# Inspection of the Isle of Man children's social care services

**Inspection dates:** 24 to 28 April 2023 (children's homes); 15 to 26 May 2023 (wider children's social care services)

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## Background

1. An independent review was completed by Sir Jonathan Michael of the entire Isle of Man health and social care system. The report arising from the review recommended that children's social care services should be assessed regularly by independent external regulators, at the minimum of every five years, reporting to the Department of Health and Social Care (DHSC) and Manx Care. Ofsted was subsequently commissioned to complete this baseline review.

2. The report is in two sections:

   - Part One: The inspection of the Isle of Man children's homes
   - Part Two: The inspection of the wider children's social care services

## Part One: The inspection of the Isle of Man children's homes

3. This section of the report will outline the first part of the inspection process within which the island's 11 children's homes, including one secure children's home, were inspected.

### Headlines findings

4. The lack of legislation and guidance for care leavers is failing many care-experienced children once they turn 16. The lack of an adequate support system to promote the safety and well-being of these children is significantly failing them.

5. The impact of substance misuse on children is of significant concern.

6. Children do not have access to independent advocacy.

7. There are insufficient opportunities for children to be heard and seen as there is a lack of effective independent oversight and scrutiny of children's care. This means that the child's voice is lost.

8. For many children who are subject to voluntary care arrangements, it is not clear who is exercising legal parental responsibility for these children to ensure that their rights are upheld, and appropriate decisions are made.

9. Too many children do not have access to the appropriate education, training or employment.

## Care of children

10. In the children's homes for younger children, an ethos of nurturing and love is evident. Children are benefiting from attentive staff who are parenting them well. Children also enjoy many activities, and some have been taken on holidays abroad. Children told inspectors that they felt safe and happy.

11. Children are supported by staff to maintain and repair relationships with family members who are important to them. This includes within the secure setting. Children also benefit from effective individualised support and education packages at the secure unit.

12. The routine locking of doors throughout the homes gives an institutional feel. All but one home had locks on the children's bedroom doors. An inspector observed a child asking for their bedroom to be unlocked by a member of staff. The kitchen doors in all children's homes are routinely locked at night. This dated practice was not based on any individual assessment of risk and creates an institutional environment.

13. Not all children are attending school or engaged in meaningful education. This is limiting their ability to achieve qualifications and will affect their life choices and chances. Those that do attend full-time education are making progress.

14. Most older children in semi-independent homes are not in any form of education, training or employment. As a result, their ability to gain qualifications or more rewarding employment is limited or non-existent and limits their life chances. Inspectors did not see any children in these homes over the age of 18.

15. The semi-independent homes for older children were not homely. There is a much smaller budget for decoration and maintenance in these homes, which is evident from their tired and worn appearance. There is no budget for activities or holidays. This means that these children do not always have access to these rewarding childhood experiences.

16. In the respite home, the use of social stories helps children to understand and process change. This is helping to allay children's anxieties.

17. In all settings, children do not have access to purposeful advocacy. This is reducing their ability to share their needs, wishes and feelings independently of the staff who care for them.

## Safety of children

18. Risks to children are known and understood by managers. Practice is supported by clear written assessments which are regularly reviewed. Children in semi–independent homes have a great deal of free time in the community, despite known significant risks, such as drug and alcohol misuse, poor mental health, and links with adults who are known to present a risk to them. This also leads to an increased risk of children offending.

19. When children go missing, a clear protocol is in place for what staff should do. There is also an escalation process that promotes partnership working with the police when the whereabouts of children are not known. When there are escalated concerns for the children, they also link in with port authorities to reduce the risk of children leaving the island.

20. When children return home from being missing, the police speak with them about their welfare. There is limited evidence that these conversations have led to a reduction in episodes of going missing, and inspectors were told that children rarely engage in these conversations. This does not give children the necessary opportunity to share any worries they may have about the care they are receiving with an independent person or agency, to understand better why they go missing.

