WHAT SORT OF NURSE ARE YOU?

NURSING IN A SOCIAL CARE SETTING:

LOOKED AFTER CHILDREN’S VIEWS AND STORIES

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Abstract

There is a general recognition that the role of the Looked after Children's (LAC) nurse has positively influenced the health of looked after children. Yet, there is a paucity of literature available regarding the nurse, and specifically a lack of understanding of how the role of the nurse is understood and experienced by children and young people who are looked after.

The research adopts a qualitative, psychosocial approach to exploring and understanding how children and young people experience the LAC nurse. The Free Association Narrative Interpretative method (FANI) was the chosen methodology used to interview three Looked After Children and three Care Leavers on two separate occasions. Their narratives were voice recorded and transcribed, then analysed systematically through the FANI method and further analysed using thematic analysis. The findings are split into four domains, the young person, the nurse, the relationship and the system. The findings demonstrate the significance of how the young people relate to the nurse and centrality of the nurse in providing a maternal archetypal care to the young people and the role the nurse occupies in the system. The significance of loss in the lives of the young people is a main finding along the enormity of adverse childhood experiences (ACEs) being interlinked and interwoven in the young people's experience. What develops out of these findings is a conceptualisation of a trauma informed model of nursing for Looked After Children.

Recommendations are made for future practice and dissemination to interdisciplinary fields.

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Abbreviations

ACE	Adverse childhood experience
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical commissioning groups
CL	Care Leaver
DoH	Department of Health
DfE	Department for Education
FANI	Free-association narrative interviewing
FGM	Female genital mutilation
LA	Local Authority
LACs	Looked After Children/s
LSCB	Local Safeguarding Children's Board
NICE	National Institute for Clinical Excellence
NRES	British National Health Research Authority
Ofsted	Office for Standards in Education, Children's Services and Skills
PREMS	Patient-reported experience measures
PROMS	Patient-reported outcome measures
PTSD	Post-traumatic stress disorder

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Dedication

This thesis is dedicated to the many special people I have lost along the journey that has been undertaking the research and thesis. I also dedicate the findings to all Looked After Children and Care Leavers who have struggled to have their voices heard.

From myself as the author to all Looked After Children and Care Leavers, I say: the candle is not there to illuminate itself. I hope this thesis sheds a guiding light on the path to a better understanding of how we care for our Looked After Children and Care Leavers, as nurses and as people.

Chapter 1: Introduction

1.1 Personal and professional interest

My area of interest is Looked After Children and Care Leavers' experiences of the nurses who work with them in a social care setting. I have worked as a Looked After Children'ss (LAC) nurse consultant, nurse manager and commissioner for the last 18 years.

LAC is a term introduced by the Children Act (1989), which refers to all children in public care, including those who may live at home with their parents but who are the subjects of care orders. In the late 1990s a government initiative to improve the care of children and young people in the care system – Quality Protects (DoH, 1998) – scoped out the reforms that would create positive outcomes for LAC. One of the recommendations included a nurse post, to complement the existing medical adviser post, and I was the first nurse in London to take up this new position. Over the years I have been working with LAC I have become very interested in understanding the relationships the children and young people make with their nurses, and this gave me the inspiration I needed to undertake this doctoral study.

There were 67,050 LAC in England and Wales at the end of March 2012 (DfE), when I first considered this study. However, the most up-to-date figures (DfE, 2017) show that the number of LACs continues to increase: by 31 March 2017 there were 72,670 LACs – an increase of 5,620 since I began my research. The number of new LACs in 2016/17 was also up by 2 per cent on the previous year. Older LACs are defined as CLs. The Children Leaving Care Act (2000) states that a CL is someone who has been in the care of the Local

Authority (LA) for a period of 13 weeks or more, during which time they turned 16 years old.

I have worked with both LACs and CLs and from the start of my time in social care I began to realise that I was working in a chaotic environment filled with personal pain and trauma. I found my social work colleagues trying to work with extremely complex and distressing cases. Whilst I had come from a hospital setting where I had worked with pain and illness, I now found myself immersed in a very different environment and context of pain and trauma. I found myself being drawn into case discussions, professional meetings and forums with very little preparation or experience to enable me to function in this way. Indeed, I spent my first year in post not knowing if I was a nurse or a social care worker, and not knowing who to support: the children and young people or their social workers – in my practice experience, the two didn't seem to fit well together and regularly disagreed with each other. I would often find myself in a conflicted state, trying to advocate for the wishes and feelings of a young person while supporting a social worker with often very difficult decision making. Often these aims are incompatible: in one example, a young person wanted to stay in their current foster placement while the social worker believed that their long-term health and well-being needs would be best met in another permanent placement. I found myself caught in the middle of the organisational structure, without a framework to hang my thinking on, or a way to understand the dynamics of the situation: personal professional and organisational. I undertook a Master's programme which drew heavily on psychoanalytic theory and learning by experience. This allowed me to find a space to think about my role as a professional and as a person within social care. It also afforded me space

to think about my role as a nurse – what it meant and how to put boundaries around it.

As well as my professional experience, I took inspiration directly from a work-based project that focused on eliciting feedback form children and young people about the service provided by the nurses. This further drove my commitment to undertake doctoral research. The project's aim was for Looked After Children and Care Leavers to feed back their experience of the nursing service of being a patient, using a variety of data collection tools and mediums. Children and young people have talked at length and creative pieces, including stories and poems and offered drawings, paintings and pieces of sculpture related to the time they have spent with the LAC nurses and these all gave me the inspiration the undertake doctoral research.

The data I collected conveys powerful messages about their experiences with the LAC nurses, but it also portrays and describe aspects of their life experiences in their care networks and sometimes in families. I have become very interested in exploring and trying to understand more about these factors and what meanings they might have, as well as that which is not communicated verbally. The interactions children and young people have when they are given this type of space and opportunity to express their thoughts and experiences is also of interest. The children and young people I worked with are referred to in my organisation as the patient story group, however I was reminded of how powerful an experience this can be for some of our children and young people, as a very eloquent child told me in a focus group: "it's not a story, it's real and it's about my life" (Anon, looked-after child, age 16, 2012).

I was interested in trying to gain an insight into what the meaning and context of the relationships might be that children and young people form with

the LAC nurses, and what is different for them when they are offered time with them. During my very first meeting with a looked-after child, I was asked, “So what sort of nurse are you, then?” This is a question that has stuck with me, and I have always been interested in trying to find an answer that could explain what it is to be a nurse working in social care with LACs and CLs. In as much as I can explain my experience to date in a professional context, I want to know what was behind the child’s curiosity in asking me the question, as well as what LACs and CLs think the nurses do for them. Is our work of use and value to them, and what can LAC nurses do to assist them in having a positive experience of the health services we provide?

I have presented aspects of the patient story work at national and international conferences and have generated much interest within my professional field. This has also informed my thinking and the processes that led to this research. Drawing on the work to date, I decided to pursue a research investigation that would offer an opportunity to undertake a qualitative exploratory investigation of Looked After Children’s and Care Leavers experiences of LAC nurses that would also be a useful contribution to the emerging professional field LAC nursing practice.

1.2 Context

The context in which the research takes place was a central London LA. The population of Looked After Children at the time of the study was 300, and approximately 200 CLs. The service functioned under one management structure with a service manager, two managers for CLs and three team managers for LAC for the LA. At the time, nurses supporting this service in terms of health for LACs and CLs included myself (as nurse consultant and manager) and two other nurses. Over the course of this research a nursing post

was lost as part of austerity measures, so a team of three became a team of two, which then was merged with two other boroughs' nursing teams. This reduced significantly the capacity to work with children and young people but was still able to meet the statutory functions of the role: to undertake annual health assessments. As part of the merger my position also had to cover the designated function. The designated function covered three clinical commissioning groups (CCG) and it is a statutory requirement that every CCG has a designated nurse for LAC to ensure that the CCGs meet their statutory commissioning functions and responsibilities to/for LAC. Managing all these roles and functions with reduced capacity lead to me taking up the opportunity to become a full-time designated nurse and commissioner in another area. This was after the research phase had been completed and the study was in the writing-up phase. It was a very difficult decision to leave after 18 years, but the research supported my decision, as it underlined to me the importance of having a resource-appropriate LAC nurse service and I felt I was best placed to influence this in a commissioning role. I have since had the opportunity to influence the national agenda for LAC and CLs in both a commissioning and policy capacity.

1.3 Background and why this research is needed

The pathway around health care for Looked After Children is that they should receive a health assessment within 28 days of coming into care and then annually if they are aged over 5 and bi-annually if they are under 5. The nursing service is set up to undertake all the health assessments of children aged over 5. The practice model I implemented in 2009 was that every looked-after child be allocated a nurse to undertake their health assessment. This nurse would also stay with them for their care journey, regardless of where they were or

would be placed in the future. Prior to 2009, health assessments were undertaken in a very fragmented and chaotic way. Children and young people would be seen for a health assessment based on where they lived and their nearest practitioner. There were high do-not-attend rates and a certain amount of anxiety amongst clinical staff that even when LACs and CLs did attend, they would find them time consuming, troublesome and awkward.

My colleagues would say the LACs and CLs didn't really engage with the clinicians, and there seemed to be a very one-dimensional view generated from the health assessment that focused on illness rather than wellness. Baruch, et al. (2007) recognised this phenomenon in relation to young people and their families, who they describe as being buried under a mountain of relational trauma and deprivation.

However, I came to understand that often these children and young people were quite mistrusting of some professionals, but not the nurses, and this dynamic interested me. I wondered what the nurses did or didn't do that was different. I was also committed to making children and young people's experiences of health contact positive, so the service was designed around their feedback, and I took note of how and where they wanted to meet the nursing team. So the service delivery model became that LAC nurses went out to see children and young people in a place and time they wanted to be seen. This was a very important first step in how the service was developed: to try and offer something statutory in a way that they felt was helpful and in a space they wanted to be in. This posed some issues around practicalities, as often children and young people would be placed in care settings far away from the nurse's base. However, feedback from children and young people showed they didn't like being seen by health professionals local to their placement; they preferred

to see their ‘own’ LAC nurse. This was mainly attributed to the fact that they felt local health professionals didn’t really know them. I took from this feedback that the first principle should be to provide consistency and continuity, particularly when discussing health matters, which were often quite complex and personal to each child or young person. Through my own experience and the feedback from children and young people, I was able to develop a service that moved away from the very traditional medical model of care, to a much more specialist nursing model. Whilst the feedback from children, young people and the care network was positive, I had my own questions about this type of nurse provision, as it was new and very much under-researched and evaluated, and I only had my own in-service feedback and evaluations as evidence of good practice. I had noticed that children and young people used the contact with nurses to talk about their life experiences and health issues and in so doing, formed relationships. I found the nursing team was able to actively work with the children and young people in a meaningful way and particularly with children and young people who had previously refused services. I had a curiosity about this and wanted to understand what this might mean for children and young people. Also, I noticed that the relationships with the nurses was sustained for long periods of time, where other relationships often faltered or became difficult.

There was also external accreditation in the form of outstanding Ofsted inspections (2010), the Nursing Standard and the Royal College of Nursing Child Health awards (2009) and positive citations in the literature (Pearce, 2009; 2010). I was also proud and humbled to receive the award of Nurse of the Year in 2009 for designing and delivering the service.

In the more recent climate of austerity, and especially after losing a nursing post, it felt important to me to undertake an in-depth study that would

give more weight to my argument of continuing delivery the service in this way. Another driver was creating an evidence base that could be used in dialogue with commissioners of services, as presently we risk a situation where we provide a service we are told to provide by commissioners, rather than working with commissioners and evidence from practice to enhance and deliver best practice, using patient experience as the foundations for building excellent services (Bate and Robert, 2006).

1.4 Theoretical basis

I felt very drawn to a theory that would allow me to explore not just my professional role and personal interest, but also to further my understanding and interest in the underlying relationships between nursing and social care. Having previously studied psychoanalytic theory and its relationship to working with Looked After Children and as a practitioner experiencing it as a useful framework for thinking about my work and professional practice, I wanted to find a theoretical framework and methodology that would draw together my experience of undertaking the research with my interest in psychodynamic theory. I also wanted to combine my experience of working in social care which has led me to operate in a much more relational and personal style, moving away from traditional models of nursing and medicine to a more social care-centric mode that focuses on relationships. The free-association narrative interviewing (FANI) method offered this opportunity: whilst not being too ridged or defined it fostered interpretation of the research and analysis through a psychoanalytic lens that allowed interpretation and investigation without being overly restricted.

1.5 Aims

I have long wanted to understand what happens in the relationship and the encounter between Looked After Children and the nurses that work with them. I have also had questions about internal working models. So, the broad aims of this research are:

1. To explore how relationships between Looked After Children, Care Leavers and the nurses who work with them are formed and developed in a social care setting.
2. To critically analyse the existing field of knowledge in this emerging, yet under-researched area of nursing.
3. To generate empirical data from interviews with Looked After Children and Care Leavers and formulate analysis that contributes to the body of professional knowledge.
4. To identify factors that are raised through the process of conducting research and being a researcher that also contribute to understanding the experience of Looked After Children and Care Leavers nursing.

The aims broadened through the research process and subsequent analysis to also consider how the organisation featured in the narratives of the young people.

1.6 Research questions

1. What are the experiences of Looked After Children and Care Leavers of specialist nursing in a social care context?
2. What does it mean to Looked After Children and Care Leavers to work with nurses during their care journey?
3. What meaning do Looked After Children and Care Leavers derive from this experience?

4. What can this tell us about the care experience and the role of nursing?

1.7 Rationale for methodology

As I conducted my literature review it became even more apparent to me that what was missing in existing LAC and CL research was their experiences and narratives about health. Much has been written about Looked After Children and Care Leavers in other respects, including placement stability, education, offending and mental health (MacCauley, 2009; Beagley et al., 2014; House of Commons Education Committee, 2016; Meltzer et al., 2000; Rock et al., 2013; Berridge, 2012; Munroe and Hardy, 2006). I was disappointed to find very little was written in relation to Looked After Children and Care Leavers nursing and this is explored further Chapter 2. Given my desire to examine this area and heartened by the fact that I had undertaken patient experience work prior to starting this thesis, I felt very strongly that I wanted to facilitate the voice and story of Looked After Children and Care Leavers in a research setting.

I chose to use the FANI method (Holloway and Jefferson, 2000) as the authors emphasise the unconscious dynamics between the researcher and the research participants and the benefits of a psychosocial approach. This method seems better suited to young people, as it allowed for a facilitative interview. Given my previous experience of working with Looked After Children and Care Leavers, eliciting patient stories, my own personal/professional questions around relationships and the significance of them, I thought this method was most suited to my research and investigation. I will give more in-depth critique of this method in Chapter 3.

1.8 Thesis ethos

Throughout my research and analysis, it became important to me that I held onto the individual story of each young person, and so I have structured the thesis in a way that keeps this narrative alive by introducing each respondent and giving a brief outline of the salient points about their life and experience that they shared with me during the research. I then progress to present the case and life narrative of each respondent in depth and to explain how this contributed to the analysis, before presenting the discussion and findings across the domains that were formed during the analysis. I have also written a patient story about each young person that can be used for the purposes of training and sharing and a case profile for each young person (see Appendix A).

What emerges from the data is an account of how three Looked After Children and three Care Leavers experienced being cared for by LAC nurses. The young people give articulate and poignant narratives about their experiences, intertwined with their experiences of being in care and their relationship with social workers and the LA as an organisation. Cutting across the findings is a central theme that relates to the emotional impact and life experiences narrative for this group, that gives voice to the nuances of how young people experience nurses and nursing, with emphasis on the emotional connection with the nurses who look after them.

Chapter 2: Literature Review

2.1 Introduction

This chapter sets out the background, policy, and practice context of my practice area which includes nursing and Looked After Children. This has been structured to demonstrate and clarify the contemporary issues related to Looked After Children and Care Leavers' nursing, at the point in time the study was undertaken and from prior knowledge of the existing policy and practice landscape. The chapter then progresses to present a structured systematic literature review using the Critical Appraisal Skills Program - CASP. (2017) CASP tool. This is presented in two stages, the first being a systematic review of the literature about Looked After Children's nursing and the second, a systematic review of the literature related to Looked After Children, trauma and adverse life experiences (ACES), all of which conclude that there is a gap in the literature and underline the importance of the research.

2.1.1 Background

Understanding the role of the Looked After Children's nurse in the lives of children and young people in the care system is fundamental to understanding the context of this study at this time. There is an ever-growing population of children and young people in the care system with figures for both Looked After Children and Care Leavers. The most recent figures reported on 31 March 2018 showing that there were 75,420 Looked After Children in England, an increase of four percent on 31 March 2017 (DfE, 2018a). The overall trend is that the numbers have been

increasing year on year since 2000. Thus, the Looked After Children nurse's role is an increasing integral of the journey of more and more children and young people.

2.1.2 Context

During the late 1990s, there was a government campaign to improve the outcomes for children and young people in care, called Quality Protects, with one of the key areas for improvement being health outcomes. It was evident from reviews (House of Commons Select Committee, 1997; Rushton and Dance, 2002) that despite the provision of statutory health surveillance, the uptake of these reported low uptake in Looked After Children populations. One of the many proposals put forward by the Quality Protects agenda was for Looked After Children to have a designated nurse in addition to a medical adviser; a responsibility that was historically undertaken exclusively by doctors. The role of the designated nurse was to provide a direct health service to Looked After Children and ensure they received the same standard and uptake of health care as the rest of the population. In early 2000, key performance indicators for health were defined nationally by the central government. Each Local Authority (LA) had to report these to the departments of health and education on an annual basis. Over the years it is evident from these measures that the health of Looked After Children has improved but not in line with the non-Looked After Children population. The most up-to-date data is from 3rd March 2018 and shows a small percentage improvement in some areas and a slight decline in others. As much as 85 percent of Looked After Children were reported as being up to date with their immunisations, compared to 84 percent in 2017 and 87 percent in 2016. Meanwhile, 88 percent had their annual health check, compared to 90 percent in

2017 and 2016. Finally, 84 percent had their teeth checked by a dentist, compared to 83 percent in 2017 and 84 percent in 2016.

Therefore, the data gathered demonstrates improvement in these areas of health data.

