RESEARCH REPORT 2026

Closed Supported Accommodation Providers in England

A thematic and quantitative documentary analysis of 37 closed providers with published Ofsted reports

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Publication note: This whole-population analysis covers the 37 closed supported accommodation providers in England for which published Ofsted inspection or monitoring reports were available within the research eligibility criteria. Inspection findings alone do not establish why a provider closed.

Executive summary

This research examines the entire eligible population of 37 supported accommodation providers in England recorded as closed and with publicly available Ofsted inspection or monitoring reports at the time of the study. A total of 48 reports were analysed and linked by Ofsted registration number. The study examines inspection outcomes, statutory requirement references, regulatory themes and subsequent monitoring findings. It does not assume that inspection or enforcement activity caused closure.

Full inspection outcomes were available for 23 of the 37 providers (62.2%). Within that subgroup, 17 (73.9%) were assessed as having serious or widespread weaknesses, four (17.4%) had inconsistent quality of service delivery and two (8.7%) were assessed as consistently strong. Fourteen providers (37.8%) had no full inspection outcome available within the assembled report set. These percentages describe the available inspection evidence, not the wider population of registered services or all closed providers in England.

For the provider-level regulatory analysis, the full inspection was used where available (23 providers), and the monitoring report was used where no full inspection was available (14 providers). Each regulation was counted once per provider. The resulting documentary coding identified Regulation 4 in 27 of 37 providers (73.0%), Regulation 5 in 25 (67.6%), and Regulation 7 in 24 (64.9%). These are recorded statutory requirement references, not independently established counts of outstanding breaches. Monitoring reports were also reviewed separately for subsequent compliance and enforcement. The coding is provisional pending manual verification of each requirement against its source page.

The analysis indicates that leadership, admission suitability, safeguarding, meaningful support and record quality should be assessed as interconnected systems. The most important practical implication is the need to test whether policies, audits and training lead to safer decisions and demonstrable outcomes for children. The study does not establish why each organisation closed; the evidence includes two consistently strong full inspection outcomes and monitoring reports that recorded improvement, which rules out any simple explanation equating closure with regulatory failure.

1. Purpose, scope and research design

1.1 Research questions

The primary question is: what regulatory and practice patterns can be identified across the published Ofsted histories of the entire eligible population of 37 closed supported accommodation providers? The analysis also considers how full inspection outcomes relate to subsequent monitoring findings and what the evidence means for governance and frontline practice.

The research identified 111 closed supported accommodation providers in the reference population. Of these, 37 met the study eligibility criterion of having a publicly available Ofsted full inspection or monitoring report. All 37 eligible providers were included; no sampling was undertaken. Findings therefore describe the full report-eligible closed-provider population identified at the research cut-off, rather than a sample. They cannot be generalised to the 74 closed providers without published reports or to currently operating services.

1.2 Documentary analysis of published Ofsted reports

This study uses documentary analysis to examine published Ofsted full inspection and monitoring reports as primary regulatory evidence. The approach enables systematic comparison of recorded inspection outcomes, statutory requirement references and recurring practice themes across a defined cohort. It does not involve new inspections, interviews or direct observation of practice. Findings therefore describe the evidence documented by Ofsted and the interpretations arising from that evidence, rather than independent verification of conditions within each service. The distinction is especially important when considering why providers subsequently closed: an inspection judgement or enforcement action cannot, by itself, establish the reason for closure.

1.3 Evidence structure

The corpus comprises 48 published reports relating to 37 providers. For the primary regulation-frequency analysis, one source report per provider was selected: the full inspection where available (23 cases), otherwise the available monitoring report (14 cases). Eleven subsequent monitoring reports relating to providers with full inspections were used for a separate longitudinal analysis of improvement and enforcement, without adding their statutory requirements to the frequency count. Thus the denominator remains 37 unique providers, not 48 reports.