21. Many staff have a sound understanding of children's emotional well-being. This helps them to support children to find better ways of coping with unconscious emotions and subsequent behaviours. All children consistently have access to therapeutic services to help promote their emotional well-being. Many children are engaged with the wraparound therapy service on a regular basis.

22. Restraint is used when necessary and no significant concerns were identified regarding practice. However, conversations with children by staff about their feelings after restraint do not routinely take place. Scrutiny by managers and learning taken from each restraint is not always evident. It is also important to highlight that agency staff do not always undertake the same restraint training as employed staff.

23. The short-term home, which is intended to accommodate children while their needs are assessed, is not effective. The inspector could not ascertain whether risks for children were understood or professionally managed in this home due to the poor practice. For example, known high risks for children, such as substance misuse, child sexual exploitation and going missing, were evident and children were not safeguarded effectively. During incidents in which children are thought to have used drugs, these concerns are not escalated. On

one occasion, a child told staff that they had been having sex for money to enable them to buy drugs. Records do not make it clear whether this concern was escalated, professional curiosity pursued, or additional safeguards put into place.

24. In the respite home, when children sustain bruising, the process for exploring whether such injuries are of concern is poor. Currently, staff identify and record this information in isolation and scrutiny of any concerning bruising or repeat injuries is not evident.

25. Children rarely make allegations of poor practice. Children cannot share their concerns or views independently as the lead for managing allegations is also the head of service.

## Effectiveness of leadership and management

26. Most managers know children well and promote their best interests. Due to the nature of island life, children are also known more widely by social care staff. This supports the sharing of information. Most managers are trying hard to promote the best interests of children despite significant flaws within the wider social care system.

27. Most staff said that they felt well supported by their managers and received regular supervision and training, including recent training which helped them to understand the impact of trauma on children.

28. Managers complete regular reports on their homes, which are provided to senior leaders. These reports demonstrate progress made by children and in some cases areas for development within the homes. In contrast, at the assessment home there was insufficient evidence of effective managerial oversight of the home. The last independent monitoring visit to many of the homes was in January 2023 by an independent visitor from the UK.

29. Agency staff are used in homes. The assessment home has only one employed member of staff and all other staff are recruited on an agency basis, which leads to a lack consistency for children. Inspectors were unable to clarify the safer recruitment process for agency staff. The information required is held by one member of staff, who was not available during the inspection time frame.

30. Manx Care is the island's health and social care delivery service. The inspection by DHSC of the respite home was delayed by COVID-19 and has not now been inspected since January 2019. Inspectors could not clarify whether a regulatory inspection by Manx Care of the respite home has been completed since 2018. This does not support improvement or help to raise standards. This also limits the ability of children who may be non-verbal to share their feelings through independent observations of the home. This is also having a negative impact on the staff team, whose members feel overlooked by senior management.

31. Inspectors viewed several inspection reports completed by the DHSC Registration and Inspection Team following their inspection of the homes. It was evident that the current regulatory system is not child-centred and does not drive improvement effectively.

# Part Two: The inspection of the wider children's social care services

## Headlines findings

32. Services for children on the Isle of Man need significant improvement in certain key areas of practice, particularly services for disabled children, foster families for children in care and services for care leavers.

33. Risks in relation to children at risk of exploitation are not always fully identified, understood and assessed, meaning some children are at risk of further exploitation.

34. Not all children on the island receive the right help at the right time. Leaders show a clear commitment to a journey of improvement but the pace in some areas has not been quick enough. Information, quality assurance and performance management systems are not robust enough to give leaders sufficient oversight of the quality and impact of services.

35. Children aged 16 and 17 who are either homeless or at risk of homelessness receive a poor service due to a lack of a thorough assessment of these children's needs, and a lack of suitable accommodation means for many of these children that their needs are insufficiently met.

36. Different interpretations of legislation relating to data protection among agencies leads to gaps in the sharing of relevant information about children. There is a clear desire to work productively in partnership with parents. However, there is a reluctance on occasions to override parental consent when concerns about children are evident to gain a full understanding of risks or needs concerning children.

37. Provision for disabled children is limited and as a consequence many children and their families do not receive the necessary help or support. Consequently, their needs are not fully met.