The reported performance indicators are statutory and show an increase in terms of what is measured by the Department for Education (DfE), but these type of measures do not offer any context as to how this was achieved, or if any of this could be directly attributed to the impact of the nurse function. Hill et al. (2002) identify the emergence of Looked After Children's nursing as a new specialty of nursing and acknowledge the need for an evidence-base for practice in this field (Royal College of Nursing, 2015). Whilst most Looked After Children's nurses (I included) assumed their posts from 2000 onwards, it is clear that Looked After Children's Nursing is still a new and emerging field of specialist nursing.

2.1.3 Policy Context

In order to frame the context, I will set out the policy context first. Currently in the NHS, there is a renewed emphasis on listening to patients. The recent recommendations of the Francis inquiry, and subsequent report (2013), places great importance on listening to patients. Both reports stem from incidents where care of vulnerable people fell short of the basic elements of both care and nursing care that anyone would consider acceptable. Significant harm, and in some cases death, occurred due to a multitude of issues and system failings, but at the heart of the reports was a central element of not listening to patients and their relatives. The Darzi report (2008) and its recommendations have been instilled in current NHS

practice with all organisations capturing patient experiences using feedback questionnaires and interview-based techniques such as patient-reported experience measures (PREMs) and patient-reported outcome measures (PROMs). These are quantitative survey tools that seek to provide service-user feedback. There has been much praise in the literature for the use of these tools (Black, 2013; Dawson et al., 2010; Reay, 2010; DoH, 2010). However, most are disease or diagnosis-led and use customer satisfaction-type language to elicit set responses. An example of this is a mandatory question that is described as a 'net promoter': would you recommend this service to a family member? Cooper and Lousada (2005) suggest that this type of approach fails to recognise the "irrational and unpredictable forces and processes" of "human activity and complex adaptive systems" which require a different, more participative approach (2005, p.171). It could be argued that performance targets, national indicator sets, and other technocratic systems have captured statistics where the unintended consequences may be that they act as an unconscious defence, acting as defences against the anxiety of working with child abuse. However, it has also been suggested by Appleby and Devlin (2004), that these methods are more aligned to measuring the performance and success of NHS organisations, rather than getting in touch with the emotional part of experiencing care. Birheim-Crookall, (2016) observe that a commonality in the reported literature is that surveys and studies, that have attempted to capture the voice of the child in care, have been designed by adults and fail to recognise that children and young people are experts in their own experiences (Birheim-Crookall, 2016). Other recent policy documents have also highlighted the centrality of the patient's voice and the importance of listening to their needs in service design and provision (NICE SCIE, 2010; DoH, 2012; NCB, 2013) as an important reflection of the many and

multifaceted failures in the child protection and Looked After Children's care system (Munroe 2011). Within the arena of the Looked After Children's health policy, the National Institute for Clinical Excellence (NICE, 2013) has a quality standard for Looked After Children's health and well-being and there is an onus on LAs and clinical commissioning groups (CCGs) to meet the standards set. The standards are set in eight domains and acknowledge the importance of relationships and stability for children and young people. Each domain sets out best practice and highlights measures that can be enacted to best support, promote and sustain health and well-being. This is encouraging to those of us that work in the field. But there is yet to be any published evaluation of the tool, or any literature detailing how using the standard can improve professional practice or enhance the health and well-being of Looked After Children.

2.1.4 Practice Context

Looked After Children and Care Leavers are particularly vulnerable to having poorer health outcomes than their peers. A national survey in the UK found two-thirds of all Looked After Children have at least one physical health complaint and are more likely than their peers to experience problems, including speech and language, coordination difficulties and eye or sight problems. About 60 percent of Looked After Children in England have been reported to have emotional and mental health problems, around four times the rate for children generally (DCSF, 2009).
The health needs of this group of children and young people are often linked to their life experiences; including the circumstances through which they became looked-after and their experience of care, which are cited as neglect, instability, inconsistent

parenting, exposure to domestic abuse, and related harmful early experiences (DfE, 2018b) .

There is a sizeable amount of literature available concerning Looked After Children and Care Leavers' experiences of being in care, as contributing to the poor health outcomes (NSPCC, 2014; Jones et al., 2011; Viner et al., 2005; Bass et al., 2004; Hill and Mather, 2003). The literature also states that Looked After Children go on to live out these health inequalities when they leave care, particularly concerning poor mental health (Meltzer and Mindell, 2006; Lindsey and Shlonsky, 2008; Knei-Paz, 2009; Munroe, 2011). Ofsted (2012) recognised that Looked After Children were not being consulted and encouraged to reflect on their experiences in order to assist with the future commissioning of services, (Ofsted, 2012). Whilst some literature about Looked After Children and Care Leavers experience of social work practice is available (Coram, 2015; Biehal and Wade, 1996; Buchanan, 1995; Cafcas, 2008; Cossar et al., 2011; Dickson et al., 2009), there is not any literature on individuals, or life experiences of Looked After Children and Care Leavers and their interactions with Looked After Children's nurses, or health care professionals.

There is a sizeable amount of literature available about Looked After Children and Care Leavers' experiences of being in care, as contributing to the poor health outcomes (NSPCC, 2014; Jones et al., 2011; Viner et al., 2005; Bass et al., 2004; Hill and Mather, 2003). The literature also states that Looked After Children go on to live out these health inequalities when they leave care, particularly about poor mental health (Meltzer and Mindell, 2006; Lindsey and Shlonsky, 2008; Knei-Paz, 2009; Munroe, 2011). Concerning Looked After Children being consulted and encouraged to reflect on their experiences for the future commissioning of services, relatively low proportionality is achieved and reported on (Ofsted, 2012). Yet, there

has been a rise in the amount of literature available in the public domain, with many Looked After Children and Care Leavers, who have been known to child protection services, penning their own stories (Kelly, 2016).

2.1.5 Nursing Context

Until the mid-19th century, nursing was not an occupation that was thought to demand either skill or training. As Florence Nightingale (1857) put it, nursing was left to "those who were too old, too weak, too drunken, too dirty, too stupid or too bad to do anything else". Whilst both time and experience have improved the image of nursing, and educational attainment and qualifications have raised the position of nursing to professional status, there is still a belief that nursing is a vocation and not a profession (White, 2002). This causes great angst amongst nurse academics and many nurses (Yam, 2004; Hallam, 2002) with the discussion in the literature in recent times questioning if nursing and nurses should be more academic and qualified to be able to care of today's population's complex health needs (Watson and Thompson, 2000). It also appears that despite many high-profile national tragedies when nursing seems to have been at the centre of poor patient care and neglect (Francis, 2013), and in some cases abuse (DoH, 2012), there is still high public regard and affection for nurses today (MORI IPSOS, 2017). There is also a discussion in the literature about the positive portrayal of nurses in the media and television, arguing that this furthers society's perception and admiration of the nursing profession (Summers and Summers, 2015). It is widely accepted that nursing is diverse and responsive to the many different needs of society (Giger and Davidhizar,1999) and widely acknowledged that nurses work in many different settings to help patients by either preventing illness, managing illness, or promoting

well-being (Tanner, 2006). Powers (2002) observes that more studies looking at the role of nurses in supporting emotional health and well-being is needed. With Looked After Children and Care Leavers, much of the national policy drivers have been to specifically target and bring nursing into the health and well-being of Looked After Children (DfE, 2015).

As my area of research is within the field of children's nursing, I took a retrospective look at the origins of children's nursing. The first documentation of the specific role of the children's nurse is found in the setting of the Foundling Hospital. Founded by Thomas Coram (1742), archived material documents the role of female caregivers as nurses (Allin, 2010). There is also discussion in the literature about the evolving and changing role of children's nurses over time: first, they were described as carers of infants and children without mothers, leading eventually to the emergence of specialist children hospitals (Glasper and Mitchell, 2006). It seemed significant that the origins of children's nursing are traced to the very first children's social care setting i.e. the Foundling Hospital. There has been a steadfast and resolute campaign by children's nurse advocates over some time to ensure that children's nursing has developed into the specialism it is today, with specialist skills and core competencies for all children's nurses (Glasper, 1995). This led to the present-day acknowledgment of children's nurses as a highly-skilled child and child-and-family-centered practitioners, enabling children and families through the most challenging times of ill health (Jones, 1995; Casey, 2015). With Looked After Children's nursing, there has been intercollegiate guidance on roles and competencies in the UK (RCN and RCPCH, 2015) and competency and capability frameworks in Scotland (NHS Scotland, 2006). There has also been statutory and the National Institute for Clinical Excellence (NICE) (DfE, 2015; NICE/SCIE, 2010) guidance, which refers to Looked

After Children's care by nurses. There has also been a survey by the Royal College of Nursing (RCN, 2015), which looked at caseloads and role descriptions. Yet, to date, there has been no research or evidence-based literature published by Looked After Children nurses, other than those previously mentioned, which relate more to innovation.

2.1.6 Context-Nursing and Psychoanalysis

Working with children and young people who come from a background of abuse and adversity can be painful and distressing for the worker. Menzies-Lyth (1970) recognised the distress and pain evoked in nurses caring for sick and dying patients and looked at the organisational defenses that were created within the institution of the hospital as an organisation, thus deflecting and defending against anxiety. This concept is one that I have experienced directly as a qualified nurse and a student nurse whose clinical education was in a clinical and academic setting where such organisational defences were enacted, whether they were conscious or unconscious. An example being referring to a patient by their condition rather than name and recently a child's health report listing their medical conditions and under diagnosis "Looked After Child" was stated. I was too immature in my practice to question calling a patient by their diagnosis, but with reflective hindsight, I can see how this type of practice goes on without much consideration or question (Ashburner et al., 2004; Barber, 1991; Gilmartin, 2008). I did, however, have a long peer support discussion with the health professional who thought Looked After Child was a diagnosis. The literature further supports this idea about not questioning practice and has recently gone as far as to say it has some bearing on the current failings of care and lack of compassion in nursing (Black, 2008; Corbin, 2008; Cornwell and

Goodrich, 2009; Dietz and Ord, 2000; Johnson, 2008; Woodward, 1997); also questioning if this is in fact a defence mechanism. This is something that was also highlighted by David Cameron in 2009 during a nursing convention which I was a part of. Here, the core values of nursing were questioned, leading to both a defending of nursing by nurses and questioning of practice (Wright, 2004).

The work of Obholzer and Roberts (1994) supports the theory of organisations and individuals creating defences against anxiety in response to stressful situations. This is in addition to organisational processes and defences and the internal conflicts and difficulties that are evoked in the individual worker, who may have previous experiences that now impact on the work they are currently undertaking.

Bion (1961) relates psychoanalytic thinking to the workplace, both in terms of the organisation and the individuals within it. He argues that devices such as splitting and projection exist that locate undesirable feelings, such as anxiety in other areas, organisations, or individuals. For nursing, Peplau (1952) brought the concept of psychodynamic theory into practice. Her specialist field was mental health nursing, but many other disciplines adopted her theory and thinking and applied them to other nursing settings (Fitzpatrick and Whall, 1983). Peplau's (1952) main conceptual ideas were based on the idea that nursing relied on interpersonal skills and relationships and the nurse brought as much to the relationship, as did the patient, in terms of how they relate to each other and the influence this has on both being cared for and caregiving (Peplau, 1962). Howk et al. (1998, p. 339) summarise Peplau's (1952) theory about nursing as follows:

> 'Nursing is a significant, therapeutic and interpersonal process. It functions cooperatively with other human processes that make health possible for individuals and communities.'

Howk et al. (1998, p. 339)

Howk et al. (1998) further summarise Peplau's (1952) ideas on nursing as an instrumental and maternal force that facilitates growth, creativity, and positivity in the lives of patients and communities. Peplau (1952) describes phases in the nurse-patient relationship that change over time and move the patient to a place of resolution from their ailment. Peplau's theory (1952) was an important driver in thinking radically differently about nursing and bringing key concepts of psychodynamic theory to nursing practices (Barker, 1993), along with the concept of psychosocial nursing (Phillips, 1977). Psychosocial nursing is defined as the culturally competent provision of psychological, social and spiritual care (Hodgkinson, 2008). Legg (2011) argues that nurses are uniquely placed to support the psychosocial needs of patients supporting patients and have developed interpersonal skills that enable them to understand how patients view themselves as individuals and establish what is important to them. There is also a body of literature about many different nursing specialisms and the utilisation of a psychosocial approach to care, published over many years (Barnes, 1968; Reed, 1987; Olson, 2002; Brosz-Hardin et al., 2002; Goreman and Sultan, 2008), yet these are in the main related to mental health nursing and/or chronic illness-based care. There is also some evidence in the literature concerning therapeutic residential family care and the benefits of this approach to working with children in a family context (Healy and Kennedy, 1993).

Whilst there has been research into both nursing and psychoanalytic thinking and organisations and nursing/anxiety, despite extensive on-line literature searches, I have not been able to find research into nursing in a social care setting or Looked

After Children’s nursing or any references to the psychosocial approach being used in Looked After Children’s nursing. Therefore this study begins to address this gap.

2.1.7 Context - The interface between Nursing and Social Care

Whilst there has been much written about the interface between health and social care and nursing in social care, most of this relates to the care of the elderly patients at the end of life care who require palliative care support (Kodner and Spreeuwenberg, 2002). Some studies describe multidisciplinary care in a variety of health and social care settings for people with both learning and special needs (Kirk, 1998). In recent times there has also been much media focus on the need for health and social care to be much more integrated – particularly around the discharge of patients from hospital settings to community provision (Gonçalves-Bradley et al., 2016). Little is written about the specific role of Looked After Children’s nurses located in social care or working alongside social workers. There is some mention of this as being good practice in nationally and locally published guidance (Hill et al., 2002). I have already discussed how Looked After Children’s nursing is a relatively new specialism, and this may explain the lack of available research, as this way of working is in its infancy compared to other branches of nursing and indeed social care research. Where there are parallels between social care and nursing and Looked After Children’s nursing, this is in the core components of each discipline’s training and ongoing professional development.

Both child social care and children’s nursing have strong theoretical links to key aspects of children’s health, well-being, and development. An example of this would be a focus on attachment (Munroe 2011). Children’s nurse training has, since the early 1990s, moved away from a focus on nursing sick children to a focus on health,

well-being, and normal children's development. In so doing, children's nurses are given an introduction to key aspects of children's development. Similarly, social workers choosing to focus on children's social care, have the same grounding in the health and well-being and normal development of children. When you look at further education for both children's social care and children's nursing, many courses focusing on the effects of trauma and abuse of the child are available (Hill and Mather 2003). In addition to research and professional training, there are also the present-day organizational structures; whether there are statutory/mandatory or developed local arrangements that facilitate and put together both health and social care and the professionals that work within the organisations. An example of this includes local Safeguarding Children boards and, more recently, corporate parenting boards. I am an officer on a corporate parenting board and lead member of the local Safeguarding Children board. Munro (2006) highlights both the importance and positive aspects of these arrangements and the difficulties inherent in agencies and professionals working this way, highlighting how all too often these groups become focused on when things have gone wrong or failed, rather than looking at what works well in how we support and manage risk with children and families.

There is also some suggestion in the literature, that there is a heavy focus on serious case reviews within organisations. Whilst it is intended that these be an opportunity for learning, there is much reported about them being counter-productive and having an acute emotional impact on the workers involved in the cases. In my extensive search for material, I have not found anything that directly relates to Looked After Children's nursing and social care. I do hope that this study may go some way to address this at a starting point and from the perspective of Looked After Children and Care Leavers.

Professionals from social care tend to have a very person-centered approach, and their ideas and strategies are constructed around such approaches. Social care constructs are found in the interrelationships concerning the individual, their family, social networks and the wider community (Northern and Kurland, 2001). In health, however, the dominance of the medical model emphasises the notion of disease and pathology, i.e. an illness requiring treatment (Crinson, 2007). The medical profession is based on science and biomedical understanding of the illness.

Todd (2007) refers to the "systemic embodiment of the medical model" (p. 89) that underpins the integrated service delivery model. That service delivery is built upon the theory 'that something is wrong and 'needs fixing': a deficit model with the client having an inherent problem with little regard to the contextual influences that abound: "a complex interaction of social practices and institutional, political and cultural influences" (p. 89). This deficit model is opposing social frameworks of practice. In recent years, there has been a consensus within the literature regarding the value and importance of multi-agency collaboration, but there tends to be a focus and emphasis on the inherent problems or barriers to effective implementation (Barr and Ross, 2006; Salmon and Rapport, 2005; Stead et al., 2004). The literature often emphasises the inherent difficulties of the multi-agency process, rather than the impact on outcomes for children and families. It also indicates that there are immense complexities underpinning core children's service relationships, especially regarding ethos, practice, and philosophies which are not easily resolvable.

2.2 Literature Review

A systematic review was undertaken as it was aligned to the study design and best suited to the papers I knew to be available from previous knowledge. Systematic review is defined as "explicit, formulated, reproducible, and up-to-date summaries" (All answers, 2018); utilising this method produced a structured and analytical precis of the available literature. This systematic review incorporated the Critical Appraisal Skills Programme (CASP) tool (Public Health Resource Unit 2006). This process involved asking questions of the papers and scoring according to ten factors to build an overall critical analysis of the available literature. This approach has been used to develop an evidence-based approach in health and social care, working with local, national and international groups (Melnyk and Fineout-Overholt 2011). CASP aims to help individuals develop skills to find and make sense of research evidence, helping them to apply evidence in practice. The Critical Appraisal Skills Programme (CASP) tool was used as an evidence-based framework to review the papers (Singh, 2013) resulting in a structured approach to assessing the rigor of studies reviewed.

A range of questions were systematically applied to each of the studies (Table 1). A structured and systematic approach was used to conduct this review.

The review aimed to establish if there were any existing research studies about Looked After Children's nursing. Specific questions I was interested to explore were:

- Has the role of the Looked After Children's nurse been evaluated?
- Has the role of the Looked After Children's nurse been able to demonstrate any impact for Looked After Children?
- Has any research investigated the experiences of Looked After Children and nursing?

A systematic literature review (Smith and Nobel 2016 was undertaken to critique and summarise the literature. This was carried out systematically to review all the literature and research relevant to nursing and Looked After Children.