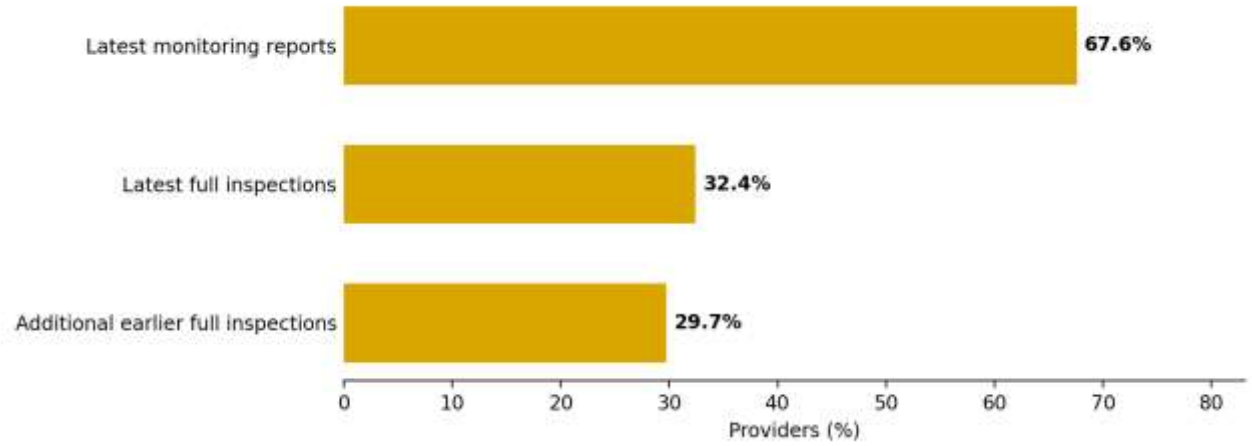


Figure 1. Report coverage expressed as a proportion of the 37-provider cohort. The additional earlier full inspections are a separate report layer, not additional providers.

2. Inspection outcomes: distribution and interpretation

The full inspection outcome is the most consistent available summary measure of service quality, but it exists for only 23 providers in the assembled dataset. The distribution is heavily concentrated in the serious or widespread weaknesses category: 17 of 23 providers (73.9%). A further four (17.4%) were judged inconsistent, while two (8.7%) received a consistently strong outcome. Taken together, 21 of 23 (91.3%) had an outcome other than consistently strong. These findings justify close examination of the weaknesses described in inspection narratives, but they do not justify treating the 14 providers without an available full inspection as poor performers.

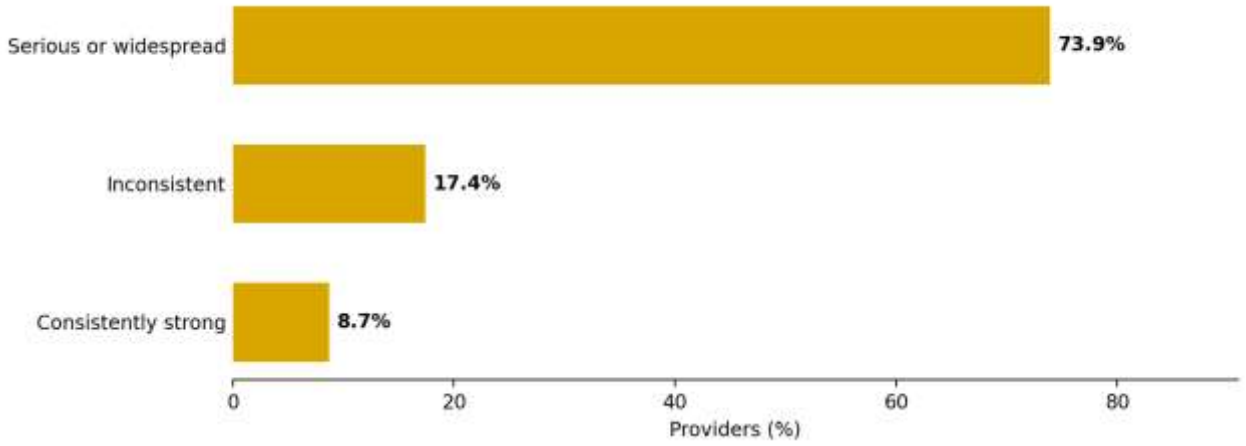


Figure 2. Full inspection outcomes among the 23 providers with an available full inspection. Denominator: 23, not 37.

The 23 available full inspection outcomes cover 62.2% of the 37 eligible providers. The remaining 14 providers (37.8%) cannot be assigned a full inspection judgement from the research material. Consequently, the 73.9% serious-or-widespread figure is a percentage of the 23 providers with an available full inspection, not of all 37 eligible providers. Inclusion of the complete eligible population removes sampling within that population, but report availability still limits comparisons with providers without published reports.