38. Children in care benefit from positive support from social workers. Their health needs are well met. Planning for permanence for some children is not robust, meaning there are delays in them achieving the security of permanent placements.

39. Delays in implementing a fostering recruitment strategy mean there is a lack of carers on the island, limiting the choice of provision when children need to come into care.

40. Gaps in education provision for children in care when they are suspended or have difficulties in accessing education mean some children do not receive an adequate education.

41. The provision for care leavers on the island is insufficient and ineffective. There are significant gaps in the provision of accommodation, the assessment, planning and review of support for them and consequently most care leavers do not benefit from a service that meets their needs.

42. A lack of accommodation options for care leavers means many have to move into independent accommodation when they do not have the necessary life skills to navigate this.

43. There is a lack of a clear, coherent vision and strategy across the island as to how services for vulnerable children are to be prioritised and delivered

## What needs to improve?

### Service delivery for help and protection

- The consistency of information-sharing among partner agencies.
- The evaluation of the impact of parents withdrawing consent to assessments.
- Services for disabled children.
- Tracking and interventions for children who are the subject of pre–proceedings.
- The identification, tracking and planning for children who may be at risk of exploitation.
- The recognition and identification of children in private fostering arrangements.
- The assessment and response to 16- and 17-year-old children who are homeless

### Service delivery for children in care

- The provision of education for children in care when suspended or unable to access full-time education.
- The voice of children in care being heard and influencing service delivery.
- Permanence planning for children.
- Life-history work for all children in care.
- Recruitment of foster carers.

### The legislative and strategic approach to care leavers

- Pathway planning for care leavers.
- The accommodation options for care leavers.
- Opportunities for care leavers to access education, training and employment, including apprenticeships and access to higher education.
- Care leavers' participation in their own pathway planning and in service design.
- The healthcare offer, both for mental and physical health, to care leavers.
- Assessment, planning, review and support for care leavers post-18 during their transition into adulthood, including practical and financial support.
- Performance management and quality assurance information to ensure effective oversight of the provision for care leavers.

### Leadership

- A strategic analysis of the social care needs of children on the island.
- Performance management and quality assurance by the DHSC of children's social care services delivered by Manx Care.
- Quality assurance systems within Manx Care.
- Oversight, scrutiny and challenge by the corporate parenting board.
- The development of a coherent workforce strategy.
- Being outward-looking for examples of effective practice in other jurisdictions and their relevance for social work practice on the island.

## The experiences and progress of children who need help and protection

44. When children are referred to early help there is a delay for some families in receiving support while their needs are assessed. Early help assessments when completed clearly identify the areas for interventions to target. Information-sharing is not sufficiently robust, with all agencies involved with families at an early help level of intervention. Agencies are not being updated with relevant information concerning the level of progress, which is hampering an understanding of children's and family's current needs.

45. Early help operational guidance is not up to date. It does not cover emerging areas of need, such as child exploitation, resulting in gaps in practitioners' understanding of such significant areas of need. The need for further training to enhance the understanding of and response to exploitation concerns are recognised by managers.

46. The processes for stepping down to early help and up to children's social care when concerns about children are decreasing or increasing are not well understood or articulated. There is a lack of a clear, well-understood escalation

policy when agencies have different perspectives concerning the service children receive and there is not a shared understanding of thresholds. Workers report being unsure how to escalate concerns to statutory levels of intervention when risks increase. As a result, a small number of children at risk of harm are inappropriately held within early help, and arrangements to safeguard these children are insufficiently effective.

47. When referrals are made to children's social care, they are mostly responded to in a timely and proportionate way. Parental consent is sought to contact other agencies and share information appropriately. Advice and signposting are helpfully provided when families do not meet the threshold for children's social care. Professionals making referrals are not routinely informed of the outcome of their referrals. This is a gap in information-sharing, which means they do not have all the relevant information to work effectively with children and their families.

48. When risks increase for children, multi-agency strategy meetings are appropriately held in a timely way. Partners share information effectively, but actions arising are not given clear timescales for completion, and it is not clear how and when progress will be reviewed.

