NICE National Institute for Health and Care Excellence

Public Health England

NICE guideline

Looked-after children and young people

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

Contents

This guideline replaces PH28.

This guideline is the basis of QS31.

Overview

This guideline covers how organisations, practitioners and carers should work together to deliver high-quality care, stable placements and nurturing relationships for looked-after children and young people. It aims to help these children and young people reach their full potential and have the same opportunities as their peers.

Who is it for?

- Social care, health and education practitioners working with looked-after children and young people and care leavers
- Commissioners and managers, policy makers and providers in the NHS, health and social care, public health and local authorities, and third-sector organisations
- Commissioners, managers and providers of residential accommodation and housing for looked-after children and young people and care leavers
- Looked-after children and young people and care leavers
- Birth parents, carers and prospective adoptive parents of looked-after children and young people

Context

As of 31 March 2020, there are 80,080 looked-after children and young people in England, with the total number of children being looked after increasing yearly since 2010. Most of the looked-after children are cared for in foster placements (72%), with 14% in connected care, and 13% in residential care, secure units or semi-independent living accommodation. In addition to these, 7% of looked-after children are placed with birth parents.

Although each child or young person will have a unique journey into care, the most common reason for becoming looked after was abuse or neglect (65%). These are considered to be major adverse childhood events (ACEs). These can cause trauma and can lead to long-term damaging effects on children and young people's physical and mental health. Other adverse childhood events experienced by looked-after children and young people include physical abuse (48%), emotional abuse (37%) and sexual abuse (23%). Trauma can also include domestic abuse, serious harm, exposure in the home or community to alcohol, drug misuse or violence. All looked-after children and young people will have experienced trauma in some way.

Every child in care is a unique child with individual strengths and needs. However, the physical, emotional and mental health of some looked-after children and young people will have been compromised by neglect or abuse. The rate of mental health disorders in the general population aged 5 to 15 is 10%. However, for those who are looked after, it is 45%, and 72% for those in residential care. In addition, frequent placement moves can keep looked-after children and young people from receiving the support they need by disrupting treatment plans and access to services. Frequent placement moves are linked to poorer mental health and a lessened sense of belonging. Practitioners and services involved with the child need to work collaboratively to assess and review the child's needs and how these can best be met. Key statutory guidance for promoting the health and wellbeing of looked-after children is available from the Department for Education and the Department of Health and Social Care.

Looked-after children are also at a greater risk of poor educational outcomes. In 2019, 55.9% of looked-after children had a special educational need compared with 14.9% of all children. At key stage 2, 37% of looked-after children and young people reached the expected standard in reading, writing and maths (compared with 65% of those who were not looked after). The higher prevalence of special educational needs, as well as speech, language and communication needs, among looked-after children, in part explains this

difference. As of 2018, the rate of permanent exclusions for looked-after children has fallen and is now less than the rate for all children. However, looked-after children and young people continue to be significantly over-represented in the criminal justice system. Around half of the children currently in custody in England and Wales have been in care at some point. Virtual schools oversee the pupil premium grant, which is used by them – or designated to schools – to support looked-after children's education. This and other statutory guidance for the education of looked-after children can be found in the Department for Education's statutory guidance on promoting the education of looked-after and previously looked-after children.

Once a child or young person enters care, a suitable placement will be sought for them. Looked-after children leaving care most commonly return home to their birth parents (29%), but two-thirds of children who return home to birth parents re-enter care within 5 years. However, as of December 2019, although the number of children entering care has been rising year after year, the number of children ceasing to be looked after during the year due to adoption has been falling down to 3,570 from a peak of 5,360 in 2015. This has increased pressures on health and social care providers to continue to provide high-quality care with existing resources. Reductions in adoptions have been partially compensated for with increases in Special Guardianship Orders, which increased from 3,550 to 3,700 in the same period. Statutory support for the transition out of care into adoption, including preparing adopters and arranging contact, is outlined in the Department for Education's statutory guidance on adoption.

From 31 March 2019, the number of young people aged 16 and over leaving care to move into independent living has risen each year from 3,720 in 2015, to 4,560 in 2017, and to 4,680 in 2019. Care leavers as a group also have poorer outcomes on key measures such as housing, health, employment, and continuing in education and training post-16. For 19- to 21-year-olds, 6% were known to be in higher education, 21% were in other education, 25% were in training or employment, and 39% were not in education, employment or training (compared with around 12% of all young people aged 19 to 21 years). Statutory support for care leavers, including providing a personal adviser for all care leavers, can be found in the Department for Education's Children Act 1989 guidance and regulations: transition to adulthood for care leavers (volume 3).

Local authorities have a statutory duty to support looked-after children and young people. Partners cooperate to produce individual care plans covering health, education and placement. In addition, clinical commissioning groups, NHS England and Public Health England have a statutory duty to support local authorities to meet their health needs. The

Children Act 1989, Children Act 2004, Care Standards Act 2000, Care Planning, Placement and Case Review Regulations 2010, Children and Social Work Act 2017, Fostering Services Regulations 2011, Children and Adoption Act 2006 and accompanying regulations and statutory guidance provide the legal framework for local authorities, providers of fostering services and children's homes. Other relevant safeguarding legislation and statutory guidance includes the Safeguarding Vulnerable Groups Act 2006, Working Together to Safeguard Children 2018, Children's Act 1989 Guidance and Regulations and Keeping Children Safe in Education 2021.

Despite the gap in health and educational outcomes between looked-after children and young people and the general population outlined above, research suggests that the longer children remain in care, the better they can improve in these areas. And, accounting for their disadvantages, they can do better than children not in care.

The original NICE guideline on looked-after children and young people duplicated existing statutory guidance. This update focuses more on the specific interventions needed to help practitioners improve outcomes for looked-after children and young people, as well as how statutory care is best delivered. It complements existing national statutory guidance, which focuses more on service delivery. It also recognises that looked-after children and young people experience inequality, and these recommendations seek to ensure that their needs are at the centre of any plans being made and are adequately met. This requires special attention and expertise.

The guideline covers support provided to looked-after children and young people and care leavers (from birth to age 25), and their families and carers (including birth parents, connected carers, prospective adoptive parents and special guardians). This includes all who are classed as 'looked-after' under a full or interim local authority care order, whether temporary or long term. For example, it covers looked-after children and young people on remand, those temporarily looked-after under section 20 of the Children Act 1989, and those preparing to leave care. The guideline covers all parts of the care pathway, from entry of looked-after people into the care system, to support provided when moving into permanency and out of care into independent living.

The guideline does not cover children and young people who have moved out of care and are no longer looked after (not including care leavers) – that is, those who have been successfully adopted or reunified with birth parents. It also does not cover those on the edge of care and their families.

Impact of COVID-19

The guideline committee wished to acknowledge that the impact of the COVID-19 pandemic on looked-after children and young people's mental and emotional health and wellbeing, as well as their educational progress, cannot be underestimated.

Although children and young people have been less affected by the virus than adults in terms of infection and mortality rates, the committee raised concerns about lost learning and greater safeguarding risks to this vulnerable group during lockdown. COVID-19 has disrupted practitioners' relationships with children and families, and the longer-term impact on the voluntary and charitable sector is unknown.

To address the impact on educational progress, the UK government has announced £1 billion of funding for schools (the 'catch-up premium'), which includes millions of pounds specifically for vulnerable and disadvantaged children (including looked-after children) whose education has been most affected. Services, including health and social care services, have also been increasingly delivered remotely using digital technology.

Implementing new ways of working, reconfiguring services to meet evolving social distancing requirements and offering emergency support has resulted in increased cost pressures on local authorities, the healthcare sector and other organisations and agencies involved in the care of looked-after children and young people. The impact of the pandemic on vulnerable groups outside of the care system, such as those experiencing domestic abuse and neglect, and families suffering financially, has also led to more children being referred to children's services who had not previously been known to local authorities and children's social care, leading to a greater impact on the system.

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

This guideline should be read alongside NICE's guideline on children's attachment.

1.1 Diversity

1.1.1 Be aware that many looked-after children and young people are from groups that may face additional disadvantage. Ensure that their needs are met and that they do not face further marginalisation. These groups include those from black, Asian and other minority ethnic groups, Gypsy, Roma and Traveller communities, and those from different religious backgrounds, as well as other groups such as refugees and unaccompanied asylum-seeking children, disabled people with complex needs, autistic children and young people, children and young people with a learning disability or neurodevelopmental disability, lower socioeconomic groups and people who identify as LGBTQ+.

For a short explanation of why the committee made this recommendation and how it might affect practice, see the rationale and impact section on diversity.

Full details of the evidence and the committee's discussion are in evidence review D: barriers and facilitators for supporting positive relationships among looked-after children and young people.

1.2 Supporting positive relationships

Positive relationships in the care network

1.2.1 Ensure that the care network around a looked-after child or young person consists of positive relationships. These are characterised by:

- genuine caring – being treated by carers as 'one of their own'
- availability – being there when needed
- reliability – providing promised support in a timely manner
- listening that is engaged and non-judgemental
- continuity of relationships
- promoting agency and shared decision making that is appropriate to developmental age
- providing well-communicated and fair discipline and boundaries
- persistence and understanding, to respond to behaviours that challenge and to support positive behaviours
- positive role models who offer guidance.

1.2.2 If the looked-after child or young person has speech, language and communication problems (whether or not these have been previously diagnosed), refer them to speech and language therapists, if needed, for assessment and for advice on how to communicate effectively with them.

Sibling relationships

1.2.3 Consider interventions and support to improve the relationship between siblings in care, including biological siblings who live apart and non-biological siblings who live together (for example, other looked-after children or young people in the placement, and the carer's biological or adopted children). Take into account

safeguarding issues and the looked-after child or young person's preferences.

1.2.4 For primary-school-aged children, or those needing greater assistance, ensure that the primary carers are present during interventions to improve relationships between siblings in care. Components of this intervention should include:

- structured conversation around relationships and conflict resolution
- incentivised cooperation, for example shared activities and outings to encourage prosocial, cooperative behaviour
- shared activities with coaching in prosocial skills using life story work.

1.2.5 Consider relationship coaching independently from the carer for adolescent siblings in care.

1.2.6 Offer carers support to help them understand and maintain stable sibling relationships before offering interventions to improve the relationship between siblings in care.

Relationships with the birth family

1.2.7 Respect the wishes of looked-after children and young people about contact arrangements (where and who with) and take them into account when making plans. Balance them against safeguarding considerations and the risk of repeating trauma.

1.2.8 Provide contact supervisors for contact with birth families if this is necessary for safeguarding, or if it will help support the relationship between the looked-after child or young person and the birth family. Ensure that the looked-after child or young person always has the same contact supervisor if possible.

1.2.9 Contact supervisors should receive training in:

- safeguarding the looked-after child or young person, including trauma-informed training in recognising signs of distress (including in babies and in non-verbal children and young people) and how and when to end a session

- providing emotional support for the looked-after child or young person, including in transition to and from contact with the birth family
- providing support for and feedback to birth parents to help them build positive relationships during contact
- knowing when to support, and how to reduce support when necessary
- record keeping and sharing information with the broader care team.

1.2.10 Consider the need for more intense contact supervision (in terms of monitoring and feedback provided) between the birth family and looked-after child or young person in the early stages of care placements, with reduced intensity as needs decrease over time.

1.2.11 Provide interpreting services for contact supervisors if the people taking part in contact are non-English speaking. Consider any additional communication support as needed, for example sign language.

1.2.12 Think about using text, email or social media to support contact for looked-after children and young people. Safeguarding plans should also take account of the possibility of ongoing unmonitored online contact and ensure that the time spent in digital or social media contact and the content of these interactions is appropriate.

1.2.13 Consider the contact needs of children placed out of their local area – for example, additional support for the birth family to attend contact centres.

Relationships with social workers

1.2.14 Support the looked-after child or young person's allocated social worker, to reduce professional turnover. Support could include, for example:

- supervision with regular meetings to check on the wellbeing of workers, and reflect on practices that promote positive relationships (see recommendation 1.2.1)

- consultation for complex and specialist problems (see recommendation 1.4.3)
- trauma-informed training in communication skills to support positive relationships (see also recommendation 1.3.18).

1.2.15 Managers of social workers should use and review ways of working to reduce duplication of effort, increase staff retention and enable more one-to-one time between social workers and looked-after children and young people (for example, by improving administrative support).

1.2.16 Local authorities and partner agencies should collect and review data on staff turnover to assess the impact on looked-after children and young people and the success of existing staff support systems. They should use this data to inform action plans to support greater continuity of practitioners working directly with looked-after people and care leavers.

1.2.17 If possible, social workers should tell looked-after children, young people, care leavers, and primary carers pre-emptively, and in a manner appropriate to developmental age, about upcoming changes in their job that will affect their relationship with the looked-after child or young person. This should include a joint meeting in person between the previous and new social worker and the looked-after child or young person. Recognise the emotional impact of such changes and provide an opportunity to say goodbye.

Mentoring

1.2.18 Consider programmes (with professional oversight) to support mentoring relationships. For example, by pairing looked-after young people with near peers with care experience to provide positive role models, particularly for looked-after young people with social, emotional and mental wellbeing needs.

Friendship

1.2.19 To support overnight stays with friends, ensure that safeguarding checks are completed in good time so as not to cause a barrier to relationships.

1.2.20 Consider providing funding to support contact with friends (for example, for travel or activities), particularly for friendships that existed before the looked-after child or young person entered care.

Placement stability

1.2.21 Provide out-of-hours support services (separate from those provided for carers) for looked-after children and young people to help resolve urgent problems, and tell looked-after children and young people about these options. Services could be provided, for example, through social workers 'on call', voluntary or independent agency helplines or advocacy organisations.

1.2.22 Adopt a proactive approach to identify children and young people who may be likely to present out-of-hours (for example, they may show early warning signs such as skipping school, lying or stealing), for whom out-of-hours support could be planned ahead of time.

1.2.23 Discuss the priorities and needs of carers sensitively and transparently with the looked-after child or young person in a manner appropriate to developmental age. For example, if placements are at risk of breakdown, social workers should facilitate communication between the carers and the looked-after child or young person (and birth parents if relevant) to try to resolve problems.

1.2.24 If a placement changes:

- Discuss the reasons for this with the looked-after child or young person in a way they can understand and that is appropriate to their developmental age.
- Offer the child or young person emotional support, if possible by a practitioner they have an existing relationship with.
- Use ongoing life story work to help them process changes in placement.

1.2.25 Provide the new carer with appropriate health information in good time before the new placement starts (for example, the health plan recommendations, any new health concerns, health contacts and upcoming health appointments).

Serious behavioural problems

1.2.26 Consider multidimensional treatment foster care for looked-after adolescents with a history of persistent offending behaviour.

1.2.27 For guidance on service design and delivery for learning disabilities and behaviour that challenges, see NICE's guideline on learning disabilities and behaviour that challenges.

Disorganised attachment

1.2.28 For guidance on attachment difficulties, see the NICE guideline on children's attachment.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on supporting positive relationships.

Full details of the evidence and the committee's discussion are in:

- evidence review A: interventions to support care placement stability for looked-after children and young people
- evidence review B: barriers and facilitators for supporting care placement stability among looked-after children and young people
- evidence review C: interventions to support positive relationships for looked-after children, young people and care leavers
- evidence review D: barriers and facilitators for supporting positive relationships among looked-after children and young people
- evidence review F: interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers
- evidence review G: barriers and facilitators for promoting physical, mental and emotional health and wellbeing of looked-after children and young people and care leavers.

1.3 Valuing carers

These recommendations cover support for primary carers, including foster carers, connected carers, key workers in residential care and birth parents (when the looked-after child or young person is placed with the birth parent).

Supporting and involving carers

1.3.1 Involve and value the carer's input in decision making in the broader care team, and keep carers fully informed about a looked-after child or young person's care plan.

1.3.2 Provide out-of-hours support services for carers to help resolve urgent problems, for example through social workers working 'on call', emergency duty teams or out-of-hours service, voluntary or independent agency helplines, or carer peer support associations.

1.3.3 Ensure that carers log any help sought outside of usual operational hours as part of their routine and urgent reports.

1.3.4 Facilitate peer support for carers at accessible times and places, including online if people may find it difficult to attend a physical meeting.

1.3.5 As part of the care plan, think about the need for planned respite care (or 'support care') for carers.

1.3.6 Ensure that respite (or support) care is used in the looked-after child or young person's best interests and explain this to the looked-after child or young person. For example, make use of short breaks that are fun for the child or young person, such as staying with relatives or extended carer family.

1.3.7 Use a respite (or support care) carer who the child or young person is familiar with if possible, and take into account the skills or training needed to meet the looked-after child or young person's assessed need.

1.3.8 Keep carers fully informed and updated about the support services available to carers and looked-after children and young people in their local authority.

1.3.9 Inform the looked-after child or young person's carers about any interventions used to support the looked-after child or young person, including the purpose of these interventions.

1.3.10 For further guidance on support for adult carers, follow the NICE guideline on supporting adult carers.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on supporting and involving carers.

Full details of the evidence and the committee's discussion are in:

- evidence review A: interventions to support care placement stability for looked-after children and young people
- evidence review B: barriers and facilitators for supporting care placement stability among looked-after children and young people.

Training for carers

1.3.11 Plan training for carers so that it is delivered before it is needed. Think about the need for multiagency involvement in training programmes and ensure that the organisations involved agree the source of funding between them.

1.3.12 Supervising social workers should work with carers to assess the needs of the looked-after child or young person, to inform and tailor training and development needs for the carers.

1.3.13 Provide a schedule of mandatory training for carers, excluding birth parents. Ensure that this training covers:

- Therapeutic, trauma-informed parenting (covering attachment-informed, highly supportive and responsive relational care).
- Safeguarding procedures.
- How to communicate effectively and sensitively (for example, using de-escalation techniques).
- Life story work to promote a positive self-identity, which has a consistent, child-focused and planned approach (see the section on life story work for identity and wellbeing).

- How to be an educational advocate (this part of the training should be delivered by practitioners from the virtual school).
- Identifying problems with, and supporting, good oral health, diet and personal hygiene (particularly among those coming into care).
- Encouraging positive relationships and sexual identity (covering issues such as consent, encouraging healthy intimate relationships, 'coming out' and transitioning).
- Self-care for carers, preventing burnout and coping with placements ending.
- The importance of health assessments, supporting attendance and issues of consent for medical treatment.
- Record keeping and sharing the information in the record with the looked-after child or young person in a constructive and positive way, considering the need for confidentiality, and the impact the record may have on the looked-after child or young person.

  Training can be delivered in person (for example, at home or in community group settings) or virtually.

1.3.14 Provide targeted support and training for birth parents if reunification is a possibility or if the child or young person is to remain in placement with the birth parent. This should be provided through transition planning with family support teams.

1.3.15 Think about providing tailored training for carers if there are specific needs related to race, ethnicity and culture. This could include, for example, understanding and respecting cultural and religious identity (including dietary requirements or preferences), and understanding specific hair and skin care needs.

1.3.16 Provide tailored training for carers if there are specific needs relating to special educational needs, long-term health conditions and disabilities, for example sensory and communication needs. Training could be provided through specialist healthcare teams and voluntary organisations.

