Appendix One

Feasibility study in respect of residential care provision for children in the County Borough of Bridgend (BCBC)

1.0 Introduction

1.1 This document should be considered in conjunction with the *Residential Services Review* report by Val Jones, Group Manager, Service Provision in August 2009 and the revised Comprehensive Placement Strategy April 2009 -March 2012.

1.2 The review report concluded that there are currently four options for Bridgend County Borough Council to consider in respect of its current residential provision. From the evidence collected, Option 1 was indicated as the preferred option, while Options 2 and 3 required examination of alternatives to the in-house emergency/assessment provision outlined in option 1. It also concluded that Option 4, retaining the status quo, was not the best use of resources and could be disregarded.

1.3 This feasibility report mainly concentrates on an analysis of two models, with consideration of the strengths and weaknesses and the risks involved in the adoption of either; it also considers the merits of emergency/assessment provision.

2.0 Overview

2.1 It is clear both from the review and subsequent research that, overall, the in-house provision currently being provided within the borough is both of a good quality and good value for money, being significantly cheaper than the provision in any of the other 10 local authorities examined. It is important to note that, notwithstanding the relatively low cost, the quality of care and the dedication of staff and managers are impressive and they are to be commended on this.

2.2 There is currently much debate on whether the higher price of external provision is reflected in higher quality of care; the evidence in Bridgend would suggest that this is not the case.

2.3 A number of local authorities have disinvested in residential care in recent years and many are now re-investing in residential care development, recognising that there will always be some children who require group living. This point was also made clearly by Lord Laming in 2003. Residential care has long been thought of negatively as not being a 'natural' home environment and therefore not the best form of care for children and it is often seen as a last resort. However, recent research indicates there is also significant evidence to suggest that outcomes for children who experience good quality residential care are

frequently better than for those children who are returned home and that small group home settings may be the best alternative for those children and young people:

- with challenging emotional and behavioural issues;
- who experience foster care breakdown;
- who are moving on to independent living.

2.4 Current analysis would suggest that, in Bridgend, the quality of care being delivered is high and costs are relatively low, and that this level of quality:cost would be difficult for a private agency to achieve. The main advantage of outsourcing such provision would be to relieve the Council of the operational management functions of the units though there is also anecdotal evidence that outsourcing may provide value for money. The evidence is not overwhelming but has to be taken into account alongside the fact that these advantages could be offset by the resulting loss of control in terms of intake and quality of provision. Building on existing resources of an excellent standard as demonstrated year on year by CSSIW would produce faster results and would not rule out outsourcing in the future.

2.5 In terms of size, the residential units currently in service in Bridgend County Borough Council are approximately the size that is considered 'good practice 'i.e. small units with 4 or 5 beds per unit.

3.0 Assessment

3.1 This is based on an outline of Models 1 and 2, which differ only in the matter of emergency/assessment provision.

3.2 Information gathered indicates that Bridgend County Borough Council is possibly not large enough to support a stand alone in-house emergency bed provision although recommended in Option 1. Other issues in respect of emergency provision also need to be considered;

- where the facility of in-house emergency beds exists, there is the danger that this becomes the first option rather than a focus on crisis intervention to prevent family breakdown;

- the availability of such a provision can lead to an avoidance of rigorous preventative work and result in many more emergency placements than are strictly necessary;

- maintaining empty beds so they are widely available for emergency placements is prohibitively expensive;

- there is clear evidence that a critical success factor in placement stability is getting it right in the first place. Mismatched initial placements tend to lead to a cycle of placement breakdowns;

- emergency placements are not only problematic for the child being placed, they can cause turmoil for children already placed;
- if emergency placements are not managed rigorously it is more likely that beds will be required.

3.3 Model 1 (Three in-house units)

a) In-house emergency / assessment provision
Unit 1 could be re-focussed into a short term 5 bed assessment unit. The purpose of this unit would be to offer an intensive assessment of a young person's needs whilst at the same time working with that young person's family to complete any work that can be done to facilitate a rehabilitation plan. Such a unit could also develop outreach support to children in foster care or those at home but at risk of entering the care system. Evidence would suggest that if such a proposal were to proceed this should be a strictly time- limited unit, possibly 12 weeks maximum stay, which would mean robust work would need to be done with the child and family or foster carer to promote rehabilitation. The overall objective of such a unit would be to return young people home from care or where this is not possible, to identify alternative care which appropriately addresses their needs. The specification of this unit would have to be considered in much more depth but units such as these often also provide short –term bridging placements.