A national benchmark should only be used where the reporting date, inspection methodology, denominator and provider status are sufficiently comparable. A headline comparison with the entire active sector would be illustrative rather than causal, because it would compare differently selected populations. This report therefore prioritises the internal distribution and avoids implying that the observed 73.9% is a national closure-risk estimate.

3. Provider-level regulatory-reference patterns

Statutory requirements were coded from one report per provider, using the full inspection for 23 providers and the available monitoring report for the remaining 14. The resulting provider-level frequencies were: leadership and management (27/37; 73.0%), protection (25/37; 67.6%), support (24/37; 64.9%), notifications (19/37; 51.4%), accommodation (17/37; 45.9%), quality-of-support reviews (10/37; 27.0%) and records (9/37; 24.3%). Providers may have requirements under more than one regulation, so percentages are not additive. Counts reflect references extracted from statutory requirement sections and should be independently checked against the original PDF wording before final external publication.

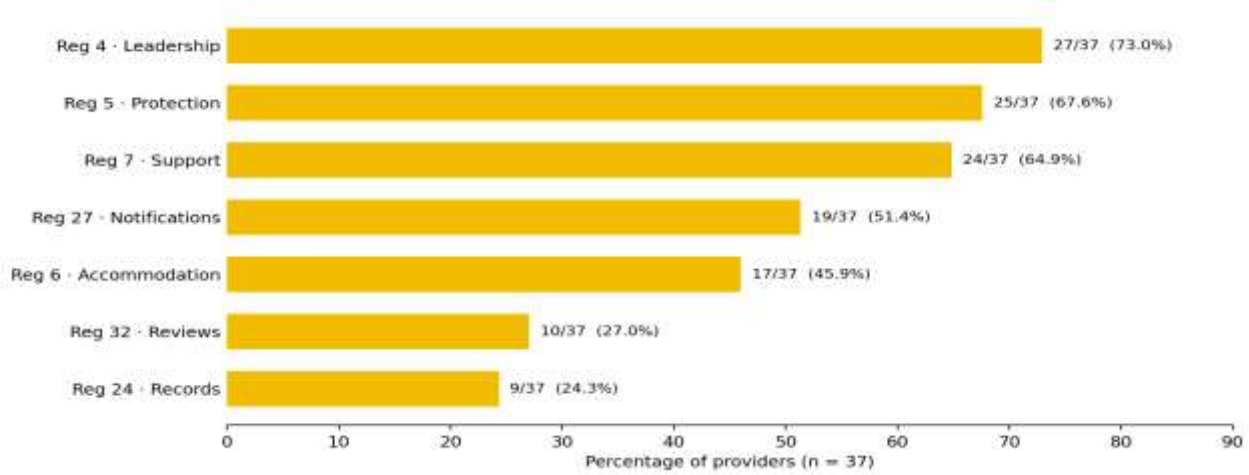


Figure 3. Provider-level frequency of statutory requirement references, based on 23 full inspections and 14 monitoring reports (n = 37). Each regulation is counted at most once per provider; later monitoring is excluded from this frequency calculation where a full inspection is available.

The pattern places leadership, protection and support at the centre of the documentary evidence. That is analytically significant because these areas are not operationally separate: a poorly assessed admission can create safeguarding risk; weak support planning can leave risk management generic; and ineffective leadership oversight can prevent either issue from being identified and corrected. The percentages indicate where statutory requirements appear in the reviewed reports, not the proportion of providers with a proven breach at closure.

This provider-level approach avoids double counting a regulation when both a full inspection and subsequent monitoring report are available. It does not establish that each recorded requirement remained outstanding at closure. In the 14 monitoring-only cases, a requirement may have originated at an earlier inspection not present in the corpus. A further longitudinal coding stage should classify requirements as newly imposed, repeated, met or outstanding, with page-specific references.

4. Leadership, governance and regulatory accountability

Regulation 4 was referenced for 27 of the 37 providers (73.0%), making it the most frequent statutory requirement in the provider-level analysis. The qualitative narratives describe management oversight that did not consistently detect unsafe admission decisions, failures to escalate incidents, gaps in staff competence or deficiencies in support planning. The common governance issue is not simply the absence of written systems; it is the gap between formal arrangements and evidence that those arrangements were implemented, scrutinised and adjusted in response to risk.