1.3.17 Based on the individual needs and developmental age of the looked-after child or young person, consider more intensive training methods for carers to support the delivery of therapeutic, trauma-informed caregiving. These methods should use video feedback, coaching and observation, role play, and follow-up booster sessions and be delivered by trained facilitators.

1.3.18 Ensure that trauma-informed training covers:

- understanding behaviour as a form of communication and as a response to trauma
- understanding, recognising and processing triggers for trauma responses
- understanding attachment and loss.

1.3.19 Ensure that trainers for carers are trauma informed and have a good understanding of attachment issues and therapeutic approaches.

1.3.20 Ensure that new permanent or long-term carers are trained and prepared so that there is continuity of care and support, including therapeutic support if needed, between placements.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on training for carers.

Full details of the evidence and the committee's discussion are in:

- evidence review A: interventions to support care placement stability for looked-after children and young people
- evidence review B: barriers and facilitators for supporting care placement stability among looked-after children and young people
- evidence review C: interventions to support positive relationships for looked-after children, young people and care leavers.

1.4 Safeguarding

1.4.1 Local authorities should facilitate a multidisciplinary approach to safeguarding looked-after children and young people, recognising that, like other children, looked-after children may need a full safeguarding response despite already being in care. This approach should:

- include all relevant agencies in meetings to address safeguarding concerns
- facilitate the sharing of data between agencies
- seek the views of looked-after children and young people and their carers, to ensure that responses to safeguarding risks are effective and acceptable, for example by coordinating safeguarding responses for siblings in care.

1.4.2 Hold safeguarding meetings to bring together practitioners from multiple agencies involved in the care and support of looked-after children and young people, such as: social care; fostering, residential and connected care; education and the virtual school; healthcare; voluntary agencies; housing services; emergency services; policing; and immigration.

1.4.3 Local authorities should seek specialist support to address safeguarding risks outside the home (contextual safeguarding), exploitation and children missing from care. This practitioner should lead and facilitate safeguarding meetings and build clear lines of accountability. The practitioner could be, for example, a missing person's coordinator or another trauma-informed specialist with knowledge of exploitation and safeguarding issues in the looked-after population.

1.4.4 Assess the safeguarding risk of a looked-after child or young person using data shared across agencies. This could include data on vulnerabilities:

- at the individual level (such as those captured by risk-assessment tools)
- at the group level (red flags specific to subpopulations such as young girls and boys, trafficked children and unaccompanied asylum-seeking children)
- at the community level (gathered from community-level health and mental health data, area deprivation indexes, number of county lines operating in a single area and area-specific missing person reports).

1.4.5 Use training and review meetings to ensure that practitioners and carers working directly with looked-after children and young people are:

- able to recognise critical moments for looked-after people; that is, times when they may be more open to change and receiving help
- aware of the early signs of, and risk factors for, gang involvement, exploitation and going missing
- familiar with how to report concerns.

1.4.6 Promote positive relationships (including broader relationships such as those with carers, siblings and practitioners) as the main way to prevent exploitation and children going missing from care (see recommendation 1.2.1).

1.4.7 Provide tailored support for the looked-after child or young person to prevent exploitation, by addressing issues specific to young girls and boys, trafficked children and unaccompanied asylum-seeking children (for example, addressing issues of self-esteem, domestic abuse, negative relationships and previous exploitation).

1.4.8 Review the case files of looked-after children and young people who have been the subject of safeguarding meetings, to help the safeguarding partnership learn and develop future safeguarding responses (or to inform best practice).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on safeguarding.

Full details of the evidence and the committee's discussion are in evidence review G: barriers and facilitators for promoting physical, mental and emotional health and wellbeing of looked-after children and young people and care leavers.

1.5 Health and wellbeing

Building expertise about trauma and raising awareness

1.5.1 Ensure that all practitioners working with looked-after children and young people are aware of the impact of trauma (including developmental trauma) and attachment difficulties and appropriate responses to these, to help them build positive relationships and communicate well.

1.5.2 Ensure that practitioners and carers working with unaccompanied asylum-seeking children are aware of the issues that affect this group, including health needs, safeguarding issues, language and culturally sensitive care needs, and the danger of going missing.

1.5.3 Ensure that there is sufficient specialist professional expertise to support, and provide consultation for, looked-after children and young people with more complex needs. This could be provided through more intensive (responsive) trauma-informed training, or by sharing expertise across agencies.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on building expertise about trauma and raising awareness.

Full details of the evidence and the committee's discussion are in:

- evidence review C: interventions to support positive relationships for looked-after children, young people and care leavers
- evidence review D: barriers and facilitators for supporting positive relationships among looked-after children and young people
- evidence review E: interventions and approaches to support practitioners in completing physical and mental health and wellbeing assessments (and act on findings during the care journey) for looked-after children and young people
- evidence review G: barriers and facilitators for promoting physical, mental and emotional health and wellbeing of looked-after children and young people and care leavers.

Physical and mental health and wellbeing assessments

1.5.4 In line with statutory guidance, when a child or young person enters care, local authorities must ensure that healthcare teams are informed as soon as possible about the legal status of the looked-after child or young person and why they have entered care (within 5 working days, as specified by the Care Planning, Placement and Case Review Regulations 2010). Get consent to share this information from an adult with parental responsibility, or from the looked-after child or young person directly if appropriate.

1.5.5 When a child or young person enters care, social workers should:

- Make a formal request for the initial health assessment, giving the reasons that the child or young person is coming into the care system.
- Ask for consent from the birth parents (or from another adult with parental responsibility, or from the looked-after young person directly if appropriate)

to access and share information from the child health record.

- Ask for consent from the birth parents to share their own health information, and ask them to complete a parental health questionnaire to help with this. If the birth mother has agreed to share her health information, ask the relevant hospital about her health during pregnancy.

  All this information should be available in time for the looked-after child or young person's initial health assessment.

1.5.6 Ensure that statutory review health assessments for a looked-after child or young person are carried out by the same healthcare professional each time, if possible.

1.5.7 Consider the need for confidential and private access to healthcare for looked-after young people, for example if phone use or internet use are restricted because of safeguarding needs, or when seeking out sexual health advice or treatment. For guidance on one-to-one interventions to prevent sexually transmitted infections (STIs) and contraceptive services, see NICE's guidelines on STIs and contraceptive services.

1.5.8 Healthcare professionals should compile a history of the looked-after child or young person's health from the information they hold in the health records and additional information given to healthcare professionals from other teams, to give practitioners and carers a clear sense of their past, present, and likely future physical and mental health needs.

1.5.9 Be aware that care leavers are very likely to request access to their health and social care records. Practitioners should ensure that the language used in the records and the way events are captured are sensitive and empathetic.

1.5.10 Offer a culturally appropriate, registered interpreter to communicate in person with looked-after children and young people for the initial health assessment if language is a barrier to communication. If language remains a barrier to communication, think about the need for a culturally appropriate, registered interpreter to be available in person for subsequent health and social care assessments.

1.5.11 Offer unaccompanied asylum-seeking children tailored initial health assessments that address risks arising from their country of origin and journey to the UK. Include:

- diet and nutrition, including nutritional deficiencies such as vitamin D deficiency
- gastrointestinal symptoms
- oral health
- tuberculosis screening and general immunisation status
- sexual health, tailored to the individual (for example, testing for sexually transmitted diseases; and being aware of signs of assault and abuse, including abuse linked to faith and culture such as female genital mutilation and breast flattening). For guidance on one-to-one interventions to prevent sexually transmitted infections (STIs) and under-18 conceptions, see NICE's guidelines on STIs and contraceptive services
- other infectious diseases and bloodborne infections, for example HIV and hepatitis testing
- sensory issues not previously identified because of lack of screening, for example hearing, vision or mobility problems
- an assessment of mental health, with referral to specialist mental health teams if indicated
- sleep disturbances.

1.5.12 After looked-after children and young people (including babies) have had their initial health assessment, consider the need for an additional specialist mental and emotional health assessment once the looked-after child or young person has begun to form a relationship with the primary carer. This could be, for example, up to a year or by the first review health assessment.

1.5.13 Healthcare professionals responsible for the care of looked-after children and young people should review whether care recommendations in the health plan have been completed, particularly if the child or young person has been moved

out of area, checking with the professionals concerned across agencies.

1.5.14 For guidance on the diagnosis and management of attention deficit hyperactivity disorder (ADHD) in children and young people, see NICE's guideline on ADHD.

1.5.15 For guidance on the recognition, referral and diagnosis of autistic spectrum disorder, see NICE's guideline on autism spectrum disorder in under 19s: recognition, referral and diagnosis.

1.5.16 For guidance on the recognition, assessment and treatment of post-traumatic stress disorder (PTSD), see NICE's guideline on PTSD.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on physical and mental health and wellbeing assessments.

Full details of the evidence and the committee's discussion are in evidence review E: interventions and approaches to support practitioners in completing physical and mental health and wellbeing assessments (and act on findings during the care journey) for looked-after children and young people.

Mental health and child and adolescent mental health services

1.5.17 To avoid delays in care, provide intermediate therapeutic or specialist support for the care network around looked-after children and young people who are on a waiting list for child and adolescent mental health services (CAMHS), for example a specialist outreach team. This should not be used as a replacement for CAMHS.

1.5.18 Offer a range of dedicated CAMHS that are tailored to the needs of looked-after children and young people – for example, making them longer term, more trauma informed and relationship based.

1.5.19 Offer preventive services based on assessed need (see recommendation 1.5.12), with timely delivery to prevent serious mental health problems that need tier 3 or 4 specialist services.

1.5.20 Be aware that children moving placements must not lose their place in the waiting list for CAMHS, as there is a statutory right to not lose a place in a waiting list for a health service.

1.5.21 Provide specialist, trauma-informed mental health and emotional wellbeing support for unaccompanied asylum-seeking children. Take into account cultural sensitivities (for example, the different perspectives of unaccompanied asylum-seeking children about mental health services) and that symptoms of trauma could come to the surface over the long term.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on mental health and child and adolescent mental health services.

Full details of the evidence and the committee's discussion are in:

- evidence review F: interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers
- evidence review G: barriers and facilitators for promoting physical, mental and emotional health and wellbeing of looked-after children and young people and care leavers.

Life story work for identity and wellbeing

1.5.22 Start life story work as soon as possible after the looked-after child or young person enters care, to support care placement and emotional stability, rather than as an intervention to deliver once placements are stable.

1.5.23 Schedule regular, dedicated times for life story work to help the looked-after child or young person make sense of their journey through the care system and beyond, their significant relationships and their identity.

1.5.24 Ensure that life story work is done in the setting preferred by the looked-after child or young person, and conducted by a named carer or practitioner with

whom they have a continuous and close relationship. This named person may change over the period in care.

1.5.25 Include the following in life story work for looked-after children and young people:

- the present – identity, strengths and significant relationships
- the past – reasons for entering care and for any placement breakdowns, important memories and relationships
- the future – building independence, careers, hopes and dreams.

1.5.26 Take a flexible approach to life story work, and tailor it to the developmental age and needs of the looked-after child or young person. The content could include life mapping, pictures, art, narratives, and toys or play.

1.5.27 Compile life story work in 1 place (such as a ring binder) and build on this in each session. Give the child or young person control over who this is shared with and how it is stored. Help them to choose a safe and secure storage option.

1.5.28 Ensure that life story work for looked-after children and young people captures and embraces ethnicity, cultural and religious identity, as well as other personal aspects of identity, for example, sexual identity or disabilities.

1.5.29 Ensure that a social worker oversees the life story work if another carer or practitioner is carrying out the work. For example, the social worker may share background information to support the carer or practitioner carrying out life story work, with the looked-after child or young person's consent.

1.5.30 Think about and plan how to carry out life story work for looked-after children and young people, with sibling groups, in a manner appropriate to developmental age. This may include:

- preparing siblings for navigating conversations with older siblings or siblings not in care
- deciding whether it is appropriate to deliver life story work sessions in a sibling group or individually

- determining whether conversations will include sensitive information.

1.5.31 Ensure that the experience and skillset of the practitioner or carer delivering life story work for looked-after children and young people is sufficient to deliver good quality work, particularly in complex situations.

1.5.32 Explain to the looked-after child or young person's wider support network that life story work is ongoing, so that they can support it as needed. For example, if sensitive or emotional information has been discussed with the child or young person during life story work, schools may need to be informed.

1.5.33 Plan regular reviews of how life story work may affect contact arrangements and the looked-after child or young person's relationship with their birth family. Use information from these reviews to adjust the support provided. This could include, for example, involving birth families in life story work to encourage consistencies in narratives explored, and helping the looked-after child or young person with reframing previous relationships.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on life story work for identity and wellbeing.

Full details of the evidence and the committee's discussion are in evidence review B: barriers and facilitators for supporting care placement stability among looked-after children and young people.

Relationships and wellbeing activities

1.5.34 Promote a positive relationship between the primary carer and the looked-after child or young person as the main way to support the social, emotional and mental wellbeing of the looked-after child or young person.

1.5.35 When making safer caring plans, think about a looked-after child or young person's need for:

- Physical touch and affection as a part of a healthy relationship with male and

female primary carers. Take into account any adverse childhood experiences.

- Play, particularly for babies and young children.

1.5.36 Develop the interests of looked-after children and young people to help them develop their identity and to find peer support and new friendships. Do this by helping them to find, and setting aside time, for outings, interest groups and other activities that will help them to build skills. These may include:

- one-to-one activities accompanied by the primary carer (at least initially) to promote opportunities for listening and positive relationship building (for example, visiting outdoor green spaces such as parks)
- funded, supported and facilitated activities (such as school clubs, for example making use of the pupil premium grant as determined in the personal education plan) specifically to address emotional health and wellbeing needs
- activities or outings to support identity, for example community support groups, cultural or religious activities, events or festivals
- activities to bring together children, carers and practitioners in informal settings, for example group outdoor activities.

1.5.37 For guidance on managing obesity and promoting physical activity, follow NICE's guidelines on preventing obesity, identifying, assessing and managing obesity, weight management and physical activity for children and young people.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on relationships and wellbeing activities.

Full details of the evidence and the committee's discussion are in evidence review G: barriers and facilitators for promoting physical, mental and emotional health and wellbeing of looked-after children and young people and care leavers.

1.6 Learning and education

Readiness for starting or changing school

1.6.1 Consider the following to support social competence and emotional stability in looked-after children:

- early years education, including playgroups
- other opportunities to encourage child-led play.

1.6.2 The virtual school should plan bespoke, individual transition support for supporting readiness for school and resilience in looked-after children and young people moving between schools and settings (including those moving out of care to permanency). This includes:

- moving from preschool to primary school
- moving from primary to secondary school
- moving in the middle of a school year
- returning to school after an extended absence.

  Individual transition support for school moves may include structured visits to the school beforehand, school preparation for the carer, meeting the designated teacher, catch-up support and handover between designated teachers (for example, drawing from weekly diaries and life story work).

1.6.3 Think about providing multidisciplinary specialist support for transition between school placements, tailored to the looked-after child or young person's needs and alongside or part of the virtual school and the team around the child – for example, including healthcare professionals in transition support for looked-after people who have health conditions that affect their education.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on readiness for starting or changing school.

Full details of the evidence and the committee's discussion are in evidence review H: interventions to support readiness for school in looked-after children and young people.

Support in schools

1.6.4 Inform looked-after children and young people and their carers of:

- their rights to educational support **and**
- the purpose of the pupil premium grant for education and how it is distributed by the virtual school.

1.6.5 Schools should ensure that behavioural management policies reflect trauma-informed practices and cover attachment issues.

1.6.6 Schools should ensure that the designated teacher is a consistent advocate for the looked-after child or young person's educational progress.

1.6.7 The designated teacher should:

- collaborate with school staff (who the looked-after child or young person is most comfortable with), primary carers and named practitioners in the personal education plan and the education health and care plan
- provide timely assessment and ongoing monitoring of learning needs, particularly in times of transition between educational placements
- refer for specialist support when needed (for example, educational or clinical psychology), and be aware of the impact of trauma on learning and behaviour
- be aware of special educational needs and link up with the special educational needs coordinator

- liaise with specialist looked-after children nurse teams if a health problem has been identified that affects education
- work to ensure that young people are able to access the most appropriate and inspirational educational opportunities, especially post-16
- have regular one-to-one informal conversations with the looked-after child or young person and their primary carer, at a frequency informed by the looked-after child or young person.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on support in schools.

Full details of the evidence and the committee's discussion are in:

- evidence review G: barriers and facilitators for promoting physical, mental and emotional health and wellbeing of looked-after children and young people and care leavers
- evidence review K: barriers to, and facilitators for, supporting learning needs of looked-after children and young people.

Virtual schools

1.6.8 Ensure that the virtual school includes all of the following:

- early years expertise
- a special educational needs coordinator
- a post-16 coordinator.

1.6.9 Ensure that the virtual school covers early years provision, incorporating information from nurseries and health visitors (such as the Ages and Stages Questionnaire) and other involved health services. Complete the early years personal education plan and link it to the foundation stage profile if possible.

1.6.10 Ensure that the virtual school special educational needs coordinator is trained in the special educational needs and disability legal framework so they can help looked-after children and young people access all the provision and support that the law entitles them to.

1.6.11 The post-16 coordinator in the virtual school should help looked-after young people navigate opportunities for training and education (including further and higher education, and apprenticeships) and available funding streams to support these.

1.6.12 Ensure that the expertise in the virtual school reflects the needs and profile of the school-aged population it serves. For example, the population may include unaccompanied asylum-seeking children, trafficked children, children with a history of exploitation, and looked-after children on remand or in secure settings.

1.6.13 Make virtual school heads the key enabler for service collaboration and a link between named specialists in the following:

- social workers
- independent reviewing officers
- school admissions and further or higher education admissions
- other virtual schools if a looked-after child or young person is placed out of area
- designated teachers
- school improvement services
- designated practitioners working with looked-after children and young people who have a health need, including mental health services or therapeutic services.

1.6.14 Local authorities should simplify and merge meetings about looked-after children and young people if possible. For example, education, health and care plan meetings for looked-after children and young people and personal education plan meetings may benefit from occurring together.

1.6.15 Include healthcare professionals in multiagency review meetings for looked-after children and young people who have additional health needs that affect their education.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on virtual schools.

Full details of the evidence and the committee's discussion are in evidence review K: barriers to, and facilitators for, supporting learning needs of looked-after children and young people.

Improving educational outcomes

1.6.16 To improve educational outcomes, such as literacy and numeracy, in primary-school-aged looked-after children:

- offer paired reading
- consider individual or small group tutoring (for example, by trained foster carers, trained volunteers or professional tutors).

1.6.17 Ensure that interventions for improving education in secondary-school-aged looked-after young people are regularly evaluated to check they are appropriate for the user and effective as part of the personal education plan.

1.6.18 Assess the language and communication needs of unaccompanied asylum-seeking children:

- Offer English language lessons to those who are not fluent in English.
- Consider intensive English lessons for those with no previous knowledge of English.