2.2.1 Search Strategy

Initially, I searched the Cochrane library to determine whether a research study on the role of the Looked After Children's nurse had been undertaken. This did not return any results. I then searched the following sources via the Royal College of Nursing Library and the online database and journal finder, open to all students, at the Tavistock and Portman NHS Trust, both online and in-person monthly from 2015-2019. Table 1 outlines the online literature data bases searched.

Table 1 Online Literature bases searched:

Data Base/Online Search	Time frame searched	Search Dates
British Nursing index	1994-2019	June 2015 then monthly to 2019
CINAL	All dated up to 2019	June 2015 then monthly to 2019
Medline	All dated up to 2019	June 2015 then monthly to 2019
OVID	All dated up to 2019	June 2015 then monthly to 2019
ProQuest Dissertations and Thesis	1997 to September 2018	June 2015 then monthly to 2019
PubMed	All dated up to 2019	June 2015 then monthly to 2019

Table 1 Online Literature bases searched continued:

Royal College of Nursing Allied Health database	All dated up to 2019	June 2015 then monthly to 2019
The British Library online thesis	E thesis 1999-2019	June 2015 then monthly to 2019

As the focus of this review is very specific, wider search terms were used to ensure that any research that related or had the potential to add new knowledge to my narrow focus, was included. The search terms are detailed in Table 2.

Table 2 Literature Search Terms:

Care Leavers
Care Leavers and Health
Looked After Children
Looked After Children and Health
Looked After Children's Nurse
Health outcomes for Looked After Children and or children in care
Nursing and Looked After Children
Nursing and Care Leavers
Policy in practice in nursing and social care: either published or unpublished

Due to the length of time Looked After Children’s nursing has been established in the UK, literature was eligible for inclusion in the review if it fulfilled the following criteria:

Table 3 Inclusion and Exclusion Criteria

Inclusion criteria	**Exclusion criteria**
Studies published after 1997	Studies published before 1997 (Looked After Children’s nurse role did not exist until 1997)
Studies based in the UK	Studies based outside the UK (the Looked After Children’s nurse does not exist outside the UK)
Empirical studies	Articles that are opinion pieces

Titles and abstracts were vetted, and I also scrutinised the references sighted and searched by hand for any additional papers. Full-text articles and chapters were obtained and details from each extracted into a table to ensure capture and to facilitate comparison.

The process was repeated every six months between 2017 and 2019 to ensure that all of the relevant up to date literature and research were appraised and included in the study.

2.2.2 Search Outcomes

Initially, more than 3000 articles were found. Many were excluded as they did not relate directly to Looked After Children’s health in any way, but more to social care

only, or social care and education. Table 4 captures this process and details the numbers.

Table 4 Search Outcomes

<table>
<tr><td colspan="2">Articles and published literature identified from databases and online searching
n = 3014</td></tr>
<tr><td colspan="2">The literature identified from prior knowledge
n = 42</td></tr>
<tr><td colspan="2">The literature identified from reviewing references cited in articles
n = 16</td></tr>
<tr><td colspan="2">Excluded following abstract review
n = 2740</td></tr>
<tr><td colspan="2">Full articles reviewed
n = 342</td></tr>
<tr><td>Articles excluded

n = 339</td><td>Reason for exclusion
• Not empirical research = 301
• Non-UK research = 4
• Emphasis not on health and well-being = 11
• Focus not in the role of the nurse = 20</td></tr>
<tr><td colspan="2">Final papers included in the synthesis

n = 3</td></tr>
</table>

2.2.3 Data Collection and Analysis

The searches were undertaken by myself and I assessed the studies obtained from the search.

2.2.4 Quality Appraisal

The Critical Appraisal Skills Program (CASP) qualitative checklist tool was used as a framework to review papers (CASP, 2017). A range of questions was applied to each of the studies and scored on a range of 0-20, (0 being no information) and higher score ranges indicating high-quality studies were addressed. Table 5 sets out the studies and CASP scores.

Table 5 CASP Scores

	CASP Criteria	Cope (2015)	Dickinson and Divencenzi (2015)	Hill et al (2002)
1	A clear statement of aims	2	1	2
2	Appropriate methodology	2	1	2
3	Appropriate research design	2	1	2
4	Appropriate recruitment strategy	2	1	1
5	Appropriate data collection Methods	2	1	2
6	Research relationships considered	2	2	0
7	Consider ethical issues	1	2	0
8	Rigorous analysis	1	2	2
9	Clear findings	2	2	2

Table 5 CASP Scores continued

10	Value of the research	2	2	2
Total score out of 20		15	17	15

2.2.5 Synthesis

I intended to undertake a meta-analysis of the research studies; however, following critical analysis of the findings this was not possible due to the non-availability of any appropriate studies. Thus, a systematic review was undertaken using recognised guidelines and involved a detailed systematic review of the individual papers and synthesis of key findings from those papers (Poppay et al 2006).

All three-studies sample groups were the same, although varied in size, with the smallest being 49 (Hill et al 2002) and the largest 100 (Cope 2015). All three studies had an overarching theme around engagement in health appointments and a need for individuality in service provision. All three also made similar recommendations in terms of service provision and models of working. This is presented in Table 6.

Table 6 Data Synthesis

Study/citation	**Cope (2015)**	**CASP score** **15**
Aims	To understand why Looked After Children were refusing health assessments.	
Sample	Co-hort of 100 Looked After Children.	
Data collection method	Survey and interview.	
Key findings	• Using a multi-agency and child-centered approach is effective in engaging 'hard to reach' children and young people.	
Recommendations	• A model of co-working.	

Table 7 Data Synthesis continued

Study/citation	Dickinson and Divencenzi (2015)	CASP score 17
Aims	To test a new model of health care delivery for the teenage population looked after.	
Sample	Young people who were new to care within six months.	
Data collection method	Quality assurance tool.	
Key findings	• Young people were more likely to attend a health appointment with a Looked After Children's Nurse.	
Recommendations	• That the statutory guidance should be reviewed with a proposal to change the regulation concerning the initial health assessment.	

Table 8 Data Synthesis continued

Study/citation	Hill et al (2002)	CASP score 15
Aims	To describe the spectrum of health difficulties presented by the children and assess the efficiency of the healthcare planning process. A secondary aim was to make a judgment about the professional skill base required to address the children's problems.	
Sample	49 Southampton children who had attended for at least two statutory medicals.	
Data collection method	A retrospective case-note analysis.	
Key findings	• The findings of this study highlight both the heterogeneity of health needs of Looked After Children and the range of skills required to offer the holistic health assessment.	
Recommendations	• Recommended a review of the statutory guidance and furthering the role of the Looked After Children's Nurse.	

2.2.6 Results

The analysis of the three papers that were included in the review, revealed two themes that reflected the nursing care provided to Looked After Children. This is presented in the next section as a discussion.

2.2.7 Discussion

Theme 1: New Specialism of Nursing

The studies all described referral and management practices that improve access to services for Looked After Children in a service evaluation context (Eichler, 2009) and in the same vein, Cope (2015) has described methods to engage Looked After Children in statutory health assessment processes, defining Looked After Children as a 'hard-to-reach' group. There is also acceptance from national guidance that Looked After Children are reluctant to engage with statutory health assessments, or indeed health services (DfE, 2015; NCB, 2013).

What is evident within the three studies and further supported by the wider literature quoted, is that a new area of nursing specialism is emerging, and a cross-study recommendation has been made for further research and review of existing policy and guidance to be undertaken.

Theme 2: The health of Looked After Children and Care Leavers

All three studies identify that the literature tends to refer to Looked After Children and Care Leavers as a homogenous group, detailing issues around health, well-being, and outcomes particularly about experiences of the health and provision of statutory services. A commonality is addressed in the studies around challenges in delivering

health services and promoting good health. Looked After Children and Care Leavers move from home, from care placements, and foster placements, sometimes frequently. Amongst many issues of stability, this also means they lose the connections they may have made in their communities. For Looked After Children and Care Leavers, the absence of continuity of health care and, frequently, multiple moves of care, contribute to a lack of information or knowledge regarding past health history – an essential component of caring for any child and an essential element of a child knowing their history.

2.2.8 Strengths and Limitations

The strengths of the studies are in the emergent themes which are useful because they provide a contextualisation of nursing within Looked After Children care networks. Previously, they attempt to undertake a systematic review of a relatively new service provision. The obvious limitations are in the study's size being small, thus generalisability. However, it is the first foray into a very narrow and under-researched field and the benefit of having these papers as a starting point for further research and thinking, shouldn't be underestimated. This also supports the need for my research. as there is a clear gap in the literature that involves hearing from the young people themselves about their experiences of the Looked After Children's nurse.

2.3 Secondary Literature Review

As the analysis of the transcripts was undertaken it was evident that I needed to undertake a systematic review of the available literature about Adverse Childhood Experiences (ACEs) and Trauma; I therefore undertook a secondary literature

review. The same process was followed as described in sections 2.2.1 and detailed in the next sections.

2.3.1 Literature Search Terms

The search terms were: ACEs, trauma, Looked After Children and Care Leavers. No exclusions were made at the search stage. As from prior knowledge I knew this to be a small field of mainly American studies, however, I hoped there would be some studies replicated in the United Kingdom or some literature about ACEs. The search outcomes are found in Table 9.

Table 9 Data Bases Searched

Data Base/Online Search	Time frame searched	Search Dates
British Nursing index	1994-2019	September 2017 and monthly June 2019
CINAL	All dated up to 2019	September 2017 and monthly June 2019
Medline	All dated up to 2019	September 2017 and monthly June 2019

Table 9 Data Bases Searched continued

OVID	All dated up to 2019	September 2017 and monthly June 2019
ProQuest Dissertations and Thesis	1997 to September 2018	September 2017 and monthly June 2019
PubMed	All dated up to 2019	September 2017 and monthly June 2019
Royal College of Nursing Allied Health database	All dated up to 2019	September 2017 and monthly June 2019
The British Library online thesis	E thesis 1999-2019	September 2017 and monthly June 2019

Table 10 ACE Trauma Search Outcomes

<table>
<tr><td colspan="2">Articles and published literature identified from databases and online searching
n = 112</td></tr>
<tr><td colspan="2">The literature identified from prior knowledge
n = 3</td></tr>
<tr><td colspan="2">The literature identified from reviewing references cited in articles
n = 2</td></tr>
<tr><td colspan="2">Excluded following abstract review
n = 99</td></tr>
<tr><td colspan="2">Full articles reviewed
n = 18</td></tr>
<tr><td>Articles excluded
n = 12</td><td>Criteria
•Not related to children or young people in care = 6
•Not related to children, young people or adults who had experienced the care system = 2
•Not empirical research = 2
•Commentary or opinion = 2</td></tr>
<tr><td colspan="2">Final papers included in the review
n = 6</td></tr>
</table>

The same quality appraisal, data abstraction, and synthesis was then undertaken as presented in sections 2.2.3-2.25

Table 11 ACE Trauma CASP Scores

	CASP Criteria	Felitti and Anda (1998)	Ford et al (2007)	Hunter et al., (2011)	Kisiel et al (2014)	Read et al (2005)	Van der Kolk (1995)
1	A clear statement of aims	2	1	2	2	2	1
2	Appropriate methodology	2	2	1	2	1	2
3	Appropriate research design	2	2	2	2	2	1
4	Appropriate recruitment strategy	2	1	2	2	1	2
5	Appropriate data collection methods	2	2	2	1	2	1

Table 11 ACE Trauma CASP Scores continued

6	Research relationships considered	2	1	2	2	2	2
7	Consider ethical issues	2	2	2	1	1	1
8	Rigorous analysis	2	1	1	2	2	2
9	Clear findings	1	2	1	1	1	2
10	Value of the research	2	1	1	2	2	2
	CASP Score	19	15	16	16	16	16

Table 12 ACE Trauma Data Synthesis

Study/citation	Felitti and Anda (1998)	CASP score 19
Aims	An examination of the relationship between traumatic stress in childhood and the leading causes of morbidity, mortality, and disability in the United States.	
Sample	Over 17,000	
Data collection method	Retrospective and prospective analysis.	
Key findings	• There are long-lasting, strongly proportionate, and often profound relationships between adverse childhood experiences and important categories of emotional state, health risks, disease burden, sexual behavior, disability, and healthcare costs. .	
Recommendations	• A paradigm shift in how clinicians understand the impact of adverse childhood experiences and its impact on morbidity and mortality.	

Table 13 Data Synthesis continued

Study/citation	Ford et al (2007)	CASP score 15
Aims	To find explanations for the increased prevalence of the psychiatric disorder in children looked after by local authorities.	
Sample	Compared a sample of looked after children (n = 1453), to non-Looked After Children (n = 10 428).	
Data collection method	Retrospective and prospective analysis.	
Key findings	• Children looked after by local authorities had higher levels of psychopathology, educational difficulties. • The prevalence of psychiatric disorder was particularly high among those living in residential care.	
Recommendations	• Longitudinal studies are recommended to determine whether effects persist, alter with time, or are reversible with intervention.	

Table 14 Data Synthesis continued

Study/citation	Hunter et al (2011)	CASP score 16
Aims	A systematic review of published findings on the cortisol response to a stressor, in 0–5 year- olds already exposed to adversity.	
Sample	30 published studies.	
Data collection method	Retrospective analysis.	
Key findings	• Evidence presented suggested that adversity disrupts the stress response from an early age. .	
Recommendations	• Longitudinal studies are required to determine whether effects persist, alter with time, or are reversible with intervention.	

Table 15 Data Synthesis continued

Study/citation	Kisiel et al (2014)	CASP score 16
Aims	To identify youth with histories of distinct patterns of interpersonal trauma exposure upon entry into the child welfare system and their impact trauma level.	
Sample	16,212	
Data collection method	Retrospective analysis.	
Key findings	• Youth exposed to both interpersonal violence and attachment-based ("non-violent") traumas within the caregiving system had significantly higher levels of affective disorders. • These complexly traumatised children exhibited higher levels of functional impairment.	
Recommendations	• A developmental trauma framework can more adequately capture the spectrum of needs of these multiply traumatised youth. • Utilising this framework for assessment, treatment planning, and intervention can lead to more targeted and effective services for these children.	

Table 16 Data Synthesis continued

Study/citation	Read et al (2005)	CASP score 16
Aims	To review the research addressing the relationship of childhood trauma to psychosis and schizophrenia, and to discuss the theoretical and clinical implications.	
Sample	23 articles.	
Data collection method	Literature review.	
Key findings	• Symptoms considered indicative of psychosis and schizophrenia, particularly hallucinations, are at least as strongly related to childhood abuse and neglect as many other mental health problems.	
Recommendations	• The need for staff training in asking about abuse and the need to offer appropriate psychosocial treatments to patients who have been abused or neglected as children.	

Table 17 Data Synthesis continued

Study/citation	Van der Kolk (1995)	CASP score 17
Aims	Reviews the literature on the differences between recollections of stressful and traumatic events.	
Sample	46 subjects	
Data collection method	Retrospective analysis.	
Key findings	• Traumatic memories are difficult to study since the profoundly upsetting emotional experiences that give rise to PTSD cannot be approximated in a laboratory setting.	
Recommendations	• More detailed investigations, including careful follow-up of both traumatised children and adults to check for memory distortions over time.	

2.3.2 Synthesis

Similarly, for the main literature review on Looked After Children's nursing, I intended to undertake a meta-analysis of the research studies; however, following critical analysis of the findings this was not possible, due to the very limited availability of studies, the other dynamic being any up to date or recent review of the literature. No literature was found about Looked After Children's Nursing and ACEs or trauma. Thus, a systematic review was undertaken in the same vein presenting the key themes that were found in the six studies.
Of the six studies critiqued, five (Felitti and Anda (1998), Ford et al (2007), Hunter et al (2011), Kisiel et al (2014) and Van der Kolk (1995)) utilised retrospective and prospective analysis of live cases with all utilising a combination of interviews and case review. All of these studies scored highly using the CASP tool scores in the range of 15-19. The one other study was a literature review that looked at 23 articles/studies, which was comprehensive in its coverage and made similar recommendations to the other six studies. All the studies had large sample sizes, with the smallest being 46 (van der Kolk 1995) and the largest being 17,000 (Felleti and Anda 1998). All studies had an overarching theme concurring with the view that children and young people who had experienced ACEs were likely to develop a trauma response to these, which affected and continued to affect them throughout their lives, not just on a social and emotional well-being level but also on a physical and mental-health presentation.

Theme 1 - Defining ACEs and Trauma and Looked After Children

All of the studies discussed the definitions of ACEs and trauma, but not in a transferable way as? it was a past event or single isolated incident. None of the studies considered the longitudinal exposure Looked After children would have to their environments and care encountered within them in their lives prior to care. There was limited discussion as to widening the concept of trauma, and ACEs were seen in a very rigid way. There was an acceptance in all studies that children in the care system would score highly with an ACE tool/checklist and would without a doubt experience a trauma response.

Theme 2 - Training and Understanding

All of the studies acknowledged the limitations of understanding the concept and contextualization in a practice setting and acknowledged the need for further thought and training. The limitations of this were that there was no narrative on how this might be achieved other than a suggestion of a paradigm shift, thus leaving the reader to make their foray into thinking differently.

Theme 3 Further Study and Analysis

All of the studies suggested the need for further study and subsequent analysis. Reflecting the narrative in Theme 2, lacking a suggestion as to how this might be achieved. I was disappointed that there was no mention in any of the studies about asking the children and young people (or as referred to 'a subject') for their view on what would be helpful to them or how they would think about the next steps to be taken.

2.3.3 Strengths and Limitations

Similar to the first literature review, it was heartening to find the studies and how ACEs and trauma were defined and thought about, was initially helpful. The limitations were; the very narrow focus the studies took in terms of what they

would define as an ACE or trauma, coupled with the lack of the experienced voice of the subjects in both the narrative of the findings and the suggestions for further research, training, and analysis. Overall, what was described was a very subjective and prescriptive way of categorising very painful and enduring traumatic life events form an early age.

