children and Families moving into the DCS role in March 2015. Given the public nature of the disagreement with Ofsted, it must have been hard for the new DCS to exert his authority. It is only from around September that he began to give much stronger messages about what needed to improve, and this was reinforced by the diagnostic.

The current Director of Children and Families took up her role in April 2015, which was a very difficult time to arrive and to take charge of improvement, when the messages continued to be ambiguous. She does not have an operational social work background and inevitably this is likely to have contributed to an initial lack of confidence in taking a very decisive and proactive role in managing her service. It is clear from talking to managers in the service that the she and the current DCS are seen as complimentary, rather than two leaders working closely together, with common objectives though different responsibilities and roles. The distinction between their roles has been too blurred. As an example, the recently issued QA framework has a single paragraph on the responsibilities of the DCS and the Director of Children and Families without distinguishing between them.

It is true that a stable management team of six group heads were recruited in 2013 and 2014 and have been a key group in managing the service. However, two years on, changes are

already happening, with one moving to another authority and another who has recently left following concerns about performance in her service. The remaining group heads have experienced a very difficult time over the past two years with all the pressures of managing their services, dealing with poor staff and recruitment, coping with six reviews and inspections in that period, and trying to play their part in actioning the improvement plan. This has inevitably been very wearing.

It is difficult to cope with the operational demands of the service whilst trying to implement the necessary changes and improvements at group head level. This requires some additional capacity and expertise to support those managers. The view was that iMPOWER were providing this, but as has been shown, this had very little impact or involvement on the main social work teams. I have encouraged the Council to employ such support and the one individual they brought in in February is already having a positive impact.

Steps were taken to address some of the most significant issues, such as recruitment. It is positive to note that the proportion of agency social workers were dramatically reduced, but the majority of recruits were AYSEs. Not enough attention was paid to the implications of this – the need to ensure limited caseloads, sufficient supervision and management to provide necessary support, and access to good training and development. There is already some evidence that too many of the ASYEs are feeling unsupported and have left and there is also a real risk that having acquired considerable experience this cohort will move on to other authorities.

Action is being taken to develop managers and to provide experienced support within the service. This includes the appointment of the PSW, and the four APSWs, but the latter have come from within the service through the deletion of team-based roles. This may be a better and more efficient use of their skills but does not add to the expertise available within the service. Again, this is a relatively new development so the impact is not yet apparent.

16. Summary of analysis and conclusion

Although there is a long history of failing to provide good services up until the present day, there are a number of evident strengths:

1. council investment – in iMPOWER and more recently in funding for the IMPRESS project;

2. expressed commitment and support from the political leadership;

3. development and implementation of a promising model of early help and MASH;

4. active recruitment reducing reliance on agency staff;

5. engagement of partners and development of SSCB and MASH; and

6. desire to get it right and to learn, especially during 2014 and since November 2015.

However, there are matters of real significance that raise major questions about the capacity and capability of the Council leadership and management to drive through improvement now where it is needed, and in a way that will be sustainable for the long term. In particular:

1. insufficient leadership and drive over the past two years to address the identified failings in the social work service, quality of practice still inconsistent and poor;

2. a failure to prioritise the right things with enough focus on frontline service delivery and frontline staff;

3. inadequate communication of what is happening; in particular, a coherent message on how all the planned activity will produce the desired impact;

4. insufficient focus on the experience of vulnerable children and the outcomes for them; and

5. a lack of sufficient pace and demonstrable impact.

In addition, there are some clear risks going forward, which will require careful management and good leadership:

1. managing the introduction of the new case management system – implementing the new system now, though imperative, is a big risk. The process will need to be well managed and resourced to ensure the service does king practice backwards,

2. ensuring that the emerging staffing issues are addressed to create confidence at a time of further significant change, and

3. continuing to address the quality of practice issues at a time of financial constraint for all of the public sector.

This remains a very sizeable task. In my view, for all the reasons above and based on the evidence in this report, it is unlikely that the Council can on its own deliver what is needed. The scale of the challenge, the length of time that the authority has struggled to achieve progress and the continued failure to respond appropriately to some of the most vulnerable children lead me to conclude that a fresh start is needed. The following table considers the

options and addresses the Secretary of State's question on alternative future delivery arrangements.

17. Options – benefits and risks

Option	Benefits	risks
1. Retain commissioner role to continue to direct and support improvement	Council's preferred option which is most likely to secure their positive commitment. Least disruptive option	Unlikely to be sustainable long term, pace of improvement too slow and with insufficient impact
2. Executive Commissioner role with improvement team	Extension of Council's preferred option which is most likely to secure their positive commitment. Will add much needed expertise and leadership capacity to increase pace of improvement.	Inability of council leadership to develop capability to drive service forward long term
3. Partnership with a 'good' local authority	Option supported by the Council. Option currently being explored. Only one good authority in West Midlands who could bring some capacity and expertise into the service, but is not in a position to take over full responsibility for the service	Only one good authority in West Midlands. Few alternatives and none local to Sandwell. Support likely to be focused on specific service issues rather than whole scale culture change.
4. Transfer of responsibility to another local authority	Could create the capacity and capability to drive the service forward	Time to negotiate arrangements and risk of negative impact on staff and current leadership. No obvious L.A.
5. Creation of independent trust with council full involvement	New start, new leadership, greater flexibility, potential to attract new people, council fully involved as shared owner	Cost of transition in terms of time and resources plus loss of momentum on improving service, and risk of losing some staff at time of uncertainty. Very likely to be actively opposed by the unions
6. Partnering with another organisation; such as a charity	New start, expertise in the organisation?	Not been done before so time consuming learning period, other organisation will want some income from taking on services. No obvious

		organisation in Sandwell and will face some of the same transition issues as above
7. Creation of independent trust without council involvement	New start, new leadership, greater flexibility, potential to attract new people	Cost of transition in terms of time and resources plus loss of momentum on improving service. Risk of losing some staff at time of uncertainty. Will be actively opposed by the unions and will be difficult to engage with the Council and Council services which also support families. Governance and accountability more complicated

18. Recommendation

I have acknowledged the full co-operation and assistance the Council have given me. The acting Leader, lead member, Chief Executive and DCS are aware of the contents of my report [1]and have fully accepted my findings. They have clearly expressed a willingness to continue to work collaboratively and constructively to address the issues.

I have reached the conclusion that the Council on its own cannot deliver what is needed. I believe that a period of time is needed when the service is not in the direct control of the Council to create the impetus needed to deliver robust and sustainable leadership. However, this should be achieved working closely with the Council.

Given this and considering the options above, in my view only option 2 and 5 will meet those requirements. The Council understands that those are the most likely options and have made the following proposal:

They have proposed that they would be 'willing to participate in the development of a detailed options paper, including a risk assessment, on these two options to further evaluate their strengths and challenges. This would assist us all in achieving the right choice for Sandwell, managing the risks and creating constructive messages to staff, partners and the community.'

I recommend that the Minister should agree this as the best way forward, with the proviso that during the process to undertake such a risk assessment there is no delay in pushing forward on the ongoing improvement activity.

Eleanor Brazil

Commissioner for children's social care in Sandwell

26/4/2016

1

I would like to acknowledge the very sad death of the Leader of the Council, Darren Cooper, during March. This meant that there was a small delay in the timing of the submission of this report.

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