

Practice Survey – Full Report

The physical, emotional health and well-being of looked after children and young people

August 2009



Contents

| | |
|--|----------|
| List of Abbreviations | P3 |
| 1. Introduction and Background | P4 |
| 2. Aims and Objectives | P4 |
| 3. Sample | P4 |
| 4. Method | P5 |
| 5. Report Structure | P6 |
| 6. Key Findings and Practice Points across Sites | P6 – 14 |
| 7. Findings Site A | P15 – 24 |
| 8. Findings Site B | P25 – 32 |
| 9. Findings Site C | P33 – 41 |
| 10. Findings Site D | P42 – 53 |
| 11. Findings Site E | P54 – 65 |
| 12. Appendices | P65 – 76 |
| a. Appendix 1 – Table of Site Respondents | |
| b. Appendix 2 - Discussion Tool - Managers Practitioners and Commissioners | |
| c. Appendix 3 - Discussion Tool – Foster Carers | |
| d. Appendix 4 – Discussion Tool – Children and Young People | |
| e. Appendix 5 – Information for Children and Young People | |

List of Abbreviations

ADHD – Attention Deficit Hyperactive Disorder

BME – Black and Minority Ethnic

CAMHS – Children and Adolescents Mental Health Services

ESOL – English for Speakers of Other Languages

ICS – Integrated Children’s System (electronic recording system)

IDS – Integrated Disability Services

IRO – Independent Reviewing Officer

ISL – Integrated Services for Looked After Children

LAC – Looked After Children

LACYP – Looked After Children and Young People

NEET – Not in Employment, Education or Training

NHS – National Health Service

NICE – National Institute for Clinical Excellence

PDG – Programme Development Group

PEA – Personal Education Allowance

PEP – Personal Education Plan

SCIE – Social Care Institute for Excellence

SDQ – Strengths and Difficulties Questionnaire

TELAC – The Education of Looked After Children Team

TRP – Therapeutic Re-Parenting Programme

TYS – Targeted Youth Support

UAS – Unaccompanied Asylum Seekers

UASCYP – Unaccompanied Asylum Seeking Children and Young People

YOT – Youth Offending Team

Practice Survey

1. Introduction and Background

- 1.1 The National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE) have been asked by Department of Health to develop joint guidance on improving the physical and emotional health and well being outcomes of looked after children and young people.
- 1.2 NICE and SCIE are currently engaged in the 2 year work programme to develop the guidance. The practice survey is one aspect of the information gathering process and will sit alongside a Rapid Appraisal of Practice, a Correlates Review, Effectiveness and Cost Effectiveness Review and a Qualitative Review.
- 1.3 The guidance will provide recommendations for good practice, based on the best available evidence of effectiveness, including cost effectiveness, and of the accessibility and acceptability to service users. It is aimed at professionals, commissioners and managers, with the health and wellbeing of children and young people as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors.
- 1.4 Action for Children – a leading children’s charity, has been commissioned to undertake the practice survey and this report summarises the findings. Phase 1 of the practice survey was undertaken with managers, practitioners and commissioners across a range of social care, education and health organisations in contact with LACYP. Phase 2 of the survey involve interviews with carers and looked after children and young people themselves. It was the intention to include interviews with birth parents of LACYP, however, none of the 5 sites provided an opportunity for the researchers to speak directly with birth parents.
- 1.5 The survey was conducted following accepted methods and processes as set out in SCIE guidelines (The conduct of Practice Surveys for SCIE: an interim Framework for SCIE Partners, 2008), and in accordance with the DH Research Governance Framework for Health and Social Care, and more specifically, the Social Research Association Ethical Guidelines 2003, Action for Children’s Ethical Framework (Appendix 1) and Safeguarding Policy (Appendix 2).

2. Aims and Objectives

- 2.1 The overall aim of the practice survey was to identify new, innovative and emerging practice in assessing, maintaining and improving the physical and emotional health and well being of looked after children and young people. The survey has sought views about the acceptability, accessibility and effectiveness of targeted and specialist as opposed to universal interventions. In addition, the survey had the objective of identifying the characteristics of practice that make interventions accessible and acceptable to children and young people themselves and therefore more likely to engage and sustain their engagement and achieve improvements in their health and well being.
- 2.2 While the practice survey does not identify representative practice or practice which can be independently assessed, it provides some evidence about current, emerging and innovative practice and identifies some of the key practice issues for service users, practitioners, and managers.

Practice Survey

3. Sample

3.1 Sites were identified by the Programme Development Group (PDG) as being of particular interest. It was expected that these sites would enable the survey access to specific groups of interest and specific areas of practice - for example, multi-disciplinary work, and specialist services for looked after children. An additional site was identified by the Action for Children team as a local authority having achieved Beacon Status for its engagement of young people and its Targeted Youth Support initiatives.

Site Summary Table

| Site | Type | Location | How Identified | Site Total Population | LAC Population Approximate (Including Care Leavers and UAS C+YP) | Fully Integrated LAC Services |
|------|------------------|----------|----------------|-----------------------|--|-------------------------------|
| A | Shire County | Midlands | PDG | 550,000 | 480 | yes |
| B | Shire County | Midlands | PDG | 527,000 | 550 | no |
| C | District Council | North | Research Team | 320,000 | 370 | no |
| D | Inner City | South | PDG | 199,000 | 290 | yes |
| E | Shire County | South | PDG | 1,579,000 | 2000 | no |

4. Method

4.1 Phase 1 of the practice survey involved consultation with a range of stakeholders including organisers of health and social care, commissioners, practitioners and managers. Phase 2 of the practice survey focused on the views of children and young people, carers and parents. Findings from both phases are summarised in this report and will be presented to the PDG on 10th September 2009.

4.2 The survey addresses the key questions identified in the Public Health Guidance Scope (appendix 3) under the three topic areas - structure and delivery of care through childhood; interventions and activities; professionals views of the preferences of looked after children, young people and their families.

4.3 Following initial approaches, all sites agreed to participate in the survey and following approval from the Assistant Director of Children's Services Research Team and local ethical approval in each site, a series of group and individual interviews with managers, commissioners and practitioners took place between April and June 2009. Discussion guides formed the basis of the semi-structured interviews – (see appendices 2-4)

4.4 All information has been anonymised with sites referenced A - E, and respondents referred to by their profession or role. All data has been recorded, used and stored in accordance with Section 7 of Action for Children's Ethical Framework.

Practice Survey

- 4.5 Two researchers from the team Action for Children research team have taken lead responsibility for the interviewing and reporting of findings across two sites each, and have collaborated in the remaining site.
- 4.6 The data collected from the survey has been analysed by the research team and this has involved the reading and aggregation of data, measuring, identifying differences and similarities, identifying and acknowledging variables, contextualising, noting correlation, identifying themes and cross-cutting issues, comparing views within and across sample sectors and ordering and grouping findings to address topics and questions.
- 4.7 All data sources and their relationship with the service have been acknowledged and this has enabled contextualisation of the information gathered.

5. Structure of the Report

- 5.1 This report presents the key findings and practice points from across sites and then gives more detailed comment on the findings from each site.
- 5.2 These findings are structured around the four topic areas identified in the guidance scope – structure of care, delivery of care, interventions and activities and the views of children, young people and their families.
- 5.3 Where specific findings emerged from discussions within particular professional groups at each site, these have been identified separately. Practice points have been identified for each site, and these communicate key activities within each site that are considered by the sites themselves to be worthy of special mention.

6. Key Findings and Practice Points across Sites

6.1 Structure of Looked after Children and Young People's Services

6.1.1 Strategy and Planning

- 6.1.1.1 Across all sites, effective strategy and planning was considered crucial in promoting productive partnership working at all levels. Joined-up, corporate and strategic planning impact on all other activity within the services, and ultimately improve the direct services to looked after children and young people and their families.
- 6.1.1.2 Managers in Site A spoke about the links between strategic planning - corporate parenting strategy, children and young people's plan and directorate plans. This high level planning provides the basis for service and team planning, appraisals of individual workers and practice on the ground. The 'Golden Thread' that runs through all planning activity is seen to be key to enabling effective partnership working on the front-line.
- 6.1.1.3 Corporate Parenting Strategies were seen to have contributed to a culture of collective responsibility for LACYP. They had impacted on the quality of relationships in the workforce and led to more contact between looked after children and young people and the decision makers. Practice examples include:
- In Site B, the Corporate Parenting Strategy sets out new services to support LACYP which include a volunteer mentoring service made up of staff from the local authority's workforce, work experience opportunities and apprenticeships for LACYP.

Practice Survey

- In Site D, Councillors receive induction training which address their corporate parenting responsibilities. A 'champions' scheme aims to improve outcomes by allocating looked after children to elected members who act as their advocate or 'pushy parent.'
- 6.1.1.4 Care Matters: Time for Change had resulted in all sites designing a pledge for looked after children and young people with most sites highlighting participatory approaches used to ensure its relevance. These included regular meetings which brought looked after children and young people into direct contact with senior officers and elected members, allowing the young people to shape agendas and raise issues at the highest level within the council.
- 6.1.1.5 In Site E, there is also a pledge for children and young people placed in the area from other local authorities.

6.1.2 Communication and Relationships

- 6.1.2.1 Communication between professionals and across services is undoubtedly aided by co-location, integrated front line working and effective communication structures including regular consultation meetings, joint strategic planning and pooled resources.
- 6.1.2.3 Sites A and D had models of service delivery which included significant integration across education, social care and health with specialist workers for LACYP co-located in buildings. All respondents at these sites viewed this as an asset in developing good working relationships, shared commitment to the needs of children and young people and facilitating improved access to mental health and education services for LACYP.
- 6.1.2.4 Joint working across professions also contributed to effective outcomes. In Site D, a social work assistant works half day a week with the LAC nurses and follows up young people who haven't attended health reviews. 98% of health reviews were completed at this site in 2007- 2008.
- 6.1.2.5 Site A has achieved no permanent school exclusions for LACYP during the present school year. This is thought to have been achieved via the shared commitment between Social Care and Education at the highest level, and has been supported by effective partnership working on the ground between schools and staff from the integrated service for LACYP.
- 6.1.2.6 While other sites did not have this level of integration, they could highlight initiatives that promoted a more holistic or a dedicated approach to meeting the needs of looked after children and young people. These included secondment of staff from other professions into looked after children and young people services and co location of staff for part of the week. Site C has a service director for LACYP and this was considered to raise the priority of LACYP and the services that are available to them.
- 6.1.2.7 In describing effective information sharing and communication, the sites talked about the importance of having a range of structured and forward planned, information sharing meetings that had clear agendas and purpose, some of which are topic led and relate to specific or emerging issues. Other examples given were regular e-mail correspondence between professionals and regular telephone conversations to discuss individuals or issues.
- 6.1.2.8 Several sites described effective partnership working with the independent sector. In Site A, respondents named the importance of building better partnership relationships with the private and voluntary sector and to view independent fostering agencies as delivery partners rather than competitors. It was anticipated that this would lead to a more joined up approach for LACYP.

Practice Survey

6.1.2.9 In Site E, respondents interviewed during the survey, included voluntary sector providers of commissioned services for children's rights and advocacy, leaving care and support for unaccompanied asylum seeking children and young people (UASCYP.) These providers felt that they were encouraged by the council to develop innovative services and they were able to be flexible and responsive to meet identified gaps.

6.1.3 Placement Planning and Resources

6.1.3.1 There was agreement across all sites and professional groups on the importance of stability and consistency in influencing LACYP's health and well being outcomes. The child or young person's placement was considered to be of paramount importance.

6.1.3.2 In all sites, foster care was seen as the placement of choice, however, residential care was valued as the best option for some children and young people who had experienced placement disruption and for some disabled young people with complex needs.

6.1.3.3 All sites had a range of mainstream, short breaks and specialist fostering schemes.

6.1.3.4 Site E ran in-house, evidence based fostering schemes including a TRP (Therapeutic Reparenting Programme) foster care project aimed at meeting needs of children aged 4-11 years who are showing sign of immature psychological development and a 'Multi- Dimensional Treatment Foster Care' programme to enable young people with complex needs between 11 to 16 years of age to live with specially trained foster carers offering supported placements within the local community.

6.1.3.5 Respondents at all sites considered that a quality placement relies on a process of careful assessment , planning, a thorough understanding of a child's needs and preferences and a good match between those needs and preferences with the skills and capacity of the residential placement or foster carer.

6.1.3.6 The matching process was considered to be aided by timely planning, with the child and carers experiencing introductory meetings and agreeing to the time frame for the planned move.

6.1.3.7 Placements were often seen as being made in a crisis and that a child or young person's education and health needs were too often overlooked in the urgency of finding a carer. In Site D, the Access to Resources Team has a role in slowing things down, locating community resources to hold situations and to provide more time and support to social workers to aid better planning.

6.1.3.8 Site C, in common with other sites has a joint complex care panel that enables health and social care to discuss and form decisions about the needs of LACYP with complex needs. The panel allocates funding from both health and social care budgets, resulting in the joint funding of therapeutic placements, specialist intervention and in some cases private operations for LACYP.

6.1.4 Monitoring and Planning

6.1.4.1 All sites and all the participants across the different professions and teams could identify numerous examples of practice that works in identifying and monitoring health and well-being outcomes. For most, examples relied on effective information sharing, communication across organisational boundaries and a shared commitment to improving the health and well-being of looked after children and young people (LACYP). Practice examples include:

- A range of monthly consultation groups take place in Site A between CAMHS, social care staff,

Practice Survey

education welfare staff and the wider Integrated Services for Looked after Children (ISL) staff team, and respondents feel that these regular communication forums help to speed up looked after children and young people's access to services.

- At Site A, an annual survey of looked after children and young people's engagement in sport and recreational activities is undertaken. Information from the survey assists ISL in identifying need, gathering children and young people's views on the type of activities that they would like to be involved in and helps to shape the planning of social and sporting events.
- Theme focused performance improvement groups are in place in Site A and these groups scrutinise the health assessment data. This analysis assists in identifying trends, themes and priorities, and supports effective forward planning for the service.
- A LAC development group meets 3-4 times a year to look at performance in relation to LACYP – this is chaired by a senior officer within children's services. Performance analysis drives strategy and service planning.
- In Site D, annual foster carer reviews are chaired by an Independent Reviewing Officer (IRO) which allows for independent scrutiny and challenge.

6.1.5 Training and Support

6.1.5.1 All foster carers interviewed valued the training provided by their authorities and fostering services:

- Site B's training and development programme for both foster and kinship carers is regularly over subscribed. The training is planned a year in advance and the dates are communicated to the carers. Courses run during daytime, evenings and weekends to ensure access for all. Foster carers' attendance at training is supported by travel expenses and childcare and it is designed to be a fun and social experience for them.

6.1.5.2 Sites also described the 'out of hours' support that is provided to foster carers:

- In Site B, a foster carer telephone helpline is in place which offers foster carers access to an experienced foster carer who has agreed to be on call during evenings or weekends. The peer support offers a sounding board to carers at times of crisis, offering advice and guidance that will help to avoid placement breakdown.
- In Site D, foster carers can access out of hours support from a fostering service worker up until midnight in addition to the 24 hours emergency duty system.

6.1.5.3 Nevertheless, several foster carers from across the sites noted that there are higher levels of support and more in depth training provided to foster carers on specialist schemes. This was seen as a benchmark that mainstream foster carers would also welcome. They thought the training should be extended to adoptive carers.

6.1.5.4 In particular, out of hours support from a mental health (CAMHS) worker was seen as an effective way to manage a crisis and help prevent breakdown.

6.1.5.5 A whole service approach to training is taken in Site A. This includes training on 'protective behaviours' which promotes children's rights to be safe. This ensures that consistent messages are communicated to young people across the range of professionals and carers who are in contact with them during their time in care (including administrators, cooks and domestics within

Practice Survey

residential settings).

6.1.5.6 A 'Kids who foster' conference was recently held in Site B. The purpose of the event was to acknowledge the impact of fostering on the birth children of foster carers, equipping them with the skills to deal with new children coming into their home. This was thought to contribute to strengthening placements and reducing the level of placement breakdown.

6.1.6 Transition

6.1.6.1 It is acknowledged that children and young people experience significant change during their journey through care and it is the responsibility of the partnership network around the child to ensure that transitions are well managed.

6.1.6.2 CAMHS practitioners from 3 sites maintained that therapeutic support can be provided to children and young people at times of change. If it is not appropriate to do direct work with the child, then support for the network around the child should be provided.

6.1.6.3 Good transition management is thought to be characterised by timely planning to ensure that young people are fully supported through the transition process.

6.1.6.4 Planning for disabled young people was seen as particularly poorly managed in spite of guidance. This was attributed, in part, to adult services' reluctance to plan owing to financial constraints, challenges around who was the responsible authority and lack of knowledge of available placements until the move becomes imminent.

6.1.6.5 In most sites, disability services were separate from the councils' looked after or leaving care services. Practice examples at Site D were given of partnership and integrated working:

- In Site D, the Leaving Care Team takes casework responsibility for disabled young people and/or work alongside staff in the disability team to provide a service. Disabled young people participate in the leaving care groups.
- In Site D, CAMHS and staff from the disability team have been working together to support parents and carers to 'let go' and enable the young people to have increasing independence.

6.1.6.6 Young people voiced concern at the stark contrast between the lifestyle and support they had experienced in foster or residential care and the situation they face when leaving care. The significant reduction in their financial means, coupled with the added responsibilities of independent living affected their diet, opportunities for exercise and added to their stress.

6.1.6.7 Practice examples of support given to young people leaving care include:

- The emergency duty team in Site B operates a telephone line for 16+ LACYP to access out of hours; this was established as a result of a recent consultation.
- In Site B, the designated doctor writes to young people as they leave care, summarising their medical history. This fills the gap in information that would usually be provided by their birth parent.

6.2 Interventions and Activities

6.2.1 Relationships

Practice Survey

- 6.2.1.1 A general view from respondents across all sites was that the quality of the relationship a professional or carer develops with looked after children or young person is as important as the intervention itself.
- 6.2.1.2 Key factors that build resilience include the looked after child having a consistent carer in their life, who doesn't reject them, has staying power, demonstrates unconditional regard for the child and gives them hope.
- 6.2.1.3 Alongside this, stability of school placement and consistency in key workers were also thought to be highly influential in promoting health and well-being in looked after children and young people. Many talked about the team or network around a child, providing clarity of roles and consistency for the child, who then receives the same messages and boundaries.