1.6.19 Consider the need for virtual schools to increase specialist education support for unaccompanied asylum-seeking children – for example, by providing designated staff members, and additional English for Speakers of Other Languages (ESOL) support.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on improving educational outcomes.

Full details of the evidence and the committee's discussion are in:

- evidence review I: interventions to support learning needs for school-aged looked-after children and young people
- evidence review K: barriers to, and facilitators for, supporting learning needs of looked-after children and young people.

Data collection, sharing and publication in education

1.6.20 The responsible local authorities should collect, publish and monitor information on educational provision for their looked-after children and young people, in particular those missing education (for example, those in schools that do not have a Department for Education number, or those on permanent or fixed-term exclusions). This may include unaccompanied asylum-seeking children and those with a history, or high risk of, exploitation.

1.6.21 Local authorities should agree and share a strategy for reducing the number of looked-after children and young people missing from education.

1.6.22 Local authorities, working with the virtual school, should develop a mechanism to check the spending of the total pupil premium grant, beyond the information recorded in the personal education plan, and evaluate the impact of the spending on the looked after child or young person.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on data collection, sharing and publication in education.

Full details of the evidence and the committee's discussion are in evidence review K: barriers to, and facilitators for, supporting learning needs of looked-after children and young people.

Further and higher education

1.6.23 Virtual schools should collaborate with universities and colleges to support looked-after young people to access higher or further education. Ways to do this could include:

- residential experiences and visits to university or college campuses, mentoring by near peers in higher or further education, and coaching
- local opportunities such as university access schemes and college support programmes
- encouraging self-identification as a care leaver, once in university or college, to help them access support such as financial bursaries.

1.6.24 Ensure that looked-after young people are aware of the possibility of re-entering education when older (up to age 25) with the financial support of their local authority.

1.6.25 Personal advisers, with the support of the post-16 coordinator, should help care leavers to understand the funding and support available for re-entering education, as part of the care offer, once they have left care.

1.6.26 Virtual schools should support a looked-after young person's entry into careers and training. Ways to do this could include providing:

- careers support and advice
- current local opportunities such as work experience placements,

apprenticeships and internships (particularly those targeted at looked-after young people and care leavers).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on further and higher education.

Full details of the evidence and the committee's discussion are in evidence review J: interventions to support entry into further or higher education or training in looked-after children and young people.

1.7 Transition between care placements and to permanent placements

These recommendations cover support for all permanent carers, including long-term foster carers, special guardians, connected carers, adopters, key workers in residential care and reunified birth parents.

Before transition

1.7.1 When planning transition between care placements, social workers should aim to have a good match between the permanent carers and the looked-after child or young person:

- assess the child or young person's case history and care needs, and the carers' strengths, support and training needs (including the length of time needed for training), **then**
- discuss relationship dynamics with the looked-after child or young person and their prospective carers.

1.7.2 During the transition period, support the foster carer and permanent carer relationship. Help to manage foster carer expectations during the planning stage (for example, the need for the permanent carer to be in the foster carer's house at times, using non-judgemental supportive language with new carers and

understanding the emotional challenges for the foster carer of 'letting go').

1.7.3 In the planning stage, discuss the need for longer-term contact and longer-term contact arrangements with the current foster carer, for example contact by letter or email or meeting up once the looked-after child or young person has settled in their new placement.

1.7.4 Encourage and help the permanent carer's family and support network, including other children in the home, to be involved when a looked-after child or young person moves into their new placement – for example, by offering a family and friends training day before the placement.

1.7.5 Consider support, by trained staff, for birth parents with substance and alcohol misuse to support reunification. If the support is given, carry it out alongside court processes, such as family drug and alcohol courts.

1.7.6 Think about providing relational, emotional and mental health support for birth parents and families, alongside court processes, to support reunification.

1.7.7 Continue mental health support and support for drug and alcohol abstinence after reunification.

1.7.8 Consider concurrent planning to speed up the transition to permanent placements. If concurrent planning is used, ensure that carers and birth parents are well informed about the risk of late changes to the permanency plan.

1.7.9 For guidance on support for drug and alcohol abstinence and behaviour change, follow NICE's guidance on lifestyle and wellbeing.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on before transition between care placements and to permanent placements.

Full details of the evidence and the committee's discussion are in:

- evidence review L: interventions to support looked-after children and young people transitioning out of care to living with adoptive or birth parents or special guardians, or into connected care
- evidence review M: barriers to, and facilitators for, supporting looked-after children and young people in transition out of care to living with their adoptive or birth parents or special guardians, or into connected care.

During transition

1.7.10 During transition to a new permanent or long-term placement, think about the need for a more integrated experience for looked-after children (including non-verbal children) and young people that takes into account previous significant caregiving relationships. This could be achieved, for example, by creating opportunities for current and new carers to meet, developing positive carer-to-carer relationships and sharing information (such as familiar routines, emotional responses and diet) before the placement move.

1.7.11 When a looked-after child or young person moves between care placements or out of care to permanent placements, ensure that:

- contact support takes into account the need for continuity with their existing social network (for example, previous friendships), especially if the care or educational placement is in a new area **and**
- the transition period allows sufficient time for new social connections to form and for coming to terms with the loss of previous relationships.

1.7.12 To ensure that the permanency process is focused on the looked-after child or young person, set aside time for 'checking in' with them. Checking in should

consist of careful observation and listening, writing a record of the conversation, and sharing the perspective of the looked-after child or young person to feed into shared decision making about transition arrangements.

1.7.13 In line with statutory guidance, advocacy services must be provided with communication support. The primary carer should also be present during check-ins, particularly for non-verbal children and young people, and children and young people with learning difficulties.

1.7.14 During transition to any new placement, social workers should give prospective carers a profile of the child and their care journey as a history of the care the looked-after child or young person has received. The information can be obtained from the statutory health reports, reports from school and the social worker's assessment.

1.7.15 Give all new carers a history of the looked-after child or young person's care. Create a summary for ease of reading with references to sections that give more detail. Gain consent for information that involves third parties and share only what is directly relevant. Include:

- Risk factors for placement instability and long-term physical and emotional health, such as:
  - family health history
  - previous exposures to drug or substance use, domestic violence and abuse, or neglect
  - other medical history, including antenatal health problems and antenatal exposure to alcohol or illicit drugs (see recommendation 1.5.4)
  - significant relationships and previous significant conflicts in these relationships (especially concerning contact)
  - significant negative events, for example behaviour with potential for harm to others (with context and timeline of previous events)
  - previous placement moves and reasons for them.
- Protective factors to build on, from life story work:

- strengths and hopes for the future
- significant positive relationships with family members, friends and adults
- how behaviours have been successfully supported in previous settings
- faith, communities and religion
- routines
- 'things that are enjoyed', such as games, shopping and favourite food
- interests, activities and achievements.

1.7.16 For emergency care placements that become long-term placements, review what information the carer has been given about the child or young person, and give them more if needed.

1.7.17 Ensure that there is continuity of the care practitioners who help in the handover of information for new carers, if possible.

1.7.18 Ensure that there is continuity of education (through virtual schools with oversight of a virtual school head) when a looked-after child or young person is placed out of their local authority area. Ensure that the current school provides a handover of information to the new school as part of the personal education plan.

1.7.19 Ensure that there is continuity of healthcare for the looked-after child or young person so that any physical and mental health and wellbeing support can continue in the new placement. This includes making sure that any ongoing referrals and existing specialist care are transferred to healthcare services in the new location, before their move to a new placement.

1.7.20 When supporting adoptive parents or other carers, recognise that they may still be learning to parent. Use non-judgemental language and ensure that they are aware of their rights to receive support.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on during transition between care placements and to permanent placements.

Full details of the evidence and the committee's discussion are in evidence review M: barriers to, and facilitators for, supporting looked-after children and young people in transition out of care to living with their adoptive or birth parents or special guardians, or into connected care.

After transition

1.7.21 When social workers give information about a looked-after child or young person's care history to the new carer, they should:

- involve the looked-after child or young person, if appropriate and the child or young person is willing, drawing from continuous life story work
- think about involving the child or young person in sharing information, after enough time has passed for a relationship of trust to form with the new carer.

1.7.22 Ensure that the looked-after child or young person can keep in contact with their previous carers and friends after the placement move, if the child or young person wants to and would benefit from it.

1.7.23 Agencies should seek feedback from carers and adopters and the child or young person to improve their transition services, after the adoption order is made.

1.7.24 Facilitate peer support for permanent carers – for example, by setting up and moderating social media networks and fun group outings for face-to-face peer support.

1.7.25 Ask experienced volunteer permanent carers to help permanent carers with strategies to manage more specialist problems – for example, when there is emotional distance in the relationship between adoptive parent and child, and with looked-after children and young people who have severe behavioural or mental health problems, or special educational needs.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on after transition between care placements and to permanent placements.

Full details of the evidence and the committee's discussion are in evidence review M: barriers to, and facilitators for, supporting looked-after children and young people in transition out of care to living with their adoptive or birth parents or special guardians, or into connected care.

1.8 Transition out of care to independence

Extended care

1.8.1 Encourage and support young people leaving care to stay in their current care placement until at least age 18. Explore the possibility of staying with current carers beyond age 18.

1.8.2 Take into account the increased risk to young people (aged 16 to 17) posed by breakdowns in placement that lead to moves into inappropriate housing. Whenever possible, avoid using unregulated housing, particularly for young people at higher risk of exploitation or risk-taking behaviour. If a move to unregulated housing is planned, thoroughly document the risks and the plans to mitigate these, and review this regularly.

Needs assessment

1.8.3 Personal advisers, working with social workers, should assess the needs of looked-after young people when transitioning out of care to independence. Take into account:

- previous life story work
- problem-solving skills and practical skills, including life skills such as financial literacy, budgeting and household management

- physical and mental health support and long-term health needs, for example managing treatments and appointments
- education, training and employment
- financial resources
- communication needs
- social network (assessing gaps, connectedness, isolation, and both negative and supportive relationships).

1.8.4 Based on the needs assessment, consider providing the following support for care leavers:

- Access to health services, including registering with a GP, dentist, optician, sexual health services and therapists (for those with complex healthcare needs), and extending access to CAMHS (to support continuity of care) or alternative emotional and wellbeing services such as online support, face-to-face counselling or group work. If needed, continue services beyond age 18 until care has been transferred to adult services.
- Support for gaps in social network.
- Life skills training.
- Support for pregnancy and parenting.
- Job preparation services, job searching and career advice.
- Flexible funding to support career development, for example for specialist equipment.
- Suitable and ongoing accommodation (through the leaving care team working together with other housing services), for example supported housing.

1.8.5 Provide the following services to give care leavers a safety net:

- drop-in services
- more frequent meetings with their personal adviser, if the care leaver wants

them

- facilitated peer support groups.

Plans and support for care leavers

1.8.6 Tell care leavers and their primary carers:

- about the rights of care leavers to statutory support (related to care-leaver status such as child in care and relevant child support) and extended support from age 18 to 25 (including reopening pathway planning and contact with the local authority)
- that care leavers can receive the full level of support to re-enter education up to age 25.

1.8.7 Explicitly outline the support available to care leavers in a care offer, and ensure that this can be accessed easily by care leavers up to age 25.

1.8.8 Consider using virtual meetings to help meet the needs of care leavers who are living outside of their responsible authority.

1.8.9 Schedule pathway plan reviews to occur near significant milestones if possible, for example education, training or employment application deadlines.

1.8.10 Explain to care leavers and their primary carers how the pathway plan works, and the care leaver's rights associated with pathway planning – for example, that they can request an additional pathway plan review.

1.8.11 Tell care leavers and their primary carers of the rights of care leavers to advocacy services, to ensure that they receive the statutory provision they are entitled to and that advocacy services are provided in good time to support them with significant milestones.

1.8.12 When developing pathway plans for care leavers, include clear timeframes for actions, and who is responsible for completing the action.

1.8.13 Quality assure and review pathway plans for care leavers to ensure that improvements in outcomes are achieved.

1.8.14 Personal advisers should tell care leavers about services available in their area to support independence. These could include work experience opportunities, apprenticeships and college support.

1.8.15 For further guidance on transition from child to adult services, particularly for those with complex health needs and disabilities, follow NICE's guideline on transition from children's to adults' services for young people using health or social care services.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on transition out of care to independence.

Full details of the evidence and the committee's discussion are in:

- evidence review N: interventions and approaches to support looked-after young people transitioning out of care into independent living
- evidence review O: barriers to, and facilitators for, supporting and developing looked-after young people to transition out of care into independent living.

Support for care leavers in further and higher education

1.8.16 Consider the need for extended care beyond age 18 for care leavers:

- in higher and further education
- with special educational needs and disabilities.

1.8.17 Virtual school heads should take into account educational opportunities for care leavers beyond traditional further or higher education when deciding whether to extend support.

1.8.18 For care leavers who move away to college or university, ensure that there is continuity of housing during holidays, with meaningful social support. This support could include 'buddying' systems for peer support, mentoring from older student volunteers on campus, and other social opportunities for care leavers to tackle isolation during the holidays.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on support for care leavers in further and higher education.

Full details of the evidence and the committee's discussion are in:

- evidence review N: interventions and approaches to support looked-after young people transitioning out of care into independent living
- evidence review O: barriers to, and facilitators for, supporting and developing looked-after young people to transition out of care into independent living.

Feedback to improve services

1.8.19 Encourage children and young people in care and care leavers to give feedback about their care placement and the services they receive. This could be done, for example, through children in care councils, care leaver forums and surveys.

1.8.20 When seeking feedback, specifically seek out the views of children and young people who are looked after out of area.

1.8.21 Include feedback in decision making to improve services.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on feedback to improve services.

Full details of the evidence and the committee's discussion are in:

- evidence review N: interventions and approaches to support looked-after young people transitioning out of care into independent living
- evidence review O: barriers to, and facilitators for, supporting and developing looked-after young people to transition out of care into independent living.

1.9 Forum for strategic leadership and best practice

1.9.1 Use forums to help communication and bring together expertise and leadership from all agencies providing care for looked-after children and young people, as well as representatives of looked-after children and young people and their carers, and care leavers.

1.9.2 Use forums for looked-after children and young people to highlight examples of exemplary practice, review recent research, align and improve tools used for health and risk assessments, educate practitioners, understand one another's roles and responsibilities (and identify important gaps in provision of services), standardise language (for example, job titles and the names of risk-assessment tools and procedures) and agree a partnership approach to practice.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on forum for strategic leadership and best practice.

Full details of the evidence and the committee's discussion are in evidence review E: interventions and approaches to support practitioners in completing physical and mental health and wellbeing assessments (and act on findings during the care journey) for looked-after children and young people.

Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions see the NICE glossary and the Think Local Act Personal Care and Support Jargon Buster.

Ages and Stages Questionnaire

The Ages and Stages Questionnaire provides developmental and social–emotional screening for children between birth and age 6. It draws on parents' knowledge and is widely used in practice to pinpoint developmental progress and catch developmental delays in young children.

Attachment

A deep and long-lasting emotional bond between 2 people. For example, it includes the child seeking to be close to their caregiver when they feel upset or threatened, with the caregiver responding sensitively and appropriately to their needs. Attachment disorder is a recognised mental disorder that affects a very small minority of children experiencing attachment problems. Insecure attachment patterns and disorganised attachment are more common and are indicators of possible dysfunction in a child's attachment system that can lead to poor outcomes.

Carer

The primary carer of the looked-after child or young person – that is, the adult who has primary responsibility for the day-to-day care of the looked-after child or young person.

Care network

The carers and professionals who support the looked-after child or young person, including, for example, foster carers, social workers, healthcare professionals and educational professionals.

Concurrent planning

Usually for babies and young children who are likely to need adoption but who have a

chance of being reunited with their birth family. In concurrent planning, concurrent carers are approved as both foster and adoptive parents. They act as foster carers while the courts decide whether or not a child can return to their birth family. During this time, the children see their parents regularly in supervised contact centres and the concurrent carers support the birth family's efforts to regain the care for their child.

Connected carers

Relatives, friends or other people who have a pre-existing relationship with the looked-after child or young person. If a child or young person cannot live with their parents, connected carers can become their approved foster carers. The child formally remains a looked-after child or young person.

Contact supervisors

The role of a contact supervisor is to unobtrusively observe contact between looked-after children and young people and their parents or other family members during their arranged visits, to ensure that all contact is safe and positive.

Contextual safeguarding

Seeks to recognise the risks to the child or young person that occur outside the home and respond to these to keep them safe. The risks can include violence and abuse from, for example, the person's neighbourhood or school, or social media.

Foster carers

Foster carers work alongside a team of practitioners to provide looked-after children and young people with full-time care in the foster carer's home. Foster care may be a temporary arrangement, with children and young people moving on to a permanent placement or returning to their own birth families. Children and young people may also live in long-term foster care placements if a return home is not possible.

Health plan

Part of each looked-after child and young person's care plan. It is written after the initial and review health assessments. Health needs or concerns are identified and actions are

formulated into the health plan to address the health concern. It is incorporated into the child's care plan. The health plan is reviewed after each subsequent health assessment and at the child's looked-after review, or as circumstances change, to ensure that health actions have been completed.

Initial health assessment

A statutory health assessment for looked-after children and young people that must be completed within 20 working days of coming into care. It must be completed by a doctor who is registered with the General Medical Council and holds a licence to practise.

Life story work

A social work intervention that aims to help children and young people in care begin to understand and accept their personal history and future. Life story books are often used to give a visual aid and reminder of important events or feelings.

Multidimensional treatment foster care

Multidimensional treatment foster care (now called Treatment Foster Care Oregon) is a solo foster placement with a specially trained foster family for between 9 and 12 months. It includes intensive support from a multidisciplinary team, with 24-hour support from the programme supervisor. The intention is to change behaviour through promoting positive role models. During the placement, the young person's behaviour is closely monitored and good behaviour is rewarded. Family therapy is provided for birth parents, and they are taught the same strategies in preparation for reuniting them with their child. Also known as intensive fostering.

Non-verbal

Not yet able or unable to talk – for example, because they are too young or they have a disability.

Paired reading

In paired reading, looked-after children read alongside a partner, such as their primary carer. This helps the child practise their spelling, comprehension and pronunciation.

Attentive and responsive feedback by the carer throughout helps the child to achieve reading fluency.

Personal adviser

Local authorities provide personal advisers to care leavers up until they reach the age of 25. The personal adviser ensures that a care leaver is given the correct level of support to achieve independence. They should have a practical knowledge of the issues facing care leavers as they make their transition into adulthood and the legal requirements for support.

Personal education plan

This is a document describing a course of action to help a looked-after child or young person reach their full academic and life potential. All children in care must have a personal education plan as part of their care plan. It is a legal requirement for every young person in care of statutory school age to have their personal education plan reviewed at least 3 times each academic year.

Permanency

The conditions that lead to a child or young person experiencing security and continuity in their relationships, particularly those of belonging to a committed family. In a permanency plan, a looked-after child or young person is assessed and prepared for long-term care that meets their needs, and takes into account their wishes and feelings. In a care and placement order, it has been agreed that a child or young person will not return home to their birth family, and parental rights and responsibilities are transferred to another carer, for example an adoptive parent.

