

ORIGINAL ARTICLE **OPEN ACCESS**

The Variations in Children Entering Care Across Local Authorities: Taking Population Characteristics Into Account

Nell Warner¹  | Jonathan Scourfield¹  | Donald Forrester¹  | Rebecca Cannings-John²  | Karen Broadhurst³ | Ann John⁴ 

¹CASCADE: Children's Social Care Research and Development Centre, School of Social and Spatial Sciences, Cardiff University, Cardiff, UK | ²Centre for Trials Research, Cardiff University, Cardiff, UK | ³Centre for Child and Family Justice Research, Lancaster University, Lancaster, UK | ⁴Swansea University Medical School, Swansea, UK

Correspondence: Nell Warner (warnerah@cardiff.ac.uk)

Received: 8 May 2025 | **Revised:** 9 July 2026 | **Accepted:** 25 September 2026

Keywords: care entry | children's social care | local authority variation | out-of-home care

ABSTRACT

The rates of children entering public care vary by local authority, but it is hard to know how much this is due to population characteristics or practice variation. This study used linked Welsh administrative datasets to run multilevel logistic regression models predicting care entry. These explored variation across local authorities when population characteristics were controlled for. Local authorities with care rates higher or lower than their populations would have predicted were identified. Focus groups with social workers in local authorities with rates lower than expected by population need saw LA practice culture and attitudes as linked to lower rates.

1 | Background

In the United Kingdom (UK) children are placed in public care by local authorities (LAs), sometimes with court involvement. The term 'rate' is generally used in the UK children's social care sector to describe the number of children per head of population who have a particular service, and these rates of children in public care vary considerably between LAs. For example, in England in 2024 the rates varied from 191 children per 10000 in the LA with the highest rate (Stoke on Trent) to 25 per 10000 in the lowest (Richmond upon Thames) (UK Government 2025). Figures from Wales for 2023, show a rate of 200 per 10000 in the LA with the highest rate, (Torfaen) compared to 52 children per 10000 for the lowest (Carmarthen) (Stats Wales 2025).

Given these disparities, it is important to understand why rates of care vary. Potential explanations fall into two main categories: variation caused by differences in the populations the LAs serve

(and therefore in the needs and risks children are experiencing), and variation caused by differences in practice. Research has identified numerous factors that are associated with an increased risk of children entering care. The relationship between poverty and care entry is well documented. Children from families living in poverty are more likely to enter care (Bebbington and Miles 1989; Barth et al. 2006; Franzén et al. 2008), as are children living in areas where poverty is more prevalent (Bywaters et al. 2020; Bennett et al. 2022). This suggests that in LAs where there are higher levels of poverty, a higher care rate might be expected, an effect that has been confirmed by previous research (Dickens et al. 2007; Elliott 2017). These studies calculated the extent to which deprivation explains the variation in care rates. For example, Dickens et al. (2007) suggested relative need accounted for about 40% of the variations between LAs in children starting to be looked after. Elliott (2017) showed that the proportion of households in a LA that are classified as being among the most deprived 10% of areas in Wales can explain 34% of the

This is an open access article under the terms of the [Creative Commons Attribution](https://creativecommons.org/licenses/by/4.0/) License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

© 2026 The Author(s). *Children & Society* published by National Children's Bureau and John Wiley & Sons Ltd.

variation in children in care between LAs. Hodges (2020a) calculates that 47% of the variations between LAs can be explained by deprivation.

Various parental factors have also been identified as risk factors for children entering care, including substance misuse, mental health issues, domestic abuse and some forms of neurodivergence (Franzén et al. 2008; Simkiss et al. 2012; Melis et al. 2023; Warner et al. 2024). Hodges (2020a) used LA reports of parental risk factors (domestic abuse, substance misuse and mental health problems) to look at how much the prevalence of these risks relates to the rate of care in a LA and found that 35% of the variance in care between LAs was explained by these factors. Her study based the prevalence of these risks within each LA on reports in children's social care data and so relies on the social work interpretation of whether or not a risk is present. Nevertheless, it suggests that the levels of these risks in a population may have a substantial impact on rates of care. Altogether Hodges calculated that the combined effects of these parental factors and deprivation accounted for 72% of the total variation. The relationship between care and population need has also been identified in England; for example, Fitzsimons et al. (2022) have highlighted that a substantial proportion of LA variation is explained by the characteristics of children, families and neighbourhoods.

While the population served by a LA and the nature of the problems in them clearly have a big effect, they cannot fully describe the differences across LAs, and there are cases where LAs have similar populations in terms of deprivation but widely varying care rates. Dickens et al. (2007) cite a range of elements of practice and support that might impact on care rates, including policies and processes, availability of preventative services, decision-making procedures, and the wider culture of departments and attitudes of individual staff members. There may, in turn, be many factors that impact on these, such as resourcing, the way that other agencies work with the LA or the practices of local courts. In England, Webb et al. (2020) found evidence of an 'inverse intervention law,' which showed that when neighbourhoods with similar levels of deprivation were considered, intervention rates tended to be higher in LAs which had lower levels of deprivation altogether when compared to LAs with higher overall levels of deprivation. However, no such effect was observed in Wales (Elliott and Scourfield 2017). Care rates have also been associated with political affiliation, with Webb and Bywaters (2024) showing that once they have adjusted for child poverty, average household income, and expenditure, then the political party controlling the LA has an impact, with Labour authorities having lower rates of looked after children than Conservative ones.