6.2.2 Universal and Targeted Provision

- 6.2.2.1 Most respondents stressed the importance of making sure that looked after children and young people are not identified as different from other children and young people and therefore it is important to offer them the same interventions and support services as their counterparts in universal settings, wherever possible. This was even more important for disabled LACYP, who generally have a strong wish to access services alongside their able bodied peers.
- 6.2.2.2 All respondents shared the view that early interventions that focus on preventing adverse behaviours such as offending, substance misuse, smoking, obesity, bullying etc. were key to improving children and young people's health and well being in the future.
- 6.2.3.3 Respondents also favoured activities and interventions that positively promote health and well being – diet, exercise, emotional health, forming friendships etc. Such interventions are delivered to varying degrees in schools and universal settings with all children, but often, LACYP miss out on sessions or do not benefit from the consistent approach to these issues from a school, due to their frequent moves during care or the periods of school absence they experienced prior to coming into the care system.
- 6.2.3.4 Most sites had leisure pass schemes that promoted access to swimming and other physical activities. Care leavers, however, were often excluded owing to the age criteria.
- 6.2.3.5 Most respondents acknowledged the importance of specialist services and the role that these play in improving health and well-being, and ultimately outcomes for the future. Respondents felt strongly that the needs of every looked after child or young person are different and that we need a range of universal and specialist services to meet the bespoke needs of every LACYP.
- 6.2.3.6 Personal Education Plans (PEPs) and Personal Education Allowances (PEAs) were seen as effective tools to plan and deliver a tailored response to meet a child's needs. In Site A, PEP meetings had been brought forward to the end of the academic year to allow better information sharing between existing and new tutors of LAC. Respondents in all sites gave examples ranging from private tuition to the purchase of bicycles to reduce commute time to school as evidence of how the PEA had been used.

6.2.3 Health Interventions

- 6.2.3.1 Approaches that engage children and young people were seen as effective in raising the numbers who participate in health plans and reviews:

Practice Survey

- In Site D, children and young people participate in the writing of their own health plan. A project worker from the Drugs Team is routinely involved in health reviews for the over 10s. He then does follow up work as required and it normalises his presence with the children and young people from an early age.
- 6.2.3.2 Health professionals at Site E considered that there should be national minimum standards governing the quality of health assessments. They have had an extensive overview of health assessments conducted throughout the UK for children placed in their county. Their observation is that the quality of documentation and adherence to guidance varies from place to place.
- 6.2.3.3 The organisation of children and young people's health records into one set rather than having separate records including health visitor, GP and child protection notes was seen as the best way forward in promoting children's health, leading to greater consistency and enhanced communication between health professionals.
- 6.2.3.4 Children and young people who come in and out of care may not reach the stage of having a health review following initial assessment. It was suggested that the child's health action plan should be put back into universal services if they return home from care so that it is followed through and remains a live plan.
- 6.2.3.5 Barriers to looked after children and young people's accessing dental care were raised in most sites. Some young people needed to travel considerable distances to reach a dentist that has the capacity to take them. A child or young person may not attend a planned dental check for reasons such as unplanned placement moves, fear, phobias or confidence issues. Missed appointments result in some dental practices de-registering LACYP. Some dentists were reluctant to embark on a treatment programme if a child is in a short term placement. There are particular needs around meeting the specialist dental needs of disabled children and young people.
- ### 6.2.4 CAMHS and Psychology Services
- 6.2.4.1 3 sites described how they provided a psychology service or CAMHS support for foster carers and residential staff to enable them to respond to the complex needs of LACYP. This was valued and carers and staff talked positively about the benefits of this approach:
- In Site A, CAMHS deliver an attachments group and a psychological consultation group for foster carers. The groups support foster carers in forming relationships, responding appropriately to LACYP and managing their behaviours within a placement.
- 6.2.4.2 However, respondents across the sites generally felt that support to carers should be an additional service to the therapeutic intervention that should also be on offer to LACYP and not an alternative to this.
- 6.2.4.3 Respondents in 3 sites said that there should be consistency in the ages that all professions work to in responding to the needs of looked after children and young people. In particular they felt CAMHS interventions should continue when young people reach 18 and should mirror the longer term responsibilities of education and social care staff.
- 6.2.4.4 Waiting lists, the need to make a new referral when children move areas and lack of mental health support available for children placed out of county were named as barriers to meeting the emotional health needs of LACYP.
- 6.2.4.5 Practice examples to improve access to mental health services include:

Practice Survey

- Site B has a ring fenced resource for CAMHS LAC services and this means that LACYP are not held on the same waiting lists as non-LACYP. This usually results in referrals being discussed within 2 weeks of receipt.
- There is a specialist CAMHS team whose role is to work with children placed out of borough. CAMHS workers are flexible and will provide therapeutic support in the child's foster home or residential unit if this is the best way to reach out to a child.

6.2.5 Life Story Work

6.2.5.1 Respondents across all sites raised the importance of life-story work and the need for looked after children and young people to have consistent information about their history and the reasons for their being looked after. It was felt that this should be an ongoing process and revisited as the child or young person moved through developmental stages. There appeared to be little consistency in approach to life story work and there was a tendency for it to be resource driven rather than needs led. It was felt that life story work was a specialist task that was most effective when carried out by designated social workers for looked after children who would give it time and priority.

6.2.6 Out of Borough and Out of County Placements

6.2.6.1 Practice in supporting out of area children was inconsistent with some sites highlighting good models of practice. This was not the case across all sites with some respondents, including young people, feeling that those placed out of the local authority area did not get access to the same level of services as children placed in area. This was ultimately thought to impact on their health and well-being.

6.2.6.2 Sites would welcome guidance to support the delivery of care to children placed out of area, and to children placed in area when they are looked after by another local authority.

6.2.6.3 Education and health professionals in Site E voiced concerns that in spite of guidance, they were not always notified of the out of county children and young people who have come to live in or have moved out of the area. They felt there was a need for national standard protocols to effect the necessary change.

6.2.7 Unaccompanied Asylum Seeking Children and Young People

6.2.7.1 Some sites were concerned that there is a lack of appropriate mental health services for UASCYP and, furthermore, that services in their site are unable to meet the complex needs of this vulnerable group. Young people expressed concern at the poor quality of accommodation in which some UASCYP are placed and considered that their eligibility and access to support did not match that provided to other care leavers.

6.2.7.2 Site E has commissioned specialist fostering provision for UASCYP from a voluntary agency and works in close partnership to develop new services to meet identified gaps. This has resulted in the voluntary agency running a training flat for vulnerable young people, a supported lodgings scheme and a befriending scheme.

6.3 Views of Looked after Children and Young People's and Birth Families

6.3.1 Relationships

Practice Survey

6.3.1.1 Most children and young people interviewed across the sites were critical about the quality of their relationships with social workers. Social workers were considered to have control and to make decisions, however, they were not to be trusted to carry through agreed actions. There was a high turnover of social workers who had worked with the LACYP.

6.3.1.2 Children and young people regularly said that they did not feel listened to by their social workers and that they were hard to reach. More typically, children and young people named foster carers, staff at school, independent reviewing officers and independent visitors as a source of trusted support.

6.3.1.3 Many children and young people interviewed across all sites expressed high levels of satisfaction in their current foster placement, however, others interviewed included those who had had multiple placement moves and were now living in residential care. The latter were critical of the motivation of foster carers and of the care they had received. They advocated that there should be more regulation, inspection and spot checks of foster carers.

6.3.2 Participation

6.3.2.1 All sites gave examples of young people's involvement in activities to raise awareness of the needs of LACYP and to support their peers in the 'looked after' system. Practice examples include:

- In Site A, LACYP made a DVD to help encourage other young people to engage in health assessments.
- In Site D, young people made a DVD about the promises they would like foster carers to sign up to – a baseline of care that standards shouldn't fall below.

6.3.2.2 These activities were seen as effective as they did make a difference. In Site D, foster carers sign up to the LACYP's promises and the DVD is used in induction training.

6.3.2.3 In Site C and D, other examples of influence included LACYP's involvement in recruiting social care staff, training foster carers and reciprocal arrangements where young people in residential care inspect the quality of residential provision in other boroughs or councils.

6.3.3 Birth Parents

6.3.3.1 Respondents at three of the sites talked about the important role birth parents have in enabling a child or young person to settle into a placement. It was felt that ongoing work with birth parents was a neglected area which did not take on board the likelihood that LACYP would return to their care at some stage in their lives. Where respectful relationships are built between carers and birth parents, this was seen as helping a child to thrive in their placement.

Practice Survey

7. Findings Site A

7.1 Background and structure of looked after children and young people services

- 7.1.1 Site A is a county council situated in the West Midlands that covers a wide geographical area. 80% of LAC within site A are placed within foster placements. There are 230 local authority foster care placements and 30 residential placements within the district. An additional 90 in district placements are provided by the independent fostering sector.
- 7.1.2 Integrated Services for Looked After Children (ISL) is a multi agency, holistic service that is jointly provided and managed by Health and Children's Services. It works in partnership with all relevant agencies and services to maximise looked after children and young people's access to educational opportunities, positive health and well-being, community and leisure opportunities and positive stable social care environments.
- 7.1.3 This multi-agency service consists of 2 education support teams providing flexible, rapid response support for LACYP to prevent exclusion and/or raise achievement. A further team provides carer support and promotes inter-agency working, aiming to maximise placement stability through the provision of advice and guidance to carers and the network.
- 7.1.4 ISL consists of managers, social care workers, community psychiatric nurse, teachers, education welfare officer, mentors, LAC nurse, engagement and participation worker and community leisure and development worker.
- 7.1.5 Clinical psychologists also work as part of the carer support team providing psychological advice, support and training for the carers and other professionals. Some psychological assessments and therapeutic interventions are provided directly to children and young people, however, more usually, children are referred to the generic CAMHS teams across the county.

7.2 Delivery of care

- 7.2.1 Respondents in site A speak consistently about the importance of how their services to LACYP are structured and the benefits of integrated working. The ISL model is supported by pooled budgets and joint service planning.
- 7.2.2 As well as the practical benefits that arise from co-location, such as good levels of communication, understanding of roles and responsibilities, improved information sharing and close working relationships between the different professionals, respondents also spoke of a 'joined up' approach at all levels, and this results in joint planning, shared responsibility and a common understanding of purpose amongst those in contact with LACYP.
- 7.2.3 Managers in Site A spoke about the links between strategic planning - corporate parenting strategy, children and young people's plan and directorate plans. This high level planning provides the basis for service and team planning, appraisals of individual workers and practice on the ground. The 'Golden Thread' that runs through all planning activity is seen to be key to enabling effective partnership working on the front-line.
- 7.2.4 All site A's planning and activity is driven by effective performance analysis, assisted by theme focused performance improvement groups. The numerous groups meet on a monthly basis to discuss performance in areas such as health assessment take-up rates, teenage conceptions, academic attendance and performance, youth crime etc and the work of these groups informs strategy and helps to shape new services.

Practice Survey

- 7.2.5 Across the site, there appears to be a strong pro-active approach to promoting health and well-being. A practice example was given whereby all LACYP had been recently surveyed to find out about their level of engagement in leisure activities and data from this survey informed the planning of an activity day, specifically targeting LACYP.
- 7.2.6 A range of monthly consultation groups take place in Site A between CAMHS, social care staff, education welfare staff and the wider ISL staff team, and respondents feel that these regular communication forums help to speed up Looked after children and young people's access to services.
- 7.2.7 Respondents raise concerns about social worker retention rates, the depleting pool of qualified social work staff and the pressures upon LACYP teams, resulting in the frequent change of lead worker. Managers and staff within disabled children's teams were less concerned about staff turnover as staff within specialist roles tend to be less professionally mobile, in the view of respondents.
- 7.2.8 The quality of the placement is also considered to be a key factor in affecting health and well being outcomes. Central to ensuring quality of placement is good planning and matching, and a commitment to effective initial and ongoing training for foster carers and residential staff.
- 7.2.9 Site A takes a 'whole staff' approach to training whereby all staff that are potentially in contact with a LACYP (including admin workers, cooks and cleaners within residential) receive a consistent message about the importance of children and young people's health and well being via appropriate training and development activity. Staff development activity supports the 'Protective Behaviours' approach that is detailed in the next section of this report.
- 7.2.10 Placement reviews are seen as the key forum in which to identify and act upon health, social and emotional concerns about a LACYP. Independent reviewing officers (IROs) were considered to be a strong group in Site A and play an active role in promoting the well-being of LACYP and offer challenge to decisions made by professionals, where appropriate.
- 7.2.11 All respondents in Site A identify 'stability' as being crucial to a child developing resilience and achieving good long term health and emotional well-being outcomes. Consistency in placement is considered to be the main stabilising factor for a child, alongside stability of worker, and stability within their educational placement.
- 7.2.12 Respondents identify teachers, social workers, CAMHS workers, LAC nurses and mentors as potential 'consistent adults' that could follow the child throughout their period in care to offer a long term relationship, a consistent approach and to build a wealth of knowledge about a child that could be shared with others as they progress through their care pathway. This is considered to be even more important where a child moves in and out of the care system, experiencing many different placements.
- 7.2.13 Respondents in Site A are of the view that the interventions that they receive during their time in care need to be shaped by an initial assessment of need.

'Children that have experienced neglect in the past tend to do well once they are in a stable placement, but children that have experienced physical and sexual abuse have more hurdles to jump.' (Social Care Manager)

- 7.2.14 In terms of resilience, respondents are of the view that a LACYP's ability to overcome issues that

Practice Survey

they have faced during their childhood and go on to become healthy adults is significantly influenced by factors such as contact with birth family, their attachment experiences with carers, capacity and opportunity to form friendships, educational attainment and achievement, how safe they feel, having someone to talk to and the extent to which they have come to terms with the reasons for them being looked after. All this needs to be supported by a clear care plan that identifies what needs to be done to support the young person to move forward in the above mentioned areas and the person who is responsible for providing or coordinating the intervention.

'The most important thing is to have someone to talk to - a person that stays with them as long as that young person needs. They need someone who sends a birthday card every year. It's all about the people the young person meets and it's about the young person being aware of their needs and feelings so that they can ask questions and get the support when they need it.' (participation worker)

7.2.15 Respondents across the different professional groups and within the same profession expressed differing views about the timing of interventions and activities. Some are of the view that periods of transition for LACYP should be avoided and that interventions and activities should take place during periods of stability, preferably in universal settings and alongside their peers. Others are of the view that LACYP are sometimes more responsive to interventions and activities during transition periods and therefore transition points such as moving placement, changing schools, adolescence should not necessarily be avoided. There appears to be no correlation between the different groups and professions and the opinion on this subject does not appear to be influenced to any degree by professional background.

'There's often no such thing as 'settled in care' so if CAMHS won't see them, they may never settle. If they are seen and considered not ready this month, then they need to be brought back the following month- don't throw them off the waiting list.' (health professional)

7.2.16 However all respondents do agree that intervention and activity with looked after children and young people should be needs led and that a bespoke package of support should be available for LACYP that combines universal provision and specialist support as needed.

Practice Survey

7.3 Interventions and activities

- 7.3.1 Activities and interventions that are considered by LACYP to be fun, inclusive and welcoming are seen to be the most successful in engaging with children and young people in the first instance, and in improving health and well-being outcomes.
- 7.3.2 Participative approaches are considered to be important by respondents in site A and all respondents referenced a DVD that had been made by young people in collaboration with a media company. The DVD's target audience is LAC and it aims to dispel the myths around health assessments, encouraging and supporting LAC to attend their own health assessment.
- 7.3.3 The 'Protective Behaviours' approach was referred to by all respondents in Site A, who spoke positively about the impact of the approach on health and well-being outcomes for LACYP. The approach is based upon two themes, firstly that we all have the right to be safe at all times and secondly, that nothing is so awful that we can't talk with someone about it. In residential settings posters were displayed promoting the approach.
- 7.3.4 Protective Behaviours encourages children to share concerns with their carers and trusting adults around them. All staff and carers in Site A had received training around protective behaviours on some level and this promoted a consistent approach across the service.

7.4 The preferences of looked after children, young people and their families

7.4.1. Professionals and carers' views

- 7.4.1.1 In the view of respondent in Site A, LACYP tend to be less concerned with having regular health assessments, eye and dental checks than the professionals in contact with them.
- 7.4.1.2 Respondents are of the view that LACYP and are more likely to be concerned with their physical appearance, fitting in with their peers, having friendships, being happy, maintaining relationships with their families and being able to participate in sport and the other physical activities enjoyed by their peers. It is thought that similar priorities for health and well-being would be identified by the families of LACYP.
- 7.4.1.3 Participative approaches are thought to be highly valued by LACYP. Respondents identified the recent activities that had seen high take up rates by children and young people. Typically, the planning of these successful and engaging activities were characterised by a participative and inclusive approaches.

'Historically the young people have struggled to engage with mainstream services so we have built the bridges by bringing them into the residential setting. They then develop relationships so that they have the confidence to access mainstream services'. (operational manager- residential)

- 7.4.1.4 Respondents are of the opinion that straightforward, honest approaches that 'tell it like it is' are preferred by LACYP. They are also thought to value approaches that are respectful and unassuming, with professionals taking the time to explain things clearly.

'The straighter you are even if they don't like the message, the more responsive they are' (participation worker)

Practice Survey

7.4.1.5 One set of foster carers with 24 years experience emphasized the importance for a child to see that the carers could respect and not judge their birth parents.

'Children are forced to compartmentalise their lives and this is not healthy. We like children to talk about their parents. It helps children to feel good about themselves. It helps them if they can see that we are all working together.'

7.4.1.6 They had experience of having had whole family units placed with them as well as mother and baby, father and child placements etc. This was considered to meet parents' preferences to stay with their child and seen as promoting longer term better outcomes for the child. Even if a child could not return to live with their parents, the parents were able to see that they could not meet their child's needs and be more able to 'let go' and enable their child to move into long term care or adoption.

7.4.1.7 Foster carers know that siblings want to be placed together, however, their complex needs can mean that this would be too much for an adoptive parent to manage. Ideally carers should support contact between the siblings if placed separately but too often this isn't maintained over time.

7.4.1.8 Residential staff in a unit for children with autism recognised the stress and anxiety that birth parents have at the time of transition when their sons moved on to adult services. Parents want planned moves to a unit that can offer similar care and want to be guided or have an expert to make the right decisions for their child.

7.4.2 Children and young people's views

7.4.2.1 Children and young people interviewed included young people living in two of the Site's residential units. A group interview took place with children and young people who attend the children in care council. This group was mainly made up of children and young people in foster care but did include representation from residential care and independent living. Children and young people were evenly split in relation to their gender and their age ranged from 12 – 19 years.

7.4.2.2 In general children and young people who were stable in foster homes were more positive about their relationships and the systems in place to promote their health than young people in residential care and those who had moved on to independent living.

7.4.2.3 All the children and young people were able to name physical activities that they were involved in after or outside of the school/college setting and felt they were encouraged and supported by their carers and schools to take part. Some young people linked their activities to future career aspirations e.g. army cadets. Free leisure passes were seen as a boost to participating in exercise. One of the young people with autism was able to point at picture cards to show what he liked and this included dancing, foot massage and the playground in the garden which has a slide and trampoline. For those in independent living, there was more of a challenge in that they had less money and support to take part in activities.

7.4.2.4 Children and young people in foster care were relaxed about having annual health reviews and described them as something you need and get used to. One young person said 'it was another place that you could get support.' They talked about the DVD they had been involved in which aimed to promote health reviews as a good option for LACYP. There was a preference for health reviews to be held after school so that attention wasn't drawn to the fact that they were LACYP.

