Determining the Optimum Supply of Children's Residential Care

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CONTENTS

EXECUTIVE SUMMARY

INTRODUCTION

Deloitte MCS Limited (Deloitte) was commissioned by the Department for Children, Schools and Families (the Department) to undertake a fact finding review into children's residential care services in England. In accordance with the brief, the scope of this project was to undertake primary and desk based research to gain insight into the children's residential care market and to provide insight into the optimal level of provision of places in registered children's residential care homes in England.

The intention of the review is to provide a clearer picture of supply and demand issues affecting the residential care market both at present and into the future. Outputs of the review include this report, highlighting insights gained through consultation, and an economic model which estimates the supply of residential care units needed in England.

The purpose of the review is to inform the Department and local authority policy making and provide insight and tools to support the planning and commissioning process. Through a series of interviews, the Department wished to understand the key factors underlying how the available supply and demand differ. Factors that were shown to affect supply and demand include the need for capacity to handle emergency placements and placement breakdowns, to provide choice and a range of provision to meet individual needs, and to place children within geographic proximity to their homes when possible.

KEY FINDINGS

Setting the context

Across England, approximately 6,600 children and young people are in residential care, requiring varying levels of emotional, psychological and physical support to achieve good outcomes. They are cared for in a variety of homes including 'mainstream' general provision, specialist homes for children with complex needs and intensive support units, which are run by local authorities, independent providers and the voluntary sector.

Insights gained through consultation

The key issue for local authorities appears to be how to deliver efficient and effective market management in an environment that must:

- Provide choice of placements;

- Respond to a largely demand led need (often within a fluid and rapidly changing environment); and

- Deliver good outcomes, which may conflict in the short-term with managing the market efficiently (e.g. balancing degree of specialisation of homes with the need to retain children within a 20 mile radius).

Interviews provided insights into the realities of delivery and the practices that need to work better on the ground in order to optimise the supply of residential care. The following issues were highlighted:

- Negative perceptions of residential care have contributed to a preference for other types of care for looked after children, sometimes at the expense of long-term positive outcomes for children who would benefit from residential care.

- Joint working is a prerequisite for effective holistic care provision but the extent to which joint working happens varies widely across the country.

- Effective commissioning and contracting of care services are at the heart of achieving an optimised supply of care. However, commissioning is generally not well developed in the social care market.

- Needs analysis, planning and forecasting within and among local authorities are critical for shaping the market to meet children's needs. Again, however, the extent to which this happens is limited.

- Value for money includes a focus on quality as well as price consciousness; the current funding of care can lead commissioners to make short-term decisions that can be counter-productive to improved long-term outcomes.

- Attracting, recruiting and retaining high quality people to work in residential care is critical but the negative perception of residential care can make this difficult to achieve.

The extent to which children's needs are currently being met varies. In our interviews, for example, placement fit, proximity to home and placement stability were most often cited as being problematic to achieve.

Findings from the model

The model is presented with the intention of stimulating debate around the needed supply of residential care. It is envisioned as one tool within a larger toolkit, to be used alongside in-depth needs analysis and as part of a planning and commissioning process.

The model demonstrates that there is an excess supply of registered placements nationally, validates that local authorities are more likely to be able to meet needs and reduce costs if they consider placements over a wider area, and illustrates the trade-off between distance, needs and cost. However, it does not make a judgement as to how this trade-off should be managed.

A key finding of the model is that fewer beds are required if placements are allocated over a wider area. For example, based on the model:

- Allocation within a local authority area for the approximately 6,600 children in residential care would require a total supply of just over 10,000 beds across England, whereas placement at a sub-regional level would reduce the total beds needed to under 10,000, regional level placements would require just over 8,500 beds, and placements across England would require approximately 7,200 beds in total;

- An average of 1.51 beds per child is required if allocation is within a local authority; this falls to 1.47 beds at a sub-regional level, 1.29 beds if allocation is regional and 1.09 beds per child if placements take place across England.

Modelling by its nature requires a simplification of reality. There are limitations to the model, both in terms of its inputs and its outputs. Limitations to building the model include minimal data on market segmentation, the duration of specific types of placements and children's needs in residential care. Furthermore, some factors in the residential care market could not be modelled, such as the impact of outcome-based commissioning, the increasing difficulty of placing children as their needs become more severe and complex, immature commissioning practices, and financial pressures that influence placement choice. These limitations should be considered along with the model findings.

POLICY BACKGROUND

There are currently significantly more CSCI registered places available than children placed in these homes. However, this seeming oversupply masks a more complicated market in respect of ensuring, in line with government policy, that there are good quality placement choices for children and that local authorities fulfil their duty to meet children's assessed needs as they arise.

The Green Paper *Care Matters* states that *"it is vital that every child be given a choice of placements which meets their needs, creates a good learning environment and offers value for money."* This, along with imperatives described in the *Every Child Matters* White Paper to provide placements that truly meet the needs of children in care, has influenced the move towards outcome-based commissioning. Local authorities aim to provide a high standard of care and meet children's needs with respect to stability, demographics, environment, geographic location and other factors. However, these policy imperatives exist in tension with pressures to increase governmental efficiency, particularly championed in the *Gershon report*.

METHODOLOGY

Our methodology for understanding the key issues facing the residential care market included desk based research as well as interviews with a cohort of 10 local authorities, 20 care providers and 6 representative groups. The cohort was selected to provide a wide and diverse range of perspectives and totalled over 150 professionals working across the spectrum of residential care commissioning and provision. A questionnaire was used to gather qualitative and quantitative information about the residential care market and was followed up with semi-structured interviews to draw out key issues and on the ground experience in the field.

In parallel to desk based research and consultation, we built a model to calculate the number of beds required to meet the demand for residential care. This is then compared to the actual level of supply in the market. The model uses a combination of results from two methodologies: a deterministic model based on queuing theory and a Monte Carlo model based on stochastic techniques. Ultimately the model indicates how the number of available beds compares with the requests for new beds and indicates how this relationship varies in the different local authorities, sub-regions and regions of England.

CONCLUSIONS

This study has brought to the fore a number of steps that may be taken to both move towards optimising the children's residential care market and develop the model for wider applicability.

Next steps in optimising the market

- Facilitating structures and cultures that promote joint working;

- Promoting more effective commissioning, contracting and market management;

- Embedding strategic level needs analysis and long-term planning; and

- Promoting value for money with a focus on quality.

Next steps in developing the model

- Segmenting the market for clarity of purpose;

- Collecting data that enables greater depth of analysis of residential care; and

- Coming to clear conclusions on how to balance the tensions introduced by different government policies, particularly that between children's choice and governmental efficiency.

1 INTRODUCTION

Deloitte has been commissioned by the Department to undertake a fact finding review into children's residential care services in England. In accordance with our brief, Deloitte has undertaken consultations with key stakeholders from the public sector i.e. local authorities, as well as with care providers who are involved in the delivery of residential services. In addition we have interviewed representative groups who advocate children's and other stakeholders' perspectives on care.

The intention of the review is to provide a clearer picture of the supply and demand issues affecting the residential care market both at present and into the future. This will help the Department and local authorities optimise the match between children's needs and placement options, creating policy to reshape supply that will meet demand across the country.

This report presents the findings of our study. In addition we have produced an economic model which has been developed to estimate the needed supply of residential care units in England. The model's outputs should be considered in light of the model's limitations and the further factors affecting supply in the care market that are discussed in this report.

1.1 BACKGROUND

In 2005/6 there were an average of 6,600 children in residential care at any given time of a total of 60,300 looked after children. Whilst the trend has been to place children in foster care wherever possible, residential care remains an option for many children who become looked after. A more detailed overview of residential care is provided in Section 2.

There are currently significantly more places registered by the Commission for Social Care Inspection (CSCI) than children placed in these homes. However, this masks a complicated issue: the market must have the necessary spare capacity to ensure that there are good quality placement choices for children. Dr Roger Morgan OBE, The Children's Rights Director, expressed the views of over 200 children in the publication *Children's View on Standards: a Children's Views Report*, issued in September 2006. Their collective view was that there needs to be *"a sufficient range of places available for there to be a choice of which one suits us best, make sure there is a choice of at least two alternative placements each time, keep checking with us that the placement is working out, and have a back-up placement ready for us."*

This view has been endorsed by the Green Paper *Care Matters: Transforming the Lives of Children and Young People in Care* which states that *"it is vital that every child be given a choice of placements which meet their needs, creates a good learning environment and offers value for money."*

Similarly, *Every Child Matters* feeds into the imperative to provide placements that truly meet the needs of children in care and influence the move towards outcome-based commissioning within local authorities.

It is, however, recognised that there are financial implications associated with retaining choice in the market and the Green Paper, *Care Matters*, stresses that it is equally important to understand the extent to which we can *"increase placement choice without increasing the financial burden on the system."*

Pressures such as the requirements coming from the *Gershon report* into efficiency in local authorities are also requiring local authorities to make efficiency savings and to use their

commissioning function more effectively and innovatively to maximise potential savings and ensure value for money.

The apparent excess of supply in this market also fails to address the issue of suitability, which must be understood in order to assess the numbers of appropriate placements in the market. A recent children's inspection report has highlighted the following issue: *"The shortage of suitable local placements for looked after children can have a profound effect on their development and life chances. Children may 'drift' whilst waiting to be placed with long-term carers. They may be placed in other parts of the country where they lose touch with their own community and cultural identity. Councils find it harder to support them appropriately."*

The Green Paper alludes to this issue when it talks about the need to increase efficiency in the supply of residential care while simultaneously providing a high standard of care, meeting children's needs with respect to stability, demographics, environment, geographic location and other factors. However, the extent to which children's needs are currently met varies. In our interviews, suitable placement environment, location and stability were the needs cited most often as being difficult to meet.

The key issue for local authority commissioners therefore appears to be how to deliver effective market management in an environment that appears sub-optimal for delivering efficiency due to the need to:

- Provide choice of placements;

- Respond to a largely demand led need (often within a fluid and rapidly changing environment); and

- Deliver good outcomes which are often counter-productive in the short-term to managing the market efficiently (e.g. balancing degree of specialisation of homes with the need to retain children within a 20 mile radius).

1.2   SCOPE AND OBJECTIVES

In accordance with the brief, the scope of this project was to undertake primary and desk based research to estimate the optimal level of provision of places in registered children's residential care homes in England and to gain insight into the children's residential care market.

The purpose of the review is to inform the Department's policy making, including better understanding of the impact on the residential care market of proposals contained in the *Care Matters* Green Paper.

In particular outputs of the review include:

- Estimates of the number of beds required in the market per child, including key factors that cause this estimate to vary significantly, taking account of relevant proposals set out in *Care Matters*;

- An explanation of the key factors on which this estimate is based, such as policy, geography, child's age and demographics; and

- A broad estimate of the number of beds necessary at a regional level and implications for the current supply of residential care places.

In addition, through a series of interviews, we have sought to understand the key factors that drive how the quantity supplied and demanded differ. Some of these factors include the need for capacity to handle emergency placements and placement breakdowns, to provide choice

and a range of provision to meet individual needs, and to place children within geographic proximity to their homes when possible.

1.3 METHODOLOGY

1.3.1 RESEARCH METHODOLOGY

In addition to desk based research, our methodology for understanding the key issues facing the residential care market included consultation with a cohort of local authorities, care providers and representative groups. These were selected based on the following criteria:

- Local authorities – a sample of 10 local authorities was identified based upon geographic location, type of authority, number of looked after children, number of children with disabilities, degree of placement stability, proportion of children placed out of authority, number of children looked after from other authorities, level of deprivation and spend on children;

- Care providers – 20 care providers were included in the study. They were selected to ensure we had a mix of ownership (local authority, independent and voluntary sector), locality, size and type of care provided; and

- Representative groups – 6 groups were included in the study, selected to give insight into children's views and independent views on residential care.

A questionnaire was used to gather qualitative and quantitative information about the residential care market based upon a range of questions which tackled key operational issues. Semi-structured interviews were also conducted to draw out key issues and provide an opportunity to discuss them in depth. In the case of local authorities, on-site interviews or sets of interviews were arranged with key stakeholders within each local authority. In the case of care providers and representative organisations, interviews were carried out over the telephone with senior members of staff.

We were able to draw on Deloitte's extensive expertise and experience in market evaluation to support commercial due diligence to help shape our thinking and analysis.

1.3.2 MODELLING METHODOLOGY

In parallel to the desk based research and the interview process we built a model to calculate the number of beds required at each geographic level to meet the demand for residential care. This was then compared to the actual supply in the market.

Modelling assumptions were discussed with the Department and were tested and refined throughout the research process on the basis of stakeholder interviews. Data used in the model was sourced from the Office of National Statistics (ONS) and Commission for Social Care Inspection (CSCI).

The model uses a combination of results from two methodologies:

- Queuing theory, which indicates the number of beds that need to be kept as a buffer to accommodate the uncertain pattern of requests for placements (Deterministic model); and

- Stochastic techniques, which allow us to test numerically the impact of the uncertainty on the level of demand (Monte Carlo model).

Ultimately the model indicates how the number of available beds compares with the requests for new beds and indicates how this relationship varies in the different local authorities, sub-regions and regions within England.

It is important to appreciate that, while we have attempted to differentiate the types of homes by dividing both placements and beds into a number of segments, we understand that in order to maximise the welfare of children in residential care it is fundamental not only to have the correct number of beds, but also to ensure that residential homes have the right characteristics to meet the different needs of the children. The limitations of applying the model in practice are discussed in depth along with its outputs in Section 4.

1.4   REPORT STRUCTURE

The remainder of this report covers the following issues:

Section 2 – Overview of residential care: describing the current residential care market;

Section 3 – Optimising the residential care market: covering the key factors affecting supply and demand in the market;

Section 4 – Modelling the required supply: presenting the economic model; and

Section 5 – Conclusions: identifying next steps for consideration by the Department.

2 OVERVIEW OF RESIDENTIAL CARE

Section 2 provides an overview of residential care, looking specifically at the children and young people in care and the types of provision available.

The profile of children in residential care:

- Approximately 6,600 children are in residential care in England (around 11 percent of all looked after children), most of whom are over 13 years old;

- There is significant variation in the number of children in care by region (ranging from 1,600 in London to 330 in the North East), but between 8 and 14 percent of looked after children are in residential placements across all regions;

- Around one third of local authorities have a large number of children in residential care (51+ children), while over 20 authorities have few children in residential placements (10 or fewer); and

- There are significant variations in the levels of emotional, psychological and physical needs of the children and young people entering the residential care system.

The profile of provision of residential care:

- The residential care market is a mixed economy, with 53 percent of children's beds provided by the independent sector, a third by local authorities, 11 percent by the voluntary sector and a small minority by the NHS and others;

- There are a number of different types of home ranging from 'mainstream' general provision to specialist homes catering for complex specific needs and intensive support units;

- In 2005/06 most homes had six beds or more, although the size of homes is declining and there is a preference among providers for 3-6 bed homes, with 1-2 bed homes for intensive support units; and

- Gaps in provision were identified including intensive support units for children with complex needs (particularly autistic spectrum disorders), support with therapeutic inputs for children with mental health needs, long-term and respite care for children with disability, and supported accommodation or transitory residential care.

Overall, the profile of needs of children in residential care is becoming increasingly complex. This complexity of need is mirrored to some extent by the complexity of services that providers now offer. Whilst this is useful in helping to deliver better outcomes for children it adds to the problems of shaping and managing this market. This section explores the current users and providers in the market.

2.1 PROFILE OF CHILDREN IN RESIDENTIAL CARE

2.1.1 NUMBER AND AGE OF CHILDREN IN RESIDENTIAL CARE

Overall in 2005/6 there were about 6,600 children in residential care in England. This represents approximately 11 percent of all looked after children in England.

Residential care is aimed at children aged 10-18. Placing children younger than 10 in residential homes happens only in exceptional circumstances. In the main, children in residential care are over 13 years old[1]. For younger children, foster care is preferred and every effort is made to secure this as a first option. During the interviews it was noted that the average age of children in residential care has continued to rise. This trend is linked to the attitude towards residential care as a 'last resort'; the reluctance of authorities to place children in residential care until all other options have been exhausted and a presumption that, in general, children will achieve better outcomes in a home environment, such as foster care.

The figure below summarises the profile of children in residential care by age.

Figure 2.1 The proportion of children in residential care by age
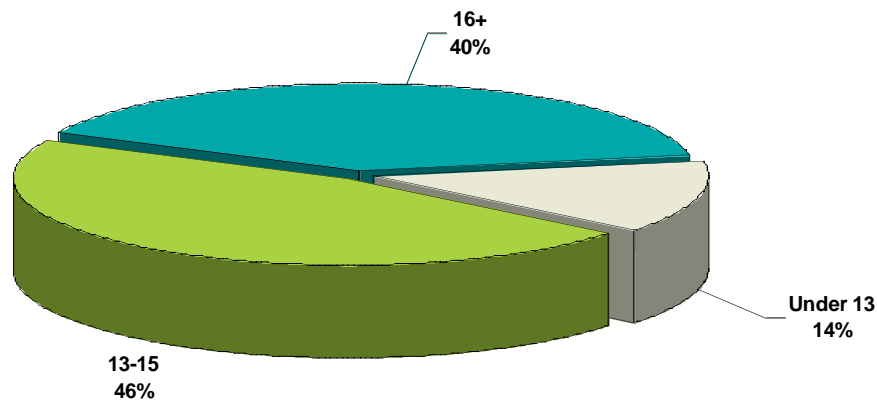
Source: DfES, 2006

2.1.2   LOCATION OF CHILDREN IN RESIDENTIAL CARE

Figure 2.2 below shows the number of children in residential care by region. There appears to be significant variation in the number of children in care by region. London and the North West place 24 percent and 17 percent respectively of the total number of children in residential care, whilst five regions place 10 percent or less of the total number of children in residential care.

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[1] The majority of care providers interviewed stated that children in care were between 13 and 16 years old. National DfES data also shows that 46 percent of children in residential care are 13-15 years old. However, 14 percent are under 13 and one care provider interview offered respite care to look after children as young as 5 years of age.

Figure 2.2 Number of children in residential care by region of origin
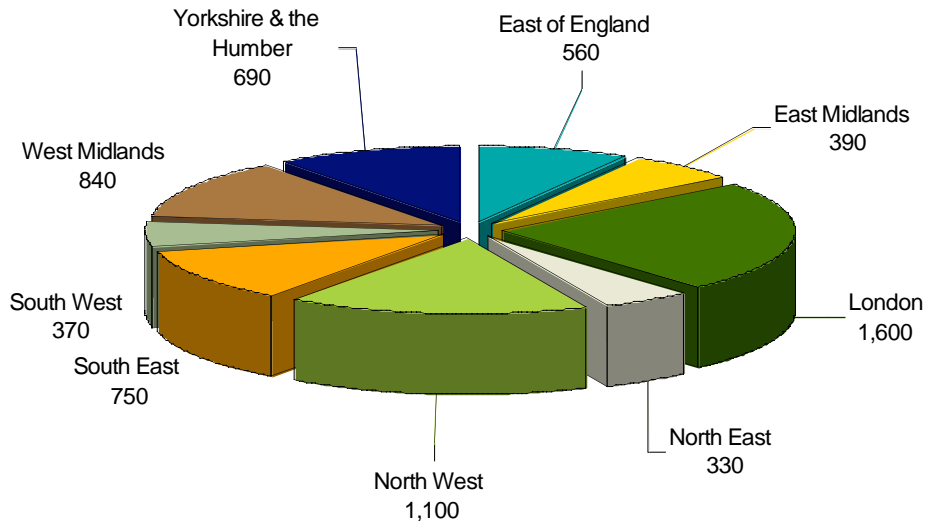
Source: DfES, 2006

Figure 2.3 below considers the relationship between the numbers of looked after children, children in residential care and population by region. The regions with proportionately higher numbers of looked after children also have more children in residential care. The South West is a slight exception to this trend having fewer children in residential care than would be expected – the region ranks 7th for the number of looked after children per 10,000 population but ranks lowest (9th) for the number of children in residential care.

Figure 2.3 Numbers of looked after children and children in care by region

	Number of children in residential care per 10,000 of population in the region	Number of looked after children per 10,000 of population in the region
London	2.23	16.53
North West	1.60	14.86
West Midlands	1.58	13.11
Yorkshire and the Humber	1.37	12.97
North East	1.27	12.67
East	1.04	10.71
South East	0.94	9.45
East Midlands	0.94	9.02
South West	0.75	9.92

Source: DfES, 2006

The numbers of looked after children and children in residential care differ greatly by region. However, when considered as a proportion of the total number of looked after children, there is less variation (only 6 percent) in the numbers of children in residential care, as shown below.

Figure 2.4 Children in residential care per region as a percentage of looked after children in the region
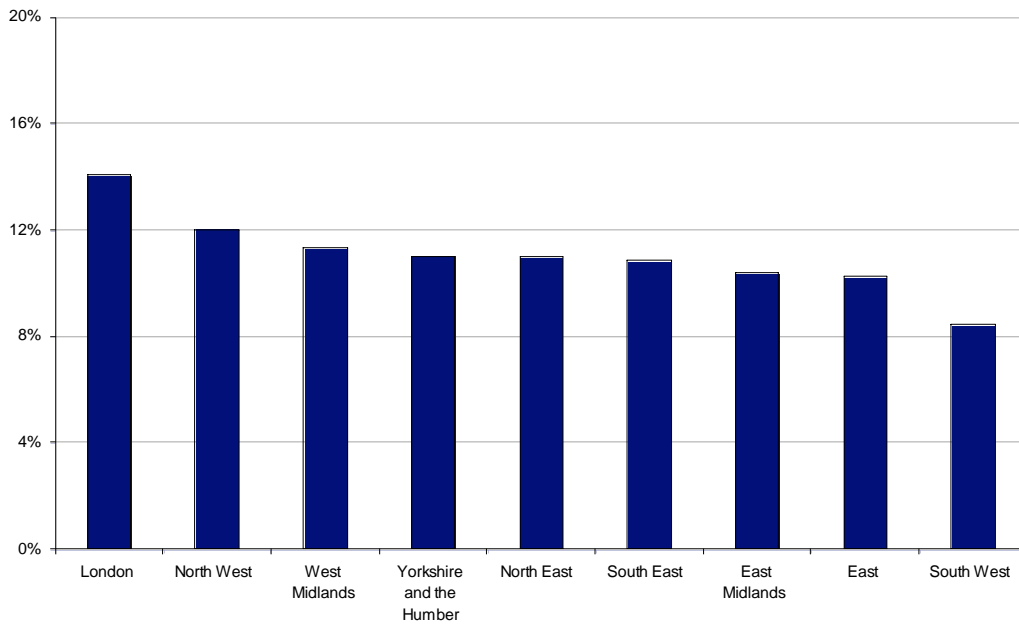
Source: DfES, 2006

Whilst London has the highest proportion of looked after children in residential care (14 percent) and the South West has the lowest (around 8 percent), the majority of regions have 10-12 percent of looked after children in residential care. Therefore, it is clear that the understanding and management of the market is an issue applicable to all regions.