Another area of difference between LAs can be found when we look at how care rates within different LAs have changed over time. Overall, the numbers of children in LA care in both England and Wales have been rising over time (Thomas 2018), however, within this, the numbers in some individual LAs have decreased (Wijedasa et al. 2018; Forrester et al. 2021). As Forrester et al. (2021) point out, these changes are not accompanied by similar changes in underlying population factors, nor could they be driven by national policy or economic change. They therefore suggest changes to policy and practice within these LAs. Forrester et al. (2021) also found that within those LAs where rates were decreasing, practitioners were more likely

to report that they were confident about their practice, had positive values about birth families and used an outcomes-focused approach. They also reported more consistency in the values of leaders and workers.

This paper presents the findings of a mixed methods study to explore the relationship between risk factors and variations between LAs in rates of children in care. The evidence suggests that variations in care rates are influenced by the nature of the populations that LAs serve and the practices within LAs. However, because different LAs serve different populations, with different levels of risk factors associated with care entry, there is a methodological challenge for researchers to unpick how much the differences between LAs might be due to local practice and how much is due to the population. This is further compounded by challenges that arise because statistical work with larger populations is inherently more reliable than that on small populations, so findings resulting from smaller local authorities can be misleading. This paper presents a way of doing this, as a proof of concept by using multilevel modelling methods with linked administrative data to explore the differences between Welsh LAs once area-level deprivation and parental problems have been controlled for. This shows how this method can identify LAs where the care rates are different to those that would be expected by their populations. This method also has the advantage that it can compensate for the problems of small areas (Moura and Holt 1999). This quantitative analysis was complemented by focus groups within these LAs to present the multilevel modelling results and find out what practitioners felt they could be attributed to. The paper answers the following research questions:

1. How much variation is there between Welsh LAs in rates of children in care once deprivation and parental risk factors have been controlled for?
2. In LAs where rates of care are lower than expected what do practitioners attribute these low rates to?

2 | Method

2.1 | Quantitative Stage

2.1.1 | Development of Dataset

The quantitative element of the study used a dataset derived for a retrospective, national-scale, observational cohort study of children entering care in Wales. Data were derived from Welsh anonymised individual level linked administrative datasets from social care and health care, accessed through the Secure Anonymised Information Linkage (SAIL) Databank, which is a privacy protecting environment (Lyons et al. 2009). The datasets used in the study are outlined in Table 1.

The Welsh Demographic Service dataset (WDS) was used to derive a dataset of households with children aged 3 to 17 in Wales between 2016 and 2020. Households were derived using Residential Anonymous Linking Fields (RALFs) (Rodgers et al. 2009), which used GP registrations to link those registered with a GP at the same address.

TABLE 1 | Datasets used.

Dataset	Contents	Used to identify
Welsh Demographic Service Dataset (WDS)	Register of all individuals registered with a Welsh General Practice (GP) and individual's anonymised address	Household members living with children prior to care entry, LAs, and deprivation level
Looked After Children Wales (LACW)	LA information submitted to Welsh Government about looked after children	Children (aged 3–17) who entered care, and LA of care entry
Patient Episode Database for Wales (PEDW)	Inpatient and day case activity for NHS Wales as well as data on Welsh residents treated in English Trusts	Risk factors in adults in households
Welsh Longitudinal General Practice Dataset (WLGP)	Information about all interactions with general practices registered to share their data with the SAIL Databank	Risk factors in adults in households
Emergency Department Dataset (EDDS)	Information about all attendances at Accident and Emergency	Risk factors in adults in households
Substance Misuse Dataset (SMDS)	Data on individuals presenting for substance misuse treatment	Risk factors

The data on households derived from WDS was linked to the Looked after Children Wales (LACW) dataset to determine whether or not these households had one or more child enter care during the time period. Unaccompanied asylum-seeking children were not included, as their pre-care entry households were not in Wales. Children who entered care for short breaks only (under Part 6 section 76 of the Social Services and Well-being (Wales) Act 2014) were also excluded since they were in care temporarily whilst mostly living with their families. Linkage was carried out using Anonymous Linking Fields (ALFs) (Ford et al. 2009). For the LACW dataset, the ALFs are derived by a third party using quasi-identifiers that use a combination of factors to identify an individual, such as their name, gender, date of birth, and postcode. Within the LACW dataset, this process results in a particularly poor linkage rate for children aged two and under (Bailey et al. 2025), and because of this, it was decided to limit the study to children aged 3 to 17.

Households were given an index date. For households from which a child entered care, this was the earliest date on which a child entered care. For other households, this was randomly assigned according to the distribution of care entry over the period. Households were removed if they contained more than 10 individuals. This was done to minimise the possibility of RALFs identifying institutions and other addresses that do not relate to household units. The delineation of more than 10 individuals had previously been used by Evans et al. (2020). Households with no adult over 18 were also removed, and comparison households were removed if they had data about LAs missing.

2.1.2 | Variables

For households where a child entered care the LA was defined by the LACW data as the LA from which they entered. For those that did not have a child enter care, LA was derived from the WDS.