Practice Survey

- 7.4.2.5 Young people in residential care were more resistant or not engaged in the process of health reviews and were more likely to opt to have theirs over the phone rather than face to face.
- 7.4.2.6 When looking at their support networks, children and young people named friends as an important source of support. Those in foster care spoke warmly of their carers. The characteristics of these carers varied widely in terms of age and circumstances- there was no ideal type. Some could name that they were supported by their birth parents as well as their foster carer and they felt that this fitted together into a nice package with different needs being met by the different people. Siblings placed together were at the developmental stage of ignoring each other in public so were not able to comment favourably on the benefits of living in the same placement.
- 7.4.2.7 The children and young people in foster care were able to name ISL and the psychology service and participation service in particular as a support. A music therapist visited the residential home for young people with autism and this was particularly enjoyed.
- 7.4.2.8 In common with all the interviews that took place with children and young people; social workers were not held with high regard. They changed too frequently, didn't follow things through and were associated negatively with their coming into the looked after system.
- 7.4.2.9 School was seen as a place where LACYP could get a lot of support and most had a named person they could go to when needed. Many talked favourably about schemes operating at their schools where 'time out' cards enable you to walk out of the classroom if you need to opt out or 'chill out'. Examples of when this was needed included teachers' favourite activity when you start secondary school to draw family trees.
- 7.4.2.10 Young people in residential care had had many placement moves. They were not positive about foster care. They also didn't display a great attachment to the units they were living in, however, they did see this as a better option than foster care and they felt safe. In particular, they felt that the residential staff knew them, that they could not get away with anything and they understood that when they moved on it would be planned rather than a disruption. Family members were typically named as the most important people in their network.
- 7.4.2.11 Reviews and the availability of personal education allowances were viewed favourably by all, however children and young people didn't always feel listened to. Examples included a child who regularly asked for education support but was always told that they were doing fine and didn't need it.
- 7.4.2.12 Support for those over 16 years and living independently was seen as less consistent. Young people struggled to live on their weekly income and this impacted on their diet and activities they could take part in.
- 7.4.2.13 Where care leavers had additional needs e.g. Aspergers, then they felt that there were particular problems in getting Connexions workers, benefit advisers etc to respond appropriately to them. Frustration was expressed over form filling, getting the right advice and proving eligibility for allowances.

Practice Survey

7.5 Views across Professional and Carer groups

7.5.1 Social Care – Disabled Children’s Team

7.5.1.2 Respondents who were responsible for the management and delivery of services to disabled young people felt that transition planning should commence sooner than 16 years (the generally accepted age) and should commence at the age of 14 years due to their complex needs and their reliance on multiple services. In many cases, LACYP with disabilities continue to require support services into adulthood and responsibility for provision moves to adult services at the age of 18. Earlier transition planning for this group would ensure that adult services were better equipped to meet LACYP’s needs in adulthood.

7.5.1.3 It is also acknowledged that services aimed at supporting the families of disabled children, such as the short breaks service does not go beyond a child’s 18th birthday and there is no equivalent service available for disabled young people when they enter adult services.

7.5.1.4 A manager with responsibility for disabled children’s services felt that health and well-being outcomes for disabled children were sometimes compromised as there was a tendency in the families of disabled LACYP to ‘hold on for too long’. In his view, social care professionals tend to support the wishes of the family and continue to support disabled children within their birth family, when the best decision would have been for the local authority to look after the child sooner.

7.5.2 Psychology Service

7.5.2.1 The psychology service within ISL delivers an 18 session, fostering attachments group that takes the carers through an understanding of attachment theory, patterns of attachment and implications for parenting. Foster carers are provided with guidance on how to help the children experience the family as a secure base. This in turn provides a context within which the parent or carer can build a relationship with the child and manage their behaviour. Foster carers reported that the training was effective, raised their confidence and gave them skills to work with the children in their care.

‘The attachment course was like a nurture group. You are given the theory but it’s based in everyday practice. You are encouraged to ‘try this out’ and come back and let us know how it went. This is important as work with children needs to happen in the foster home. It’s ok to go to a therapist ½ hour a week but you have to then build the attachment and trust in your home’

7.5.2.2 The service also provides a psychological consultation service to carers of LACYP. This service increases access for carers and their network to psychological advice. The consultation explores the difficulties being presented by the young people and the needs of the carers in supporting them. The forum leads to shared understanding and ideas for helping the carer and young person further.

7.5.3 Social Care - General

7.5.3.1 Social care managers spoke about the ICS recording system for LACYP, saying that that this is a cumbersome system and that inputting is time consuming for social care staff. This in turn limits the amount of time that social care staff have to engage in direct work with young people and to fulfil their statutory duties to them.

7.5.3.2 One social care manager felt that current social work training did not fully equip social workers

Practice Survey

with the necessary assessment skills that they needed to do their jobs properly and that additional post qualifying training in this area would be useful.

7.5.4 Social Care and Education

7.5.4.1 Respondents from both social care and education backgrounds raise issues about the accessibility and attractiveness of the generic CAMHS services in site A. All respondents valued CAMHS, and its capacity to offer the much needed therapeutic services to LACYP, however, their frustrations arose from lengthy waiting lists for therapeutic type interventions.

7.5.4.2 Respondents also felt some young people were alienated by the name of the CAMHS service and the buildings from which they delivered their services (usually hospital or clinic location).

7.5.5 Education

7.5.5.1 Educational achievement and the positive rewards that come from this were considered to be crucial in building LACYP's self esteem and therefore in enabling their emotional and social well-being in the future. Respondents in site A report that all agencies, including schools prioritised the welfare of LAC and this had resulted in no permanent exclusions for LACYP within the current school year. This is thought to have been achieved via the shared commitment between Social Care and Education at the highest level, and has been supported by effective partnership working on the ground between schools and ISL staff.

7.5.5.2 Education staff are attempting to bring forward the PEP meeting to the end of the school year as opposed to existing arrangements whereby the PEP usually takes place in the first term. Bringing forward this meeting will enable the LACYP's existing form tutor and new form tutor to come together to share vital information and enable a seamless transition from year to year. This new system is not in operation yet, but site A is keen to pilot this approach this year.

7.5.6 Commissioning

A commissioner of services in site A spoke about the value of effective screening tools and exemplified the substance-misuse screening tool that was in use in site A. His view was that more screening tools were needed for other areas of concern, for example – NEET, youth crime, teenage pregnancy.

7.5.7 Foster Carers

7.5.7.1 Foster carers generally felt that it was a challenge to gather or track down health and background information about a child's life before being placed in their care. They were tenacious in following things through and often described the 'battles' they had gone through in order to get education statements for children etc. This advocacy role was seen as normal by foster carers who described it as just doing what parents do for their children.

7.5.7.2 Foster carers talked about the importance of life story work in helping children understand 'why they are where they are.' This was seen as a social worker's task in that they have access to all the information on the files, however, foster carers felt they could have a useful role to play in reinforcing or developing life story work if they had better access to the information on file.

7.5.7.3 Training opportunities were welcomed even by those with many years' experience and the 18 week attachment course was considered to be particularly valuable. The foster carers described how they were allowed to choose from a wide programme of training courses as long as they

Practice Survey

attended 4 each year. The by-product of training was considered to be the mutual support foster carers could give each other as well as the ability to learn from each others' experiences.

7.5.7.4 The competency based training that is required by 2011 for foster carers was considered as a time-consuming hurdle to jump rather than contributing to their learning and development.

7.5.7.5 Relationships between social workers and foster carers and birth parents and foster carers were seen as central to placement success.

'There had been just one social worker for a long time so we were lucky that they knew the child so well.'

7.5.7.6 One set of foster carers felt strongly that there has been a move away from contact taking place in the foster home. While they accepted that there were sometimes good reasons why contact had to be in a neutral setting, they felt that this shift has resulted in newer foster carers coming through who have an expectation that contact doesn't take place in their home. They felt that this led to a missed opportunity to build relationships with birth parents and therefore a missed opportunity to contribute to the emotional well-being of the child.

'If we get a relationship with the parent, the child benefits. It is much more difficult if a child goes to contact sessions as their loyalties are split. A child flourishes if you are not judging their parent'

7.5.7.7 Foster carers interviewed at Site A have met kinship carers at training events. They felt that providing kinship care was a 'massively hard job' and described how these carers had to face the usual challenges of fostering coupled with the need to protect the child from their birth parents e.g. a grandparent having to cut herself off from her daughter. As such they felt that kinship carers should have the same support and training as specialist foster carers.

7.5.8 Residential Workers

7.5.8.1 Residential units visited at Site A provided specialist placements - one for young people with autism and the other for children and young people who had had typically more than 8 placement disruptions. Both were well resourced with a stable staff group and a high staff ratio to number of children placed.

7.5.8.2 Staff at both units preferred the term 'home' to unit, believing this described the ethos of their establishments. The unit for young people with autism described themselves as a home from home, friendly and family oriented. All the young people placed there were accommodated rather than being on care orders and family members were encouraged to visit whenever they wanted.

7.5.8.3 Staff at both homes named 'protective behaviours' as the dominant philosophy.

'It has been drilled into us. Everyone has a right to feel safe. It keeps staff safe and that's important as it is a tough environment'

7.5.8.4 There was commitment to staff training. Staff at one home that had opened 2 years ago received 3 months of training on attachment and protective behaviours with considerable input from ISL before children were admitted.

7.5.8.5 This home described how they have a 2 month preparation phase before a child is placed with them. This gives staff time to prepare, ensure they have the chronology and have learnt about the young person before they are admitted. This is then supported through risk assessments,

Practice Survey

multi agency meetings that make explicit who does what and there are comprehensive handovers between staff at shift change. Staff are then in a position to make expectations clear to the young person and to provide consistency in the staff approach. The emphasis in the first 3 months is to build trust and to secure relationships with the young person. It is recognised that the young people have gone through a lot.

'If they were adults they'd be signed off from work with stress but we expect these children to go to school and cope.'

7.5.8.6 Staff at this home were proud of the service they gave to young people. They emphasized that they were not a 'doss house' but a place where all the young people were involved in education and learning. Challenging behaviour was never overlooked and was managed consistently with an emphasis on restoration. Young people didn't get confused as all the staff used a plain honest approach with them.

7.5.8.7 3 of the 4 young people living in the residential home for young people with autism had non verbal communication and challenging behaviour resulting in their not living in a larger residential unit which was attached to a special school next door. There was great stability in the home with the young people having lived there for several years. Staff demonstrated their pictorial methods to promote choice and display feelings. Strong relationships existed with the neighbouring school and local professionals including GP, dieticians, psychiatrist etc. The school nurse carried out the health reviews. The ISL psychology service supported the staff group to manage and care for a child.

7.5.8.8 Transition to adult services has proved a big challenge with adult services only responding 3 months before a young person is due to move. This seemed to be influenced by adult services' belief that an assessment with validity would have to be a recent one and their not knowing what places will be available for purchase in the independent sector until the move was imminent.

7.5.9 Other

7.5.9.1 A respondent whose post sat within the ISL, but did not have a professional background in social care, health or education raises a number of key issues and observations.

7.5.9.2 Her general perception was that LACYP that were placed with foster carers are more likely to take up positive leisure opportunities and get involved in wider social activities than their peers who are placed within residential care. In her view, this was due to the increased capacity of the foster carers to support a LACYP's uptake of activities, in comparison to the residential workers who are typically juggling the competing demands of a number of LACYP at any one time.

7.5.9.3 She went on to say that in her opinion there was a great degree of inconsistency between carers in terms of the practical support that they give to children to access the positive social and leisure opportunities that will ultimately impact on longer term physical and social health outcomes.

"The carer's attitude is key to helping a young person to achieve a physically healthy lifestyle. Sometimes carers are not physically active, and don't generally live a healthy lifestyle and this impacts on the children that are placed with them – they are their role models – we need to be clear about our expectations of foster carers at the recruitment stage"

7.5.9.4 She identified the LAC statutory review as an ideal opportunity to focus upon the LACYP's social and recreational health needs, but in her view the reviews are strongly focused on education and that a more holistic approach to improving health and well-being outcomes needs to be taken.

Practice Survey

8. Findings Site B

8.1 Background and structure of looked after children and young people's services

- 8.1.1 Site B is a shire county delivering services to children in care via 12 operational teams across 5 district areas. Staff within these teams work generically across children's services although they are separated into short term and long term teams. The county's Assistant Head of Children's Services has the strategic lead on LACYP across the county.
- 8.1.2 Site B has a specific CAMHS LACYP service with ring fenced resources to support it but neither the CAMHS or the other health professionals are co-located alongside social care or education workers in teams specifically for LACYP.
- 8.1.3 The exception to this is Integrated Disability Services that has 3 teams within the county and these teams hold case responsibility for LACYP who are disabled.
- 8.1.4 Site B has up to 600 foster care placements at any one time provided by approximately 300 sets of foster carers and within this there are 50 short breaks placements.
- 8.1.5 The county is piloting four new approaches- The Virtual School for LAC, Staying Put, Private Tuition and Wright2BCared4. The pilots are commented upon in more detail later in the Activities and Interventions section of this report

8.2 Delivery of care

- 8.2.1 Although services for LACYP in Site B are not fully integrated, in the main respondents in site B spoke positively about the nature of the working relationships between health, education and social care practitioners and managers. It was commented on specifically that social workers and school nurses benefited from having close day to day contact and close working relationships.
- 8.2.2 There appears to be a strong focus on participative approaches and many respondents commented positively on the county's Children in Care Council and the group's contribution to the Service Improvement Plan.
- 8.2.3 A comprehensive development plan drives forward the work with LACYP and this is summarised in the 3 year Corporate Parenting Policy, Strategy and Service Development Plan, with health and well-being being an integral part of the document.
- 8.2.4 Site B successfully engages young people statutory health assessments with 85% of all health assessments completed on time. Initial health assessments are undertaken by paediatricians with health assessment reviews being undertaken by LAC nurses.
- 8.2.5 Site B benefits from having Integrated Disability Services (IDS) for children and young people and this results in close working between social care staff, school nurses, educational inclusion staff and occupational therapy as they are located in the same building.

'This multi-disciplinary approach enables the network around the child to be effectively established....regular communication and good working relationships help us to work together and improve health outcomes for children and young people' (Team Leader – Integrated Disability Team)

- 8.2.6 Site B has a well developed training and development programme for both foster and kinship carers and this is regularly over subscribed. The site reports that they always have sufficient

Practice Survey

numbers of foster care placements and this is considered to be as a result of targeted marketing activity. Predicted shortfalls in carers are identified 3 months in advance and marketing activity takes place at this stage. Specific targeting has aided with filling geographical gaps, ethnicity gaps and has aided in the recruitment of carers with specific interest in caring for unaccompanied asylum seeking young people.

'It's crucial to recruit foster carers that have the 'stickability factor' and this is not easy to detect, that's why we rely on good marketing, recruitment and training.' (Foster Care Manager)

8.2.7 The general consensus of respondents in Site B was that in the vast majority of cases a local foster care placement would be the placement of choice for a LACYP, and that this was generally speaking the most effective type of placement to meet a LACYP's needs and to ensure positive health and well-being outcomes. It was acknowledged also that some young people had complex care needs that could only be met by a specialist placement out of district and for these young people, respondents could not confidently say whether they had good access to wider health and well-being support services.

8.3 Interventions and activities

8.3.1 Site B is involved in piloting 4 new approaches with LACYP – Virtual school for LAC, Private Tutoring, Right2BCared4 and 'Staying Put'.

8.3.2 The virtual school for LAC is being piloted in 11 areas, all receiving funding specifically to appoint a head teacher of a virtual school to oversee the education of LACYP. As the pilot period draws to an end, the project will continue and funding for this will be met via the area based grant.

8.3.4 A governing body for the virtual school is in place and members of this group represent a range of interested partner agencies and this helps to link the work of the virtual school in with other strategic groups. The head teacher for the virtual school is invited to attend the various local strategic and planning groups that have an interest in LACYP.

8.3.5 The virtual school head and The Education for Looked After Children Team (TELAC) work closely together. TELAC coordinate the personal education plans for LACYP and these go to the head teacher.

8.3.6 The Private Tutoring Pilot is sponsored by HSBC and is delivered by a private company. 4000 hours of private tuition have been available in the site over the last two years and LACYP are prioritised for this service. Private tuition is valued in site B as it is considered to re-engage young people in the positive relationship with their teacher and encourages them to return to mainstream learning.

8.3.7 The 'Staying Put' pilot scheme enables young people to stay with their carers (or in some cases transfer to a staying put placement) at the age of 18 years. Previously young people would stay with their carers on a supported lodgings basis which meant a reduction in the allowance received by the carers. This scheme brings foster care payments for post 18 young people, nearer to the original figure and therefore encourages more carers to continue the offer of a placement to the young person. This pilot is in its infancy but most respondents in Site B made positive comments about the pilot and potential benefits to young people.

8.3.8 All respondents in Site B spoke about the CAMHS focus on supporting the carers and rarely the child. There appear to be long waiting lists for therapeutic type interventions and respondents commented on how weighty the referral form is – this can be off putting for referrers. All

Practice Survey

respondents valued the input that CAMHS offers to carers, but felt that both approaches were often needed.

'It's a chicken and egg situation. The child behaves disruptively and they are considered to need a therapeutic intervention. The CAMHS referral is not acted upon until a child is in a stable placement. The placement is not stable because of the child's disruptive and destructive behaviour, so the child struggles to get the support that they need.' (Social Worker)

8.3.9 Other respondents from across the different professional groups supported this statement.

8.3.10 Respondents in Site B were of the opinion that young people engage in and get the most benefit from services that allow them to have a say in the planning and development of those services – participative approaches to strategic planning as well as their individual interventions.

8.3.11 The site did benefit from having some services that saw young people on a 'walk-in' basis through into the evening time for example sexual health services but it was acknowledged that most other services operated during usual office hours.

8.3.12 Respondents in Site B felt that their area benefited from having special schools that were well equipped to meet the needs of disabled LACYP

'Our special schools are great, there is good physio on tap, dentists go into schools, medicals are set up if needed...there are good health services attached to our special schools.' (Social worker)

8.4 Preferences of looked after children, young people and their families

8.4.1 Professionals and carers' views

8.4.1.1 Respondents in Site B felt that children and young people were more likely to attend and benefit from services that were enjoyable and involved making social contacts in an environment that did not identify them as looked after. It was also thought that being listened to was important, and having the opportunity to build trust and confidence in the adults around them. They prefer honest and open approaches

'Young people prefer to access services without strings attached....they like to go with their friends or families.' (Social care manager)

8.4.1.2 Being happy, keeping friends, fitting in with their peers and not being forced to move schools were also identified as important.

8.5 Children and young people's views

8.5.1 The 3 young people that were surveyed in Site B all presented as articulate and confident young people and they were all members of the district's Children in Care Council. In light of this, the group cannot be seen to be a representative sample of LACYP, but they do offer some insight into the views and experiences of LACYP in Site B.

8.5.2 Two young people were interviewed jointly and the third was spoken to alone, but all young people shared similar views on which physical, social and emotional health outcomes were important to them – being able to participate in exercise, having a healthy diet, having an attractive physical appearance, having a supportive social worker and carers, having a good social life, friendships, relationships with families were identified by all as being important to them.