Practitioner

A paid professional providing direct care for looked-after children and young people. Practitioners may include social workers, independent review officers, educational professionals, healthcare professionals and therapists.

Prosocial

Prosocial behaviour is social behaviour that benefits other people, characterised by actions that show concern for the feelings and welfare of other people – for example, helping, cooperating and sharing.

Randomised controlled trial

Trials in which participants (or clusters) are randomly allocated to receive either intervention or control. If well implemented, randomisation should ensure that intervention and control groups differ only in their exposure to treatment.

Safer caring plan

Enables foster carers to consider potentially abusive or risky situations that may arise in the foster home and create a plan to minimise risks.

Shared decision making

A joint process in which a healthcare professional works together with a person to reach a decision about care. It involves choosing tests and treatments based both on evidence and on the person's individual preferences, beliefs and values. It makes sure the person understands the risks, benefits and possible consequences of different options through discussion and information sharing.

Special guardians

People or a person appointed by a Special Guardianship Order for children and young people who would benefit from a legally secure placement but cannot live with their birth parents. A birth parent cannot apply to discharge the order unless they have the permission of the court to do so, but the order does not end the legal relationship between the child and the birth parents (as in adoption).

Staying put

When a foster placement becomes a 'staying put' arrangement, the young person staying put is no longer a looked-after child but is a care leaver. They are therefore entitled to

support (for example, a personal adviser) as a care leaver but will remain in the foster home. However, the former foster carer is no longer officially a foster carer for that young adult.

Support network

This covers carers, professionals, friends, birth family and any other supportive adults who provide formal or informal support to the looked-after child or young person.

Unaccompanied asylum-seeking children

Children and young people who have left their country of origin without the care or protection of their parents or carers and are seeking asylum in the UK.

Virtual school

The virtual school champions progress and educational attainment of looked-after children and young people in the local authority. The virtual school is not 'attended' but provides coordination of educational services for looked-after children and young people at a strategic and operational level. Looked-after children and young people within the local authority remain the responsibility of the school at which they are enrolled.

Recommendations for research

The guideline committee has made the following key recommendations for research.

Key recommendations for research

1 Interventions to support placement stability in residential care

What interventions are effective in promoting placement stability among looked-after children and young people in residential care?

For a short explanation of why the committee made this recommendation for research, see the rationale section on supporting positive relationships.

Full details of the evidence and the committee's discussion are in evidence review A: interventions to support care placement stability for looked-after children and young people.

2 Interventions to support stability of permanent placements

What interventions are effective in supporting the stability of placements in looked-after children and young people moving out of care to permanency (incorporating the perspectives of looked-after children and permanency carers)?

For a short explanation of why the committee made this recommendation for research, see the rationale section on after transition between care placements and to permanent placements.

Full details of the evidence and the committee's discussion are in evidence review L: interventions to support looked-after children and young people transitioning out of care to living with adoptive or birth parents or special guardians, or into connected care.

3 Supporting mental health of unaccompanied asylum-seeking children

What interventions are effective in supporting the mental health of unaccompanied asylum-seeking children?

For a short explanation of why the committee made this recommendation for research, see the rationale section on mental health and child and adolescent mental health services.

Full details of the evidence and the committee's discussion are in evidence review F: interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers.

4 Using and safeguarding social media in contact with birth parents

How does social media contribute to contact arrangements for looked-after children and young people, and how can this be safeguarded?

For a short explanation of why the committee made this recommendation for research, see the rationale section on supporting positive relationships.

Full details of the evidence and the committee's discussion are in evidence review D: barriers and facilitators for supporting positive relationships among looked-after children and young people.

5 Mental health support for reunification with birth parents

What is the effectiveness of mental health support for promoting reunification with birth parents?

For a short explanation of why the committee made this recommendation for research, see the rationale section on before transition between care placements and to permanent placements.

Full details of the evidence and the committee's discussion are in evidence review L: interventions to support looked-after children and young people transitioning out of care to living with adoptive or birth parents or special guardians, or into connected care.

Other recommendations for research

6 Continuing support for the physical and mental health needs of care leavers

What interventions are effective in promoting and continuing to support physical and mental health and wellbeing in care leavers?

For a short explanation of why the committee made this recommendation for research, see the rationale section on transition out of care to independence.

Full details of the evidence and the committee's discussion are in evidence review N: interventions and approaches to support looked-after young people transitioning out of care into independent living.

7 Promoting physical exercise, and a healthy diet and lifestyle

What interventions are effective in promoting physical exercise, and a healthy diet and lifestyle, in looked-after children, young people and care leavers?

For a short explanation of why the committee made this recommendation for research, see the rationale section on relationships and wellbeing activities.

Full details of the evidence and the committee's discussion are in evidence review F: interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers.

8 Therapeutic interventions for promoting school stability and learning

What therapeutic interventions are effective and cost effective in improving learning outcomes and school attendance and reducing exclusion in educational settings for looked-after children and young people?

For a short explanation of why the committee made this recommendation for research, see the rationale section on improving educational outcomes.

Full details of the evidence and the committee's discussion are in evidence review I: interventions to support learning needs for school-aged looked-after children and young people.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice.

Diversity

Recommendation 1.1.1

Why the committee made the recommendation

The committee noted that children and young people with certain protected characteristics may be over-represented among looked-after children and young people, for example through race or sexuality. They also understood that looked-after children and young people themselves constitute a vulnerable group and therefore certain subgroups of looked-after children and young people may be disadvantaged in multiple ways. Based on their own knowledge and experience, as well as focus group and interview-based evidence, the committee recognised that ensuring these groups are not marginalised, and that their needs are met, may need additional attention and expertise.

How the recommendation might affect practice

This recommendation is not expected to need significant additional resources. It is the statutory duty of local authorities to ensure that children and young people in their care are not disadvantaged or marginalised as a result of their protected characteristics.

Return to recommendation

Supporting positive relationships

Why the committee made the recommendations

Positive relationships in the care network

Recommendations 1.2.1 and 1.2.2

The committee discussed that supporting positive relationships is often spoken about as an aim of care, but it may be poorly defined in practice. A large amount of evidence from the UK based on interviews and focus groups (qualitative evidence) considered the factors that help to build these relationships. In many cases, the committee observed that looked-after children and young people were not asking for more specific interventions or programmes. On the contrary, they often perceived an excess of practitioners involved with their daily lives. Rather, they wanted genuine caring relationships that reflected core principles outlined in this recommendation.

The committee considered that a common barrier to these relationships lay in the ability of the looked-after child or young person to communicate. They were aware that the prevalence of speech and language problems is higher among children who grow up in disadvantaged homes and experience neglect, which includes many in the care system. Implementing this recommendation could result in more timely referrals to speech and language therapists, if needed.

Sibling relationships

Recommendations 1.2.3 to 1.2.6

The committee looked at robust study designs (randomised controlled trials) on interventions aimed at enhancing the relationship between siblings in care. The evidence from these showed that the interventions improved the quality of sibling interaction and reduced aggressive behaviour.

The committee considered the main features of the interventions described in these US-based studies. Carer members of the committee agreed that these activities could have been useful in their own home situations, not just with biological siblings but also non-biological siblings they were living with (biological or adopted children of the carer).

However, they noted that harm could result if safeguarding considerations were not taken into account because facilitated sibling relationships may not always be beneficial. Therefore, these interventions were not to be recommended in every case.

The committee noted that the specific evidence-based programmes were drawn from studies in other countries with very different social care contexts. Using the evidence and their own experience, they recommended the features that could be implemented with success in the UK setting. The committee noted that 1 study showed adolescents may benefit from individualised coaching, with time separate from the primary carer to build the sibling relationship, whereas the committee considered primary-school-aged children would benefit from having the primary carer present. For primary school children, this can help to create a non-threatening environment and improve relationships between the siblings and the carer. It can also teach the carer new methods for mediating sibling relationships.

The committee emphasised that training to promote positive sibling relationships should start at the time of placement. However, based on their own experience, the committee agreed that the relationship between siblings needs to be stable before any activity-based interventions could be attempted. This could be achieved by support targeted at helping carers understand and maintain stable sibling relationships – for example, in the home setting with a professional who is trained in mediating strategies.

Relationships with the birth family

Recommendations 1.2.7 to 1.2.13

One of the key themes of the interviews and focus groups was the need for those in the care network to form a relationship with the child or young person and with other practitioners within the network and use shared decision making. This is to support the person's capacity to act independently to make their own choices. The committee were keen to highlight this, particularly for contact arrangements, and agreed that the child or young person's ability to choose who to have contact with should be supported. They noted the need to balance this against any safeguarding risks.

The committee reflected on evidence based on interviews and focus groups concerning contact with the birth family and the role of contact supervisors when observed contact is necessary for safeguarding. They also discussed that using contact supervisors can be helpful if the birth family is receptive to support and feedback to improve the quality of

contact.

Evidence based on interviews and focus groups in the UK showed that it is important to not overwhelm looked-after children and young people with too many practitioners, and to promote continuity of relationships with practitioners. The committee agreed that retaining the same contact supervisors for a looked-after child or young person, if possible, would help to provide this continuity.

The committee discussed the fact that contact supervisors sometimes share intimate experiences and vulnerable moments with the looked-after child or young person and their birth family. Based on their own experience, the committee considered that if the role of the contact supervisor was more developed, there would be the potential to better support birth family relationships, give greater feedback of information to the care team and have better safeguarding. The committee therefore agreed that more training was needed for contact supervisors to improve the contact experience.

Evidence based on interviews and focus groups showed that contact may need a high level of support at the start of placements. However, this could, in some cases, be hindered by high levels of monitoring, and decreasing levels of support may be needed as time progresses. Therefore, the committee considered that a more cautious approach to contact may be needed in the early stages of care placements, adjusting supervision intensity according to needs over time.

Based on expert testimony, the committee were mindful of unaccompanied asylum-seeking children and those of non-British nationality, so they also stressed that non-English contact supervision needs an interpreter present to make good safeguarding and support possible.

The committee discussed interview- and focus group-based evidence on social-media-based contact. They recognised that such resources could help ongoing relationships much more easily than traditional methods because social media is easily accessible for young people and needs little organisation, but unobserved contact online could pose serious dangers by bypassing safeguarding measures. The committee therefore agreed that safeguarding considerations need to always take into account the possibility of online contact. For example, if social media contact was permitted in cases with moderate safeguarding considerations, it would be important for the content of interactions to be monitored and the amount of time spent communicating managed.

Large amounts of UK-based interview and focus group evidence considered positive relationships and contact arrangements and how these might be supported. However, no themes considered how social media influences contact arrangements or how this might be facilitated by carers and the risks be managed. The committee agreed that research is needed to determine the effectiveness of support mechanisms and interventions to manage the use of social media in care placements, particularly among those at risk of exploitation (see the recommendation for research on using and safeguarding social media in contact with birth parents).

Based on committee experience and knowledge, the committee sought to highlight the extra support that may be needed for children who are placed out of area. Geographical distance may present an obstacle to their ability to remain in contact with family and friends. Support to help overcome this could include financial support to help birth parents pay travel costs and attend contact sessions.

Relationships with social workers

Recommendations 1.2.14 to 1.2.17

Based on UK-based interview and focus group evidence and committee experience, the committee recognised the importance to looked-after children and young people of their relationship with their social worker. The committee agreed that training and support for social workers should include communication skills. This would improve transparency of care and help maintain positive relationships. It would also mean that any information given to the child or young person would be done in a way that they can understand and accept, particularly when a carer transition is approaching.

Based on committee experience and knowledge, and some interview and focus group-based evidence, the committee recognised the need for more support for social workers to prevent burnout, which can lead to greater turnover in staff and loss of continuity for looked-after children and young people. The committee considered factors that could help prevent burnout at work, as well as improving the amount of time available for direct care. These included supervision with regular check-ins and a focus on reflective practice; consultation for complex and specialist problems; and trauma-informed training to promote positive relationships, as well as more practical support to increase the time available for direct one-to-one work.

The committee noted that when social workers are trauma informed, they can make sense

and meaning of how the child or young person is behaving in relationships, in the context of their experiences. As the lead professional, they can influence how the network views the child or young person, what language is used and how it will be most helpful to support them in more helpful positive relationships. This is the ripple effect of different levels of trauma training for the network.

Social workers on the committee commented on the increase in workload, lack of funding and an upwards trend in the number of looked-after children and young people. Much work is needed to complete performance indicators and other administrative tasks and this is often prioritised over one-to-one work with young people. Some interview and focus group-based evidence suggested that one-to-one time could be improved by increasing the administrative support for social workers within local authorities. Although recognising that services are often overwhelmed and that resources are limited, the committee agreed that a culture change was also needed that prioritised more time for direct care between social workers and looked-after children and young people. The committee agreed that if managers use and review systems to free up more time for direct care, this could both increase professional retention, and enable more one-to-one time between social workers and looked-after children and young people.

UK intervention and focus group evidence on the impact of professional moves (particularly those of the allocated social worker) on looked-after children and young people supported the committee's own experience that local authorities do not have good systems for monitoring the level of social worker turnover. They agreed that if local authorities could collect and review data on turnover among their frontline staff and reflect on its impact on looked-after children and young people, this would help local authorities assess the success of staff support systems. They could then develop action plans to keep turnover as low as possible.

There was substantial UK-based interview and focus group evidence that looked-after children and young people reacted strongly against the changing of social workers they had built a positive relationship with. The committee discussed the complexity of addressing this issue. Turnover of social workers was frequent as a result of workload, burnout or the need to change work for career progression. Drawing on this evidence and their own experience, the committee noted that these reasons were often not well communicated to looked-after children and young people, and social workers were perceived to simply disappear. The committee agreed this could be ameliorated by informing looked-after children and young people pre-emptively and transparently about changes of social workers, taking care to recognise the emotional impact of such changes

and providing an opportunity to say goodbye.

The committee, based on their knowledge and experience, also discussed the problem of the departing social worker and primary carers not giving a consistent message about the reason for leaving. They agreed that this problem could be reduced by informing primary carers in advance about the reasons for professional transitions, particularly if strong relationships had formed.

Mentoring

Recommendation 1.2.18

The committee recognised the potential benefit, both for positive relationships and health and wellbeing, of having a mentor for friendship and guidance, particularly one with care experience. Evidence from robust study designs suggested that older children may be more responsive to coaching and mentoring, particularly those with pre-existing emotional and mental health problems. The committee also noted that professional oversight of safeguarding was important to prevent inappropriate or negative relationships forming, and that a significant mentor–mentee age gap would be advisable.

Friendship

Recommendations 1.2.19 and 1.2.20

Based on UK-based interview and focus group studies, and their own experience and knowledge, the committee considered the importance of friendship groups to looked-after children and young people. They recognised that looked-after children and young people may rely on these friendships to play a greater supportive role because of the lack of close relationships of other kinds (for example, with the birth family). As a result, the committee were concerned that contact with friends, particularly those from before coming into care, or other placements in care, should be supported if possible.

Based on their own experience and knowledge, the committee were also aware of some of the barriers faced by looked-after children and young people seeking to have 'normal' relationships with peers while in the care system. Sleepovers can be a normal part of such relationships. However, looked-after children and young people can feel stigmatised and exposed if such plans are delayed or prohibited as a result of waiting for safeguarding checks on the family they wish to sleep over with.

Placement stability

Recommendations 1.2.21 to 1.2.25

Many studies, using data from UK-based interviews and focus groups, reported that looked-after children and young people particularly valued care that was available, accessible and reliable. They benefitted from knowing that support was available even out-of-hours for urgent problems. Committee experience also suggested that looked-after children and young people felt the disparity if an out-of-hours call service was available for carers when one was not provided for them. This could lead to a sense of power imbalance and insecurity.

The committee agreed that out-of-hours support should be available for looked-after children and young people. However, they recognised that employing an on-call social worker may need substantial changes to contracts or add expense to already stretched social care budgets. So they agreed that other options might be used to fill this gap. In addition, identifying people at 'higher risk' for presenting out of hours could help with planning out-of-hours service provision.

There was strong UK-based interview and focus group evidence on the importance of shared decision making, including all agendas being laid out transparently to help the looked-after child or young person make their own decisions. For example, the committee discussed occasions when an option for a new placement was 'dressed up' as a great opportunity, when in reality, the young person was being nudged into the placement because of financial pressures, for the local authority, or because the foster carer had decided to end the current placement. The committee agreed that it was better to discuss the reasons for placement breakdown openly, giving emotional support built into ongoing life story work and using accessible and age-appropriate communication.

The committee noted that there was little evidence for interventions to support placement stability in residential care. They therefore made a recommendation for more research on interventions to support placement stability in residential care).

Serious behavioural problems

Recommendations 1.2.26 and 1.2.27

Evidence based on robust studies of multidimensional treatment foster care in adolescents largely covered youth offenders referred from the criminal justice system, or populations

with significant pre-existing behavioural and conduct disorders. The committee were impressed by the evidence of effectiveness, particularly evidence showing reduced involvement with the criminal system and reduced rates of violent crime and imprisonment across these populations. So, they agreed that this intervention would be suitable for looked-after young people with behavioural issues that are significant and persistent enough to merit regular involvement of the criminal system.

The committee recognised that behaviours that challenge can be a form of communication and may occur as a response to trauma. In addition, behaviours that challenge may be more common in people with learning disabilities - which are themselves more common among looked-after children and young people. The committee therefore agreed to cross-refer to existing relevant NICE guidance.

Disorganised attachment

Recommendation 1.2.28

The committee considered evidence based on robust studies looking at interventions to support development and school-readiness in preschool children. Particularly, they noted evidence on the Attachment and Biobehavioural Catch-up intervention for babies and toddlers, which resulted in improvements in language, attention problems and cognition. The committee looked at the similarity of this intervention to interventions recommended in the NICE guideline on children's attachment. They discussed the overlap between the population in the children's attachment guideline and this guideline. The committee agreed that all looked-after children and young people were at risk of attachment difficulties, and therefore that the evidence base for and recommendations in the children's attachment guideline were also relevant to looked-after children and young people.

How the recommendations might affect practice

Trauma-informed training may have a limited resource impact because it could be incorporated into existing training for social workers. The committee recognised that existing training has limited capacity for additional material, but they agreed that trauma-informed training was a priority for inclusion. There are freely available resources for trauma-informed training and, although there would be a cost associated with adapting these resources for purpose, these costs are expected to be minimal.

Supervision with regular check-ins to support the social worker is likely to need more

personnel time from the social workers and their supervisors. It may also need a culture change that focuses on reflective practice and increasing the amount of direct one-to-one time social workers get with looked-after people. Improving systems to increase professional retention, enable more one-to-one time between social workers and looked-after children and young people, and reduce duplication of effort, could be less costly than purchasing additional social worker time.

Collection and review of data on staff turnover, and development of action plans to address high levels of turnover, are likely to be associated with administrative costs in collating data that is already collected. However, lower levels of staff turnover would allow for better continuity of care and minimise the negative impact of personnel changes on looked-after children and young people, the benefits of which are considered to outweigh the small costs associated with this recommendation.