Adults, aged over 18, in each household were linked to health datasets using ALFs. The health datasets were then used to

identify factors in adults in the households that were known to be risk factors for children entering care. Evidence about the relationship between these factors and care entry is provided in our earlier paper (Warner et al. 2024). The following adult risk factors were identified: drug misuse, alcohol misuse, assault at home, schizophrenia, anxiety, depression, self-harm, learning disabilities, learning difficulties, Attention Deficit Hyperactivity Disorder (ADHD). The term learning disability was used to describe people who have a significantly reduced ability to understand new or complex information and new skills and a reduced ability to cope independently, equating to an IQ under 70, while learning difficulty described those with scholastic difficulties. Risk factors were derived from health datasets: Welsh Longitudinal General Practice Dataset (WLGP), Patient Episode Database for Wales (PEDW), Emergency Department Dataset (EDDS), and the Substance Misuse Dataset (SMDS). Assault at home was derived from EDDS and indicated if an adult had reported to an Emergency Department having been a victim of assault that took place in their home. The remaining risk factors were derived from published code lists. See for example John et al. (2016) for an explanation of how to do this. All code lists used are provided in Appendix 1 (Table A1). Drug misuse, alcohol misuse, assault at home, anxiety, depression, and self-harm were classified as being present if they had happened within the two-year period before the index date. The remaining conditions schizophrenia, learning disabilities, learning difficulties, and ADHD were classified as present if they occurred at any time. Households were denoted as having the risk factor present if any of the adults in the household had the risk factor. An additional variable denoting the number of adults in the household was also created.

Area-level deprivation was classified by the Welsh Index of Deprivation 2019 (WIMD) available for each household from the WDS dataset. This is the official measure of area-level deprivation used by the Welsh Government and is based on Lower Super Output Areas, small areas each with a population of about 1600 people. Areas are ranked from the most deprived to the least deprived. This study used WIMD deciles,

with one being the most deprived and 10 the least (Welsh Government 2019).

2.1.3 | Analysis

The quantitative analysis was carried out using the group level residuals of multilevel models, a method that can be used to rank institutional performance (Leyland and Groenewegen 2020). Two multilevel logistic regression models (households within LAs) were developed to predict the likelihood of a household having at least one child entering care. The first model predicted the likelihood of care with no adjustment for known risk factors. The second model predicted the likelihood of care adjusting for health-related risk factors in the household, the number of adults in the household and WIMD decile. Both models had random intercepts, with households nested in LAs. The first model contained no covariates, and the second individual-level covariates only. No group-level predictors were used. Estimates are presented as odds ratios alongside 95% confidence intervals. Where the health-related covariates are added, then the number of adults in the household was added to control for the fact that where there are more adults in the household, there are more adults for the risk factors to be identified in. The purpose of doing this was to explore how the variance between local authorities changed when the covariates were added. We did this by plotting LA level residuals for the risk of children entering care for both models. These group level residuals are Empirical Bayes estimates of the level-2 random effects on the log-odds scale, which can be used to compare differences in groups with and without covariates (Snijders and Bosker 2012). The plot from the first model shows how much each local authority varied from what is typical for Wales, while the second plot showed how much they vary from what is typical for Wales while taking into account the covariates. Intraclass Correlation Coefficient was also used to compare how much the total variance in the models is due to the LA. There are 22 LAs in Wales and caterpillar plots display the ranks of these against their raw residuals ($\pm 1.96 \times$ standard deviation). All analysis was carried out in Stata.

2.2 | Qualitative Stage

This was carried out with LAs among whom care rates were lower than expected according to the group level residual plots created through the quantitative analysis. The aim was to find out if staff in these LAs attribute these lower care entry rates to any aspect of policy or practice. Four LAs were approached

and two agreed to host focus groups. Local authorities were contacted through Heads of Children's Services and senior managers to ask if they were willing to take part. Among those that did, local authority staff offered the opportunity to participate to those in relevant roles. Both focus groups were carried out by the lead author. One focus group contained four participants and was held in person and the other contained six participants and was held online. Participants were shown a short presentation of the quantitative findings showing how their LA compared to the other LAs in Wales, they were then asked about the reasons why they thought their LA was performing the way it was. The schedule of research questions is shown in Appendix 2. The focus groups were semi-structured, so although there was a schedule of questions the discussion was allowed to flow in the direction that the participants wished. The focus groups were recorded and transcribed, and analysis was influenced by Charmaz's (2006) version of grounded theory, that is, acknowledging the researcher as co-creator of focus group content and accepting that prior knowledge of relevant literature had a role in the analysis. Coding was conducted in NVivo software.

2.3 | Ethical Approval

Ethical approval was obtained from (removed for anonymity) University School of Social Sciences. All focus group participants provided informed consent for their involvement in the research. Additional approval to use the SAIL datasets was provided by the SAIL Information Governance Review Panel (IGRP) at Swansea University.

3 | Results

3.1 | Quantitative Findings

Once households that were not eligible for the study had been removed (i.e., those with over 10 people, no adult aged over 18, or no LA data) the dataset consisted of 293 373 households of which 2763 had entered care (Figure 1), spread over the 22 local authorities.

Table 2 provides descriptive statistics for risk factors in the entire dataset. As expected, all the risk factors are associated with an increased likelihood of a household having a child enter care, as is being from an area of deprivation and a single adult household. Similar findings, using the same dataset but excluding those without birth data, have already been published and

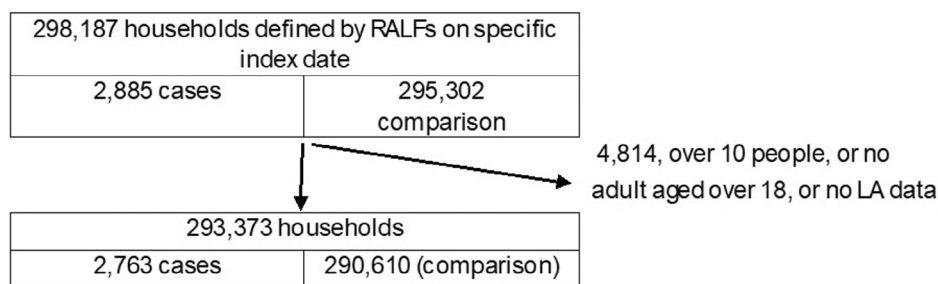


FIGURE 1 | Numbers of households removed from the dataset.

were discussed in more detail in our previous paper (Warner et al. 2024).