2.4 Conclusion

The purpose of this systematic review was to present an analysis of the findings from existing research to highlight the role of the Looked After Children's Nurses and emphasise innovation in the evaluation of the role. Secondly to explore ACEs and trauma related to the same population. It was notable that no specific articles were found on the role of the Looked After Children's nurse and Looked After Children's nursing from the perspective of Looked After Children and Care Leavers. Another dynamic highlighted that the role of the nurse was not always made specific or explicit within the three studies. The literature critiqued ACEs and trauma was similar in that the role of nursing was not mentioned.

This chapter has reviewed the literature surrounding nursing within the context of Looked After Children's nursing in the absence of any formal study or research. The development of policy about the health care of Looked After Children and research that is near to my practice area has also been critiqued and reviewed to give both scope and depth to the narrow area of focus, I have chosen to take. The literature reviewed was critical in directing my thinking and approach to the research. It initially confirmed in my mind that there was indeed the gap I hypothesised would be concerning nursing and Looked After Children and Care Leavers. Therefore, the gap in the literature clearly highlights the

urgent need for this study and in particular hearing from the young people about their health needs and their experiences of the Looked After Children's nurse.

Chapter 3: Methodology

3.1 Introduction

The chapter focuses on the approach taken for this research and sets out the research questions. This is followed by the choice and rationale for methods chosen, and a description of how the data were collected and analysed. The ethical issues concerned with this research and the validity of methods used are also discussed.

3.2 The young people

The Looked After Children (LACs) and Care Leavers (CLs) who took part in this research were not known to me prior to the research interviews, and to protect those who took part and the boundaries of the research, they have been allocated to other LAC nurses in the service for their ongoing health and well-being needs, rather than myself.

3.3 Approach

This research study is built on a realist approach using qualitative methodology and is primarily based in the field of narrative research. Realism refers to the process what happened and storified though narrative to increase our knowledge and understanding of the world develop through the interaction of both environment and subject (Hopkinson and Hogarth-Scott, 2001, Kitson et al., 2012). As Robson (2002, p. 27) states that reality is socially constructed, and this seemed the most applicable approach to asking young people to share their experiences with me as the researcher.

3.3.1 Rationale for methodology

A range of factors had to be considered whilst developing the rationale and choosing the methodology for this research. Firstly, having outlined the paucity of literature available in my chosen area of research, I thought a methodology focused in narrative research was required as I wanted the starting place to be with the Looked After Children and Care Leavers , as the focus of my inquiry is to understand the relationships and human experiences of Looked After Children and Care Leavers in their care context with LAC nurses. Whilst there is a discussion in the research field about the validity of this type of research and its methodology in terms of data analysis and findings (Fonagy and Tagart, 2003), and there is also a view in some of the literature that more quantitative research and in particular randomised controlled trials are much more valid (Campbell et al., 2000), there has been a notable change in thinking in recent literature critiquing the need for quantitative research to be supported and include qualitative methods, particularly in health research (Lewin et al., 2009).

Within the parameters of the area I aim to research, there is a need to attend to the psychosocial dynamic of experience in that I am trying to gain an in-depth picture and understanding of what human experience is. This is significant as through both my own research and experience I came to understand that I am much more interested in gaining a contextualised, individual, in-depth analysis of patient experience, which these methods aimed to address. Therefore, I felt it was important to look at a methodology that could encompass this dynamic in a qualitative way. Boucher and Riggs (2014) view is that narrative inquiry seeks to humanise human sciences, placing people, meaning and personal identity at the centre, inviting the development of

reflexive, rational and interviewing methodologies that draw attention not only to the actual but also to the possible and the good.

The following position by Taylor (1989) seems key to explaining and rationalising the use of narrative enquiry. We place our lives in a narrative. To understand who we are, we must have a notion of how we have become and without knowing our past, or future. Zaner states:

> We tell stories because that's what we do. It's what we're all about. We care for one another with the stories we place in each other's memory; they are food for thought, and life.
>
> Zaner (2004, p. 9)

Given that my patients are all children and young people, I also thought that a methodology that drew on a medium that was familiar to them – telling stories, or telling me about their experiences – was something that would assist the young person in being able to participate in the research. I have used this method before when undertaking consultation work with children and young people in the care system, and whilst it was not research in the same sense as this current study, it was a basis for piloting a method of talking and listening and attempting to understand experience (Graham-Ray, 2014). Holloway and Jefferson (2000) state this approach to research that can be broken down into four key principles; the first being the use of open-ended questions. The second principle is in eliciting stories, the third principle being the avoidance of why-questions and the fourth, using the respondents' ordering and phrasing. The prevailing and overriding principle is that the research respondents can talk and reveal more about their experience without the researcher offering their own interpretations or evaluations (Holloway and Jefferson, 2000). It was also vital to me as the researcher that the research method itself would support and enable Looked After Children's and Care Leavers to be directly involved in producing

knowledge related to their care and support needs and the free-associating narrative interview (FANI) method lent itself very well to these aims.

3.4 Objectives

- To explore how relationships between Looked After Children and Care Leavers and the nurses who work with them are formed and developed in a social care setting.
- To critically analyse the existing field of knowledge in this emerging yet under-researched area of nursing.
- To generate empirical data from interviews with Looked After Children and Care Leavers and formulate analysis that contributes to the body of professional knowledge.
- To identify factors that are raised through the process of conducting research and being a researcher that also contribute to understanding the experience of Looked After Children and Care Leavers nursing.

3.5 The methodology: free-association narrative interpretation

I have utilised the FANI method as used and developed by Holloway and Jefferson (2000), as this is both a data collection and analysis tool. It has also allowed me to think about the research as an environment co-constructed between researcher and respondent. I found this to be a helpful way to think about what I would be undertaking given my experience to date with patient story work and focus groups. Clarke and Hogget (2009) describe the position of the researcher and interviewee as defended subjects who are both guarded by unconscious processes that are part of understanding the experience of the research. Understanding this context and this aspect will also allow me to think about what the underlying dynamics might be and what is not said in words

during the interview but by the process of reflecting on the experience and trying to understand the underlying communication that is not always said in words. This description seemed to strike a chord in me when I was in the initial stages of researching which methodology to use, as I have often felt like a defended subject working with a very defended Looked After Children and Care Leavers, it seemed most appropriate to choose this method given my newness as researcher my wish to capture this aspect as part of the research and also the ability within the interview and research to talk to experiences that Looked After Children and Care Leavers were articulating by commenting and trying to draw out more narrative. I thought this would allow me to explore the deeper meaning of what was being said and experienced within the interview.

The FANI method also lends itself to psychoanalytically informed analysis of the data (Holloway and Jefferson, 2010) which is a theoretical framework I have drawn on in my professional experience and have found particularly useful and helpful. Dartington (2010) also poses the view that this method offers some insight into the relational aspects of care and the wider consideration of the issues involved. This resonated with me not only as a practitioner involved in policy implementation, but also as a nurse who cares for a population of Looked After Children and Care Leavers . The other dynamic that this method allowed me to explore was that of becoming a researcher (Briggs, 2005) and being able to use my own reflections as part of the data and subsequent analysis. Arguing for research that looks at deeper attitudes and is meaning-making seemed particularly necessary given the current policy context of listening to patients (DoH, 2012) and the data I have generated from the focus group work I have undertaken. Story work has long been used as an integral part of children's social work (Aust, 1981; Ryan and Walker, 2007) and more recently it has been

extensively used as part of memory, recall and reminisce work with patients with dementia (Gibson and Carson, 2005) and has increasingly been taken up in nursing practice as a way of engaging and communicating with patients (Thompson, 2010). The FANI method allows for this type of opportunity.

3.6 Ethical considerations

This section examines the ethical issues raised by study and procedures used to address them. At all times, the research was undertaken within the guidelines, boundaries and codes set by British National Health Research Authority (NRES). In addition, I sought and gained written consent from the Local Authority (LA) who are corporate parents to the participants to undertake the study.

Ethical considerations involved in the undertaking of this research include consent, confidentiality, protection of participants and any issues they may discuss. Full consent from NRES and my university was obtained and can be found in Appendix B. Table 18 details the process and timelines.

Table 18: NHS Ethics Approval Process and Timelines

Date	Action	Comment /Reflection	Response
September 2014	Online application made to NRES	The form was not easy or understandable. 4 submissions were made until the 5th was accepted	
November 2014	Amendments to form requested by NRES	The Patient information forms submitted were not approved due to formatting	I resubmitted
December 2014	Submission of Patient information and Consent forms made	This was done by post rather than online as the forms originally submitted could not be amended	

Table 18: NHS Ethics Approval Process and Timelines continued

April 2015	1st Attendance at Ethics Committee	The panel was large and a difficult experience. None of the Patient information forms or Consent forms that were co-designed by patients were accepted as they were not NRES templates/same format.	I amended and resubmitted
		Consent and who could give it was questioned in depth and the solicitor present gave rationale, but members were not assured	I resubmitted with supporting letters from the local authority Assistant Director for Children's Services and Director for Social Care

Table 18: NHS Ethics Approval Process and Timelines continued

May 2015	Written request for amendments received from NRES	The amendments to forms were received in writing. I was also advised that I had to exclude any young person that was an unaccompanied minor	I had no option other than to agree in order to proceed
June 2015	Amendments submitted to NRES		
July 2015	2nd attendance at Ethics Committee	I attended with an expert patient who explained to the panel consent from his perspective	I discussed the experience in supervision Also contacted the children's lead at the Royal College of Nursing to think about guidance and assistance for children's nurses undertaking research

Table 18: NHS Ethics Approval Process and Timelines continued

September 2015	Final approval to commence from NRES		
September 2015	All documents form NRES submitted to Academic Quality at University of East London (UEL)		
October 2015	Approval form Academic Quality at UEL received		

The learning that took place was an important outcome for me and I have produced a very simple do's and don'ts list to assist any of my colleagues who need NRES approval. I also spent a lot of time reflecting about the process in supervision and thinking about how anxious the Ethics Committee were, which they attributed to the fact that I was talking to children in the care system who they thought no one could consent for, and were also concerned that talking to a researcher may trigger bad memories or experiences. To capture this aspect and as part of the dissemination, the short film will be made, highlighted the young people's positive experiences of being involved in research and the implications it had for them in terms of their confidence and identity.

3.6.1 Consent

Written consent forms were completed for each participant by whoever had parental responsibility for the Looked after Child. In cases where the birth parent shares parental responsibility with the LA, a written consent form was also completed by the birth parents and the social worker. In cases where the

LA has a care order and there is no longer contact with the birth parents, written consent was gained from the social worker.

In addition, all interviewees signed a consent form. I then ensured informed consent was gained by reading both the consent form and the patient information sheets with the participants before the research interviews took place. The right to decline involvement or to withdraw at any stage was made explicit during this conversation (see Appendix C).

3.6.2 Confidentiality

Ensuring the participant's details are not disclosed and cannot be traced to an individual has been undertaken to ensure confidentiality and anonymity, and I will not be sharing the data with my social care or nursing colleagues other than by an overview of the analysis. Secure storage of data were also undertaken to safeguard any possible breach of confidentiality and the contents therein. All participants have been given pseudonyms and are only written about in the research by their pseudonyms.

It was not expected that participating in the research would cause anxiety, distress or upset to the participants, however they were informed of the procedures for contacting the researcher should any of these issues arise and signposted to other support services to assist them with such issues.

If, during the interviews, anyone expressed any incident that could be viewed as poor practice by a professional or carer I stated that I would follow the local process for escalation of concern and ensure that the interviewee is aware of this and involved in the process should they wish.

3.7 Selection and exclusions

To avoid any bias, I only offered the interview spaces to Looked After Children and Care Leavers who I have not previously worked with and who are known to other staff from the nursing team. They were asked by my social care colleagues if they would like to take part in the research, talking to me about their experiences of LAC nursing. Any respondent who would need an interpreter had to be excluded from the study: this was in part due to the complexities of gaining informed consent and the added practical and ethical considerations that would be a requirement if working with interpreters. This was also a condition of my NHS ethical approval. Once six young people had come forward, my social care colleagues ceased to ask any more young people and no more came forward during the research process.

3.8 The process

The sample size was chosen for the research was six, with three Looked after Children and three Care Leavers. This was chosen, as some initial piloting work I had undertaken had indicated that extensive qualitative data could be drawn from just one interview, so a sample of six would generate rich, in depth qualitative data. It also permitted a thorough research enquiry within the scope of the aims and objectives of the study. On a very practical level the sample size felt big enough to generate lots of data but small enough to be a manageable sized cohort for myself as a lone researcher undertaking a qualitative research study. In addition, the focus of the research design was practice-based and near to my own practice experience, and using a small cohort afforded me the opportunity to undertake in-depth interviews that generated rich data for analysis.

The criteria was nonselective in terms of race, gender, ethnicity. It was selective by age - they had to be over the age of 14, currently looked after and English had to be their first language; these all being criteria imposed by the NHS Ethics Committee. The research group were self selected from the practice setting I worked in an, inner London Local Authority. I talked to my social care colleagues about my research plan and they were all willing to ask the young people they were working with if they would like to be part of the research and an invitation was made for volunteers to opt into the research. Patient information sheets and consent forms (in appendix C)ere given to social workers to give to any interested young people. Within two weeks of my initial conversations with social workers, I had details of six young people who wanted to take part. I then contacted each young person and arranged to interview them and follow the consent process; this involved reading the patient information sheet they already had with them and gaining consent from them, with the right to withdraw being made explicit.

3.8.1 Preparing to research

Given the age and background of the respondents, I also provided some creative material to offer the option of drawing or writing to make the process more child-friendly and informal. I had already used this method in action research groups and knew it could generate useful additional data, whilst also putting the respondents at ease in an interview-style setting. I also saw this as an opportunity to introduce another way of data collection whilst utilising a FANI method. There has also been recent research by leading nurse researchers advocating this type of medium when trying to engage with and understand children and young people's experience of health care (Carter and Ford, 2013) that is supported by a field of research in relation to interviewing children and

young people (Bagnoli, 2009; Barker and Weller, 2003; Carter, 2011; Darbyshire et al., 2005; Driessnack, 2005; Gibson, 2007).

3.8.2 Research in motion: organisational and professional anxiety

I encountered no problems at all with getting the research started within social care, in fact it was quite the opposite: there was a willingness and excited anticipation about me undertaking the work, with social workers thinking of numerous cases that would really like to partake in the research. However, my experience within my own professional field and employment with the NHS was somewhat different, with many of my colleagues being quite concerned about my ability to undertake the research, both in relation to how I would find the time but also what impact it would have and that it was not quite scientific enough to be of value. There was also a view that I should not be doing this research at all, as Looked After Children and Care Leavers were quite traumatised enough without me asking them to retell their stories. As I thought more about this, I came to understand through discussion with my professional peers that there was not so much a concern about the child or young person telling me their story it was much more about the professional's ability to listen to and hear stories they found painful and traumatic.

In relation to the research not being scientific enough, I reasoned that if it's important enough for the patient or respondents tell me then that's all the validity that I needed to shed light on their story. However, my research question was about their experiences of nursing care rather than their lived experience of being in care. Throughout the research journey of children and young peoples' lived experiences, the nurses often became intertwined and were talked about. However, this was in a way which was thought about within

the interview, and none of the participants communicated any anxiety or concerning behaviour that I felt unable to contain within the research process. I was assisted greatly by maintaining links with the social workers who had put forward the children and young people I would interview; by the fact that I was not the LAC nurse to any of the participants, and that they had the additional fallback of the support of their own LAC nurse.

3.8.3 What happened?

Three Looked After Children and three Care Leavers were seen on two occasions, as was envisaged in the research plan. All young people involved also created artwork and imagery which was sent to me either before, during or after the interview and, except for one respondent (due to a change in his circumstances), all sent me additional artwork after I had closed the research and written to the young people to thank them.

My only concern throughout the fieldwork stage of the research and conducting the interviews was one young person who expressed a wish to continue to see me and to stop attending her existing therapeutic support. I will discuss this further in later chapters. As well as recording the interviews and the thematic analysis, I also made recordings of my own experiences and what I have observed during the interviews. Doing this gave me a much richer and vivid picture of the overall experience of being a researcher, but also on the material that the young people brought to the interview. Reflecting on this has given me a different level of understanding that I had not previously experienced.

3.9 Locating the findings

At the end of the interview process I was left with a large volume of transcripts and my own recorded observations. I used all this material to develop an initial analysis which I have called the ‘first-sweep analysis’. Table 19 details what data was collected, used and in what way.

Table 19 Data Collection and Application:

Data Collected	**Description**	**Process/How used**	**Overall contribution**
Transcripts from interviews	All 6 interviewed transcribed generated 322,223 words	• Coding developed • Themes developed- from coding • Direct quotes used in thesis	• Developed case narratives • Developed shortened narratives for teaching/lear ning

Table 19 Data Collection and Application

<table>
<tr><td>Reflections immediately after interview</td><td rowspan="3">My own notes and observations transcribed into a research log</td><td rowspan="3">• Coded into responses and assisted in asking specific questions of the data
• Informed analysis</td><td rowspan="3">• Added to the analysis
• Informed section on being a researcher and overall reflections
• Informed limitations of study</td></tr>
<tr><td>Observations and notes made during transcriptions</td></tr>
<tr><td>Researcher reflections post transcription</td></tr>
</table>

Table 19 Data Collection and Application:

Observations from interviews	Observations written immediately after interviews generated an additional data medium for refection	• Used alongside coding to tease out themes • Used in thesis as direct quotes to support analysis/findin gs	• Added a depth of reflection to the analysis and findings
Reflections and notes from supervision	Interviews presented at group supervision sessions and peer reviewed- offering other insights into the data-processing and extracting ideas/thoughts and reflections	• Assisted with defining codes and themes and thinking about each young person's story and experience	• Assisted with the initial coding and themes and lead to inclusion in domain findings

I then progress to develop subsections and key questions in relation to each of the interviews. I then tried to develop themes and further questions from what emerged.

As I am interested in formulating meaningful analysis that generates new ideas and thinking from the interviews, I felt the FANI method was most aligned in terms of trying to achieve this. It allowed me to think about the research and findings in a way that facilitates not only analysis but reflection and interpretation as an ongoing process rather than a separate stage of the research process. This method of analysis also lends itself to a psychoanalytically informed analysis of the data (Holloway and Jefferson, 2010), which I find very helpful in understanding my practice and work in a social care setting with Looked After Children and Care Leavers that have experienced emotional trauma and who come from a background of abuse and neglect.

