Submission to the Review of the Safeguarding Board for Northern Ireland
27 November 2015

The Northern Ireland Commissioner for Children and Young People (NICCY) welcomed the opportunity to meet with Alexis Jay on 6 November 2015. This submission highlights many of the key themes of that meeting.

Introduction

The office of the Commissioner for Children and Young People (NICCY) was created in accordance with 'The Commissioner for Children and Young People (Northern Ireland) Order' (2003) to safeguard and promote the rights and best interests of children and young people in Northern Ireland. In carrying out her duties, the Commissioner's paramount consideration is the rights of the child and in exercising her functions the Commissioner has regard to all relevant provisions of the United Nations Convention on the Rights of the Child (UNCRC).

Under articles 7(2)(3) of NICCY's legislation, the Commissioner has a mandate to keep under review the adequacy and effectiveness of law, practice and services relating to the rights and welfare of children and young people. It is with these duties in mind that we are providing a number of comments which we hope will be helpful to the Review of the Safeguarding Board for Northern Ireland (SBNI).

NICCY is a member of the British and Irish Network of Ombudsmen and Children's Commissioners and the UK Children's Commissioners recently presented a joint report to the UN Committee on the Rights of The Child on the UK Government's implementation of children's rights.[12] The report includes a recommendation that article 3(5) of the Safeguarding Board Act (Northern Ireland) 2011 is commenced forthwith to enable SBNI to review child deaths.

SBNI is designated a 'relevant authority' for the purposes of NICCY's legislation and NICCY consistently provided advice on the primary and secondary legislation and guidance for the Board. Following its establishment in 2012, NICCY and SBNI

[1] UKCCs (2015) Report of the UK Children's Commissioners to the UN Committee on the Rights of the Child on the Fifth Periodic Report of the UK.

developed a Protocol with particular reference to the Board's Case Management Review (CMR) and child death overview functions.

The establishment of SBNI was part of a wider process of reform in children's services following the 2006 Social Services Inspectorate Overview Report on child protection services[3] which documented inconsistencies and systemic failures in the discharge of statutory duties in some health and social care boards and trusts. The report highlighted the need to improve ownership of the Area Child Protection Committee system across sectors and stated that a range of initiatives, including the setting up of a regional safeguarding board and the dissemination of learning from case reviews, should be progressed urgently.

NICCY warmly welcomed the establishment of SBNI and remains of the view that, in order to better protect children and safeguard their rights and best interests, Northern Ireland must have a strong, effective, independent children's safeguarding body. We also note, as has been observed in equivalent structures in GB[4], that SBNI is uniquely placed within Northern Ireland's arrangements to consider how well organisations and professionals are working together to safeguard and promote the welfare of children.

Review of SBNI

The Commissioner would note concern about the timing of the Review which has begun when SBNI is still in its first years of establishment and would also highlight disappointment that the Department did not consult with NICCY regarding the Terms of Reference or review process.

SBNI within current arrangements

Reform within health and social care: the Minister for Health has recently announced significant changes to the organisation of health and social care and the current Scheme of Delegation which exists between DHSSPS, the Health and Social Care Board and Health and Social Care Trusts. The structure, operation and discharge of statutory duties across these bodies is critical to child protection

[3] Social Services Inspectorate (2006) Our Children and Young People – Our Shared Responsibility: Inspection of Child Protection Services in Northern Ireland, Belfast: DHSSPS.
[4] E. Munro (2011) The Munro Review of Child Protection: Final report, A child-centred system.

and safeguarding and NICCY would highlight the importance of ensuring stability in arrangements for children's services, including child protection, particularly in times of transition and budget cuts. The Review should take account of this in considering any structural changes to SBNI.

Legislative context: it would be helpful for the Review to take account of the strengths and weaknesses of SBNI's primary and secondary legislation and should give particular consideration to the functions of the Board which are not within the clear statutory responsibilities of other agencies, including CMRs and child death overview which are discussed below.