The results of the multilevel logistic regression models are presented in Table 3 and group level residual caterpillar plots in Figure 2. Plot 1 shows the group level residuals from the unadjusted model, when no covariates are added. These group level residuals show how much each LA varies from the average Welsh LA. The 'average LA' would be expected to have a residual of 0 represented by the solid line—those LAs with residuals significantly above the line are more likely to have households with children entering care while those below it are less likely.

LAs are ranked in order of the likelihood of children entering care, and are anonymised and denoted by the letters A to X, with A the least likely and X the most likely to have children entering care. As can be seen there are six LAs (authorities S to X) on the right-hand side of the chart whose confidence intervals do not overlap with zero. These LAs are more likely than average to have households with children entering care. One of these LAs, LA X, was significantly more likely than all other LAs to have children entering care. This can be seen by the confidence interval that does not overlap with the confidence interval of any other LA. There were also eight LAs on the left-hand side (LAs A to H), which were less likely than the average to have children

TABLE 2 | Prevalence of household risk factors according to whether or not one or more children in the household entered care.

	Households where child entered care (cases)	Households where child did not enter care (comparison)
	<i>n</i> (%)	<i>n</i> (%)
Total households	2763	290 610
Drugs	420 (15.2)	5989 (2.1)
Alcohol	333 (12.1)	6993 (2.4)
Assault at home	49 (1.8)	684 (0.2)
Schizophrenia	125 (4.5)	2921 (1.0)
Anxiety	690 (25.0)	38 262 (13.2)
Depression	1346 (48.7)	68 531 (23.6)
Self-harm	203 (7.3)	4443 (1.5)
Learning disability	91 (3.3)	2651 (0.9)
Learning difficulty	89 (3.2)	3126 (1.1)
ADHD	116 (4.2)	4203 (1.4)
Adult number		
1	1103 (39.9)	60 667 (20.9)
2	1032 (37.4)	147 083 (50.6)
3	408 (14.8)	52 984 (18.2)
4 plus	220 (8.0)	29 876 (10.3)
WIMD decile		
1 ^a	709 (25.7)	34 206 (11.8)
2	513 (18.6)	31 556 (10.9)
3	374 (13.5)	29 709 (10.2)
4	292 (10.6)	29 966 (10.3)
5	213 (7.7)	26 656 (9.2)
6	187 (6.8)	27 453 (9.4)
7	165 (6.0)	27 906 (9.6)
8	146 (5.3)	26 366 (9.1)
9	103 (3.7)	27 537 (9.5)
10	61 (2.2)	29 255 (10.1)
Total	2763 (100)	290 610 (100)

^a1 = most deprived decile, 10 least deprived decile.

TABLE 3 | Regression output Models 1 and 2.

	Unadjusted model			Adjusted model		
	OR	95% CI		OR	95% CI	
Drug misuse				3.50	3.09	3.96
Alcohol misuse				2.27	2.00	2.58
Assault at home				3.35	2.65	4.24
Schizophrenia				2.14	1.79	2.57
Anxiety				1.26	1.13	1.41
Depression				2.12	1.95	2.31
Self-harm				1.33	1.13	1.56
Learning disabilities				2.11	1.47	3.05
Learning difficulties				1.97	1.52	2.55
ADHD				1.47	1.18	1.83
Adult number				0.66	0.62	0.70
WIMD decile				0.84	0.83	0.85
Constant	0.01	0.01	0.01	0.03	0.03	0.04
Random-effects	Variance^a	95% CI		Variance	95% CI	
LA variation	0.06	0.03	0.11	0.09	0.05	0.16

^aVariance of the random intercept across LAs on the log-odds scale. Unadjusted Model Intraclass Correlation Coefficient = 1.8%, Adjusted Model, Intraclass Correlation Coefficient = 2.7%.

entering care. The intraclass correlation coefficient (ICC) of 1.8% suggests that 1.8% of the variance in whether or not a household has a child entering care is due to the LA they live in.

At the second stage of the analysis the risk factors were added, and group level residuals were plotted again (Figure 2, Plot 2 Adjusted Model (Covariates added)). The intraclass correlation coefficient (ICC) for the adjusted model goes up to 2.7%, suggesting an increase in variance between local authorities when the covariates are added. On this plot the residuals are displayed in their new rank order; however, they are labelled in their old rank order (A to X), enabling changes in the ranking once risk factors are controlled for to be explored. As can be seen, some of the local authorities have moved compared to their original rankings. Those LAs with high levels of risk or deprivation moved towards the left-hand side of the chart. In some cases, this had a big impact on their position. For example, local authority T, which had high levels of risk and deprivation, moved 12 places to the left to sit with confidence intervals below the line. This suggests that the reasons for the high numbers of children entering care in that local authority are more associated with the nature of problems that families in that local authority are facing rather than local authority practice. In contrast, there are also local authorities that have moved to the right-hand side of the plot. Once the risk factors and deprivation decile have been controlled for, there are four LAs on the right-hand side that were significantly more likely than all the rest to have children entering care. The local authority that had previously been ranked 22, LA X, which in Plot 1 had been significantly more likely to have children entering care than all the others, is now no longer the most likely to have children entering care, and is

grouped together with three other local authorities. These are significantly different from the other 18 LAs, but similar to each other. Two of these local authorities (P and O) had originally been ranked 15 and 16 respectively, and the odds of children entering care from them had not been significantly different to the Welsh average. However, these were local authorities where there were lower levels of risk factors and deprivation, and once this has been taken into account they appear to be just as likely as LA X to have children entering care. Two additional LAs were also significantly above the mean for Wales, but not to the extent of the four LAs on the right of the chart. On the left-hand side of the plot we see a total of eight LAs that are significantly below the average once risks and deprivation are controlled for. Unadjusted odds ratios for each risk factor are also available in our previous paper (Warner et al. 2024).

