A Review of Jersey's Safeguarding Partnership Boards

Conducted for the Community and Constitutional Affairs Department of the States of Jersey

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8th June 2018

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1. INTRODUCTION

In October 2012 the Council of Ministers agreed to the establishment of a children's safeguarding board and an adults safeguarding board. Prior to this Jersey had operated the Jersey Child Protection Committee (JCPC). There was no formal process for safeguarding vulnerable adults. An independent chair of both boards was appointed in February 2013. Both the children's and adults boards were formally established in April 2013.

The intention to conduct a review of the Safeguarding Partnership Boards was agreed over a year ago. It was felt that it would be good practice to review the operation and function of the Boards, given that it was now around five years on from the decision to establish them. It was not until late 2017 that the review was commissioned and set up.

Three other matters provide additional context for the review:

The first is the publication of the Wood Review in 2016. Led by Alan Wood CBE, former Director of Children's Services in Hackney and past president of the Association of Directors of Children's Services. The review was commissioned by the then Secretary of State for Education and Skills, Rt. Hon. Nicky Morgan MP. The Wood review identified a range of issues relating to the operation of Safeguarding Boards and made a series of recommendations for change to local Safeguarding Boards, conduct of serious case reviews and child death reviews. Those working in the field did not universally accept the findings and conclusions of the Wood review. Despite this, in their response to the review, published in May 2016, government in England and Wales agreed with the findings and set out a range of planned actions in response to the recommendations.

The second factor is the publication of the Independent Jersey Care Inquiry (IJCI). Published in July 2017 and chaired by Francis Oldham QC, the IJCI was commissioned to examine deficits in children's services on the island over a number of decades. It had a particular focus on historical allegations of child sexual abuse, but also highlighted a range of other areas for improvement. An initial Government response to the main recommendations made in the final report of the IJCI along with an overview of progress in the first three months following the publication of the Inquiry was published on 30th October 2017. A programme to address the recommendations contained in the inquiry report has now been put in place. A new Children's Plan is being developed and is expected to be published during the summer of 2018.

Thirdly, the States of Jersey is currently undergoing a period of change. The Chief Executive has set out plans for a restructure of the workings of government in Jersey, which is currently being consulted upon. The ambition of the changes is for all islanders to enjoy a good quality of life, in a fair and balanced society, a sustained prosperous economy and outstanding public services.

Should the plans progress as proposed, there will be seven new departments of government, including a Department for Children, Young People, Education and Skills and a Department for Health and Community Services. Clearly the role of safeguarding within a revised government structure will be central to delivering effective and safe public services.

Whilst it had always been the intention to review the Safeguarding Partnership Board (SPB) after five years of operation, these three factors form an important wider context in which it has taken place. The review should also be viewed from the perspective of the wish to ensure that the Safeguarding Boards are working effectively to achieve their objective of protecting and promoting the safety, welfare and wellbeing of children and vulnerable adults in Jersey.

The reviewers have recognised and appreciated that the process has been viewed by some with a degree of concern. Understandably any review brings with it a level of uncertainty for those who have a stake in its outcome. This uncertainty was also heightened by the time lag between the proposal to hold the review being made and its eventual commencement. The reviewers have conducted the process in a transparent and open way and have sought to engage with as many people as possible, conducting over 40 consultative interviews. Despite some of the concern expressed there has been a broad acceptance that the time was right to consider the future of the SPBs.

The report is not intended to set out or comment on all the work and achievements of the SPB. It is acknowledged however, that considerable work has been undertaken in the development of policies and processes and training programmes; all of which have helped drive improvements across the system. Examples include improvements in safeguarding arrangements put in place via the SPB in sport, social security, and housing, safeguarding foundation training which over 11,000 professionals and third sector representatives have attended since 2013, and the production and regular of excellent multi-agency safeguarding procedures

It is also important to emphasise that the wish to undertake the review was not intended to be a quasi-inspection. It was and continues to be an opportunity to engage Board members and stakeholders in a constructive and positive process to examine the current purpose and function of the Board and help to ensure it can refresh itself, as required, in order to remain effective over the next five years.

2. METHODOLOGY

The review of the SPBs was undertaken using three phases of work:

Phase one:

Reviewing documentary material and initial briefing conversations to develop an understanding of recent history relating to safeguarding and of the current arrangements. This included:

- The current Safeguarding Partnership Boards membership
- Safeguarding Partnership Boards Annual Report 2016
- Safeguarding Partnership Boards Annual Report 2017
- Safeguarding Partnership Boards Business Plan 2017
- Safeguarding Partnership Boards Memorandum of Understanding
- Minutes of the Safeguarding Partnership Boards meeting
- Multi-agency improvement plan
- Independent Jersey Care Inquiry Report

It also involved a desk-based review of the approach of other jurisdictions, specifically:

- England
- Scotland
- Wales
- Northern Ireland
- Isle of Man
- Guernsey

Phase two:

A series of semi-structured consultative interviews were held during January and February 2018. Community & Constitutional Affairs (CCA) supplied a list of stakeholders to be interviewed. In compiling that list, CCA asked Board members to suggest other stakeholders for interview. A

set of questions was developed and shared with CCA for review prior to the interviews.

The set of questions was used to guide the conversations, although not every question was asked of every interviewee.

The majority of the interviews were conducted face-to-face with individuals in Jersey. A group approach was taken when meeting with Ministers, largely due to diary management and availability. The discussions with the staff of the Regulation and Inspection team also took place as a group. A small number of interviews took place on the telephone, again due to scheduling. Notes of the interviews were taken by the reviewers and transcribed within one week of each interview. In total the reviewers spoke with 47 people.

In addition to the interviews, one of the reviewers observed part of the meeting of the SPB in February 2018.

Phase three:

A participatory workshop was held on 12th March 2018, some of whom were members of the SPBs and others who had a connection to or direct interest in its work. The majority of the attendees had taken part in the consultative interviews. The two main reviewers and an associate consultant from Contact Consulting, who is an expert in workshop facilitation and group working, facilitated the day.

The aims of the day were to share the initial draft findings of the review, to enable participants to reflect on them and to conduct a 'sense check' for the reviewers to ensure that those findings resonated with those present. It also provided an opportunity for participants to think about the themes that have emerged and for those present to begin to consider what might need to change, and their role and that of their organisation in making any change. The initial draft findings were not circulated to non-attendees to avoid those findings being misinterpreted.

Following the workshop, the reviewers considered the comments and feedback received, and combined with the content of the consultative interviews and the desk-based review process, produced this report.

3. THE CURRENT ARRANGEMENTS

In October 2012 the Council of Ministers gave approval to create a children's safeguarding board and an adult's safeguarding board. The two boards were formally established in April 2013. The two boards are chaired by an independent chair, who was first appointed in February 2013. The current chair was re-appointed to the role for a second term, which ends in February 2019.

At the point at which the Boards were established, it was agreed by the then Children's Policy Group, that consideration would be given, once the Boards were up and running, as to whether they should be established in statute. To date, this has not happened.