Sponsor department and hosting arrangements: NICCY notes that concerns regarding the Board's ability to act independently from DHSSPS were expressed during Assembly scrutiny of the draft legislation, particularly in regard to Departmental directions being given to the Board and SBNI's ability to publish information. The Review should consider how well the balance between ensuring SBNI is accountable to the sponsor department while developing and maintaining its capacity to act and function independently (including in relation to establishing its priorities and programmes of work) has been achieved. We note that in the context of the proposed restructuring of health and social care, that measures should be in place to mitigate against any potential conflict of interest with the sponsor Department, who may be commissioning services and to whom Health and Social Care Trusts will report directly.

In relation to hosting arrangements with the Public Health Agency, we highlight the need to ensure that accountability arrangements and procedures are proportionate. In regard to other bodies and partnerships, NICCY notes the importance of ensuring clarity of role and remit between the SBNI and the Children and Young People's Strategic Partnership.

Multi-agency basis and chairing arrangements: a body of work including research and reviews of equivalent structures in England, studies into serious case and case management reviews and the 2006 Northern Ireland Overview Report have identified the importance of embedding child protection and safeguarding work within a multi agency framework rather than restricting this to social care. NICCY notes it is critical that any structural changes to SBNI ensure that it is founded on a multiagency basis. In relation to chairing arrangements, NICCY is supportive of the appointment of an independent Chair and we note the importance of maintaining this principle in future appointments. It would be helpful for the Review to consider whether the role of Chair needs to be further strengthened in order to fulfill its role effectively.

Specific duties

CMRs: NICCY welcomed the statutory responsibility placed on SBNI in relation to CMRs, although we also advised that monitoring the implementation of CMR action plans and recommendations should have been a positive duty placed on the Board by primary or secondary legislation. This has been informed by NICCY's concerns regarding the implementation and monitoring of action plans and recommendations under previous arrangements. We have also stated that the Board's CMR work, including its assessment of learning and recommendations, should be outlined the annual report. We also note the resource intensive nature of CMR work. NICCY would welcome the Review considering this concern.

Child deaths: NICCY welcomed the statutory responsibility placed on SBNI to review of information regarding child deaths and has been deeply concerned by the delay in the Department commencing this function of the Board's legislation. This concern has also been raised by the Royal College of Paediatrics and Child Health.[5] We do not view that DHSSPS has provided sufficient rationale for the decision not to commence the relevant legislation and are further concerned that a non-statutory mortality review process is being developed within the Department. In relation to child deaths, the Review should also note that Northern Ireland remains without a regional multiagency protocol for responding to the sudden and unexpected deaths of children following DHSSPS's consultation on this in 2006. It would be helpful for the Review to reflect on this SBNI duty.

Engagement with children and young people: NICCY also welcomed the duty placed on SBNI to promote communication with children and young people. We recognise that a range of activities undertaken or commissioned by SBNI have sought to engage directly with children and young people and note the importance of further developing this work, particularly through direct engagement with children who have experience of child protection and children in need processes and services.

Coordinate and ensure the effectiveness of members

[5] Royal College of Paediatrics and Child Health (2015) Why Children Die: Death in Infants, Children and young People in the UK; NCB and RCPCH.

The Board's objective to coordinate and ensure the effectiveness of members in safeguarding and promoting the welfare of children is, of course, central to SBNI's work. The ability of the Board to differentiate between operational responsibility (held by members for the functions of their individual organisations) and ensuring and evaluating the effectiveness of members (held by the Board as a core duty) is important to this. While SBNI can be understood as having a strategic rather than operational role, the distinction between these should be carefully considered in relation to the remit of the Board in being accountable for ensuring the effectiveness of multiagency work (and for seeking to strengthen and improve this).

SBNI must have robust mechanisms in place to assess and hold to account the activities of members and their organisations. The Review should consider the development and operation of such mechanisms by SBNI. NICCY notes that the **duty to cooperate** placed on Board members is critical to achieving SBNI's objective. The operation of this duty in practice, including how the functioning of SBNI may be impacted by conflicts of interest among members or tension between members role in representing their own organisation and the Board, should be considered. These concerns should also be reflected in reviewing the relationship between Committees, Panels and the Board. In addition to this, it would be helpful for the Review to consider how SBNI can best ensure that necessary work to develop and review policies, protocols and procedures does not divert from maintaining a central focus on children and young people.