3.2 | Qualitative Findings

The focus groups were held in two LAs. These were both LAs that our analysis had shown were much less likely to have children entering care than the typical Welsh authority, once the levels of deprivation and parental risk factors had been taken into account. The discussion focused on why their rates were lower. The participants were shown the findings of the quantitative analysis and were able to talk freely about what they thought the reasons for the differences were, with additional prompts added if needed. Analysis identified commonalities in the discussions. Several of the issues raised were similar across the two groups, and five themes were identified: culture of support for families, differences in practice culture

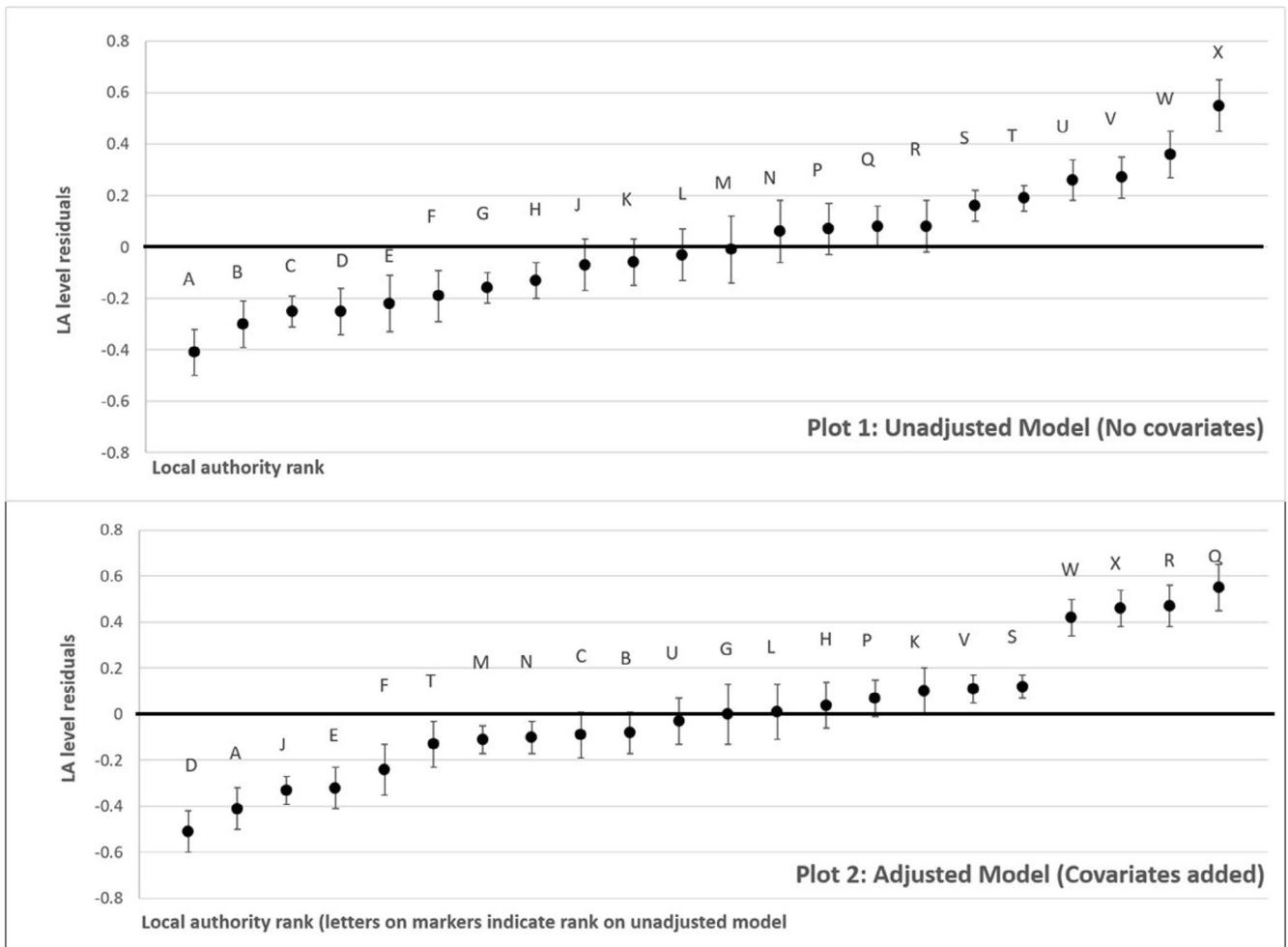


FIGURE 2 | LA level residuals for unadjusted (Plot 1) and adjusted (Plot 2) models.

when compared with other LAs, relationships with managers, issues relating to families, and congestion in services to which families are referred for help.

Saturday, and it is paid overtime and everything else, but you find a lot of people say oh I don't mind doing that, I'll do that.

Participant LA2

3.2.1 | Culture of Support for Families

In both focus groups, participants highlighted the culture in their LAs, which they saw as one of trying to support children to stay with families. Social workers discussed the hard work that they put in trying to support children to stay at home:

I do think that we have got quite a like positive kind of culture of social workers as well, who absolutely work to the bone like, to support families and to support the kids remaining in the care of their families.