In creating the boards, the independent chair drew upon the English statutory guidance as the model of best practice. Given that the adults board was being created from scratch, and the children's board was to evolve from the previously established child protection committee, this was the most appropriate way to ensure the SPBs were created, giving them a framework, which whilst not statutory, drew upon the experience of a recognised system from another jurisdiction with particular relevance for Jersey.

The functions and responsibilities of the SPBs are set out in their Terms of Reference, with further detail provided within the Memorandum of Understanding. In summary they are:

- To co-ordinate what is done by each organisation participating in the Boards, for the purposes of safeguarding and promoting the welfare of children and adults in Jersey.

- To promote the understanding of the need and means to protect children and adults from harm.

- To monitor and ensure the effectiveness of the safeguarding systems that exist both within and between organisations in Jersey.

The same independent chair chairs the two boards, and both have a vice-chair, drawn from one of the membership organisations. For the children's board the vice-chair is a senior police officer, for the adult's board the vice-chair is a senior manager from the Health and Social Services Department. Their appointment is periodically reviewed and approved by the board.

A Memorandum of Understanding (MoU) is in place covering the co-operation of organisations with the SPBs for the purpose of safeguarding children and adults in Jersey. The signatories to the MoU agree that their organisations will "take all appropriate and proportionate steps to support and facilitate the work of the SPBs". Furthermore, the signatories to the MoU agree that their organisation will provide at least one representative who will be a member of the relevant SPB and will regularly attend and participate in the meetings of the Board(s). The MoU also sets out a range of other areas which, by signing, organisations agree to support. These include:

- Contributing to the development of the Annual Report
- Information sharing
- Learning and improvement
- Safeguarding standards

The MoU is reviewed and re-signed every April. Given that there is no primary legislation covering the work of the SPB or safeguarding as a process, the MoU is an important tool that, in lieu of legislation, engages partners and provides agreement to ongoing multi-agency co-operation.

The SPBs produce an annual business plan which follows the statutory guidance in England. This plan outlines the priorities for each year and is agreed by the membership. It reports what has been achieved and what has not yet been completed. It includes the work of the subgroups, members' attendance, finance and serious case reviews. It does not

reference or include all the activity of the SPBs, much of which is contained in the work plans for each of the sub-groups. The 2017 business plan set out six priorities:

- Strengthening the quality assurance role of the SPBs
- Communication, consultation and participation
- Streamlining SPB business processes and supporting the development of SPB members
- Delivery of the multi-agency improvement plan
- Continuing to support the development of multi-agency safeguarding adults practice
- Responding to the relevant recommendations of the IJCI

In 2017 the SPBs were allocated £240,000 ring-fenced funds to develop the multi-agency improvement plan, with the aim of improving the safeguarding of children prior to the publication of the IJCI. The plan sets out 29 areas of work to be completed by the end of quarter one of 2019.

The independent chair is currently accountable to the Chief Minister of the States of Jersey. Day to day liaison with the Chief Minister is via the Assistant Chief Minister and the Director of Social Policy in the CCA Department. The Director also provides support, where required, to the SPB staff who are all States Employment Board employees. The purpose of this support is to help ensure that the SPBs operate in accordance with SOJ policy and procedures.

The SPBs now meet on a bi-monthly basis, previously they met quarterly. The membership of the Board is currently comprised of 27 representatives, drawn from a range of organisations and agencies. Some organisations have associate membership, meaning that they do not attend the SPBs meetings, but may be co-opted if necessary and are kept appraised of the work of the SPBs. They do receive agendas and board papers. The independent chair determines who joins or leaves the SPBs based on English statutory guidance with recognition of the arrangements in Jersey.

The SPBs meet together as a joint board. The independent chair develops the agenda in consultation with the membership. The meeting usually lasts for around three hours. Issues relating to children and adults are included on the agenda. Initially the boards met separately but as they developed and matured, and given some duplication of membership, they were brought together. Depending on how the agenda is structured, those members with responsibility for only children or adults are able to leave the meeting once their business in concluded.

The work of the SPBs is supported by a range of sub-groups:

- A joint core business group (CBG) which meets six times a year to plan the business of the main SPB. Four of these meetings take place as a full group and twice as a group comprised of the SPBs Chair, the two SPB vice-chairs and the SPB Manager. The CBG agrees agendas and receives update reports from the other sub-group chairs to ensure the delivery of the overarching business plan.

- A joint Serious Case Review sub-group. This group holds responsibility for the commissioning of SCRs and receiving those reports. The SCR sub-group is chaired by the independent chair of the SPBs and it is the independent chair's decision, following consultation, about whether to progress to an SCR.

- A joint training sub-group which holds responsibility for monitoring the effectiveness of multi-agency safeguarding training across the island. It also develops an annual training plan to support the overarching business plan.

- A joint domestic abuse sub-group. Most recently this group has led the development of the Domestic Abuse Strategy.

- An adults' policy and procedures and performance sub-group which is responsible for monitoring the effectiveness of safeguarding

practice for adults at risk. It is also responsible for monitoring and reporting performance data and delivering an audit programme relating to the implementation of recommendations from SCRs.

- A child sexual exploitation (CSE) and missing persons sub-group. This group has been involved in an updated referral pathway and has recently been involved in highlighting CSE issues across the island.

- A children's performance, procedures and audit sub-group, the aim of which is to promote, produce and disseminate multi-agency safeguarding procedures, policies and multi-agency audits such as the LAC audit of 2017.

- A Child Death Overview Panel (CDOP) has been established as a subgroup of the board. It operates jointly with the Guernsey and Alderney Islands' Safeguarding Children Partnership. The panel reviews the deaths of all children under the age of 18 excluding still births and planned terminations. The panel is advisory and considers the circumstances of individual cases, the contributory factors relation to the death as well as reaching a view about preventability. The CDOP met twice in 2017

An early help project sub-group that focused on the development of approaches to support earlier intervention and support for children, young people and families has been part of the SPB.

The sub-groups are not executive or decision making bodies. Their role is to deliver their part of the business plan, the chairs appoint their own members and develop their own work plans.

The independent chair has established a process of annual one to one meetings with each of the members of the SPBs. This process is intended to enable the independent chair to ensure that each member is clear about their role and responsibilities, to review their membership, to

identify the contribution they have made to the boards and to discuss any concerns they might have so that these might be addressed.

The CCA hosts the SPBs, so that they act as an arms-length body. The staff working for the SPB are employed by the CCA department and effectively seconded to it to carry out their duties. Those staff have a line management link back to the Director of Social Policy within the CCA department. However, their priorities and work plans are set by the independent chair.

The overall budget for 2017, the most recent figures available to the reviewers, was £362,544. Most of this resource was spent on the staff team including the independent chair, who is currently commissioned to provide 72 days of input per year.

It is noted, from on-line research, that Chairs of Board in England and Wales are usually contracted for around 24 days per year, equating to 48 days for both a children's and an adults board.