A registered service manager's oversight should provide a coherent account of each child's needs, current risks, support objectives and significant events. Nominated individual oversight should provide independent challenge to the quality and reliability of that account, including whether staffing arrangements, admissions and restrictive practices remain compatible with the supported accommodation model. Where responsibility is diffuse, information can remain within a staff team without being escalated to the people who have authority to act.

The findings support a governance model built around triangulation: case-file sampling, staff supervision, children's feedback, incident trends, external professional concerns and evidence of completed actions. A management action tracker is insufficient if it only records that a policy was rewritten or a meeting occurred. Closure of an action should require evidence that practice changed and that the change was sustained.

5. Safeguarding, risk recognition and escalation

Protection under Regulation 5 was referenced for 25 of the 37 providers (67.6%). Inspection narratives described failures in recognising or responding to risk, inconsistent assessment and recording, weak information-sharing and insufficient escalation of concerns. These findings point to the need for a safeguarding system that works in real time: staff must identify the concern, decide the appropriate protective response, notify relevant professionals and managers, and record the reasoning clearly enough to support review.

A safeguarding procedure may be formally compliant but ineffective if staff interpret risk too narrowly, assume that consent removes all safeguarding considerations, or fail to consider the interaction between age, vulnerability, exploitation and power dynamics. The regulatory question is not confined to whether an incident is a criminal offence. It includes whether the service understood the child's circumstances, assessed potential harm, sought appropriate advice and kept the placing authority informed.

Effective oversight should include periodic reconstruction of significant incidents from first disclosure to management closure. This can reveal delays, inconsistent thresholds and missed professional communication that would not be apparent from a count of incidents alone. The findings support scenario-based supervision and learning reviews that test staff judgement, not merely whether training was attended.

6. Admissions, matching and the care–support boundary

The qualitative review identified admissions and matching as a recurrent substantive concern, particularly where the assessed needs of a child exceeded what the service could safely provide within supported accommodation. A separate verified provider-level frequency for this theme has not been established, so a percentage is deliberately not assigned. The available narratives nevertheless show why suitability decisions should be treated as a safeguarding and regulatory control rather than an administrative step in filling a vacancy.

Matching requires more than confirmation of a child's age and placement availability. The assessment should consider the young person's needs, abilities, exposure to exploitation or harm, emotional and behavioural presentation, compatibility with existing residents, staffing competence and the actual support model. Intensive supervision or restrictive arrangements may indicate that a placement is operating closer to a care model than an independence-focused support model. The decision must be grounded in the individual circumstances rather than a single staffing ratio or diagnostic label.

Where a referral is accepted with known gaps in information, the assessment should identify what remains unknown, how those gaps will be addressed, and whether the placement can remain safe in the interim. Admission decisions should be reviewed when new evidence emerges, including after significant incidents. A provider's willingness to support a child cannot substitute for evidence that the placement is suitable and that the service is registered and equipped to deliver the required provision.

7. Support quality, participation and independence

Regulation 7 was referenced for 24 of the 37 providers (64.9%). Qualitative findings concerned support plans that were generic or incomplete, insufficiently purposeful key-work, limited participation and support arrangements that did not demonstrably develop independence. The important distinction is between activity and impact: a scheduled session or completed form does not demonstrate that a child has acquired skills, exercised choice or experienced improved safety and wellbeing.

A meaningful support plan should translate assessed needs into specific goals, agreed actions, timescales and evidence of progress. This includes practical areas such as budgeting, education, relationships, managing accommodation and accessing services, but also the child's own priorities and views about the support received. Plans should be revised when the placement changes, a safeguarding concern arises or progress stalls. Where support becomes disproportionately restrictive, the rationale and legal basis require scrutiny.

The research therefore supports a stronger distinction between compliance documentation and lived experience. Quality assurance should examine whether the child recognises the goals in their plan, understands the support available and can describe how decisions affecting them are made. Direct feedback and professional challenge are essential because a technically complete file may still obscure poor engagement.

8. Accommodation, workforce and operational readiness

Accommodation requirements under Regulation 6 were referenced for 17 of the 37 providers (45.9%). Narratives described physical safety and maintenance concerns, including the need for reliable checks and prompt remediation. Accommodation quality should be treated as a component of safeguarding: defects in fire precautions, security or basic living conditions affect both immediate safety and the child's sense of stability and dignity.