Participant LA1

In the other LA this was linked to teamwork, with social workers emphasising how much they provide support to each other:

It is literally teamwork. Quite often you will see on our systems, I need help, this child is driving their parents mad, can somebody take him out for three hours on a

3.2.2 | Differences in Practice Culture When Compared With Other LAs

In both groups, the perceived differences in culture compared to other LAs were also expressed by participants who had previously worked elsewhere. These participants strongly expressed how much easier it was to carry out social work in environments that were supportive of them working to help children remain at home, and how difficult they had found working in previous LAs:

I come from a LA where I thought I had done the worst thing in the world going into social work, I couldn't sleep at night. You know our team was called the kiddy snatchers. When I came to [LA1] their view on thresholds was completely different, I felt at ease with my practice. I felt we were doing the best to keep the families together. So for me, fundamentally due to my experience, it may be

about different services, but it is about different LAs, different team managers views, even social workers' views on risk.

Participant LA1

Some of the differences highlighted between current and previous LAs included material differences in practice and working conditions such as lower caseloads, whereas others focused more on the workplace culture within the LAs.

This is the best LA for the way you are treated, and the way you are left to do your job that I have ever worked in.

Participant LA2

In other LAs they are very HR driven it is all about discipline, being in on time.

Participant LA2

3.2.3 | Relationships With Managers

In both LAs, the participants highlighted the attitudes of their managers. This included a more positive approach to risk management at all levels:

It is not only the workers on the ground. It is the people above you – your manager, his manager, the principal officers, the service manager, because if they are risk averse then you have no chance, or you can take that child out now. But because we have built up a culture that we manage risks, and we are able to manage risks, all our high management are the same.

Participant LA2

They also discussed the way that managers supported them and mentored them:

I've come to [LA1], and I have been mentored by people who are like minded as me, and I think I have thrived, you know we all fit in together.

Participant LA1

That is the big thing, we are being treated as a professional, so if you go and speak to a manager and the manager will listen to you. Even if they don't agree with it you get listened to, and that is a massive thing for me anyway in my job, you want someone to say, oh right your opinion is respected.

Participant LA2

3.2.4 | Issues Relating to Families

In both LAs the social workers also raised issues relating to working with families that were of relevance to preventing children entering care, although the issues discussed were slightly different

in each one. In one LA the social workers raised the nature of the community that they worked in, emphasising the family networks in the area. This meant that there was often a wider family network of support that they were able to access, and the first stage in their practice was to access that

Yeah, we have families that tend to stay in the same area, so a huge raft of networks for family support.

Participant LA1

In the other LA there was an emphasis on relationship building with families, with social workers discussing the need to build relationships with people. Participants stressed the value of the low caseloads they had in enabling them to do this. They also discussed specific skills they had acquired, such as motivational interviewing, to enable them to build relationships.

I have picked up a case, and I know to get it [.to.] where you don't remove a client, I need to go every day, pop in, how are you, what are you doing, build that relationship, build that trust.

Participant LA2

3.2.5 | Congestion in Services Used for Referral

In both focus groups, the discussion naturally led onto the circumstances in which they are still unable to prevent children from going into care, and in both groups the same issue was raised: that they would be able to prevent children from going into care if their parents were able to access certain services in a timely manner. However, this was said to not happen, with children taken into care as a result. This was particularly pertinent to parental mental health problems and access to support such as Perinatal Mental Health Services and talking therapies such as cognitive behavioural therapy. Although not the specific subject of this study, both groups raised that this is a problem for mothers who have babies removed and are unable to access services before becoming pregnant again.

4 | Discussion

In this paper we presented a method for exploring the differences in the rates of children entering LA care which takes into account area-level deprivation and parental problems. In doing so we presented one way of disentangling the effect of population-level factors and LA practice factors, enabling variations that are likely to be due to differences in local policies and practices to be identified. We followed this up by discussing our findings with participants from two LAs with relatively low rates of children in care, and identified factors that staff in those LAs felt were important for contributing to this effect, particularly LA culture and management.

We believe that this work may be useful to those in policy and research who wish to understand the differences in care rates between LAs, and for identifying LAs which are outliers in terms of care entry rates. However, there are some important factors to consider in interpreting what we have presented in this paper.

Firstly, we have presented this as an illustration of the method. The data we present are now 6 years old, and so may not reflect the current situation. We know that relative care entry rates change over time (Hodges 2020b), and so this analysis may not reflect current variations between Welsh LAs. Since 2021, the Welsh Government has focused policy and some investment on reducing the numbers of children in care.

Overall the ICCs suggested that differences between LAs only account for a small proportion of the variance in whether there might be a child entering care. However, some care needs to be taken in interpreting this. There are many factors that are associated with a child entering care and in an ideal world the local authority that they live in should not be having an effect at all. Also, while there are a number of local authorities that do not vary significantly from the 'average' local authority, there are some that clearly do. What is perhaps more startling is that the ICC went up in the adjusted model. This means that when we account for the nature of the population in terms of deprivation and the risk factors we looked at, then there were more differences between local authorities. This is counterintuitive; if the differences were because the local authorities were serving different populations, we would have expected this to reduce, and suggests differences due to things that we did not measure, including LA practice effects.

We were also limited in the variables that we controlled for by what was in the administrative data, and had more information been available then we would have been able to control for more variables. We used this method to look at how risk factors in adults and levels of deprivation affected the risk factors; however, it would also be useful to consider using it to account for any variations in other factors such as the age of the child and the year. However, that said, this method does provide a way of taking into account population differences so that discussions with LAs about their care entry rates can be targeted on differences that occur because of LA practice. It is also important to note that this study focused on care entry, as opposed to overall care levels, which are affected not just by children entering care, but also by how likely they are to leave care.