The staff team is comprised of a Board Manager, who works 30 hours per week. The current post holder has been in the role since July 2017. A full-time business manager post, a part-time training officer, part-time training administrator and a part-time policy officer complete the team. An additional post of Practice Improvement Officer was funded in 2016 for a two-year period, but as a result of delays to recruitment, this funding was carried forward with the majority of the expenditure taking place in 2017/18.

Not all the posts within the team are currently filled and the SPB Manager is covering these vacancies in addition to her substantive role.

The budget for training was £8,000, a reduction of £2,000 on the previous year, though some additional training events were held which participants paid a fee to attend.

£41,427 was spent on the commissioning and conducting of serious case

reviews using independent reviewers who are not from Jersey. During 2017, the joint Serious Case Review sub-group completed SCRs that began in 2016 and considered new cases, in relation to both adults and children. In 2017, five notifications were received for consideration. Of these, two were considered as not having met the criteria and one was subject to other single agency or partner review processes. Three SCRs were commissioned. Four SCRs were published in 2017, two of which were learning reports to protect the identity of the subjects.

The Independent chair is responsible for commissioning serious case reviews (SCRs). In making that decision a set of criteria are applied. They are as follows:

SCR – children

- Abuse or neglect of a child is known or suspected;
- Either the child has died, or the child has been seriously harmed, and;
- There is cause for concern as to the way in which the SPB partners or other relevant persons have worked together to safeguard the child.

Additionally, even where one of these criteria is not met, an SCR will be conducted when:

- A child dies in custody, on remand or following sentencing;
- In a secure children's home;
- Where a child has died by suspected suicide.

SCR – adults

- The adult has died and the SPB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died), or;

- The adult is still alive and the SPB knows or suspects the adult has experienced serious abuse or neglect and there is reasonable cause for concern about how the SPB, members of it, or other persons with relevant functions, worked together to safeguard the adult.

The decision to publish the reports of the SCRs is made by the independent chair, following consultation with the SPB members. The SPB is responsible for monitoring the implementation of the recommendations and actions arising from SCRs.

It has been agreed that the decision to publish should rest with the independent chair, in order that the chair may consider local factors relating to risk of identification of parties referred to in the SCR and associated harm.

4. THE KEY FINDINGS AND THEMES EMERGING FROM THE REVIEW

The consultative interviews, desk review of documentation and the workshop revealed a range of important issues relating the current and future operation of the SPB, as well as various perceptions about its role and function.

During the workshop the reviewers provided feedback on what stakeholders had said and a set of initial findings. Following the workshop process, the reviewers have refined the findings and they are set out here under a set of themed headings.

Progress has been made in Jersey

The reviewers heard that progress had been made over the past five years, and the position in relation to safeguarding has improved. The establishment of the SPB represented a step forward for Jersey, bringing much needed process to bear and accelerated the progress of the JCPC.

The design of a system, almost from scratch drawing on other models to create a system that works for Jersey is recognised by those spoken to as having been a complex task that has required time, expertise and determination.

The work of the SPB is recognised by stakeholders for its high standards. Those stakeholders report that the profile and awareness of safeguarding has improved among a range of local organisations and agencies, but this is not yet as widespread or embedded as it could be.

There was felt to be a strong and sustained commitment from member organisations to safeguarding and to the work of the SPB. The expertise and knowledge around the SPB table is valued and appreciated. There is felt to be an ongoing commitment to continuing to work together as effectively as possible.

The SPB has established a range of polices that address issues including child sexual exploitation, self-neglect in relation to adults, capacity in relation to adults, allegations management, child sexual abuse, and information sharing.

The recent appointment of a designated doctor and designated nurse for safeguarding have been important developments as has been the production of multi-agency safeguarding procedures.

Chairing arrangements

The current Chair has been in post since 2013 and has overseen the development of the current SPB arrangements, creating a board for children's safeguarding to replace the previous Jersey Child Protection Committee and to establish an Adult Safeguarding Board. The Chair has brought these Boards together through joint working and management arrangements and a joint SPB meeting.

The Chair is independent and has independently chaired other safeguarding boards in England and Northern Ireland and has recently been appointed as the independent chair of the statutory joint board for Isle of Man There is a recognition amongst key stakeholders of the contribution the Chair has made to safeguarding in Jersey.

The independence of the Chair is valued and brings particular benefit to the system. This was seen as having been important in establishing the credibility of the new arrangements and creating confidence amongst stakeholders of the robustness of the processes being put in place.

From its outset the SPB has had its own own secretariat at arms-length to the CCA Department and the Chair has had a line of communication to the Chief Minister, via the Assistant Chief Minister. Whilst this is acknowledged as important it has, at times, cut across line management and executive accountabilities, for example; with regard to the appointment and management of staff.

Although independently chaired, it is important to note that the SPBs themselves are not independent, autonomous bodies.

SPB meetings

The SPB meetings are generally well attended. The meetings now take place on a bi-monthly basis with six meetings scheduled in 2018. Prior to this year meetings were held once a quarter.

The meetings are structured by a pre-prepared agenda which differentiates the business relating to children and adults and where appropriate, brings areas of business that cut across both together for discussion. Opportunities are given to members of the SPB to contribute either in the main Board meetings or in sub- groups.

Time and attention has been dedicated to ensuring that SCRs are being delivered effectively and the findings reported to the wider system. The view of some that contributed to the review was that this had led to the SPBs having a retrospective focus, and this can give the impression of the SPB being an 'inspectorate' rather than a place where actions that require a whole system focus and multi-agency working are decided.

The meetings are felt to be long, and though time limited, the agenda is often very full. The length of meetings and a very full agenda with items of varying degrees of importance can mean that there is a sense among some members that important items can be rushed through, whilst some, less important but more engaging items are lingered over.

Several agenda structures have been tried but there is a sense that important items sometimes come at a point in the meeting when energy levels have dropped.

From the reviewers' observation of part of SPB meeting, it was evident that contributions to the discussions are invited from all present but the level of input is varied. Some attendees do not make verbal contributions

during the meeting. This was reported to the reviewers as well as being observed.

The reasons for the lack of participation by some members of the SPB are mixed. For some it may be that they do not feel the topic of discussion is relevant to them or their organisation. For others it may be that they do not wish to be seen as being critical of another organisation or individual and that any contradiction or negative comment may be interpreted as personal rather than as a professional opinion. It has been suggested that some Board members might feel that others with more expertise present the views they themselves might want to express and so do not contribute as fully. The size of the membership attendance may also be a factor, with some people suggesting that the environment can feel intimidating to them and not a place where they feel comfortable to contribute. Put simply, the SPB demonstrates that offering professional challenge is just as difficult in these settings as it can be in front line practice.