49. Most assessments are timely and thorough. The needs of children and their families are well considered, and the initial response team is skilled at completing some time-limited work to ensure that children and families get help as soon as possible.

50. When child protection enquiries are initiated, and assessments undertaken, there is often a reluctance to override parental consent when this is withdrawn by parents. This results in some children's needs remaining unassessed, which could lead to them suffering harm. This, combined with overoptimism concerning parents' capacity to change and failure to recognise disguised compliance, means some children are subject to repeat interventions without there being significant change in parenting capacity to reduce safeguarding concerns over time.

51. The response to children and families out of hours is effective. Workers respond to emergencies appropriately and ensure detailed and timely handover to daytime services the following working day.

52. When children are the subject of a child protection plan, visits to them and their families are mostly purposeful and well recorded. Parents are helped to understand concerns that professionals have about their children, and workers spend time with children to gain insight into their world. Children and families are well supported by additional work from the supporting families and edge of care teams. Their work is targeted and thoughtfully tailored to individual circumstances to reduce risk.

53. Reports completed by social workers for child protection conferences provide up-to-date, well-considered assessments which demonstrate professional curiosity and tenacity to explore key issues impacting on children. A specific participation worker ensures that when children do not attend in person, their views are represented in both initial and review conferences. Conferences capture concerns effectively and enable multi-agency information-sharing leading to well-focused actions to reduce risk.

54. Core groups are well attended by most partner agencies and progress is evident for most children. Clear, focused plans are in place for most children, but the lack of longer-term contingency planning results in delay for some children when their situation does not improve. In a minority of cases, particularly where there are concerns about neglect and long-term patterns of domestic abuse, there are delays in progressing plans when children have been the subject of previous periods of planning. This is exacerbated by gaps in specialist support for children and families, such as domestic abuse, substance misuse and adult mental health.

55. When risks have reduced, decisions to step down to a child with complex needs plan are appropriately made. Planning for children at this level of intervention remains purposeful, with continued engagement from partner agencies. For some children, the decision to step down is too early and there are some delays in the allocation to specific support services, meaning for some children they are not getting the right help at the right time.

56. The tracking of children during the pre-proceedings phase prior to issuing proceedings is weak. As a result, for some children there are delays in the making of timely permanence decisions relating to their future care, meaning they remain in harmful situations for too long. The use of parallel planning is absent, with very little use of family group conferences or viability assessments of potential carers within the extended family at an early stage.

57. Children aged 16 and 17 who present as homeless remain very vulnerable. The pathway for meeting the needs of these children is severely hampered by the absence of suitable accommodation options. Assessments are not routinely thorough or curious enough about the wider risks and needs they may be exposed to. Options such as coming into care are not routinely explained to them, and bed and breakfast accommodation is routinely the only option while assessments are undertaken, increasing the risk to these vulnerable children.

58. The response to children at risk of exploitation remains insufficiently robust. Services and systems are being developed, such as exploitation assessments, but interventions are not started soon enough. There is inconsistency in the quality and effectiveness of work in response to risks of exploitation, which means that the effectiveness of social work intervention is variable and for some children risks continue to escalate.

59. A lack of a restorative approach in the youth justice service reduces the effectiveness of work with young people who have offended. When children are the subject of both probation orders and other forms of planning, such as children with complex needs or child protection planning, there is a lack of integrated planning, and youth justice workers do not attend key meetings, resulting in key gaps in information-sharing. This means that workers do not have all the key information concerning children to help inform their interactions and planning with children.

60. Disabled children receive a very inconsistent service, and for many the service does not meet the needs of these very vulnerable children despite the best efforts of workers in the service. Visits to children are well recorded and contain a proportionate balance of parents' views, their needs as carers and of observations and interactions with children. Higher worker caseloads in the service impact on the timeliness of assessments and the frequency of visits and support that workers can offer. Progress through plans is hampered by limited service capacity, which hinders the ability of social workers to be proactive and ensure that children receive the right service at the right time.