Providing consultation for complex and specialist problems is likely to need additional personnel time and resources to implement. The committee noted that expertise for this can often be found 'in-house' rather than needing to fund a new role or external training agency, but in some cases an initial investment may be needed to build up expertise within the local authority. Where consultation can be from more advanced social workers or from multiagency professionals in the network, this should not incur significant cost. Consultation provided by specialist agencies and professions may need to be bought in, for example from experts on sexually harmful behaviour.

There are currently limited services specifically aimed at siblings, although there is generally funding already available for shared activities and days out for siblings from local authority leisure budgets. Interventions to promote sibling relationships are potentially costly, but if they could be delivered by trained youth workers rather than graduate-level practitioners, or if existing roles could be adapted to deliver these interventions, this could help contain costs. Similarly, funding to support contact with friends could come from local authority leisure budgets, and there are several activities that are freely available, such as visits to local parks.

Mentoring interventions by peers with experience of the care process would often be carried out on a voluntary basis or through informal peer-to-peer interactions and would not need an increase in resources. Some additional costs may be incurred in providing professional oversight to mentoring programmes, which would need organisation and the processing of, for example, DBS (Disclosure and Barring Service) checks.

Contact supervisors are already a part of the care team, and any additional training needed could be incorporated into existing training, so the recommendation is expected to have a small impact on resource use. Similarly, translation services are already available in NHS settings when needed, so these should not be a substantial extra cost. A child's right of expression is mandated by statutory guidance so expenditures on translation services are justified.

Facilitating online contact, and the additional safeguarding considerations, is not expected to have an impact on current resource use because these contacts are likely to replace other forms of contact that would need similar management.

Resources needed to support the birth family to attend contact centres for children placed outside of their local area are most likely to consist of travel expenses. Although there may be some financial implications as a result of this recommendation, facilitating contact is a statutory duty and so expenditure by local authorities is justified.

Multidimensional treatment foster care is a resource-intensive intervention and will be associated with high implementation and running costs. But when used in adolescents with a history of persistent offending behaviour, these upfront costs are likely to be offset by the lower recurring monthly costs and additional health and social benefits from the intervention compared with usual residential care. A costing analysis comparing these costs of multidimensional treatment foster care with residential care is detailed in evidence review F: interventions to promote physical, mental, and emotional health and wellbeing of looked-after children, young people and care leavers. Additionally, improving the outcomes for adolescents who are offenders will reduce the greater impact on social care and judicial sectors.

Return to recommendations

Supporting and involving carers

Recommendations 1.3.1 to 1.3.10

Why the committee made the recommendations

The committee discussed UK-based interview and focus group evidence that carers often feel their input is not valued. They agreed that carers have the most intimate knowledge of the looked-after child or young person, so their perspective and the information they

provide are important alongside professional input for decision making by the broader care team.

Studies showed that carers could feel 'left alone' to deal with severe problems on evenings or weekends, and lack of out-of-hours support can make them feel isolated. The committee agreed that out-of-hours support services are important, but recognised that employing an on-call social worker may need substantial changes to contracts and expenses. So, they agreed that various alternatives might be used to fill this gap. For completeness of records and continuation of professional oversight, the committee also agreed that carers should log any help sought outside usual operational hours.

Many UK-based interview and focus group studies looked at the value of peer support, and the committee also heard from experts that peer support could help fill the gaps in support left by overburdened social care systems and social workers. Carers may offer support to each other that is more accessible and available than from practitioners, and such support only needs to be facilitated and moderated to prevent the transfer of misinformation. Creating online spaces for this could be both cheaper and more accessible than hosting in-person groups.

The committee discussed UK-based interview and focus group evidence showing that respite (or support) care was valued. They agreed that it was vitally important to offer carers rest, to prevent burnout and subsequent placement breakdown. They noted that some carers may feel that their caregiving duties prevent them from going on holiday or travelling.

The committee discussed that it is helpful if respite (or support) care is provided by a person the child or young person knows, to prevent the feeling that they are being 'sent away'. This also builds up a network of supportive adults for the child or young person and childcare options for carers. In addition, the respite (or support) care period can be more easily seen as being in the best interests of the looked-after child or young person if it is an enjoyable break for them – for example, through short breaks to stay with relatives.

Based on their own knowledge and experience, and some UK-based interview and focus group data, the committee discussed that planned and proactive offers of respite (or support) care are more effective than respite (or support) care offered reactively in response to crisis, when it may already be too late to prevent placement breakdown. They also discussed the importance of the person who is providing respite (or support) care having the skills needed to support the individual needs of the looked-after child or young

person.

The committee looked at UK-based interview and focus group evidence on resource constraints, stretched services, information gaps between carers and practitioners and reactive care (responding to problems as they arise, rather than anticipating). They found that carers were often unaware of the services available for support from their local authority and partner agencies, and therefore felt as though certain services had been kept hidden to save costs. The committee agreed that carers need to be fully informed about the support available before the placement starts. This enables carers to negotiate the support they need, and empowers them to act on a more equal footing with practitioners.

The committee saw UK-based interview and focus group evidence showing that carers (particularly shorter-term foster carers) are often unaware of ongoing interventions for a child placed with them, such as life story or relationship work. They agreed that informing carers about the contents and aims of interventions to support placement stability was in the best interests of the child, and would improve continuity of care with marginal costs.

The committee recognised that there was an additional set of recommendations for carers in the NICE guideline on supporting adult carers, and that these recommendations may be relevant for some carers of older looked-after children and young people.

How the recommendations might affect practice

Using alternatives to on-call social workers will mitigate the cost of increasing out-of-hours support. A range of possible ways in which out-of-hours support could be offered was included in the recommendation to allow local authorities to use a system that works best for them, both logistically and financially. Some of the options listed would be more affordable, such as the use of volunteer-operated helplines or peer support or advocacy groups. Local foster carer associations may have people working on-call, or provide round the clock access to a peer support network. The use of generic emergency duty teams may also reduce funding pressures.

However, the committee recognised that the availability of alternative options may vary between local authorities. To provide out-of-hours services with social workers 'on call' would need a contract change for social workers, but they agreed this could be done by reallocating existing social worker time from day work to out-of-hours work. This contract change and reallocation would have cost implications, but the committee agreed that

having social worker availability for out-of-hours emergencies and urgent problems could allow for problems to be addressed more quickly. This would help to avoid more significant costs and adverse consequences (for example, placement breakdown, self-harm, hospital visits and police being called).

Facilitating accessible peer support for carers is unlikely to have a substantial impact on resources, because most would be peer led and would not need much additional personnel time or physical resources from the local authority. Message boards may need to be moderated to prevent misinformation, but this could save time and resources by helping to resolve issues that would otherwise need the attention of care staff.

Respite (or support) care for carers to prevent placement breakdown is already broadly available in the care system. Costs vary depending on individual needs and local funding streams. The committee recommended the approach to respite (or support) care that should be taken if respite (or support) care is needed, rather than necessarily recommending additional respite (or support) care beyond what is already provided.

Return to recommendations

Training for carers

Recommendations 1.3.11 to 1.3.20

Why the committee made the recommendations

Based on their experience and knowledge, the committee recognised that, in practice, training – such as behaviour management training – is often delivered reactively, in response to difficulties that a carer is currently experiencing. This threatens placement stability because the carer may feel underprepared and under-supported to continue the placement. The committee advocated a greater emphasis on forward planning support for carers (before placement) based on the recognised and documented needs of the individual child, and involving other agencies as needed.

The committee discussed evidence, from robustly designed studies, on the effectiveness of parent-training interventions (some of which also included child-training components). This evidence covered a wide range of training programmes. The committee agreed that the evidence broadly supported the benefit of parent-training interventions in tackling child behaviour problems, and in improving the child–carer relationship.

However, they noted that the components of these training interventions may differ. Common components in the interventions studied included teaching and information giving focused on different aspects of parenting theory such as sensitive caregiving, attachment, social interaction learning theory, being trauma informed and broader behavioural management techniques. To support teaching, some interventions used video-feedback techniques, and others used homework or home assignments, role play, coaching, practical activities and follow-up booster sessions.

The committee noted that training can be expensive, and it is likely that different carers would need a different intensity of training. To reduce costs, a mandatory schedule of training could be delivered as a tutorial (perhaps virtually) to all carers. The committee were aware that mandatory training, for example for foster carers, may already be extensive. However, rather than recommending additional capacity to deliver more training, the committee sought to recommend which topics were most important to include in existing training schedules for carers. In addition to these, more intensive methods could be used with carers of looked-after children and young people who have more severe emotional and behavioural problems.

Based on their experience and knowledge, they agreed that how to provide consistent, child-focused and planned life story work to promote positive self-identity, would be an important addition to the mandatory schedule of training for all foster carers.

The committee were not aware of any widely available training for carers on how to be an educational advocate. In their experience, some carers are good at it naturally, but this is not consistent. For example, some may feel a responsibility for providing a home for their child but not see educational advocacy as part of their 'role'. The committee agreed such training is necessary as part of the mandatory training for carers. The importance of involving the primary carer was backed up by UK-based interview and focus group evidence suggesting that looked-after children and young people preferred carer-delivered educational support (as opposed to interventions delivered by other adults or professionals), because of fears of yet more transient practitioners developing a relationship with them and then leaving.

The committee discussed subgroups of carers who may need more individualised training. Using their own experience and knowledge, they considered birth parents in situations in which reunification is a possibility or when the child or young person remains in placement with the birth parent. They recognised that joining mandatory training schedules may not be ideal for birth parents who may have significant personal challenges to overcome and

need additional support.

The committee used UK-based interview and focus group studies and their own experience and knowledge to consider other subgroups of carers who may need specialised training. They looked at evidence highlighting the challenges for carers of adapting to a looked-after child or young person's cultural, religious or dietary needs. For example, the committee recognised that certain ethnic groups may have hair and skin care needs that a carer would be expected to support. Likewise, carers of looked-after children and young people with special educational needs, long-term health conditions and disabilities may need specific training.

UK-based interview and focus group evidence and expert testimony both suggested the importance of a knowledge of trauma in those caring for the looked-after population. Based on their experience and knowledge, the committee agreed what trauma-informed training should cover. They recognised that there are multiple levels to this training, from simple awareness of trauma-related issues (for all carers and practitioners working with looked-after children and young people) to training in trauma-responsive care, which may be needed for more specialised carers and practitioners. For effective delivery of training programmes, the committee agreed it was important for trainers themselves to have a good understanding of trauma and attachment disorders as well as the various effective therapeutic approaches.

The committee also discussed evidence on a parent-training intervention for looked-after young people with behaviour that challenges or more severe mental health problems who are moving out of restrictive care and into the community. This showed that it could help maintain their school placement and prevent a return to that care. The committee agreed that, in temporary placements for which training and development needs had been identified and delivered for current carers, new carers in the follow-on or permanent placements would need the same training to provide consistent care. This would help continuity of behaviour management approaches and trauma- and attachment-informed, high-support and high-nurturing relational care. The committee noted that this was particularly true for connected carers, who enter the fostering system quicker than mainstream carers. Often a child or young person is placed with them while assessments are ongoing and there is little time for preparation and training.

How the recommendations might affect practice

Family support services already offer behavioural management support to birth families,

but available training for foster carers and, particularly, other kinds of carers, is more variable.

Training in educational advocacy for carers would be delivered by the virtual school. This could be delivered at low cost, virtually or in person.

Tailored support and training for birth parents if reunification is a possibility should already be available through transition plans with family support teams, and should not incur additional cost.

Cultural or religious needs, or needs related to race or ethnicity may need more tailored training for carers who have no expertise in these areas. Although this may come at some additional cost to time or resources, these looked-after children and young people form a minority of the overall looked-after population. In addition, it is a statutory duty to ensure that looked-after children and young people do not receive poorer care on the basis of race or religion.

Tailored support and training for carers if there are special educational needs and disabilities can be provided through specialist healthcare teams and voluntary organisations (for example, the National Autistic Society and the Independent Provider of Special Education Advice), thereby helping to keep costs down. Trauma-informed training and therapeutic parenting training for all foster carers is part of current practice in some local authorities. The recommendations will reduce variation in practice across the country. Intensive, specialist training given in the home is likely to incur substantial costs in some areas that do not already provide it, but these could be partially offset by preventing placement breakdown. Placement breakdown is associated with significant short-term costs because of increased social care case management work and the need for additional placement arrangements, some of which will be high-cost emergency placements. In addition, placement instability can have long-term consequences, contributing to further disruption of looked-after children and young people's social and emotional relationships, sense of belonging and educational outcomes.

Mandatory training schedules already exist for carers (particularly foster carers) and it is anticipated that trauma-informed training, and other recommended training components, could be incorporated into these sessions without the need for extra training capacity in many cases. For example, the committee noted that there is often already mandatory training on de-escalation that could feasibly be altered or updated to include trauma-informed practice. There are freely available resources for trauma-informed training and

other kinds of training. Although there would be a cost associated with adapting these resources for purpose, these costs are expected to be minimal.

Return to recommendations

Safeguarding

Recommendations 1.4.1 to 1.4.8

Why the committee made the recommendations

The committee heard from experts about looked-after children who are at risk of criminal exploitation or going missing or are placed out of area. The experts highlighted the importance of multiagency working and appropriate data sharing for safeguarding looked-after children. They gave examples showing how important moments had been missed for sharing information between agencies (for example, policing and social services), and how these missed moments had led to extremely negative outcomes for the looked-after child or young person involved. Although the committee noted that statutory safeguarding procedures exist, they agreed that once a child or young person had become 'looked after', any further safeguarding issues were often dealt with 'in-house' in the care system. Whichever safeguarding system was used, the committee considered the need for it to be as thorough as statutory systems of safeguarding while also addressing additional contextual safeguarding risks. These risks are more commonly an issue among those in care.

The committee discussed ways in which local authorities could facilitate multiagency working and data sharing. They suggested that meetings were needed to bring together practitioners and facilitate information exchange. Based on expert testimony and their own experience, the committee agreed that representatives from education, care, healthcare for looked-after children, and external services could provide vital perspectives on safeguarding looked-after children and young people. Experts told the committee that it was very important to include the views of looked-after children (particularly those with special educational needs or disabilities) and their carers when shaping responses to exploitation and missing children. This supports shared decision making and makes responses effective, accessible and acceptable to looked-after children and young people and their carers.

Based on expert testimony, the committee considered that leadership was needed to

organise successful multiagency review meetings, bring practitioners on board and help define clear lines of accountability. The committee considered that leadership in multiagency working would be best provided by a specialist in contextual safeguarding, exploitation and missing children in the looked-after population. If such a practitioner was not readily available, the committee considered that local authorities could build capacity by investing in training a trauma-informed specialist with knowledge of exploitation and safeguarding issues in the looked-after population.

Based on expert testimony, the committee discussed the kinds of data that are most readily available and useful across agencies to inform the safeguarding of looked-after children and young people, and assess the risk of exploitation in any given placement. The committee considered routinely collected indicators at the community level: area deprivation indexes, community-level health and mental health data, number of county lines operating in a single area and missing person reports per 1,000 population (which were considered particularly linked to risk of trafficking).

The committee, in light of their experience and expert testimony, noted that risks and 'red flags' may be different for certain subgroups, such as young girls and boys and unaccompanied asylum-seeking children, as well as the approaches needed to protect from exploitation or going missing. For example, young girls in particular may be at risk of sexual assault, domestic abuse, and attempts through social media and otherwise to coerce and undermine self-esteem.

The committee heard from experts about the need for practitioners and carers working with looked-after children and young people to be able to spot and communicate safeguarding risks. Based on this, the committee discussed the training needs of practitioners working with looked-after children and young people. The committee acknowledged that training is not inexpensive. However, training on the signs of exploitation or abuse, and 'red flags' for going missing, and how to 'flag' or report concerns about these could be included in the regular training schedule for all practitioners working with looked-after children and young people.

The committee discussed how else multiagency working and review meetings could help to re-enforce and educate about 'reachable or critical moments'. That is, moments when looked-after children and young people at risk of criminal exploitation and grooming could be spotted and interventions employed at the earliest possible moment, particularly when looked-after children and young people could be more open to change and receiving support. Experts told the committee that any intervention could constitute a critical

moment, for example attending an A&E department.

Likewise, evidence based on UK-based interview and focus group studies and expert testimony about gangs, criminal exploitation and going missing from care strongly suggested that establishing a network of strong, supportive, positive relationships is the primary mechanism to protect looked-after people from these risks.

Experts also suggested to the committee that certain subgroups of looked-after young people may need more tailored care to address issues that increase their risk. These groups include young girls, who may have issues of low self-esteem, and be at risk of targeting on social media; children with a history of trafficking; and unaccompanied asylum-seeking children who have been subject to previous trauma or exploitation. The committee were aware that tailored support for these groups is already offered through well-established organisations such as Abianda.

Based on their experience and knowledge, and on hearing from experts, the committee discussed that safeguarding meetings offer an opportunity to educate and inform health and social care practitioners (for example, by bringing the perspective of emergency services to social workers). The committee were keen that learning opportunities were not lost and that a review of case files could help to spot mistakes or areas in which best practice could improve.

How the recommendations might affect practice

Tailored support for groups at particular risk from exploitation groups is an important and necessary safeguarding consideration for vulnerable groups. Existing organisations that already focus on these groups can help to supply such support, so this recommendation is unlikely to have a substantial additional resource impact. As well as improving outcomes for these groups, this tailored support may help to avoid future costs associated with negative outcomes, for example legal costs and costs associated with placement breakdown if relationships have deteriorated.

Necessary data are captured in most areas, but the information often needs to be better shared. This is unlikely to need increased resources because the data sharing mechanisms and roles for multidisciplinary teams already exist, and the emphasis of the recommendations is on bringing this work together. Using standardised language for things such as risk assessment tools, processes and personnel titles across agencies and geographical areas is not expected to be resource intensive. It can be achieved over time

by greater communication between agencies and local authorities.

Training in risk indicators is unlikely to have a substantial resource impact because it would probably be absorbed into and prioritised in existing staff training. Likewise, training to recognise suitable moments to reach out to the child could be incorporated into existing training for foster carers and social workers.

Return to recommendations

Building expertise about trauma and raising awareness

Recommendations 1.5.1 to 1.5.3

Why the committee made the recommendations

The committee considered UK-based evidence from interview and focus group studies and heard from experts about the high prevalence of trauma in looked-after children and young people. Based on this and their own experience and knowledge, the committee agreed that all practitioners working with looked-after children and young people need greater awareness of the impact of trauma, including developmental trauma and attachment difficulties. Such awareness is vital for spotting safeguarding situations. It can also help practitioners working with looked-after children and young people to better understand them and communicate more effectively with them.

UK-based evidence from interview and focus group studies and expert testimony highlighted specific issues faced by unaccompanied asylum-seeking children. The committee agreed that those who were working with unaccompanied asylum-seeking children needed to have additional awareness of the specific risks facing this group and issues that may arise when providing care.

The committee noted that when social workers or other care professionals are trauma informed, they can make sense and meaning of how the child or young person is forming and maintaining relationships, in the context of their experiences. As the lead practitioner, they can influence how the network views the child or young person, what language is used and how it will be most helpful to support them in more helpful positive relationships. This is the ripple effect of different levels of trauma training for the network.