Many of the members of the SPB hold senior management roles in their organisations. The level of seniority reflects the seriousness of the work of the SPB. The reviewers were told that this seniority also enables more effective decision-making because those present hold sufficient authority to act. However, there is a sense that full use of this seniority is not always made in seeking to address some of the '*wicked*'[1] issues that affect the safety of Jersey residents.

There is a sense that the meetings of the SPB can involve lengthy discussions to amend and ratify proposals that have been agreed within the various sub-groups. There was a view expressed that some of these decisions could be taken in the sub-groups themselves if they were so empowered and that those decisions could be noted at the main SPB.

[1] A wicked issue is a one that is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognise.

Given the scope and size of the Health and Social Services Department, it has a number of representatives as members of the SPB. Some who were consulted felt that perhaps the HSSD was over-represented, but at the same time there was recognition that it was unlikely that one person alone could adequately represent HSSD at the SPB.

There have recently been changes to board membership which have been achieved via the internal safeguarding oversight arrangements put in place by, for example, education and the customs authority. These arrangements help manage membership whilst ensuring a specific group of professionals can focus on key issues that are relevant to them (e.g. establishment of the education department's oversight arrangement has meant that two head teachers are no longer board members but there is a link to a professional officer in education who feeds into a wider group of teachers).

SPBs structures

There are a range of sub-groups that support the work of the SPBs as a whole. The sub-groups are not decision-making bodies.

It was reported that there can be a 'lag effect' between meetings in getting decisions approved by joint SPB, but this should be mitigated by more regular meetings taking place in 2018.

It was also reported by some members of the Board that that chairing arrangements and membership of the sub-groups appear to be ad-hoc. Furthermore, some of the chairs of the groups said they were not clear why they are chairing, and some members are unclear why they are member of sub-groups and what they should be doing or what they are accountable for. This may, in part, be a reflection of the fact that, for some people, it is difficult to volunteer to chair or actively participate in a group due to other time pressures.

The question of whether there could there be a clearer scheme of delegation and whether some of the main business of the SPB could be dealt within the sub-group structure was raised. It was suggested that if the Chair felt the need to have a core business group then it could be used as a place where some of the more process issues could be addressed. It is the reviewers understanding that consideration of new structures has taken place but action was put on hold pending the outcome of this review.

Frameworks and joint working

The SPB has recently given more emphasis to children, and less to adults. This is due to a system-wide children's focus following a number of critical reports and inspections and the establishment and reporting of the IJCI.

The more recent focus on children is recognised as having been necessary but for many, their view is that the time is now right to rebalance and to give additional focus to adult safeguarding. Concerns have been expressed, albeit with no supporting evidence, about potential weaknesses in adult safeguarding arrangements. Very recently, new work has been commissioned, which focuses on adults as opposed to children.

Currently, neither the SPBs nor their functions are provided for in law. This includes there being no statutory duty to co-operate with the board. There is, however, a Memorandum of Understanding (MoU) in place. Its aim is to engage partners, set out the membership requirements of the SPB, and secure agreement to co-operate among the organisations that are signed up to the MoU. The MoU is revised and re-signed every April.

Some who contributed to the review felt that more needs to be done to embed a way of solidifying and formalising organisational co-operation. Some felt that the Memorandum of Understanding works well but that a legislative framework or a 'duty to co-operate' could usefully strengthen it.

Serious Case Reviews

Serious case reviews have been and are continuing to be undertaken. They form the principle learning process for organisations in Jersey but some who contributed to the review asked whether there could be other processes.

Any decision to commission an SCR is taken against agreed criteria and an audit trail of decisions is maintained. However, the reviewers nevertheless heard that decisions about when SCRs are undertaken are viewed by some as opaque and that these decisions are not always communicated effectively.

Some also reported a lack of clarity about the threshold for conducting an SCR and questioned whether it is too low. Overall it was felt by some that there was a lack of a consistent threshold among the agencies, with some agencies having a lower bar than others. These people felt that this required further consideration.

There has been a perception that there may be too many SCRs. This may have gained credence as a result of the need to address a number of legacy cases. The reviewers' own analysis of the numbers provided by the SPB officers suggests that proportionally the number of SCRs does not appear excessive.

As in other jurisdictions, similar issues appear to arise from SCRs, with similar recommendations. There is concern about this and why things are not changing as a result of SCRs. Some of this is due to there being some issues that always come out of such reviews e.g. a lack of communication or that there are *'wicked issues'* across the system. We describe this as being the 'gap to practice' and there is general acceptance that this gap remains too wide and that changes in practice required of individual agencies and which they are responsible for are not being made or, where they are, they are not having the desired impact.

Where changes and improvements are not being made there is not sufficient leverage for the SPB to hold organisations to account for delivery of recommendations and actions. This raises the question of whose role it is to hold agencies to account for not delivering improvements. If it is the role of the Chair to do this, do they have sufficient leverage and authority? If it is the role of the SPB as a whole, then the issue of members of the SPB representing the agencies being held to account can present challenges to effective accountability and delivery of change.

Assurance and accountability

SPB hosting arrangements, oversight and accountability are not clear and cause confusion and some degree of tension. Questions were raised about whether the Chair would be accountable to the Chief Minister, and what the role of the Chief Executive of the States of Jersey should be.

A consistent refrain from those consulted was the need to develop a culture of constructive criticism of practice and process in Jersey. This is not an issue that is restricted to the SPB, but cuts across the whole system.

To date there has been a failure of the system in Jersey to establish such a culture. The monitoring of the implementation of recommendations and practice change is felt by many to be patchy and follow-up is limited. This is in part a consequence of a lack of capacity in the SPB staff team and in part a lack of accountability for, and assurance, about delivery.

There was an overriding sense of a lack of accountability among the members of the SPB. This may be characterised in three ways. Some SPB members feel that others are not held to account, whilst others feel that they (and their organisations) are not being sufficiently held to account. In addition, there is a view among some stakeholders that contributed to the review that the SPB itself is not held to account.

There is also a lack of clarity about how those members of the SPB who are responsible for delivery of improvements and change provide adequate assurance to the SPB. Equally, how the SPB provides assurance of improvement and change to others is not clear.

Whilst it is noted that the SPB holds a risk register, there is a view amongst some that the SPB lacks a collective view of the key risks and how these will be mitigated and by whom.

Given the breadth and seniority of members there is an opportunity to address the risks to the safety of islanders, the key drivers of risk and to discuss how these can be mitigated either by individual agencies or, more likely, by multi-agency working. It is felt by some that at present these opportunities are not being sufficiently grasped.

There is currently little in the way of assurance, either in terms of process but perhaps more significantly, in terms of content. A Board assurance framework that identifies the key risks, the proposed mitigations and the residual risk would support wider system change and the accountability of the SPB both to the Chief Executive and in turn to the Chief Minister of the States of Jersey.

Facing the future

The SPB faces a number of current and shorter-term challenges. There is a need to put in place a plan to recruit a new Chair, given that the current Chair is due to step down in February 2019. Urgent consideration will need to be given to the role, person specification and contractual arrangements associated with that appointment.