The focus group findings are interesting as the notion of local practice cultures clearly made sense to participants and chimed with their experience. They also spoke about wider organisational cultures in LAs and influential factors in the wider service context—especially mental health services, including those specifically for new parents. Just as lack of investment in adult social care can be a drain on health services, it appears from the perspective of social services' staff that lack of investment in adult (mental) health services can be a drain on children's social services. Even though our study size was limited, the findings resonated with the Care Crisis Review (Thomas 2018) and other evidence such as Forrester et al. (2021).

4.1 | Limitations

The quantitative analysis presented above was based on population level administrative data. This data contains small errors based on LA data inputting mistakes. The analysis was also limited by the variables that we were able to control for in the regression models. We were unable to control for issues such as domestic

violence and criminal exploitation which are also risk factors for children entering care. Had we also been able to control for these issues we might have had different findings. As more data sources with information about these issues become available in the future this method could become even more effective at disentangling the effects of LA practice and LA population. There will also be additional unknown factors affecting the likelihood of care entry, and even were these to be known, it might not be feasible for busy professionals to routinely collect data on all issues about families that might be relevant. We were also limited by having to restrict the analysis to children aged three and over, as this meant we were not able to consider the important area of child welfare decisions about the youngest group of children. It should be acknowledged that focus groups reveal only perspectives, which reflect local organisational culture. We only have the social services perspective, and future research could ask similar questions to families with experience of receiving services and professionals from other sectors. We spoke to staff in just two areas with lower-than-expected public care rates, and the selection criteria were stated, which is likely to have affected the discussion. We do not claim these are representative of all authorities. For future studies it would be beneficial to also carry out focus groups in LAs that have care entry rates that are higher than expected. Future mixed-method studies could also consider other important dimensions of public care such as length of stay and family reunification.

5 | Conclusion

Our study has emphasised the role of local need in driving variations in entry to out-of-home care. There are, nonetheless, some substantial differences between LAs in the likelihood of intervention that are not explained by differences in population need, and the method that we used was an effective way of disentangling these factors. Focus groups with social services staff highlight changes to practice culture that can be implemented even in the absence of structural changes that would reduce population need, including a move away from risk aversity and more trusting relationships both with families and between frontline social workers and their managers. Addressing care rates and ensuring that children only come into care when absolutely necessary is an important social policy goal with social justice implications. Our study shows that local practices, policies, and leadership also have a significant impact.

Author Contributions

Nell Warner: conceptualization, investigation, funding acquisition, writing – original draft, project administration, formal analysis, writing – review and editing. **Rebecca Cannings-John:** methodology, writing – review and editing, writing – original draft. **Ann John:** conceptualization, funding acquisition, supervision, data curation. **Donald Forrester:** writing – original draft, supervision. **Karen Broadhurst:** funding acquisition, conceptualization, supervision. **Jonathan Scourfield:** conceptualization, writing – review and editing, supervision.

Acknowledgements

ADP and the authors would like to acknowledge the data providers who supplied the datasets enabling this research study. The views expressed

are entirely those of the authors and should not be assumed to be the same as those of ADP or MQ Mental Health Research Charity.

Funding

The authors would like to acknowledge the support of Health Care Research Wales, who funded the research project (SCG-19-1667) and provide infrastructure funding for the CASCADE partnership.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data were accessed via a privacy-protecting Trusted Research Environment, and the authors do not have permission to share it. Methods and algorithms are available for sharing.