Practice Survey

8.5.3 Young people in Site B valued placements in which their carers were supportive and encouraging.

'Some foster carer's are just in it for themselves and they don't care about you. When you get good carers, you can recognise the difference.... They support you with your education and encourage you to go on and do your best....I am going on to University and I couldn't have done this without the support of my carers...' (18 year old young man)

8.5.4 In terms of accessibility and acceptability of services in Site B, young people stated that they knew where and how to access the support that they needed and that generally speaking the range of support services were accessible and mostly acceptable to them. However two young people had had a negative experience of accessing the local CAMHS service with one young person reporting that she had been on the waiting list for a CAMHS service for over 2 years now. Another young person had accessed bereavement support from CAMHS but he did not feel able to communicate effectively with his counsellor and therefore he stopped attending.

8.5.5 The two respondents that were interviewed together shared the view that their preference would be to access the range of support services – sexual health, connexions, drug and alcohol, counselling via a one-stop-shop coordinated by the youth service as opposed to a social care agency. In their view this would be less stigmatising for them and they would be able to access services alongside their non-looked after peers.

8.5.6 When asked about the services that they would be least likely to access, their prime concern was the waiting time involved, stating that the length of the wait was the most influential factor in their decision whether to access a service or not.

8.5.7 Due to the timing of the field work, only two of the three were asked their views on having access to summary statement setting out the reasons why they were in care and their care history, and a medical summary setting out their medical history, previous illnesses and immunisations. Both young people surveyed in relation to this said that they would find this to be useful. Although both young people said that they had a full understanding of the reasons for their admission to care and their care history neither knew their full medical history nor could identify an adult in their lives who would know this.

8.6 Views across the different professional and carer groups

8.6.1 Social workers

8.6.1.1 There was a feeling that other agencies saw social services as responsible for leading on the coordination, planning and organising of partnership events in relation to LACYP. Social workers felt that this added extra pressure to staff teams that were already under resourced. They did feel that the introduction of the Common Assessment Framework had gone some way in getting partner agencies to realise that ensuring the welfare of children and young people is the responsibility of all agencies and not just social care.

8.6.1.2 Social workers in Site B felt that they weren't able to visit LACYP as often as they would like to – statutory visits are 6 weekly but in some cases this is not frequent enough. Respondents went on to say that it seems to them that resources are becoming increasingly pressured and that at times they have prioritise their safeguarding work over their statutory duties to LACYP. Social workers in Site B felt that LACYP would benefit from having a dedicated team of social workers that did not have generic responsibilities across children's social care.

Practice Survey

8.6.1.3 It was reported that administrative systems that support work with LACYP are cumbersome and time consuming for social work staff.

'There are 21 separate forms to complete when a child is admitted into the care system and we struggle to get them all done. Some of them are internal forms that are supposed to help the system to work but I'm not convinced that they are all necessary....also we are reliant on signatures and consent from other people in order to complete these – it's a time consuming job!' (Social Worker)

8.6.1.4 This group of respondents felt that LACYP should be referred for a CAMHS assessment on their entry to the care system, this was on the basis that for all LACYP there will undoubtedly be unresolved issues in relation to attachment or loss and that if left, problems would be likely to manifest themselves in adolescence.

8.6.1.5 Life story work was considered to be an important piece of work that should ideally be done by the LACYP's designated social worker. It was thought that this work could be added to by the carers during their time in care. Where life story work has not been undertaken, it was the social workers' view that at the very least there should be a summary statement setting out the reason for the child's admission to the care of the local authority in language that they can understand. It was suggested that this summary statement should be kept at the front of the case file for ease of access should the child's social worker change and that the reviewing officer should also have access to this to aid their introduction at the start of the LACYP's review meeting.

8.7 Commissioner of services

8.7.1 This respondent suggested that a Strengths and Difficulties Questionnaire (SDQ) should be completed at the start and end of every CAMHS intervention and this would enable the distance travelled to be measured but this would need to be supported by an electronic database that would hold this information.

'At the moment there is no way of measuring the impact of the work that CAMHS does with the carers and we need a way of measuring impact.'

8.7.2 From a commissioning perspective, the preferred scenario in Site B is for carers to be fully trained to deal with and respond to children and young people appropriately within the placement. It is thought that this would ultimately reduce the need for LACYP to access CAMHS directly. It was this respondent's strong view that practitioners and managers should not lose sight of the role and purpose of CAMHS – essentially this is a mental health service and should be reserved for those children and young people experiencing significant emotional difficulties.

8.8 CAMHS

8.8.1 The CAMHS representative felt that placement breakdown could be avoided if carers were trained to respond appropriately to challenging behaviour.

'...the answer is to train all carers so that they give a consistent approach. We need to stop carers falling into the trap of getting drawn in to the negative behaviour, responding to young people with anger and hostility as this just reinforces the negative self image of the child...'

8.8.2 Work with carers in Site B promotes a nurturing response that avoids negative messages and promotes trusting relationships.

Practice Survey

'Work with the carers needs to be complemented by interventions that challenge LACYP's mindset and negative self image such as outward bound, activity based problem solving, team work, relationship building, cubs, guides, football, theatre groups etc...' (CAMHS representative)

8.8.3 It was felt that CAMHS LAC needed more of a team work approach. Presently workers were 'dotted' around the district and rarely came together; they tended to work in isolation for the majority of the time.

8.8.4 This respondent raised his concern that it is very difficult for young people approaching adulthood to access adult mental health services as there is not a clear process for transfer into adult services or for communicating information between the children and adult mental health services.

8.9 Advocacy

8.9.1 Again, this group shared the strong view that LACYP should be referred to CAMHS automatically on entry to care so that an assessment can be made around the impact of loss and attachment. In relation to this, the group felt that specific training around building resilience in LACYP should be core component of foster care training rather than being an optional extra.

8.9.2 This group stressed that in their view organisations in contact with LACYP don't go far enough to make the environment welcoming for them. The example of the signing in sheet was given.

'Take this building for example, this is a place where young people come to see their worker and they are asked to sign in to the building but the signing in sheet asks them for the purpose of the visit and which organisation they belong to – this automatically makes them feel as if they don't belong here....they need to be met with a friendly reception and the offer of a drink always helps!....' (Advocacy worker)

8.9.3 This group went on to suggest that reception staff needed to be trained in how to deal with children and young people. Simple explanations such as where to sit, when they are likely to be seen, where to go if their name is called and where the toilets and drinks are go a long way to making the child or young person feel comfortable in the environment.

8.10 Integrated Disability Services

8.10.1 Staff from this service appeared to be a highly motivated group with a firm commitment to improving health and wellbeing outcomes for LACYP. Staff turnover in this service is low and staff reported high levels of job satisfaction and positive team working relationships. They reported that long term relationships with disabled LACYP placed both in and out of area were able to be established and often, young people were supported by the same worker throughout their care journey.

8.10.2 It was reported that case work in this area was very diverse as families were from a range of socio-economic backgrounds and the physical and emotional needs of the young people receiving support from the service were all different. This offers workers variation in their workload and leads to increased job satisfaction – typically workers in this area were experienced, mature and had been with the service for a number of years. Staff are able to access a range of training that is offered by the partner agencies that make up IDS.

8.10.4 Respondents in this group raised the issue of disabled children and young people not being able to access mainstream services due to access and escorting issues. In some cases disabled children were not able to access positive leisure services due to insurance and liability issues.

Practice Survey

8.10.5 The IDS respondents felt that they work hard to keep families together but sometimes the most important thing was to meet the needs of the child or young person – even if this means placing the child out of the area.

8.11 School Teachers

8.11.1 This group felt that asylum seeking children and young people did not always get the same access to services as their peers. This was sometimes due to the language barrier, where English is not their first language but respondents in this group questioned whether the expectations of school staff were lower for this group, as some felt that asylum seeking young people were rarely encouraged to access further education post 16.

8.11.2 Professionals from this group felt that at times, LACYP were moved to another school when the placement changed and this was unnecessary and detrimental to the child. All could instance a child that was doing well and had been moved due to logistical issues – they felt that sometimes, more effort should have been made on the part of the adults around the child to maintain them at their existing school rather than moving them to a new educational placement.

8.11.3 The teachers felt that there was a distinct cultural difference between social care and teaching staff, and that this cultural and practice difference hindered partnership working at times.

‘Social workers don’t keep time in the same way that schools have to- they are often late for meetings or fail to arrive at all. The school day is very much governed by time slots and if we don’t keep to time, the system falls down – we have to keep to the arrangements that are made..... if we are invited to a review and it doesn’t start and finish on time, this is a problem for us but it does not seem to matter too much for the social workers’ (School Teacher – LACYP)

8.11.4 The teacher’s general impression of IFA carers was that they had a more professional approach to their role and responsibilities. For example, the IFA carers tended to be accessible by phone and able to attend meetings, transport young people to different venues as needed whereas the local authority carers tended to be less accessible and less willing or able to commit their time to the young person that is placed with them. It was also the teacher’s impression that IFA carers had access to more training and development opportunities which resulted in them considering their role as a profession as opposed to a lifestyle choice.

8.12 Health Professionals

8.12.1 LACYP in Site B have designated doctors and nursing staff that provide strategic leadership and advice across the county on health care structures and processes to ensure that quality health assessments are undertaken and that they inform health plans. They are also responsible for ensuring that appropriate treatment and therapies are delivered to LACYP.

8.12.2 Generally, health professionals in Site B felt that better information sharing was needed and that although systems were set up to allow information sharing, often this was let down by a lack of data inputting.

8.12.3 It was reported that there are often occasions where paper work goes astray and therefore it does not get to its intended destination.

8.12.4 Health professionals felt that initial health assessments would be more effective if the young person was accompanied by the social worker and their birth parents where possible. This would

Practice Survey

enable the person undertaking the assessment to gain a fuller picture of the child or young person's medical history and the factors that may have influenced this.

8.12.5 The team of health professionals felt that it would be useful for LACYP to have a written summary of their medical history on leaving the care system. This would provide basic information such as childhood illnesses, immunisations etc. One of the doctors in Site B was already putting this into practice.

8.13 Foster Carers

8.13.1 The foster carer group of respondents were of the view that placements were more likely to be successful in meeting the LACYP's needs if the placement had been planned in advance, with the foster carers having relevant information about the child and their needs made available to them in advance of the start of the placement.

8.13.2 In the group's experience, placements were rarely planned and they were often faced with caring for children whose needs were not fully understood. In defining the characteristics of a good placement the group identified boundaries, routine, understanding, patience, uninterrupted time, love, genuine care and trust as the most important factors.

8.13.3 It was considered that the foster carer's relationship and level of contact with the child's social worker was a key factor in influencing the success of the placement and the group reported great differences in experience here with some having a good relationship with the social worker and regular contact, whereas others reported that the social worker kept minimal contact with them and that communication was not easy.

8.13.4 Two carers in the group raised the issue of respite care and their unmet needs in this area. Both were of the opinion that foster care breakdowns could be avoided if there was a system in place for offering foster carers respite care for children with challenging behaviour. The group did value the foster carers support group that meets regularly in site B, but most were unaware that there was a foster carer support line in existence that offered them out of hours peer support from an experienced carer.

8.13.5 All respondents stressed the importance of having the time and motivation to challenge the LACYP's negative behaviour patterns in relation to their health and well being – avoidance of healthy food, poor hygiene, and avoidance of teeth cleaning etc. Many examples were offered where the carers had invested time and energy into supporting LACYP with establishing healthy life styles.

8.13.6 Foster carers reported no concerns about LACYPs access to either GP or dental care in Site B.

8.13.7 Some foster carers had attempted to pull together a basic life story for a LACYP but felt that this area of work needed to be better supported by the child's designated social worker as only they had access to historical information that was important to the LACYP – in their experience, social workers in Site B rarely had the time to devote to undertaking life story work and the group felt that this area of work should be a higher priority.

8.13.8 Finally this group suggested that they would benefit from having access to an out of hours help line that was staffed by a CAMHS worker. Often, times of highest stress and crisis within foster care placements are at weekends or evenings. Foster carers would feel better supported if they were able to access advice and guidance in how to manage crisis situations as they were unfolding and in their view, the extra support may prevent placement breakdown.

Practice Survey

9. Findings Site C

9.1 Background and structure of looked after children and young people services

9.1.1 Site C is a district council within the North of England. Approximately 70% of the LACYP in Site C are fostered with local authority foster carers (including Kinship) and up to 12 of these young people are placed within the local authority's residential homes in the district. Of the remaining 30%, the majority are placed in a combination of in and out of area independent fostering placements.

9.1.2 This site was identified by a member of the research team who had previous experience of working in the site, and was aware of the site's Targeted Youth Support (TYS) initiatives and its Beacon Status for involving young people.

9.2 Delivery of care

9.1.1 The overwhelming consensus from respondents from all disciplines in Site C is that stability and consistency is the key factor in influencing the health and well-being of a LACYP. However, there were different definitions of stability and consistency, with respondents identifying many different examples of what these look and feel like for a LACYP.

9.1.2 Most agreed that stability of placement is the most important factor – living in a placement that meets the young person's social and emotional needs via a trusting and quality relationship with their carers.

9.1.3 Respondents in the same sites spoke consistently about the importance and impact of good quality training for all those in contact with LACYP. It was stated that all workers and carers shared understanding and priorities around promoting health and well-being in LACYP. Emotional and social well-being was considered to be equal in importance to physical well-being.

9.1.4 Stable care arrangements result in educational stability, with fewer school moves and long term relationships with school staff. A consistent placement also provides a LACYP with long term access to friends, neighbours and wider community networks that are often lost if the LACYP experiences frequent moves.

9.1.5 It is apparent that professionals in Site C work together to keep LACYP in their existing school placement when they come into care or move between placements, but the requirement for planned transport arrangement often means that LACYP are not always able to participate fully in extended, social and recreational activities that schools offer.

9.1.6 Professionals from all groups in Site C are of the opinion that the local authority has a shortage of foster care placements and this often results in children and young people not being matched to their placement and being placed wherever is available rather than where they need to be to meet their individual needs. Often this is in residential care or an out of district placement when the preferred option would have been a family placement with a local foster carer.

9.1.7 The recruitment and retention of good quality foster carers is a key priority for Site C and they have recently been engaged in recruitment campaign to attract new foster carers.

9.1.8 Site C reported a significant change in the demographics of their LACYP population in the last 5 years having experienced increasing numbers of asylum seeking children and young people, a good proportion of whom are unaccompanied.

Practice Survey

9.1.9 In the case of unaccompanied asylum seeking children and young people (UAS), social care and health professionals in Site C raised the issue of increasing numbers of UAS young people that are accessing services as 'Children in Need' under Section 17 of the Children Act 1989.

9.1.10 Unaccompanied asylum seeking children and young people under the age of 16 are accommodated in the care of the local authority under Section 20 of the act and are placed in appropriate foster care placements, and therefore the local authority has responsibilities to them under the act. UAS assessed to be over the age of 16 are frequently assessed as not requiring care, and are supported by the local authority under section 17. Respondents were not fully confident that the health and well-being of this group were being met.

Practice Survey

9.3 Interventions and activities

- 9.3.1 Site C reports that take up rates of the initial health assessment and reviews are good and currently stand at 90%. Respondents place the importance of having high standards for health and well being as high priority and this is underpinned by a shared understanding of this across all those in contact with LACYP – foster carers, residential staff, social workers etc.
- 9.3.2 Respondents in Site C feel that a looked after child or young person's health and well-being outcomes are influenced heavily by their experiences prior to coming into the care system.
- 9.3.3 Respondents identify diet, nutrition, lifestyle, routine, habit, attachment, abuse and neglect as just some of the issues that influence health and well –being outcomes in later life and which need to be addressed during their time in care.
- 9.3.4 The general consensus from Site C is that interventions should ideally take place in a planned and structured way, with the LACYP fully involved in decision making and prepared for the intervention where possible. Early interventions in universal settings are favoured by most, focusing on health promotion, healthy lifestyles, with LACYP receiving advice, information and support in school alongside their peers.
- 9.3.5 Some respondents in site C stressed the importance of making sure that LACYP are not identified as different from other children and young people and therefore it is important to offer them the same interventions and support services as their counterparts in universal settings, wherever possible.
- 9.3.6 Most respondents acknowledged the importance of specialist services and the role that these play in improving health and well-being, and ultimately outcomes for the future, but respondents felt strongly that the needs of every LACYP is different and that we need a range of services to meet the bespoke needs of every LACYP.
- 9.3.7 Respondents identified key transition points for a LACYP as changing key worker, moving from one placement to another, changing schools and the transition between childhood and adulthood. Leaving care is identified by all respondents in Site C as a crucial time for looked after young people and all acknowledged the importance of effective and timely transition planning.
- 9.3.8 LACYP's legal status changes at 18 years, resulting in a change in placement status from foster placement to supported lodgings. This comes with a reduced placement allowance for foster carers which sometimes leaves the foster carer feeling unable to continue to care for the young person under changed terms and conditions. It was suggested that a more flexible approach to foster care payments should be adopted, with fostering allowances continuing to be paid after the young person's 18th birthday, if that will support the continuation of the placement.
- 9.3.9 Generally, respondents feel that interventions that are fun, inclusive and welcoming are likely to have more effect on improving outcomes than interventions that are not. All respondents share the view that participative approaches help to engage LACYP, build their skill, knowledge and self esteem, enabling them to shape services resulting in the interventions being fit for purpose and attractive to LACYP. Various examples of good practice were given by respondents in Site C such as LACYP playing a significant role in the planning and training of foster carers, participating in foster carer and social care worker recruitment and selection panels.
- 9.3.10 The Targeted Youth Support Practice Manager (TYS) in Site C spoke about the benefits of the TYS approach to working with LAC. The TYS Practice Manager and the LAC Service Manager had a shared understanding of how the TYS agenda in their district could be shaped to meet the

Practice Survey

needs of LAC and improve their health and well-being outcomes. Examples were offered where LAC had been referred to TYS by their social worker and had received an individually tailored package of support to prevent adverse outcomes such as teenage parenthood, involvement in youth crime, becoming NEET (not in education, employment and training), and substance misuse. The TYS activity offers LAC additional opportunities to influence service delivery via the TYS Involving Young People's Group, of which a LAC is part.

- 9.3.11 Professionals in site C raised concerns about LACYP's access to dental care. LACYP sometimes struggle to get access to a dentist within their local area as dentists are often full to capacity and have prioritised private patients. This results in LACYP travelling to the two dentists within the district that have space, but often the logistics of transporting a LACYP to a dentist that is in some cases 15 miles away, is difficult to manage, time and resource intensive for social care staff. The outcome is that LACYP tend to attend fewer dental checks and do not receive the prompt treatment that would otherwise be received if they were registered with a local dentist.
- 9.3.12 It was suggested by one group of mixed social care and health respondents that LACYP should be prioritised for dental care with the dentist of their choice as they are with school placements.
- 9.3.13 Respondents reported that they were at times dissatisfied with the level of GP care for LACYP and numerous examples were given where a young person was registered with a new GP on moving placement, and GP records were not immediately transferred. A social work manager gave the specific example of a vulnerable 15 year old girl who had a history of attempting suicide. She was prescribed anti-depressants by a GP who did not have access to her medical records.
- 9.3.14 In Site C, CAMHS workers have recently moved from their clinic bases to be co-located with the LACYP teams for 2/3 days per week. Although these arrangements are in their infancy, the consensus from all respondents was that this move was a positive one and had the potential to impact significantly on working relationships, communication, understanding of each others' roles, joint planning and opportunities for future integrated working.