The other dynamic that this method allows me to explore is that of becoming a researcher. Given my personal and professional interests and the context in which I would be undertaking the research, all these aspects seemed important to consider and undertake as an integral part of the study and any write up. I could look at the material and data generated as part of an academic and peer supervision process that is offered on the current professional doctorate programme I am undertaking. This process will also offer the opportunity to reflect and explore the data with a skilled team who are experienced at looking at the type of qualitative material I am interested in researching and analysing.

3.9.1 Data analysis

Methods of interpretation used in the research include thematic coding and content analysis. The data were compared, with similarities and differences manually recorded and then analysed individually and collectively.

I undertook all the research interviews over a period of six months. I discussed the research in both seminar and supervision sessions regularly during the research phase and kept a notebook and research log where I commented and kept a record of my very early theory formulations as I went along. I also continued to read other research related to my practice during this time, building on my own ideas and encouraging me to think through my very early ideas around themes. After each interview I also wrote a log of my own experience and observations and I began quite early on to code themes that emerged from both the research data and my own reflexivity and notes. I began exploring very early on in the research process what connected themes there might be, and I started to code categories of responses and findings.

All the respondents who had agreed to take part did so, although I had to rearrange one interview due to one respondent’s busy lifestyle. Before and after each interview I began to build a case profile of each respondent. This was helpful in trying to understand the person I was interviewing, and to make some chronological sense of their life experiences by drawing out significant events that were told to me during the research phase. It also assisted me in trying to hold onto the individual story of each respondent as, throughout the research and write up, I found myself being overwhelmed with themes, but also compelled to keep each young person’s story alive within the narrative.

The Looked After Children and Care Leavers also created pieces of artwork that I now had in my possession. In addition to the interview data I also

kept a reflective log throughout the experience. I also found my interest in my own background history and personality grew and I began to ask questions about my own feelings in relation to the research and how much of this was tied into my own life experiences. It felt important to draw this data together as both a personal and professional learning experience and to get to some of the subject matter that Holloway and Jefferson (2010) refer to as the researcher being a defended subject.

In the initial phases of looking at the data I felt quite overwhelmed with the amount of life experience I felt I was holding within the transcripts. Very poignant and powerful life experiences seemed to communicate very loudly to me within the body of the overall material. At times I struggled to know how to move forward with thinking about how to disaggregate and break down the data without losing the whole picture. I would also feel torn between looking at each individual respondent's experience and how meaningful that was, particularly when they would articulate something that really spoke to my professional experience, or indeed my attitude to my life as a LAC nurse. I also found it difficult to draw out themes, as almost every line of every transcript seemed to speak to something meaningful and my whole drive, passion and commitment to doing this research was to shed light on Looked After Children and Care Leavers in a way that could be heard for professionals working with them. The artwork also became a very powerful force in helping me think about the young people's experiences. It seemed to convey an experience that was not articulated during the interview, or indeed by spoken word. I have included the artwork in the findings chapter, as certain pieces were very expressive and representative of the themes.

I feel a huge responsibility to convey the Looked After Children and Care Leavers voices and experiences, not least as nobody had looked at my research questions previously, and because each young person shared their experiences with me in a very personal and moving way. Whilst I need to produce a thesis that is academically credible and to achieve an educational award, I am also committed to writing something that is not completely devoid of feeling and emotion. Mosh and Gates (2000) write about the importance of this aspect in both conducting and writing up research findings and how useful this is in furthering the understanding of patients' experiences.

Writing up and revisiting the transcripts brought many insights and became a very large-scale piece of work. I was drawn to using thematic analysis as a method as it was evident that there were strong themes and commonalities across the young people's experiences. I used a thematic analysis method based on Braun and Clarke's (2006) model. I felt this was needed, and perhaps one element of the FANI method I struggled with was how to undertake the analysis in a structured way. Holloway and Jefferson (2010)'s framework for thinking about the analysis and drawing on reflexivity and key psychoanalytic concepts was very useful, however I found that given the volume of data I had in my possession, I needed quite a structured starting point from which to try and form some boundaries. Holloway and Jefferson (2010) suggest a way of doing this would be to complete a one-page pro forma and write what they describe as, a pen portrait of each participant. I undertook this and found it helpful, however I didn't find that this alone was enough to encapsulate each young person's experience. I undertook a phased approach to the analysis which I will go onto describe.

3.9.2 Stages and layers of thematic analysis

The only way I can describe how I undertook the analysis was to refer to it as stages and layers. The first stage of which is the Braun and Clarke (2006) stages of thematic analysis. It was akin to the Braun and Clarke (2006) phases of thematic analysis which I adapted to suit the highly qualitative narrative data, which I would describe as a narrative analysis based on the FANI methodology (Holloway and Jefferson 2010) deployed in the study.

3.9.3 Rigour

The strategies I employed to enhance the validity, dependability and authenticity of this study were that all interviews were conducted and transcribed by myself, and no one else was involved in any of the transcribing. To capture my experience as researcher I kept comprehensive reflective notes, a research log and had regular supervision, both within a group and as an individual, with the aim to have a focus on reflexivity

Table 20 Stages and layers of thematic analysis

Description of the process		
Stages	**Layers**	**Process**
1. Familiarising yourself with your data	• reading and listening to transcripts • noting reactions to both	• transcribing data from handwritten accounts • reading and re-reading data • discussing and taking notes in individual and group reflective case discussions
2. Generating initial codes	• identifying important concepts • taking note of detail within the data as well as emerging themes	• creating a set of 20 questions based on my initial research questions • matching relevant data from each data set to each question
3. Searching for themes	• identifying a case narrative	• coding each section of matched data for each question and each young person • writing a short summary of the main themes
4. Reviewing themes	• involving supervision and looking again at Stage 3	• collating key aspects of the main points and conclusions from each question for case narrative • collating these as four core domains.
5. Defining and naming themes	• defining four core domains with core findings • looking at the commonalities within the domains to define findings	• compiling each case narrative using the themes identified at Stage 4 • generating clear definitions and names for each domain • analysing each of the finished case narratives to arrive at overarching themes

Table 20 Stages and layers of thematic analysis continued

6. Producing the report	• layering the raw data • co-construction at all stages analysing the case narrative to understand the experience related to the role of the nurse	• using the findings section and writing and re-writing to further refine the themes

Whilst Braun and Clarke (2006) define the phases of thematic analysis in numerical order, I found myself having much more fluidity between the stages, and the data took me frequently between phases 1 and 5. This process became very absorbing initially and then in the later stages of analysis I was able to move to a narrow focus on key themes using the data to support my findings.

3.9.4 The layers in the stages

I have tried to summarise the phases and my actions as suggested by the Braun and Clarke model (Braun and Clarke 2006). However, it is important to emphasise that this process was not as staged as the model suggested, as phases 1-3 were interchangeable and repeated many times through an iterative process. The duration of phases 1-5 took two years and was a repetitive and constant cycle. At phases 4-5, whilst there were obvious and clear findings, it was also the case that myself and supervisors had agreed that we had totally submerged into every aspect that could be found by us at the time and had somewhat exhausted all lines of enquiry and questioning of the data, as well as recounting and retelling both the case narratives and all of the components therein. Detailed narrative pictures had been crafted on each young person and the overall thinking and analysis thoroughly tested in supervision with both, individual and within the seminar group. The following gives an illustration of the process, whilst not trying to distract from the rigour and respective nature of the analysis.

During Phase 1, I submerged myself in the data by reading and transcribing alongside recording my own feelings and responses in relation to the transcription. I also included my own research log and observations before and after the interviews and complied a research diary. I had the opportunity whilst I was doing this to take some of the data into group seminars and individual

supervisions. I also recorded and transcribed the data generated from supervision and seminars and included this in my overall thinking, which added another dynamic to thinking about the data. This formed a tabled matrix of codes and themes which is detailed in table 21.

Table 21 Code Matrix:

	Domains				
Domain Theme	**The Young Person**	**The Nurse**	**The Relationship**	**The System**	**Meta Themes**
Maternal Representation	Identification /Idealization	Represents the maternal	Functions as a maternal reference	Maternal representation in the system	Loss Missing Advocacy Empathy
Advocacy	Young people feel advocated for by the nurse	Can advocate for young people	Has an advocacy remit	Professional advocacy within system around health and wellbeing	Loss Missing Advocacy Empathy
Empathy	Experiences empathy	Is empathetic	Empathy based relationship	Empathy Based care	Maternal Missing Advocacy Loss
Loss	Trajectory of Loss across life span	Loss as a part of core nursing	Allows loss to be named	The Nurse role attends to the loss and grief	Maternal Missing Advocacy
Missing	Parts of self and identity are missing	Seeing the missing parts	Fills some of the missing aspects and voids	Nurse aspect is missing from the system- but on the edge/periphery	Maternal Loss

In Phase 2 I found myself looking back on my main research questions and trying to find data to support thinking about some of the responses. This generated another layer of asking additional questions of the data, creating sub-questions to my main research questions. I then reviewed all the data line by line with the key questions in mind and later, the development of themes.

In Phase 3 I considered and contemplated the data continuously, and it became apparent that there were key themes in each interview that connected all the interviews. Underneath this there was the individual deeper more subtle findings.

In phases 4 and 5 it became obvious to me and my supervisors that there were very clear findings that were easy to identify and translate. It became important to set out each young person's experience as these have become case narratives, to which there is a dedicated chapter. From the case narratives a four-domain framework emerges: the young people, the nurse, the relationship and the system. This is used to set out the core findings and then progresses in the next chapter to form an evolved discussion of the main findings.

Utilising this layered approach afforded me a position where I had broad themes that related to all the young people whilst maintaining a powerful narrative for each of them. Due to this factor and my personal aim within this thesis to make the voices Looked After Children and Care Leavers heard, I decided I would also create a learning narrative for each young person and my plan or hope for how I might take this forward is part of my dissemination of findings.

Finally, I treated Phase 6 a more fluid process than producing a report, and even many drafts in I found myself returning to the raw data and coding stage and re-evaluating my initial analysis.

Table 22 Application of the process construct table

Key concepts	Themes	Sub-themes	Synthesis
Derived from the data analysis: what the young people talked about most and had in common	The overarching heading that related to the key concepts	The phenomena within the themes derived from both the theme and the key concepts	Bring together: • key concepts • themes • sub-themes • case characteristics • case narrative experts …to form a **finding**.

3.10 Reflections on the method

The interaction between two people is important to consider, particularly within the FANI methodology, where the research environment is co-constructed. Paying attention to the unconscious processes that were taking place seemed very important, yet quite overwhelming in this research. It became important to write down what had taken place within the interview, including feelings and things I couldn't work out. This added to the richness of the data and could be drawn on in supervision. Trying to decipher the transference and countertransference that occurred and how it manifested itself allowed a deeper level of analysis from the data. Trying to balance this with being objective was important for me as the researcher and trying to understand all the material whilst reflecting on my own emotional and counter transference responses to the material enabled me to explore what was being communicated within the relationship, which was my primary research question.

The writing up was difficult on many levels, not least because the young people lived on in my mind and my experience long after I had met them. The emotional impact of what they told me lived and continues to live with me as a person and professional. Whilst I was writing and with every direct quote, I

could visualise the young people and often wondered about them, where they were, what they were doing and how they were getting on.

Their existence seemed to live on through the writing as much as if they were characters in a story, however this was not a work of fiction but a narrative of their real lives and experience and with that comes a responsibility that often put me in a position of not knowing how to convey the power of the message from the data in a way that did not dilute what they had shared. The whole process of researching and writing really made me reconsider my position on what nursing is. When I started nursing, I thought the key areas I needed to know about were biology, anatomy, pharmacology and the patterns of illness and disease. I now know nursing in my specialist field is comprised of psychology, art, ethics, empathy and kindness.

3.11 Summary

Conducting the research using the methodology I chose presented some challenges. My first area of concern was how valid my findings would be within such a qualitative and small study, particularly within the context of currently favoured health research. Also, the very individual narratives that the young people offered me gave a richness to the data to be analysed, and I was concerned that this depth and richness would be lost if I was to follow an overall 'key themes' presentation in the findings. I found the FANI method to be very flexible when conducting the research, but I found it challenging at times, especially when dealing with the volume of data generated.

3.12 Thesis Structure

As discussed in the previous section, the nature of the research, data collection and analysis were multifaceted and resulted in a considerable amount of data.

In order to best present the findings and remain in keeping with the FANI method, keeping the whole picture this thesis structured as four findings-chapters and that which discuss the themes and findings, was essential. Chapter 4 introduces the young people, discussing their characteristics and initial thoughts about their narratives. Chapter 5 presents a more in-depth discussion and subsequent findings about the young person's narratives which are presented as case narratives. There is a findings-chapter per domain as to do justice to the data findings. Chapter 6 sets out the commonalties in the young people's experience and case narratives and presents them as four domain-findings, the young people, the nurse, the relationship and the system. Chapter 7 is the culmination of the analysis of chapters 4-6 which lead to the key findings of the study drawing on all the previous discussion, data analysis and findings

Chapter 4: Everything changed when I was 13 The Young People

4.1 Introduction

In this chapter I introduce the young people who took part in the research, as a group and individually. I start by outlining their characteristics and move on to give a summary which introduces each of them. As I would like to introduce them as children and young people and not just data, I have given a condensed case, as the focus of this thesis is the narrative given to me by the respondents. I felt it important to do this before I embarked on the initial analysis and more in-depth findings.

As the focus of my research and intention was always to have the voice of Looked After Children and Care Leavers heard, I have decided to construct this thesis in a way that introduces the impact the young people's powerful narrative had at the time of the research and write up, and then the subsequent analysis from this point. I would like the reader to hold the young person in mind as I attempt to articulate and represent their stories as findings in subsequent chapters, and then move to the more complex task of the meaning and analysis I have drawn out of the initial findings.

4.2 Profiles and data

All the young people were Looked After Children's and Care Leavers who were looked after by the same inner London Local Authority (LA). Table 23 outlines the case characteristics, and I have given each young persona pseudonym. This is for ease of writing, and because it felt important to relate to the young people with a name.

Table 23 The young people: profiles and data

Pseudonym	Age	Gender	Ethnicity	Care status
Dinar	18	Male	Afghani	CL
Isla	19	Female	Filipino	CL
Luna	24	Female	Filipino	CL
Fleur	14	Female	Black/British	LAC
Narisa	16	Female	Black/African	LAC
JT	14	Male	White/British	LAC

4.3 Data summary

The group of respondents was made up of:

- two males and four females
- three Looked After Children and Care Leavers.

The age range of participants was 14 to 24

This group does not reflect the profile of the Looked After Children and Care Leavers population of the LA in terms of age, gender and ethnicity. However, the young people were volunteers who came forward and as such, I chose to proceed with the research rather than wait for a sample group that best reflected the population of the LA. Also, the emphasis of this thesis is on trying to understand experiences and relationships rather than demographic data or epidemiological factors. I didn't think I needed a reflective population sample group to answer my research questions. All the young people spoke fluent English, although for two of the respondents English was their second language. There were no communication difficulties in undertaking the interviews.

4.4 Presenting the young people

4.4.1 Dinar: a misplaced and displaced unaccompanied asylum-seeking minor

Dinar is an 18-year-old Care Leaver who first came to be looked after as an unaccompanied asylum-seeking minor. Dinar fled war-torn Afghanistan when he was 15. Dinar's mother passed away when he was 6 years old and it is believed that his father was also killed in Afghanistan. Dinar spoke very eloquently throughout both his interviews about his experiences of war and his passage to England. Dinar is a very talented artist and used creative materials in the interviews as well as sending me separate pieces.

4.4.2 Isla: a bubbly, happy young woman

Isla is a 19-year-old Care Leaver who has been looked after since the age of 4 along with her sibling group. Isla is the middle child of a sibling group of five. Isla has experienced multiple placement breakdowns during her time in care. Isla is currently in higher education undertaking a vocational qualification.

4.4.3 Luna: a calm, quiet and gentle young woman

Luna is a 24-year-old Care Leaver and was a Looked After Child from the age of 8. Luna is an only child and her mother passed away in 2000. Luna doesn't know her father. Luna spoke very little about her social care history during the interview. She is currently a social worker in a children social care department.

4.4.4 Fleur: a troubled, feisty yet fragile young woman

Fleur is a 14-year-old Looked After Child who has been known to social care since the age of 8. Fleur has two half siblings who are also Looked After Children. Fleur frequently goes missing from care and has experienced multiple placement breakdowns. Fleur is currently attending secondary school, albeit

with sporadic attendance. Fleur spoke extensively about her experience of being looked after and attending statutory services.

4.4.5 Narisa: a resilient, positive and quietly powerful young woman

Narisa at the time of interview was 15 years old. Narisa is originally from a West African country and arrived in the UK aged 14 as an unaccompanied asylum-seeking minor. Narisa is currently attending secondary school and hopes to pursue higher education. Narisa spoke movingly about her experiences of working with the nursing team in relation to her experiences of female genital mutilation (FGM).

4.4.6 JT: resilience and fragility personified

JT is a 14-year-old Looked After Child. JT has experienced mental health challenges from an early age and has experienced care in a variety of placements, including mental health settings. JT's mother passed away when he was 12. JT talks extensively about his experience of the health system and the looked-after system.

4.5 Case characteristics

As part of the analysis I have tried to get some sense of the characteristics and themes that were talked about by all the young people, or issues which featured heavily in their stories. I have thought of these in terms of stressors. I found charting these (see Table 24) gave me a sense of the challenging experiences or environments the young people had experienced. I then looked for positive or protective factors (see Table 25) that were part of each young person's experience or were talked about in the data by all of them. I then aggregated and scored the two lists. I found this gave me a useful way to interpret some of

the commonalities between the young people, and it also represented the data in a form that allowed me to develop a framework for thinking and moving forward with the analysis.