At a local authority level the number of children in residential care varies widely due to the differing size and characteristics of local authority areas. For example, Manchester and Birmingham each have more than 200 children in residential care, yet more than twenty authorities have fewer than 10 children in residential care.

Figure 2.5 Number of children in residential care by local authority

Number of children in residential care in a local authority	Number of local authorities	Proportion of local authorities	Proportion of children in residential care
Under 10	22	15%	3%
11 to 30	46	31%	16%
31 to 50	37	25%	23%
51 to 100	31	21%	31%
Over 100	13	9%	27%

Source: DfES, 2006

Figure 2.5 shows that around 30 percent of local authorities have 51 or more children in residential care, which accounts for 58 percent of all children in residential care in England. By contrast, around half of local authorities (46 percent) have fewer than 31 children in residential care, accounting for only 20 percent of all children in care. However, more than 85 percent of local authorities have more than 10 children in residential care, which again suggests that understanding and managing the market is highly important.

2.1.3 VARIATION IN NEEDS

The consultations highlighted the lack of consistent categorisations to identify the needs of children coming into the care system. Whilst it is recognised that each child and their needs are individual, it is important to have a clear understanding of the types of needs that exist in order to help shape the market to meet those needs. Local authorities interviewed for this review do assess need at the level of the individual child but many do not yet use that data systematically to help determine the needed supply in their areas.

The national picture of need is of limited use in helping to understand the demand issues in this market. Currently the ONS categorises children based on the reason for which they entered care, as shown in Figure 2.6 below.

Figure 2.6: Number of children by category of need
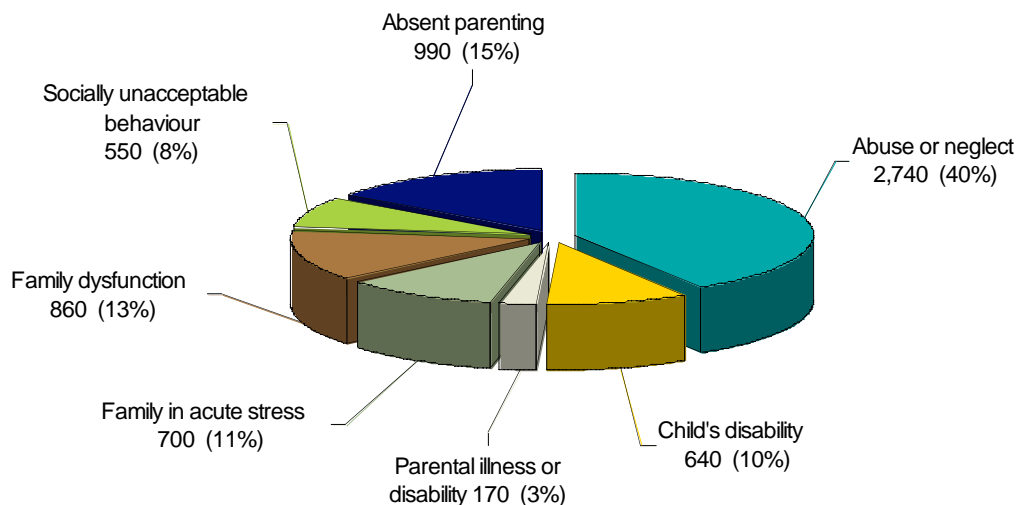
Source: DfES, 2006

Discussions with local authorities, care providers and representative organisations during this study highlighted wide variations in the levels of emotional, psychological and physical needs of the young people entering the residential care system. The spectrum of changing needs of children while they are in care also appeared to be significant but this data is not systematically collected. Interviewees highlighted that residential care must provide for children and young people who have:

- Relatively straightforward, simple needs requiring short-term residential care, perhaps due to a crisis in their family;

- Deep-rooted, complex or chronic needs and a requirement for specialist care and services. They may have suffered from abuse, neglect or multiple episodes of substitute care;

- Extensive, complex and enduring needs compounded by very difficult behaviour. Such children require more specialised and intensive resources;

- Physical and/or learning disabilities requiring specialised, intensive resources and possibly additional medical services; and

- Requirements for secure accommodation either for welfare reasons or because they have been sentenced by the Youth Justice Board.

Care providers interviewed during this study expressed the view that children entering the care system have increasingly complex and severe needs. Reasons given for this trend included:

- The tendency to place children in residential care later and only when all other options have been expended;

- Medical advances which have enabled more children to survive past birth and enter the care system than were able to in the past;

- Increased diagnosis rates of impairments such as autistic spectrum disorder; and

- An increase in the number of children and young people entering the residential care system with drug and alcohol problems.

The result of this trend is that intervention from health partners is increasingly required as part of a care package, as more and more children have challenging behaviours, mental health needs and other disabilities. Furthermore, specialist provision is increasingly in demand at a time when local authorities are trying to keep children close to home when they are placed in care. The changing profile of children in residential care is, therefore, causing significant issues within the areas of supply and demand. For example:

- *Should the market be supplying* specialist units equipped to cater for the particular needs of certain children from a wider geographic area or more general provision catering for children within a more local area?

- *Should local authorities be demanding* specialist care over and above local care?

The issue for local authorities is the extent to which they as individual authorities can meet these needs efficiently and effectively or whether a joint or regional approach will deliver better more efficient outcomes. The role of joint and regional commissioning in managing the market is discussed in Section 4.

2.2   PROFILE OF PROVISION OF RESIDENTIAL CARE

2.2.1   PROVIDERS OF RESIDENTIAL CARE

The residential care market is a mixed economy. In England, 53 percent of children's beds are provided by the independent sector, about a third by local authorities, 11 percent by the voluntary sector and a small minority by the NHS and others as shown below:

Figure 2.7 Proportion of beds by type of provider
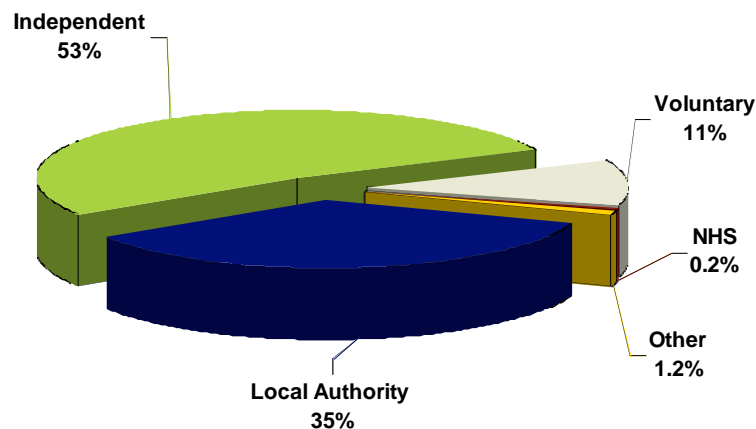
Source: CSCI, 2006

On average, independent homes have just under five places compared to almost 6.5 places in local authority services and over 10 places in voluntary sector-owned services (CSCI).

However, this mix of provision is not static nationally; the provider market for residential care varies significantly by local authority. Lewisham, for example, outsources all of its residential care placements to independent providers, while Leeds and Durham place most of their looked after children in local authority-managed beds.

Whilst a mixed economy remains, there has been significant investment in the residential care market by venture capitalists, which has triggered consolidation within the market. Although independent and voluntary sector providers do vary in size, increasingly the market consists of larger companies and groups of providers who manage a number of care homes.

2.2.2 TYPE OF PROVISION

There are a number of different types of home ranging from 'mainstream' general provision to specialist homes catering for complex, specific needs and intensive support units.

- **Homes intended for 'mainstream' children** include many sub-categories but in general they are homes for children between 10 and 15 years of age; provide care and support to children with relatively straightforward needs and in some cases provide further emotional and psychological support and treatment. Our interviews indicated that many local authority providers are moving towards flexible 'mainstream' provision within which they can manage cohorts of children (i.e. clustering 10-13 year olds in one home and 14-15 year olds in another) with similar needs and minimise the number of empty beds.

  An increasing focus for many children's homes is on children with diagnosed behavioural problems or disabilities. This is evidenced by CSCI data which shows an additional 307 services registered in 2006 to deal with these groups of needs. Of these new services, 61 percent are registered to take children with emotional and behavioural difficulties compared to just over 51 percent of homes that were active at the start and end of the year.

- **Residential units providing high levels of treatment** require access to a range of specialised support services such as psychiatric and psychological advice, special educational support, employment, counselling or other therapeutic input for individual children, and high levels of supervision and consultancy for the residential staff. Independent care providers appear to be increasingly offering such services directly and/or building relationships with other service providers who can supplement their offering.

- **High support units** offer the most specialised residential care and treatment to young people with severe, complex needs. These units often contain one or two beds and allow tailored individual support and treatment.

There are two types of **provision for children with disabilities**, long-term care and respite care:

- **Long-term care** for children with disabilities differs from other care homes in that children frequently remain in a stable placement situation as they mature, rather than moving among homes based on their age.

- **Respite care** for children with disabilities provides support to the parent-carer and involves flexible stays ranging from day care to weekly care through to care lasting several weeks. These units may provide medical support, education and training, as well as support for young people as they are preparing to transition to adult services.

Secure units are also a specific type of provision:

- **Secure units** may be contracted by the Youth Justice Board for young people who are sentenced or may provide intensive support in a controlled environment for welfare reasons such as suicidal tendencies, serious self-harming behaviours and eating disorders. Secure units are highly regulated and monitored.

2.2.3   SIZE OF UNITS

Figure 2.8 below shows that in 2005/6 most homes across all sectors had six beds or more. However, larger homes are more common in the voluntary sector and less common in the independent sector.

Figure 2.8 Number of beds by provider
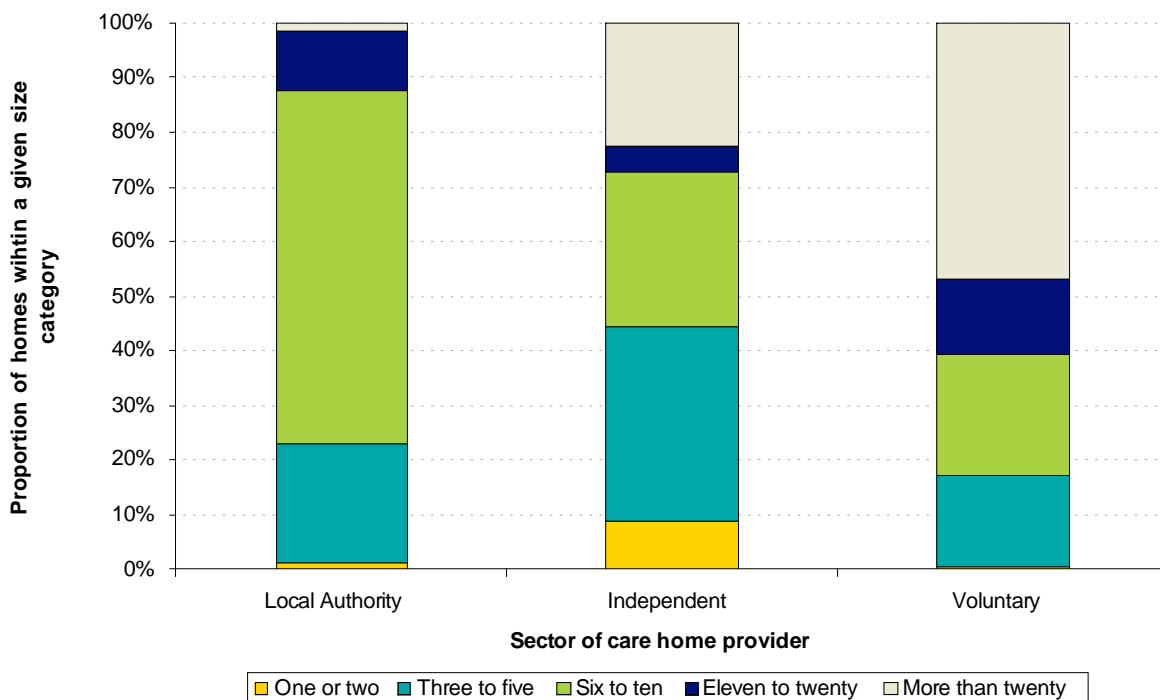
Source: CSCI, 2006

The data shows that 45 percent of homes owned by independent providers have fewer than 6 beds compared to 23 percent of local authority and 18 percent of voluntary run homes. The majority (65 percent) of local authority run homes have 6-10 beds. More than twenty beds is most common in the voluntary sector, with 47 percent of their homes in this category. Some of these homes have created separate units with fewer beds per unit.

Interviews conducted as part of this study suggest that a common trend across providers and types of residential care is a move towards smaller units. All providers interviewed suggested a preference for homes smaller than six beds. Both independent care providers and local authorities commonly suggested a 3-6 bed preference. Many highlighted their move towards smaller

"As the degree of complexity of needs increases, having children in placements with more beds means that we are just containing them. In that case there is no point talking about outcomes at all."

Service Manager Placements & Procurement and Business Support at a local authority

units and the increased need for solo and dual units for children with specific needs.

A charitable organisation within the sample highlighted that they are currently closing their 6-8 bed homes because they are 'too institutional' and are focusing now on 4 bed homes.

The benefits of smaller units are seen to include:

- An environment that more closely mirrors a 'traditional' family setting;
- Children developing a greater sense of belonging;
- Higher staff to child ratios; and
- A decreased likelihood of children feeling isolated or being bullied.

Some interviewees from both local authorities and care providers, however, highlighted the benefits of larger group settings, which include:

- The ability to be more 'anonymous', which some young people prefer;
- The home's ability to tailor activities to specific groups, including planned evenings and weeks targeted to specific cohorts of children for respite care; and
- The increased ability to create cohorts and target learning to children and young people's needs in on-site educational provision.

Overall, however, the market is moving towards smaller units, a trend which is felt to deliver better outcomes for children but which can be counter-productive to delivering efficiencies.

2.2.4 GAPS IN PROVISION

Our interviews highlighted shortages in the provision of specific types of residential care as follows:

- Intensive support units for children with complex needs, particularly autistic spectrum disorders;
- Support with therapeutic inputs for children with mental health needs;
- Long-term and respite care for children with disability; and
- Semi-independent and transitory residential care.

Intensive support units for children with severe, complex needs

Interviews highlighted placement difficulties for children with severe, complex needs, particularly when combined with challenging behaviours that make it difficult for them to be placed in homes with other children.

This was particularly noted in relation to children with autistic spectrum disorders combined with disability. Given that the number of children with autism going into care appears to be increasing, this shortage can be expected to grow unless suitable provision is increased.

Support with therapeutic inputs for children with mental health needs

The increasing complexity of needs and children with challenging behaviours has meant that an increasing number of children and young people in care would benefit from input to address their mental health needs. This support is technically available to all children and young people with need for it through the Children and Adolescent Mental Health Service (CAMHS) though shortages in provision and barriers to accessing it mean that many children go without this input. The issue of accessing CAMHS support is discussed further in Section 4.

Long-term and respite care for children with disability

CSCI data suggests that whereas 53 percent of the homes in England and Wales are registered to take children with emotional and behavioural difficulties only 29 percent are registered to take children with learning difficulties and 12 percent children with physical disabilities.

A number of interviewees highlighted a shortage of long-term care for children with disability and nearly all described shortages of respite care. The number of disabled children is increasing along with medical advances.

> **"There is a lack of respite provision for children with disabilities in all areas of this country."**
>
> A care provider

Children with disabilities need diverse combinations of support which may include any or all of the following: staff trained to deal with severely challenging behaviours, intensive medical support, a physically accessible layout and learning support.

The shortage of suitable long-term beds has a knock-on effect on respite placements, some of which are being used as de facto long-term placements rather than respite beds, with negative consequences for the child affected as well as the other children there for respite care.

During our interviews, local authorities commented that this can be a serious issue. The lack of support can lead to families placing a child in care, which appropriate respite care might have prevented.

Semi-independent and transitory residential care

DfES data shows that approximately 40 percent of young people in residential care are currently over 16 years of age.

There is a disparity between foster care – in which young people may stay until the age of 21, and residential care – from which young people must leave at 18. Allowing young people to stay in residential care until age 21 is being considered at the policy level, though local authorities noted that such a policy could not come into effect without a significant increase in both resources and the type of provision available.

Despite the legal provision of residential care to age 18, our consultations brought out the frequent practice of transitioning young people out of residential care homes at 16 into transitional accommodation that offers less support. This transition can be very difficult, particularly for those who:

> **"Young people in residential care are neediest but they are the ones most pushed to independence earliest. There's a gap."**
>
> A local authority

• have been in placements far from home and now have to return to an unfamiliar place;

• suffer from a lack of continuity (e.g. autistic young people with learning disabilities); or

• have disabilities but upon turning 18 will not be eligible for adult services and support.

The aim should be for a seamless transition from children's to adult services or on to independence. Yet, transitional services were mentioned as a 'significant issue' by almost all authorities interviewed because of the serious shortage of suitable provision and, in some cases, funding to place children in available provision. Interviews brought out the fact that provision of support and accommodation varies widely, ranging from unsupported B&B provision in the worst cases to a broad range of provision moving to independence in the best cases.

Interviewees suggested that the following steps could be taken to improve the situation for young people in residential care:

- starting to plan for the transition at age 14;

- introducing adult social workers when the young person is 16 so that they can gradually become responsible for case management; and

- increasing the provision of supported lodgings to 16 and 17 year olds to aid the transition.

In awareness of this gap, a number of independent care providers and local authorities are developing services specifically targeted for young people 16-17 years old, as demonstrated by the two case studies below.

Case Study: Horizon Care Offering Post-16 Residential Care to Aid Transition

The Managing Director described young people leaving care for hostel or B&B accommodation as *"setting the child up to fail."* In response to this, the provider opened a facility for young people aged 16+ which offers them accommodation, usually for one year, to aid their transition out of care. The accommodation provides the young people with support and guidance but also freedom. This provision costs approximately half that of residential care, but because it is substantially more expensive then other housing provided by the authority, budgetary constraints have been a barrier to its wider use.

Case Study: Lewisham's Leaving Care Support

Lewisham's leaving care group is recognised for the high quality of service it provides. The leaving care group looks after young people from 16 years of age as well as young adults from 18-21. They conduct a needs assessment and then create a pathway plan for the young person through to 21 years of age, based on their needs, capabilities and risk profile. Lewisham provides key worker support, accommodation, careers advice through Connexions, money advice, evening groups, homework groups and CAMHS support. They place their young people in semi-independent accommodation in residential homes or in semi-independent placements, with varying degrees of support depending on the young person's needs. Lewisham is currently planning a tender for care provision of semi-independent placements.

3   OPTIMISING THE RESIDENTIAL CARE MARKET

Section 3 describes issues for consideration in optimising the residential care market, highlighting emerging themes from our consultations, including the following:

- **Negative perceptions of residential care** have contributed to a preference for other types of care for looked after children. This has reduced the quantity required but has also potentially suppressed demand. Residential care, if seen as a positive option, could potentially be used to achieve specific goals and outcomes for specific periods of time.

- **Joint working** at the local level focuses primarily on providing children with access to the range of services needed for good outcomes. Effective joint working that would facilitate access to services such as healthcare, education and therapeutic support would allow a smaller supply of mainstream beds to provide more optimal service. It will also serve as a springboard to more effective joint commissioning.

- **Effective commissioning** of care services is critical to managing the quantity and type of bed required and is at the heart of achieving an optimised supply of care that is based on proactive rather than reactive management.

- **Needs analysis** involves looking beyond the level of individual needs to analysing needs at the strategic level, examining the child population to identify needs in advance, and examining trends as a way of understanding future needs. This is a critical input to effectively manage of supply and demand in residential care, shaping the market such that services commissioned in the present and created for the future will meet children's needs. Poor needs analysis increases the likelihood of placement breakdowns, which means that a greater quantity of beds is required.

- **Planning and forecasting of demand** enables local authorities to commission the appropriate quantity and type of residential care provision. Planning must incorporate existing and forecast needs as well as allow adequate provision for emergency placements and placement changes either before or as a result of placement breakdown. Improved planning in the areas of information management, preventative services and emergency placements could potentially deliver better outcomes.

- **Improving contracting** through developing the use of longer term and block contracts, which provides opportunities for risk sharing and joint planning, as well as provision of a specific number of beds that are fit for purpose.

- **Value for money** is a driver to reduce demand, with the high cost of residential care impacting the type of provision that is made available and how it is sourced. Care providers expressed concern that decision making is often focused on price rather than value. This price focus is a driver of market consolidation, influencing available supply.

- **Capacity to deliver quality** is an issue because of recognised shortages in trained and qualified staff. The difficulty in attracting, recruiting and retaining talent in the market has reduced overall supply and is linked with the poor perception of residential care.

- **Market management** is integral to effective commissioning, shaping the market such that there are incentives for suppliers to provide the services that are required. Effective management will enable the supply to be reduced without a negative impact on outcomes, insofar as children still have access to the right beds for their needs.

Care Matters' emphasis on placement choice and outcomes suggests maintaining spare capacity to tailor placements to individual children. *Every Child Matters* emphasised the importance of 'placing the child at the centre'. The *Gershon report* focuses on maximising efficiency and suggests eliminating excess capacity. Optimising the supply of residential care therefore requires striking the appropriate balance between the various national policies, which drive supply and demand in the market.

Achieving this balance naturally produces some tensions, both within and amongst sectors of the residential care home market.