Practice Survey

9.4 The preferences of looked after children, young people and their families

9.4.1 Professionals and carers' views

- 9.4.1.1 The majority of respondents said that LACYP would prioritise their personal appearance as highly important with them having a strong need to 'fit in' with the rest of their peers. Adolescence was seen by respondents to be a key transition, during which all young people form their adult identity, learn how to form adult relationships and this period significantly shapes behaviour in adult life. A LACYP's ability to socialise with confidence and form relationships during adolescence will heavily influence self esteem and therefore emotional health outcomes in adulthood.
- 9.4.1.2 Other important issues were identified as – having friendships, being ready to leave the care system and being heard by those making decisions for them.
- 9.4.1.3 Respondents felt that generally, families of LACYP are concerned with the same issues but that they have additional priorities such as their child keeping free from substance and alcohol misuse, being physically active and physically well.
- 9.4.1.4 Respondents from the variety of professional backgrounds in Site C shared similar views on their area's CAMHS services. All felt that the term 'mental health' was stigmatising and off putting to children and young people. CAMHS services tend to be based in hospitals and this implies a medical model of intervention. LACYP are alienated by the terminology and location of the service. CAMHS appointments tend to be offered Monday-Friday 9-4pm and therefore LACYP would need to be absent from school in order to keep appointments or attend at the end of the school day when they are tired.
- 9.4.1.5 Most respondents in Site C feel that the CAMHS title needed to be replaced with a name that was more acceptable to young people and that interventions needed to be flexible to meet the needs of individual young people. Suggestions for outreach, community based, school based work were given.

9.4.2 Views of children and young people

- 9.4.2.1 2 young people in Site C participated in individual interviews, and the remaining 12 were interviewed together as a group. There was an even gender split with young people ranging from 14-19 years of age. The group comprised of young people living in foster care, kinship care, residential accommodation and independent living. Three young people were unaccompanied asylum seekers and an interpreter supported them with their participation. Some of the young people had not met before and they had been identified to be involved by either the Advocacy Service or Leaving Care Team.
- 9.4.2.2 Young people in Site C agreed that there was an abundance of services on offer that were there to support them with their health and well-being needs and in most cases these services were accessible and acceptable to them. They knew when and where to go, and neither transport nor cost appeared to be an issue for them. The services that they talked about were stand alone services in various locations across the district, and most of the group was unaware of the 3 local youth hubs that had been established as one-stop shops for young people's support services, with a range of health and well-being support services available in one place.
- 9.4.2.3 It was reported by two young women in the group that some sexual health services in the district have a cut off age of 19 years and that young people over this age are directed to adult sexual

Practice Survey

health services – the adult services tended to be less locally based and involved travelling on public transport to the city or town.

9.4.2.4 All spoke positively about the role of the LACYP nurses, and for the UAS young people, the nurse would be their person of choice to ask for support with their health and well-being. They went on to suggest that the LACYP nurses would be more accessible if they worked more closely with the local colleges, as this would be an ideal place for young people to meet with the nurse without having to make a special journey to the health centre.

9.4.2.5 Most were of the opinion that they would like to have better and easier access to their designated social worker to talk through health and well-being concerns or issues, but they reported that their social worker changed too frequently and that they were difficult to contact by telephone.

9.4.2.6 Young people talked about attending CAMHS and their experience of being encouraged to talk about issues that were very difficult for them within a 1 hour time slot. Some felt that appointments needed to be more flexible so that a session could be extended, if the young person needed extra time with the CAMHS worker.

‘CAMHS bring-up loads of stuff that you’ve been bottling up for ages and then it’s ‘close-down’ after an hour – sometimes you’re just not ready.’ (16 year old young woman)

9.4.2.7 Four young people spoke of their dissatisfaction with their experiences of CAMHS and none of the young people spoke positively about the service.

9.4.2.8 All agreed that they like to access services where they are treated with respect and are not viewed or treated differently because of their care status.

9.4.2.9 Two young people shared the view that LACYP are not always listened to, and this can make them very vulnerable at times. In order to address this, they felt that social workers should be more accessible to LACYP – even if this is by telephone.

9.4.2.10 One young person reported that he had been badly affected by an abusive foster care placement and that in his view, foster placements should be subject to the same inspection regime as residential homes, with spot checks and closer scrutiny of carers via criminal record and reference checks.

9.4.2.11 One young person had a strong view that LACYP should not be treated by professionals or agencies as different to any other young person, as there is a danger that LACYP will be too sheltered during their time in care.

‘...Kids in care are not well-prepared for the outside world – they are too sheltered. Your social worker makes all your appointments for you and the workers in the care home sort everything out for you – you don’t know how to manage on your own two feet and you struggle when you have to go it alone.’ (18 year old young woman)

Practice Survey

9.5 Views across professional groups and carers

9.5.1 Social care staff

9.5.1.1 The inflexibility of the CAMHS service was raised as an issue by social care staff. Respondents gave examples where they had attempted to refer a LACYP but CAMHS had asked them to wait until the LACYP was experiencing a period of stability. For some of the LACYP that are most in need of CAMHS support, a period of stability is not anticipated in the near future and therefore they are unable to access the service.

9.5.1.2 Where a LACYP is offered a CAMHS service, they are written to and offered an appointment but if they fail to attend two consecutive appointments without explanation, CAMHS close the case. This is reported as a common problem.

9.5.1.3 Waiting lists for non-acute CAMHS services were also raised. Some social care staff in Site C state that they do not refer young people to the service if they are approaching their 17th birthday as it is likely that they will have reached 18 years before they are offered an appointment, and by this time, they will be eligible for adult mental health services.

9.5.1.4 In contrast to this, social care managers in Site C said that CAMHS services had become more accessible to LACYP of late and waiting lists were significantly reduced.

9.5.1.5 Some respondents in Site C feel strongly that CAMHS services should extend to age 21 for LACYP.

9.5.1.6 Social care professionals in Site C raise the issue of life story work with LAC. Some feel that is an intervention that enables a LACYP to come to terms with their situation and emotionally develop to become an emotionally healthy adult. It was apparent that life story work is not undertaken with all LACYP and takes place on an ad hoc basis. This area of work is considered to be supplementary to the statutory responsibilities that professionals hold and tends to be delegated to student social workers and pre-qualifying social care staff with limited or no training and often without experience. It was acknowledged that the quality and extent of life story work varied greatly and decisions about whether or not to do it is resource driven rather than needs led.

9.5.1.7 A LAC team manager in Site C felt strongly that all LACYP have the right to a coherent explanation from their allocated worker as to the reasons why they are looked after. Professionals within the same group discussion (3 x Social Workers and 1 x Health visitor) confirmed that in their view, often LACYP did not know why they were looked after and some had drawn upon information from a number of sources – distant memory, accounts from birth family, fragmented information from former workers etc. to reason why they were looked after.

9.5.1.8 The LAC team manager suggested that all LACYP had the right to an accurate explanation and that this should take place at a time of the LACYP's request.

9.5.2 Education

9.5.2.1 Education staff raised the issue of communication between social care staff and staff based within schools. In some cases, levels of communication were good with the social worker keeping regular contact with the schools of LACYP that they are responsible for. Other examples were given where there had been significant delays in informing the school that a child had been looked after and it was felt that a more organised and consistent method of communication was

Practice Survey

needed.

9.5.2.2 It was also their observation that children appeared to be entering the LACYF system later than they would have done previously. They felt that they were seeing children and young people that were already damaged or disturbed by their experiences of living within a neglectful or abusive household and had reasoned that this was due to the changed priorities of social care staff, with their priority being to keep families together.

9.5.3 Fostering Services

9.5.3.1 There was acknowledgement from those working in fostering services that there was a shortfall of good foster care placements in the district and that it was a priority to recruit more carers.

9.5.3.2 It was felt that an out of hours support line for foster carers would be beneficial and that this may prevent foster placement breakdown at times of crisis.

9.5.3.3 A respondent who currently worked within fostering services and had a social work background within residential and LAC services felt that workers within children's teams are struggling to meet the competing demands of their roles and that services are under resourced.

'Social workers can see which children are at high risk of becoming looked after at an early age but resources mean that they can't consider doing the prevention work – they have to concentrate on the child protection work – they have unmanageable workloads.'

9.5.3.4 It was her view that early prevention work would undoubtedly avoid admission to the LAC system for many children.

9.5.4 Health professionals

9.5.4.1 The LAC nurses are based with the LAC teams for one morning per week and their role was seen to be useful in facilitating communication between health and social care professionals as they tend to work across organisational boundaries and have a broad knowledge base. LAC nurses feel that they offer support to social care staff and help them in 'unpicking medical models' that social care staff would otherwise struggle to understand.

9.5.5 Foster carers

9.5.5.1 This group reported that historically, the placing of LACYF tended to be unplanned. All agreed that they had noticed a change over recent years and that social workers and managers in Site C were communicating and consulting with foster carers much sooner than before. It is now common practice for introduction and preparation visits to take place prior to the placing of a child with the foster carers.

9.5.5.2 Foster carers in site C felt that LACYF's emerging health needs were picked up and acted upon very quickly as a result of the regular communications between foster carers and the LACYF's social worker, and the regular placement reviews that take place. Foster carer's experience was that access to relevant support services for LACYF was usually speedy and this included access to the local CAMHS.

9.5.5.3 This group felt that foster placements that were more likely to improve long-term health outcomes for LACYF were characterised by consistency, stability, encouragement, love and having clear boundaries in place that are communicated to and understood by the child. The work "stickability" was used to describe placements where the carers did not give up when a LACYF's behaviour

Practice Survey

tested the boundaries that had previously been agreed.

9.5.5.4 Their perception was that the fostering team were working intensively with carers at times of stress and crisis as they were committed to limiting the number of moves that a child experiences.

9.5.5.5 Foster carers in Site C felt that LACYP were served very well by the range of health and well-being support services that are available in the district in terms of their attractiveness, accessibility and acceptability. Although many services were based in the city or towns, support services were also considered to be locally accessible. The group reported a distinct change in the attitude of behaviour of LACYP over the last 10-20 years (some members of the group had been fostering over a long period of time), reporting that LACYP were very aware of their right to access services and were confident and well informed to access services as they need them.

Practice Survey

10. Findings Site D

10.1 Background and structure of looked after children and young people services

- 10.1.1 Site D is a small, inner city unitary with contrasts of extreme wealth and poverty. It has a large and diverse BME community. Significant features include the co-location of specialist posts within the looked after children services and the development of co-ordinated support for looked after children living in neighbouring boroughs and for those placed in specialist provision further afield.
- 10.1.2 Fostering and kinship care are the placements of choice for looked after children and young people regardless of their age or placement history. There is one in borough residential unit commissioned from the independent sector. Where resources are unavailable in-house, specialist placements are spot purchased from the independent sector.
- 10.1.3 Referrals come through the Access to Resources Team which has a role in managing the presenting crisis and looking at available support that will hold a situation to give time for better planning and matching. There is a weekly care panel that tries to make placements in a way that is planned and needs assessed. Additionally, a complex needs panel meets with commissioner representation from health, education and social care to work together to agree best placement for a child and to share costs of the package of care.
- 10.1.4 The borough's in house fostering service has around 130 foster carers who provide mainstream care, supported lodgings and short breaks provision. There is also a specialist carer scheme that meets the needs of harder to place young people. Most of the foster carers live within a 45 minute commute from the inner city area, however this results in many looked after children living in neighbouring boroughs.
- 10.1.5 Staff responsible for looked after children including social workers, the education of pupils in care team, CAMHS for looked after children placed out of borough, fostering services, access to resources team, staff from a drugs team and looked after children's nurses are co-located on one floor of an office. Staff voice how this contributes to a strong ethos of multi agency working and supports the development of quality relationships and effective communication.
- 10.1.6 The Leaving Care Service is located in a building a short walk away and the CAMHS staff and LAC nurses are regular visitors for drop-ins and groups. The multi disciplinary team includes a seconded youth offending team (YOT) worker for looked after children, Connexions workers and housing support staff. All young people accessing the service have regularly reviewed pathway plans.

10.2 Delivery of Care

- 10.2.1 Initial health assessments are carried out by the designated doctor with parents actively encouraged to attend this appointment in order to involve them in providing as much health information as possible. Efforts by the LAC nurses to introduce a template to gather background information prior to the initial assessment proved unrealistic. The nurses expressed the view that it would be better if a follow up health review was required 2-3 months after the initial health assessment. This would bring in the LAC nurses at an earlier stage and enable the latest observations and knowledge about the child's needs to be attended to.
- 10.2.2 98% of health reviews were completed in 2007/2008 and this success is attributed to good

Practice Survey

planning and engagement with social care colleagues, health professionals in other authorities, foster carers, children and young people etc

10.2.3 All health plans are quality assured and the nurses build up a good knowledge of the LAC. This means that if a health plan is carried out by another borough and doesn't match up with what the nurses would expect to see in it, relating to that child, then follow up enquiries are made.

10.2.4 Staff in the disability team and foster carers talked about barriers to LAC receiving good dental care.

'There's a need for more specialist dentists or an extension of the dental therapist role being developed for adults to be copied for children. Now dentists don't like to anaesthetise, specialist intervention is needed to support severely disabled children to open mouths.' (manager -children with disabilities team)

10.2.5 For non disabled children, there can be a fear or reluctance to attend appointments and mainstream dentists do not respond well to young people missing appointments or needing time to feel comfortable. One foster carer described her ongoing struggle to encourage a young person placed with her to attend dental appointments and the dentist's frustrated response 'that he wasn't a social services dentist.'

10.2.6 In this site, recent contact has been made with a dental clinic which provides the required specialist support and is going to be a useful partner in the future.

10.2.7 Good matching at the point of placement was considered very important, however professionals from different backgrounds talked about how the pressure to place in a crisis can mean the education and health needs of children aren't given priority. This can particularly impact on disabled children who may have a need for skilled carers who can respond to special needs, including autism or hearing impairment.

10.2.8 The Commissioner for Health Services suggested that there should be a template devised by health professionals which could be used by those vetting potential placements so they know how to ask the right questions about health provision in areas outside of the borough.

10.2.9 It was acknowledged that a child's history before they came into care can affect their long term health outcomes and that if they were already out of school at time of placement, then there was an even harder climb to make, however all felt that regardless of their history and the reasons why a child came into care, it was still possible to make a positive impact.

10.2.10 The consensus across the professions was that stability in a thriving foster placement had the most significant effect on children achieving good holistic health outcomes.

10.2.11 In order to provide a thriving placement, foster carers should have many qualities including giving a child the same as they would give their own child, being accepting, tolerant, bearing a lot, hanging on in there when the going gets tough and having passion and commitment.

10.2.12 These views were echoed by foster carers themselves who also said that it was important to be well organised, consistent and loving.

10.2.13 All the practitioners interviewed contributed to the raising of skills, confidence and resilience of foster carers through the provision of support groups, out of hours support in times of crisis, targeted training on meeting children's health and educational needs, through network meetings

Practice Survey

and provision of CAMHS support for carers.

- 10.2.14 Although the residential unit within the borough is an alternative to family based care, similar training and support was given to the staff to assist them to give stability and maximise children's capacity to achieve good health and educational attainment.
- 10.2.15 For all looked after children, it was felt that there should be a core group of carers and professionals who follow a child through time and give that child a sense of relationships. Attention was drawn to the fact that in this borough many staff from across health, education and social care have been there for years and this has contributed to stability and consistency for the child.
- 10.2.16 In considering transition points, the most common concerns centred on the move of LACYP to adult services. Many LACYP do not meet the thresholds for adult services. This leaves them vulnerable, with unmet needs and their carers unsupported.
- 10.2.17 Examples put forward included young people who were receiving and benefitting from CAMHS input but weren't eligible for adult mental health services. Moderately disabled young people with Aspergers were highlighted as a group who do not fit the criteria for either adult mental health or adult disability services.
- 10.2.18 All felt CAMHS should continue to have a role with children at times of change and while it may not always be possible to directly support the child; it could be as effective to work with the network around the child.

'When a child is in crisis they may be ready for an intervention at that point but once they are settled, the moment for engagement has passed.' (IRO)

- 10.2.19 CAMHS staff echoed this view

'The thinking has changed around not providing therapy at a time of change. Children have capacity to manage change. Transition is a difficult time but it is a fact of life for the children we work with.' (CAMHS Practitioner)

Practice Survey

10.3 Interventions and activities

- 10.3.1 In interviews staff highlighted the strengths of the integrated model of delivery for looked after children and young people which facilitates a quick response in getting the right services to meet a child's needs. Many talked about the team or network around a child, providing clarity of roles and consistency for the child who then receives the same messages and boundaries.
- 10.3.2 Key factors that build resilience and contribute to good health outcomes included the looked after child having a consistent person in their life, who doesn't reject them, who sticks with them through thick and thin and gives them hope.
- 10.3.3 School was seen as having the potential to promote a looked after child's resilience and it was considered important for the child to have a named person in school to link with. Similar importance was attached to the relationship between school and the foster carers. The education team felt strongly that school staff should know who is looked after in their school in order to give appropriate support.
- 10.3.4 Looked after children placed in borough are able to access tier 3 CAMHS which includes specialist workers with skills to meet the needs of disabled children. Out of borough children's needs are met by the specialist CAMHS team for looked after children. This team often has knowledge and working relationships to link children into local CAMHS services, however if this is not possible, they follow the child and provide direct services to them.
- 10.3.5 Everyone felt that all children in care need more support with their emotional well being and that greater attention should be given to the needs of younger children.

'Too often the symptom is assessed or treated rather than looking at what younger children are saying e.g. bed wetting, crying, nightmares.' (LAC Nurse)

'There can be a denial of the emotional needs of under 5s. People don't want to look at the damage. There is a feeling of not wanting to stir things up. It can be a wasted time when a child is placed and it is assumed all is ok - then the placement disrupts 2 to 3 years later and it would have been better to have addressed needs earlier.' (CAMHS Practitioner)

10.4 The preferences of looked after children, young people and their families

10.4.1 Professionals and carers' views

- 10.4.1.1 Most practitioners and managers spoke about looked after children not wanting to stand out as physically different from their peers, however they did want a recognition that it is difficult being in care.
- 10.4.1.2 Physical appearance was seen as important, even to the extent that a young person may start to smoke in order to lose weight.
- 10.4.1.3 CAMHS staff mentioned that children are worried but often unable to articulate their concerns that they may end up with a mental illness like their parent.
- 10.4.1.4 Staff in the disabilities team felt that disabled young people's health priorities have a different

Practice Survey

emphasis than for non disabled young people. Priorities include independence, catching a bus to college, being treated with dignity, not being bullied, good sexual health information. In contrast, parents' priorities can be a young person's safety at a cost to enabling them to have independence.