The workforce evidence identifies the importance of recruitment, induction, supervision, retention and competence. An exact percentage for workforce-related deficiencies cannot be derived from the current seven-regulation reference index, because workforce concerns can be recorded under different statutory requirements and narrative sections. The practical implication is to assess workforce capability against the actual profile of children accommodated, rather than assume that mandatory training completion establishes readiness for every referral.

Management review should connect staffing stability and supervision quality with incident trends, placement endings, children's feedback and the quality of direct work. Where a service experiences vacancies or turnover, the resulting risk assessment should address continuity of relationships and professional decision-making, not only whether rotas are covered. Similarly, premises audits should record the risk, owner, deadline, interim controls and confirmation of completion.

9. Notifications, records and transparency

Regulation 27 was referenced for 19 of the 37 providers (51.4%) and Regulation 24 for nine (24.3%). These figures capture provider-level statutory requirement references rather than validated counts of late notifications or missing records. The inspection narratives nevertheless identify an important practice concern: significant events were not always recorded, escalated or communicated in a way that enabled managers, placing authorities and regulators to understand the risk and response.

A robust system should distinguish immediate safeguarding action, notification to Ofsted where required, communication with the placing authority, internal management escalation and the recording of the event. Completing one of these steps does not necessarily discharge the others. Decision-making records should show what happened, what was known at the time, who was consulted, why the action was considered proportionate and what follow-up was agreed.

The most useful quality assurance test is reconciliation across information sources: daily logs, missing-from-home records, safeguarding referrals, complaints, incident records, manager reviews and Ofsted notifications. Discrepancies should trigger investigation rather than retrospective completion without explanation. Such checks also strengthen the reliability of Regulation 32 reviews and the nominated individual's oversight.

10. Quality of support reviews and evidence of improvement

Regulation 32 was referenced for 10 of the 37 providers (27.0%). This does not establish that quality review arrangements were satisfactory in the other 27 providers; it means the regulation was not recorded in the statutory requirements extracted from the selected source report. Effective reviews should move beyond compiling activity data and assess children's experiences, emerging patterns, the quality of support and whether earlier actions improved outcomes.

Inspection and monitoring reports also show why corrective action must be interpreted carefully. A monitoring visit may confirm that specified compliance notices have been met, while not providing a new overall full inspection judgement. Conversely, revised policies, training plans and governance documents may demonstrate preparedness without proving their effectiveness where no children are currently accommodated. The distinction between procedural compliance and demonstrated practice improvement is essential when interpreting trajectories.

A defensible improvement cycle links an identified weakness to a measurable action, an accountable owner, a deadline, implementation evidence and a subsequent impact check. It should record unresolved risk explicitly. This approach allows leaders to distinguish progress that has been independently tested from progress that has only been planned or asserted.

11. Enforcement, monitoring and closure: what can be concluded?

The latest-report dataset contains preliminary indicators of enforcement-related language, including compliance notices, suspensions, restrictions and proposals to cancel. These indicators were identified through document coding and have not been fully reconciled against the legal status and chronology of every notice. They are therefore not presented as verified rates of enforcement, nor are they added together, because more than one measure may apply to the same provider.

A full inspection outcome, compliance notice, suspension, restriction on accommodation, notice of proposal to cancel and final cancellation are different regulatory events. Their sequence matters. A provider may have had a serious inspection outcome and later met the notices; another may have faced continuing action; and a third may have closed for reasons that the published inspection reports do not establish. Treating these events as interchangeable would overstate the evidence.

The correct interpretation is that the selected closed-provider cohort contains a high proportion of serious full inspection outcomes among cases where those outcomes are available, alongside evidence of improvement and favourable outcomes in other cases. This supports research into regulatory vulnerability, but does not establish that serious weaknesses caused closure, that closure was necessarily enforced or that the observed percentages predict future closure.

12. Implications for governance and practice development

12.1 For registered service managers

Priority should be given to defensible admission decisions, dynamic safeguarding assessments, purposeful support planning and incident escalation. Monthly oversight should bring together the child's voice, case-file evidence, staff supervision, professional feedback and incident analysis. The objective is to identify discrepancies between policy and practice early enough to intervene, rather than wait for an inspection to expose them.

12.2 For nominated individuals and provider leaders

Oversight should test the reliability of management information and the quality of professional challenge. Regular review should cover service suitability, staffing competence, the effectiveness of safeguarding decisions, regulatory notifications, accommodation safety and progress against improvement actions. Where concerns recur, leaders should consider whether the underlying issue is one of culture, capability, resources or accountability rather than repeatedly rewriting the same procedure.