Table 24 Case characteristics

Case characteristics	Dinar	Isla	Luna	Fleur	Narisa	JT	Total
Absent mother	1	1	1	1	1	1	**6**
More than three changes in placement/care	1	1	1	1	1	1	**6**
Death off a parent; mother	1	1	1	-	1	1	**5**
Residential care case	1	1	1	1	-	1	**5**
Separated from siblings	1	-	1	1	1	-	**4**
Temporary accommodation or homelessness	1	-	1	1	-	1	**4**
Neglect	1	-	1	1	-	1	**4**
Psychological or emotional abuse	1	-	1	1	-	1	**4**
Ethnic minority group	1	-	1	1	1	-	**4**
Going missing	1	-	-	1	1	1	**4**
Death of father	1	1	1	-	-	-	**3**
Mental health	1	-	-	1	-	1	**3**
Physical abuse	1	-	1	1	-	-	**3**
Other services involved	1	-	-	1	-	1	**3**
Refusal to attend CAMHS	1	-	1	1	-	-	**3**
Criminality/offending	1	-	-	1	-	1	**3**
Child sexual exploitation	1	-	-	1	-	-	**2**
Death of a significant person	1	-	1	-	-	-	**2**
Perceived manipulation or deception (by SW)	-	-	-	1	-	1	**2**

Table 24 Case characteristics continued							
Case characteristics	**Dinar**	**Isla**	**Luna**	**Fleur**	**Narisa**	**JT**	**Total**
Active court involvement: offending	1	-	-	1	-	-	**2**
Home office involvement	1	-	-	-	1	-	**2**
Sexual Exploitation	1	-	-	1	-	-	**2**
Self-harm/suicide	-	-	1	-	-	1	**2**
Co-existence of mental ill health, family violence, substance misuse	-	-	1	-	-	1	**2**
Violence and/or aggression	-	-	-	1	-	1	**2**
Post traumatic memory	1	-	-	-	1	-	**2**
History of parents in care	-	-	-	-	-	1	**1**
Parent with history of childhood maltreatment or neglect	-	-	1	-	-	-	**1**
Violence/aggression towards SW	-	-	-	1	-	-	**1**
Domestic violence or abuse in childhood- witnessed	-	-	1	-	-	-	**1**
Trafficking	1	-	-	-	-	-	**1**
Gang affiliation	1	-	-	-	-	-	**1**
Home Office involvement	1	-	-	-	1	-	**3**
Aggregated factors each young person	25	5	17	20	9	17	

Table 25 Positive or protective factors, aggregated from analysis and themes

Factor	Dinar	Isla	Luna	Fleur	Narisa	JT	Total
Articulated a positive response to the research	1	1	1	1	1	1	**6**
Contact by young person post-research	1	1	1	1	1	1	**6**
Sense of supportive relationship with social care	1	1	1	1	1	1	**6**
Enduring relationship with LAC nurse	1	1	1	1	1	-	**5**
In education training or employment	-	1	-	-	1	-	**2**
Attending CAMHS or other mental health support	-	1	-	-	-	1	**2**
Significant relationship with foster carer	-	-	-	-	1	-	**1**
Consistency relationship with social worker	-	-	-	-	-	-	**0**
Aggregated factors for each young person	4	6	4	4	6	4	

Whilst the scores are not reflective of the level of stress or impact from any one event, tables 24 and 25 provide a sense of the totality of challenging experiences encountered by the young people and the experiences of something good that can be drawn upon.

I didn't find any data relating to addiction or substance misuse, learning difficulties or disabilities or sexual abuse. Whilst no data were found during the research, these cannot be excluded from the possible life experiences of the young people – only that they didn't disclose or acknowledge them as part of during the interviews. There is a possibility that this was a hidden narrative that I didn't find evidence for.

4.6 Summary

This chapter has set out an introduction to the respondents in a way in which I hope can be thought about throughout the thesis and as I progress to examine and discuss the key findings. I have also attempted to document and chart a framework for thinking about experiences. This might be helpful when conducting interviews or assessments, by assessing case characteristics against protecting factors.

Chapter 5: Yes it's a conversation, it's a chat The Case Narratives

5.1 Introduction

In all research there is a question of how to present and represent the data and begin to demonstrate the findings. Within this research there was the added pressure to communicate the findings in a way that reflected the voice and experience of the young people who took part, and which did not take away from or dilute the essence of their experience. What emerged from the interviews was some very powerful and emotive narratives that gave an insight into their experience, not just of nursing but of the care system and the networks around them. In all cases, life experience and care history were also spoken about, some more in depth than others.

I struggled to confine to a piece of writing how the data could be used in its entirety, and to also confine myself to the themes. It seemed unethical and neglectful of me as researcher and writer to leave out any of the narratives of any of the young people. Therefore, after much careful thought and supervision, in this chapter I present each young person's case narrative. I have defined them as case narratives as they are what the young people told me during their interviews, and a narrative recording and interpretation of what they have chosen to say. This differs from a classic case study, as I had no other supplementary information from statutory agencies to cross reference what was presented in the interviews.

By taking this approach and taking each young person's narrative, my discussion is based on a description of their emerging story, an analytical

reflection, dominant emotional themes and then the dynamics that shaped the analysis of the themes that emerged.

5.2 Dinar: surviving war, loss, injustice

A child victim of the war, displaced in his country, childhood and life

> I have always been missing or without.
>
> Dinar, Interview 2

Dinar was born in Afghanistan in the late 1990s, although he's unspecific about his exact date of birth. At the time of the interviews, Dinar tells me that he is 19 years old. Dinar spoke very little about his early history or family, other than to tell me that his father was in the local police and held a position of high command. He tells me later in his interviews that he has a brother and a sister but is unspecific about their ages.

Dinar lived in Afghanistan with his parents and siblings. Dinar's employment enabled them family to maintain a comfortable lifestyle and gave Dinar the opportunity to attend education.

Because of the war and personal tragedy, Dinar fled Afghanistan. His passage was initially assisted by friends and family associates. Dinar was then trafficked across several countries, although his exact journey is somewhat unknown to me as the researcher.

5.2.1 Dinar's case narrative

Dinar arrived in England somewhere along the Kent coast. He described being found on a beach and taken to hospital. He then goes through the process of Home Office assessment as an unaccompanied asylum-seeking minor and the age assessment process to verify his age. Dinar describes his life before coming to the UK only briefly and in snippets, where glimpses of happiness in childhood are intermingled with scenes of violence, death and destruction. Dinar

depicts his initial experience in England in a very positive way and tries to rebuild his life, focusing on becoming an artist. He was supported in this by his then social worker and talks very warmly of his relationship with her. Tragedy strikes when Dinar's social worker dies very suddenly after a short illness. Already experienced in losing family and friends, Dinar now finds himself losing his social worker too. Dinar was initially placed within a foster family and then in a semi-independent unit. When I first interviewed Dinar he was living in independent accommodation, part-funded by social care. Between my first and second interview Dinar was detained in custody; he lost his leave to remain in England and was awaiting deportation to Afghanistan.

At the start of the unrest in Afghanistan Dinar's family circumstances changed drastically. Dinar describes how everything changed when he was 13; he was forced to grow up quickly and see things a child should never see. Dinar describes graphically watching their family home being blown up and discovering his mother's foot amongst the debris, amongst other images of people burnt to death. Dinar is almost back in the moment reliving the memory as he describes this to me in the interview, even describing the smell around him. Dinar was taken during this incident by a male and they fled for their lives. Dinar was taken to the outskirts of a town in Afghanistan to his aunt's house, where he describes not feeling any emotional warmth despite his recent bereavement, separation and trauma.

With the assistance of what Dinar describes as his father's friends, he managed to make his passage to the UK. For a few years, he was not aware of the fate of the rest of his family, but believed his father was dead. However, Dinar later discovered that his brother was alive in Germany. Because of the instability in the region, his relatives encouraged him to escape to Europe and

begin a new life. Dinar makes many references throughout his interviews to his struggle and the things that he finds difficult, yet there is a hidden and underlying resilience to him and the way in which he has learned to manage his feelings. Dinar poignantly states that he has created many versions of the truth in his head just so he can live with what's happened.

5.2.2 Dominant emotional themes

Dinar's narrative is incredibly powerful, poignant and sad. The centrality of loss and hope is the dominant discourse in Dinar's interview.

What unfolds from the interviews is a compelling depiction of the impact of war on a child, and his forced removal from his home country and his struggle with all he has experienced. Throughout his interview there is a profound and deep sense of distress and pain.

His opening sentences introduce the listener to his family and the tragedy unfolds and very quickly. I am left considering the following:

> Everything changed when I was 13… back at home suddenly I was no longer a child. There was this pressure to be grown up; some of the things I saw made you grow up fast. I remember the day, it was sunny… a load of kids was flying kites and there was this red one high above the others… I wanted to fly my kite too, but couldn't I be a child anymore, I had to be a grown up.
>
> Dinar, Interview 2

Dinar begins with a very brief picture of a happy childhood that suddenly changed as he turned 13. There is something very poignant about Dinar turning 13: on the cusp of adolescence and transition in his life, when he is plunged into a tragic and terrifying situation where everything he knows and is familiar with changes and collapses around him. The adults that have dominated his life are missing or dead. Throughout the interview his living family is lost. From such early experiences, you can see how it is possible for Dinar's internal world to be

in turmoil, with not only loss and bereavement but possible guilt as he survived that day in Afghanistan. I gain valuable insight into his world when he recalls his time at his aunt's house, where he describes:

> Physically and emotionally there is no warmth.
>
> Dinar, Interview 1

At this point in the interview Dinar seemed to lose all sense of time and place and doesn't recall or talk in any great depth about his transit from Afghanistan to the UK. What Dinar does disclose about his journey to the UK is his being mistreated and by the people that were meant to be helping him:

> Even my freedom fighters were not so moral. They had their own agenda, their own price and reward.
>
> Dinar, Interview 1

In Dinar's account there is a deep sense of mistrust in people, as it turns out the adults that were helping him were traffickers. Due to one act of what Dinar depicts as kindness, his traffickers let him go, and it is only when he is on a beach in England that Dinar is told he was meant to be sold. Throughout Dinar's life he has regularly lost everything. In his story of arriving to safety, the only thing he had left was a piece of red material that he carried in his pocket, which seemed to become a symbol of hope and survival. In his first interview, Dinar describes how a nurse helped him when he woke up in hospital, and at the end of his interview he also describes how a nurse helped him to feel free. What was striking to me was the a distinct lack of any female influence throughout Dinar's life, and of the ones that he does mention – namely his mother – he witnesses die in the most brutal and graphic violent scene. His female social worker also dies, and it must appear on some level to Dinar that forming relationships leads to loss. Yet Dinar makes little mention of his mother or his social worker.

The level of grief and loss Dinar experiences is overwhelming. I struggled to think of any questions, or answers, to put to the data and I think this comes from the resonance of Dinar's experience of not being able to find a place to call home. There is a projection of absolute hopelessness and desperation and I was left with a troubling image of the 13-year-old boy for a long time.

5.2.3 Unfathomable depths of loss

I can only describe the depth of Dinar's loss as unfathomable. I was left feeling inadequate and powerless during the interview: the pain that was being communicated was almost too difficult to bear. I found myself trying to distance myself and think about the methodology as a way of defending against my own feelings of disbelief. I wondered how anybody – let alone a 13-year-old – could live through such tragic events, and wanted in some way to rush in and take the pain away. This resonated even stronger with my position as a nurse and researcher, and I thought about the position of nursing in society and particularly with Looked After Children for whom the biggest task is to alleviate pain and make situations better. These feelings presented themselves in several ways during the process, ranging from a complete numbness and inability to think about the material and data and a struggle to translate or describe it, to the other end of the spectrum, where all I could think and write about was loss. I got lost myself in the process, and this may have been a reflection on how lost Dinar has been thought his life: not being able to get past the feeling of utter loneliness, and been stuck in this position. Supervision helped move the thinking along however, and I am sure some of this related to how alone Dinar was throughout his early adolescence.

5.2.4 Injustice and alone

As I started to prepare for the second interview, I found out that Dinar was in jail. Whilst I did not know and still do not know the full circumstances for his incarceration, I believe it was to do with Dinar losing his unconditional leave to remain in the country.

To undertake the interview, I had to get special dispensation from the prison governor, and on meeting Dinar I found a very different young person: sad and thoroughly dejected. Throughout the interview I felt extremely helpless and hopeless; it was almost unbearable to see and experience Dinar's vulnerability in this setting. Dinar spent most of the interview telling me that it was not fair that he was there, and this seemed to resonate with his life narrative; how he was a victim of unjust acts and circumstances that were completely beyond his control. Dinar also placed great importance on asking if I had received the artwork that he sent me. I tried to think of some way in which I could help him and his situation. This state of mind was so intense I found it difficult to leave Dinar and only did leave after the intervention of one of the prison officers – something that is out of character for me as a nurse.

This may well indicate projective identification, which is the unconscious processes whereby vulnerable, difficult or defensive feelings can be defined by an individual and attributed to another, who then, because of the experience, has his own feelings (Bion, 1962). The artwork that Dinar referred to was of great value to him. I later found out that he carried his artwork around with him just in case he was to be picked up by the Home Office and deported. This was a real fear that Dinar had, and in leaving his artwork with me he was somehow leaving it in a safe place. I think he held the view that his life was worthless and

that he could easily be taken or killed, and the reality for him was there is no way out the situation, stuck in a cycle of constant loss.

When I look back over the interview data, the discourse and the narrative is fragmented, disturbed and disjointed. There are whole sections of Dinar's life not referred to and, in some ways, this is reflected in the content of what he has to say. Dinar only includes his early history and family life very briefly. The more he went through his adolescence and being in different places and being displaced in different countries where he was rejected and moved on since has been reflected in his language, and so towards the end of the interviews I had no sense of his real story, and what I do have seems to make no sense to me, other than his loss.

5.2.5 Missing

In terms of being 'missing' the whole beginning section of Dinar's life is missing, and not part of a chronology within the interview data at all. Dinar starts life within the research at 13-year-old. Dinar opens his interviews by telling me immediately about his history, and he clearly had an idea of what he wanted to tell me:

> It's about my history I suppose, innit. Thing is, there's the history I tell official people, the history I tell my friends says I'm not a social outcast and then there's the history that is hard to talk about, the real one that is the true one.
>
> Dinar, Interview 1

Immediately there is a sense of Dinar feeling compelled to tell different versions of his history, and I wondered about different versions of himself. Whilst this was a very powerful statement to open the interview with, I was intrigued, as already I had a glimpse of something going on in Dinar's experience that needed to be communicated. There was a sense at this point that Dinar felt

comfortable enough to tell me the truth and what was his real experience was. I wondered what this was based on, as I would have imagined that his experience of being an unaccompanied minor might have led him to be mistrusting of official figures or professionals. Dinar tells me very quickly the answer to this question:

> I was sitting on a rock just looking up and there it was: my world had changed, boom. The first of many explosions. There was dust everywhere, red dust, people running screaming. I walked home, bumping into people running away from me; it didn't enter my head to wonder why they were all going the other way. I turned a corner and just stood still, it was like I knew the place, but I didn't, it took a few minutes to realise the rubble on the floor was my house. I think I saw a foot sticking out of the rubble. I just stared and then someone grabbed me by my collar and stared to run.
>
> Dinar, Interview 1

The statement felt overwhelmingly painful at the time and I had the sense that Dinar was back in that place in his mind. As he was talking to me he was describing sights, smells and sounds and it was at this point in the interview I started to think about the research process and its ability to get to the real parts of human experience. I felt a strong sense of duty and obligation to tell these young people's life narratives as genuinely as I possibly could and in a way that would promote understanding and support rather than judgement and annoyance – particularly, today where there are many mixed views about supporting unaccompanied asylum-seeking minors, even within health and social care there are divisions of opinion.

> I was left with nothing, no parents, no family, no possessions – just what I carried in my pocket.
>
> Dinar, Interview 1

Dinars' quote is an insight into Dinar's life and how he feels. Being left with nothing Dinar, works hard throughout his time in the UK to create some sense of identity and belonging and understand his experiences. Through both what he tells me and his artwork, he communicates something I powerfully hear about people not talking to him about his experiences or losses, of communicating their condolences and sympathy or empathy whether this be by words or action. I was immediately drawn to Dinar and quite overwhelmed by his powerful experiences of bereavement and being both misplaced and displaced in society, and how caught up he was within the sometimes very unjust system. Dinar also talks about the nurse making time and protected space for him in which he felt able to talk. I explore later this being a common theme with all the respondents, and how simple and easily implemented strategies can set out the basis for a relationship based on trust and feeling safe.

> I think sometimes I am mad. I have invented so many versions of this just so as I can live with it. I tell officials what they want to know: times, places. Like, they try to trip you up. So I tell them facts, so I don't get upset. You know one report said I was clearly making it up as I showed no emotion to what I was saying. Just trying to protect my mind**.**
>
> Dinar, Interview 1

There was something very powerful about this statement, that made me think about resilience and how trusting a young person must have to be to share their most painful memories and experiences with anybody. It was at this point that I started to think about the privileged position of nurses working in social care, in which they can just be there for children and young people without the pressure and relentless focus on tasks that seems to be dominate the lives of children's social workers in the UK.

Dinar's experience of loss and bereavement is further exacerbated when his social worker dies very suddenly following a short illness. Dinar doesn't say much about this, even though he said he had a very good relationship with his social worker and misses her very much – it was almost as if he was just telling me about a sad unfortunate incident. I am left wondering how much Dinar is able to internalise around bereavement and loss and what his defensive and projected functions were. Dinar had already told me that he creates different versions of things to protect his mind, and I wondered at this point if he had ever had the opportunity to grieve.

In Dinar's words "you hold onto my thoughts" was both a communication about his wishes but also an intention or desire for someone to help him with the feelings and memories he is struggling to remember, hold onto or deal with himself. I wondered if this very difficult task that Dinar was trying to live through was partly helped by the idea that someone else could just hold onto the strands of his experience. Following my first interview with Dinar was an incident of which I cannot be sure about the detail, but that led to Dinar losing his leave to remain in this country as he was sent to prison to await appeal.

I undertook Dinar's second interview in a London prison. I had special dispensation from the prison governor to take in a recording device, a pen and a notebook. Seeing Dinar incarcerated was a testing experience and was further compounded by Dinar being very depressed and sad. Dinar had a very strong sense of injustice about being in prison and felt strongly that he should not be there. I quite agreed even though I didn't have the precise details about how this had come to be.