61. Too often, the interventions and services that disabled children need are either not available or are restricted in availability, which means services have to be prioritised, resulting in delay for children in receiving support. This has a detrimental impact on too many disabled children, meaning their needs are not sufficiently met or only met when they have escalated to a point of crisis. There are a number of children who are not allocated a worker, exacerbating the deficiency in the service they receive. Planning for adulthood is considered early, with children's workers completing a 14-plus assessment. Staff shortages in adult services mean that joint working at 16 years of age is not consistently achieved, creating further drift and late decisions for children regarding future care arrangements being made, increasing the anxiety for families.

62. Private fostering is underdeveloped both within children's services and across the safeguarding partnership. The private fostering policy is not up to date and due to staff changes it is not evident that all staff would recognise and respond appropriately to presenting private fostering arrangements. Managers and the safeguarding board recognise the need for training across the partnership to increase staff's recognition and understanding of private fostering arrangements.

63. Managing allegations strategy meetings are effective in identifying adults in positions of trust who pose a risk to children, providing timely advice and decisions to ensure that children are safeguarded.

## The experiences and progress of children in care

64. Decisions regarding when children come into care are not made quickly enough for a small number of children, meaning that their circumstances do not improve in a timely way. Despite some children already having significant social

work intervention, decisions to identify them needing to be looked after take too long. They come into care because of a particular significant incident or event rather than in an assessed and planned way. While entry into care is necessary for these children to ensure that they are adequately safeguarded, the unplanned nature of this experience causes avoidable distress and reduces still further any choice of placement.

65. When children return home, they are supported with specific interventions tailored to their needs by the edge of care service.

66. Social workers develop positive relationships to gather the views of children in age-appropriate ways. Visits to children are undertaken consistent with need. Most are well recorded, though the voice of children is not consistently evident. Case records do not demonstrate the social worker's analysis of the visit or the planning of future actions to ensure effective planning for children.

67. Childrens care plans are regularly reviewed, with reviews well attended by partner agencies. In the main, appropriate actions to promote children's well-being are identified and actioned. Care plans identify the needs of children well. There is variability in the extent to which children are involved in the creation of their care plan.

68. Workers carefully consider the need for children to remain in meaningful contact with people who are important to them. Such arrangements are consistent with children's needs and actively promoted.

69. Children in foster care are positively encouraged to engage in enrichment activities and undertake a range of hobbies, sports and activities.

70. Independent reviewing officers (IROs) know their children well, visit them in placement and remain in contact with them between reviews. IROs and social workers report regular professional discussions concerning children. This is not always recorded on children's records, meaning that children accessing their records would not know the extent to which IROs were involved in their lives. While IROs are active, the extent to which they have been involved in challenging any delays in children's journeys towards permanence is not always evident.

71. Disabled children in care are well supported by social workers who have a detailed understanding of children's needs and methods of communication. Visits are reflective of need and written recordings indicate warmth and affection from workers who are clearly invested in these children.

72. The response to children who go missing from care is not effective. There is an insufficient focus on understanding why children go missing and a lack of action planning to reduce risk. Opportunities are missed to discuss with children where they have been, and with whom, to help evaluate any potential or actual harm

they may have been exposed to. While some exploitation assessments are being undertaken to help consider risk relating to criminal or sexual exploitation, these are not sufficiently embedded within social work practice.

73. Children in care are supported by a designated nurse who offers a flexible service, visiting them at home, prescribing necessary medications and coordinating health activity. Healthcare assessments consider well children's health needs and provide clarity to carers about actions they need to take to ensure that the health needs of children are promoted. There is a lack of specialist provision on the island for complex health needs, children with a learning disability and disabled children transitioning to adult services.

74. The wraparound service provides flexible, tailored therapeutic support to all children in care who need such provision. Sensitive, well-paced work helps children to make sense of the trauma they have experienced and helps those who care for them to better meet their needs.

75. The virtual school is well established on the island, and schools value its contribution. A lack of sufficient capacity, however, means that the school is not able to track or intervene effectively for those children not in full-time education or who are persistently absent from school.