During the study local authorities, care providers and representative organisations were interviewed. A number of issues and concerns were raised concerning both quality and quantity of residential care. Some of these were commonly held whilst others represent the point of view of the particular organisation interviewed. They are presented either as issues that need to be addressed for residential care to function more effectively or as best practice that could be more widely adopted to the benefit of the market, including, among others:

- Facilitating structures and cultures that promote joint working;
- Promoting more effective commissioning, contracting and market management;
- Embedding strategic level needs analysis and long-term planning; and
- Promoting value for money with a focus on quality.

In examining the residential care market, many key findings from the interviews related to stages of the Department's planning and commissioning framework. Though this report does not follow the structure rigidly, effectively managing the stages outlined in the joint planning and commissioning process are key enablers in optimising the supply of residential care.

Figure 3.1 Joint planning and commissioning framework

Source: Department for Children, Schools and Families

We have therefore incorporated some elements of the cycle into our analysis along with other issues that emerged from our research.

3.1 PERCEPTIONS OF RESIDENTIAL CARE

The perception of residential care has a serious impact on the level of demand for residential care placements and the supply of beds. This study has found that the largely negative perception of residential care[2] has resulted in the service often being used only as a 'last resort'. The consequences of this may include:

- Artificially suppressed demand: if residential care were seen in a more positive light, demand for placements may increase;

- Reduced supply: care providers may close residential homes that are badly perceived and capacity is reduced as the sector finds it more difficult to recruit and retain a talented workforce; and

- Fewer residential care placements are planned as part of a positive intervention but are instead emergency placements or a last resort option when all else fails. This would make planning the supply and demand of this sector particularly difficult.

> **"There is a sense that residential care is second class and therefore a last resort. It really is a Cinderella service."**
>
> A representative organisation for children in care

3.1.1 THE LADDER OF CARE

Discussions during this study highlighted that children typically progress to residential care along a ladder which begins with family support and then steps up to foster care before residential care is considered.

Figure 3.2 The typical ladder of care
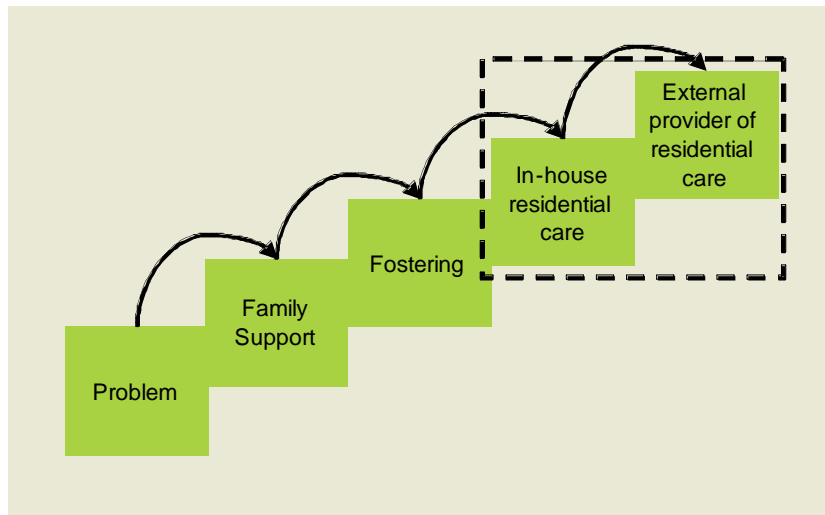
Source: Deloitte analysis, 2007

Care providers suggested and social workers confirmed that numerous foster placements would be tried before considering a residential care placement. This substantiates the widely held belief among interviewees that residential care is the 'last resort'. With few exceptions, only those children that have been unsuccessful in a number of foster placements, or else cannot

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[2] Residential care catering for children with extensive, complex and enduring needs such as severe physical disability is seen in a slightly more positive way.

obtain a foster placement, enter into a care home. The negative perception of residential care therefore can be a largely self-fulfilling prophecy:

> **"The reality is that whatever type of child is placed in residential care they are often placed at an age and stage that is something of a 'last chance saloon'; as such, many inevitably become part of a self-fulfilling prophecy."** A representative organisation

Examples were also provided of residential care not being used at the right time such as:

> **"An eight year old child who was traumatised because of abuse was sent into foster care on the assumption that this was the solution because he was still young. But then only a few years later, the same child becomes more difficult to deal with, partly because he's physically bigger and has adolescent issues to deal with. I believe that if that eight year old child had gone into a more therapeutic environment for a year, he would have had the opportunity to deal with the issues and equip himself with a toolkit to help sustain a foster placement later on in life."** A care provider

It appears that to optimise the market, perceptions need to reflect the realities of residential care so that it is given the right place in the care system and can become a planned part of a positive intervention when appropriate.

3.1.2   RESIDENTIAL CARE AS A POSTIVE INTERVENTION

In light of this study, the ladder of care has been re-drawn below to illustrate an alternative position for residential care within the care system.

Figure 3.3 An impression of a more optimal ladder of care
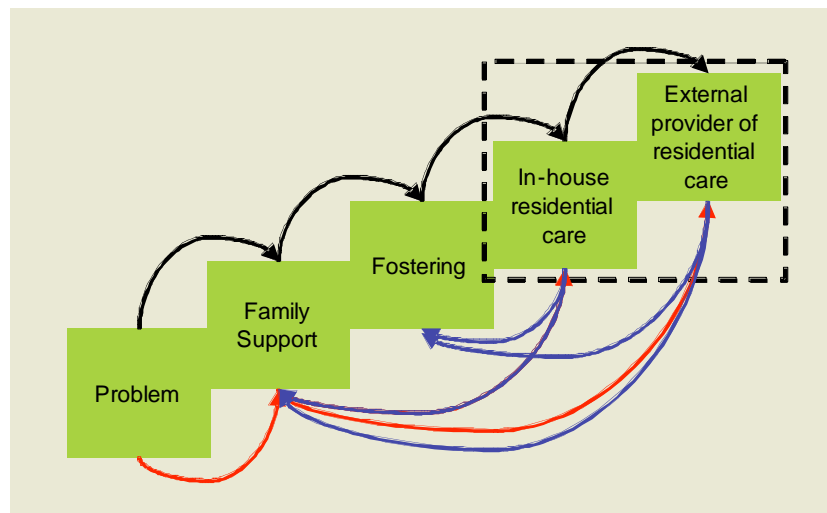
Source: Deloitte analysis, 2007

In this model residential care is no longer automatically the 'last resort' but an alternative solution viewed positively for the outcomes it can achieve in the right circumstances.

It is also considered as a time limited intervention into which children may enter and leave at any stage of care. Consequently, the ladder is no longer one way – children and young people

may step down the ladder of care and miss steps out where non-adjacent provision on the ladder better suits them.

In some areas this model already exists but it appears from this study that this is not yet commonplace and as a result appears to be a barrier to ensuring an effective and efficient residential care market.

This has been recognised by some care providers who are now offering different steps of the ladder under one umbrella organisation. The view of many of the larger care providers was that there should be a 'continuum' of care available to children and young people. Six care providers interviewed as part of this study offer fostering and residential care and some offer all stages of care from an intensive solo placement right through to fostering.

> **"There should be a continuum of care available to children."**
>
> Director of a large independent care provider

The key benefits identified include:

- The ability to keep some aspects of a child's life stable when they change placements, such as familiar staff continuing to provide support and assistance during the transition, or maintaining a continuity of education and training if the child attends a school run by the same care provider.

- The ability to minimise feelings of failure. "*In some cases, if fostering doesn't work out then the young person can return to the residential setting, minimising the feelings of failure as we are not rejecting them, just recognising that it may be too soon for them to move on*" (Referrals Manager of an independent care provider).

- Achieving a system which allows a child to move up and down the ladder of care as needs dictate. In this way, looked after children can find out what works for them within as stable and continuous an environment as possible.

There is some evidence of local authorities moving to holistic strategies for their care services, so that there is more flexibility for children's needs to be met through whichever care option is most appropriate for them at each stage of development. This enables the child to move between fostering, residential care, preventative and support services as and when needed.

If perceptions changed and residential care were seen as a positive intervention it would be likely to affect demand and supply. Impacts may include:

- A greater number of beds of a particular type required (for example, as perceptions change certain types of need may be recognised as benefiting from residential care such as children who require intensive therapeutic services over a short term);

- A greater supply of beds supplied to meet those specific needs; and

- More planned placements in residential care thus making it easier to plan and manage supply and demand in the market.

3.2   JOINT WORKING TO DELIVER POSITIVE OUTCOMES

The focus on outcomes means that children require more than simply access to a bed. They also often need access to additional wraparound services such as healthcare and education. This complexity of delivery within the residential care market means that delivering services to meet those needs efficiently will require joint working. There also needs to be an understanding of what contributes to improved outcomes, so as commissioners, local authorities can then

support the market to respond appropriately. Failure to do this is likely to result in the market failing to provide an optimal level of placements.

A mixed economy requires joint working between authorities and care providers.

Most authorities interviewed operate in a mixed economy, offering some provision themselves as well as placing some looked after children with independent providers. Few of the local authorities consulted have the internal capacity to provide intensive support for children with complex needs or disabilities.

> **"'Joined up' working is not working. There is a silo mentality – even in our own department."**
>
> Social worker,
> local authority

With few exceptions, authorities expressed the view that their homes offered better value for money with better outcomes for children. However, there were mixed views around whether statutory provision or independent provision could provide better access to wraparound services and therefore, better outcomes for children.

Manchester study findings that statutory provision provides better access to multi-agency services	**A social worker's experience of independent providers offering better wraparound services**
Three years ago, a Manchester study concluded that children in the independent sector have poorer outcomes than those in local authority placements. They attributed this to children receiving greater multi-agency support in quantity and quality in local authority homes.	*"When we use our own residential services we have problems accessing tag-on services – psychology, education – whereas private providers offer these as a matter of course."*

This mentality does, however, risk predisposing people to one type of provider without encouraging them to think about what is needed to ensure a consistent service across all providers. The risk is that the market becomes artificially segmented by a perceived ability to deliver outcomes. This perception can lead to oversupply in the market because of a perception that there is not a 'suitable' placement available outside the local authority. This is often because there is not:

- A clear understanding of what outcomes are required and how they will be measured;

- An understanding of what contributes to the delivery of improved outcomes; or

- An awareness of what the role of a commissioner is in encouraging the market to develop appropriately.

3.3 EFFECTIVE COMMISSIONING

Effective commissioning is a critical enabler for authorities to use resources efficiently, manage the market effectively and achieve positive outcomes for looked after children. It would appear that poor commissioning is one cause of a sub-optimal residential care market, in which there are more beds than looked after children but a perception (or reality) that there is a lack of suitable beds. Furthermore, the model indicated that allocating beds over a wider geographic area reduced the number of beds required. In the majority of local authorities there appeared to be an acceptance that delivering efficient services for complex needs required new ways of working such as regional or joint commissioning.

3.3.1   JOINT COMMISSIONING

The most effective joint commissioning described in the interviews has happened as a result of the amalgamation of education and social care, which most local authorities report has facilitated closer joint working and some joint commissioning. Good examples of joined up working were noted around specialist educational placements for special education needs as well as placements for children with disabilities.

> **"We have worked with other authorities to arrange social worker visits and CAMHS support when our children are there."**
>
> Director of Social Care, Local Authority

Joint working as a platform for joint commissioning.

Joint working between local authorities should facilitate joint commissioning. This would facilitate shared funding, planning and monitoring, which would result in a more efficient, fit for purpose market and produce better outcomes for children. Several local authorities mentioned reciprocal agreements with other authorities in providing services to their children in residential care in the areas of social worker visits, CAMHS support and provision of education.

Authorities are developing Children's Trust arrangements.

The development of Children's Trust arrangements is generally not very advanced, though a number of local authorities interviewed have established them. Authorities recognise that commissioning through a Children's Trust should make multi-agency services easier to deliver, but there is some confusion around how such arrangements can be implemented. One local authority noted that although its Children's Trust does not yet have absolute decision making power, it is serving a useful function by bringing people together and facilitating a more partnership-orientated approach to accessing and providing services.

Several local authorities report that they are operating Multi-Agency Looked After Partnerships (MALAP) to facilitate joint commissioning, which they anticipate will evolve into Children's Trust arrangements.

Pooled budgets are beginning to emerge within local authorities.

A number of local authorities reported moving towards integrated budgets (mostly through Children's Trusts) which will mean that children with multiple needs can receive funding from more than one source. Pooled budgets make joint working an imperative and ensure that children's needs are considered more holistically. This is less likely when funding comes from a single source (i.e. social care) but a child would benefit from a variety of services (i.e. CAMHS support, healthcare, education).

3.3.2   REGIONAL COMMISSIONING

> **"I am not opposed to being part of a lobby and using volumes to manage the market better, but there are many practical barriers to this."**
>
> Director of Social Care, Local Authority

A number of local authorities interviewed participate in regional commissioning initiatives, though they are generally either in the strategy development or early implementation stages rather than a well developed aspect of an authority's commissioning strategy.

Advocates consider regional commissioning as a way of better meeting the needs of looked after children by promoting longer term strategic planning and increased purchasing power. The model also suggested that allocating beds at a regional level can reduce the number of beds required. However, some local

authorities have found the regional commissioning agenda difficult to engage with, and report competing priorities at the local and regional levels as barriers to engaging. In some cases, for example, local authorities reported that rigidly following the regional format occasionally prevents them from being able to negotiate more beneficial deals at a local level. Furthermore, it was noted during the interviews that introducing such a new system can be extremely labour and time intensive.

Regional co-operation is seen as a way of commissioning specialised services more efficiently.

Regional commissioning could lead to a sharing of resources across local authority boundaries. A number of authorities have concluded that regional commissioning is a good strategy for specific services where demand is low and the degree of specialisation is high. Coventry, within the West Midlands Commissioning Partnerships, is considering regional commissioning of placements for children with severe physical disabilities or life limiting conditions, as well as other complex or specialist needs, as a way of gaining traction in the market. Leeds is considering ways of providing those types of placements internally, as described below.

For more generic services where demand is higher, the preferred approach may continue to be commissioning at the local authority level, which allows those children to be placed closer to home. Moreover, there are exceptions to the general trend of specialised provision being more suited to regional commissioning, in which local provision may be more desirable. This is demonstrated by the example of West Sussex below.

West Sussex example	Leeds example
West Sussex designed an innovative solution for a teenager with severe autistic spectrum disorder. His level of need means that he requires intensive solo support, which the authority could not provide itself. They provide a council property which is managed by a voluntary organisation, creating a tailored environment for the young person's needs. This option would quite naturally be reserved for another West Sussex young person once it becomes available.	Leeds is considering banding together with neighbouring local authorities, such that each would create and manage a distinct type of specialist provision on behalf of the group. This would then provide enough demand to justify distinct statutory provision for specialised needs such as a care home for teenage girls, a home tailored for children with severe autistic spectrum disorders, and a home designed for children with physical disability.

Geographic considerations may mean that commissioning across whole regions is not desirable in some locations. In some instances, sub-regions are seen as a better option.

Geography and population density impact on the viability of regional commissioning, as many authorities are increasing their efforts to place children within 20 miles of their homes. A fundamental problem with working within a designated region is that local authorities are not necessarily at the centre of their region. For an authority on a regional border, placements in their neighbouring region may be much nearer and more accessible than placements at the opposite side of their region.

Regional commissioning in areas with dense populations and many providers may allow numerous authorities to commission together and still place their children near home. For other, more remote authorities, regional commissioning could mean sending their looked after children to placements at greater distances than they see as beneficial. Cornwall, for example, is not interested in commissioning across the South West region, which includes 19 local

authorities up to Swindon – they view this area as too large for residential care placements for Cornwall children. Instead, they are working to develop commissioning at the sub-regional level, including the peninsular authorities of Devon, Cornwall, Plymouth and Torbay.

3.3.3   NATIONAL CARE FRAMEWORK AND CONTRACT

Local authorities and providers broadly welcome guidance in the area of commissioning, though some concerns were raised in terms of its scope and implementation.

The national framework on residential care is seen as an opportunity to remove some of the existing barriers to effective market management and commissioning of residential care provision for looked after children. However, there are concerns around information sharing and implications for child protection.

> **"Any approach must be supported by a good flow of information and a commitment to tackle problems as they emerge. There are often cogent and rational plans for a new approach, but they must be supported by robust practices to handle situations when things do not go according to plan – which inevitably happens when you put a new system into place."**
>
> Director of Social Care, local authority

In general, local authorities expressed positive opinions about the potential for a national framework to add value to their commissioning process but also expressed concern that if guidance is too rigid it may not be compatible with progress already made at a local level. Authorities are split between looking for a strong framework with clarity and direction that they can follow, and a flexible framework they can use as guidance and can adapt to their own needs. In general, they emphasised that it should be published in the form of guidance rather than being compulsory, because of concerns that generic terms and conditions could inhibit their ability to react locally and in their children's best interest.

Care providers particularly welcome the idea of a national framework as a way of bringing some level of consistency to the residential care market. They see it as a way of creating minimum national standards, which could be particularly beneficial in areas where the commissioning function is less well developed. However, they too see that a degree of local involvement is necessary to meet a child's needs and help them achieve good outcomes. One representative organisation recommended aspiring towards meeting the 'best available standards' rather than attaining minimum requirements.

> **"Sometimes central regulations knock against what's possible here and get in the way of doing what's best for the child."**
>
> Commissioner, local authority

Some local authorities with more mature commissioning models, and particularly those with their own accreditation systems or framework contracts, are concerned that the national framework will clash with what has already been developed. They do not want to be forced to work to a national standard that is below what they have already achieved.

3.4   NEEDS ANALYSIS

Individual level needs analysis is improving, however, there is a significant gap in the knowledge of local authorities independently and collectively in respect of needs analysis. This is effectively the foundation on which to plan future services and without this information it is

difficult to move from being reactive to being proactive. The result is a sub-optimal residential care market due to poor planning and a lack of strategic overview. This study unearthed key recommendations for improved individual and strategic level needs analysis by local authorities to address this problem.

By improving needs analysis at the individual and strategic level, there would be:

- A greater understanding of how and why children come into care. This would reduce uncertainty and the number of beds required (thus reducing cost) and authorities would also be able to put staff, systems and structures in place to focus on preventative services thus reducing the number of children entering residential care and reducing the number of beds required further.

- Greater encouragement to move children up and down the ladder of care. This would enable children and young people to receive varying degrees of support as their needs change and facilitate outcomes that will allow many of them to move off the ladder and back to a family environment or on to independent living.

- A reduced number of placement breakdowns. Insufficient needs analysis may lead to sub-optimal placements and a greater likelihood of placement breakdown. More breakdowns increase uncertainty in the market and increase the number of beds required in residential care.

3.4.1   INDIVIDUAL LEVEL NEEDS ANALYSIS

Individual needs analysis should be integrated.

All areas influencing the desired five outcomes should be considered at an individual level including health, safety, education, economic wellbeing and ability to make a positive contribution.

"There is concern that children get labelled and people 'see the label and miss the child' when making placement decisions."

Representative group

Needs analysis for disabled children has particular room for improvement.

Particular concerns relating to individual needs analysis were raised by representative groups who felt that disabled children receive a particularly poor service. In their view, the needs of a disabled child are not fully considered and there is a tendency to label them with a disability and place them in a home (or increasingly a residential school) which caters for that disability.

Though the disability may remain constant, children's physical, intellectual and emotional needs change over time, which should be considered in their care plan and provision.

Case Study: Leeds' Disabled Child's Integrated Needs Assessment

Leeds has developed a Disabled Child's Integrated Needs Assessment and Parent-Carer Assessment – documents that are used and accepted by all of the agencies involved in the child's assessment, placement and care. The child's needs assessment contains holistic information about the child, such as preferred communication method, abilities and impairments, family composition and cultural issues, personal care skills and supervision needs. The parent-carer assessment captures information about the carer's mental and physical state, emotional well being and existing support system to help care for the child. This holistic view of the child and carer helps Leeds to determine the level and type of provision that will meet the

child's needs and support the carer.

Individual level needs analysis is not always just about the child in care.

Particularly in the case of children with disability, the provision of appropriate support depends on understanding the needs of not just the child, but of the child's parent-carer and family. This should start as soon as the child is diagnosed with a disability.

Case Study: Support for Families of Children with Disability

"Often disabled children are in care because of their parents' inability to cope. Often when a disabled child is born, the parents experience feelings of loss and depression. Add on to this the extra stress of caring for a disabled child. This may cause marital stress and contribute to these parents being single carers. There may also be increased pressure if the children are not in school and the parents cannot access respite support until the child is 8. If you can help the parents at the beginning, they have less stress and they are better able to cope later on, which means better outcomes for children…. Our family placement respite service does not technically count as residential care, but without that service we would have many more children in care."

Disabled Children's Services Manager, local authority

Social workers need to be better informed about what is available to meet needs.

For all looked after children, the placing authority should ensure that they are aware of the child needs and what is possible to provide. This is particularly relevant in relation to children with disabilities. The same needs analysis and resulting decisions should be made for disabled children as would be for other children. One representative organisation gave an example of a 7 year old boy who was placed into residential care because he was disabled - "*This wouldn't have happened to a non-disabled child at that age.*"

Local authorities should be fully aware of children's needs and commission the best care possible in the context of financial realities.

Concerns have been raised that funding constraints may prevent children's needs being fully met through their placements. Poor placement decisions which are funding led and/or based on insufficient individual level needs analysis lead to more placement breakdowns. Within the model, increased placement breakdowns would increase the number of beds required.

3.4.2   STRATEGIC LEVEL NEEDS ANALYSIS

At present, there is little needs analysis above the level of the individual.

The nature of residential care for children means that there is no 'one-size-fits-all'. Each child has individual needs. However, it is possible to analyse different groupings – for example, cohorts, age groups, children within a local authority area or region, or nationally. It is also possible to examine young children, birth rates, medical trends and illnesses to forecast future demand. Analysing data at this level would enable longer-term commissioning and contracting to function.