5.2.6 Hope and being left with something good

Dinar referred to a piece of artwork he had sent me, stating that "it was important I got it". I felt that this was meant both in the physical sense that I had his drawing, but I felt it was a reflection, or deeper communication from him, that I understood his story and what he was trying to convey. The meaning I attach to this later in the findings is the significance of the holding relationship the respondents articulated they had with the nurses, and how this enables and strengthens their sense of identity and understanding about both history and emotional states.

5.2.7 Dynamics that shaped the analysis

There is a real sense throughout the second interview of Dinar feeling that he has no choice in his destiny and being marginalised in society, left to fend for himself. There is a point in the second interview where Dinar looks utterly desolate, crestfallen and I myself feel heartbroken. All too soon the second interview must end as my visiting time is over, and I leave the prison feeling very sad and tearful. Some weeks after my second interview my then social care colleagues told me that Dinar had been deported as he had lost his leave to remain. I also find that Dinar has left me all his artwork. Whilst overwhelmed with sadness I felt even more strongly I needed to represent Dinar's story truthfully, powerfully and honestly, as parts of his interviews read like the novel *The Lightless Sky* (Passarly, 2015).

I also felt a responsibility to try to represent the data in a meaningful way, that could create the possibility of change within health and social care at very difficult times. I had a very strong sense that Dinar would not live very long in his home country of Afghanistan, as he was returning to a country still at war where his family were all killed as part of the ongoing conflict. I felt that Dinar

too would be at risk. For a very long time I tried to find out if Dinar was safe and I felt stuck with and unable to tell his story and unsure of what to do with his artwork. In January 2017 I received an email from Dinar letting me know that he was alive and well and living in Germany. Dinar's story is one of loss and bereavement, but it is also one of hope and survival. I feel privileged to have known Dinar as a researcher. I have since been able to return his artwork to him. This specific way of staying in touch with Dinar's experience made me think how the role of nurses can sometimes be as a custodian of children's care. This was the first point in the research where I felt less anxious about the nurses being a maternal object for Looked After Children and Care Leavers.

5.3 Isla: surviving and thriving overcoming multiple placement breakdowns

A bubbly chatty young person with a resilient and warm personality

> I know the LAC nurse can't be a mother to all these LAC kids, but it's like they give off this like thing that you know they would be quite motherly and sometimes that's all you need to know.
>
> Isla, Interview 2

Isla is a 19-year-old CL who has been looked-after since the age of 4. She is the middle child of a sibling group of five. Isla experienced multiple placement breakdowns during her time in care. At the time of interviews, she was attending higher education undertaking a vocational qualification.

Isla was a very bubbly and happy young person. Throughout the interviews she talked very fast without pause, leaving little room for me to comment. It felt like she had a purpose with her interviews, and that was to get her opinions across. Isla put boundaries around the time and finished when she felt she'd had enough – I thought this was at the point where I was just

beginning to get a sense of her and making associations with her experience of being in care, which I think she found quite difficult to hear. I surmised that some of the fast pace was a cover for keeping from talking about more difficult experiences.

5.3.1 Isla's case narrative

Unlike many of the other young people, Isla spoke very little about any of her early life at all, apart from to tell me she had experienced multiple placement breakdowns.

Isla didn't offer any narrative about her early life or experiences and her dominant discourse throughout her interview was that of everything being fine now, and of how wonderful the nurses were. Yet, there was a veneer that I seemed to appreciate was emerging and this mainly positive narrative was defensive, as whenever we touched on any of her more challenging emotions, I was quickly shut down as Isla would move onto the next subject.

Isla approached her narrative with an almost humorous appreciation of how the nurses worked with her:

> I was sitting on the wall outside my placement and the nurse text me and it just said 'move your bum, it will get cold sitting on that wall'… I just burst out laughing and went inside but looking back on it now and like, thinking with you about it, that was like a message to me that she cared but that I needed to change my behaviour
>
> Isla, Interview 2

Whilst this was also humorous at the time of the interview, I was left with the image of a vulnerable girl literally out alone in the cold. Isla spoke very movingly about her relationship with the LAC nurse and described it in an idealised way, but not in a way that she could attach an identity or role too. Some of this may

be attributed to how little is known by Isla about her early life experience and the availability of adult role models or influences.

It was at this point in the research I started to think about the internalised, idealised maternal object and how strongly Looked After Children and Care Leavers must be drawn to LAC nurses, given the gaps in their experiences of warmth and emotion support. This then asks a question of the nurse's emotional capacity: fulfilling this void in the young person's experience is communicated unconsciously in the relationship. This leads on to thinking about how the nurses deal with this maternal transference and what the implications are for this in the longer term. I consider this further in the next chapter, as this phenomenon was common across all the data.

5.3.2 Dominant emotional themes: consolation

> I think the nurse has been the only consistent adult… professional in my life actually. Because it's when I moved into care to now, I'm a care leaver and like we are still in contact. I've had x amount social workers – I've counted 11 to 13. I try to keep track, so I think it's 13. Erm… erm yeah… and I think the nurse is the only consistent person.
>
> Isla interview 1

In addition to consistency and emotional availability, there is something deeper that Isla describes:

> I think that word you said I said its maybe what I was trying to say about the nurse. [It] wasn't consolation, it was… I felt consoled by the nurse. I learned the meaning of that in uni this week and it best describes the nurse. I felt consoled by her being there… I knew I had lost a lot of things in my life and she made me feel consoled, like it's not okay to lose something but I understand your grief.
>
> Isla interview 1

Islas' quote was very powerful at the time, and I am still struck by the resonance it provokes again. On reading, there is a strong unconscious emotional dynamic

that gets played out in the relationship between Looked After Children and Care Leavers and their nurses and whilst I will apply more thinking to this later in the thesis, this was the most powerful description I would find and it describes many levels of emotion and connection. There is a profound and deep sense of loss on a level that is experienced rather than known in the conventional sense, Isla did not say at any point that she felt she had lost certain aspects of her childhood and key parental figures, but there is a striking acknowledgement of the need to be consoled for something, as lots of things had been lost and the nurses provided a consoling, comforting function. Isla also uses the word grief, and this came at the very end of her sentence before she quickly moved on to another subject. It was difficult to pick this up in the interview and respond but I was overwhelmed by the feeling at the time. It showed that there were aspects of Isla being really in touch with the notion of grief, yet it was fleeting and barely able to be thought about.

> I've lost so many people in my life. Friends, carers, social workers. That would really hurt if you thought about it.
>
> Isla, Interview 2

Isla finished the first interview abruptly, saying that she had another appointment and I wondered if this was the case, or if the experience had somehow become uncomfortable for her. Yet her closing statement was:

> The nurse was always there for me; she never gave up on me.
>
> Isla interview 1

There was an urgency about Isla's need to leave and I felt this was appropriate for her, yet I was also concerned that she may not want to have the second interview, despite the feeling that she didn't want me to give up on her. I thought about this in supervision and with the assistance of my peers agreed that I was sensing a conflicted state that emanated from some of the feelings and

experiences Isla was describing. It also meant that I kept Isla in mind between interviews.

At the start of her second interview, Isla talked about being lonely and how she had been looking forward to her second interview. She found it embarrassing to admit, but this led the narrative in an interesting direction:

> Well I wanted to see you again because sometimes I get lonely and you seem to somehow know how to touch that bit. I rabbited on and on in the interview to try and make [myself sound] interesting, so you will want to see me again. I did that with the LAC nurse too. It's like I would maybe… not make stuff up, but maybe make out I had things that were health problems [that sounded] bigger than they were.
>
> Isla, Interview 2

This quote speaks of many different emotions and elements of experience, which fitted with Isla's presentation during both interviews, being fast paced and almost every second was filled with Isla's narrative and thoughts, leaving little space for reflection. I thought this was symptomatic of how Isla felt the need to fill the space and not let the quiet, loneliness or isolation creep in. This also bore a striking similarity to the image she left with me of the child alone and out in the cold, as if Isla found some warmth and comfort in the presence of both the LAC nurse and the interview space. I understood at the time of the interview that this was a communication from Isla about how she was feeling and the need for someone to relate to her. This raised the question within the findings of how nurses manage and address this were the nurses always able to think about this kind of communication from a young person?

5.3.3 A safe distance in a relationship

> They are a safe person, it's like they are part of your life but not like totally in all the time, like in your face constantly.
>
> Isla, Interview 2

Isla had articulated many times about feeling safe with the LAC nurses and thinking about this concept led to uncovering some of the aspects that added to that safety, like the idea of safe distance:

> I said last time that the nurse is like a professional friend. It needs to be the nurse because they might touch bits of how you are feeling in a way that makes you feel like you're normal – just being a teenager.
>
> Isla, Interview 2

This suggested that there was something assuring and normalising about the way in which difficult things were spoken about within the relationship, much in the way a patient might be assured in a consultation with a health professional. Yet there was a step beyond this?

> I think the reason I was so fond of the nurse is because although she was, like, motherly, she didn't try to be a mum or pretend to be… it's just like that caring side and caring from a distance and like knowing that you can call her if needed. I think that was so important.
>
> Isla, Interview 2

This brings out the importance of acknowledging that there cannot be another mum, but that the nurse can emulate mum-like qualities that are important:

> I've always regarded it as safe [it] was like a barrier around it, it's like you know the LAC nurse can't be your mum. I am sure some of the kids maybe wanted the nurse to be their mum… facing them as kind and generous, they would not let you come to any harm.
>
> Isla, Interview 2

The concept of harm came across very powerfully in this quote and made me think about the concept of harm and neglect in the early life and experience that Isla knew. I started to conceptualise an idea that was based on what happens when LAC nurses are available to Looked After Children and Care Leavers, what core principles of caring the nurses enact when faced with a patient population who have all experienced, neglect, harm and trauma.

> It's about how ready you are as a person to accept someone caring in your life. If you know about the nurses from like the medical stuff you know they will always try and help. They don't try and harm people.
>
> Isla, Interview 2

5.3.4 Dynamics that shaped the analysis

Isla's interview was the beginning of my starting to think about the associations may have to the nurses in terms of maternal parenting. This broadened into Looked After Children and Care Leavers how they experience parenting in social care and looking at the current model of corporate parenting.

The quality and quantity of the relationship is a factor – just enough to be tolerated, yet enough to be enduring. This was mirrored by the availability of the nurse in the young person's experience and journey though the care system, and Isla defined this very well.

5.4 Luna: the corporate care leaver

A former looked-after child, care leaver and now social worker

> [The nurse visit] was especially meaningful for me because she was able to remember things about me that mattered, and her style, it wasn't 'social worky'.
>
> Luna, Interview 2

5.4.1 Luna's case narrative

Luna is a 24-year-old CL who had been a looked-after child from the age of eight. Luna is an only child and her mother passed away in 2001 and she did not know her father. I am unsure of the circumstances surrounding her mother's death and Luna did not offer any details. Following this Luna spent time with extended family members, and I am unclear whether this was as a placement made by the Local Authority (LA) or not. However, Luna talks about being a Looked-after child and various placements and different careers and the

consistency of the LAC nurses vising her, so I would deduct form this that she had been a looked-after child since her mother's passing. Other than to tell me about various placements Luna doesn't offer anything about her early life or history, other than memories related to either the LAC nurse or social care. Luna is currently a social worker in a children social care department, the same department that accommodated her as a Looked-after child and supported her through leaving care. The interviews brought up a lot for her in thinking about and relating to her experience of social work as a child in receipt of social care and nursing and how this has shaped her role and practice as a child care social worker.

Luna is a calm quiet and friendly young person to interview. The interviews were very reflective, and she seemed able to connect her interview experience with her experience of nursing and social work in a very eloquent. I did observe that Luna didn't tell me much about her early history, parenting or reasons for being taken into care. I had a sense that Luna was a very confident and able social worker, but all her confidence was about her role and her work and I knew little of her personality and values in any of the narrative. On reflection, as the researcher it felt like I was interviewing a professional colleague rather than a Care Leaver.

Luna made me think about how LAC nurses undertake their work and the context in which Looked After Children and Care Leavers see the nurses. Luna is account in both interviews made me think about what is it that nurses do differently, as the beginnings of starting to find evidence to support my initial thoughts around is nursing therapeutic? And what is it that makes this relationship feel that way to Looked After Children and Care Leavers .

5.4.2 Dominant emotional themes: relationships with systems and roles

Initially I thought that Luna's void of narrative relating to her early life and history was since I had invited her to talk about her experiences of LAC nursing in social care, but it became apparent that perhaps there was no early history that Luna was able to access, either because she really couldn't remember, or it served as a defence. Luna was able to immerse herself in her professional identity throughout both interviews relating her experience of the LAC nurses and the care system to be a social worker today. All the examples Luna gave me of her engagement with the nurses was around statutory meetings where the nurse supported her, or the statutory health assessment. There was an inability to see the child and this concerned me as I wondered how in touch a children's social worker could be with children if there were unable to see themselves as the child in their own history and experience.

> I remember this one meeting, I think it was my review. The nurse seemed to be the only one that realised I was still in the room.
>
> Luna, Interview 1

The lowliness of this image and the fact that Luna was identifying herself in this situation felt very painful. Yet Luna appeared to convey this without emotion in a very detached way, almost as if she were telling me about someone else's experience. When promoted further by me Luna gets in touch with her experience, but even this is in a retrospective way.

> I guess when you are in a disruptive situation you are just living it by the day. You are not looking at it, especially in my experience. I didn't realise it was having an ongoing emotional impact on me. I couldn't put that link together until two years later, and it was at one of my meetings with the nurse that I was able to make that link.
>
> Luna, Interview 1

When I tried to explore this with Luna I was quickly shut down and the conversation turned towards professional roles and work.

> Tick box, needs met, procedure, policy. It's how you survive as a social worker, you put limits on your exposure to things.
>
> Luna, Interview 2

I couldn't help but wonder if this was more of a comment about how Luna was experiencing the present in the interview and how she coped with her life experience.

5.4.3 The right time, place and space

Luna offered me much valuable insight into her relationship with the nurse and tangible practical aspects of how they delivered their services and what is was that did that made the foundations for a positive relationship.

> I was in a kinship placement with my uncle, and I remember thinking it was nice they were coming to visit me. When the nurse came, she sat on my bedroom floor. She took her shoes off and felt really at home. I guess her mannerisms and the way she behaved was very laid back, and very easy to speak to, and she really seemed to know what she was talking about. She took things I was saying seriously and she put across her concerns. I didn't feel she pushed me to speak about things I didn't feel comfortable talking about.
>
> Luna, Interview 1

> There are no time limits. They don't have another appointment to go to or someone waiting to see them. They had made time and space to see us in our time.
>
> Luna, Interview 1

The physical environment and how the LAC nurse acted within it was very important in the initial introduction. Luna highlighted that it was not just how something was said, but the taking time, care, listening and confidence. Luna seemed to suggest that this was a different experience of a professional

compared to what she was used to, and it was also very important that another appointment was not present in the mind of the nurse. This type of being present and holding the child in mind at the point of engagement and after resonated strongly with the child part of Luna that she herself seemed to find hard to access or articulate. I was sharply reminded of the maternal role and how easily the nurse portrays this. Luna articulated this point well in the context of her experience and the present in the interview:

> It's because you invited it… you gave the opportunity to think about it… most people wouldn't do that but because I know you're an LAC nurse and because I've had that experience with an LAC nurse it's like you have an imprint for the previous relationship and you transfer it and feel safe in investing your feelings and talking about intimate stuff that you don't often go there.
>
> Luna, Interview 2

The invitation and what's invited in the relationship was a point statement in the context of the research and lead me to look for more examples of this concept and if there were correlations with others experience.

5.4.4 Beyond the professional

When reflecting on Luna's interviews there is a striking, contrasting double image of a young person. On one side I experienced a resilient, high achieving young person, overcoming adverse childhood experience (ACE) to become a competent child care social worker, but on the other side I saw a fragile but tenuous connection to a lost childhood in a young woman who seemed to be stuck and unable to move on from her own corporate parent, but being a the LA's success story, becoming a beacon example of how successful an LA parent can be. There was something very uncomfortable about this dynamic and when I presented this in group supervision my peers became very angry, suggesting that a good parent allowed their children to move on and grow and

develop. In Luna's case she seemed to be very stuck and unable to leave the confines of the LA. This issue made me reflect on what is a place to call home for Looked After Children and Care Leavers and what do they define as home, is it a place a system or a feeling? This developed into thinking about the concept of homeliness and if it was something that surfaced in the interactions with LAC nurses whereby a safe feeling that was an outcome of the relationship gave rise to feelings about home and a place to be?

5.4.5 Dynamics that shaped the analysis

On the surface Luna is a shining example of success and all the indicators that on which the LA pride themselves for being successful, Luna attended full time education, is degree educated, lives independently and is financially stable and if this is how successful corporate parenting is measured then this would be a marker of great success and achievement. Yet, within Luna's case narrative I was left asking what internal reference to point this young person has for her own measure of success and achievement and how does this impact on her ability to be a corporate parent, or is it a case as Luna suggests:

> Tick box, needs met, move on.
>
> Luna, Interview 1

Has Luna carried on her experience to become a corporate parent? The overall case narrative lead me to think about the concept of corporate parenting within the data and how the LAC nurses fit in with this model and what the challenges might be, were there unintended consequences, both positive and negative and what impacts did this have on the system caring for Looked After Children and Care Leavers and the those Looked-after within it.

The other compelling theme that arose was what internal reference point do Looked After Children and Care Leavers have for home and is this

connected to the core and fundamental aspects of what is connected to nursing?

5.5 Fleur: a troubled, feisty yet fragile young person

Desperate for a parental response but receives the statutory one

> Once at CAMHS I sat there for the whole time in silence, just to piss them off and so my social worker wouldn't send me back.
>
> Fleur, Interview 1

Fleur is a 14-year-old looked-after child has been known to social care since the age of eight. Fleur has two half siblings who are also LACs. Fleur frequently goes missing from care and has experienced multiple placement breakdowns, which she describes as too many to count. Fleur's current placement is with a single female carer who has two grown up daughters. Fleur was attending secondary school at the time of the interviews albeit with sporadic attendance. Fleur spoke extensively about her experience of being looked-after and attending statutory services in an eloquent way, but there was a real sadness about Fleur that came across powerfully.