76. Most children who are accessing the full-time curriculum make clear progress in educational attainment. Personal education plans (PEPs) are mostly up to date and have a focus on children's attainment and attendance. There is some variability in PEPs, particularly for those children who are not making the expected progress and in the identification of future plans to help them achieve. Future ambitions and choices for children are not consistently articulated into aspirational targets. While future careers are considered, planning for these important choices is not embedded sufficiently in PEPs or the work of the virtual school.

77. Children on part-time education timetables or who are suspended from school do not receive an adequate education. This makes them more vulnerable to risk in the community and severely hampers educational attainment, and as a consequence their future life chances. There is a significant gap to help provide them with alternative education provision and to help them reintegrate into mainstream provision.

78. Foster carer recruitment is significantly underdeveloped and has effectively been on hold since 2018. There are not enough foster carers on the island, which results in too many children being placed in residential care when their needs could be better met in a foster home. There has been a lack of drive to develop a fostering recruitment strategy and the pace has been very slow. The strategy is not sufficiently detailed to cover the range of activity needed to improve sufficiency. The planning lacks clear timescales, processes for keeping

progress under review and an accountability framework to enable senior leaders to monitor progress.

79. Many children move to semi-independence accommodation shortly after their 16th birthday. This is far too early for most children. It means that young people are having to take on the responsibility of looking after themselves and experiencing a reduction in support at the very point in their lives when they are beginning their maturity to adulthood – a time when they need most support.

80. Foster carers spoken to are broadly positive about the support they receive from their supervising social workers. Those involved in the Mockingbird project feel particularly well supported. Foster carer assessments are detailed and explore a potential carer's capacity to care for vulnerable children. Training is varied and well utilised.

81. Instability within the fostering service has resulted in delays in completing key activities, such as annual reviews. An agreed system of key performance indicators is not embedded, hampering managers' full understanding of the service.

82. The tracking of permanence plans for children is not robust. Permanence planning is not proactive, with often an absence of parallel or triple planning. A start-again approach is being instigated when the primary plan is not able to be implemented, resulting in delays for some children in achieving permanence. A focus on long-term matching for children with carers is not pursued early enough, which means for some children their long-term security is not assured soon enough.

83. When children are placed with connected carers, these arrangements are well supported through regular visits and additional support when needed.

84. Special guardianship orders are appropriately used, particularly when children are placed with extended family members. Appropriate support is in place through well-considered plans. However, timescales agreed in children's reviews are not always adhered to, resulting in some delays in permanence being achieved through this route.

85. Decisions to place children with their parents when they are the subject of an interim or full care order are thoroughly considered through comprehensive parenting assessments. Parents are well supported through a range of different interventions.

86. Life-history work for children in care is not pursued quickly enough. Even where it is identified as a need for the child, it often remains as planned work for the future. There is a lack of clarity as to when life-history work should commence. The need for life-history work to be ongoing through a child's life rather than an

event is not well recognised. There is some variability in the quality of life-history work, but some strong examples are evident, particularly for adopted children, with visual, colourful work written directly to the child in a way they will understand that explains their story and relationships.

87. Some children experience delays in achieving permanence through adoption. Changes in social worker, a lack of parallel planning and slow matching processes mean for too many children that the process takes too long before they are placed with their adoptive family. Adopters spoken to report mixed experiences of adoption support, with gaps and limits on support due to changes in staff.

88. The participation of children in care in evaluating service delivery and having their voice heard is not strong. The Voices in Participation group has only recently been re-established and is starting to develop training and awareness videos about becoming a child in care, but there is little evidence of the voice of children being heard and acted on strategically.

## The experiences and progress of care leavers

89. Provision for care leavers on the island is very weak, under-resourced and underdeveloped. Aftercare staff show tenacity and commitment to care leavers, but fundamental weaknesses in provision for care leavers mean most care leavers receive a poor service.