10.4.1.5 Residential staff described how young people placed with them want an instant response to illness e.g. they want to see a doctor then and there rather than wait 2-3 days.

10.4.1.6 In general, staff struggled more when thinking about what matters most to parents rather than the young people.

'Parents have a level of need that we don't even get to as we are fully stretched. Yet we know that children may well return to live with their parents.' (CAMHS Practitioner)

10.4.1.7 The quality of relationships was often considered to be more important than the intervention or the activity itself.

'Looked after children respond to a person- it's the quality of the relationship that counts. What children will remember is the person- the good social worker who can get on with children, show empathy and likes them.' (Practitioner Looked After Children Team)

10.4.1.8 Children and young people were considered to prefer interventions and activities that took place in everyday settings like their schools and foster homes. Good foster care training and support was seen as important in order to 'skill up' foster carers to have natural conversations with children in their care that promote health. Some children are so stable in care that they don't want to be involved in targeted interventions and don't want to be considered as different. Other children, however have moved around and missed out on universal delivery of services in school settings. They are therefore in need of targeted services.

10.4.1.9 Targeted services can still be delivered in a natural way. An example was given of a child not wanting to have direct input from the drugs worker so the intervention was carried out with the whole foster family group together.

10.4.1.10 CAMHS is a specialist service and practitioners acknowledged that a child's first thought when CAMHS is mentioned is to say 'I'm not mad.' Effective approaches therefore centred on normalising the service and taking it out of a clinical setting into the homes of children and young people.

10.4.2 Views of children and young people

10.4.2.1 Thirteen young people whose age ranged from 16- 21 years were interviewed at their regular leaving care group. The group included five young people from UK. Several of the other young people had arrived in UK as unaccompanied asylum seekers. The group was diverse in relation to their gender and ethnicity including those with dual heritage. One young person described herself as having a disability. The young people's living arrangements included foster care, living at home on a care order, shared lodgings, own flat and university halls.

10.4.2.2 Two of the young people held the position of 'ambassador' for LACYF and were regularly involved in consultation events and representing young people's views. They brought these views to the general discussion.

10.4.2.3 For the young people who had arrived unaccompanied in the UK, there was a general lack of

Practice Survey

trust in the interpreters who had been provided. It was felt that the interpreters made up their own versions of what they were trying to say. The young people recognised that they were also not in a position to trust anyone and that it was completely unrealistic to have discussions with them at this time about feelings of stress, personal circumstances and their mental health needs.

10.4.2.4 These young people also didn't have knowledge about what was available, so that if they were unhappy in a foster home, they didn't know there were alternatives or how to get their feelings across. It was hard to be 'listened to' and for social workers to acknowledge that it wasn't working.

10.4.2.5 Generally all the young people were accepting of health reviews and happy to 'co-operate' as long as they were treated with respect. They were seen as important in identifying health needs however the system was seen to have failed one young person who had been in care for many years before her hearing impairment was picked up.

10.4.2.6 The young people considered that they had a good understanding of what keeps them healthy but obstacles included lack of money to exercise and having a healthy diet – the 5 portions of fruit and vegetables a day.

'Once you turn 18, your finances pretty much reduce to a quarter of what they were so there is no gym and just £25 a week to spend on food.' (young person who is now at university)

10.4.2.7 When younger, one person recalled that he wasn't ready for any of the health information and guidance that was offered to him. He felt that he more usefully gained information from TV and the internet and that images rather than language was more effective for him. In some ways, what was needed was to take a longer term view. Although he had been reckless and troubled - over time he had sorted himself out and was now at university and was an independent visitor for other young people.

10.4.2.8 In terms of spiritual health - all felt that they had been given opportunities and the choice to follow their religion or not. For some this was important and church or mosque etc was part of their network, particularly if they had no family in UK.

10.4.2.9 The ambassadors reported back on some of the concerns that have been expressed by LACYP about their placements. Some foster carers were seen as putting on a superficial front before social workers came - cleaning up and having a home-made meal cooking. It was for this reason that the young people have made a video about the basic promises and standards of care to which they want foster carers to sign up.

10.4.2.10 Social workers were not generally seen as consistent although one young person named a social worker they had had for several years and the positive effect this had. IROs were named by some as having had a good impact.

10.4.2.11 The days leading up to a LAC review were seen as triggering a flurry of activity by social workers who tried to carry out what had been agreed at the previous review. One young person described reviews as -

'Lots of people asking the same questions over and over again. Sometimes they make the decisions for you or give false promises. Two reviews down the line and it still hasn't happened.'

Practice Survey

- 10.4.2.12 Generally, the group of young people had aspirations in terms of their education and choice of careers. All were in college or at university or planning to take up a course in the near future. For this reason, some members of the group expressed concern at the lack of aspiration and lack of knowledge held by Connexions staff who were geared up to lower level ambitions. The young people had had to find the relevant information about the courses themselves.
- 10.4.2.13 The young people had worked hard to get themselves to where they were and some resentment was expressed about LACYP who are NEET (not in employment, education or training) who were seen as getting extra resources and in particular paid driving lessons, trips abroad and activities.
- 10.4.2.15 Particular issues expressed by the unaccompanied young people related to them not being eligible for the same support as other care leavers once they reach 17 ½ years old. An example was given of being placed in unsuitable hostel type accommodation where other young people were growing weed on their balconies etc. There were also particular problems with some of the young people still having uncertain status in UK as no decision had been made in relation to their case. This affected their access to benefits, capacity to travel abroad, work etc. Lack of solicitors willing to take on immigration work meant that some had no access to specialist legal advice.
- 10.4.2.16 Some of the young people involved in the interview had had placements both within and outside of the borough. The view was expressed that services (education, leisure, support etc) were better when placed within the borough.

Practice Survey

10.5 Views across professional groups and carers

10.5.1 LAC Nurses/Paediatrician

- 10.5.1.1 The LAC nurses are planning to send all health plans and reviews to designated colleagues in the areas where children are placed. They felt that this could be a useful recommendation in guidance.
- 10.5.1.2 They are also going to seek an update from CAMHS on their involvement before medical reviews take place rather than just sending the health plan to CAMHS after the review.
- 10.5.1.3 LAC nurses described how it is decided on a case by case basis whether 'out of borough' children should have their reviews carried out by someone in their locality or return to home borough for the review. Factors influencing this included whether a child was in a stable placement or not- if unstable, it may well be better to provide the consistency of the in borough LAC nurses.
- 10.5.1.4 As a child's case is transferred from team to team – duty to LAC team to leaving care etc – it was felt that this can lead to inconsistent application of the health plan and knowledge of the child and health issues can be lost.

10.5.2 Education of pupils in care team

- 10.5.2.1 The manager of the team is a member of the borough's care panel and is routinely consulted on placement decisions. This is to ensure that educational needs are paramount when considering care placement.
- 10.5.2.2 The education team produce a regular education newsletter for foster carers and hold an annual education conference for them. They train foster carers to equip them to support children's literacy and numeracy.
- 10.5.2.3 The Personal Education Allowance (PEA) scheme which allocates £500 to each LACYP to support their education is described as having had a significant impact on self-esteem and the attainment of children and young people. There is an extensive programme to ensure each LAC has an entitlement to private tuition. Over 50% have received this in the last 2 years.
- 10.5.2.4 There is an annual achievement ceremony for looked after children and care leavers as part of the borough's corporate parenting role in celebrating and rewarding educational achievements.
- 10.5.2.5 The education team has worked with the national organisation Aim Higher to encourage young people to think about the benefits and opportunities of higher education. 12 young people in KS4 have been involved in a programme of activities to encourage them in their aspirations to go to university.
- 10.5.2.6 Education case workers support new social workers through the induction process by attending their first Personal Education Plan (PEP) meetings and reviews with them.

10.5.3 IROs and Participation Staff

- 10.5.3.1 Additional points made by independent reviewing officers included an observation that contact arrangements for LAC can have an impact on a child not being able to maintain leisure
-

Practice Survey

activities.

10.5.3.2 It was felt that 'Life Story' work is not always started as soon as it could be and that it should fit into everyday life for a child as a recording of their journey. The IROs said that it was sometimes made to be more skilled and complicated a task than it really is.

10.5.3.3 Kinship care was described as being on the increase with an emphasis on Family Group Meetings to explore if this is an option for children and young people. Kinship carers, however were considered to be generally reluctant to move onto special guardianship.

'It's always around financial issues where they are used to what they get and feel they are being punished if pushed down guardianship route.' (IRO)

10.5.3.4 The participation worker spoke of new developments that were being explored, including the development of a 'virtual care council' for children and young people placed out of borough.

10.5.3.5 Targeted recruitment was underway, aimed at increasing the number of black male independent visitors.

10.5.4 CAMHS

10.5.4.1 Access to emotional well being services for children placed out of county/borough can be a significant obstacle. This has been addressed by the borough having its own specialist LAC team that follows and supports children who have been placed out of county/borough.

10.5.4.2 CAMHS staff emphasised the need to consider the needs of younger children.

'There's a lot of drama around the challenging adolescents but not enough thought about those in typical fostering services from aged 3-4 onwards....'

10.5.4.3 They felt that foster carers need more support and training to monitor the under 5s so that good long term decisions are made about whether they are returned home and what is the best placement for them. This training should include how to carry out observations.

10.5.4.4 Transition of looked after children to other teams or changes in worker was seen as a challenge to providing looked after children with consistency and it was felt that the child's history can get lost with a new broom approach to supporting or planning services for a young person.

10.5.5 LAC Team

Practitioners in the Looked After Children Team make efforts to widen the staff group that children have contact with. This is assisted through holding regular events like healthy sports days. This contact helps a child feel they are supported by a team rather than a social worker, so if a staff member leaves or is off sick, there is a familiar face to take over. In particular the team talked about the role of social work assistants who can be very important in terms of providing consistency.

10.5.6 Disability

10.5.6.1 Staff in the disability team considered that best practice for the children in specialist placements out of borough with autism or cerebral palsy etc would be to have their LACYP health reviews carried out by health professionals who already visit their placement or school setting, however

Practice Survey

this doesn't always happen and some with complex needs have to come back into borough or children in 38 week placements have to have their medical reviews fitted in to school holidays.

10.5.6.2 The disability team felt that approaches to sexual health education for disabled children need to be thought through as the young people need something different from non disabled children.

10.5.6.3 GPs were sometimes seen as being reluctant to meet the universal needs of disabled children, believing they need specialist intervention.

10.5.7 Leaving Care

10.5.7.1 Six staff including a seconded YOT Worker based with leaving care, a clinical psychologist and leaving care practitioners and managers discussed how they had all worked together to meet the needs of a care leaver. What had worked well through all the challenges was being consistent with the young person so that he got the same messages from people in the network. It was considered that a small network around the child was more effective than a larger one with people dipping in and out all the time. This network stuck with the young person through thick and thin and even engaged with him after he 'took himself out of care.' He is now actively involved with services again and attending the leaving care groups.

10.5.7.2 Leaving care staff could highlight many participative approaches used with young people, including collaborative work with 'Who Cares?' Trust in producing materials to raise professionals' awareness and understanding of the care system. A weekly peer support group takes place with young people buying the ingredients and cooking a healthy meal. The service provides a range of therapeutic arts based sessions and activity holidays

10.5.8 Fostering

The fostering team carry out 50-60 assessments of family members each year and describe the majority of their kinship carers as grandparents based in UK and abroad. Staff said that their experience was in keeping with research findings. Where they work they go well but when it doesn't work they can go very wrong. Kinship carers need high levels of support, frequent visits and there can be particular challenges as they may have struggled as parents themselves. Contact issues can cause additional problems and stresses.

10.5.9 Foster Carers

10.5.9.1 Foster carers responded to requests that took them away from the traditional fostering role including providing day foster care in a parents' own home. They saw this as a strength – responding flexibly to meet the needs of children and their parents, and that you can't always compartmentalise foster carers or their task into specialist schemes.

10.5.9.2 All spoke highly of the support they received from CAMHS and described how it assisted them to develop strategies to care for the children placed with them.

'If a child is not ready to engage, then the therapist can support us.' (foster carer)

10.5.9.3 The foster carers interviewed who were from BME communities emphasized the importance of education and described the team that provides support for the education of pupils in care as being invaluable in securing the best educational placement, coupled with enabling their access to private tuition.

Practice Survey

10.5.9.4 Training provided by the fostering service was viewed as excellent and of a high quality, contributing to their skills and confidence as carers.

10.5.9.5 Living in an inner city borough, the carers interviewed were reliant on public transport. The logistics and time taken to accompany children on long journeys to school, to appointments and to contact sessions were demanding and described by some as 'exhausting' for the child.

10.5.10 Residential Workers

10.5.10.1 Staff at the residential unit felt they were well resourced and benefited from having a stable staff group. Young people arrived in a planned way and residential care was seen as a positive option for them. Staff felt that the unit provided genuine care and capacity to help young people feel safe and contained.

10.5.10.2 Although the unit was commissioned from an independent provider, the borough input 4 hours of CAMHS worker time into the unit each week. The staff member attended team meetings and talked with staff about how to approach issues coming up as well as providing direct support to the young people on relaxation techniques, anger management etc.

10.5.10.3 Similarly, other LACYP staff including drugs workers, education services and LAC nurses regularly visited the unit. When a child has been 'dentist phobic', then arrangements are made for a paediatric dentist to visit the unit.

10.5.10.4 Young people at the unit participated in writing their own case notes. They had also been involved in carrying out Regulation 33 inspections of residential units in other boroughs.

10.5.10.5 The unit had piloted use of a web based file system from Sweden called Journal Digital which includes behaviour charts etc that assist in measuring a young person's progress.

10.5.10.6 The residential unit emphasized the importance of positive activity for the young people placed there, the value in taking young people abroad, the importance of education, participation in a children's homes football league and attendance at the leaving care support group etc.

10.5.10.7 Staff acknowledged the significance of peer pressure in residential settings and that this can contribute to the success or failure of a placement. If other young people in the unit are involved in offending, drug misuse, smoking etc then this has a strong influence. The staff were pleased that the current group of young people living in the unit were able to exert positive influences on each other e.g. by the majority being non-smokers etc.

10.5.10.8 Another key factor in placement success or failure was seen as the influence of parents and whether they gave their child 'permission' to settle.

10.5.11 Commissioner for Health Services

10.5.11.1 The Commissioner for Health Services for looked after children expressed the view that there isn't enough commissioning of placements. There is a trend of buying what's on offer, rather than commissioning what is needed. She pointed to the 'world class' commissioning model used in health as the way forward.

'Most placements are spot purchased so no one is asking why a residential unit doesn't have a SLA with their local CAMHS. Local Authorities should get together and commission full packages of care.' (Health Commissioner)

Practice Survey

10.5.11.2 In looking at the most effective ways of supporting the health needs of out of borough children, she responded that the NHS could provide resources for increasing numbers of LAC nurses and CAMHS staff that follow children out of county but stressed that this was possibly flawed thinking and not a panacea. She stressed that there was a need to get the systems right.

Practice Survey

11. Findings Site E

11.1 Background and structure of looked after children and young people services

- 11.1.1 This site was chosen as it is a shire county with one of the largest children's services divisions in England. It was considered to be of particular interest as in addition to 1200 looked after children in the county, it has responsibility for over 200 unaccompanied asylum seeking children and young people with a further 600 supported under the Leaving Care Act 2000. The private and voluntary sector is particularly active in this county and provides fostering and residential placements to many children and young people who have been placed 'out of county' by their home authorities.
- 11.1.2 Fostering and kinship care is the placement of choice for looked after children and young people with over 90% placed within county with council foster carers or family members. Mainstream foster care services are supplemented by innovative schemes including specialist treatment foster care for teenagers and therapeutic foster care for younger children.
- 11.1.3 Care leavers receive their support from a national charity that works in partnership with the council and has 4 multi disciplinary teams based throughout the county with seconded staff from youth, Connexions and health. Case responsibility is transferred over to these teams from 15 years upwards. Many young people move into supported lodgings at 18 years old even if they preferred to remain with their foster carer. The reduced allowance available to foster carers if they continue to care for the young person after they are 18 was seen as the main factor for this.
- 11.1.4 The care pathway and profile for looked after unaccompanied asylum seeking young people varies from the host community children in that the majority are older boys whose needs are considered best met through residential provision in two council run units. Female unaccompanied asylum seekers are mostly placed in foster care. The unaccompanied young people teams provide the full range of service from duty and assessment to leaving care support separate from the services provided to host community children and young people.

11.2 Delivery of Care

- 11.2.1 The LAC nurses have developed tools to contribute to effective initial health assessments including accessing children's health notes, preparing a chronology and identifying gaps that need to be addressed. Initial health assessments are usually carried out by a community paediatrician and are intended to be part of an ongoing dynamic process where health plans are not 'parked' but owned and followed through by all involved in a young person's care.
- 11.2.2 Young people who come into care late were seen as more resistant to attending health reviews. It was felt that it was how you market and make them relevant to a young person that makes the difference. Effective approaches included LAC nurses coming to drop ins where looked after children meet and calling in at foster homes and residential units.

'You can do more health promotion around sex education while cooking a meal in the kitchen with a young person than in a formal meeting' (LAC Nurse)

- 11.2.3 The importance of mental health services in improving outcomes for LACYP was named by all professionals and in particular there was a call to anticipate and respond to the needs of vulnerable younger children before there was a crisis in their adolescence.

Practice Survey

'Mental health services need to be in at an earlier stage around emotional vulnerability before even looking at mental illness. Planned maintenance is better than intervention too late.'
(Education Adviser)

- 11.2.4 Older young people were seen as having their mental health needs overlooked with practitioners stating that those who self medicate with drugs and alcohol were labelled as substance misusers rather than young people with mental health needs.
- 11.2.5 Barriers were reported by all professionals concerning referral and access to CAMHS for looked after children. The county covers a large geographical area and has 7 CAMHS teams which includes specialist practitioners for looked after children. Teams are over stretched and the therapists described how much work they have to do to support children from out of county who have been placed in so called therapeutic placements but where, in reality, staff are ill equipped and poorly trained to meet their needs.
- 11.2.6 Registration with a GP determines which CAMHS team young people are referred to. If a child moves and needs to register with a new GP, then a fresh referral has to be made and there is a delay as the young person progresses up the waiting list. Records don't flow from one CAMHS team to another and it was suggested that it would be better if there were similar processes to education where records move with the child.
- 11.2.7 There was also insufficient and accessible specialist CAMHS provision for children and young people with learning difficulties.
- 11.2.8 An expert group has been set up to address these gaps and to look at the best way forward.
- 11.2.9 Children's moves were also seen as impacting on their access to dental treatment with one foster carer describing how an orthodontist was unwilling to start work as a child wasn't permanently in placement with them. Another carer described how it took the best part of a year to get dental treatment for a teenager placed with her. The teeth were so bad, that the young person had to be sedated.
- 11.2.10 Respondents mostly named placement stability as the key determinant for a child or young person having good health outcomes. This was further qualified by adding in qualities that need to be present in the placement such as a child having a sense of belonging and opportunities to develop feelings of self-worth. The required qualities of a foster carer included energy, enthusiasm, 'ownership' of the child and being well-organised.
- 11.2.11 Professionals across all disciplines had the view that coming into care late contributed to poorer outcomes as children may well have history of poor attachment and had little therapeutic input. However there was confidence that the provision of quality foster care could effect change.
- 'Good compensatory care will work.'* (fostering worker)
- 11.2.12 From an education perspective Key Stage 4 was seen as a time when stability was required and it was hard to settle young people into new educational provision if they came into care at this time. The consequence was that young people disengage for other reasons than not being academically able.
- 11.2.13 In considering transition points that affect the impact of interventions, the most common concerns centred on the needs of older young people who were seen as particularly vulnerable around the time they move towards independence.