How the recommendations might affect practice

Additional training on the specific needs of unaccompanied asylum-seeking children, including invited feedback from children that were once cared for in these circumstances, and specialist organisations in the voluntary sector, could be provided as part of existing in-house training. Funding should already be available through general funds that support routine training and activities (for example, team awareness days) for healthcare professionals.

Consultation may be provided from more experienced social workers or from multiagency professionals in the network, so it should not incur cost. However, the committee were aware that such consultation work would mean less time for case work, and therefore would incur some time costs. Consultation provided by specialist agencies and professions may need to be bought in, for example experts on sexually harmful behaviour.

Return to recommendations

Physical and mental health and wellbeing assessments

Recommendations 1.5.4 to 1.5.16

Why the committee made the recommendations

There is a statutory requirement for the responsible authority to notify in writing the child or young person's healthcare team (for example, the specialist looked-after children's health team), clinical commissioning group and registered medical practitioner about arrangements for the child or young person's placement. But based on their own experience and knowledge, the committee noted that this was often not sufficiently carried out in practice. That is, the notification is often delayed, or does not give both the looked-after child or young person's legal status and the reason why they have been entered into care.

The committee considered the importance of keeping good health records for looked-after children and young people. This should be a summary for ease of reading, with references to sections that give more detail. Based on some interview and focus group-based evidence and the committee's own experience and knowledge, the committee considered

that it was important to obtain a full health record from the birth parents, particularly information about antenatal and postnatal health. They noted that gaining consent for this may be a difficult or lengthy process. So the committee discussed the importance of attempting to gain this consent as soon as possible in the care process, to prevent missing important health information that could be important for directing the plan of care. If social workers supplied relevant information and consent to health teams before the initial health assessment, this could support health teams to make a good health plan. The committee also considered that the request for the initial health assessment should be detailed enough to provide the social care context for the child or young person coming into care.

UK-based interview and focus group studies frequently emphasised that looked-after children and young people and their carers appreciate continuity of care practitioners. The committee discussed the importance of having a continuous healthcare professional who is familiar with the looked-after child or young person, and their medical and social history, to perform routine health assessments. They agreed this is important both to promote a trusting relationship between the child or young person and the medical practitioner and to improve adherence with health plans, and to help the practitioner to spot changes in the health needs of the child or young person to support better care.

Based on their own experience and knowledge, the committee considered the needs of children and young people trying to access confidential healthcare. For example, use of the phone or internet may be restricted, particularly in residential care. The committee recognised that these measures may be in place to support safeguarding, but an unintended consequence could be difficulty or embarrassment when trying to access sexual health advice or treatment.

The committee highlighted that the initial health assessment is an important event for looked-after children and young people because it allows their existing needs to be identified and forms the base of an individualised care plan. The committee were therefore concerned that the initial health assessment should include an accurate and comprehensive review of the person's health history.

Evidence from UK-based interview and focus group studies suggested the need for carers to receive more complete and better-quality information about the child or young person at the start of care, which could include a compilation and summary of health records. The committee noted that work to compile records is done inconsistently across local authorities. The committee considered that compiling good records had the potential to transform the care of looked-after children and young people by facilitating the flow of

information between agencies and preventing identified needs and actions in the health plan from becoming lost.

Using some interview and focus group-based studies and their own expertise and knowledge, the committee considered the fact that care leavers very often request access to their health and social care records. Care leavers may do this to help make sense of their own journey through the care system. However, if the language used in the records is depersonalising or judgemental, this can result in significant emotional hurt and offence. The committee therefore agreed that health and social care practitioners should be aware of this risk.

Evidence from UK-based interview and focus group research and from expert testimony strongly supported the need for a culturally appropriate, registered interpreter to communicate in person with looked-after children and young people for the initial health assessment. And, if language remains a barrier to communication, for the same service at subsequent health and social care assessments. However, the committee noted this was particularly important for the first health assessment, which must be thorough and capture all aspects of health needs accurately to provide appropriate support. The committee considered in-person translations to be particularly important because of the difficulty receiving interpretation services over the phone. Unaccompanied asylum-seeking children were especially in need of these services.

Experts highlighted many specific health needs of unaccompanied asylum-seeking children compared with the broader population of looked-after children and young people in the UK. Unaccompanied asylum-seeking children were also frequently found to have problems with their sleep schedule as a result of travelling long distances, often with continuously disturbed sleep. So the committee agreed that tailored initial health assessments should address the additional risks to unaccompanied asylum-seeking children as a result of their country of origin and journey to the UK.

The committee considered mental health screening for children who were entering care. Some evidence (which had a higher risk of bias due to the study design) showed that using an in-depth assessment identified more children needing support and helped with providing early interventions than with the current initial health assessment. The committee agreed that current initial health assessments were often insufficiently detailed to pick up mental health needs and it was important for healthcare professionals to consider the need for a specialist mental and emotional health assessment after the initial health assessment. This is particularly important for babies and children because their

mental health needs are often missed. Based on committee experience and knowledge, the committee noted that this second assessment is better carried out once the looked-after child or young person has begun to form a relationship with the primary carer because mental health may improve as a result of a secure attachment relationship.

The committee reflected on less robust evidence (not from randomised controlled trials) showing that auditing systems before and after health assessments improved the uptake of health actions. The committee also considered the problem of actions in the health plan not being followed up or completed (either within a reasonable timeframe or at all). Based on this evidence and their own experience, they agreed it was important that the completion of actions in the health plan be reviewed to ensure the agreed service has been provided. This would need multidisciplinary input because some actions may be undertaken by other agencies.

The committee recognised the higher prevalence of attention deficit hyperactivity disorder, autism and post-traumatic stress disorder among looked-after children and young people. They were aware of existing NICE guidelines on the identification and diagnosis of these conditions and their subsequent management, and agreed to cross-refer to these.

How the recommendations might affect practice

The initial health assessment is a statutory requirement so there should not be any additional costs to the system, although auditing the health plan may need additional time from the team of health professionals involved. A detailed and well-documented plan can help with timely provision of care, thereby avoiding costs of delay and an overall negative experience for the looked-after child or young person.

Healthcare professionals performing the initial health assessment for unaccompanied asylum-seeking children may need additional training on the specific physical and emotional needs of these children, and on risk factors associated with specific countries of origin or route of travel, and the context of the child's journey. This training, including feedback from children that were once cared for in these circumstances and testimonies from specialist organisations in the voluntary sector, could be provided as part of existing in-house training. Funding should already be available through general funds that support routine training and activities (for example, team awareness days) for healthcare professionals.

Specialised interpretation services incur costs, but a child's right of expression is mandated by statutory guidance so expenditures on such services are justified.

Return to recommendations

Mental health and child and adolescent mental health services

Recommendations 1.5.17 to 1.5.21

Why the committee made the recommendations

UK-based evidence from interview and focus group studies frequently highlighted the frustration felt by looked-after children, young people and their carers about delays and waiting lists for mental health support. The committee considered the common problem of delayed support for child and adolescent mental health services (CAMHS), and systems that they had seen in practice to help avoid the delay of therapeutic support for looked-after children and young people. For example, therapeutic social workers, systems for outreach connected to CAMHS (for example, a psychologist or another worker embedded within CAMHS), or a specialist looked-after children and young people team within CAMHS.

However, other evidence, also from interview and focus group studies, highlighted the harm that can be done by introducing a child or young person to a new therapist, only for the therapist to change once CAMHS have taken over care. This can lead to demoralisation and disengagement from mental health interventions. Therefore, the committee agreed that intermediate therapeutic or specialist support should be provided for the care network around looked-after children and young people, rather than to looked-after people themselves. The committee were keen to stress that this intermediate support was only to address the delay, and should not be a replacement for CAMHS itself.

Further interview-based and focus group-based evidence and expert testimony reflected how CAMHS are often inappropriate and not designed for the needs of looked-after children and young people. Traditional techniques such as behavioural-therapy-based interventions are not always suitable for looked-after children and young people, who may need interventions that are more relationship based and trauma informed.

One committee member stated that some CAMHS teams have specialist looked-after children's services, but this is variable across the UK. The committee agreed it was important to encourage prioritised specialist services to be incorporated into CAMHS, to prevent the need for tier 3 or 4 services further down the line.

Based on their own experience, the committee were aware that children and young people could lose their place in the waiting list for CAMHS as a result of moving placements to a new location. This may be more likely to happen to children and young people who most need the attention of CAMHS to help maintain placement stability. Committee members were aware that continuity of CAMHS waiting lists could be maintained by virtual schools co-opting CAMHS or other dedicated services for looked-after children and young people in CAMHS.

Expert testimony highlighted the likelihood that all unaccompanied asylum-seeking children had experienced some form of trauma, as a minimum through the separation from their own parents, and that health and social care practitioners supplying care for this vulnerable population need specialist training. The committee agreed the importance of taking into account the different perspectives of unaccompanied asylum-seeking children in a mental health service setting.

UK-based evidence from interview and focus group studies and expert testimony also reflected the importance of cultural sensitivity and awareness of potential traumatic symptoms in unaccompanied asylum-seeking children. For example, they may have highly stigmatising views of mental health problems, based on previous cultural ideas, and may be reluctant to admit the experience of trauma or problems with mental health.

The committee noted that unaccompanied asylum-seeking children were likely to need a tailored approach to mental health support, but there was insufficient evidence to recommend any specific intervention. Therefore, they made a recommendation for research on supporting mental health of unaccompanied asylum-seeking children.

How the recommendations might affect practice

Providing dedicated CAMHS services for looked-after children and young people may have substantial resource implications if an expansion of the existing CAMHS services and capacity is needed. However, these dedicated services for looked-after children and young people are mandated by statutory guidance and the recommendations are only reinforcing the statutory provision of these services. Alternative interventions (trauma-

informed and those focusing more on relationships) may not necessarily come at greater cost than traditional behavioural approaches. However, tailored approaches would have greater adherence (for example, fewer non-attendances and less disengagement), thereby resulting in greater effectiveness. The committee considered that greater engagement in mental health services at an earlier stage can reduce the risk of more serious mental health problems, avoid the substantial long-term costs and consequences incurred when these issues go unidentified, and reduce the need for the higher tier treatments later down the line (where the greatest pressure on CAMHS services was suggested to be).

Intermediate therapeutic or specialist support for the care network around looked-after children and young people, to reduce waiting times, may need some restructuring of services and additional cost. However, in some parts of the country, existing services could fill this gap – for example, therapeutic social workers, CAMHS outreach systems (for example, a psychologist or another worker embedded within CAMHS), or a specialist looked-after children and young people team within CAMHS.

Return to recommendations

Life story work for identity and wellbeing

Recommendations 1.5.22 to 1.5.33

Why the committee made the recommendations

UK-based evidence based on interview and focus group studies showed that forming positive relationships was probably the best possible intervention to prevent placement instability. Life story work has the potential for building relationships (for example, by sharing joint activities). In addition, it is a trauma-focused technique that could help with discussing and negotiating care plans (by outlining felt priorities and experiences). However, evidence showed that life story work was often neglected or poorly completed in practice, was often started late in the care process, and was given little priority or investment. This supported the committee's own experience and knowledge. The committee discussed the importance of standardising life story work and starting it at the earliest opportunity after entry into care. They agreed this could support placement and emotional stability by helping the looked-after child or young person make sense of their journey through care.

Based on UK-based interview and focus group evidence and committee experience, the

committee discussed the importance of time for life story work being clearly set aside, with a named practitioner to ensure there is time for it to be completed to a sufficient standard. The relational aspect of this intervention could also be supported by having it conducted by a carer or practitioner that the looked-after child or young person has a close and continuous relationship with. The committee agreed it was important for this work to take place in the context of a safe and continuous relationship, because conversations would be of a personal nature.

The committee discussed the key components of life story work, based on their experience and knowledge. They agreed that this work consists of building a narrative that focuses first on the present identity and strengths before moving onto the past and reasons for entering care, and finally turning thoughts to planning for and building hope towards the future.

Based on committee experience and knowledge, and some interview and focus group evidence, the committee then considered how this may be achieved. Techniques such as life mapping, use of pictures, art, written narratives, toys and play have been used successfully. The committee agreed that these discussions should be compiled in 1 place and built on during regular sessions. They thought that the approach should be flexible according to the needs and response of the looked-after child or young person and should be a shared experience, in a setting preferred by the looked-after child or young person. However, they recognised that compiling life story work in 1 physical place could come with the danger of sensitive information being read by others (for example, peers in residential care).

The committee took into account their own experience and knowledge in considering the role that life story work could play in cultivating a positive self-image and identity – that is, one that embraces the looked-after child or young person's ethnic, cultural or religious differences, as well as sexual identity and disabilities.

The committee stated that the effectiveness of the life story work was closely related to its quality, and agreed that having social worker oversight could help to maintain standards. It would also allow the social worker to provide additional information to support the carer or practitioner carrying out the life story work.

Based on their own experience, the committee considered life story work that involves more people than the practitioner and the looked-after child or young person. For example, sometimes it may be useful to carry out life story work with siblings as a group or

pair, because they may have had very different perspectives of shared life events that need to be reconciled. The committee agreed that the need for shared life story work should be carefully planned to ensure it did not destabilise sibling relationships, for example by divulging sensitive information. In addition, particularly for complex situations such as these, it was important for the experience and skillset of the practitioner carrying out the life story work to match the complexity of the care situation. This may need the direct attention of a social worker rather than the primary carer.

Based on their own experience and knowledge, the committee agreed that the network around looked-after children and young people was important to support ongoing life story work. The committee considered it vital that the idea and purpose of life story work and its importance was expressed to the social work team, carers, educational staff, and birth family. Broader social networks can then be engaged in the work when needed. Birth families may need to encourage consistency in narratives explored and reframing previous relationships.

How the recommendations might affect practice

Life story work is mandated by statutory guidance for all looked-after children and young people with a plan for adoption. It is already current practice and these recommendations can be easily integrated into the process. Although the recommendations may necessitate a higher standard of life story work (for example, with more detail and more time devoted to it) in some cases, the committee agreed that these changes were necessary for the work to be effective and achieve its aims. Training to ensure a consistent approach to life story work could be incorporated into existing training. Social worker oversight for life story work conducted by another practitioner is anticipated to have minimal resource implications because the work is either already being conducted by the social worker or would simply need the social worker to be informed of the content of that work.

Return to recommendations

Relationships and wellbeing activities

Recommendations 1.5.34 to 1.5.37

Why the committee made the recommendations

UK-based interview and focus group-based evidence frequently emphasised that positive relationships were the most important aspect of care to looked-after children and young people and care leavers, and that, along with placement stability, they are most linked to social, emotional and mental wellbeing. They discussed that the cornerstone of positive relationships was the relationship with the primary carer. So they agreed that, before recommending specific interventions to support social, emotional and mental wellbeing, the focus of support needs to start with a stable care placement and a strong supportive relationship with the primary carer.

Interview-based and focus group-based evidence showed that some primary carers, for example in residential care or foster care, had concerns about giving physical touch and affection to looked-after children and young people. The committee discussed that physical affection, particularly for younger looked-after children, could be a major source of emotional stability and wellbeing, and yet it may be denied in some cases because of the primary carers' desire to be protected from any form of allegation. They agreed that, in some cases, it may be necessary to proactively promote or encourage appropriate physical affection (for example, through play) and that the need for physical touch and affection as a part of a healthy relationship with the primary carer should be taken into account in safer caring plans.

A variety of evidence reflected the importance of shared activities to help bond relationships with peers, practitioners or carers. The committee considered that peer support could be particularly important among looked-after children and young people because, given the absence of strong family ties, they may place more emotional investment in friendships and other non-conventional relationships (for example, with care practitioners). They agreed that it was important to support the interests and hobbies of looked-after children and young people by setting aside time for outings that would help them invest in these interests, as well as in their close relationships.

The committee considered that looked-after children and young people are more likely to be overweight and obese than standard norms and many come into care with a poor nutritional status. They recognised a gap in good quality research for interventions to help improve diet and exercise, as well as other lifestyle factors such as drug and alcohol use, among looked-after children and young people, and made a recommendation for research on promoting physical exercise, and a healthy diet and lifestyle. In the absence of good quality research to support interventions to improve diet and exercise among looked-after

children and young people, the committee cross-referred to existing NICE guidance on physical activity, obesity prevention and weight management in children and young people.

How the recommendations might affect practice

Facilitating and supporting activities such as school clubs would be unlikely to have a significant resource impact. Funding for group activities may have more substantial resource implications, so these would need to be limited to freely available or inexpensive activities. Some group activities, particularly school clubs, could be prioritised for funding through the pupil premium grant.

Return to recommendations

Readiness for starting or changing school

Recommendations 1.6.1 to 1.6.3

Why the committee made the recommendations

The committee considered US-based evidence on therapeutic playgroups for children in kindergarten entering second grade aged 7 to 8. These resulted in improved parent-rated social competence and emotional stability. But this evidence was from a small trial with no long-term follow up. Because of this, and the expense of running therapeutic playgroups, the committee did not recommend them specifically. But they agreed that early years education should include opportunities to improve socialisation, such as early years education in playgroups, as well as other opportunities to encourage child-led play.

The committee considered evidence from robustly designed studies on transition-to-school programmes for looked-after children of primary school age. These programmes resulted in improved early literacy skills, self-regulatory skills, self-competence, and attitudes towards alcohol and antisocial behaviour, as well as days free from internalising symptoms. They also reduced aggressive behaviours. A similar programme for secondary-school-aged children resulted in improved emotional, social and behavioural scores, and reduced substance use.

The committee considered the broadly positive findings for readiness for school

interventions, alongside the problems with study quality and assessment of effectiveness. But they highlighted that, particularly for a child returning to school after prolonged absence, the need of a child to cope with the possibility of peers and parents of other children finding out about their 'looked-after' situation could be traumatic, and that this is particularly a risk if the child is receiving special interventions for education. Other evidence from UK-based interview and focus group studies suggested that looked-after children and young people did not necessarily want more professionals or programmes in their lives.

The committee therefore agreed there was a broad benefit of tailored transition support into new school placements. However, they favoured approaches that would help ease the looked-after child or young person into the new school placement but not single them out. The committee also agreed that transition to a new school placement may need input from professionals beyond those in education.

How the recommendations might affect practice

The resource impact of these recommendations is expected to be low. Early years support should already be provided as a statutory service, so little additional resource expenditure should be needed, other than greater prioritisation of playgroups from existing funds. Transition support and services are also currently supported by the virtual school. Additional interventions to support the transition can be prioritised through the pupil premium grant, which is part of statutory education funding provision for looked-after children and young people.

Return to recommendations

Support in schools

Recommendations 1.6.4 to 1.6.7

Why the committee made the recommendations

The committee heard from experts that educational resources were available to support looked-after children and young people, but they may not be being spent in the most effective way. The committee agreed that ensuring that looked-after people and their carers know about their rights to educational support (for example, the purpose of the

pupil premium grant for education, and how it is distributed), and including special educational provision under the special educational needs and disabilities (SEND) legal framework, would encourage accountability in spending.