The re-organisation and restructure of the States of Jersey had raised some anxiety among staff and SPB members. This was less about their own personal positions, rather it was about where the SPB might be hosted and how safeguarding arrangements would be managed and overseen in the newly emerging structures of government in Jersey.

The capacity of the SPB management team, in respect of board management, business management, training and administration is under pressure. The SPB operates with a small budget and cannot currently expand its capacity and there is concern that workload levels are not sustainable. Further investment into the staff team of the SPB would enable the increase in capacity that is needed. There is a case for more investment to support the SPB to deliver training, including supporting other agencies to develop competency frameworks and participate in training. At present this appears to be ad hoc in terms of how requests for funding are managed by the States of Jersey and this militates against the ability to put in place a targeted and well-planned programme with certainty that it can be resourced. Investment in public promotion of safeguarding was also highlighted as being an area that requires attention, for example, increased investment in specific initiatives includes those that may be undertaken in collaboration with agencies such as the NSPCC, as recently happened with the 'Pants' campaign.

In addition to current work, consideration would need to be given to the skills and resources required to undertake any extended role, for example, in relation to public promotion of safeguarding matters.

6. CONCLUSIONS

The process of consultation and review of the responses and key issues outlined in the previous sections leads us to a number of key conclusions. These conclusions reflect what participants in the review said and it is understood that there may be a divergence of views.

- The development of the SPB has been a positive advance for Jersey. The current arrangements are a considerable improvement on what went before and have put in place foundations on which to build.

- There have been significant improvements in a number of key areas including, for example, schools, sport and border control. There is, however, a recognition that there is still more to be done to improve awareness of safeguarding in Jersey

- The role and function of the SPB, though articulated in the Terms of Reference, the MOU and in other publications, does not seem to be more widely understood. Indeed, some stakeholders expressed their own lack of clarity. What did emerge was a sense of confusion about whether the SPB operated, or should operate as, a 'protection board' or a 'safeguarding board'. For some the focus seemed to be 'protection'. It may be that protection issues have tended to rise to the top of the agenda given the broader public service focus on protection and risk mitigation, allied to the findings of the ICJI and the concerns about the effectiveness of local services. For some, there have also been concerns about 'mission' creep, a sense that the Boards have engaged in wider safeguarding policy issues – such as early help – which may be considered to fall outside it remits. It is our conclusion that the Board should be focused on safeguarding but, that clarity is needed about where work is undertaken by the Boards or by services, whether individually or in partnership.

- We have concluded that the lack of a statutory legislative framework is a gap that needs to be addressed. The current MoU has worked well, but it is our conclusion that this is no longer sufficient. Whilst it may not be necessary to put in place a legislative framework like that in other jurisdictions, the reviewers conclude that some form of statutory duty for organisations to co-operate would be helpful. It would remove the inherent risks of relying on goodwill to secure co-operation and would, in our judgment, allow the SPBs to be more effective.

- We conclude that the joint SPBs remain a developing body. In particular there are questions to address about how effectively it can assure politicians, departments and islanders, that through its work, children and vulnerable adults are safer than they were, and that learning is implemented and that improvements are continual. The Chief Executive of the States of Jersey, the Chief Minster, other ministers and Departmental Chief Officers wish to be assured by the SPB. They don't feel they are at present.

- The independent chair has sought to encourage participation and contributions from SPB members during meetings. It is our conclusion that this is a challenge in such a large group, comprised as it is of senior people, many of whom have firmly held views. The inherent risk in these circumstances is that the chair becomes the de-facto decision maker and those who find it harder to contribute may be left with a sense that they are unable to influence discussions and decisions effectively.

- We conclude that the independence of the chair is crucial. Only thorough such independence can the chair hold others to account. For the SPB to be effective an independent chair remains necessary. Given that the current Chair's term will end within the next nine months there is a need to swiftly plan and complete the recruitment of a replacement and to ensure an effective transition.

- The issue of to whom the independent chair should be accountable needs to be addressed and clarified. At present the arrangements are not clear to all the stakeholders. It is the conclusion of the reviewers that the relationship between the independent chair and politicians needs to be clarified in order to ensure that lines of accountability are better understood.

- The operation of the SPBs in joint form brings benefit and there is little appetite to change this. We have concluded that this model is helpful for a number of reasons: It reduces duplication, reduces costs by requiring only one meeting and most importantly enables consideration of and sharing of information relating to children and adults across a wider range of individuals and organisations that single boards could. The joint arrangements also provide an opportunity to give some focus to the important area of transition from childhood to adulthood.

- The range of expertise and knowledge, coupled with the level of seniority of the membership of the SPBs, is impressive. The members of the SPB value each other's knowledge and the levels of co-operation between the organisations represented are to be commended.

- The seniority of members of the SPBs could be better used to take the opportunity to discuss fully those issues that are coming through as long-standing themes from the SCRs. The SPB also needs to identify and communicate the key strategic risks to the people of Jersey not being safe and to discuss how these might be mitigated and how agencies can work together and be held to account for the delivery of these mitigations. This will also allow the SPB to give more focus on prevention and awareness.

- Decisions about who joins and leaves the SPB appear to be made without a clearly defined rationale. Whilst there will always be a need to review and refresh the membership, this must be done in

a co-ordinated and transparent way. The number of members is large and is likely to be a contributing factor both in participation and effectiveness.

- There is a commitment to safeguarding. This is reflected in the level of attendance at SPB meetings and the membership of the sub-groups, which have good representation from a wide range of organisations.

- The agendas of Board meetings are very long. Although detailed discussion takes place, it is the reviewers' conclusion that there remains a risk that some important issues do not get covered in the detail that they might. The reviewers understand steps have been taken to develop shorter, more focused agendas and this should continue.

- Some of the business conducted within the main SPB meeting could be done within the sub-groups. In particular the core business group could provide a useful place for decision making that would release time on the agenda in the main SPB meeting.

- The sub-group structure is unwieldy and their accountabilities and responsibilities appear both broad and ambiguous. They lack any decision-making power. Although there are examples of excellent work, notably in relation to CSE, serious case reviews and domestic abuse, based on what the reviewers heard, there remains a risk of them becoming forums solely for discussion rather than action.

- The culture of constructive criticism and the development of a culture of learning remains significantly underdeveloped across the whole system. There is little evidence of such an approach. Closing the *'gap to practice*' is a key priority for the Board and for individual agencies.

- The use of SCRs as a principle means of learning lessons is appropriate, but the use of other means could be explored further, for example, if additional resources would allow for better use of audits. The number of SCRs does not appear to be disproportionate. Although criteria do exist for making the decision about whether to commission an SCR, their application seems to be unclear and those decisions do not appear to be consistent. There remains a perception reported by some that the decision making process about whether to commission or not, or publish or not, is opaque. Whilst is it very clear that the Chair works to uphold independence of decision making, there are residual concerns that board members could be conflicted in their role as service providers. This must be addressed.