Practice Survey

'Post 16-17 years, young people have greater autonomy and choice. It triggers a lot of stuff for them. They get in touch with their family or family gets in touch with them. They don't know how to protect themselves. Previously contact was contained and managed by their foster carers.'

11.2.14 This period of turbulence coincided with the time that access to mental health services was also withdrawn

'CAMHS only goes up to 18 years. You'd have to be very ill - acute or chronic- to get access to mental health services'

11.2.15 Generally, adolescents were seen as less well served by mental health services than younger children. Views put forward for this included lack of psychiatrists focusing on work with 16-18 year olds.

Practice Survey

11.3 Interventions and activities

- 11.3.1 Most respondents felt that effective interventions mirrored those of everyday family life. Foster carers celebrating the children's progress rather than singling them out in an award ceremony was a better approach.
- 11.3.2 Examples were given of what really doesn't work, including LACYP being called by school tannoy to come to reception to meet with their social worker.
- 11.3.3 Although delivery of universal services was seen as important, emphasis was also given to the need for targeted services. This was considered particularly important for children and young people who have moved around and who can miss out on universal provision e.g. health promotion in schools.
- 11.3.4 The setting for targeted services was seen as important with several practitioners naming the benefits of voluntary agencies that are local and non-stigmatising. The mentoring scheme provided by the leaving care service was identified as effective, with young people matched with interested adults who they met up with in informal settings.
- 11.3.5 The quality of the relationship between the child and their carer or practitioner was often named as being as important as the intervention or activity itself. Practitioners said that children want adults to engage with them who are child friendly, not stuffy, consistent, will listen to them and don't let them down.
- 11.3.6 The county's specialist fostering schemes were regarded as providing a well resourced and effective response to meet the more complex needs of some looked after children and young people.
- 11.3.7 Respondents talked about the benefits of the personal education allowances for LACYP and how it had been used in creative ways to boost children's self esteem and interest in education.
- 11.3.8 Life story work with LACYP was seen as an important intervention, however, it can be given low priority by social workers juggling competing demands. It also was seen as an ongoing rather than one –off activity that should be revisited as children move through different developmental stages.
- 11.3.9 The county no longer had designated LAC social workers but some felt that this model had worked best in prioritising the needs of looked after children and in carrying out life story work as a therapeutic tool.

'The worst thing is to give it to a student to carry out as they get the history and leave. It works best when there are LAC designated workers.' (fostering worker)

- 11.3.10 Good chronologies and life story work were seen as a protection for LACYP, particularly given staff turnover.

'Why should the children have to explain their history over and over again when a new social worker takes over?' (fostering worker)

- 11.3.11 A foster carer highlighted that some children have constructed their own memories as a coping mechanism and that sometimes it is better that they keep these.

Practice Survey

11.4 The preferences of looked after children, young people and their families

11.4.1 Professionals and carers' views

11.4.1.1 Most practitioners and managers discussed how looked after children and young people just want to be normal and don't want to be seen as stigmatised or different. For these reasons, interventions that mirrored good quality family life were seen as the most effective. It was suggested that LAC reviews and PEP meetings were often too formal and would be better if done in a more comfortable environment where the young person had more control.

11.4.1.2 Young people value having good sexual health information. A health professional added that they also want to know about romance and how to love people.

11.4.1.3 A provider of supported lodgings emphasized that the pathway planning process and discussions on sexual health were an intrusion too far in the lives of many young people.

'Normal life doesn't have a pathway plan with a group and committee asking questions. Social workers carry a huge level of responsibility which is reduced to checklists. It is intrusive asking a young person about their sexual health. No wonder they are so uncommunicative and given the intrusion the young people are actually quite polite.'

11.4.1.4 Many professionals voiced the opinion that children and young people worry about their parents and who is looking after them, or they have concerns that they may turn out to be like their parent with the same problems.

11.4.1.5 CAMHS practitioners picked up on these issues and talked about the lack of investment in work with birth families, particularly as children so often return to live with them.

'What gets missed is working with parents and this is vital to settling children in placement. Contact is often managed badly, yet it would make a big difference to the child if it were sorted out.' (CAMHS practitioner)

11.4.2 Views of children and young people

11.4.2.1 Children and young people were seen in two established groups – a group for children facilitated by a children's rights and advocacy service and a group for young people facilitated by the leaving care service. The children and young people were aged from 12 – 20 years and included those living in foster care, guest house and independent accommodation. They were mixed in terms of gender and two young people defined themselves as having a learning disability.

11.4.2.2 Children and young people in foster care described a range of physical activities which supported their health and helped their sense of achievement. Generally, they felt that foster carers and school would support them in any activities of their choosing.

11.4.2.3 All members of the younger aged group could name someone in their network who they could turn to for support. This was usually their carers, staff at school or an independent visitor.

'I have had the same independent visitor for 6 years. When I am 21 years old, I will buy her a really nice meal. She is the only person who doesn't write down everything I say.'

Practice Survey

11.4.2.4 Social workers were not viewed as people they could trust and were associated with control of information and decisions.

'They need to share more things more regularly – even if it means going over things again. Let it sink into your head instead of us panicking about it.'

'They say they will do something and then go and do something different.'

11.4.2.5 The group for older young people focused on the challenges of transition. One young person felt that assumptions were made that you were ready to live independently when it would be in your interest to remain in a loving foster home.

'You want someone to love you. Just because you are in a job and earning doesn't mean you are ready for independent living.'

11.4.2.6 One young person hoped to stay in guest house accommodation as they had built up a good relationship with the owner and felt safe and happy after many placement moves. This had proved problematic as the costs were above agreed limits. The owner had considered becoming a provider of supportive lodgings, but as this would require all the guests to be police checked it was incompatible with running a business. Rules to protect young people were therefore seen as getting in the way of providing the best placement.

11.4.2.7 When looking at health issues, several members of the group for older young people needed to avoid discussion of emotional health as the feelings were too painful, however they were relaxed when talking about the process of health reviews and the input on sexual health.

'I don't mind the height/weight bit of the medical and the drugs talk is ok but 'don't go there' on the sexual health bit.'

11.4.2.8 The leaving care group was a good source of support for the young people who helped each other out with guidance and suggestions about options open to them. One young person who was now living independently with a job, car and own flat, saw themselves as having an ongoing role in settling new members into the group and by doing a course to become a mentor for young people.

Practice Survey

11.5 Views across professional groups and carers

11.5.1 Unaccompanied Asylum Seeking Children and Young People (UASCYP)

- 11.5.1.1 The County has developed specialist provision to meet the needs of unaccompanied asylum seekers including two in-house residential units and commissioned foster placements from a voluntary sector provider.
- 11.5.1.2 One of the residential units is defined as a reception centre which caters for boys aged 16 and over who are not considered to be vulnerable. Its focus is to prepare young people for independence. During their 10 week stay, the young people are age assessed along with a holistic assessment of their wider needs including health, education and accommodation. A comprehensive programme of physical activities is provided with opportunities to learn about resources in the community including libraries, church, mosques etc. Access is provided to solicitors. There is emphasis on educating the young people about cultural norms and the laws in UK. Independent living skills including ironing, cooking etc are taught. Sessions are held on sexual health, basic first aid, the police, use of alcohol etc.
- 11.5.1.3 Respondents from health, education and social care expressed a pride in the facilities that had been set up, describing them as giving young people a chance to rest and recuperate.
- 11.5.1.4 The grant reclaim model of funding which is based per head, provides direct costs only and does not meet the health or education costs of a looked after child or care leaver. This was considered problematic, however LAC Nurses, Social Care managers and practitioners and dedicated Education Advisers for LAC described their commitment to provide quality services to the young people.
- 11.5.1.5 Provision of interpreters was seen as important to ensure that as much information was gathered and support given to the young person through care planning and assessment processes.
- 11.5.1.6 Typically the young people have travelled to UK by lorry having lived in camps in France for several months. They arrive cold, dirty, scared and in need of food. Health problems include trench foot, burns from fires, nightmares, scabies as a result of close contact when sleeping and disrupted sleep patterns from repeated efforts throughout the night to board lorries. Some have purposefully burnt off their fingerprints to avoid identification.
- 11.5.1.7 Young people were described as welcoming the initial health assessment and were keen to see a doctor. If they have health issues they wanted them sorted out and they wanted good info about health services in the UK. They needed ongoing support to access follow up appointments as they became overwhelmed by the number of meetings they were required to attend including seeing immigration officials, solicitors etc.
- 11.5.1.8 Unaccompanied asylum seekers were considered to be less familiar with the concept of mental health
- 'Our concept of mental health is alien to them so we try to help them deal with mental health in an ordinary, every day way rather than label it.'* (Manager UASC Service)
- 11.5.1.9 Many of the young people considered a tablet as the best way of relieving stress.
-

Practice Survey

'They think that the paracetamol will make them feel better but it's offloading their stress that will take the pain away.' (residential worker)

- 11.5.1.10 Access to CAMHS was considered a real problem for UASC who were often moved from one area to another following the completion of the social care assessment process. With each move a fresh referral to CAMHS is made.
- 11.5.1.11 Specialist mental health support for unaccompanied asylum seekers was seen as lacking. Young people may have been victims of rape, witnessed violence, lost family etc, however culturally relevant services that can respond to these needs don't exist. Young people did not meet the criteria to access organisations like Medical Foundation for Victims of Torture.
- 11.5.1.12 Respondents described how they were working with partners around the CAMHS strategy to influence the commissioning of specialist services using the model of Hillingdon's well-being project for unaccompanied asylum seekers as a good way to take things forward.
- 11.5.1.13 Educational provision was not generally seen as responsive to the needs of the asylum seekers who generally came to the UK aged 15 years and over. It was acknowledged that the young people were very committed to learn but it was hard to slot them into mainstream schooling in years 10 or 11. Many became stuck on entry level ESOL in the absence of anything else to offer them.
- 11.5.1.14 A significant number of the young people admitted to the reception centre go missing as they strive to make a new life under the radar in UK. Those that remain and who are not seen as vulnerable, move on into shared flats at the end of the 10 week period.

'We see them arrive in such a state and we say goodbye to a transformed young person fitted with braces on their teeth and wearing glasses. They have developed their own sense of identity and style having had choice over hair style and trainers. We tell them they look good.' (residential worker)

- 11.5.1.15 The Council has commissioned specialist fostering provision for UASCYP from a voluntary agency and works in close partnership to develop new services to meet identified gaps. This has resulted in the voluntary agency running a training flat for vulnerable young people, a supported lodgings scheme and a befriending scheme.

11.5.2 Looked after Children from Out of County

- 11.5.2.1 The LAC nurses were clear that they had a duty of care to out of county children. They were committed to the development of effective systems to work with the children's placing authorities and the independent providers who care for them, to ensure that looked after children's health needs were met, that active health plans were in place and most importantly, that these children were adequately safeguarded while in care.
- 11.5.2.2 Problems centred on the lack of notification to LAC nurses or other statutory agencies that children were living in the county or updated information not being provided when placements ended. Many children and young people didn't have a current health plan or the quality of the plan was poor.
- 11.5.2.3 The LAC nurses advocated that it would be better if they co-ordinated and reviewed the health plans for out of county children, given that they had better local knowledge of the resources that could be harnessed to best meet the child's needs.
-

Practice Survey

- 11.5.2.4 GPs and hospitals routinely passed on information to LAC nurses if they had concerns about how a looked after child had presented at their services. These concerns were then followed through by the nurses. This safety net, however, was lacking for looked after children living in the county and who were not known to be living there.
- 11.5.2.5 The LAC nurses described how they had put a lot of work in to support the independent providers. They provide training to them and call in at the residential units to see the health plans and to make suggestions.
- 11.5.2.6 CAMHS practitioners said that a considerable amount of their time was spent supporting out of county children placed in residential units. They expressed concern at independent sector providers who described their units as therapeutic, yet had a low skills base in the staff group who struggled to meet the complex needs of the young people placed with them.
- 11.5.2.7 Similar concerns were put forward by education practitioners who said that some units claimed to provide education on the premises but were unable to sustain this. Children then came to the attention of the County when they had already been living there for some time.
- 11.5.2.8 Education practitioners discussed the impact out of county children had on available resources and felt that there should be a change in the Belongings Regulations so that the placing authority has a financial disincentive to look outside their area.
- 11.5.2.9 They considered that, by definition, children who are placed out of county were needy and likely to have come from inner city areas where staff retention is a problem. This resulted in them having either an agency worker or frequent changes of social worker leading to inconsistent planning.
- 11.5.2.10 Mainstream schools had to use a high proportion of their additional needs budgets on children and young people from out of the county and those with statements often took up scarce resources at specialist schools.

11.5.3 Leaving Care Staff

- 11.5.3.1 The team spoke about the benefits of multi disciplinary working and in particular of the value of having Connexions staff co-located with them. Young people regard Connexions as a universal service and are responsive when it is delivered in a targeted way to support them to focus on career and activities.
- 11.5.3.2 Team members spoke about shortcomings in the health assessment and review format with an insufficient focus on mental health issues. They added, however, that whatever the template, the process would not lend itself to young people sharing information as they have developed coping mechanisms to not share.
- 11.5.3.3 Particular concerns were made about the lack of mental health services for young people who were described as a forgotten age group. It was considered a false economy to not meet their needs as there would be other costs in the longer term, in relation to drug and alcohol misuse and young people ending up in the criminal justice system.
-

Practice Survey

11.5.4 CAMHS

- 11.5.4.1 CAMHS practitioners were concerned that children and young people are increasingly pathologised with labels like ADHD and, as a consequence, bypass routes to therapy. They added that the payment of disability living allowance can be an incentive to attach this label.
- 11.5.4.2 They felt that when social workers had more time for preparation and life story work, fewer children needed to be referred through to CAMHS.
- 11.5.4.3 The county's focus on fostering was seen as contributing, on occasions, to young people needing being admitted to hospital, whereas if they were in a residential home the situation may be contained and the young person supported within the community.
- 11.5.4.4 The CAMHS practitioners all challenged the view that therapy is not needed or appropriate at times of change and considered that it was important to look at the most effective model to deliver therapy at these times.
- 11.5.4.5 LAC reviews were seen as hindering progress when decisions already made to promote placement stability were revisited as a way of engaging the young person in the meeting e.g. child asking for increased contact.
- 11.5.4.6 The value of the information coming through on SDQs was questioned. The quality was described as variable and dependent on the ability of the person filling it out and on how long they had known the child.
- 11.5.4.7 CAMHS provide out of hours support for treatment foster carers. 70% of calls received from foster carers just require a talking through and de escalation of the presenting crisis, however for the foster carers, knowing there is 24 hour support helps make a real difference.

11.5.5 LAC Nurses

- 11.5.5.1 LAC nurses suggested that the child or young person's health action plan should be put back into universal services if they return home from care so that it is followed through and remains a live plan.
- 11.5.5.2 LAC nurses felt that looked after children living with birth parents are particularly vulnerable. In particular they referred to adolescents living at home where parents have no boundaries.
- 11.5.5.3 They expressed concern at the quality of health assessments and reviews taking place. This view was formed as they regularly monitor the health plans of out of county children placed in the independent sector.
- 11.5.5.4 The organisation of children's health records into one set rather than having separate records including health visitor, GP and child protection notes was seen as the best way forward in promoting children's health, as it would lead to greater consistency and enhanced communication between health professionals.

11.5.6 Education

- 11.5.6.1 Education advisers saw foster carers as having a central role in the wider education of children placed with them, believing that it is parents who instil the commitment to life long learning, ambition and an interest in education for its own sake.
-

Practice Survey

- 11.5.6.2 It was felt however that there can be too much emphasis on education or learning rather than the other satellite areas around the child or young person.

'Some of the bigger social issues are almost veiled by a focus on education. There needs to be a coming together of the elements and a need to look at the wider elements.'

11.5.7 Fostering

- 11.5.7.1 Fostering workers commented that a by-product of IROs chairing LACYP reviews was that social care team leaders were now less likely to attend the meetings. As a consequence, the team leaders become more detached from the child and this was described as a loss.

- 11.5.7.2 Concerns were expressed at how over loaded some children's diaries become with contact arrangements laid down by the court at a convenient time and venue for parents. Children were described as being under a lot of pressure.

11.5.8 Foster Carers

- 11.5.8.1 Nine carers were seen in a group or on home visits who represented those from mainstream and specialist schemes as well as contract 'short breaks' care for disabled children.

- 11.5.8.2 The carers were able to describe the model of working on the different schemes and gave many examples of everyday practice that provided evidence of the impact good quality care with boundaries, rewards and therapeutic support for both the child and carers could bring.

- 11.5.8.3 The mainstream foster carers felt that their task often mirrored that of the carers on specialist schemes and felt that similar levels of training and support would assist them. Social workers were also seen as getting more in depth training that would be of more benefit to the carers who directly worked with the children and young people. There was a feeling that adoptive parents or long term carers should *'do the same courses as specialist foster carers so that they can maintain the approach and keep the continuity when a child is placed with them.'*

- 11.5.8.4 Short break care for disabled children was seen as providing a quality experience for the child but also a vital service in preventing family breakdown and the likelihood of a child needing permanent care.

11.5.9 Supported Lodgings

- 11.5.9.1 A supported lodgings provider with considerable professional experience in education and youth offending field described how she viewed her role as different to that of a foster carer and that she hoped it didn't become over regulated.

'The young person makes the decision whether to treat you like a landlady or to avail themselves of what's on offer. We are accommodators not foster carers- we are a different animal. We provide a safe place during transition in which they come to make their known decisions'

- 11.5.9.2 She described the growing emphasis on supporting a young person develop independence skills but said that the cooking, washing etc was the easy bit.

'The real challenge is the emotional side and attachment issues. The young people may be

Practice Survey

stuck in a rotten relationship and not know how to move on. They may steal from you as a way of being thrown out so that they don't need to take responsibility for the break down. Unless it's a crisis, you can't get help for a young person and we have had the experience of a young person wanting to go to prison to get the psychiatric help he needed.'

11.5.10 Specific issues raised by professionals

11.5.10.1 An educational psychologist expressed concern about what she described as a huge over focus on attachment disorder which she considered to be '*an erroneous concept in many ways.*'

11.5.10.2 She was concerned at the number of professionals who say any looked after child has attachment disorder and felt that better training was needed to capture the concept of attachment and how it impacts on children.

'A disorder is something fixed and that can't be changed. Of course looked after children have attachment difficulties - why should they be over trusting? It needs rooting however in good, sound psychology and there is a need to be mindful of attributing everything to being looked after.'