The committee discussed the importance of trauma-informed practices for all practitioners working with looked-after people. Based on expert testimony, and on interview and focus group-based evidence describing the needs of looked-after people with trauma, the committee considered that standard behavioural policies in schools may not be adequate or may even be harmful for young people with a history of trauma and disorganised attachment. They agreed that it was important for schools and regulators to understand the impact of behaviour management policies on trauma.

UK-based interview and focus group evidence showed that looked-after children and young people experienced a shortage of adults who have higher expectations and aspirations for their education, as well as positive role models and tailored (individualised) support for education. Based on expert testimony and their own experience, the committee discussed the need for a strong educational advocate for looked-after children and young people. This would be someone who is invested in and supportive of the person's education and is willing and informed enough to fight for the educational provisions that a looked-after child or young person should receive by statutory right (and beyond). The committee agreed that this role is most readily fulfilled by the designated teacher. As well as having a committed educational advocate on the school site, the committee agreed that educational advocacy needs should also come from the primary carer. However, the committee agreed that, in many cases, the foster carer's role in their child's education had not been sufficiently encouraged.

The committee agreed that the role of the designated teacher is carried out with variable quality across the UK. Therefore, the committee felt it important to outline the key principles of practice that this role should include to improve the advocacy relationship with the looked-after child or young person in school settings. They discussed the need for the designated teacher to collaborate with those who have the best information to support and direct the looked-after child or young person's educational path. The committee used their own experience and knowledge to identify personnel as useful partners for this.

The committee used interview and focus group-based evidence and their own experience and knowledge to clarify the role further. They discussed evidence in which carers had identified and organised the diagnosis of educational issues themselves (such as

dyslexia). They considered that it would be better for the on-site educational advocate (the designated teacher) to identify and organise such assessments, and in a more timely manner. Therefore, the committee agreed that the designated teacher should ensure ongoing monitoring of learning needs, particularly during placement transition (which can be a time of greater educational and emotional challenges).

The committee also considered that multiagency review meetings, including those from the virtual school and the designated teacher, may need input from professionals beyond those in education. Therefore, they agreed that a designated teacher needs to be sufficiently competent to refer for specialist support if necessary.

The committee emphasised that 1 of the most important roles of the designated teacher (acting as educational advocate) was to 'check in' with the looked-after child or young person regularly, whether or not they have any special educational needs. Check-ins can help to develop a rapport with the looked-after child or young person and build a supportive relationship. Because interview and focus group-based evidence highlighted the importance of maintaining confidentiality about care status whenever possible, especially in school, the committee were keen that these check-ins should not add more stigmatising and formal meetings to the looked-after child or young person's schedule. Rather, the designated teacher could have regular one-to-one informal conversations with them. The committee agreed that the frequency of these conversations should be informed by the looked-after child or young person themselves, because some may favour less intense supervision.

How the recommendations might affect practice

Advocacy by a named teacher is not anticipated to need significant additional resources because this is already part of the statutory role of the designated teacher. The committee recognised that there are time-resource implications in performing this role to a high standard.

Return to recommendations

Virtual schools

Recommendations 1.6.8 to 1.6.15

Why the committee made the recommendations

The committee noted that no consistent model of a virtual school was apparent across the country but that some common features could be identified. As part of this, there was a discussion about the constituent members within a virtual school and the external services that should be linked through the virtual school.

The committee discussed including early years practitioners within the virtual school. Based on expert testimony and their own experience, they noted that early years expertise was not statutory in virtual schools. Smaller numbers of looked-after children in the early years group meant they were often allocated relatively small budgets. The same was true at the other end of the educational age range: early years and over-16 groups are not well provisioned, with most money devoted to school-aged children and young people.

The committee considered there was a need for early years expertise alongside the virtual school head to provide oversight of interventions to support the early years education of looked-after children, and champion educational services for children during the pivotal younger years. Based on their experience and knowledge, the committee suggested that information to support this role needed to be brought in through collaboration with nurseries and health visitors and using routinely collected data.

Expert testimony highlighted the need for closer working between the virtual school head and the special educational needs (SEN) service. The virtual school team needs to have a breadth and depth of knowledge across social care, education and health and to understand the legislation for each area. Very few social care staff have a working knowledge of the SEN code of practice or the legislation that underpins it. As a result, the committee considered the need for someone with SEN experience in the virtual school, ideally a special educational needs coordinator or someone with SEN specialism or training.

Based on their own expertise, the committee considered that the inclusion of a post-16 coordinator in the virtual school could help bridge the gap in information for those in care hoping to achieve higher or further education – for example, by helping with the application processes for entrance to college, university or further training (and support while there). Therefore, help was needed to help looked-after young people aspiring to further education to navigate the available support.

The committee recognised that the expertise needed within the virtual school was likely to

vary based on the demographics of the population being served. Therefore, they considered the need to take into account the prevalence of groups of special interest in each local authority when expertise for the virtual school is being recruited. They noted that the prevalence of some groups of special interest varied significantly between local authorities.

As a result of expert testimony, the committee recognised that often, virtual school heads had not been properly empowered or used, and their role had not been properly defined. In some cases, the virtual school head may be a peripheral figure, rather than a key leader enacting change in the local authority. Therefore, the committee agreed that, to be able to complete its statutory duties, the virtual school head should be considered the key leader and enabler for the collaboration of educational services for looked-after children and young people.

Expert testimony outlined the range of professionals with a statutory remit to work with, and promote, the needs and wellbeing of children and young people in care and education. These professionals are asked to work together, but the expert noted that this often does not happen sufficiently in practice. In the experience of the expert, a clear bridge is needed between the services, and when this role is taken up by the virtual school, the links work much better. The committee agreed and outlined a list of services for which the virtual school head should act as a 'bridge'.

Based on their expertise and knowledge, the committee noted that simplifying and merging looked-after children review meetings would support multiagency working. For example, merging annual reviews and personal education plan meetings could make it easier for specialists in education and social care to communicate, while also reducing the number of overall meetings that looked-after children and young people need to attend. The committee also considered the importance of including the health perspective in multiagency review meetings when health problems impacted education.

How the recommendations might affect practice

Every school in the UK is obliged to employ a special educational needs coordinator, so ensuring that one is part of the virtual school team would not incur additional resources. Some virtual schools may not have an existing early years practitioner, so there would be resource implications from adding another staff member to the team. However, it is possible that such expertise could be found, or developed (using training), in existing professionals in the virtual school.

Reviewing meeting structures and condensing them into fewer meetings if possible would not need additional resources because it would reduce the number of meetings being organised and held.

The recommendation for virtual school heads to form a bridge between named specialists in education, social, health and mental healthcare is not anticipated to have a significant resource impact because these roles already exist and would not need an additional staff member at the virtual school.

Return to recommendations

Improving educational outcomes

Recommendations 1.6.16 to 1.6.19

Why the committee made the recommendations

The committee considered evidence from robustly designed studies about interventions tested mainly in primary-school-aged children. There was some evidence that tutoring by foster parents or volunteers improved maths and some literacy scores; these were outcomes that the committee considered to be important. However, the evidence base had some problems in quality and the committee noted that some carers may not want to take on the responsibility for tutoring because this can blur the line between the carer and educator roles.

The committee considered that flexibility was important when choosing the tutoring style that best suits the child and the placement. Evidence from studies with weaker designs (non-randomised controlled trial) showed that a paired reading intervention greatly improved reading age over the course of the intervention. Although, again, the evidence was limited, the committee were impressed by the reported size of effect.

The committee considered that paired reading had potential for increasing communication and engagement between foster carers and schools. In addition, it was a simple, cheap and already widely used intervention in primary schools (with parents often encouraged to take part). It showed good evidence of effectiveness, and had historical use, beyond looked-after children. Paired reading was also considered to have a relational aspect, improving quality time spent between carer and child. Older students in primary school could engage in paired reading with younger students, which may also provide an

important mentoring role.

The committee discussed tutoring among looked-after young people attending secondary school. They noted that a large amount of money is spent on tutoring, but there is a lack of evidence on its effectiveness for looked-after young people. The committee therefore did not recommend a specific intervention but instead agreed, based on their own experience, that interventions for improving education in secondary-school-aged looked-after children are regularly evaluated.

UK-based evidence from interviews and focus group studies and expert testimony showed the importance that unaccompanied asylum-seeking children placed on educational attainment and learning English. The committee agreed that teaching an unaccompanied asylum-seeking child to speak English fluently was 1 of the first steps to helping them acclimatise to the country, settle with their primary carer, build positive social networks and succeed educationally. Therefore, the committee agreed that English language lessons were important for those who are not fluent, and recommended that intensive lessons be considered for those with no previous knowledge of English.

Likewise, the committee recognised that additional support would be necessary in mainstream educational settings for those who did not speak English fluently. So they agreed that virtual schools should consider increased specialist educational provision for unaccompanied asylum-seeking children.

The committee noted a gap in the evidence base on the use of therapeutic interventions in current practice such as art therapy, play therapy, occupational therapy, music therapy and psychotherapy. The committee highlighted these interventions as being known to have a positive impact on educational, social and emotional outcomes in broader populations of children. They made a recommendation for research on therapeutic interventions for promoting school stability and learning to assess the effectiveness of these interventions on improved learning outcomes, school attendance and exclusion to help address this evidence gap.

How the recommendations might affect practice

There was no published cost-effectiveness evidence for most of the learning interventions but the resource impact for the recommended interventions is expected to be low. There may be some hidden costs such as carer or volunteer time, training, travel and administrative support.

Paired reading is currently provided to all children in primary schools, so no additional resource is needed. Infrastructure may be needed for extra support or training for foster carers on active reading and to train volunteer paired readers. Virtual schools may be best placed to deliver training in paired reading to foster parents. The only extra costs involved should be for foster carers actually attending training, and costs may be even lower if delivered virtually.

Individual or small group tutoring delivered by trained foster carers or trained volunteers would have a low resource impact, but using professional tutors would have higher cost implications.

These interventions can be prioritised for funding through the pupil premium grant, which is part of statutory education funding provision for looked-after children and young people.

This trauma-informed training for teachers could be incorporated into the existing provision for behavioural management training, so is not anticipated to have a substantial resource impact.

Return to recommendations

Data collection, sharing and publication in education

Recommendations 1.6.20 to 1.6.22

Why the committee made the recommendations

Evidence from expert testimony highlighted the importance of developing systems of accountability by gathering and sharing data that could help monitor and evaluate services around education for looked-after children and young people. They noted that no data was being collected on the responsibility of local authorities to secure education provision. For example, many looked-after children and young people are not placed on a school roll (defined by having a Department for Education number) by their corporate parent. In addition, there may be a culture of ignoring statutory responsibilities in this area because of lack of oversight, use of unregistered provision, and 'ghost rolls'.

The committee discussed evidence from expert testimony about placement of children in unregistered schools, which results in their data not being captured in national attainment figures. This may create a perverse incentive for local authorities not to secure appropriate provision in order to artificially improve national attainment figures. The committee agreed that local authorities should collect and publish information on the educational provision for looked-after children, with a particular focus on children missing education as well as the strategy for reducing that number.

The committee discussed expert testimony on the lack of accountability for how the pupil premium grant was being spent. Schools and local authorities do not routinely collect data to demonstrate that education funding for looked-after children and young people is being spent within the terms of the grant. This hampers the ability to evaluate the spending of the pupil premium grant to improve outcomes or to ensure that the funds are used directly for the benefit of looked-after children and young people. The committee noted that the Department for Education have acknowledged that they are not able to hold local authorities accountable for either spending of the pupil premium grant or provision of educational placements, because of the lack of available data. Therefore, the committee agreed that the spending of the total pupil premium grant within local authorities needs to be tracked to develop a mechanism of accountability.

How the recommendations might affect practice

Collecting and publishing information on the educational provision for looked-after children and young people, particularly those who are missing education, and a strategy for reducing the number of these children and young people, and developing a checking mechanism for the spending of the pupil premium grant, is unlikely to have a significant resource impact. Although this data is not currently collected consistently across local authorities, there are existing mechanisms to do so. There are also existing mechanisms for checking local authority spending, so checking educational spending for looked-after children and young people could be incorporated into existing spending checks.

Return to recommendations

Further and higher education

Recommendations 1.6.23 to 1.6.26

Why the committee made the recommendations

The committee considered evidence from robustly designed studies on interventions to help looked-after young people aspire to, and be equipped for, higher education. They acknowledged that entry into further or higher education is very different for looked-after children and young people than for the wider population. For example, they have broadly lower expectations of ever attending higher education and may consider this to be something that they are not able to achieve. Interventions need to be tailored accordingly.

Particularly, evidence from a study of individual coaching and group mentoring, with a summer visit and stay at a university campus, showed improvements in several measures of readiness for post-secondary education. Most importantly, there was a considerable improvement in post-secondary participation at 6-month follow-up in the intervention group.

Based on evidence from robustly designed studies, and some interview and focus group-based evidence, the committee considered that residential experiences, university campus visits, and coaching and mentoring by near peers in higher education could have profoundly beneficial effects on looked-after young people considering higher education. In addition, the committee agreed that university access schemes (offered by several UK universities) can give important support for looked-after young people in navigating the application process and receiving assisted entry to courses. The committee also considered the importance of encouraging people to self-identify as care leavers once they are in university or college because this may give them opportunities to receive additional support. However, they also recognised that care leavers often want to keep their care history private.

Based on their own experience and knowledge, the committee also weighed up the potential harm caused by pushing looked-after young people into higher education when this might not be the best option for them. The evidence did not report whether looked-after young people enrolled in college or higher education thrived or completed their courses. But this is a concern that applies to all young people not just those who are looked after.

The committee also considered that looked-after young people may be more ready to re-enter education when older. They discussed that their personal advisers are well placed to outline the options to do this. However, the young people would benefit from the support of post-16 coordinators who would have more in-depth knowledge of the funding and

support available.

Based on their own experience and knowledge, the committee agreed that support was also important for looked-after young people considering other routes into further education and training. The committee believed careers support and advice, work experience placements, and internships to be useful and available routes into good careers for looked-after young people. Careers support and advice was strongly needed, targeted at looked-after young people because they need an extra level of support and signposting.

How the recommendations might affect practice

The resource impact of these recommendations to help looked-after young people enter higher or further education or training is expected to be low, although some apparently low-cost interventions funded by local authorities, such as volunteer coaching programmes, are likely to be associated with expenses for travel, management and administration. But the resource impact generally is expected to be small compared with the potential benefits of improved education, employability and independence. In addition, there is a possibility that the UK pupil premium grant may be extended to 16- and 17-year-olds in the near future.

It is not possible to make a robust judgement about the potential resource impact to local authorities of recommendations on university access schemes, residential experience and visits on university campus, mentoring by near peers in higher education, and coaching, because uptake is too uncertain to predict. Interventions such as residential experiences and campus visits would be delivered by universities and colleges themselves, although facilitated by the virtual school. Likewise, some interventions may simply involve signposting people to local programmes and schemes that are university, college or third-sector funded, so the resource impact for local authorities would be low.

Return to recommendations

Before transition between care placements and to permanent placements

Recommendations 1.7.1 to 1.7.9

Why the committee made the recommendations

Drawing on UK-based evidence from interview and focus group studies indicating it was important to have a good match between carers and the looked-after children and young people, the committee recommended that careful consideration in transition planning should be given to the matching of carers and the looked-after child or young person. In assessing the strengths of the carers, committee members described how they translate the child's needs into what the parenting challenge and task looks like for the carers, and how the carers can best bolster the placement and help meet these needs.

UK-based evidence from interview and focus group studies and expert testimony also highlighted how the relationship between foster carer and adopter could support the move into permanency. Good communication and support can improve this relationship, for example by helping to manage expectations of the foster carer during the planning stage. These measures could help to avoid an adversarial relationship forming between carers, rather than a supportive relationship that allows for a more integrated experience for the looked-after child or young person during transition.

The committee disagreed with perspectives in some of the interview and focus group-based evidence that suggested it was beneficial for the looked-after child or young person to experience the short sharp shock of a foster carer stepping away completely and immediately. Rather, they supported a less traumatic approach that facilitated ongoing communication with current carers if the child or young person wanted this.

The committee looked at interview and focus group-based evidence on facilitating the involvement of the new permanent or long-term carer's extended family. For example, the extended family may help by providing respite (or support) care. The committee agreed that involving family and friends early in the placement was particularly important for helping them to engage with the new family relationship. But they stated that respite (or support) care in the early stages could damage the formation of attachment with the primary carer. Based on their own knowledge and expert testimony, the committee noted that family and friends training days, which are offered through adoption agencies in some local authorities, were helpful.

For birth families involved in substance misuse, the committee considered evidence on 2 interventions to support reunification: recovery coaching and family drug and alcohol courts. This included evidence based on robust study designs, and some weaker forms of evidence (not from randomised controlled trials). Recovery coaching was associated with

greater reunification and more stable and long-lasting relationships than services as usual. UK family drug and alcohol courts were associated with improvements in reunification and longevity of reunification compared with ordinary care proceedings. The committee considered that providing independent support for families at the same time as child welfare court processes could support reunification. They agreed that, if reunification had occurred, support needed to continue after reunification to help the permanent placement to last, with clear plans for follow-up. Instead of recommending recovery coaching specifically, the committee recommended substance and alcohol misuse support, by trained staff, with a cross referral to NICE lifestyle and wellbeing guidance (which includes managing substance and alcohol addiction, and behaviour change).

The committee noted that there is evidence for the use of drug and alcohol courts to aid reunification by intervening and providing support for birth parents with drug addiction. However, rates of mental health problems are also high among birth parents who have had a child removed, and these problems may also contribute to the reasons for children going into care. Based on their own experience, the committee also recommended that mental health support continues alongside court processes. The committee made a recommendation for research about the benefit of mental health support to promote reunification.

There was evidence, based on studies with non-randomised designs as well as focus group and interview-based studies, that concurrent planning significantly reduced the likelihood of multiple moves before finding permanency and the time to finding a permanent placement. But evidence also showed 2 particular issues with it. One was that prospective adopters and birth parents found that late changes in the care plan could be particularly distressing for them. And prospective adoptive parents found that the intensive contact arrangements could be taxing for both themselves and the child (in terms of frequency and distance travelled while establishing new routines and building relationships).

The committee discussed concurrent planning as something that was already practised, with success, in certain parts of the UK. However, they considered that carers and birth parents should be well informed of the inherent difficulties of such a strategy and the possibility of late changes to the care plan meaning that adoption or reunification may not occur as anticipated.

How the recommendations might affect practice

It is not possible to make a robust judgement about the potential resource impact of setting up concurrent planning processes to speed up transition time to permanency, or of carrying out substance and alcohol misuse support alongside court processes, because uptake is too uncertain to predict. However, these processes are already available in some parts of the UK.

Some local authorities already offer family and friends training days through adoption agencies, and there is existing provision for this training, so it is unlikely that extending this to all areas will have large resource implications.