References

- Bailey, G. A., A. Lee, S. Ahmed, et al. 2025. "Improving Opportunities for Data Linkage Within Children Looked After Administrative Records in Wales." *International Journal of Population Data Science* 10, no. 1: 2383.
- Barth, R. P., J. Wildfire, and R. L. Green. 2006. "Placement Into Foster Care and the Interplay of Urbanicity, Child Behavior Problems, and Poverty." *American Journal of Orthopsychiatry* 76, no. 3: 358–366. <https://doi.org/10.1037/0002-9432.76.3.358>.
- Bebbington, A., and J. Miles. 1989. "The Background of Children Who Enter Local Authority Care." *British Journal of Social Work* 19, no. 5: 349–368. <https://doi.org/10.1093/bjsw/19.5.349>.
- Bennett, D. L., D. K. Schlüter, G. Melis, et al. 2022. "Child Poverty and Children Entering Care in England, 2015–20: A Longitudinal Ecological Study at the Local Area Level." *Lancet Public Health* 7, no. 6: e496–e503. [https://doi.org/10.1016/s2468-2667\(22\)00065-2](https://doi.org/10.1016/s2468-2667(22)00065-2).
- Bywaters, P., J. Scourfield, C. Jones, et al. 2020. "Child Welfare Inequalities in the Four Nations of the UK." *Journal of Social Work* 20, no. 2: 193–215. <https://doi.org/10.1177/1468017318793479>.
- Charmaz, K. 2006. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis*. Sage.
- Dickens, J., D. Howell, J. Thoburn, and G. Schofield. 2007. "Children Starting to Be Looked After by Local Authorities in England: An Analysis of Inter-Authority Variation and Case-Centred Decision Making." *British Journal of Social Work* 37, no. 4: 597–617.
- Elliott, M. 2017. *Looked-After Children in Wales: An Analysis of the Backgrounds of Children Entering Public Care*. Doctoral dissertation. Cardiff University.
- Elliott, M., and J. Scourfield. 2017. "Identifying and Understanding Inequalities in Child Welfare Intervention Rates. Comparative Studies in Four UK Countries. Briefing Paper 5: Wales." <http://www.coventry.ac.uk/research/research-directories/current-projects/2014/child-welfare-inequality-uk/cwip-project-outputs/>.
- Evans, A., K. Hardcastle, A. Bandyopadhyay, et al. 2020. "Adverse Childhood Experiences During Childhood and Academic Attainment at Age 7 and 11 Years: An Electronic Birth Cohort Study." *Public Health* 189: 37–47. <https://doi.org/10.1016/j.puhe.2020.08.027>.
- Fitzsimons, P., D. James, S. Shaw, and B. Newcombe. 2022. *Drivers of Activity in Children's Social Care*. UK Government Department for Education.
- Ford, D. V., K. H. Jones, J. P. Verplancke, et al. 2009. "The SAIL Databank: Building a National Architecture for e-Health Research and Evaluation." *BMC Health Services Research* 9, no. 1: 1–12. <https://doi.org/10.1186/1472-6947-9-3>.
- Forrester, D., S. Wood, C. Waits, R. Jones, D. Bristow, and E. Taylor-Collins. 2021. *Children's Social Services and Care Rates in Wales: A Survey of the Sector*. Wales Centre for Public Policy.
- Franzén, E., B. Vinnerljung, and A. Hjern. 2008. "The Epidemiology of Out-Of-Home Care for Children and Youth: A National Cohort Study." *British Journal of Social Work* 38, no. 6: 1043–1059. <https://doi.org/10.1093/bjsw/bcl380>.
- Hodges, H. 2020a. *Children Looked After in Wales: Factors Contributing to Variation in Local Authority Rates*. Wales Centre for Public Policy.
- Hodges, H. 2020b. *Children Looked After in Wales: Trends*. Wales Centre for Public Policy.
- John, A., J. McGregor, D. Fone, et al. 2016. "Case-Finding for Common Mental Disorders of Anxiety and Depression in Primary Care: An External Validation of Routinely Collected Data." *BMC Medical Informatics and Decision Making* 16, no. 1: 1–10.
- Leyland, A. H., and P. P. Groenewegen. 2020. *Multilevel Modelling for Public Health and Health Services Research*. SpringerOpen.
- Lyons, R. A., K. H. Jones, G. John, et al. 2009. "The SAIL Databank: Linking Multiple Health and Social Care Datasets." *BMC Medical Informatics and Decision Making* 9: 1–8.
- Melis, G., S. Bedston, A. Akbari, et al. 2023. "Impact of Socioeconomic Conditions and Perinatal Factors on Risk of Becoming a Child Looked After: A Whole Population Cohort Study Using Routinely Collected Data in Wales." *Public Health* 224: 215–223. <https://doi.org/10.2139/ssrn.4356771>.
- Moura, A. S., and D. Holt. 1999. "Small Area Estimation Using Multilevel Models." *Survey Methodology* 25, no. 1: 73–80.
- Rodgers, S. E., R. A. Lyons, R. Dsilva, et al. 2009. "Residential Anonymous Linking Fields (RALFs): A Novel Information Infrastructure to Study the Interaction Between the Environment and Individuals' Health." *Journal of Public Health* 31, no. 4: 582–588. <https://doi.org/10.1093/pubmed/ftp041>.
- Simkiss, D. E., N. Stallard, and M. Thorogood. 2012. "A Systematic Literature Review of the Risk Factors Associated With Children Entering Public Care." *Child: Care, Health and Development* 39, no. 5: 628–642. <https://doi.org/10.1111/cch.12010>.
- Snijders, T. A. B., and R. J. Bosker. 2012. *Multilevel Analysis: An Introduction to Basic and Advanced Multilevel Modeling*. Second ed. Sage.
- Stats Wales. 2025. <https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Social-Services/Childrens-Services/Children-Looked-After/childrenlookedafterat31marchper10000population-localauthority-year>.
- Thomas, C. 2018. *The Care Crisis Review: Factors Contributing to National Increases in Numbers of Looked After Children and Applications for Care Orders*. Family Rights Group.
- UK Government. 2025. <https://explore-education-statistics.service.gov.uk/find-statistics/children-looked-after-in-england-including-adoptions#releaseHeadlines-tables>.
- Warner, N., J. Scourfield, R. Cannings-John, et al. 2024. "Parental Risk Factors and Children Entering Out-of-Home Care: The Effects of Cumulative Risk and Parent's Sex." *Children and Youth Services Review* 160: 107548. <https://doi.org/10.1016/j.childyouth.2024.107548>.
- Webb, C., and P. Bywaters. 2024. "Inequalities in Out-Of-Home Care Rates in England: Does Local Party Politics Matter?" *Child Abuse & Neglect* 149: 106590.
- Webb, C., P. Bywaters, J. Scourfield, et al. 2020. "Untangling Child Welfare Inequalities and the 'Inverse Intervention Law' in England." *Children and Youth Services Review* 111: 104849. <https://doi.org/10.1016/j.childyouth.2020.104849>.

Welsh Government. 2019. *Welsh Index of Multiple Deprivation (WIMD) 2019 Guidance*. Welsh Government.

Wijedasa, D., N. Warner, and J. Scourfield. 2018. *Exploratory Analyses of the Rates of Children Looked After in English Local Authorities (2012-2017)*. What Works Centre for Children's Social Care.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Appendix 1.** Concepts and algorithms used to identify risk factors in health data. **Table A1.** Concepts and algorithms used to identify risk factors in health data. **Appendix 2.** Overarching focus groups questions.