90. Pathway planning is completed by social workers, though there is significant variability in how well the young person's views and wishes for the future are recorded. The majority of plans lack aspiration, clear targets and expectations as to what needs to happen and by when in terms of meaningful preparation for independence. Pathway plans are not being consistently reviewed to ensure that there is up-to-date decisive planning when risks concerning care leavers escalate or their needs increase.

91. There is no formal service offer to care leavers beyond their 18th birthday. This means that some highly vulnerable young people are left without a named worker to support them. An offer to care leavers is being developed but is not operational and does not provide enough clarity to care leavers about their entitlements.

92. While personal advisers are committed to their young people, they are hampered in their roles by a lack of information-sharing and information systems, which means that it is hard for them to be sure that they have a holistic understanding of young people's circumstances and needs.

93. The absence of any assessment, planning or review post-18 means the service that care leavers receive is reactive and unfocused. Work with young people lacks clarity of purpose, without any way of measuring progress or outcomes on an individual or service basis. This is particularly pertinent when care leavers

have increased levels of need or find themselves living in situations of vulnerability or exploitation.

94. Care leavers spoken to on this visit were positive concerning their relationship with their workers. They value the drop-in facility in Douglas. While some care leavers access this provision, there are no systems to capture the views of young people to help build on and develop this facility or the wider service offer to care leavers.

95. While the children's looked after nurse remains involved for some young people post-18, there is no specific health provision or clarity as to how the emotional, sexual and physical health needs of young people are being promoted and met. Health histories are not available or provided to help young people make informed decisions as to their future health.

96. The severe lack of appropriate accommodation options to meet the various needs of young people as they move towards independence is the biggest barrier faced in supporting improved outcomes, and for too many is having a significantly detrimental impact. Assessments of accommodation need are limited due to the lack of choices available. Accommodation for care leavers is not based on an assessment of the level of need, but as one worker described the situation, 'it's an assessment based on there is nothing else'. The consequence of this is that some care leavers move into unsupported accommodation before they have the life skills necessary for such a move. As a result, for some care leavers tenancies break down, leading to periods of homelessness. The limitations of housing stock, supported or otherwise, mean that care leavers have very little choice as to where they live or when they can move in, whether they are ready to do so or not.

97. Care leavers have access to the additional guidance of a support into employment worker. The absence of up-to-date assessments and plans means that not all benefit from this support when they may need it. When care leavers are not in education, employment or training, there are no specific plans to help them engage in such activities and aspirations are not high. There is a distinct lack of employment opportunities, apprenticeships and other development opportunities created by the government as the largest employer on the island or through commissioning arrangements to enhance opportunities for care leavers.

98. Services for care leavers are delivered by a local charity commissioned by Manx Care and there is a distinct lack of robust oversight of the quality of service provided. There is no coherent system for obtaining relevant quantitative and qualitative data to ensure that the service is meeting the many needs of care leavers.

## The impact of leaders on social work practice with children and families

99. Despite evidence of some progress, this visit has identified a number of areas which require significant improvement. These include gaps in information-sharing, the understanding and use of parental consent, the paucity of accommodation options for care leavers, the timely completion of permanence for looked after children, the services available for disabled children and the response when exploitation concerns about children emerge. Managers have acknowledged that there is significant work to be undertaken to improve these key areas influencing outcomes for children and families, but deficiencies in resources in some areas continue to hamper progress

100. Senior leaders in Manx Care have a good understanding of their service and the areas of practice which need to improve, though the pace of improvement has been too slow and is not quick enough to ensure timely, effective responses to need and risk for children on the island. During the visit, leaders responded swiftly and appropriately to any issues identified relating to the well-being of children.

101. Managers have shown a desire to improve the quality of practice. The quality assurance framework has been revised, but does not enable a clear line of sight to the quality of services. Audits are not being completed in sufficient numbers to enable managers to identify themes and issues where practice improvements may be required. Feedback from children and families is not consistently obtained as part of the audit process to explore the effectiveness of social work practice. Audit actions are insufficiently focused, or time-bound, to give workers the necessary direction to improve children's well-being.