12.3 For training and quality assurance

Professional development should be organised around decisions that carry regulatory and safeguarding consequences: admission and matching, distinguishing care from support, responding to disclosures, escalating incidents, planning independence and evaluating outcomes. Case-based learning and reflective supervision provide opportunities to assess reasoning and application. Audit should then examine whether the learning changed practice; attendance records alone cannot demonstrate this.

12.4 Suggested assurance indicators

Assurance domain	Suggested evidence of effectiveness
Admission suitability	Recorded matching rationale; unresolved information gaps; documented review after new risk information
Safeguarding	Timely escalation; consistent thresholds; evidence of consultation and learning
Support and independence	Child-owned goals; measurable progress; evidence of choice and participation
Workforce	Competence observed in practice; supervision quality; vacancy and turnover risk analysis
Notifications and records	Reconciliation of incident logs, referrals and regulator notifications
Quality reviews	Themes, impact measures, accountable actions and subsequent verification

13. Methodological limitations and research priorities

The study covers the entire identified eligible population of 37 closed providers with published Ofsted reports, drawn from a reference population of 111 closed providers. It is not a sample of the 37 eligible providers. The 74 providers without published reports fall outside the documentary eligibility criterion, and their regulatory characteristics cannot be inferred. Fourteen of the 37 eligible providers (37.8%) had no full inspection outcome in the analysed material. This limits interpretation of the distribution of full inspection judgements.

Regulatory frequencies were coded at provider level using 23 full inspections and 14 monitoring reports. This prevents double counting between the paired reports but does not establish the final compliance status of each requirement. The reported figures are provisional documentary counts and require page-by-page verification before definitive publication. Theme-specific percentages beyond explicitly counted regulation references and inspection outcomes should not be inferred from illustrative narratives. Independently verified closure dates, legal closure mechanisms, financial records and interviews were not available.

Further research could validate the closure date and mechanism for each provider, reconstruct complete report sequences, code every requirement by status and date, and compare the eligible closed-provider population with an appropriately matched operating-provider cohort. Such work would address questions of association and possible explanations for closure that cannot be answered from the published inspection reports alone.

14. Conclusion

Among the 23 providers with full inspection outcomes, 17 (73.9%) were assessed as having serious or widespread weaknesses. In the provider-level statutory requirement analysis, leadership (27/37; 73.0%), protection (25/37; 67.6%) and support (24/37; 64.9%) were the three most frequently referenced regulations. These findings describe documented regulatory concerns among the entire eligible population of 37 providers with published reports; they do not demonstrate why individual providers closed.

The strongest practical message is that regulatory compliance depends on the interaction of governance, safeguarding judgement, placement suitability, workforce capability, meaningful support and reliable information. Policies and audits only become effective when they shape day-to-day decisions and are tested against children's experiences. The research supports a preventive, evidence-led approach to quality assurance while leaving the causes of individual provider closures open to further investigation.

Appendix A. Definitions and denominators

Measure	Numerator / denominator	Meaning
Closed-provider cohort	37 / 37	Providers included in this study
Report corpus	48 reports	37 latest reports plus 11 additional earlier full inspections
Full inspection coverage	23 / 37 (62.2%)	Providers with a verified full inspection outcome
Serious or widespread	17 / 23 (73.9%)	Proportion of available full inspection outcomes
Regulation 4 reference	27 / 37 (73.0%)	Providers with the regulation in the selected full inspection or monitoring report
Regulation 5 reference	25 / 37 (67.6%)	Providers with the regulation in the selected full inspection or monitoring report
Regulation 7 reference	24 / 37 (64.9%)	Providers with the regulation in the selected full inspection or monitoring report

Regulation-reference categories overlap. The word “reference” is intentional: it does not establish a newly imposed, unique or outstanding breach. No provider names, URNs or identifying case histories are published in this version.

Appendix B. Research transparency

Primary material: 48 published Ofsted full inspection and monitoring reports relating to the entire identified eligible population of 37 closed supported accommodation providers in England with publicly available reports. Full inspection judgements were extracted from explicit outcome statements. Latest-report statutory references were counted once per provider. All percentages specify their relevant denominators. The research does not identify providers in the published analysis.

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