Return to recommendations

During transition between care placements and to permanent placements

Recommendations 1.7.10 to 1.7.20

Why the committee made the recommendations

UK-based evidence from interview and focus group studies suggested the need for a more integrated experience for looked-after children and young people that takes into account the significance of previous caregiving relationships. For example, the importance of foster carers for preparing and supporting adoptive parents, focusing on the emotional state of the child or young person during the busy transition out of care, and prospective adoptive carers wanting more information about previous care experiences and health.

The committee agreed that, beyond the benefits for prospective adopters offered by foster carers in terms of sharing information, it was also beneficial for the looked-after child or young person to see positive relationships forming between their current carers and their prospective permanent carers in the period before and after transition.

Based on their own experience and knowledge, and as part of the more integrated experience of transition described above, the committee considered the social network around the looked-after child or young person. They thought that contact arrangements, which may be focused on the birth family, should also take into account whether the

looked-after child or young person has other significant relationships with which they would like support to maintain. Such support could help create a more overlapping transition that gives more time for new connections to form and to process the loss of old ones.

Based on interview and focus group evidence about how child-focused the transition period was, the committee agreed it was important to have a practitioner regularly 'check in' with the child or young person to ensure that the transition process was going well for them and to keep the process child-centred. The committee noted that for children not yet able to talk, the primary carer may need to be present and advocacy services may also be needed.

UK-based evidence from interview and focus group studies showed that good clear information before transition was extremely important to new foster carers and prospective adopters. The committee considered the types of information that should be given to a new carer during the process of transition between care placements or out of care, based on their own knowledge and expertise. It was important that this should give new carers a clear sense of the chronology of the care process for the child or young person.

To avoid the information being handed over in an overwhelming quantity, the committee agreed that the information needs to include a clear summary. This will provide the information they need to help carers carry out their nurturing and safeguarding role. They also agreed the importance of briefing the new carer in person, rather than leaving the carer to make sense of the information by themselves. A social care practitioner who has had continuous oversight of the child or young person's history in care would be ideally placed to do this.

The committee considered their own experience and knowledge, and some interview and focus group-based evidence showing the concerns of new carers adopting looked-after children with medical conditions they were not familiar with, and of the need for information about previous placements. The committee discussed what information would be helpful for new carers and prospective adopters, to cover the needs of the new placement, including personal health history. It also included birth family health history; the committee were keen that this was collected for all children entering care, not just during adoption processes. The committee agreed it should also cover behaviour with the potential for significant harm to others (for example, sexual, violent or fire-setting). However, they highlighted it was important for prospective carers to have the context to

these events so they could assess them properly.

Based on their experience and knowledge, the committee also stated that this information giving should not simply be a record of negative life events, but that the record should lend equal weight to factors that could support the success of the placement. These include the looked-after child or young person's strengths, hopes for the future, significant positive relationships (with peers and adults), interests and activities, as well as how behaviours had been successfully supported in previous settings. The committee recognised the importance of ongoing life story work to draw out these factors.

The committee also considered the case of emergency foster placements, for which it may not be possible to deliver all information immediately. If it becomes clear these placements will be longer term, the carer may need more information to carry out their nurturing and safeguarding roles. For example, carers often need support to understand why a child or young person is behaving in a certain way in order to respond appropriately. As well as knowing about safeguarding issues, they need to know why children and young people are looked after, which family members pose a risk and why.

There was lot of UK-based evidence from interview and focus group studies showing that children and carers value continuity of care practitioners. The committee agreed that consistency in the practitioners who help in the handover of information for new permanent carers could reduce the sense of instability during transition, and support positive relationships.

Based on expert testimony and their own knowledge, the committee discussed the issue of a continuing education plan when a child or young person is moved outside their local authority area. The committee considered the need for someone who has an overview of the child or young person's educational needs and can help place the child or young person in education that matches their needs. They agreed that this could be assisted by having a transition plan and 'handover' from the old to the new school placement (for example, from 1 designated teacher to another) as part of the personal education plan.

Based on their experience and knowledge, the committee also discussed the need for continuity of healthcare as the looked-after child or young person moves to their new placement. The committee agreed that if regular mental health, physical health or dental support had been provided in the old placement, new referrals local to the new placement need to be in place before the transition, to promote continuity of care.

Expert testimony from an adoptive parent and organisations representing adopters highlighted the importance of language during the transition period. In particular, adoptive parents (who may have no experience of parenting) may feel judged by the child's foster carers. Often, adopters feel this is a highly sensitive time when they do not want to complain or do anything to jeopardise the placement. The committee therefore highlighted the need for transition teams and foster carers to consider these issues and adjust language accordingly.

How the recommendations might affect practice

Most recommendations are not particularly resource intensive, generally focusing on continuity of healthcare and education, parent and carer training, peer support and the detailed chronology of care process for the individual. Many recommendations focus on ensuring continuity of existing processes, or on processes that are already in place in some areas.

However, extra resources may be needed for those that need more professional time to produce (such as the summarised history of care) or training and preparation for long-term carers.

Giving opportunities for current and new carers to meet before a placement move, and facilitating ongoing communication, should not have substantial resource implications because these can be incorporated into existing transition planning. Similarly, supporting existing social networks to allow time in the transition period for the looked-after child or young person to form new social connections is not expected to be resource intensive because this can be incorporated into existing transition planning.

Return to recommendations

After transition between care placements and to permanent placements

Recommendations 1.7.21 to 1.7.25

Why the committee made the recommendations

The committee considered whether it would be useful for the looked-after child or young

person to give their own perspective on their journey in care to their prospective carer if the child or young person is willing, drawing from existing life story work. This could aid transparency and help the looked-after child or young person feel in control of their information. However, the committee considered that this may be better occurring once the looked-after child or young person and carer have begun to develop a stronger attachment relationship.

UK-based evidence from interview and focus group studies and expert testimony highlighted the power imbalance perceived by adoptive parents, who may feel unable to complain about the transition process because of fears about jeopardising the placement. The committee considered that although there was little that could be done about this during the transition period (other than making permanency carers aware of their rights to receive support), agencies would benefit from seeking feedback from foster carers and adopters after the permanence order is made, and they could use this to improve the delivery of transition services.

There was very good UK-based interview and focus group evidence, supported by expert testimony, that peer support was useful for adopters and permanent carers. Peer support groups could often give the personalised support and availability that social care teams could not. The committee noted that effective peer support could be achieved in a variety of ways.

The committee noted, based on expert testimony, that there was also the potential for specialised peer support groups to help deal with specific problems in permanency placements. Experienced permanent carers could be linked up with other permanent carers in need of support to provide tailored advice and empathy that may not be covered by the expertise of the support team.

The committee noted that few studies reported long-term placement durability outcomes, including post-permanency outcomes showing that the looked-after child or young person was thriving in their new long-term placement. In addition, there was insufficient evidence on the perspective of adopters and long-term permanency carers about the transition out of care and how this could be improved. The committee therefore made a recommendation for research on interventions to support stability of permanent placements to encourage more evidence in these areas.

How the recommendations might affect practice

Facilitating accessible peer support for permanent carers (such as adopters) is unlikely to have a substantial impact on resources, because most would be peer led and not need much additional personnel time or physical resources from the local authority. Message boards may need to be moderated to prevent misinformation but, overall, peer support could save time and resources by helping to resolve issues that would otherwise need the attention of care staff, or that, if left without support, could lead to placement instability.

Return to recommendations

Transition out of care to independence

Why the committee made the recommendations

Extended care

Recommendations 1.8.1 and 1.8.2

The committee considered evidence from a study, using less robust research designs (not randomised controlled trials), describing outcomes of participants who had left care at different ages. Those who were still in care placements between the ages of 17 and 23 were less likely to be involved in property crimes (men) or convicted or arrested (women). Those who had left care aged 18 or 19 had worse outcomes for time to arrest and time to first violent offence.

Other UK-based evidence from interview and focus group studies suggested that many care leavers experienced what felt like a cliff edge moving into independence too early. Therefore, the committee recommended that, wherever possible, looked-after young people approaching independence should be encouraged and helped to stay in their current care placement until at least the age of 18.

The committee noted that for some, staying put in their care placements beyond age 18 could be beneficial. However, this was complicated by the fact that carers may be paid less for young people over 18. (Levels of financial support to former foster carers are agreed and specified within each local authority's staying put policy.) In addition, the ability to take on other foster placements may be compromised by allowing an adult who

has left care to stay on the premises. Therefore, the committee agreed that the possibility for staying put should be explored with all carers before leaving care, even though this may not be possible in many cases.

Supported by expert testimony, and experience in the committee, the committee considered the danger faced by those whose care placement broke down between the ages of 16 and 17. This may lead to placement in unregulated housing at a young age, when vulnerability and the risk of exploitation may be high. The committee agreed that it was very important to avoid using unregulated housing if at all possible, particularly among those at high risk of exploitation.

Needs assessment

Recommendations 1.8.3 to 1.8.5

A needs assessment is already a requirement in pathway planning (beginning at age 15 and completed before age 16). But based on evidence from UK interview and focus group studies reflecting the unmet need of some care leavers after leaving care, the committee agreed that this process needed to be more rigorous and incorporate previous life story work to identify the person's strengths (for example, problem-solving skills and practical skills) and needs.

The committee found that, overall, evidence from studies with robust designs did not suggest that independent living services were ineffective. In the 1 study that looked at providing independent living services that were better than standard care, there were significant improvements across earnings, housing stability and general economic security. There was also some evidence of benefit for various specific aftercare services from evidence based on studies with weaker designs (not randomised controlled trials).

The committee therefore discussed the descriptions of the independent living services in the studies and recommended some core principles of care for supporting looked-after young people moving into independence. The committee sought to link the needs assessment for care leavers to the services provided in the transition out of care to independence.

UK-based evidence based on interview and focus group studies highlighted how care leavers are often lost in the gap between child and adult health services and that they often face a great amount of loneliness and mental strain. This matched the committee's

own knowledge and experience. So they agreed that the care leaver's existing mental health, health and dental care needed to be supported by ensuring registration with GP services and access to dental services. In addition, the committee suggested ways of plugging the gap between adult and child services until the transfer to adult services can be completed – for example, by extending access to CAMHS or providing alternative emotional and wellbeing services such as online support, face-to-face counselling or group work.

The committee noted that independent living services described in the evidence reviewed covered several interventions that had components supporting mental health. However, few reported mental health or general health-specific outcomes. Recognising the higher than usual rates of mental illness and health problems among care leavers, the committee recommended that more research was needed on interventions to promote the health and mental health of care leavers (see the recommendation for research on continuing support for the physical and mental health needs of care leavers).

UK-based evidence drawing from interview and focus group studies strongly suggested the benefit of peer groups and support for gaps in social network in helping to combat social isolation. The committee noted that peer support was also a common component of independent living services described in the rest of the reviewed evidence.

Evidence showed the usefulness of and need for various common components of independent living services. For example, ongoing accommodation support is a common component of independent living services and is valued by care leavers. The committee agreed that it was important and emphasised that organising this through the leaving care team working together with other housing services would promote continuity of oversight during the transition out of care.

The committee discussed interview and focus group evidence about the experience of the short sharp shock of independence, and that care leavers were not 'allowed' to make mistakes. For example, care leavers may initially reject support but then regret it. The committee therefore agreed that services that help to provide safety netting should be available for all care leavers to help prevent deterioration in housing stability, connectedness and economic independence. Based on their experience and knowledge, they suggested that the following services could be provided for care leavers without substantial cost to local authorities: drop-in services (for local guidance and signposting), possibility of more frequent meetings with their personal adviser (for individualised guidance and support) and facilitated care leavers peer support groups (to support

relationships after care, mentoring, and share ideas and resources).

Plans and support for care leavers

Recommendations 1.8.6 to 1.8.15

Based on their knowledge and experience, the committee considered that many of the problems young people encounter when transitioning out of care stem from a lack of accountability of local authorities in following and communicating statutory guidance. Care leavers may be unaware of the importance of the pathway plan for agreeing the support they will be given after transition.

Some examples the committee discussed included informing care leavers that if something is in their pathway plan and is signed, it constitutes an agreement that the local authority will provide that service, and that care leavers do not have to sign their pathway plan until they are happy with it and may request a review. The committee agreed the need for practitioners to communicate this.

The committee also agreed that other aspects that need to be communicated included rights to extended support beyond age 18 (for example, support to re-enter education), and rights to advocacy services to improve adherence to statutory requirements, and to take full advantage of rights under statutory law.

The committee considered the need for all of this information about support available to care leavers in their local authorities to be made explicit and easily accessible as outlined in statutory guidelines. They noted that, in practice, care leavers often did not know how to find their care offer and some websites outlining the care offer were not kept up to date.

Based on their own experience and knowledge, the committee considered that virtual meetings could help bridge the gap between care leavers and their personal advisers to help them continue to access support when they had moved out of area.

Based on their own experience, the committee recognised the need for pathway plans to anticipate significant milestones (such as reaching the end of qualifications or training) to help support next steps into greater independence.

The committee discussed the need for local authorities to perform some quality

assessment of the pathway plans. Based on their experience and knowledge, they discussed what made a better-quality pathway plan and agreed there was a need for plans to include actions in response to identified need. These actions should clearly identify a timeframe for completion as well as the practitioner responsible for completing the action. The committee also discussed the need for quality assessments to check that the actions were actually completed in the agreed timeframe.

From the committee's experience, the support available to care leavers is likely to differ considerably by area. So they agreed that efforts to raise care leavers' awareness of local opportunities for support in independent living were needed.

How the recommendations might affect practice

Extended care

Supporting young people staying in their current placement until at least age 18 is not expected to have significant resource implications. If a foster carer is happy to continue the placement beyond 18, the cost of this (for example, the potential loss of the foster carer to the system) is offset by the benefits of improved outcomes for those who have support for longer beyond their in-care placement.

The committee acknowledged that avoiding the use of unregulated housing for looked-after young people under 18 would have potential resource implications. However, these resource impacts can be justified on equity grounds, because any reasonable person would not consider the use of unregulated housing to be appropriate for anyone under 18. Therefore, it would be unfair and a social injustice to have looked-after young people endure such living conditions simply because of their looked-after status.

Needs assessment and plans and support for care leavers

These recommendations should not have substantial additional resource implications because most of them cover care processes that are statutory across the UK, although they are completed with variable quality. For example, many of the possible interventions for preparing care leavers for independent living are currently available across the UK, but with variable access.

Some of the recommended interventions to support care leavers may have resource implications, such as supported housing and increased mental health support to plug the

gap between child and adult services. However, the provision of these is already a statutory requirement if based on a good individual needs assessment.

Providing 'safety nets' such as drop-in services for care leavers and peer support groups is expected to be relatively low cost and has large benefits by providing a sense of availability and connectedness. Peer support groups may need administrative staff time, especially to help organise and facilitate meetings, and some monitoring may also be necessary to help prevent misinformation spreading. However, this intervention could save time and resources by helping to resolve issues that would otherwise need the attention of transition teams.

Return to recommendations

Support for care leavers in further and higher education

Recommendations 1.8.16 to 1.8.18

Why the committee made the recommendations

Based on their own experience and knowledge, the committee discussed extended educational care. They noted that, for qualifying care leavers, extended support was often offered if the person was in full-time education. However, the definition of what constitutes full-time education may be too narrow for many who would benefit from it. For example, 1 of the committee members raised the example of a care leaver who received a scholarship to train with a sports team, who may not receive the same extended support as someone in university. The committee also considered the high prevalence of those with special educational needs or disabilities among care leavers. Because this group may not progress as quickly in education, the committee agreed that they, especially, may need extended educational support.

Based on their own experience and knowledge, the committee also discussed the issue of university students living away from home and agreed that continuity of housing during holidays was needed for care leavers in college or university to prevent housing instability between terms. This was supported by evidence showing that housing was often cited as the reason for care leavers dropping out of courses in higher and further education.

Based on their experience and knowledge, and evidence showing that isolation may remain a problem even with appropriate housing, the committee agreed that a good level of social support was needed from social care and university teams. Based on evidence showing the benefit of peer support and mentoring interventions, the committee agreed that facilitating a 'buddying system' for peer support, mentoring from older students on campus to tackle isolation during the holidays or providing other social opportunities for care leavers could be beneficial.

How the recommendations might affect practice

Housing support during university holidays may not cost a substantial amount because many universities already offer the option for care leavers to stay on in their halls of residence in holiday times.

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Feedback to improve services

Recommendations 1.8.19 to 1.8.21

Why the committee made the recommendations

Drawing on UK-based evidence from interview and focus group studies suggesting that shared decision making should be a cornerstone of care provided for looked-after children and young people, the committee discussed the need for a mechanism to incorporate the feedback of looked-after children, young people and care leavers moving into independence back into the services provided. Interview and focus group evidence suggested that children in care councils specifically may facilitate such feedback, although something more focused on care leavers, such as care leavers forums or surveys, was needed to improve services during the transition into independence.

The committee recognised particularly that those who were looked after out of area may be most vulnerable to receiving inadequate statutory support. Therefore, they considered it important that the views of these looked-after children, young people and care leavers were captured and used to improve services.

How the recommendations might affect practice

These recommendations are not expected to have substantial resource costs, because care leavers may be encouraged to give feedback in numerous ways. Care leaver councils may have more running costs in terms of facilitation and organisation, but the extent to which local authorities will use these councils is uncertain.

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Forum for strategic leadership and best practice

Recommendations 1.9.1 and 1.9.2

Why the committee made the recommendations

Based on evidence from interview, focus group studies, studies with more robust study designs and committee experience and knowledge, the committee considered the benefit of facilitated multiagency working to help systems adapt to local challenges. They were particularly interested in the use of regular broad-system meetings, or forums, for care providers to exchange information and to provide the opportunity to adapt care systems to meet the needs of looked-after children and young people.

The committee considered that 1 of the key components was improving communication between disciplines (for example, health professionals, social care providers and carers) at all levels to ensure that statutory guidance was being adhered to. A forum could also display examples of exemplary practice, review recently published evidence, and align tools used for health and social care assessments. This would help educate leaders, which would enable information to be cascaded down to other professionals. Based on expert testimony, the committee also agreed that these meetings would help standardise the different agencies' use of language, risk-assessment tools, and job titles and roles. The committee agreed that such forums could adapt to situations specific to the local authority – for example, increasing numbers of unaccompanied asylum-seeking children or increasing risks of going missing in care. The committee agreed that risk-assessment tools were useful to determine increased risk of exploitation at the individual level (for example, someone placed out of area is at increased risk), but it needed to be standardised across local authorities and agencies.

How the recommendations might affect practice

There may be organisation and facilitation costs for starting a forum to bring together agencies and representatives providing care for looked-after children and young people within a local authority. However, these are justified by the benefits of facilitating communication between agencies, providing education, sharing tools and expertise, and giving examples of best practice. Virtual forums may also help to bring costs down.

The committee noted that, in many cases, various boards, groups and councils already exist within local authorities. Partnerships with these could be organised to bring leaders together from several sectors. Some examples of existing relevant boards, groups and councils include: corporate parenting boards; children's safeguarding boards; children's trust boards; health and wellbeing boards; children's care councils; youth councils; foster care liaison groups; and clinical commissioning groups.

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Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on vulnerable groups.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

Update information

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