Example of focus on the level of individual needs.	Example of ability to analyse above the level of the individual.
"Children's needs are all very different now; they are more difficult and more complex; there's no one-size fits all." A care provider	"We need a co-ordinated, coherent model. What are children's needs along the age continuum? How many children do we have now and what are their needs? What types of needs can we anticipate in the future based on the profile of our young population?" Commissioner, local authority

Some local authorities are beginning to form a longer term strategic view. This can be seen through examples such as Durham's successful preventative strategy and move towards a Children's Trust, and Birmingham's strong outcome-based commissioning framework. Yet, a number of local authorities spoke of cohorts but few systematically plan for the needs of a specific group of children.

However, strategic level needs analysis is required if local authorities are to be proactive.

It is necessary to have an understanding of the needs and thresholds in advance so that when seeking a placement local authorities are proactive rather than reactive. If local authorities consider trends and demographics they can take a more strategic approach to purchasing services and commission over a larger area. This would have the effect of reducing the number of beds required in the market because it would reduce uncertainty of demand and, if commissioning over a larger area, would increase the number of providers and the probability of obtaining the right placement. As one commissioner noted, "*Needs are currently considered at the individual level, there is no systematic approach.*" Robust needs analysis that would allow local authorities to forecast demand and plan accordingly are practically nonexistent, though a couple of local authorities have taken steps in this direction.

Rigorous needs analysis at the strategic level enables the development of long-term strategic planning and is a critical part of the process of providing care to looked after children. However, practice is neither developed nor systematic. This is an area of concern to local authorities and one they are beginning to focus on increasingly as they develop their commissioning function.

Strategic level needs analysis can be done most effectively by utilising regional networks and information collected by partners, but the current level of analysis is almost exclusively done by single organisations. Supporting better needs analysis at the local and regional levels will drive economies of scale.

If care providers understand the requirements of local authorities they are able to provide a better service. During interviews, care providers expressed a desire to be involved with local authorities in conducting strategic level needs analysis and planning as part of a partnership approach to care provision. As front line service workers, they have a valuable perspective on what needs children have and how they can be met. In most cases they are integrally involved in needs assessment and planning at the individual level. Care providers would like local authorities to take a medium and long (5-10 years) view in light of demographics in the area.

Case Study: Durham's Process of Conducting Needs Analysis

In Durham, needs analysis is undertaken as a continuous process, with all teams sharing information to ensure the whole picture is seen. Statistics are collated quarterly and presented to the Corporate Parenting Panel. Residential care and fostering needs analysis are undertaken in parallel, so information is continuously collated and shared.

Such high level analysis should also incorporate children's views.

At the strategic level, children's views on what they need and want in care have been collected through bodies such as the Children's Rights Directorate. Policy encourages children's choice in placements and involvement in developing their care plans. Some local authorities have incorporated children's views into strategic decision making about provider selection, such as Coventry, where children were represented on the procurement panel to award a long-term block contract to a care provider.

The need for strategic level analysis is widely recognised and local authorities are taking steps.

There is a clear awareness that understanding children's needs now and being able to forecast needs is critical to effective commissioning. This is an area many local authorities are focusing on. As one commissioner said, "*Our vision is to plan based on the needs and then commission services, rather than being an organisation that plans its service and then delivers.*"

Case Study: Birmingham's Process of Conducting Needs Analysis

Birmingham conducts needs analysis in partnership with its agencies on an ongoing basis. Prior to developing their strategy for residential childcare, they conducted a needs analysis and a trend analysis of the residential children's population based on data from the last three years and compared their placement usage with other local authorities in their comparator group. They found that the population in children's homes is not necessarily increasing but that young people within the provision are growing up and staying with the homes for longer periods of time. Based on their analysis of children's needs and their capacity, they intend to increase statutory provision, providing additional types and ranges of care targeted to specific groups within their residential care population and expanding their provision of three, four and six bed homes.

Because needs analysis and planning is generally underdeveloped, most authorities have not yet considered the implications of regional commissioning forums to inform their needs analysis.

There are also moves to forecast needs based on developmental stages and cohorts.

There are recognised critical developmental stages that all children go through. Many of these stages involve rapid physical, mental and emotional development and are accompanied by predictable needs as children mature. One commissioner noted that there are "*critical cognitive and physical development processes at ages 4-6, 11-13, and 16-18. These are critical developmental times in every child's life, regardless of their extra needs. We need an organic model recognising that every child will have certain needs at these transitional ages.*" One care manager noted the absence of this when he said, "*In an ideal world, we would look at our children in care and say, 'this group will be in care for the next five years, let's create a service that will meet their needs', but it doesn't work that way.*"

3.5 PLANNING

The critical next step after identifying needs is to plan appropriate services to meet those needs. Authorities are moving towards longer term planning as they gain experience with commissioning and contracting, placing increased focus on forward planning as well as responding to immediate needs. In order to optimise supply in an environment of scarce resources and an emphasis on delivering improved outcomes, it is important to examine where resources can be focused to deliver long-term gains.

Three areas were identified during this study as holding the potential to deliver better outcomes through improved planning:

- Information management;

- Preventative services; and

- Emergency placements.

3.5.1 INFORMATION MANAGEMENT

Collecting and using data effectively can provide critical input to the planning process.

Many authorities do not have either a system or a process of data collection that is able to provide insightful and timely information. However, Lewisham has focused resources on data management and has yielded positive results.

Case Study: Lewisham's Use of IT to Support Planning

Lewisham has developed an integrated information management system that contains all information about its looked after children. Their operational performance and project manager is responsible for liaising between the IT department and operations staff.

The project manager gathered information from operations staff, including social workers, the commissioning team and others, regarding what type of information they would find useful, and then worked with the IT team to create structures and reports to produce it. There was initial resistance to inputting data into a central system because of the increased administrative burden on staff, but acceptance has increased as the benefits and power of this information have become apparent.

The team have access to comprehensive information about their preferred providers and their children in residential care, providing insight into placement stability, duration, location, information about their looked after children population, and much more. It is possible for the social care team to request tailored reports to help them with planning, forecasting and caseload management, among others.

3.5.2 PREVENTATIVE SERVICES

Careful planning and focusing resources on preventative services could reduce the number of children entering the residential care system.

The importance of preventative services was highlighted throughout the interviews, some of which provided examples of effective strategies they have put into place to help children stay out of care. Examples include care providers offering outreach support programmes to work

with families, training schemes managed by local authorities, and respite care to ease the family's burden by caring for children with disability.

Case Study: Planning to Meet Children and Young People's Needs in Respite Care

Frequently, respite units plan their intake such that there are cohorts and groups of children who see each other regularly in the home. This allows the home to schedule group activities that are suited to the specific children and young people that are present. One respite unit, for example, has a youth group for teenagers one evening each week, another night has a support group for girls to discuss issues of self-esteem and image, and reserves another evening for children who need a quiet environment. They aim for a consistent environment in which children have their own bed and room that they stay in every time they are in the home.

In general though, a full suite of preventative services is an 'aspirational' target. Budgetary constraints and short-termism were raised as significant barriers to creating and maintaining preventative services. In an environment in which it is necessary to show immediate benefits and the results of investments, preventative care is often sidelined for expenditures that bear immediate fruit.

Because the cost of residential placements is so high, one commissioner noted that eliminating even one residential care placement could free up budget to invest in services focused on foster care, respite services, training opportunities and other preventative care.

Authorities stress that it will take time to see the benefits of a preventative approach. A number of commissioners highlighted that preventative services may take a decade or even a generation before they demonstrate a significant impact – breaking cycles of poverty, hopelessness and joblessness is a lengthy process. In the long-term however, this should bring a reduction in the number of children needing residential placements.

> **"We developed a number of initiatives, including training schemes for teenage boys and support groups for teenage girls and their mothers. These visibly prevented family breakdowns and reduced the number of young people coming into care."**
>
> Manager of Internal Provision, Local Authority

Case Study: Durham City Council's Preventative Services Strategy

Durham has implemented a well resourced 'invest to save' strategy. They have empirical evidence of the success of their preventative strategy, and in particular the success of their short-term placement centre. This centre operates like a crisis intervention centre, and is available as long as a child needs support. Children are placed for no more than three nights at a time, and staff undertake intensive work with the child and family to return them to the most suitable living situation. 'Respite' stays can be planned weekly if needed, and the shortest intervention undertaken is three days with the longest being across the course of a year. Last year they carried out 88 successful interventions, this year to date they have undertaken 77. Approximately 45 percent of children who receive intervention support and short-term placement at the centre are prevented from going into care.

3.5.3   EMERGENCY PLACEMENTS

Dealing with emergency placements.

By their very nature, emergency placement decisions are made within a short space of time. Limited availability and choice of emergency placements means that local authorities struggle to match the placement with a child's needs; however, maintaining empty beds so that they are widely available for emergency placements is prohibitively costly. This often reduces the chance of making the right placement in terms of location, 'fit' and wraparound services, particularly education, which can result in a negative impact on children's outcomes.

There is clear evidence that a critical success factor in placement stability is getting the first placement right.   Mismatched initial placements tend to lead to a cycle of placement breakdowns, which creates instability. Because of that, the ideal would be for children to be placed appropriately immediately, though sometimes that is not possible because of bed shortages or the need for an assessment prior to determining long-term placement options.

> **"It's hard if you're running lastminute.com."**
>
> Social Worker,
> Local Authority

Planning and greater visibility of children at risk can reduce the number of emergency placements. Though most local authorities expressed the view that "*there will always be some,*" they also state that many emergency placements could be predicted in advance. This is particularly true in regard to existing placements that are in danger of breaking down and crisis intervention for children with disabilities.

Emergency placements are not only problematic for the child being placed. Some care homes are moving away from holding emergency beds open because the turmoil of an emergency placement can frequently cause significant disruption and upheaval for children already in the home.

Managing emergency placements.

Emergency placements are managed differently across local authorities interviewed.   For example, Manchester has enough children coming into the care system to justify maintaining a separate unit for emergency placements, while West Sussex has recently decided to decommission its emergency bed to allow it to utilise its internal provision more efficiently. They are looking at developing emergency placement alternatives, such as spot purchasing or using emergency foster placements, which can house children for up to 10 working days while a suitable long-term placement is arranged. If emergency placements are not managed well it is likely that more beds will be required.

Some authorities go through a planning process for every placement.   In Durham, all placements are planned, including emergencies. A weekly Resource Network meeting is held each Friday to discuss cases where no suitable placement has been identified, and the most suitable alternative is identified, which may consist of home support, wraparound services or another options. This is chaired by service managers, and a full risk assessment is undertaken and signed off by the service manager.   There is also a fortnightly placement pressures meeting.

Planning to reduce the negative impact of emergency placements.

A number of care providers have made special provision for emergency placements so as to minimise disruption to other children. For example, some will only admit emergency placements

into solo units; others will take the child on an emergency placement away for an 'induction' before introducing them to the home and the other children.

3.6 CONTRACTING

Contracting provides opportunities to share risks and plan. It creates a more certain environment for local authorities and care providers. If care providers have greater certainty of their income stream it is possible that they may reduce costs. It also reduces back office costs for local authorities when they place children within the contract. However, it does raise concerns that children may be placed in their contracted beds even when the 'fit' is not ideal.

Authorities have different approaches to contracting depending on their level of overall commissioning maturity. Technical expertise is still being developed to use the contracting process to gain leverage for achieving good outcomes; currently, the contracting process is often seen as the 'bureaucratic' side of commissioning. Repeated and protracted negotiations around inflation rates and lack of long-term relationships with providers means that in some cases contracts are not negotiated, signed and agreed in a timely manner.

To help address some of the issues around contracting, a model national contract for residential child care is currently being developed. It includes service specifications and performance indicators and will be available for use by local authorities across England.

Local authorities use a wide range of contracting options.

Contracts are mainly short-term, one-year agreements. A lack of technical expertise and training may mean that contracts contain generic terms and conditions with individual care plans attached to serve as the service specification. However, a critical component of optimising the supply of residential care is to build long-term plans and agreements based on a strategic level needs analysis. Longer term contracts with providers, including block contracts, are a natural outgrowth of such analysis, though progress is slow in this area.

Local authorities therefore use a wide range of contracting options including block contracting, cost and volume contracting, contracting frameworks and preferred supplier lists. However, many local authorities use spot purchasing as their first method of contracting, viewing this as a way of paying only for services and beds that are actually used.

Spot purchasing can avoid unnecessary payments but does not allow for planning.

There are some advantages of spot purchasing for local authorities: they are flexible, require little advance planning, and only impact the budget at the time of use. There are also disadvantages for local authorities: they eliminate leverage for price or quality negotiations, and require intensive administrative and staff input to produce, manage and monitor a high number of spot contracts.

> **"We do our out of authority placements on a spot contracting basis. We keep some information on hand and use word of mouth, which is not exactly ideal."**
>
> Local Authority

Case Study: The Peninsular Placements Project and Contracting

The Peninsular Placements Project is working to change commissioning in the South West. Cornwall has adapted its contracting system as part of a longer term strategy to understand how to better meet the needs of its children in residential care.

As the first stage, Cornwall created a prequalification process for providers. The base criterion

for eligibility was geographic – only providers on the Peninsula or within 20 miles of Devon were able to apply. After evaluating applications, a shortlist of providers was created. That shortlist is now used whenever a residential placement is needed.

When a child needs to be placed, an invitation to tender is sent out to the shortlisted providers, who then submit a brief response outlining how they will meet the child's needs. Because they have already been approved as a provider, placement decisions are made based on the appropriateness of the match of services with the child without needing to evaluate the basic fitness of the home. Tenders are evaluated within 24 hours and a child is then placed.

Beyond providing a speedy and tailored placement process, the objective of the tendering process is to help the local authority better understand what each provider is able to deliver, based on which tenders they respond to and what services they offer.

Evaluation of these placements and their success will help Cornwall narrow the list of providers, with the longer term objective of developing block contracts with providers that deliver better outcomes for children. They intend to incorporate performance based incentives into the contracts based on children achieving their desired outcomes.

Preferred provider frameworks are being developed.

Case Study: Lewisham's Preferred Provider Framework

Over the last several years, Lewisham has developed a preferred provider framework for its residential care placements. The list has been reduced more than four-fold in that time. Currently, providers are on the list who are able to cater for specific needs of Lewisham's children. There are a number of advantages to this framework:

The providers on the list have more certainty of receiving children;

Lewisham's placement team knows the individual providers and their services better because there is a manageable number of them;

Lewisham has more traction in negotiating costs because they are likely to place a higher number of children with individual providers; and

Lewisham and the providers are able to develop closer working relationships and focus energies on achieving positive outcomes for the children.

Block contracting can be used to meet a demand not catered for in local authority managed homes.

Case Study: Coventry's Block Contract for Residential Care

Coventry has recently completed a two-year commissioning project to award a block contract to a single provider for residential care which cannot be met by its statutory provision. The process included an in-depth needs analysis, the development of a business case, and the inclusion of children and young people in the bid evaluation process. The Primary Care Trust was involved in the project group from its inception and applauded the local authority for its partnership approach, which promoted joint working and considered children's needs holistically.

The result is a 10 year contract, with fees agreed in advance for three levels of care provision and a 'no reject' clause. There is a break clause in the contract in 2008 to allow both sides to evaluate whether the partnership is beneficial, and it includes a scaling up of beds to a

maximum of 30 beds within two years. The contract includes a provision that within two years, placements will be 100 percent within the 20 mile recommended radius. Specific placements beyond the scope of the contract include children with acute mental health needs or disabilities and those requiring secure accommodation.

As the block contract takes effect and more children are placed through it, the average cost per child will decrease while a focus on outcomes increases. Performance measures such as stability should also increase. A streamlined process for both Coventry and Northern Care will bring back office efficiencies.

Northern Care has 23 care homes across the country with 130 beds. Each home has 4-6 beds. There are education facilities available on site. They have committed to meeting the needs of the children they accept, which may mean increasing staffing ratios or bringing in staff with specialist skills. The managers of homes make placement decisions based on their home's ability to meet each child's needs.

The contract came into effect in January 2007 so is still being tested, but social workers were generally supportive, noting that placement breakdowns with Northern Care were much less frequent than in many other care homes.

There are also some good practice examples of contracting being used to ensure quality of care and good outcomes.

Case Study: Birmingham's Contracting Framework

Birmingham has developed an evidence-based evaluation of outcomes which they use with providers. Performance monitoring of placements involves monthly reports from each home on their key performance indicators, monthly monitoring reports summarised into outcomes for each child, and monthly and quarterly progress meeting. The council has developed an outcomes framework upon which the homes evaluate their own performance. Each home scores itself and provides evidence from its staff and young people to support the evaluation, as well as an action plan based on the evaluation to continue working towards the outcomes.

3.7   VALUE FOR MONEY

Within an optimised residential care market value for money would be achieved. There appears to be a growing awareness amongst local authorities of value for money as developing the right provision at a mutually agreeable price that achieves the right outcomes. In other words, value for money does not necessarily amount to contracting with the lowest cost provider or selecting the first available bed. Although all authorities and care providers are aiming to offer a high quality service and good outcomes, there are a number of significant barriers to achieving the optimal, value for money solution. The barriers identified in this study include:

> **"The difficulty for local authorities is matching children correctly in the context of a number of different competing priorities."**
>
> Chief Operations Officer, a care provider

- The competing priorities of local authorities;

- Short-term approaches to commissioning; and

- The difficulties evidencing value for money.

Addressing these issues will help to optimise demand and supply of residential care.

3.7.1   LOCAL AUTHORITIES' COMPETING PRIORITIES

Local authorities are unique within the residential care market because they demand the services, hold the funds and also, in some cases, provide residential care. This does, however, lead to competing priorities which can make optimal allocation of funds difficult.

Local authorities as the corporate parent demand the best for their looked after children.

Local authorities have a role, as corporate parents, to achieve the best outcomes possible for their looked after children.

> **"We strive to equitably use the public purse to meet needs, which may mean that the bronze standard is our choice sometimes."**
>
> Commissioner, local authority

Therefore, the corporate parents will identify what the needs of children are, taking into account the needs of the child, the type of provision available in the market and the preferences of the child being placed in light of funding constraints.

Like all parents, corporate parents have difficult decisions to make when prioritising their spending. Commissioners, therefore, have to balance the competing demands of a number of looked after children to provide the best outcomes overall within a specified budget.

However, in many cases social workers take on the role of corporate parent while commissioners focus on balancing the budget. The result is a conflict with neither side fully appreciating the needs of the other.

For example, one commissioner involved in this study stated that "*You can't negotiate a service when you're responsible for the welfare of a child*" when discussing the involvement of social workers in pricing decisions.

Care providers suggested that the system would work better if social workers had training on the commissioning process.

Local authorities as care providers supply the highest quality care they can within funding constraints.

Local authorities expressed the view that the ideal occupancy in their homes would be 75-80 percent, allowing for placement

> **"We sometimes feel that they [commissioners and social workers] are on opposing sides within a local authority and this creates tension for everyone."**
>
> Referrals Manager, care provider

flexibility and choice. However, they are under intense pressure to fill the homes to stay within budget. Consequently, local authority managed homes were generally full. Furthermore, this study found that having an available bed managed by the local authority led to a temptation to use it rather than explore other alternatives – "*There's virtually no choice for children and social workers.*" This is not optimal if achieving good outcomes is the aim.

3.7.2   TAKING A SHORT-TERM VIEW

One of the most significant criticisms laid at the door of local authorities by some independent care providers and representative organisations was the failure of local authorities to consider value for money over the longer term.

At the strategic level, taking a short-term view can impact on supply. For example, according to many care providers, the focus on price is a driver of consolidation in the market, which influences the available supply. Consolidation may be good for a market if there is an

oversupply; however, consolidation that is based purely on price without consideration of what supply is needed may have negative consequences in the longer term.

Many providers perceive that funding constraints often create a focus on short-term solutions rather than value for money over the longer term.

A number of care providers during the study highlighted the need for local authorities to "*spend money now on quality provision to break the cycle, otherwise a child is in the system for the rest of their life.*" Investing in children could generate greater savings in the future if the lifetime cost of care per child is considered. Unfortunately, local authorities face a dilemma as they are caught between short-term budget constraints and the need to consider the lifetime cost of care if value for money is to be achieved over the longer term.

Example of short-term focus.	Example of focus on value for money.
"*Deals could be done if it wasn't for this frustrating short-termism which stands in the way of providing a variety of opportunities for young people…currently local authorities just want things for less and that's the end of it.*" A care provider	"*We were looking to create a partnership with a provider, promoting long-term thinking and sharing risks. Our goal is to make it advantageous for them to be committed to meeting the needs of our children, flexible enough to accommodate the changing patterns of children's needs, and willing to work with us towards our priorities.*" Head of Children's Special Services, local authority

Current funding constraints appear to be over-riding longer term considerations in many cases. One independent care provider stated that "*Local authorities are trying to push children along because they are often putting costs ahead of needs. There is a trend of putting children who need solo care into dual or group provision and those who need dual or group care into fostering.*" Another care provider agreed, highlighting that short-term investment can "*save money long-term*" but that "*most work year to year within a budget*".

Evidence of the impact of short-term funding constraints was provided by a care provider who responded to a tender which had stated that 60 percent of the decision would be cost based, while only 2 percent would be based on evidence of the provision of quality care.

Such approaches are not limited to residential care provision. Examples were also given during this study of more holistic, supported fostering solutions being overlooked due to their higher cost despite the fact that, according to care providers and representative organisations, consulted, they may achieve better outcomes.

The result of this short-term approach is greater instability in the residential care market because placements are more likely to break down if children are being pushed to a particular provider based on cost. One local authority's Director of Children's Services commented that "*As you move children, you're not only moving them from one placement to another, but also predicting a break-up in future placements. It gets harder and harder for a placement to stick as children are moved.*" The result is inferior outcomes for looked after children.

Some care providers felt that this short-term focus was particularly evident when financial constraints tightened during the year.

Due to the high cost of residential care per child, which may range from £120,000 to £400,000 annually, just one additional child requiring residential care, or a child remaining in residential care for longer than expected, can have significant budgetary impact.

Some care providers indicated that variances in forecasts can lead to placements being funding-led than needs-driven towards the end of the financial year rather than being based on a sound needs assessment.

Care providers and representative organisations have also suggested that existing placements can be affected. For example, one representative organisation stated that they had spoken to children who have been moved out of residential care and into fostering very quickly and that they felt this was because of finances rather than changes in the needs of the children.