On a related matter, NICCY views that SBNI should disseminate an assessment of the effectiveness of safeguarding arrangements in Northern Ireland, including gaps, weaknesses and emerging trends, on a regular basis. This may be done through the Board's annual report or another medium.

Monitoring and Oversight

The Commissioner notes that the role and performance of the Chair, lay members and the Board's Effectiveness and Governance Committee is critical to effective internal challenge within SBNI in relation to both the functioning of the Board as a whole and to ensuring the effectiveness of members and their organisations in working to safeguard children.

In considering reporting and oversight arrangements beyond those currently in place in relation to the hosting agency and sponsor department, the Review may wish to give thought to mechanisms which would provide external review or

evaluation of SBNI. Consideration should also be given to requiring that the Board regular reports to the relevant Assembly Committee.

In order further support transparency in SBNI's work, NICCY notes that Board meeting minutes should be made available in a timely manner, thematic concerns arising from CMRs, audits/reviews and other work of the Board should be publicly available, including on its website and in its annual report. The annual reports of Committees and subcommittees should also be freely available. We note that, to date, no Executive Summaries of CMRs have been published.

Resources

NICCY notes that SBNI must be provided with appropriate resources in terms of funding, expertise, staff and organisational time, including that of members, in order to discharge its functions. Evaluation work concerning LSCBs in England has noted that without adequate resourcing the viability of boards can be compromised.[6] As highlighted, we are particularly mindful of the resource intensive nature of the CMR function. It would be helpful for the Review to provide advice on this area.

Themes from reviews and evaluations of Local Safeguarding Children Boards (LCSBs) in England[7]

The following themes emerge from review work that has been conducted into the effectiveness of safeguarding bodies in England and the Review may find it helpful to consider how these elements can be most effectively embedded and sustained in SBNI's work in Northern Ireland.

Effective LCSBs include the following elements:

- *Chair:* independent; good expertise; commands respect; provides good leadership; is well connected to relevant decision makers and networks.

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[6] A. France, E. Munro and A. Waring (2010) The Evaluation of Arrangements for Effective Operation of the New Local Safeguarding Children Boards in England, London: DE. The report noted operational costs ranged from £136,000–472,000 with annual attendance excluding SCR and CDOP ranging from £20,000–135,000. One SCR was stated to potentially cost over £12,000.

[7] Ofsted (2014) The new Ofsted framework for the inspection of children's services and for reviews of local safeguarding children boards: an evaluation.
C4EO (2014) Desk Study Review of Effective LSCB Practice.
E. Munro (2011) The Munro Review of Child Protection: Final report, A child-centred system.
Ofsted (2011) Good practice by Local Safeguarding Children Boards.
A. France, E. Munro and A. Waring (2010) The Evaluation of Arrangements for Effective Operation of the New Local Safeguarding Children Boards in England, London: DE.

- *Relationship with children's services:* clarity in respective roles of board and children's services structures; regular communication between bodies.
- *Priorities:* focused on core child protection functions and practice (including for vulnerable groups) while the board is establishing and developing clearly defined priorities before moving to a broader safeguarding agenda. Stronger boards are clearer about their role to ensure the effectiveness of what is done by each member for the purposes of protecting children and promoting their welfare and delineate between this and operational responsibility which is outside their remit.
- *Members:* clarity of members' roles and responsibilities; good engagement including consistent attendance and participation in meetings; shared ownership, including sharing/providing resources and funds.
- *Children and frontline staff:* children and young people influence the work of the board and do this through established mechanisms; fontline staff provide a 'touchstone check' on progress and challenges.
- *Scrutiny and challenge:* openness to and engagement with scrutiny and challenge, examples include chair holding one to ones with members, peer review from other boards, good use of audit, members act as critical friends to other members in structured sessions.
- *Outcomes:* the literature recognises the challenges of evidencing outcomes but notes that more effective boards have measures in place to monitor impact and ensure practice is focused on "doing the right thing rather than doing things right", this is ensuring that children are being helped and are safe rather than simply checking procedures are followed.