The critical success factor in such a unit would be the willingness of staff to extend their remit beyond the care of the children and to be willing to develop and deliver packages of support to parents in crisis.

This unit could also have an emergency provision, although, for the reasons outlined above, it is not generally seen as good practice to have a unit where emergency provision and longer term placements are based together. There is some evidence that, in short-term units, the turnover of placements does have less impact and therefore the emergency provision could be trialled in unit with careful monitoring and evaluation.

b) Complex needs facility
The proposal is that a complex needs facility is developed. The principal aim of such a unit would be to meet the needs of some of the children who are currently placed in out of county provision. This would provide 4 beds. The staff profile undertaken as part of the residential review indicates that the skill base amongst current residential staff is broad and encompasses a range of disciplines and skills not being currently being fully utilised. There will of course be some staffing training/development implications. Staff would certainly need to be trained in direct work techniques and some other therapeutic techniques (such as play therapy, art therapy etc). Notwithstanding this, it is fair to assume that the staffing resources already exist to run

and manage such a facility. There is evidence to suggest that care leavers from more therapeutic residential units are 4 times as likely to find employment and 3 times less likely to be convicted of a crime than children from other more generic types of residential settings. The significant factor in the success of providing a complex needs/ intensive support unit will be significant levels of support from a multi agency partnership. This will need to include education, CAMHS and other health services, social work and other service providers. In order to ensure high staff:child ratios, additional staff could be redeployed from other units. Essential features of such a unit would be:

- robust educational arrangements;
- support to families at evenings and weekends;
- accessible support from CAHMS;
- above average level of support and training for staff;
- co-ordinated method of working that aims to address behaviours in the home, school and community;
- structured therapeutic interventions.

Case files of seven children identified as possible candidates for a unit such as the re-configured complex needs unit have been reviewed. Whilst a lot more detailed work would have to be done to ensure the care of these children is not compromised, there is sufficient evidence to show that there are children currently in independent foster placements who could be returned to the borough and be supported in such a unit. The key element for such children would be the provision of appropriate education and in some cases specialist mental health services. The final key ingredient of success will be staff commitment, which is evidenced in the residential care review.

c) Transition Unit

It is proposed that this should be a transition unit: this would be a 16+ unit dedicated to preparing care leavers for independence. This could provide 5 beds. It could be expected that there would be some staff savings as slightly lower staff: child ratios would be required to support the semi-independent brief. However, again significant support would be required from a range of professionals to support the remit of the unit. These would include the careers service, benefit agencies, aftercare and housing. Key to the success of such a unit would be the development in tandem of a post 16 service, already identified in the new Safeguarding and Family Support Service structure. There is a lot of research to indicate that it is the lack of support for young people who have been in care that is more likely to result in the poor outcomes associated with care leavers than the care system itself. Thus, this kind

of provision is crucial to improving outcomes for the most vulnerable care leavers.

The key element of such a unit will be a commitment from decision-makers to ensure that only appropriate young people are placed in such a unit. This would not be a high support needs unit and if young people with high support needs are placed in this unit, the impact will be that the work to support others into independence would be impeded in the drive to support a particularly needy young person. The evidence suggests that such a unit could have a profound and positive effect for vulnerable young care leavers but that it could not support those with complex problems who will continue to need adult services post 18.

3.4 Model 2

Accepting that Bridgend County Borough Council currently has a higher number of residential beds than many other authorities pro rata, we could consider streamlining our provision and closing one unit. The focus of the remaining staff group could be re-configured to incorporate the remit of an outreach crisis intervention / prevention of accommodation team (with possible additional remit of assisting with the rehabilitation from accommodation). A critical feature of such a team would be the ability to respond out of hours. There would be some skills development and training issues for staff, but largely the current staff team would be able to undertake this kind of work with little additional training. A key function of this team could also be to support foster carers when there is a potential placement breakdown and to work with them on the rehabilitation of accommodated young people. Effective prevention will save money, but ineffective attempts at prevention may well do the opposite. It is therefore vital that preventative models that have evaluated evidence of efficacy are employed, and that a robust system of monitoring and measuring outcomes is established. Department for Education and Skills research found that the value of such services lies in the extent of direct work undertaken with the families, the promotion of strategies to change the young person's behaviour and address emotional problems and the reframing of parent/child relationships and mediating between them.