Such changes in approach during a financial year have not been substantiated by local authorities involved in this study.

3.7.3 EVIDENCING VALUE FOR MONEY

A barrier to achieving value for money is the difficulty faced by those commissioning the services and those providing care to evidence that it has been achieved. This difficulty exists for both costs and outcomes. Local authorities have found it difficult to obtain visibility of costs and there is currently no universal framework for measuring the quality of care provided in terms of outcomes achieved for children and young people. To consider value for money over the longer term, outcomes would have to be considered for looked after children into adulthood but there is currently no approach for this.

To ensure that value for money there needs to be good data on costs and outcomes.

Most local authorities have limited data on placement costs or outcomes, whether local authority managed or externally delivered. This creates problems because commissioners cannot effectively compare options. It also causes problems for independent care providers if they are unable to justify their costs to local authorities. This was evidenced by care providers who highlighted problems with local authorities refusing price uplifts in line with inflation.

Our study highlighted some approaches local authorities are taking to try and improve their visibility of prices. For example, Blackpool has developed a method of costing placements.

Case Study: Blackpool's Process of Estimating Placement Costs

Blackpool has made progress on the issue of costing placements and has established a 'usual price' for residential placements. Indicative areas that contribute to the cost of a placement in externally provided residential homes were identified as:

- Staff time (day and night rates, professionals, support staff etc.)
- On-going cost of facilities (mortgage, rent etc.)
- Physical upkeep of buildings (repairs, gardening etc.)
- Consumables (food, clothing, equipment, etc.)
- Overheads (management, head office, full cost recovery, etc.)
- Cost of borrowing (loans, shareholder dividends etc.)

- Profit (acceptable ranges of profit or surplus).

Blackpool engaged with local providers and also spoke to council statistical neighbours about their average costs as further evidence and benchmarking.

Birmingham has also established a method for examining the 'total cost' of their internal provision in order to effectively compare its cost with that of external provision.

Case Study: Birmingham's Total Cost Evaluation and Transparent Pricing

Birmingham performs a total cost analysis of its own provision, including average unit cost and average occupancy rates per home, and compares those costs against the rates in its block contract with an independent provider. They intend to use this model across all of their external placements. This has led to more clarity when making decisions and improved ability to choose the most suitable placement in view of the full cost.

They have created a core cost specification that will be rolled out for residential care, including minimum requirements in provision and associated costs. Contract will specify provider discounts as well as additional services available and associated costs for each.

There is also limited data on out of authority placement costs. This leads to local authorities who are net receivers of looked after children from other local authorities having only a limited idea of the impact they may have on other local services such as health and education.

There also needs to be effective monitoring of outcomes.

Currently, local authorities are monitoring placements predominantly in terms of contract compliance, rather than monitoring the progress towards outcomes for the individual child. There is still a certain amount of over-reliance on CSCI inspection reports to assess and monitor the quality of providers. Inspection results cannot indicate what a home is doing to achieve outcomes; it is just looking at whether minimum standards are being maintained.

Some local authorities have responded by developing their own 'accreditation' processes. These range from pre-contracting systems where providers must submit all policies, procedures and CSCI reports to fully comprehensive systems where providers are assessed in terms of quality. Durham provides a good example:

Case Study: Durham's Provider Accreditation System

Durham has instigated their own provider accreditation system for all external providers. The system is designed to supplement the existing CSCI inspection process, not to duplicate, and so their system focuses on the aspects of quality and deliver that are outside CSCI's remit.

The accreditation process is a whole authority approach to contracting and commissioning and is based on the recognition that there is existing expertise available in the council which they should be able to take advantage of. This means that their Health and Safety experts give input around health and safety policies, the legal department checks legal requirements, etc. Providers are accredited before contracts are issued, and are re-accredited annually.

The system means that all staff are confident in the quality of their external provision, and that where they have concerns they have a full range of tools available to ensure both the best outcome for the children in the placement, and the relationship with the provider.

However, there has been little progress towards monitoring outcomes more specifically because of uncertainty around how best to do this. There was recurring uncertainty across most local

authorities with regards to how to record evidence of very good practice and the less 'quantifiable' actions of a good quality provider. Nevertheless, many care providers which to be monitored on outcomes and recognise the need to develop ways to evidence good outcomes, including long-term outcomes in order to realise the true value of the provision.

Yet, many care providers wish to be monitored on outcomes and have recognised that they need to develop ways to evidence good outcomes.

> **"Many providers jumped on the band wagon and shouted that they could achieve the outcomes and now we have to evidence it."**
>
> Residential Care and Provision Manager, independent care provider.
>
> **"There is a need to monitor outcomes both whilst a child is in care and beyond to highlight what long-term advantages and disadvantages might be from different care packages and type of providers."**
>
> Director of Development, a representative organisation for children in care.

Visibility of what care providers actually do was highlighted by one interviewee as a step along the road to monitoring outcomes. They stated that their best experience was when a commissioning officer visited a young person in one of their homes and witnessed their violent and challenging behaviour first hand. As a result the commissioner admired what the care provider was doing and appreciated that they were receiving value for money.

3.8 CAPACITY

An optimally performing residential care market requires good quality staff to demand the right services and provide high quality care. Many participants in this study from all sectors stated that the capacity to achieve good outcomes for children depends on the ability of staff. Furthermore, the supply of residential care in the market relies on staff being available to care for the children in those beds. To optimise supply there is, therefore, a need to:

- Build the skills and capabilities of people working with residential care both within local authorities and within care homes; and

- Increase the prestige and visibility of the profession to attract and retain good people.

3.8.1 BUILDING SKILLS AND CAPABILITIES

Standards of skills and capabilities vary across the sector but there was a general feeling across all participants in this study that training needs to improve.

This study found a need for better training across all areas of the process – from commissioners and social workers to care workers in homes. For commissioners and social workers, training may include a focus on raising awareness of residential care, while care home workers' training would focus on aspects of care for the children and young people in their homes. There is, of course, variation within the sector. Funding was typically stated as the primary constraint to providing more training, however, a shortage of training capacity was also noted.

Some commissioners are extremely well qualified whilst others would benefit from a higher level of expertise. Similarly amongst care providers, some differentiate themselves by the quality of training provided whilst others pointed to difficulties in providing training because of the

budgetary impact. To overcome this one provider highlighted a forum in their area which allows smaller providers to share information and training costs.

There was also a relatively consistent call amongst care providers for a minimum standard of qualification of care home staff along with requirements for on-going training and mentoring to ensure high quality care within the sector.

3.8.2   ATTRACTING AND RETAINING GOOD PEOPLE

Attracting high calibre people is difficult.

The key constraints to attracting high calibre people to the sector were stated to be:

- The negative perception of the sector (as discussed in Section 4.1);

- Lack of career progression;

- Poor pay; and

- Lack of incentive for school leavers and graduates to enter the sector (for example, there is no pool of money for anyone wanting to go into this line of work).

One independent care provider highlighted steps they were taking to try and address these issues by going into schools and talking to students about the reasons why residential care is a good career option.

There is also evidence of poor retention.

Retaining staff was also found to be an issue. There appears to be fast turnover of staff leading to too much reliance on temporary/agency staff. On the whole those interviewed felt staff are under-paid, under-valued and under-developed. Large case loads were also particularly cited as a reason for the high turnover in social workers.

> **"Staff are the most important input to achieve good outcomes for children. They create an environment of safety and challenge so that children can get on and achieve."**
>
> CEO of an independent care provider

Those interviewed also felt that retention was vital because consistency is a key ingredient of good outcomes and because beds are only truly available when a home has the required staff to care for the child who would take that bed. Retaining frontline staff is, therefore, particularly crucial if those in care are to develop relationships with a consistent adult figure. Social workers are particularly important in this regard yet many are leaving the field.

Suggestions were made by interviewees to aid retention. Generally they felt that to get the best results for young people you need the best experience so you need to keep staff by paying them well, training them and providing them with a career plan wherever they sit within the residential care market.

The importance of retaining high quality leaders in the sector was specifically highlighted.

Managers of homes, Director's of Children's Services and CEO's of local authorities are all responsible for setting the ethos of the home and driving policy, priorities and standards. As one Senior Service Commissioning Manager at a local authority stated:

> **"A children's home is only as good as its last mistake. It only takes one bad case and people are reluctant to place. One manager can destroy a home's reputation."**

Care providers felt that government and local authorities don't currently recognise the value of the independent care sector and the complexities of the work involved. They feel that staff and leaders of the sector in particular, need to be recognised for the challenging work that they do, seen as professionals, not just carers, and rewarded for the difficult job they do.

3.9   MANAGING THE MARKET

Discussions with local authorities, providers and representative organisations during this study suggest that there needs to be more proactive market management in order to make optimal use of resources. Effective management could enable supply to be reduced without a negative impact on outcomes, insofar as children still have access to the right bed for their needs.

Currently, market management appears to be happening on an ad hoc basis and varies between areas. Both local authorities and providers articulated that they would welcome national guidance around how they should be shaping the market. However, there have been some steps made towards more effective market management including the development of forums, the use of tendering and market management through effective commissioning. It is felt that further adoption of emerging best practice in these areas would improve the functioning of the residential care market and provide better outcomes for looked after children.

3.9.1   THE CURRENT MARKET ENVIRONMENT

Currently the market is being shaped to a large extent by consolidation and price pressure.

This study found little evidence of authorities using the commissioning and contracting process to manage the market. Instead, consolidation and price pressure, both largely driven by venture capitalists, have been the catalysts for recent market development. Further consolidation in the market is considered likely because it is believed amongst the care providers that:

• New entrants will not be attracted by current low returns and will be deterred by high barriers to entry (such as the cost of property and neighbourhood relations); and

• Small providers will find it increasingly difficult to survive in the highly competitive environment.

Three core reasons were stated as to why some providers are finding it difficult to survive.

The main reasons provided by care providers involved in this study can be summarised as:

• Price pressure within the market generated by both the entry of venture capitalists and the "*bullying tactics of local authorities*";

• The reduced number of referrals within residential care market due to the drive towards fostering and the drive to place children within a 20 mile radius; and

• Oversupply at a time of price pressure and reduced referrals in some areas of more general provision. The majority of care providers involved in this study felt that there is over supply in the residential care market due to an influx of ill-advised investments. Such investments,

it is believed, were encouraged by an incorrect assumption that residential care for children was a 'money pot'.

Views are mixed as to the benefits of further consolidation.

Example of the benefits of consolidation.	Example of the problems of consolidation.
"We are seeing more consolidation in the market, which is leading to improved services for children and better quality standards across the sector." A care provider	*"Private equity companies just want to get bigger and take over the sector… Soon the 'big boys' will have a monopoly…fees will go up but the quality of service provided will decline."* A care provider

In the absence of national guidance or significant improvement in commissioning there is likely to be a further decline in the number of small providers and an increased market share amongst larger providers funded by venture capitalists, plc's and banks.

Larger providers feel that consolidation in the market will be beneficial and raise standards because ultimately it will improve consistency, partnership working and improve quality. For example, local authorities may benefit from a reduced number of providers to liaise with and providers may benefit from the ability to have dedicated sales teams to liaise with local authorities.

However, concern has been raised that if there are too few providers in the future local authorities will be at risk if providers disinvest. Particular concerns were raised around the ability of the voluntary sector to survive in this increasingly consolidated and competitive market because they have often focussed on specialist provision for children with special needs.

Furthermore, some care providers within the sample suggested that if the market does consolidate to a few 'big players' then it will reduce choice for purchasers. However, others thought that those big providers are likely to diversify to provide a range of services under their one umbrella company, possibly also generating economies of scale and reducing costs.

There is also a concern that the short-term view of Venture Capitalists and their focus on returns will be detrimental to care services. The general feeling was that this market should be firstly about what is right for the children and secondly about considering financial implications. Yet, one care provider responded by stating:

"It is immoral to look at profits first. You have to start from what is best for the child and if you do, appropriate margins will follow."

3.9.2   STEPS TOWARDS MARKET MANAGEMENT

Forums

Some independent providers have responded to the pressures of consolidation by creating forums which also works to improve the functioning of the residential care market because local authorities have a core contact for a number of services.

Case Study: Developing Forums in Response to Pressures of Consolidation

One mid-size care provider has set up a forum for trusted, high quality, small independents so that they can share information, share reports, pool referrals, join together for training etc. Only

care providers of a good standard can join. *"The forum offers all the specialisms without the 'supermarket effect' that a large firm is trying to create."* Managing Director, Care Provider

Tendering

Currently, some local authorities appear resistant to tendering as a process to manage the market. On occasions this was due to the perceived bureaucracy involved in the tendering process and in others it stemmed from the higher value placed on care provided internally by the local authority. For example, one local authority determined, based on previous tendering experience, that in some cases the provision does not exist externally and that it is "*quicker and easier to deliver the service in house*".

Yet some local authorities are using the tendering process to support their needs analysis, and many report the desire to use the tendering process to rationalise the market. The goal in many cases was to get a manageable list of providers who provide the services an authority really needs.

Case Study: The South West's Prequalification Process

"The prequalification and tendering process will give insight into matching providers with the needs they can address – based on which tenders they respond to. This will give us information about where to invest and where not to. We aim to have fewer relationships with providers and to strengthen those. We will maintain relationships with providers that complement our in-house provision."

Commissioning

Integral to effective commissioning is the ability to shape and manage the market such that there are incentives for suppliers to provide the services that are required. Some local authorities have recognised this and begun to make headway:

Case Study: The Benefits of Good Market Management in Blackpool

Blackpool has reduced its commissioning costs through good market management. They have assessed placement costs, established a set price for services based on an understanding of costs in the area and in statistical neighbours, analysed the market place, engaged with suppliers, and acted as a good negotiator.

Blackpool engaged providers directly in dialogue about what Blackpool needs in terms of provision and this has led to the development of a 10 year plan to assist Blackpool planners and commissioners to pull levers to move towards the type of market that will deliver outcomes efficiently, effectively and in a sustainable way for children in care.

In summary, the management plan describes:

- How they might want the market to look;

- What the split of in-house, voluntary and independent providers might be;

- The relationship they would like between providers and commissioners;

- What quality provision should look like to deliver better outcomes, including the most effective models of provision; and

- What the largest range of prices might be.

Information sharing and partnerships

All providers and local authorities interviewed agreed that good commissioning is the direct result of good partnership working and relationship building with care providers and voluntary organisations. Furthermore, they felt that the key to building strong and effective partnerships was the continuous flow of information. There was a belief that information sharing and partnership working needed to improve so that:

- Care providers know what local authorities are looking for and can cater appropriately;

- Care providers understand the resources of local authorities and can determine what they can provide in view of such resources;

- Care providers can invest ahead in wraparound services in light of an increased understanding of what local authorities want in terms of additional services and how that can be provided. As one CEO at an independent service provider stressed, "*You can't say you have a service until you have brought it in and proved that it works*;"

- Local authorities can enhance their knowledge of what is available in the marketplace. Some care providers felt that in some instances, local authorities don't know what they are buying because they often rely on forms which they send to care providers but which quite often don't have the right boxes to tick so that care providers can demonstrate the range of services they offer;

- Local authorities can benefit from the knowledge of providers. Currently there is a belief amongst many care providers involved in this study that the independent sector is underused and that the local authority should seek the advice of care providers as professionals and specialists in their field;

- Local authorities can obtain discounts. It was suggested by some care providers that discounts could be offered based on predictability of income if they are aware of trends and can ensure that enough children will be referred.

However, there are obstacles which will need to be overcome to promote information sharing and development of partnerships, including the current reluctance within many local authorities to have dialogue with service providers, the focus on cutting costs within local authorities (rather than a focus on dialogue with suppliers), and the lack of trust within local authorities of independent care providers borne largely of the past practices of independent care providers. Yet, some see the relationships improving as local authorities commission more.

> **"In some ways it is the sector's own fault that we are in this position because for many years a number of care providers have over-charged and under-delivered but quality is out there and the local authorities should trust quality providers"**
>
> Managing Director of a care provider

Provider forums

Provider forums have begun to develop in response to the need for improved information sharing. To date, the experience among care providers involved in this study has varied. For example, one care provider's Director of Social Care felt that provider forums that currently exist are ineffective. The care provider had been involved in provider's forums where "*they [local authorities] are telling us rather than consulting*". Yet, another care provider highlighted that they had attended a number of Provider Forums hosted by local authorities for independent sector providers and had found them positive. "*They [the local authority] outline their commissioning needs at these forums and invite providers to comment or ask questions. These*

have been really useful in understanding what is driving the placement needs of local authorities".

Although the idea of a 'joint' provider and commissioner forum, or a commissioner led forum for providers, was discussed as a possibility in a number of areas, no evidence was found that this has been realised anywhere as yet.

The general consensus appeared to be that the key changes required to improve the functioning of the residential care market are openness, flexibility and all stakeholders working together to provide the best outcomes for young people.

4 MODELLING THE REQUIRED SUPPLY

This section describes the economic model developed as part of this study, which is intended to be used as a tool to consider placement supply as part of a comprehensive planning and commissioning process.

In order to develop the model, assumptions were made covering issues such as how the placement process works, types of needs, supply of beds, the impact of difficult placements, duration of placements, area boundaries and the characteristics of local authorities. The reliability of input data is limited, particularly in terms of residential care beds supplied and information on the specific children and young people in residential care (rather than all looked after children); optimal data is not systematically collected and available across the national, regional and local levels.

An economic model cannot incorporate all the complexities of residential care. Such complexities include:

- The need for placement choice, proximity to home, consideration of complex needs and good outcomes for children and young people in residential care.

- The impact of barriers to effective sub-regional and regional co-ordination, immature commissioning practices and the pursuit of value for money in the way that local authorities manage residential care.

- Staffing implications of rising occupancy rates, the impact of contracting on available beds, and a preference for local authority-managed placements in the way that providers look at the residential care market.

The outputs of this model do not consider specific complexities, but do offer a general adjustment indicating the probability of a placement being unsuitable.

The model sets out figures based on the required supply. Key findings of the model include the following:

- The model suggests that the number of beds currently supplied is in excess of the number required, with the excess varying substantially based on the geographic area that is considered for placements.

- The number of beds required nationally ranges from 10,081 if allocation is made at a local authority level to 7,228 if allocation is across England.

- At a local authority level 1.51 beds are required per child in residential care to meet demand; this figure declines as wider placement regions are considered, to a minimum of 1.09 beds per child if beds are allocated nationally.

There is a trade-off between distance, specialisation and cost of placement; the way in which these factors are prioritised influences the quantity of supply required.

A model has been developed to calculate the number of residential placements required and compare it with actual supply in the market. Modelling by its nature cannot capture all the complexities of residential care. However, subject to this proviso, the model does provide a tool for considering the supply of placements at the national, regional, sub-regional and local authority levels. It provides some estimates as to the number of beds per child required per

area and by segment of need and is flexible enough to accommodate some local area variations.

This section presents the approach taken to modelling the residential care market, assumptions and data used, key findings and limitations of the model.

4.1 APPROACH TO MODELLING THE MARKET

The figure below summarises the logic underlying the approach to modelling the residential care market.

Figure 4.1 Linking supply and demand
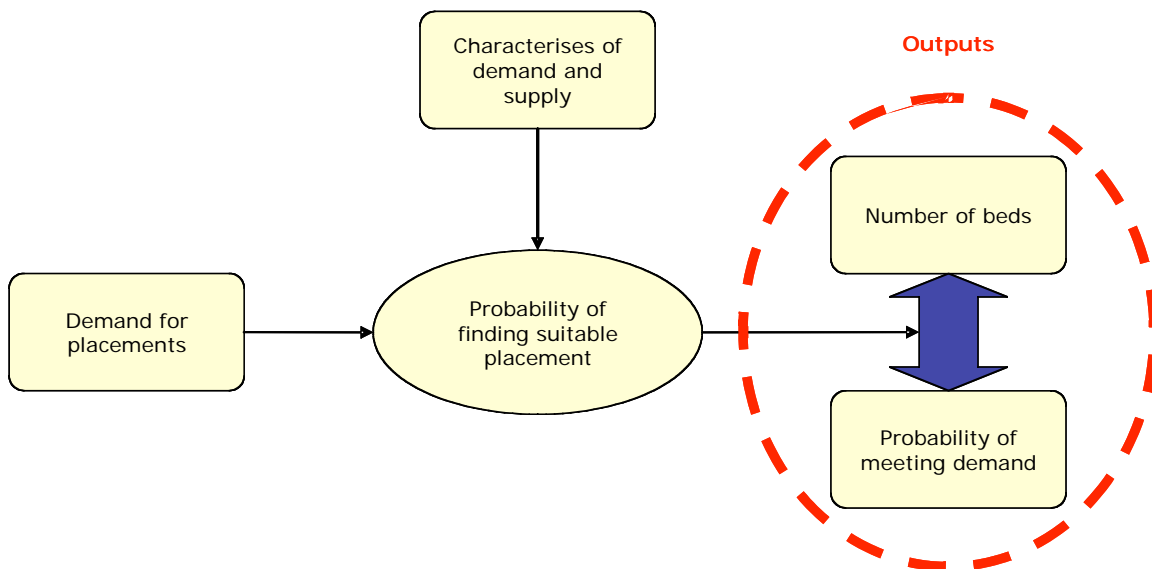
Source: Deloitte analysis, 2007

The output of the model is characterised by a combination of supply, in terms of the number of beds, and an associated probability that the supply will be able to accommodate demand at any point in time. There is the option to either set a minimum probability level and calculate the level of supply required to guarantee this level or, alternatively, set the level of supply and calculate the probability of meeting demand associated with this level of supply.

The outputs of the model are dependent on the level of demand in the market, the level of uncertainty around the average demand at any point in time, and the probability that the supply available is able to accommodate the need of the children requiring placements. The probability that supply is able to accommodate needs is further dependent on the characteristics of both demand and of supply.

Furthermore, one of the main challenges in defining the appropriate number of beds needed for children in residential care is represented by the uncertainty of the timing of a request for a new placement. This timing is difficult to predict since it will depend on factors that are outside the control of the local authorities and on the probability that a certain bed is suitable to the needs of a specific child.