- Organisations represented on the SPB have their own differing thresholds for services and in relation to risk and its management. How these inform, and are used in requesting and determining the commissioning of SCRs, is unclear.

- SCRs produce a range of recommendations for action. Sometimes these will be similar across different cases, given some of the issues they examine. However, where those recommendations consistently appear, we conclude that there are questions to be considered about the effectiveness of system-wide action plan implementation and practice improvement. It is our conclusion that the *'gap to practice'* remains too big in Jersey and this is an issue for all agencies on the board

- The SPB is in effect an arms-length body but the mixture of independence of chairing and the secondment of the SPB staff from the CCA to the SPB and the reporting lines and management accountabilities do not seem to be well understood. They have led to confusion causing an unnecessary level of personal tension between key actors in the system.

- The SPB is felt, at times, to have strayed into operational and policy matters. This is in part due to the lack of other supporting bodies or forums in Jersey. The SPB should have a contributory role in policy development, however, the reviewers conclude that the SPB needs to continue to make the shift that is has begun, back to its core role and functions, and a more strategic approach to the issues that impact on the safety of the people of Jersey. The SPB needs to hold others to account for operational and policy deficits; it should not be filling the gap itself.

- Holding organisations to account can be challenging but the SPB needs to be able to do this and should be empowered to do so. Colloquially put, it needs more and sharper teeth. In addition there is a need for greater clarity on whether it is the Chair holding to account, or the SPB as whole holding to account.

- There is a need to plan for the future. The business planning process for the coming year must address the ways in which accountability and assurance can be strengthened as the essential underpinning that a new Chair will need.

7. RECOMMENDATIONS

In response to the information gathered from this process and the conclusions we have drawn from that, we offer a set of recommendations for consideration.

1. We recommend that the SPBs should continue to operate and that they should do so in joint form. There remains an important role for them to play in safeguarding children and vulnerable adults. This role can be enhanced by continuing to operate jointly.

2. We recommend that the SPBs should continue to be independently chaired. The independence of the chair is critical to enabling the effective function of the SPBs, holding organisations to account and maintaining the confidence of the public and their representatives.

3. We recommend that given its status as an arms-length body, the staff of the SPB should continue to have line management accountability into the States of Jersey department structure. At the time of writing, proposals for changes in that structure are being consulted upon. It will be for the Chief Executive with Departmental leaders to agree where this line management should rest in the new structure. The SPB requires more resource to help it do more to develop its identity and 'brand'. In doing this, it should aim to achieve greater recognition among wider organisations and the public.

4. We recommend that the SPB receive further investment to enable the development and provision of an expanded training programme, the provision of advice and guidance to organisations and the public and the enhancement and updating of the SPB website.

5. We recommend that in order to ensure a smooth transition, a process for the recruitment of a new independent chair should be put in place as soon as possible. The appointment of a new independent chair should be completed by October 2018. We recommend that the new independent chair should be invited to join the SPBs immediately on appointment and work alongside the current chair, possibly as Deputy Chair, to ensure a satisfactory handover by the end of February 2019.

   It is our view that the independent chair should continue to be someone who is not resident in Jersey. This will further aid independence.

6. We recommend that as part of the recruitment process, the CCA review the current job description and person specification for the role of independent chair. In so doing, the CCA should ensure clarity of accountability and reporting for the role. We recommend that the independent chair should be accountable to the Chief Executive of the States of Jersey.

7. We recommend that the number of contracted days of input from an independent chair be reconsidered as part of the recruitment process. The current independent chair is contracted to provide 72 days of input per year. We believe that there is scope for a reduction in the number of days and any saving could be invested into SPB staffing capacity.

   As with any appointment, thought should be given to the matter of term limits and how long the independent chair should serve in order to mitigate the risk of familiarity affecting the independence of judgment.

8. We recommend that work be undertaken to provide greater clarity about the role and purpose of the boards. This needs to make more explicit the focus of the SPBs on safeguarding, rather than protection. It should also make clear that the role the SPBs have in raising the public awareness of safeguarding and the contribution this can make to reducing the incidence of abuse of vulnerable children and adults.

9. We recommend that it should also make clear where the SPBs remit ends. Specifically that it may be consulted on or contribute to discussions about policy but it is not responsible for its formation and that it does not have responsibility for operational matters, nor should it be required to extend its role to fill deficits elsewhere in the system. Where the SPBs believe there to be deficits, these should be raised with operational and policy leads. In making this recommendation, the contribution of the SPB in stepping up to fill such gaps is acknowledged. Critical activities would not have been undertaken if the SPB had not taken the lead.

10. We recommend that the membership of the SPBs be reviewed and where possible the number of members be reduced to create a smaller 'core' membership that will enable meetings of the boards to be more participative and effective. Within that process, thought should be given to addressing the concern that HSSD is overrepresented and how this might be streamlined.

11. We recommend that the role and function of the sub-groups be revisited. In particular we suggest that the role and function of the Core Business Group could be strengthened to enable some of the business of the SPBs to be undertaken and decisions made, thus releasing some time on the agenda of the SPBs meetings. The authority of those groups to make decisions (or not) should also be considered.

12. We recommend that the chairing and membership of the sub-groups be revisited. Thought should be given to how chairs are appointed, how long they serve, and to the membership required for each group, in order that people with the right skills, knowledge and expertise are part of those groups, and that they are clear about their role as members. If people are not clear about their role, they should ask. It is understood that attendance by some agencies at sub-group meetings is low.

13. We recommend that the period between now and the arrival of a new Chair could be usefully spent in developing a Board Assurance Framework that highlights the strategic risks to the safety of children and vulnerable adults in Jersey and how they might be mitigated through multi-agency working. This will be used to set the 'flight plan' for the SPBs. More operational risks can be allocated to sub-committees and sub-groups who would only escalate to the main Boards by exception. This should form the basis for delivering improved assurance about the implementation of improvement actions and changes.

14. We recommend that a legislative framework for safeguarding in the States of Jersey should be a priority for the new Government following the May 2018 elections. At the very least we would recommend that a duty to co-operate is introduced.

15. We recommend that whilst the Independent Chair continue to present the annual report to Ministers, the primary relationship would be with the Chief Executive of the States of Jersey who would be accountable to the Chief Minister for progress. The Independent Chair would, however, have access to the Chief Minister in exceptional circumstances.

16. We recommend that there should be a Memorandum of Understanding between the Chair of the SPB and the States of Jersey setting out the principles that underpin the working relationship, accountability and assurance matters, and day-to-day working arrangements. This should be developed regardless of the SPB being established in statue.

17. We recommend that there is a development programme for the Board and that a Maturity Matrix[2] is developed to help the Board to track progress across a number of domains. In particular it will be important to explore how to close the "gap to practice" and the owners of key strategic risks provide assurance that the learning loop has been closed.

[2] A Maturity Matrix can be used as a simple self-assessment tool to track progress across a number of areas of a Boards' work. For example it could be used to test how different stakeholders understand the governance arrangements, and to identify any communication or other developmental issues.