Initial discussions indicate that there is a demand for such interventions and that such a remit could be accommodated within the structure of the existing family support team in partnership with other providers.

For Complex Needs Unit and Transition Unit within Model 2, see sections 3.3b and 3.3c

4 Conclusion

Taking the above into account alongside findings in the review on emergency placements and the fact that Bridgend currently has quite a

high level of residential provision compared to similar sized authorities, it is proposed that Model 2 is adopted, closing one unit, with minimum disruption to residents. Emergency provision would be spot purchased in the short term, with consideration being given to methods of rigorous gate- keeping of the use of such provision. In the longer term, in-house emergency fostering provision could be developed, with consideration to be given to retainer payments for a small number of beds.

For further information, see a SWOT analysis of both models (see Annex 1) in order to consider the strengths and risks of the proposal.

4.0 Financial considerations

4.1 If Model 2 was adopted (ie. closure of one unit) overhead costs could be saved in the region of approx £33,000 pa. There may also be some savings in staff costs if the option to re-focus the remaining staff group did not utilise all posts.

4.2 The cost of spot purchasing an emergency bed is on average £800 per week and it is vital to this possible re-configuration of services that such placements are severely limited in both time and quantity and this will rely on robust gate- keeping and a clear focus on the prevention agenda.

4.3 The complex needs facility costs would be slightly higher to reflect a more intensive staff:child ratio. There would be some staff training costs but the additional expertise would mainly be coming from a re-configuration of related services. In order for this unit to be cost-effective, it would have to achieve a cost saving of at least 2 private provider placements per year. This has previously been costed at approximately £40,000 per placement in an IFA or approximately £100,000 in a residential placement.

The transition unit costs would be broadly the same as currently.

Notes

- It is possible that there maybe some job evaluation costs associated with requiring staff to become more skilled and specialised than they are currently.
- If Model 1 were to be adopted (i.e. keeping all 3 units) some additional staff would be required to ensure that the complex needs facility had high enough staff: child ratios.
- There maybe some additional cost savings associated with the vacated building, if the decision is taken to close a unit and sell or rent the excess unit.

Nicola Echanis

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ANNEX 1

<u>SWOT Analysis</u>:Model 1 (with in-house emergency/assessment provision)

Strengths

Addresses the need to reduce numbers of children placed out of county

Addresses the need to provide better 16+ services

Reduces the number of emergency admissions

Enables a thorough assessment of children to ensure future placements are appropriate and therefore less likely to breakdown.

Weaknesses

Limited in-county emergency provision

Requires significant staff commitment

Requires significant multi agency support

Additional staff will be required

Opportunities

Staff will be able to use skills not currently employed fully

Builds on current good practice

Robust assessments of children’s needs can be undertaken before long term placement decisions are made.

Threats

Possible staff resistance

Multi agency support is crucial to success

Cost of spot purchasing if emergency bed access is not controlled

May require some job evaluation

<u>SWOT Analysis:</u>- Model 2 (complex needs and transition units only.

<u>Strengths</u>

Addresses the need to reduce numbers of children placed out of county

Addresses the need to provide better 16+ services

Will reduce the number of emergency admissions

Increases the capacity for focussed preventative work

Will deliver cost savings

Reduces infrastructure costs

Frees a building for another use/sale

<u>Weaknesses</u>

No in-county emergency provision

Reduced overall availability of in-house residential beds

Requires significant staff commitment

Requires significant multi agency support

May require some job evaluation

<u>Opportunities</u>

Staff will be able to use skills not currently employed fully

Builds on current good practice

Costs should be reduced enabling re-focus of resources

Prevention agenda will be strengthened

Enables BCBC to establish a unit of excellence

Threats

Possible staff resistance

Cost of spot purchasing emergency beds

Closed home will need to be used or de-commissioned

Possibility of redundancies

Inadequate multi-agency support

Public opinion