These factors have been taken into account and a dual approach has been developed:

Figure 4.2: **Description of dual approach**
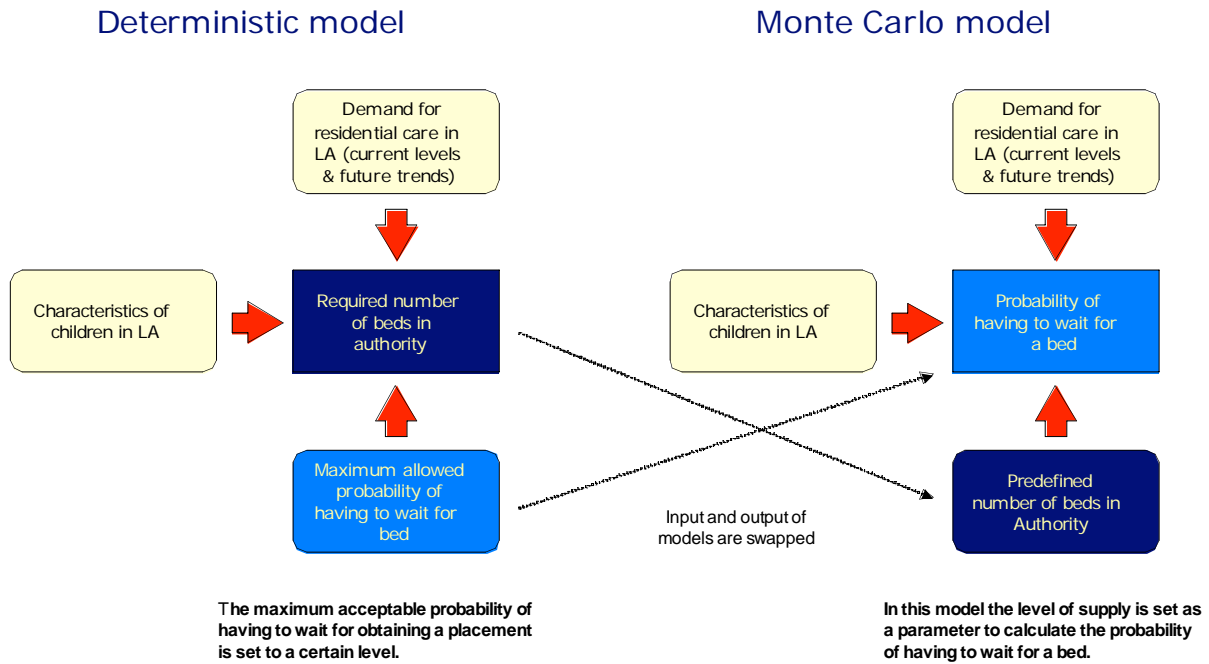
Source: Deloitte analysis, 2007

Firstly, using queuing theory in the deterministic model, the number of beds needed to guarantee that enough beds are available to meet the requirements of children in residential care is determined given the timing of demand for a new placement and a set probability of finding a suitable placement.

The results obtained will change depending on the potential co-ordination at the local authority and regional levels to share extra capacity to accommodate requests, particularly when the number of requests for beds is highest.

Secondly, using the Monte Carlo approach, the impact of uncertainty in the timing of the requests for placement is tested and the probability is calculated that, given a certain supply of beds, all requests for placements will result in a suitable placement[3].

4.2   ASSUMPTIONS AND DATA USED

In this section the detail of the data and assumptions used in the model is presented. In general, the assumptions cover:

- the placement process;

- the type of needs and supply of beds within the residential care market; and

- the impact of difficult placements.

Assumptions are also discussed relating to the deterministic model, the Monte Carlo model, the data used and the functioning of the residential care market.

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[3] A suitable placement is defined as a placement that has a high probability of lasting for a significant period of time.

4.2.1   SIMPLIFYING THE PLACEMENT PROCESS

In developing a model to determine the number of beds required to meet demand, an assumption has been made about the process local authorities use to define a placement. This process is a simplification of reality as the placement process is likely to vary between local authorities. In particular, this simplification does not differentiate between providers. In this context, therefore, beds within the local authority refer to a geographic area and the beds may be run by the local authority directly or by an independent or voluntary sector provider.

Figure 4.3: The simplified placement process underlying the model logic
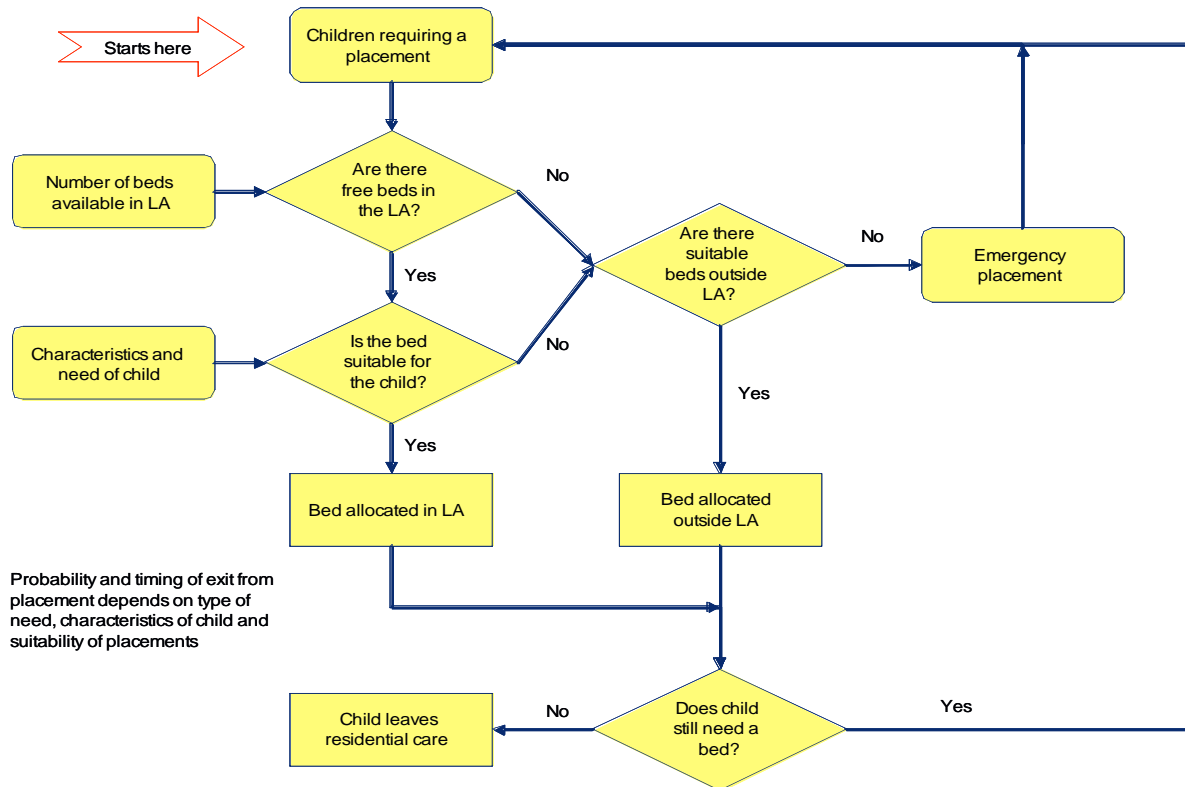
Source: Deloitte, 2007

From this figure the process of finding a suitable bed can be described as follows:

- As the need for a residential care placement materialises, the local authority first seeks to find an available bed within the local area.

- Going through the list of available beds, the local authority confirms that such beds are suitable for the specific needs of the child. The characteristics of the child, including the type and acuity of need among other factors, are likely to influence the probability that a child is able to find a suitable placement.

- If no beds are available or suitable within the local area, a suitable bed is sought elsewhere, first in neighbouring authorities, then at a regional level and finally at the national level.

- The child remains in a placement for a certain period of time. At the end of this period it is possible that the placement is no longer suitable for the child or that the child is ready to leave residential care.

- If the placement is no longer suitable, a new placement will need to be found for the child, and the process starts again.

4.2.2 SEGMENTING THE MARKET

When structuring the model attempts were made to identify ways to segment the market. Defining segments is an important part of modelling the complexity of assigning children to placements and makes it possible to estimate the number and type of beds required. The exercise of defining segments also reveals how well suppliers meet the needs of children.

Segmenting the market involved a trade-off because a child centric view of the problem would tend to define a large number of different segments that reflect the complexity of children's needs, yet for the model to function the number of segments must be contained. The reason for this is that a segment should be characterised by a set of needs for which, on both the demand and supply side, it is possible to clearly separate the segment from the rest of the market. The segments in the model are, therefore, mutually exclusive. This implies that a child in one segment (e.g. a disabled child) needs to be looked after in a home categorised in the same segment (i.e. a home for disabled children).

Within each segment all homes are considered equal and it is assumed that any child can be placed in any home within the appropriate segment. Variations in the quality of beds as well as other qualitative placement considerations such as 'fit' are, therefore, not taken into account within this model.

The segments identified for the model are:

- Homes for disabled children (all ages);

- Secure homes (all ages);

- Homes for children aged 12 and under;

- Homes for children aged 13 to 15; and

- Homes for children aged 16+.

In addition to the five segments identified above, emergency placements were recognised as an additional segment which may need to be modelled separately. An emergency placements segment has, therefore, been determined[4] but there is a concern that while some large local authorities and some providers have a certain number of beds reserved specifically for emergency placements, others may manage such placements differently and in some cases may not consider 'emergency' placements at all.

The figure below shows the level of demand of children for each one of the segments based on data on actual placements in 2005 and 2006 provided by CSCI. Only 20 percent of children are categorised on the basis of their needs. The remaining 80 percent are categorised according to their age, and half of these children are between 13 and 15 years of age.

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[4] In developing the model, the emergency placements segment is determined based on the assumption that they represent 2 percent of total bed usage in residential care (excluding those in placements for children with disability or in secure accommodation). This figure is comparable with the total number of nights that beds are used for short-term placements (i.e. duration less than a month) as a proportion of total occupancy.

Figure 4.4: The proportion of children in residential care by age or need for specific accommodation
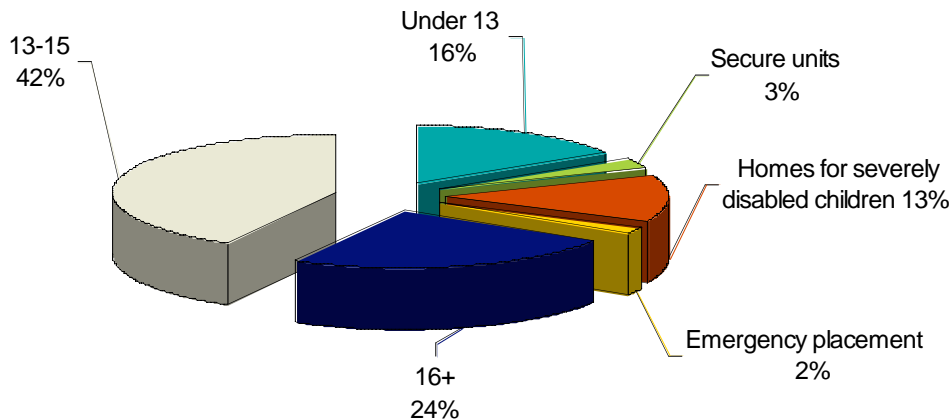
Respite care for disabled children is not modelled as a separate category, but is considered within the segment of provision for disabled children. The main reason for adopting this approach is the lack of available data on either the demand or the supply of placements broken down by respite care and long-term care.

A separate category for single sex homes has not been created. In addition to the limitations imposed by the available data, which does not provide any information on the number of such homes, it was felt that given the limited number of children looked after in the majority of the homes, it would be possible, for example, to restrict admissions if an all female or all male environment was required.

4.2.3 THE IMPACT OF DIFFICULT PLACEMENTS

It is likely that within each of the six segments identified there are a number of children for whom not all placements are suitable. This may be because they have special needs or because they are a potential danger for the children that live with them.

For the purposes of the model, these children do not represent a separate segment because they are not necessarily looked after in a different type of home. Often such children have a bed in a home that can also host other children[5].

In addition to defining six segments, parameters have been created in the model to indicate the extra capacity needed within the system to accommodate children for whom it may be more difficult to find a suitable placement. The challenges considered were:

* Children and young people of an ethnic minority who may be placed in areas with a different ethnic and cultural make-up from their own. This may be relevant, for example, when placing children and young people from London in other, less diverse regions, which may be less able to accommodate their cultural traditions or language needs;

* Children and young people whose needs are particularly severe or acute and who would, therefore, need extra attention and support;

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[5] Within each segment there are homes offering different types of care to children who have particular types and acuity of needs. This is reflected in the probability of these children being able to find a suitable placement.

- Children and young people with aggressive or sexualised behaviour who may not be suitable for a placement in a mixed gender environment;

- Children and young people with Global Developmental Delay or ASD; and

- Children and young people with emotional and behavioural difficulties.

Tailoring these assumptions to reflect the make-up of a particular local authority directly affects the output of the model. Changing the assumptions will affect the model's output showing the required number of beds for that authority, based on how likely it is that a bed will be suitable for an average child. The model is highly sensitive to adjustments, which can be made in the following areas:

- The proportion of children belonging to an ethnic minority in the local authority/region;

- The proportion of children who cannot speak English;

- The geographic characteristics of the local authority/region (used as an indication of how far a care home in the local authority is from the child's home);

- The deprivation index (used as a proxy for the number of children that may have challenging behaviour); and

- A wildcard, which allows the probability of finding suitable placements to be adjusted based on particular variations or factors within an area.

The figure below shows how the probability that a placement may fail is defined and how this is linked to the characteristics of each local authority.

Figure 4.5 Definition of parameters to model probability of unsuitable placements

Input - Definition of parameters

Return to splash

Impact on suitability of placements

Probability of unsuitable placement for ethnic minorities	10%
% of children from ethnic minorities who do not speak English	5%
Probability of unsuitable placement if child cannot speak English	10%
Increased probability that placement is not suitable because of distance from original home	
Urban	0%
Semi urban	3%
Rural	5%
Increased probability for each 10 points of the deprivation index	2%
Increased probability to capture other factors	0%

Source: Deloitte Model, 2007

4.2.4 DETERMINISTIC MODEL ASSUMPTIONS

The deterministic model determines the number of beds needed to guarantee that sufficient beds are available to meet the requirements of children in residential care given:

- The timing of demand for a new placement; and

- A set probability of finding a suitable placement.

The relationship between supply and demand within a certain geographic area and a certain segment is defined by the results of a basic queuing theory model. The main characteristics of this model are:

- The **time of a new placement being needed** (the inter-arrival time) which is assumed to be 7 days for emergency placements and 198 days for all other placements based on the total number of requests in the year divided by the average length of each placement[6].

- The **length of the time that each child stays in a placement** (service time) which is assumed to be set to the total number of beds divided by the average length of each placement[7].

- The assumption that each segment contains a **set number of beds available which are interchangeable** and that could potentially be used for each child in the segment.

Queuing theory defines the waiting time as a function of the number of children requiring beds, the supply level, and the average length of a placement.

The number of beds necessary to ensure that the probability of waiting is below a set level is then calculated. It is possible to define different probabilities for the different segments.

It is also assumed that there may be different probabilities required within different geographic areas. For example, the probability that a bed is available within the local authority is set to be lower than the probability that the bed is available in the region.

The model is then adjusted to reflect the complexity of the placement (and the probability that a bed is not suitable) based on the parameters defined in section 3.2.3 above.

The number of beds necessary to meet needs is therefore considered at the following geographic levels:

- Local authority level (150 local authorities);

- Sub-regional level (about 50 local areas); and

- Regional level (9 English regions).

4.2.5   MONTE CARLO MODEL ASSUMPTIONS

The Monte Carlo model takes an opposite approach to the deterministic model. Demand and supply are the inputs of the model and the probability that the number of beds accommodates demand at each of the geographic levels is the main output of the model[8].

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[6] The inter-arrival time is assumed to be distributed exponentially, and is set to the total number of requests in the year divided by the average length of each placement. The number of placements needed at each point in time is, therefore, distributed according to a Poisson distribution. This means that at each point in time the probability of having a certain number of requests for beds is independent of previous periods. No seasonal pattern is considered.

[7] The length of time that each child stays in a placement is assumed to be distributed exponentially.

[8] The outputs of the Monte Carlo model are obtained by considering the results of a number of iterations in which one or more variables is flexed randomly to reflect a certain statistical distribution. A Poisson distribution was used to reflect uncertainty in the level of demand, represented by the number of children in the system at any point in time within each local authority. This assumes that the timing of requests for placements is random and that the probability that a new request comes through is the same at each point in time.

This probability is calculated on the basis of the results from the iterations in the model, which assess the proportion of iterations for which the number of suitable beds was higher than the number of requests. Different scenarios are then run to show how this probability changes as the number of beds available is varied.

It is assumed that if a bed cannot be found within the local authority area, the local authority making the placement will look at whether it is available within the sub-region and the region.

Also, as in the deterministic model, it is assumed that there is a certain probability that placements are not suitable, which increases the probability that a child will have to wait for a placement (i.e. reduces the probability that the number of beds accommodates demand).

4.2.6 DATA USED AND RELATED ASSUMPTIONS

The model is fed with publicly available data and data provided by the DfES including:

- **Number on residential placements by local authority**: DfES collects information on looked after children by local authority. As part of this information it provides the number of children in residential care. Separate information at the regional level is available for children in secure placements. The most up to date information available at the time of analysis refers to 31st March 2005. These numbers were adjusted to reflect the changes shown by more recent data available at the regional level. Estimated projections of the number of children in care were also provided by DfES but could not be disaggregated to consider figures specifically for residential care.

- **Breakdown of residential placements by type of need**: the ONS also provided the breakdown of children in residential care by type of need based on the reason for a child entering residential care. The categories are:

    - abuse or neglect;

    - child's disability;

    - parental illness or disability;

    - family in acute stress;

    - family dysfunction;

    - socially unacceptable behaviour;

    - low income; and

    - absent parenting.

    Due to small numbers of children this information is available only at the regional level.

- **Duration of placements**: the DfES holds information on the duration of placements but the information is only available at the national level. No breakdown is available based on the category of need. Consequently, the average duration figure used incorporates the duration of respite care placements.

- **Availability of beds**: CSCI collects data on the number of beds available within a single care home. Using this data it is possible to derive local authority level data on the number of beds available. The data used refers to 2006. Some information is also available on the type of beds provided within these homes but this information does not correspond to the six segments. Therefore, some assumptions had to be made to map this data to the segments used in the model.

- **Characteristics of the local authority**: additional data on the characteristics of the local authority was also collected. This included:

    - the deprivation index (provided by the Department of Communities and Local Government);

   – the ethnic make up of looked after children by local authority (provided by the DfES); and

   – information on the size and density of population of each local authority (taken from the 2001 census).

Where local authority level data was not available due to the small number of children in residential care, regional or national averages are used as a proxy for the local authority data.

4.2.7   OTHER ASSUMPTIONS

Other assumptions also had to be made during the course of this modelling including:

- The assumption that **demand is characterised by the current number of placements**. It is assumed that this is a good measure of demand because:

   – At a national level, supply exceeds the number of placements demanded by more than 60 percent. Although it is understood that it would not be possible to utilise all available beds at all times, given the different types of needs, at the national level there are likely to be virtually no supply constraints. It would, therefore, always be possible to find a bed for a child in residential care, although not always in the ideal location. Therefore at the national level the number of placements would reflect actual demand; and

   – Data collected by the local authority that commissions the placement categorises the child by their need and not by the characteristics of the residential home that looks after them. For this reason it is assumed that the number of placements reflects the actual demand of placements for each local authority and each type of need.

- Assumptions relating to **geographic aggregation**:

   – Local Authority: The definition of local authority consistent with the creation of unitary authorities through the Local Government Act 1992 has been used. For simplicity the Isle of Scilly has been merged with Cornwall giving 149 local authorities in total.

   – Sub-region: A number of sub-regions have been defined which mainly correspond with the ceremonial counties of England. Changes to the definition of ceremonial counties include the division of Greater London into 5 areas: central London, North East, North West, South East and South West.

   – Region: These correspond to the 9 Government Office Regions of England.

- Assumptions about the **preference for outsourcing**. In the model the preference of local authorities to place children outside their boundaries is not modelled specifically. For example, one local authority may outsource the majority of its residential care placements to other local authority areas (for example because of high property costs) whereas there may be residential placements available in other local authority areas in excess of local needs. This is visible in the model at the local authority and the sub-regional level, and is mainly absorbed at the regional level (although London is an exception).

- It is assumed that **local authorities and sub-regions may co-ordinate their placements** depending on the sub-region and region of which they are part. However, this is based principally on the administrative organisation of the regions and not on the geographic location of each child. For example, a child in east London may be geographically very close to Essex, where there may be a large number of homes, but in our model he would appear as part of North East London and of the London region.

- It is also assumed that there are a **certain number of beds available in each segment and in each local authority.** Variation in the size of homes has not been considered,

although it is likely that it will be more difficult to place a child requiring specialist care in a small home, than a child with more general needs who can be accommodated in a larger unit. However, it is possible to factor size of home into the wildcard parameter by reducing the probability of difficult placements, for example, for local authorities or regions that have a smaller average size of residential homes.

4.3 MODEL OUTPUTS

This section presents the key outputs from the deterministic and Monte Carlo models.

These outputs should be considered in light of the limitations outlined later in this section as well as the previous discussion around optimising the residential care market. They should be seen as one piece of information among many within a broader discussion of residential care, rather than as a definitive answer to the question of how much supply is required.

By considering both the supply required to guarantee (at a pre-set confidence level) that children will not have to wait when they require a bed and the probability of beds being available to meet demand given current supply, the model produces estimates for:

- The number of beds required per child at national, regional, sub-regional and local authority levels; and

- The number of beds required per segment.

A key finding of the model is that the number of beds currently supplied is in excess of the number required overall, although there is variation at the regional, sub-regional and local authority levels. Similarly, although there is a general oversupply it appears that some of the segments considered are often in substantial shortage or excess, particularly the local authority level.