Appendices

APPENDIX ONE
EXAMPLES FROM OTHER JURISDICTIONS

The application of safeguarding for both children and adults is different in the devolved areas of the UK. The reviewers have looked at these systems to try to understand how they work and the differences or similarities between them and Jersey. The approach to safeguarding in two other crown dependencies has also be examined.

England

England – Safeguarding Children

The Department for Education is responsible for child protection in England. The Children Act 2004 placed a requirement to establish Local Safeguarding Children's Boards (LSCBs). Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

- to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area; and
- to ensure the effectiveness of what is done by each such person or body for those purposes.

At the local level, LSCBs coordinate and ensure the effectiveness of work to protect and promote the welfare of children. Each local Board includes local authorities, health bodies, the police and others, including the voluntary and independent sectors. LSCBs are responsible for local child protection policy, procedures and guidance and all have Independent Chairs. They are also the subject of Ofsted inspection.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that the functions of the LSCB, in relation to the above objectives under section 14 of the Children Act 2004. They are responsible for developing policies and procedures for safeguarding and promoting

the welfare of children in the area of the authority, including policies and procedures in relation to:

- The action to be taken where there are concerns about a child's safety or welfare, including thresholds for intervention;

- Training of persons who work with children or in services affecting the safety and welfare of children;

- Recruitment and supervision of persons who work with children;

- Investigation of allegations concerning persons who work with children;

- Safety and welfare of children who are privately fostered;

- Cooperation with neighbouring children's services authorities and their Board partners;

- Communicating to persons and bodies in the area of the authority the need to safeguard and promote the welfare of children, raising their awareness of how this can best be done and encouraging them to do so;

- Monitoring and evaluating the effectiveness of what is done by the authority and their Board partners individually and collectively to safeguard and promote the welfare of children and advising them on ways to improve;

- Participating in the planning of services for children in the area of the authority; and

- Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

There is no single piece of legislation that covers 'child protection' or 'safeguarding', rather there are a number of laws that are continually being amended, updated or revoked.

The Department for Education published an updated version of the key statutory guidance for anyone working with children in England in March 2015. It sets out how organisations and individuals should work together and how practitioners should conduct the assessment of children. Effective safeguarding arrangements should aim to meet the following two key principles:

- Safeguarding is everyone's responsibility: for services to be effective each individual and organisation should play their full part; and

- A child centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

England – Safeguarding Adults

The Care Act 2014 put adult safeguarding on a legal footing. From April 2015 this has meant that for adults every local authority must:

- Protect their rights to live in safety, free from abuse and neglect;
- People and organisations working together to prevent the risk of abuse or neglect, and to stop them from happening;
- Making sure people's wellbeing is promoted, taking their views, wishes, feelings and beliefs into account.

Local authorities have safeguarding adults duties. They must:

- Lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens;

- Make enquiries, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed;

- Establish Safeguarding Adults Boards, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy;

- Carry out Safeguarding Adults Reviews when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them;

- Arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

Most SABs, prior to the Care Act 2014, had developed a formal agreement to underpin their governance and activity. These agreements varied in length and complexity and took several forms:

- constitutions
- terms of reference
- memoranda of understanding

The Care Act does not make any specific requirements of SABs with regard to governance, infrastructure and links to other local multi-agency partnerships. The Statutory Guidance (14.114) states that 'local SABs decide how they operate but they must ensure that their arrangements will be able to deliver the duties and functions under Schedule 2 of the Care Act' In effect, this means that SABs need to seek cooperation and collaboration from their member agencies in implementing their strategic plan.

SCOTLAND

The Scottish Government is responsible for child protection in Scotland. A system of Child Protection Committee's (CPCs) operates and it is their responsibility to ensure that all agencies work together to protect children. They broadly cover local authority areas.

CPCs are not described or mandated in primary legislation, rather they are described in guidance. The *National Guidance for Child Protection* published in 2014 by the Scottish government is the principle guidance. CPCs are not required to have an independent chair.

The Adult Support & Protection (Scotland) Act 2007 seeks to protect and benefit adults are risk of harm. It requires councils and other public bodies to work together to support and protect adults who are unable to safeguard themselves

Under Section 42 of the Act each council must have an Adult Protection Committee (APC). APCs set the strategic direction for multi-agency working at local level in accordance with the Act. Each local authority has a committee in place, chaired by a Convenor. Convenors are independent and cannot be members of the council

APCs have a range of duties:

- Reviewing adult protection practices
- Improving co-operation between agencies
- Improving skills and knowledge
- Providing information and advice
- Promoting good communication

They monitor practice and quality relating to the safeguarding of adults at risk and audit performance of the agencies in their APC area.

An Adult Protection Policy Forum meets quarterly to consider key issues and inform national strategic direction. Membership is drawn from a range of agencies nationally

WALES

The Welsh Government is responsible for child protection in Wales. The Social Services and well-being (Wales) Act, which came into force in 2016, strengthened partnership approaches to safeguarding

A National Independent Safeguarding Board has been established to work with the boards for children and adults across Wales. Its duties are:

- Provide support and advise to safeguarding boards to ensure they are effective
- Report on the adequacy and effectiveness of arrangements to safeguard children and adults
- Make recommendations to Ministers as to how those arrangements can be improved

There are six safeguarding board areas in Wales. The objectives of a Safeguarding Children Board are to protect children in its area who are experiencing or are at risk of abuse, neglect or other harm and to prevent children in its area from becoming at risk of abuse, neglect or other harm. “Abuse”, “harm” and “neglect” are defined in section 197(1).

The objectives of a Safeguarding Adults Board are to protect adults in its area who have needs for care and support and who are experiencing, or are at risk of, abuse or neglect, and also to prevent adults with needs for care and support from becoming at risk of abuse or neglect. Chairs of the SABs are not always independent.

NORTHERN IRELAND

Safeguarding Board Northern Ireland (SBNI) was set up in 2012. It replacedthe previous Regional Child Protection Committee structure. It has statutory functions and is chaired independently. Its functions include:

- Develop policies and procedures for safeguarding and promoting the welfare of children and young people;

- Promote an awareness of the need to safeguard children and young people;

- Keep under review the effectiveness of what is done by each person or body represented on the Board to safeguard children and young people;

- Undertake Case Management Reviews in cases where a child has died or been significantly harmed, or where there has been multi-agency involvement, and to learn from them; and

- Promote communications between the Board and children and young people.

New statutes and regulations have been agreed but not implemented due to Northern Ireland being directly ruled from Westminster at the time of writing.

GUERNSEY & ALDERNEY

Safeguarding Children is the responsibility of the Islands Safeguarding Children Partnership (ISCP). The ISCP is a multi-agency committee with representatives from the public, private and voluntary sectors. It was given legal status in the Children (Guernsey and Alderney) Law, 2008.