102. Strategic oversight of the quality of service provided through Manx Care by the Department of Health and Social Care (DHSC) is insufficiently robust. Issues relating to the availability and accuracy of data and quality assurance activity in a timely manner thwart this process. While there is oversight by the Manx Board, there is insufficient oversight or challenge by DHSC about the quality of services provided by Manx Care. This is significantly hindered not only by data availability and quality but by the lack of an effective performance and quality assurance system.

103. The children's safeguarding board is showing an increased understanding of multi-agency safeguarding practice across the island, with relationships between key partners improving to enable greater understanding of their respective roles. The board recognises that there is more still to do, including increasing the number of multi-agency audits of safeguarding practice and the implementation of the quality assurance and scrutiny framework. Different interpretations of legislation and practice guidance among agencies is a serious impediment to effective information-sharing, meaning not all agencies receive all information necessary to protect children in a timely way. As a consequence,

workers across agencies have described a culture of being 'scared to share' information.

104. The lack of any strategic assessment of need means there is no effective sufficiency strategy, which is severely impinging on the availability of placements for looked after children, and other specialist support services, to meet the needs of children and young people. Placements for many children are determined on the basis of availability rather than need. The impact of this is particularly acute in the paucity of provision for care leavers, with some care leavers having to leave supported accommodation when they are clearly not ready to become independent. Equally, 16- and 17-year-old homeless children being accommodated in bed and breakfast accommodation, or indeed remaining homeless, leaves them increasingly vulnerable to harm and exploitation.

105. Performance management arrangements within Manx Care are helping managers to increase their focus on outcomes for children, but these positive efforts are being hampered by the lack of information systems to give accurate, specific data. These systems and oversight of a number of key areas of practice have not been sufficiently robust. Senior managers are taking credible action to review and improve these deficits.

106. There is a recognition of the need to improve outcomes for children in care and care leavers. There is a corporate parenting board in place which is determined in its efforts, but this does not yet show sufficient impact in improving the lives of children looked after. There are gaps in the range and quality of data, particularly qualitative data the board receives in order to understand the experience of children effectively. There is insufficient challenge from the board to delivery services and there is insufficient engagement with children, young people, foster carers and provider services. The lack of legislation around corporate parenting responsibilities contributes to the lack of power and influence the board has in driving practice among agencies and in improving outcomes for looked after children and care leavers.

107. While there is provision of core training, there has been no training needs analysis of the workforce to help the commissioning of appropriately targeted training, and no capacity to measure the impact of training on practice over time.

108. Language used by professionals both within children's services and across agencies about exploited children can on occasion be expressed in victim-blaming terms. While awareness is increasing among staff and professionals, more needs to be done to improve practice.

109. While there is no overarching workforce development strategy, a range of creative approaches have been applied to strengthening and stabilising the qualified social work staff group. For example, opportunities are in place for

unqualified staff in the supporting families team to be supported in gaining qualification. The work of the wraparound service in supporting vulnerable children and families is providing a strong and much-valued service to children and families.

110. Workforce development is hampered by the absence of strategic capacity, through, for example, a principal social worker post and social work academy, which is leading to a more ad hoc approach to filling vacancies on a reactive basis, rather than having a long-term proactive strategic plan. This would have the potential to reduce agency costs and increase the permanent workforce over time, with children benefiting from stronger relationships with a consistent social worker. This is particularly pertinent given that some children in care have experienced numerous changes of worker inhibiting their capacity to form trusting relationships with workers.

111. Most workers are positive about working on the Isle of Man. Managers are identified as being supportive and available, although more challenge in improving practice and outcomes is needed. Caseloads are at a sufficient level to enable workers to undertake meaningful work with children individually and their families. The quality and frequency of management oversight and supervision are very variable. While inspectors have seen some positive examples, in many cases there has been insufficient focus on the analysis of children's current circumstances and actions workers need to take. Supervision has not been sufficient to prevent drift for a small number of children, including some children who are subject to the pre-proceedings phase of the Public Law Outline or ensuring permanence for some children in care.

112. Leaders are slow to identify and act on innovative and good practice employed in other jurisdictions and this could be used to improve social work practice on the island.

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