The model also shows that the number of beds required declines as beds are allocated over wider geographic areas. This presents a trade-off, especially at local authority level, between distance, needs and costs. If the priority is to keep looked after children in residential care within the local area, more beds will be required per child, thus increasing costs.

4.3.1 DETERMINISTIC MODEL

As discussed, the deterministic model compares the actual level of supply with the level of supply that would guarantee, at a pre-set confidence level, that children will not have to wait when they require a residential care bed.

It is assumed that:

- If the child has to wait for a suitable bed, they will be allocated a bed outside the authority or, alternatively, will be given a placement which may be unsuitable and will therefore need to find an alternative placement;

- Not more than 20 percent of children will have to wait for a suitable placement within the local authority area;

- Not more than 5 percent will have to wait for a suitable placement within the sub-region; and

- No more than 1 percent will have to wait for a bed within the region.

The number of beds required per child falls as the demand for placements increases as shown below in Figure 4.6. It becomes easier to manage uncertainty in the pattern of needs for residential placements as the number of children increases.

Figure 4.6: Required number of beds per child relative to the number of placements demanded
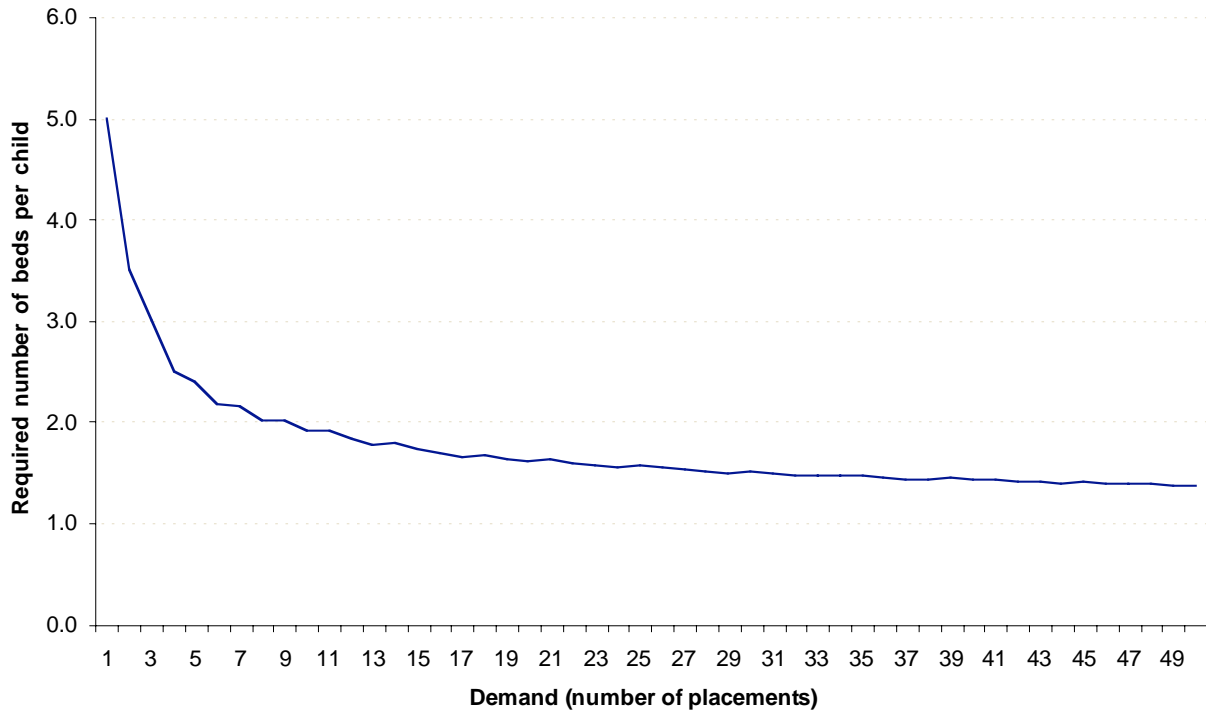
Source: Deloitte analysis, 2007

Consequently, as the geographic area of allocation increases, the associated number of children demanding placements increases and the number of beds per child required declines. It is also easier to find a placement that suits the child's needs when the number of potential homes increases.

Figure 4.7: Required number of beds at different geographic levels

	Max prob of 'waiting'	Number of children	Required beds	Actual beds	Beds per child
Allocation within LA	20%	6,656	10,081	11,417	1.51
Allocation within sub-region	5%	6,656	9,796	11,417	1.47
Allocation within region	1%	6,656	8,562	11,417	1.29
Allocation within England	0.10%	6,656	7,228	11,417	1.09

Source: Deloitte analysis, 2007

This figure shows that there are more registered beds than required beds. It also shows that the number of beds needed per child decreases from 1.51 to 1.29 to 1.09, depending on whether placements are considered nationally, regionally or locally, with expected waiting times for a placement increasing for less than 20 percent of children.

The number of beds required per child can also be considered at the regional level, as shown below.

Figure 4.8 Required number of beds by region and geographic area of allocation

	Required number of beds per child			Actual number of beds per child
	Allocation within LA	Allocation within county	Allocation within region	
Maximum probability of waiting	20%	5%	1%	
East	1.47	1.57	1.32	1.60
East Midlands	1.55	1.67	1.37	2.26
London	1.52	1.35	1.24	0.61
North East	1.61	1.57	1.38	1.54
North West	1.48	1.35	1.25	2.12
South East	1.49	1.57	1.27	2.44
South West	1.62	1.74	1.35	3.06
West Midlands	1.48	1.45	1.29	1.98
Yorkshire and the Humber	1.53	1.47	1.30	1.61

Source: Deloitte analysis, 2007

This analysis shows that the actual number of beds per child exceeds the number required in seven of the regions. However, it indicates that in London, fewer than beds required are available even when allocation is conducted regionally, which supports anecdotal evidence from the interviews of a lack of provision in London, attributable to the higher costs of property and staff. The North East also has slightly fewer beds than required when allocations are made at the sub-regional or local authority level.

By contrast, according to the figure above, the South West has the largest excess of actual beds per child relative to what is required. At most, it appears that 1.74 beds would be required per child yet 3.06 beds are currently supplied.

It was previously shown that the number of beds required declines when allocations are made over a wider geographic area because of factors such as reduced uncertainty and a larger number of homes. However, four of the nine regions actually witness an increase in the number of beds required per child when allocations are made at the sub-regional rather than the local authority level. The reduction in the maximum probability of waiting from 20 percent to 5 percent has clearly had an impact which has outweighed the benefits of an increased allocation area.

The figure below breaks down the requirements into the six segments defined in the model.

Figure 4.9: Required beds versus actual beds

England	Demand	Required supply	Actual supply	Gap
Homes for disabled children	903	999	1,787	788
Secure units	175	219	199	(20)
Under 13	1,079	1,184	1,133	(51)
13-15	2,691	2,855	4,250	1,395
16+	1,716	1,847	3,857	2,010
Emergency placement	92	124	191	67
	6,656	7,228	11,417	4,189

Source: Deloitte analysis, 2007

These results indicate that there is an oversupply of beds nationally (an excess of 4,189 beds) across four of the six segments but fewer beds in secure units and fewer beds for children under 13 years old than required. However, these results are based on assumptions made about the distribution of beds by segment[9] and should be considered in view of this limitation and others described further in the section on limitations.

It should be noted that, while it is possible to segment demand, CSCI data does not provide a precise indication of how many beds are allocated to serve the segments. Consequently, a number of assumptions have been made as to how beds are segmented, which impacts on the outputs of the model and particularly impacts on the results by segment.

Comparing the actual and required supply of beds at the local authority level shows that there are several local authorities in which there appears to be a shortage of supply, and several local authorities in which supply exceeds demand. Figure 4.10 below presents the number of local authorities that have substantially fewer beds than needed (the red column on the left), the number of local authorities that are within 50 percent of required supply, and the number of authorities that have beds in excess of the amount required.

Figure 4.10: Analysis of gap between required and actual number of beds by local authority

Local Authorities	Less than 50% of required supply	Within 50% of required supply	More than 50% of required supply	Total
Homes for disabled children	56	48	45	149
Secure units	54	79	16	149
Under 13	75	62	12	149
13-15	40	72	37	149
16+	24	74	51	149
Emergency placement	49	97	3	149

Source: Deloitte analysis, 2007

These results suggest that beds are provided inefficiently at the local authority level. Fewer than 50 percent of authorities are within 50 percent of the required supply across four of the six segments and only up to 65 percent of authorities are within 50 percent of required supply in the remaining two segments (secure units and emergency placements).

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[9] It was assumed that the proportional split of beds by type would reflect the proportional split of demand (i.e. if 42 percent of children in residential care are aged 13-15, 42 percent of beds supplied are assumed to be for that segment).

In the case of homes for disabled children only around one third of authorities have within 50 percent of the required supply whereas 56 authorities (38 percent) have a shortage and 45 have an excess (28 percent).

The model shows that beds for children under the age of 13 are in especially short supply – 52 percent of authorities have less than 50 percent of the required supply. By contrast, there is an oversupply of beds for young people aged 16+ in a third of authorities. Again, the assumptions used to segment supply will impact on these results.

Overall, more authorities have a substantial shortage of required beds than an excess across the six segments. This is highlighted by the fact that only in the case of beds for young people aged 16+ do the number of authorities with more than 50 percent of required supply exceed the number of authorities with less than 50 percent of required supply.

A similar table is also produced by analysing the data at the sub-regional level.

Figure 4.11: Analysis of gap between required and actual number of beds by sub-region

Sub-regions	Less than 50% of required supply	Within 50% of required supply	More than 50% of required supply	Total
Homes for disabled children	13	21	19	53
Secure units	23	30	0	53
Under 13	17	32	4	53
13-15	4	28	21	53
16+	2	21	30	53
Emergency placement	10	41	2	53

Source: Deloitte analysis, 2007

This figure indicates that as the region is enlarged, some of the disparities between demand and supply cancel each other out and a higher proportion of sub-regions than local authorities see their supply of beds balance their actual requirements. At sub-regional level, four segments are adequately provided for in over 50 percent of sub-regions, yet at local authority level only two segments are adequately provided for in more than half of local authorities.

The model suggests that at the sub-regional level, beds in secure units and homes for children under 13 years old are the most frequently undersupplied (in 43 percent and 32 percent of sub-regions respectively) and beds for young people aged 16+ are oversupplied in 57 percent of sub-regions.

4.3.2   MONTE CARLO MODEL

Using the Monte Carlo model it is possible to calculate the probability that, given the current level of supply, the number of residential care beds available is sufficient to meet the requirements of children in England[10].

In line with the results from the deterministic model, at a national level the number of beds is always in excess of the number of requests.

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[10] The results presented in this section have been obtained by running 1,000 iterations, in which the level of demand for each local authority has been drawn randomly from a Poisson distribution.

As the analysis is broken down at the regional level it can be seen that London has a shortage of beds in each segment. This is likely to be a reflection of the high cost of real estate and running of care homes in the London region.

The figure below shows the probability that the number of residential care beds available is sufficient to meet the requirements of children in each region.

Figure 4.12: Probability given current supply of meeting total demand by region

	Homes for disabled children	Secure units	Under 13	13-15	16+	Emergency placement
East	100%	52%	3%	100%	100%	96%
East Midlands	97%	98%	99%	100%	100%	100%
London	0%	0%	0%	0%	0%	0%
North East	100%	17%	13%	100%	100%	88%
North West	100%	97%	100%	100%	100%	100%
South East	100%	96%	100%	100%	100%	100%
South West	100%	79%	100%	100%	100%	100%
West Midlands	100%	94%	95%	100%	100%	100%
Yorkshire and the Humber	100%	55%	15%	100%	100%	98%

Source: Deloitte analysis, 2007

Focusing on this figure, it is clear that there is likely to be an undersupply of beds in secure units and homes for children under 13 years of age in many regions. It is also evident that there is zero probability of meeting the total demand for beds across any of the segments in London, based on the existing supply of beds in the capital. While there are a large number of residential care beds in London, the higher property and labour costs in the capital limit supply. This makes it highly unlikely that the existing beds available will be able to meet the entire demand for placements in the region, which causes the 0 percent outputs above. This leads many London authorities to outsource a large number of their placements

A more useful picture of how the demand for placements in London is met by beds within London is given in the figure below.

Figure 4.13: Probability that the number of beds in London meet a certain percentage of the demand for children's residential care placement in London.

Percentage of demand	Homes for severely disabled children	Secure units	Under 13	13-15	16+	Emergency placement
30%	100%	97%	100%	100%	100%	100%
40%	100%	49%	18%	100%	100%	100%
50%	100%	10%	0%	68%	100%	100%
60%	86%	1%	0%	0%	100%	94%
70%	12%	0%	0%	0%	69%	71%

Here it possible to see that there is a high probability that the beds available in London can host between 30 percent and 70 percent of the requests for placements, though the probability does vary between the segments. For example, based on the inputs used in the Monte Carlo model, there is a:

- 86 percent probability that the beds available in London can host at least 60 percent of the requests for disabled placements;

- 97 percent probability of hosting at least 30 percent of requests for beds in secure units; and

- 94 percent probability that the beds available in London can host at least 60 percent of requests for emergency placement beds.

Considering the probability of meeting demand at a sub-regional level also highlights difficulties in meeting the needs of children requiring secure beds or beds for children under the age of 13. However, at the sub-regional level there also appears to be shortages of beds in homes for disabled children.

Figure 4.14: Probability that the number of beds meets children's needs at the sub-regional level

Sub-regions	Meet demand less than 50% of the time	Meet demand 50-80% of the time	Meet demand 80-95% of the time	Meet demand more than 95% of the time
Homes for disabled children	20	3	3	27
Secure units	17	12	16	8
Under 13	22	9	3	19
13-15	1	0	2	50
16+	5	3	3	42
Emergency placement	8	8	11	26

Source: Deloitte analysis, 2007

These results are based on the probability that in each area the number of beds available for each of the six segments exceeds demand. The probability is calculated using the percentage of the 1,000 iterations in which the level of demand is lower than or equal to the number of beds. The results therefore show that between 32 percent and 42 percent of authorities can only meet demand for secure, under 13, or disabled beds, less than 50 percent of the time.

As the analysis is extended to the local authority level, it is clear that supply is insufficient more than 50 percent of the time in many areas. This indicates that as the geographic area considered becomes smaller and the number of children and beds falls, the probability that the existing beds will match children's needs at all times decreases. It becomes more difficult to manage the uncertainty of demand efficiently when small numbers of children and placements are considered.

Figure 4.15: Probability that the number of beds meets children's needs at the local authority level

Local Authorities	Meet demand less than 50% of the time	Meet demand 50-80% of the time	Meet demand 80-95% of the time	Meet demand more than 95% of the time
Homes for disabled children	60	13	13	63
Secure units	55	55	22	17
Under 13	80	26	10	33
13-15	60	22	12	55
16+	38	12	18	81
Emergency placement	40	32	26	51

Source: Deloitte analysis, 2007

This also indicates that some local authorities do not have enough beds for their own needs and others who have many more beds than they actually require.

4.3.3   KEY FINDINGS

The key findings of the model produced to forecast supply and demand are:

Fewer beds per child are required as the geographic area of allocation increases; conversely, more beds per child are needed as the allocation area decreases (e.g. as placements are considered within a short distance of a child's home).

- Figure 4.7 showed that the number of beds per child required is 1.5 if allocating within the local authority but falls to 1.3 beds per child if allocation is regional. This suggests that 10,081 beds are required if allocating locally but 8,562 beds are required in England if allocating regionally.

- The total number of beds required declines as the allocation area increases; there is less uncertainty of demand and more supply across larger areas, increasing the likelihood of a bed being allocated quickly.

- Figure 4.15 showed insufficient supply more than 50 percent of the time in many areas, when considering a more limited geographic area and fewer children and beds, because of the decreased probability that the existing beds will match children's needs at all times.

Regional analysis shows that in most regions the required number of beds per child is lower than the number of beds currently registered.

- Only London has fewer beds than it needs regardless of whether beds are allocated at local authority, sub-regional or regional levels. (The majority of London boroughs currently compensate for this by arranging out of borough placements.)

- The North East shows a shortage of beds per child unless allocation takes place is at the regional or national level.

- All other regions have excess supply at all geographic levels of allocation.

- The required number of beds generally falls as the allocation area increases in size. However, there are some exceptions where the reduced waiting times imposed at sub-regional level have a greater impact than the benefits of allocating at sub-regional rather than local authority level.

Across the segments there is generally an excess supply at the national and regional levels, with the exception of secure units and homes for children aged below 13.

- As shown in Figure 4.9, when the six segments are considered nationally, there is a shortage of beds in secure units and homes for children under the age of 13 (estimated to be equivalent to 20 and 51 beds respectively). The remaining four segments are oversupplied, with beds for young people aged 16+ exceeding demand by the greatest margin (estimated to be around 2,010 beds).

- Some sub-regional areas have an excess supply in some segments while others have a substantial shortage. Secure beds and beds for children under the age of 13 are most frequently undersupplied (by 43 and 32 percent of sub-regions respectively) whereas beds for young people aged 16+ are oversupplied in 57 percent of sub-regions (Figure 4.11).

- London currently has a very low probability of meeting placement requirements within its boundaries across each of the six segments (Figure 4.12).

- When considering the probability of meeting demand, supply is most insufficient for children with severe disabilities as well as children requiring secure beds or beds in homes for

children below the age of 13. In over a third of sub-regional areas supply is unable to meet demand in over half the cases where such placements are required (Figure 4.13).

A greater proportion of local authorities have an excess supply or substantial shortage across the segments.

- More local authorities than sub-regions fail to match supply and demand for placements.

- A greater proportion of local authorities have a substantial shortage of beds in each segment rather than a substantial excess and would fail to meet demand more than 50 percent of the time (Figure 4.10 and Figure 4.14).

- The segment with the most significant shortage is beds for children under 13 where around half the authorities fail to provide adequate supply (Figure 4.10).

- Beds for young people aged 16+ is in greatest excess with around a third of authorities having more beds than required and over 50 percent of authorities being able to meet demand more than 95 percent of the time (Figure 4.10 and Figure 4.14).

Local authorities are more likely to be able to meet needs and reduce costs if they consider placements over a wider area.

- A declining number of beds is required per child as the area within which a placing authority is attempting to find beds increases because:

  - It is easier to manage the uncertainty in the pattern of arising needs; and

  - It is easier to find a suitable placement across a larger number of homes.

- Consequently, disparities witnessed at the local authority level cancel out.

- Needing fewer beds is, therefore, likely to reduce costs because it will reduce the number of empty beds in the market at any given time.

There has to be a trade-off between distance, needs and cost.

- Planning placements over a wider area increases the likelihood of meeting needs.

- If authorities want to place children nearer to home more beds are required to meet needs and as a result costs increase.

- Given that funds are constrained it is important to consider the trade-off between providing beds that are close to the child's original home but offer a more generic service and offering homes that are more specialised in catering for specific needs but that may not be available locally and may be more expensive.

- A potential solution may be to focus on local placements for children with generic needs but plan specialist placements over a wider area.

4.4   LIMITATIONS

Two types of limitations must be considered in relation to the model: limitations based on data inputs available, and limitations of applying the model in practice. These limitations are highly significant and suggest that this model should not be seen as a solution in itself but as a tool to be used alongside other considerations of supply and demand in the residential care market. The limitations of applying the model in practice also highlight a number of factors which should be further considered when determining the quantity of beds required. These factors are explored further in Section 4.

4.4.1   LIMITATIONS OF THE INPUTS TO THE MODEL

The results of the model rely heavily on the assumptions made and on DfES and CSCI data. It is therefore, important to highlight some of the main limitations of these inputs.

Reliability of data input is limited.

Checking the reliability of data used was out of the scope of this project but may have significant bearing on the reliability of the results. Of particular concern is the fact that much of the available data was from 2005/6. For example, data on the number of placements by local authority refers to 31 March 2005. This means that recent market trends (such as continued consolidation in the sector or changes in the needs of children) are not taken into account.

Data on the types of beds supplied is particularly limited.

The data that is collected on the number of available beds provides only limited information on the type of beds. A key constraint is that this data does not correspond to the segmentation used in the model. A number of assumptions therefore have to be made to break down supply to the different segments. For example, we have used the breakdown in placements by age group to indicate how supply is divided by age. This is a particular constraint which makes analysis of the model outputs by segment difficult.

Data on the location of specific types of home was also unavailable.

Optimal data is not systematically collected and available at the national, regional and local authority levels.

Some data required was only available at the regional or national levels. For example, national data had to be applied relating to the duration of placements by type of need and assumptions had to be made as to the average duration of emergency placements.

In some cases data was unavailable below the national level because the number of children in a category is so small that the figures are not released to protect their identities. For example, this constraint affected the availability of data on residential placements by type of need.

Information specific to the residential care market is limited in some cases.

Projections of the number of children in care were only available at the aggregate level and did not differentiate between residential care and other types of care for looked after children (such as foster care). Furthermore, there was no data available on the needs of children when they are in care (only on their needs as they enter care).

Furthermore, some significant sub-sections in the market were not broken down in statistics. In particular, data for the number of respite care placements was unavailable. Consequently, respite care is amalgamated into the overall figures for beds suitable for children with disabilities. This is a constraint because evidence from the interviews indicated that there is a shortage of respite care and that as a result more children with severe disabilities are entering the residential care market full time.

A breakdown between beds in secure units allocated to the Youth Justice Board (YJB), as opposed to being used for welfare cases, was not obtained during this study. This is significant as YJB beds are contracted and unavailable to local authorities placing children outside the court system.

4.4.2   LIMITATIONS OF APPLYING THE MODEL IN PRACTICE

Modelling by its nature requires a simplification of reality. Consequently, a number of the complex realities existing in the residential care market could not be considered within the model. These realities are discussed below.

Effective residential care is underpinned by a focus on outcomes.

As emphasised in *Every Child Matters* and *Care Matters*, residential care is not simply about placing a child in a bed within their relevant segment. As corporate parents, local authorities are aiming to achieve the best possible outcomes for looked after children in terms of their ability to:

• Be healthy

• Stay safe

• Enjoy and achieve

• Make a positive contribution, and

• Achieve economic wellbeing

Consequently, even though the model suggests an oversupply of beds it is limited by the fact that it does not consider the quality of these beds in terms of the outcomes a child placed there could achieve.