Its main purpose is to enhance the safety of children and young people in the islands through promoting effective co-ordination and co-operation between agencies providing services to children and families.
It has no similar arrangement for safeguarding adults

ISLE OF MAN

The Isle of Man is putting in place a statutory joint Safeguarding Board (bill received Royal assent in April 2018). It aims to enable children, young people and adults to safeguard themselves, support the minority that are at risk and vulnerable and intervene when protection is needed.

One purpose is to ensure everyone knows about safeguarding and understands what to do if they identify any risk to themselves or others. This includes information about how to spot the signs of risk and how to report concerns. A second purpose is to raise the visibility of the Safeguarding Children Board ('SCB') and Safeguarding Adults Partnership ('SAP') across the Isle of Man.

It operates as a joint Board and has an independent chair. New legislation in the Isle of Man introduces duties to safeguard and to co-operate.

What does the experience of other jurisdictions tell us?

In reviewing the arrangements in other jurisdictions we have provided the most information about the English model as this was the one most often referenced in our conversations with stakeholders. It was also considered to be important to look at other smaller jurisdictions.

The first thing that it is important to say is that there is no consistency of approach across the different jurisdictions. This variance may in part lie in the history of the countries themselves in relation to child protection and vulnerable adult policy and legislation. In part it may reflect the overall governance model operating. The devolution of powers in the UK has enabled countries to develop their own approaches and models, or to retain previous arrangements.

In particular, there is no consistency in relation to whether safeguarding is a statutory or non-statutory function. There is also no consistency about having a joint board or separate boards for children and adults. The Isle of Man has the only statutory joint board. Another area of variance can be found in the arrangements for chairing boards. For some, independent chairs are seen as central to effective board working and assurance, in Scotland however this appears to be less of a critical issue.

In the smaller devolved countries, a national oversight approach has been taken to safeguarding and in particular in relation to assurance, governance and setting policy direction.

The quality and effectiveness of Serious Case Reviews continues to be topic of debate among those working in the safeguarding sector, as does the broader process of review of serious incidents, mental health homicides and domestic homicide reviews. In particular, the debate centres on the process and whether it is regarded as helpful and a way of learning, rather than a means by which to apportion blame on organisations or individuals. In addition, how the learning and recommendations are applied continues to be considered by those working in the sector, and within health and social care organisations in particular.

Most of those jurisdictions reviewed were continuing to debate issues relating to governance and effectiveness. For England in particular there was a continuing debate regarding the outcomes from the Wood Review and the local responses to it. Whilst in smaller jurisdictions there has, understandably, been a national oversight approach to policy, governance and assurance. There is no great consistency around structure and form.

Appendix Two

List of those interviewed during the review

Julian Blazeby	Acting Chief – SoJ POlice
Christine Blackwood	Regulation & Inspection
Sarah Brace	Legal Advisor - SoJ
Mary Campfield	Adult Safeguarding Team Manager - HSSD
Mark Capern	Jersey Youth Service
Andrew Cozens	Independent Consultant
Mike Cutland	Probation Service
Susan Devlin	Managing Director – Community & Social Services
Justin Donovan	Chief Officer - Education Dept.
Chris Dunne	Vice Chair – Adult Board
Claire Farley	Training Officer - SPB
Judy Foglia	Family Nursing & Home Care
Julie Garbutt	CEO – Health & Social Services Dept.
Peter Gavey	Chief Ambulance Officer
Andrew Green	Health Minister
Ruth Le Gresley	Board Manager - SPB
Julie Gibney	Children's Social Work lead - HSSD
Dr Peter Green	Designated Doctor
Ian Gorst	Chief Minister
Stewart Gull	Vice Chair – Children's Board
Andrew Heaven	Director of Children's Policy – CCA Dept.
Kate Hocquard	Regulation & Inspection
Ruth Johnson	Director of Social Policy – CCA Dept.
Glenys Johnston	Independent Chair - SPB
Debbie Key	Previous SPB Board Manager
David Luscombe	Regulation & Inspection
Deborah McMillan	Children's Commissioner
Wendy Middleton	Business Manager - SPB
Kristina Moore	Home Affairs Minister
Linzi Mudge	Regulation & Inspection
Rose Naylor	Chief Nurse

Gary Le Neuve	Customs & Immigration - SoJ
Charlie Parker	Chief Executive - SoJ
Jo Poynter	Head of Operations - HSSD
Anne Pryke	Housing Minister
Julian Radcliffe	Education Dept.
Shelly Regal	Training Officer - SPB
Paul Routier	Assistant Chief Minister
Sophie Le Sueur	Social Security
Fiona Vacher	Jersey Childcare Trust
Tom Walker	Chief Executive – CCA Dept.
Susan Walters	Designated Nurse - HSSD
Dr. Kate Wilson	GP
Sarah White	Regulation & Inspection

Three independent care home managers/owners were interviewed

Sindy Gartshore	Siver Springs Care Home
Tracey Gentry	Maison le Corderie
Rosie Goudling	Barchester

The authors

Contact Consulting is a consultancy and research practice working in health, housing and social care. First established in 1995 Contact Consulting has worked with government departments, local authorities, housing associations, NHS organisations and commercial and voluntary sector bodies, including working internationally.

Steve Appleton is Managing Director of Contact Consulting (Oxford) Ltd. He has almost 30 years experience of working in health and social care, as a practitioner, operational manager and as a senior manager in an English Strategic Health Authority. Steve brings detailed knowledge of practice, central government policy, regional and local planning and delivery and care quality and standards. He combines this with an analytical and strategic approach to service evaluation and review, problem solving and project management.

Steve has particular experience in relation to safeguarding. He has chaired and authored serious case reviews and worked closely with safeguarding boards on a range of cases. He has been involved in supporting boards to consider future ways of working and has provided training on safeguarding to a range of organisations. He has also spoken at several UK conferences on safeguarding issues. Steve is an established Domestic Homicide Review (DHR) Chair and has chaired and written a dozen DHRs.

Steve is an Associate of the Health Service Management Centre at the University of Birmingham. He is also serves on the Board of the Association of Mental Health Providers, the national representative body of the mental health voluntary sector in the UK.

Peter Molyneux is an experienced senior consultant, who has worked extensively with Contact Consulting over the past decade with a strong track record of delivering success for organisations through the development of strategy and effective board working.

He is a special advisor to Boards on their governance, quality systems, reputation management and service user involvement. Peter has expertise in policy, governance and board assurance within and between organisations and has a current and detailed understanding of regulatory requirements.

Since 2011 he has been Chair of SW London and St George's Mental Health Trust and has recently been appointed as chair of Sussex Partnership NHS Foundation Trust. Prior to that he was Chair of NHS Kensington and Chelsea and Chair of the Audit Committee at NHS Southwark.

Peter is a Visiting Fellow at the John Madejski Centre for Reputation Management at Henley Business School, a Board Member of Recovery Focus and a Stonewall Ambassador. He is Chair of the London Mental Health and Employment Partnership.