Appendices

Appendix 1 – Table of Site Respondents

| LACYP Health and Well-Being Practice Survey | | | | | |
|---|--------|--------|--------|--------|--------|
| Profession | Site A | Site B | Site C | Site D | Site E |
| Social care staff – fieldwork, fostering and asylum seeking services. | | 1 | 8 | 20 | 5 |
| Social care staff – complex needs | | 3 | 1 | 3 | |
| Social care staff – residential | 5 | | 2 | 3 | 3 |
| Social care staff – Manager | 4 | 4 | 6 | 5 | 5 |
| Social care - strategic leader | 1 | 3 | 1 | 2 | 3 |
| Education – teaching and co-ordination | 3 | 5 | 1 | 1 | 2 |
| Education – Manager | | 2 | 1 | 1 | 2 |
| CAMHS managers and practitioners | 1 | 1 | 1 | 8 | 7 |
| Health Practitioners including designated doctors and nurses | 3 | 4 | 4 | 6 | 6 |
| Health –leadership role | | 4 | | 1 | |
| Advocacy services | | 2 | 1 | | |
| Leaving care | | | 1 | 4 | 4 |

Practice Survey

| | | | | | |
|---------------------------------|-----------|-----------|-----------|-----------|-----------|
| services | | | | | |
| Fostering support services | | 1 | 1 | | |
| Targeted youth support services | | | 1 | | |
| Complaints services | | | 1 | | |
| Participation services | 1 | | | 1 | |
| Leisure development | 1 | | | | |
| Commissioning role | 1 | 1 | 2 | 1 | 1 |
| Access to resources | | | | 2 | |
| Independent reviewing officers | 1 | | | 4 | |
| Connexions service | | | | | 1 |
| Foster carers | 3 | 8 | 11 | 4 | 9 |
| Independent Fostering Agency | | | | | 1 |
| Supported Lodgings | | | | | 1 |
| Children and young people | 13 | 3 | 15 | 13 | 7 |
| Totals | 37 | 42 | 58 | 79 | 57 |

Appendix 2

Discussion Tool - Managers Practitioners and Commissioners

1. Introduction

1.1 What is your current role and service user group, length of time in position?

1.2 What are the main drivers of practice in your field?

- *Prompts of policy and legislation*

1.3 Can you sum up what you think is a healthy looked after child in 1-2 sentences?

2. Structure and delivery of care through childhood

2.1 What practitioner / professional groups do you work most closely with, and how would you describe relationships and the ways services work together or not?

- *Prompt –do you know how to get in touch with colleagues from the different service, get advice etc?*

2.2 Children follow different care pathways when they become looked after; how do the following affect these?

-service organisation

-placement options/ availability

Practice Survey

2.3 How do the pathways they follow have an impact on their health and well being?

- *Prompts - think of a particular child/ children where things have gone well /not so well Look at delivery and models of care for different age and service sub-groups including BME children and young people, those with disabilities, mother and baby, unaccompanied asylum seekers, young people who offend and/or have challenging behaviour etc. Use of voluntary or independent sector providers, out of borough placements, supported lodgings, secure placements etc.*

2.4 What systems do you have locally to identify and monitor children's health and well being?

2.4.1 Do you think that these work to enable children and young people to get access to the health care (including physical health and emotional health and closely related services like education?)

2.4.2 What's working well and what could be improved?

- *Prompts include examples of joined up working between social care, education, physical health and mental health providers for looked after children and young people. How are views of carer, parent and child/young person taken into account? What's the impact of change in workers or move of placements on health outcomes?*

2.5 What do you think are the key points or transitions in the care pathways of looked after children and young people where intervention may be particularly helpful/ beneficial or not?

- *Prompts include exploring including key points of transition e.g. leaving care, moving into adult disability services, changing school and evidence on the appropriateness and effectiveness of therapy at times of change. Can more harm than good be done if not timed right?*

3. Interventions and activities

3.1 What types of interventions and activities in your experience make the most difference in maintaining, improving or promoting the health and well-being of looked after children and young people? Are there any examples of local practice that have made a positive difference –or not? Can you give examples of new/innovative/ developing practice?

- *Prompt –doesn't have to be a whole service change, can be smaller changes and service adaptation. Encourage discussion on range of interventions in different settings and at different levels of intervention including specialist services for looked after children CAMHS, LACES, mentoring and advocacy schemes as well as those targeted at specific issues e.g. truancy, sexual health. Also look at the impact of training programmes on foster carers and residential workers' confidence and ability to promote health outcomes for looked after children and young people. Cost implications of different interventions and impact on availability.*

3.2 What services do young people and children (and families if they know) like/ prefer? Do you think children and young people prefer to use universal or specialist services and in your experience what works well/ not so well?

- *Prompts include asking about local services and activities that promote the health and*

Practice Survey

well- being of looked after children and young people such as community based specialist health services interventions or one to one interventions for example mentoring and advocacy schemes, those interventions and services specifically for looked after children and young people in particular CAMHS and LACES as well as services delivered to all children and young people or targeted at a specific issues e.g. truancy.

4. Views of looked after children, young people and their families

4.1 What's the most important thing for children and young people in your view?

- *Prompt: the top three for you*

4.2 In your opinion what types of intervention and activities are most acceptable (inclusive, welcoming and helpful) to looked after children and young people and their families? How do services make themselves welcoming and helpful?

4.3 Do you think that if services are more acceptable to children and young people and their families this helps to make them more effective?

- *Prompts include teasing out what makes the difference - environment, staff, what's on offer, useful, attractive, helpful, privacy, non- stigmatising, responsive to needs of BME children and young people, involvement of young people in delivery and decision making.*
- *Prompts include waiting lists, distance, opening hours, training needs, child friendly information.*

1. Opportunities to share practice

5.1 Is there anything new /innovative that you or colleagues have done recently that has contributed to improving and developing services/practice etc, for example improving outcomes, children's resilience, can you describe why , how , when etc .

- *Prompt - this may be a smaller adaptation to service design or delivery.*

2. Summing up

6.1 Is there anything you would like to ask/ add?

Appendix 3

Discussion Tool – Foster Carers

1. Introduction

1.1 Please give brief details of your current role and the type of placements you provide and scheme/agency details. How many children are currently in placement and how long have they been with you?

1.2 How do you see your role in relation to promoting the physical and emotional health and well-being of looked after children and young people?

Practice Survey

1.3 What practitioner / professional groups do you work most closely with; how does this relationship work?

1.4 Overview and shared understanding of terms used in discussion guide including: definition of health, distinction between structure of care and interventions, universal and targeted services for looked after children

2. Structure and delivery of care through childhood

2.1 How do children or young people get referred to you? What degree of matching is involved when children/young people are referred? How long can they stay with you and if they do not return to live with family where do they go and at what stage do they move on?

- *Prompts include how long do placements last, number and type of previous placements, number and type of follow on placements, children coming direct from family and/or direct return to family, how are decisions made, planned or due to placement disruption.*

2.2 Once in placement, what systems are in place to identify and monitor children and young people's physical and emotional health and well-being?

2.3 If a need is identified how is access to the health, education and mental health services ensured?

2.4 What's working well? What could be improved and how?

- *Prompts include level of involvement from social worker, responsibility of foster carer, wishes of parent and child/young person. Access issues including time of appointments, stigma, taking children out of school. Cultural and language needs of unaccompanied asylum seekers. Impact of change - in social worker, placement moves etc.*

2.5 In your opinion, what are the characteristics of a placement that is most likely to be successful in improving the physical and emotional health and well-being of a child/young person?

- *Prompts include looking at age of child when enters care and significance of gender or ethnicity on outcomes. Matching considerations, length of placement, other children in household, specialist placements.*

2.6 Does the initial reason a child or young person is placed with you affect the likelihood of their achieving good physical and emotional health outcomes? Why is this and how can barriers be overcome?

- *Prompts include exploring age of child at time of placement, the child's understanding and acceptance of why they have become 'looked after', placement history, physical and mental health issues at time of placement etc.*

2.7 Are there key points or times of change during a child or young person's time in the care system where intervention may be particularly beneficial or harmful? At what times are they least able to engage with or benefit from interventions?

- *Prompts include exploring examples of practice including key points of transition e.g. leaving care, changing school and evidence on the appropriateness of therapy and specialist support at times of change. Can more harm than good be done if not timed right?*

Practice Survey

3. Interventions and activities

3.1 What types of interventions and activities make the most difference in maintaining, improving or promoting the health and well-being of children and young people in your care?

- *Prompts include looking at participatory approaches that enable children and young people to take part in decision-making processes.*

3.2 What training /support etc do you get to help you maximise children and young people's health and well-being?

3.3 Do children and young people prefer to use specialist or non specialist services for different types of health care and if so which ones? What are their reasons?

- *Prompts include looking at how children and young people respond to the involvement of specialist LAC services including CAMHS, LACES etc. Are targeted services provided in universal setting e.g. schools stigmatising in that the child is identified as a child 'in care.'*

3.4 What factors or interventions do you think enables some looked after children and young people to develop coping mechanisms and build resilience? What role do school/education and mental health services play? Have you examples of what works well?

- *Prompts include relationships with key individuals – professionals/carers/family members, consistency of placement, role of community, hobbies, friends, getting the right services at the right time, child/young person feeling included and in control.*

4. Views of looked after children, young people and their families

4.1 What physical, emotional and social outcomes are most important/least important to children and young people in your care? In what ways does this change as they get older or when they become settled/less settled in placement?

- *Prompts include ability to hold down a job, live a healthy life, have a family, sustain a relationship, live within a community, enjoy lifestyle etc.*

4.2 Can you describe examples of health and well-being services that have been viewed as welcoming and helpful to the children and young people you have looked after? What factors make these services more acceptable to the children and young people?

- *Prompts include teasing out what makes the difference - environment, staff, what's on offer, useful, helpful, privacy, non stigmatising, responsive to needs of BME children and young people. What services have children/young people and foster carers liked best?*

4.3 Do you know where to access health and well-being services for children and young people in your care? What can get in the way?

- *Prompts include waiting lists, distance, opening hours, training needs*

4.4 Overall which type of services work best in giving looked after children and young people the help and support they need in relation to their health and well-being?

Practice Survey

4.5 Summing up

4.5.1 Is there anything you would like to ask/ add?

Appendix 4

Discussion Tool – Children and young people

1. Views of looked after children and young people

1.1 What's important to you in terms of your health and happiness and living a healthy, happy lifestyle in the future We are going to split the first question into 3 parts

1.1.1 Physical Health

- *Prompts for discussion– fit, strong, active, exercise, career, looks, pain free, mobile, sexually healthy, fertile, pregnancy, diet, lifestyle, drugs, alcohol, diseases, smoking, obesity, hereditary conditions, access to prevention and treatment services, dentistry/ eyesight/ inoculations/ long standing (chronic) conditions and urgent conditions you may have, your health records and history*

1.1.2 Emotional Health

- *Prompts for discussion– relationships, attachment, feelings, love, respect, fear, anxiety, understanding, empathy, loss, bereavement, parenthood, happiness contact with family friends (siblings /grandparents, parents etc , pets) Handling anger and aggression.*

1.1.3 Social Health

- *Prompts for discussion - confidence, appropriate behaviour, fitting in, friends, groups, neighbours, colleagues, phobias, assertion, stigma and labelling, communities*

2. Interventions and activities

2.1 Do you know where to go to get the services that you need to keep you happy and healthy?

- *Prompts – ask a social worker, school, health professional, residential worker or foster carer, internet, telephone book, posters, ask a friend. Levels of intervention - prevention advice and acute services.*

2.2 How do you like the services that are on offer?

- *Prompts - explore different services providing physical, social and emotional health services*

2.3 Are they easy to get to?

- *Prompts – time, venue, transport, cost, someone to go with you.*

2.4 Do you find them helpful and useful?

- *Prompts – do the services provide what you need in the way that you want?*

Practice Survey

2.5 Do you go, and if so, why do you go?

- *Prompts – environment, staff, what’s on offer, useful, helpful, get the help that’s needed., which do you like best?*

2.6 If you don’t go, why not?

- *Prompts – practical issues, usefulness, relationships, stigmatising.*

2.7 How do you like to get the support that helps to keep you happy and healthy?

- *Prompts – one-to-one, with other young people in school, other young people in care, via a referral, via a walk in centre, help line, internet FAQ, opening hours, immediate response services – e.g. emergency contraception, sexual health, substance use, counselling, crisis line etc.*

2.8 Which type services work best in giving you the help and support that you need?

- *Prompts – remind young people of how they responded to the ‘how’ question and cross reference with the services that they identify as working best.*

2. 9 Why do you think this is?

2. 10 What doesn’t work for you?

3. Structure and delivery of care

3.1 Can you give us a brief summary of your time in care? The number of different placements and the different types of accommodation that you have lived in?

- *Prompts – foster placements, residential homes, out of area placements, specialist units, secure units, custody (possibly the number of different school changes?)*

3.2 Did you find that you got the support that you needed at the right time for you?

- *Prompts – to soon - not ready, not soon enough – too late.*

3.3 Looking back, when would have been the right time for you to get support with your health and well-being needs?

- *Prompts – on entering the care system, during periods of change or loss, key transitions – puberty, education, change of placement, entering custody, leaving custody or secure accommodation.*

3.4 What do you think has helped you to cope with growing up in care and preparing you for adulthood?

- *Prompts – relationships with key individuals – professionals/carers, consistency – school, carer, community, friends, hobbies, getting the right services at the right time for you*

3.5 Thinking specifically about your health and well being, is there anything that could have been done better or differently during your time in care?

Appendix 5

Information for children and young people

Invitation to take part in a survey

You are being invited to take part in a research survey that will help us learn about the best ways to help and support looked after children and young people's health and well being.

The research involves us talking with people who look after or make decisions about children in care like social workers, doctors, foster carers etc. However if we are trying to change things for the better, then we need to hear the views of children and young people who are being looked after or have been in care at some point in their lives.

Before you decide whether to take part, it is important for you to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Why is the research being done?

Research has shown that looked after children and young people do not always get the right services and support to keep them healthy and happy while in care and that this can lead to more serious health problems when they grow up.

Our names are Lisa Hewitt-Craft and Juliet Ramage and we work for Action for Children which is a charity that provides services to children and young people including those in care.

We want to know what gets in the way of looked after children and young people getting the best health care and examples of things that work really well. This includes services and support to keep your body healthy as well as those that help with your emotions and happiness.

If we learn from children and young people about good ways to provide support, then this can be shared so that other areas of the country may change the way they do things and improve services for the children and young people in their care.

What questions will the project ask?

Apart from some basic information like your age, the number and type of placements you have had, we don't need to know personal matters such as how you came to be looked after. What we really need to know is about the services that you have received and what has worked well for you.

Therefore the questions we will ask will all be about what you think is important in terms of your health and well-being, and what services or support work well in helping you stay well, happy and healthy during your time in care and set you up for a healthy and happy lifestyle in the future. You can also tell us about what doesn't work and what could make it better.

These questions have no right or wrong answer and you can give as little or as much information as you feel comfortable to do so. You can choose not to answer the questions.

Practice Survey

What will happen to me if I take part?

We plan to hold the discussions with groups of children and young people at places where they already meet or live. For instance you may have left care and belong to a group at a 'leaving care' service or we may hold a discussion in your residential home. This means that things will be more relaxed as you won't be in a group of strangers.

We are looking to talk with children and young people aged from 14- 25 years however if you are younger and already belong to a group that is taking part, we may be able to include you if that's what you want.

If you want to take part but don't feel comfortable in group, we may be able to arrange to see you separately.

The survey discussion will take place for about 1½ hours and will be led by either Lisa or Juliet who will take you through the questions that let us hear your views. We will tape record the interview so that we don't distract you by trying to write at the same time as people are speaking.

We hope you will enjoy talking to us but sometimes people get upset when talking about their lives, and if they want to stop, we stop.

Support staff who you know will be available to give you help during and after the interview.

Do I have to take part?

It is up to you whether you take part in this survey. No one should feel forced to agree. You do not have to give a reason for saying 'no', although giving a reason might help the survey.

Before you agree, you need to feel sure that the survey is worthwhile. If you are not sure what to decide, take time to think. You may want to talk to other people before you decide.

Even if you say 'yes' you can drop out at any time. And you can tell us if you want to stop, or have a break. If you do not want to answer some questions, just say "pass". You do not have to tell us anything unless you want to.

If you decide to take part, then we will ask you to sign a consent form so that we know you're ok about being involved. If you are under 16 years, we also need to get someone who is responsible for your care to give their permission to your involvement.

We want to make it easy for you to meet with us so will help out with transport, child care costs or other expenses that you or someone who cares for you has to pay out in order for you to take part.

We want to recognise and thank you for your time and effort and are able to give you a £10 gift voucher for your involvement. You would receive this on the same day as the survey takes place.

What will happen to the information that I give?

We will write about and share what you tell us but we won't say where the information came from unless there is something that we want to draw attention to, for example if you have an example of something that you have experienced, like a really great service or a positive relationship with a worker or carer, we could use this information without giving away your name or the area that you come from.

Practice Survey

If we are planning to use one of your quotes – that is something that you tell us, word for word, we will only do so if you are happy with this. We would still change details like your name and age.

Everything that you tell us will be confidential but if during this discussion, you tell us something that leads us to believe that either you or someone else has or are likely to be harmed; we may need to pass this information on.

We will treat the information you give us with respect for example we will keep tapes in a locked cabinet so that they can't be seen by anyone else. Once the report is written, the tapes will be carefully destroyed.

What will happen to the results of the research study?

Your views are very important and we will take away your experiences and ideas and these will be compared with lots of other information from other groups of young people across the country and pulled together into a report. The final report will be a summary of all the information that has been gathered, so it won't mention you specifically or what you have said, but it will pull together the themes.

This report will go to an organisation called SCIE. That stands for Social Care Institute for Excellence. It has an important role in spreading information about what works best in practice and what does not so that others can learn how to improve their services. Your views will contribute to a bigger study that they are organising and when all this research comes together it will lead to new government guidance to help improve things for other children and young people in care.

You will be able to see all the research findings and new guidance on web-sites and we will give you information about how to get hold of this. We will also write a shorter report that just concentrates on what children and young people told us and we will provide you with your own copy of this.

What to do now

If you would like to take part, a consent form is attached. We will be in touch with the services you attend or the places you live, to find out if you would like to meet with us.

Who to contact for more information

If you want to know more then Lisa and Juliet who are carrying out the survey can be contacted by email:

Lisa.hewitt-craft@actionforchildren.org.uk

Juliet.ramage@actionforchildren.org.uk

Phone messages can be left for them with Shami Kesav at Action for Children on 0207 288 7894.

You can also write to us at Action for Children, Performance and Inclusion Division, 85 Highbury Park, London, N5 1UD

Practice Survey

Having your say

If you are unhappy or have any comments that you want to make about the survey and your experience in taking part, then we want to make sure you get your say. We will give all children and young people leaflets about how to make complaints and comments...

We welcome your feedback.

Thank you

Report Authors Lisa Hewitt-Craft and Juliet Ramage

Organisation Action for Children

Contact details. 0207 288 7894