In particular, beds for young people aged 16+ consistently came out of the model as being oversupplied. Yet, a number of participants in this study from care providers highlighted the inadequacies of many of these beds.

Factors influencing the quality of provision therefore need to be addressed in order to optimise demand and supply within the residential care market with respect of achieving good outcomes.

Complex needs and the need for choice must be considered.

The model assumes that the market can be divided into six segments and that a child within each segment can be placed in any bed of that type. However, the reality is that children in residential care have complex needs and some available beds will not meet those specific needs. Such needs may require a specific type of care (such as psychological or emotional support) or a specific size of home (a child may require a solo unit or dual placement).

Furthermore, children need access to wraparound services including education and healthcare. In some cases such services are accessed within the local authority and in others they may be offered by the care provider. Clearly, a child requiring access to specific medical services or particular educational provision will have a reduced number of appropriate options available to them. The model does not consider such needs or constraints.

Nor, due to its static nature, does the model consider changes in demand. The model, built on data from 2005/6, is backward looking and considers only the average supply and demand at a given time; it does not consider fluctuations. Particularly in areas with few children in residential care, relatively small increases in the number of children requiring placements could have a significant impact on the number of beds required (for example, East Riding's small population of children in care doubled because two large sibling groups were taken into care).

Therefore, to optimise the quantity of beds available within the residential care market, needs must be more fully considered than is currently possible in the model.

Demand may be artificially suppressed.

The model is based on an assumption that the number of children currently in care is an adequate reflection of demand. However, interviews with care providers and social workers conducted as part of this study indicated that residential care may not be used optimally at present, largely because of negative perceptions surrounding residential care. This suggests that demand may currently be suppressed below optimum levels and that both demand and the quantity of beds required could change if such perceptions were addressed. This was considered in Section 3.

Barriers to effective co-ordination inhibit sub-regional and regional placements.

The model assumes that local authorities will co-ordinate to place children in residential care. Discussions with local authorities and care providers suggested that such methods of joint working are developing but remain immature.

Furthermore, the model assumes co-ordination and placements based on administrative boundaries yet co-ordination within a geographic area may be a more pragmatic approach in some cases, particularly if a local authority lies on the boundary of two or more regions.

Commissioning practices are not mature.

The model cannot take into account commissioning practices which may impact on the quantity of beds supplied, such as existing agreements between local authorities, a preference to relocate looked after children due to high costs of care in particular areas (as witnessed in London), and a preference for local authority managed provision.

The model clearly shows that the likelihood of finding a suitable placement increases over a larger geographic area. However, regional commissioning is just developing and presents challenges in terms of keeping children within 20 miles of their home, which is a performance indicator that many local authorities are taking increasingly seriously in placement decisions.

Planning considerations impact placement decisions.

The sophistication and approach to planning varies by local authority, with some embracing longer term planning and others focusing primarily on the immediate needs of individual children. Some have preventative services that reduce the number of beds required, while others take an ad hoc approach to emergency placements, thus increasing the beds required.

The model assumes that the process of placing a child relies only on the decision of the local authority. However, in the case of beds within secure units, all beds for young offenders are managed by the Youth Justice Board. The Youth Justice Board has a different placement process and is governed by regulations which are not considered within the model.

Contracting changes the actual supply available.

There are practices within the market to contract beds and block contract a number of beds at once. As a result, at any one time not all empty beds may be available.

Rising occupancy per home may have staffing implications.

The model assumes that all empty beds are available yet certain staffing levels are required per child in a home. It may be that some empty beds cannot be filled because a home does not have the staff required to care for any additional children.

The pursuit of value for money is a priority.

Value for money is a key pursuit and relies on clear visibility of costs and placement quality. The model does not consider price or quality, though price and budget considerations may limit placement options. Difficult decisions have to be made by commissioners who aim to commission care for all children in residential care that will achieve the best outcomes possible.

Clearly, reality is more complex than a model and this section has highlighted that whilst the model gives commissioners a useful tool, it cannot incorporate all the complexities involved in this market and therefore should be considered alongside a needs analysis as part of a planning and commissioning process.

5 CONCLUSIONS

The conclusions section summarises key findings from our primary and secondary research. They focus on general findings in relation to optimising the supply of children's residential care and on specific issues in further developing the economic model.

5.1 NEXT STEPS IN OPTIMISING THE MARKET

Throughout our consultations, a number of themes recurred regularly. Often they were presented as issues that need to be addressed in order for residential care to function more effectively; occasionally they emerged as good practice that could be more widely adopted to the benefit of the market. They include:

Facilitating structures and cultures that promote joint working.

- Creating the necessary mechanisms, eliminating the bureaucratic barriers and making the financial and human resources available to facilitate joint working among departments and authorities.

- Effecting joint working and pooled budgets such that children have access to the breadth of needed resources regardless of the type and location of their care home.

Promoting more effective commissioning, contracting and market management.

- Designing an optimal commissioning structure within local authorities that includes corporate parenting, an integrated view of service provision and a 'whole-organisation' approach to commissioning.

- Developing an outcomes framework based on Every Child Matters outcomes that can be used nationally.

- Creating a clear standard contract and placement process for residential care that can be tailored based on local requirements but which is transparent and not bureaucratic.

- Establishing preferred provider frameworks and closer links between local authorities and care providers.

- Integrating placement monitoring and reviewing processes into commissioning practice.

Embedding strategic level needs analysis and long-term planning.

- Moving beyond exclusively analysing individual needs to aggregating needs at the macro level within authorities, regions and partnerships.

- Considering children's changing needs in planning for care provision.

- Examining cohorts, children in care, children in need, healthcare and trends as a way of forecasting demand and stimulating the market to provide supply that is fit for purpose.

Promoting value for money with a focus on quality.

- Developing a target strategy for managing the trade-off between choice and efficiency.

- Increasing the visibility of costs for care provision.

- Developing an outcomes framework and monitoring against it to determine which providers deliver quality care.

• Resourcing staffing capacity for quality care provision.

5.2 NEXT STEPS IN DEVELOPING THE MODEL

This section highlights the most critical gaps in data that would be necessary to fill in order to increase the reliability of data in the model and therefore make it more widely applicable.

Segmenting the market for clarity of purpose.

• Creating a clear segmentation strategy for segmenting the market that is accepted in the market and can be used across the market as a standard way of describing types of care provision.

Collecting data that enables greater depth of analysis of residential care.

• Collecting data on the average annual and monthly occupancy rates and actual capacity of individual care homes.

• Collecting data on the needs of children as they progress through care as well as at the point of entry and making that data available locally, regionally and nationally to identify trends and needs.

• Providing a user friendly tool for local collection of relevant data.

• Disaggregating data on children in residential care from looked after children to increase transparency of figures and trends.

• Creating a user friendly and easily accessible clearinghouse of information about care homes, including what services they offer, how they are evaluated, their size, and the type(s) of provision offered.

Coming to clear conclusions on how to balance the tensions between the preference for local provision and the gains allowed by regional or national co-operation.

• Determining when local placements should be preferred and when needs are specialised enough to warrant care provision that may be further afield.

• Understanding the cost implications of developing and maintaining specialised service provision to place children close to home.

6   ANNEX A – LIST OF INTERVIEWEES

The following is a list of the local authorities interviewed:

Local Authority	Urban	Rural	Unitary Authority	County Council	Block / regional commissioning experience	High deprivation	Low deprivation	High # of children in residential care	Low # of children in residential care	Significant # placed out of authority	Net receiver from out of authority	High % LAC with 3+ placements	High % LAC on remand / detained
Birmingham	✓			✓	✓	✓		✓		✓		✓	✓
Blackpool	✓		✓			✓						✓	
Cornwall		✓		✓				✓					
Coventry	✓			✓	✓							✓	✓
Durham	✓			✓					✓				
East Riding		✓	✓		✓								
Leeds	✓			✓		✓		✓					
Lewisham	✓		✓							✓		✓	
Manchester	✓			✓	✓	✓		✓		✓			✓
West Sussex		✓		✓				✓		✓		✓	

We spoke with the following representative groups:

Representative organisation	Overview
Council for Disabled Children (CDC)	The Council for Disabled Children (CDC) provides a national forum for the discussion and the development of a wide range of policy and practice issues relating to service provision and support for disabled children and young people and those with special educational needs. CDC talk to parents of disabled children, and disabled children themselves, as well as voluntary and statutory agencies, in order to collate and share examples of good practice in children's services. Their membership is drawn from a wide range of professional, voluntary and statutory organisations, including parent representatives and representatives of disabled people. "Our membership and extensive network of contacts gives us a unique overview of current issues. It helps us promote collaborative and partnership working among organisations, and develop quality support for disabled children and their families." CDC are currently working on several projects including work with children's trusts, accessibility planning, and disabled children from black and minority ethnic communities.
Independent Children's Homes Association (ICHA)	The Independent Children's Homes Association (ICHA) is the voice of independent providers of child care services and resources for children and young people. ICHA is a not for profit Association, representing professionals who have chosen to work in the independent sector. ICHA currently represent more than 60 member organisations. Those members represent over half of the independent capacity in England and Wales.
National Youth Advocacy Service (NYAS)	The National Youth Advocacy Service (NYAS) is a UK charity providing children's rights and socio-legal services. NYAS offer information, advice, advocacy and legal representation to children and young people up to the age of 25, through a network of advocates throughout England and Wales. NYAS is also a community Legal Service.

Representative organisation	Overview
National Centre for Excellence in Residential Child Care (NCERCC)	The National Centre for Excellence in Residential Child Care (NCERCC), based at NCB, is a major collaborative initiative to improve standards of practice and outcomes for children and young people in residential care in England. The centre aims to become a principal reference point for all matters relating to residential child care in England with the scope to work collaboratively and to target key stakeholders, including commissioners, providers, researchers, practitioners, regulators, children, young people and families. NCERCC is funded by the Department for Children, Schools and Families to deliver a two and a half year programme (November 2005 to March 2008) steered by a Programme Board representing key stakeholders. NCERCC is based within NCB's Social Inclusion Department. The Social Inclusion Department aims to enhance the inclusion and life chances of potentially marginalised/excluded children and young people.
The Who Cares? Trust	The Who Cares? Trust is a national charity working to improve public care for around 60,000 children and young people who are separated from their families and living in residential or foster care. The Who Cares? Trust work to promote the interests of children and young people in public care and work with all those interested in their well being in England, Scotland, Wales, Northern Ireland and around the world. The Who Cares? Trust designs and manages a variety of development programmes with an overall aim to promote the improvement in outcomes for children in care in terms of their education, health, employability and preparation for leaving care and independent living. The Trust also produces the only national magazine for young people in care. Established in 1987, the magazine is quarterly and is read by 31,000 13-18 year olds throughout the UK.
Voice	Voice is one of the UK's leading voluntary organisations working and campaigning for children and young people in public care. Their core services are: • Individual advocacy service direct to children and young people in care or in need and care leavers accessed through their Free phone helpline. • Visiting advocacy services to children in residential care, Secure Units, Secure Training Centres and Young Offenders Institutions. • Independent services for agencies including the provision of Independent Persons and Investigating Officers for Children Act complaints procedures and Independent Persons for secure accommodation criteria review panels. Voice work directly with over 3,500 young people each year and all 61,000 children and young people in care benefit directly from Voice's campaigning work. Voice also support other professionals in the childcare field by providing specialist advice and training services. Voice is the working name for voice for the child in care.

Source: All information taken from the websites for each organisation.

We met the following care providers:

Care providers	Ownership S=state I=independent V=voluntary	Size S=small M=medium L=large	Overview
Acorn Care and Education	I	M	Acorn Care and Education is a group of **special schools** and **foster networks** committed to providing individual care and education to children and young people. The foster networks recruit, train and support carers to provide safe and nurturing homes on both a short-term and permanent basis. The specific learning needs of pupils are accommodated across a range of residential and day schools (ten in total), some focusing specifically on the youngest pupils, whilst others expertly support the achievement of school leavers.

Care providers	Ownership S=state I=independent V=voluntary	Size S=small M=medium L=large	Overview
Advanced Childcare	I	L	Advanced Childcare is a leading provider of **residential care, education and fostering** for children and young people with behavioural, emotional and social difficulties. The organisation aims to deliver high quality, outcomes-focused care and education, distinguished by:- • City centre provision. All Advanced Childcare's facilities are in urban settings, in Greater Manchester and the West Midlands. • Dedication to education. An absolute commitment to the provision of first-rate education, through schools registered through the Department for Children, Schools and Families. • A range of solutions. From solo placements, to large family-type homes, from semi-independent to crisis, from outreach work to fostering. • Stickability. Advanced Childcare pride themselves on sticking with young people. • Ethical pricing. Advanced Childcare does not profiteer at the expense of local authority partners.
Atkinson Unit	S	S	The Atkinson Unit was opened in the late 1970s as a South West Regional Secure Unit providing **secure accommodation** for up to 16 boys and girls. 10 of the 16 beds are booked by the Youth Justice Board (YJB). The Unit provides **education**.
Barton Moss	S	S	Barton Moss **secure unit** has 20 beds for young males contracted to the Youth Justice Board (YJB). The unit takes children aged 10-17.
Beaumonds	V	S	Beaumonds provides **short-term regular breaks** to children and young males with a **learning disability** living in the Bath and North East Somerset area. The project is a registered children's home and is registered for children from 5-18 years of age. The project currently provides a service to more than 20 young people, of which only 5 can be in at any one time. Beaumonds is a Quarriers project. Quarriers is a registered Scottish Charity provides more than 100 projects for adults and children with a disability, children and families, young people, young people with housing support needs, people with epilepsy and carers.
Beechfield	S	S	Beechfield is a six bedded, mixed gender unit, which offers **secure accommodation** to young people aged 10-15 years (9-13 years with Secretary of State Approval). Beechfield is a national resource. Supported by the local authority, Beechfield has opted not to contract placements to the Youth Justice Board for young offenders and therefore specialises in offering placements for children with **welfare needs** under sec 25 of the Children Act 1989.
Care UK	I	L	Care UK is a leading independent provider of person-centred care to a broad spectrum of service users throughout the UK. They operate 90 community based care homes and independent hospitals supporting older people, those with learning disabilities, mental health problems and children. Care UK's services for children include Corvedale Care which is a leading provider of **specialist residential, educational, therapeutic care services** to young people aged 10 to 17. Corvedale Care runs a number of children's homes in Shropshire and Wales including Crisis Care (an adventure activities facility on the Welsh border). Services include: • **Learning for Lif**e - a highly specialised service offering care, education, adventure activities and psychotherapy to children in care aged 10 to 16. • **Safe & Sound** – medium to long-term placements for young people who need higher than normal levels of supervision, a programme of activities that allows a purposeful style of life and a programme of education that can provide flexibility and a great deal of individual teacher input. Care UK also offers: • **Little Islands** which provides a **range of homes** for both boys and girls 11-17 years old; • a **Fostering Support Group** which provides foster placements across Kent and South London; and

Care providers	Ownership S=state I=independent V=voluntary	Size S=small M=medium L=large	Overview
			• **Into Independence** which specialises in meeting the needs of young people who are not emotionally or practically equipped to cope on their own. Accommodation is provided for up to 4 young people aged between **15 and 17 years of age**, all of whom have their own bedroom and 24 hour staffing.
Castlecare	I	L	Castlecare is a national network of **children's homes with education**. Castlecare provide comprehensive care packages from crisis to long-term solutions and offer specialist programmes for sex offenders and for children within the learning disability spectrum.
Clifford House	I	L	Clifford House provide residential **children's homes, independent fostering agency and registered school** for looked after children. Resources include: • Initial assessment/same day referral unit; • Small group homes; • Enhanced support units; • Intensive/shared intensive placements.
Continuum Care & Education Group Ltd	I	L	Continuum Care & Education Group Ltd offers a full range of services. Continuum's philosophy is to offer a continuous and individual service, based upon quality **care, education and health**. The Continuum Group supports over 140 young people in their development. There are 19 schools registered by the Department for Children, Schools and Families, 40 LEA schools and 80 homes accessible across the UK. Services include: • Solo care; • Dual care; • Group care; • Education services; • Clinical intervention; • Fostering; • Residential family assessment centre; • Supervised contact; • Respite care; • Domiciliary care; • Escorted transportation; • AALA registered outward bound services; and • 16+ independent living.
Five Rivers	I	L	Five Rivers provides family-sized homes located in residential areas. The family atmosphere is important and underpins the environment in a Five Rivers home. Five Rivers also provides **education, foster care placements, intensive singleton placements, emergency and medium stay residential placements**.

Care providers	Ownership S=state I=independent V=voluntary	Size S=small M=medium L=large	Overview
Hesley Group	I	L	The Hesley Group helps people with special needs demands. It provides a **safe environment and individually tailored care, education, encouragement and positive therapies** which can help a person develop their skills and maximise their potential. The Hesley Group serves 154 children and adults with significant special needs in 3 establishments of which two are schools and one a college/village and includes several satellite homes. • Fullerton House School is a 52 week residential school which exists to help those special children and **young people aged 8 to 19** who experience autism, severe and complex learning difficulties and who exhibit associated challenging behaviours. • Wilsic Hall School is a 52 week residential school which exists to help those special children and **young people aged 11 to 19** who experience autism, severe and complex learning difficulties and who exhibit associated challenging behaviours. • Hesley Village and College exists to help those special **young people and adults over the age of 16 years** who have a range of complex special needs due to autism, severe learning difficulties and associated communication problems. The Hesley Group is dedicated to supporting people with **autism** and **complex and severe learning difficulties.**
Horizon Care Ltd	I	M	Horizon Care Ltd specialises in the **care and education** of young people who are behaviourally challenging and emotionally vulnerable. **Individual behaviour management programmes**, prepared and supervised by their 'in house' clinician, address high risk behaviours such as, self harm, sexual exploitation, absconding, offending and drug & alcohol abuse. The **education programme** is delivered in partnership with the National Teaching & Advisory Service who prepare and support inclusion plans designed to promote the educational achievement of looked after children and ensure statutory requirements are met. Horizon Care Ltd has **small homes** in Lancashire and Staffordshire ranging from single occupancy to four beds. Placements are accepted on a **short, medium or long-term basis** and requests for same day **emergency placements** for up to 28 days are facilitated at their mobile unit with either 1-1 or 2-1 staff ratio depending on level of need and risk assessment. This placement option includes full social, educational and psychological assessment reports. In preparation for discharge **outreach support** services are available to work alongside families or future placements to reduce the risk of disruption during the transition period.
New Horizons Childcare	I	M	New Horizons Childcare specialises in **medium to long term therapeutic residential childcare and education** for children and young people. It is dedicated to: • Ensuring that each young person gets exactly the care, education and support they need. • **Personalised therapeutic care** to assist significantly harmed young people to achieve positive outcomes. • Care focused on improving the emotional well-being of the young person so that they are able to make positive choices for their future. • Educational excellence through supporting young people in **mainstream school as well as providing in-house education**. • Stickability, no matter how difficult a young person's behaviour. • **Pathways to fostering** through a fostering partnership. • **Care for a range of young people** including those who have experienced sexual abuse, are perpetrators of abuse, experience mild to moderate mental health issues including Autism and ADHD, are self harmers, and display EBD. The organisation is committed to being perceived as the best residential childcare provider by continually striving for service excellence in order to achieve the very best outcomes for young people.

Care providers	Ownership S=state I=independent V=voluntary	Size S=small M=medium L=large	Overview
Northerncare	I	L	Northerncare is one of the largest providers of **residential children's homes with education** registered with the Department for Children, Schools and Families in the UK. Northerncare predominantly look after children of **5-17 years** with challenging behaviour/complex needs and children on the periphery of offending. They also offer residential childcare for children displaying inappropriate sexualised behaviour and specialist services for girls. In addition, they have opened a short-term Assessment Centre offering psychological, educational and behavioural assessments by a team of specialists for children suffering crisis and trauma. Northerncare can accommodate **emergency and planned** placements in homes for short, medium or long-term periods.
Safe n Sound	I	S	Operate locally. 2 homes. Look after the **higher end need** of young people (multiple placements, labelled multiple behavioural difficulties, learning disabilities.)
Senad Group	I	L	The Senad Group was formed in 2003 to create a group of **schools** for children and young people with a range of special educational needs and to develop care **homes to support them into adulthood**.
The Grange	S	S	The Grange is one of Coventry's **local authority run homes**. It has under 10 beds and is designed to provide general residential care provision for relatively **short-term** stays.
The Priory Group	I	L	The Priory Group is Europe's leading independent provider of **acute and secure mental health, neuro-rehabilitation and specialist educational service**s. Operating a network of acute hospitals, clinics, specialist schools, rehabilitation centres and secure units, Priory offers treatment and support services for a range of psychiatric and related conditions. In addition to the hospitals, which provide acute psychiatric services covering conditions such as addictions, eating disorders and depressive illness, Priory runs a number of specialist schools and adolescent psychiatry units as well as centres treating patients with acquired brain injuries. Through Blenheim, the Group also operates a number of low and medium secure units for people with enduring mental illness. The four core business areas of the group are: • Special education facilities including residential special schools for young people with emotional and behavioural difficulties, mild learning difficulties, autism and asperger's syndrome. • Acute Hospitals providing high quality care for psychiatric disorders, addictions and eating disprders. • Neuro-rehabilitation Centres providing neurological assessment, treatment, rehabilitation and respite care on a residential basis to both adults and children with acquired brain injury. • Secure and step-down facilities including the Priory Secure Services hospitals.
The Together Trust	V	L	The Together Trust is a charitable organisation, operating in the North of England and North Wales providing **care, education, support** and improved life opportunities for young people in need. The Trust serves **serve children, young people and young adults** who are experiencing emotional, behavioural or social difficulties, physical and/or learning disabilities and autistic spectrum disorders. Their **services cover residential homes, fostering, adoption community services, special schools and a college.**

7   ANNEX B – BIBLIOGRAPHY

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Ofsted, CSCI (2006/7) *Annual Performance Assessment Services for Children and Young People* (Ofsted, CSCI)

In addition, numerous documents were received from participants in this study (local authorities, care providers and representative organisations) including needs analyses, placement process overviews, commissioning strategies and case study information.

department for
children, schools and families