5.5.1 Fleur's case narrative

Fleur's lack of understanding about why she is looked-after was a recurrent theme within the interviews. Fleur spoke meaningfully about her lack of understanding being linked to how things were explained to her and how no one seemed able to talk to her in a way she could hear apart from the nurses.

> Like the others [nurses], you seem interested in what I have to say, and you really seem to listen. You don't come with a list of things to ask or check notes from your meetings.
>
> Fleur, Interview 1

I found Fleur to be quite a challenging young person. Fleur would articulate her anger and quite clearly there was something about Fleur that was quite testing

to my boundaries as a researcher by wanting to see me, but on her terms. Following the first interview Fleur refused to continue with her Child and Adolescent Mental Health Services (CAMHS) appointments. This resulted in myself and her social worker talking to Fleur and eventually she agreed to re-attend and continue with her second interview. Throughout the process I found Fleur to be a very engaging and intriguing young person. There were mixed messages about her behaviour as a form of communication, and how she was feeling which varied between lonely and misunderstood to being angry. However, she couldn't seem to find words to put to these feelings. Fleur seemed to live in a very conflicted state most of the time. There was a vulnerability and fragility to Fleur that permeated her sense of anger and loss and I thought this related to her not feeling safe or secure.

5.5.2 Dominant emotional themes: no place to call home

There is an overwhelming sense of loss in relation to Fleur not knowing her history, or why she is in care, but this loss seems to permeate through to her very existence day to day. Whilst Fleur didn't tell me the reasons, she kept going missing she alluded to not feeling she belonged any where

> My placement is somewhere I sleep. It's not my home.
>
> Fleur, Interview 2

> Like, I am really on eggshells and don't want to upset the placement. My social worker is nice, but I feel like she just writes stuff. I know she tries to understand me, but she just writes reports.
>
> Fleur, Interview 2

This was reflected throughout her case narrative, as she talked about not being able to access services for support and not being understood. Fleur was reluctant to attend CAMHS as it was near to her school and she felt embarrassment and I thought, shame about the possibility of being seen there

by her school friends. Whilst this was a valid reason when I looked back on the data there was an added dynamic that Fleur felt she was being passed on or ignored and her needs were not anyone’s priority.

> My social worker at the time just wanted to pass me on, me and my problems – send them to CAMHS [so] they can think about them.
>
> Fleur, Interview 2

Fleur acknowledges that she is difficult to work with and she does get angry but there is a desperate neediness in Fleur that doesn’t seem to be met in either social care or her placements. Fleur does talk about being listened to, heard and understood by the LAC nurses and describes the way in which this happened.

I reflected that there may have been a history of neglect in Fleur’s history as most of what she was describing seemed to relate to a need of a much-neglected child. Some of these needs were met by the formation of her relationship with the nurse when she felt unable to make any links to other professionals. What came across very powerfully was the need to receive a parental response from someone, Fleur was desperate for this and even asked if she could live with me at one point. An important reflection on this was to facilitate a better understanding of Fleur’s needs with her social worker which I undertook, however as an initial theme this created an opportunity for me to think about the connection between neglect of children and nursing and I explore this further in the next chapter.

5.5.3 Missing parts

There was a very powerful sense of fragmentation in a lot of Fleur’s narrative where she didn’t feel able to access help or support and that parts of her and her sense of being were missing

> I would rather call the Samaritans than duty.

Fleur, Interview 1

I wondered if these feelings in some way explained her need to go missing from care and if how she felt she was being treated by the system and workers triggered a response in her. The need to be noticed and acknowledged was a huge factor in Fleur's narrative.

> Duty like that write down stuff and it's like a record of everything you're ever done wrong… like the social worker will just list stuff like, 'you ran away this many times'; 'you didn't go to school this many times'; 'your behaviour isn't convincing me you can do this, that and the other.'

Fleur, Interview 2

Whilst this was a parental response it was not the one I believe Fleur was looking for when I explored this with her further she offered the following.

> I want to be in a family. I want a family.

Fleur, Interview 2

This was an incredibly sad but honest reflection and Fleur went on to think a lot about this during the interviews.

> It felt like someone finally had something good to say about me.

Fleur, Interview 2

5.5.4 Dynamics that shaped the analysis

Fleur's interview and the data generated made me think about the concept of "missing". Fleur had a history of going missing from her placements and I had a sense that Fleur didn't understand why she was taken into care. Fleur made me think about the concept of loss further and I began to think about the experiences of in Looked After Children and Care Leavers care in terms of them being told what's happened to them and what is happening to them currently in a way that they can understand. Fleur didn't understand why she was taken into care and has a lost sense of history and self-identity

5.6 Narisa: hope strength and resilience

Having experience female genital mutilation and civil war Narisa rebuilds her life

> I think you help me by writing my experience. Its safe in words now and not in my head, and it is anonymous, so no one will know it's me, but now others can learn from my experience.
>
> Narisa, Interview 1

Narisa at the time of interview was 15 years old. Narisa is originally from a West African country and arrived in the UK aged 14 as an unaccompanied asylum-seeking minor. Narisa was an eloquent, charismatic, and happy young person. Narisa is currently attending secondary school and hopes to pursue higher education. Narisa spoke movingly about her experiences of working with the nursing team in relation to her experiences of female genital mutilation.

5.6.1 Narisa's case narrative

In her first interview Narisa spoke only positively about her experiences of being a Looked-after child, of social care and the nurses. There were no references at all to her early history, family, reasons why she came to be an unaccompanied asylum-seeking minor, or anything connecting her to her past. It was not until the second interview when I invited her to talk about things that might not be so good that she started to tell me:

> When I was small – very small, I'm not sure how old – I was taken to my auntie's house… I don't think she was my real aunt, but everyone they call her Auntie in my village… I didn't know at the time, but some of the other girls they were scared of her and I thought they were being respectful of an old auntie, but now I learn why [tears form].
>
> Narisa, Interview 1

There is a reference in this extract to respect for elders and a vague association with a cultural identity mixed with something very sad and painful.

> The aunty cut me… that's what they called it… I was told I was going to be made to look pretty like a woman [crying].
>
> Narisa, Interview 1

There is a true painfulness in the way Narisa tells this and a rejection of this being OK. This might explain some of Narisa's position about everything being good and OK now and her past experiences not being able to be talked about. It did feel like this took away any sense of Narisa's childhood, this barbaric and tortuous act carried out on a child. In many ways it presented that this wiped out any early life narrative Narisa might have been able to access.

5.6.2 Dominant emotional themes: trust

It felt to me that trust has been built within the first interview that allowed Narisa to tell me her story. This made me think about what is it that the nurses might unconsciously invite or allow in the relationships they have with Looked After Children and Care Leavers.

There were subtleties in the narrative which alluded to Narisa not wanting to be associated with anything bad, be that bad experiences, painful words or harmful situations. An example of this being when Narisa is very defensive to her peer who doesn't think the nurse was kind to her.

> I know the nurse… she can't be your friend as she is always a nurse, but she helps you in a friendly way.
>
> Narisa, Interview 1

There was a sense in the first interview that nothing bad could be spoken about and I wondered if this might have been a defensive coping mechanism taken up by Narisa. I made a point of starting the second interview offering a space to think about things that might not be good and within a few minutes Narisa was recounting her childhood experience of female genital mutilation:

> …but you helpfully say it's a crime in this country… it was a crime against me… to also pretend it was something nice … 'this will make you pretty, like a woman'… that was also a crime, to lie and to misrepresent truth… [tone changes to angry]. FGM is a horrible word.
>
> Narisa, Interview 1

Narisa was an eloquent, charismatic, and happy young person. Narisa made me feel as if things could be put right or, at least made better by supporting Looked After Children and Care Leavers with their emotional health and well-being, as well as whatever physical health problems they may have. Narisa also left me with a very powerful sense of feeling the need to change things in social care, for children and young people to better understand how their social workers can support them.

5.6.3 Agent for change

Narisa set me a very clear agenda in terms of what she wanted me to think about within the analysis. I was to take forward her ideas about social work and change the system and, she wanted me to show her experiences of female genital mutilation (FGM) to help others who may find themselves in a similar situation. Narisa was very clear about the role of social work and social care today and suggested, ways I could help to improve public opinion about social workers and social care. Narisa made me think about how we could do better for children and young people and social workers.

It felt to me that trust has been built within the first interview that allowed Narisa to tell me her story. This made me think about what is it that the nurses might unconsciously encourage or allow in the relationships they have with. Looked After Children and Care Leavers.

Narisa's story is one of trauma and being brutalised at a very young age, yet Narisa conveyed an inner resilience, poise and eloquence that transcends my

own understanding at times. Narisa makes extremely mature judgements in the interviews and provides compelling support and rationale for her beliefs.

> I think because no one wants to face problems in society… or admit the truth. Social workers, they find out the truth of a situation, and [other] people, they close eyes and ears and don't want listen… so social workers get blamed for bad things [that] happen. They also get blamed for trying to save things and people because this country don't want to admit [there are] problems with how they treat children… they like to bury problems, or signs of problems. It becomes like history, then we find out later and everyone is upset. But if they didn't try and hide from social workers then social workers would have helped. That's not fair. Also the name… I don't think it is right, 'social worker'… what does that mean? They should change maybe to something else.
>
> Narisa, Interview 1

Yet underneath this I felt there was an inner fragility to Narisa and a real sense of the loss of a childhood and the need for a nurturing female role model in her case narrative.

> Like the nurse remind me more like my mum and social worker more like my dad, though not a man. I mean [they are] both not my parents, but way they act reminds me of parents and both are interested in me being okay. I'm not from this country, so I don't have parents, so maybe my experience different to other children in care.
>
> Narisa, Interview 1

5.6.4 Dynamics that shaped the analysis

Narisa made me feel as if things could be put right or, at least make better by supporting wit Looked After Children and Care Leavers h their emotional health and well-being, as well as whatever physical health problems they may have. Narisa set me a very clear agenda in terms of what she wanted me to think about within the analysis. I was to take forward her ideas about social work and change the system and, she wanted me to show her experiences of FGM to

help others who may find themselves in a similar situation. Narisa was very clear about the role of social work and social care today and suggested, ways I could help to improve public opinion about social workers and social care. Narisa made me think about how we could do better for children and young people and social workers.

It was during my interviewing and reflections with Narisa that I first had evidence for the role of the nurse in Looked After Children and Care Leavers experience and story being part of their narrative rather than being concerned about creating or setting up relationships based on the internalised idealised other. What Narisa was communicating very clearly through the data were an acceptance of the nurse in her story and an acknowledgement that this was helpful but not in a way that would replace a mother figure but in a supportive ay that would replicate in a safe way some of the maternal functions.

5.7 JT: living with a legacy

A life lived surrounded by systems and professionals, but a lost child within it

> My mum had schizo[phrenia] and I was born on a psychiatric ward. My mum went into labour with me really quickly and the paramedic delivered me on the floor of the psychiatric ward.
>
> JT, Interview 1

JT is a 14-year-old looked-after child. JT has experienced mental health challenges from an early age and has experience care in a variety of placements including mental health settings. JT's mother passed away when he was 12. JT talks extensively about his experience of the health system and the looked-after system.

5.7.1 JT's case narrative

JT tells me his life narrative as being part of an institution, or organisation and this type of existence continuous throughout his life. He tells me very little about his early life and is clear in subsequent parts of the interview that JT doesn't have any early memories that he can draw upon. His mother is completely absent from his life due to poor mental health and he has no idea who his father is. I didn't get any sense from anything he had told me that social care, or any other person had tried to locate his father. From what I can establish from the data JT's mother was unclear who the father might be. JT grows up with the sense of not knowing his own identity and the only one he can articulate is that of a family history of mental health problems.

> The system, innit, the health system… the NHS. I've been in it all my life. If you think about it, I was born in the NHS and detained in it, so it's like a friend.
>
> JT, Interview 1

JT talks in a compelling narrative about his experiences of health and social care. By his own definition JT describes himself as the product of the system being part of it, born into it. JT talks about the institution of the NHS in a way that it is as a person, or influence that is part of his genetic makeup. JT talk's in a matter of way about this and there is a cold hardness in the way he describes this as what I imagine the hospital floor to be. This was incredibly sad and shocking time I was almost winded by the image of a newborn baby brought into the world into an environment which I imagined to be surrounded by madness and psychosis.

5.7.2 Dominant emotional themes: rejection

JT talks of his own experiences of being unwell and struggling with mental health issues. There is a profound sadness and painfulness in JT's narrative, as

he talks about being rejected and moved on by people are meant to care for him and be his parents.

> So, born on a psychiatric ward to a mother with mental health problems… no let's say it as it is: schizophrenia [looks at the floor and starts to hold his hands together, hence I lose eye contact] and I don't know anything about my dad and I doubt my mum did. My mum's mum, so my grandmother, also had schizophrenia, so… hey – its odds on I'm going to have issues. In and out of foster care as I don't have any other family… social services tried to get me adopted but like, who would take on a kid like me for life with the likelihood of me turning psycho at the drop of a hat? I don't remember a lot from being little until I went to long-term foster care, and there was some agreement that I could have like some status so I was not an LAC anymore. That went really well until two years ago, so I would have been like 12, and I stared to have my friends round and like, that was the start of the trouble.
>
> JT, Interview 1

There is also an overwhelmingly sad expression of JT believing that it's his fault that he was rejected, and he is somehow mad or bad.

> Gutted… gutted… I'm not disputing that I needed to go to hospital. And my behaviour was, I mean… it must have been really hard to understand and, like, live with… and I did need to be sectioned. But what killed me was when she said I couldn't come back. That just like, if you can imagine being hit in the stomach so hard you can't breathe.
>
> JT, Interview 1

5.7.3 Finding hope in a hopeless place

> They tried to do a mental assessment and I just saw these two big men coming towards me… they were the… what's it? approved social workers, and the doctor, but my head was telling me they were going to kill me, so I just kicked off. Then they called the police… the nurse had been in another room at the time and when the police arrived and rushed past her, I think she like twigged it must be me, and she came in behind them. I was kicking everyone and she just said, 'What's going on here?

> This isn't right, he's a child,' and then they like stopped forcing me about and I sat down. The nurse calmed me down and explained I would have to have an injection and I was calm. I got taken to another specialist unit then for adolescents, but I remember I looked up and the police officer was crying. I felt like crying too. I didn't – the nurse gave me a hug. Then she went over and gave the police officer a tissue. I don't know what she said but he stopped crying, anyway. It was a bit like the nurse tried to help in a really difficult situation.
>
> JT, Interview 1

From JT's narrative I started to think about the unconditional positive response all the young people talked about in relation to their interactions with the LAC nurses:

> I do though, but it's like there's something inside that I don't get. I just don't understand, like nothing makes any real sense. I think that's why my head might go somewhere else and tries to make sense of it all, but in a mad way.
>
> JT, Interview 2

JT also tells me there's something about the relationship between the LAC nurses and young people that there is a very quick engagement and understanding by both parties:

> Erm, right… I suppose that goes back to my experience, like the LAC nurse. It's like they get right to the point, like right to the heart of the problem very quickly, like no messing about. That might be just because they are just interested in your health and well-being… like, they are not trying to do loads of other things and fill in loads of forms, or get applications to panels and all that.
>
> JT, Interview 1

There is a real sense from the JT experiences the nurses being able to stay with him their witness to the very difficult things that he was experiencing at the time. Whilst some of this may be connected to JT is need for a maternal presence of the strong sense that JT was talking about the nurse's ability to sit

with him. This made me think about how the nurses contribute to the emotional well-being of b Looked After Children and Care Leavers by their presence not just in a way that is part of the health assessment that in a way they can be held in the nurse's mind.

5.7.4 Wish to be well

JT talks a lot about his wish to be well and has a powerful insight into his own illness.

> Yes it is not sad in like, a pathetic way, but sad like in a… like it's never going to end way. Sometimes all I want is for it to be quiet in my head so I can get on with my life… like the medication helps, but it just dulls it, like fades it. And even when you can't hear them, you have this fear that they will get louder, and then you start like, the stupid behaviour stuff.
>
> JT, Interview 2

JT describes some of his experience and make the link in the interview about him needing to run away and how this might be linked to when he's unwell or feels unsafe.

> Last time I ran away just to get some distance like, some space. I thought that would help, but it just made it worse. I ran out of meds and was like, on the streets for a couple of days. Leicester Square and that. I just walked… I think I stayed awake all the time trying to get away… eventually a police officer found me. He was kind. He said, 'Come on, son, you can't stay out here, it's too cold.' He gave me his jacket and put me in the police car. He said the food at the station awful this time of night and he stopped and got me a McDonalds.
>
> JT, Interview 1

There is something incredibly sad about this narrative and I thought JT was craving some sort of parental response and the need to be found and supported. JT had previously talked about negative experiences with the police was now describing a situation where he experienced kindness. JT presents a

life narrative never knowing if someone is going to be kind to him. I thought he recognised how tragic his situation was by the reactions of the police who cried and kept him safe?

5.7.5 Saved and safe

> They wanted me to see the police doctor but couldn’t because I was a minor or something like that about consent or some such shit. Anyway, no one from duty could come and I don’t know how it happened, but the LAC nurse came to get me at eight in the morning. I must have smelled really bad, but she gave me a hug. Then we had to go back to the office. I didn’t go back to the assessment unit they found me a bed at ******… it was much better.
>
> JT, Interview 1

This was a powerful communication at the time about how an unconditional response was needed that was non-judgemental and how this might be linked to the idealised internalised projection of the maternal. This is further triggered when JT talks about his lack of anything to tie him to be early memories how the nurse had really tried to find out things for him.

> I know. You know I couldn’t tell you how many social workers I’ve had. This one’s nice. No one really knows my story. I think the nurse tried and she has found out, like, random stuff for me and like, that’s great, it helps a bit, but no one really knowns about me. I don’t have a photo album full of baby photos or a memory book.
>
> JT, Interview 2

5.7.6 Dynamic that shaped the analysis

Whilst all of JT’s case narrative was powerful and multi-layered it offered me the opportunity to explore and important dynamic, that of the very difficult situation for the nursing professional who comes into social care to work with Looked After Children, who have experienced a multitude of undesirable and unwanted exposures throughout their development the rest of society only reads about or

the media should they choose to listen too. So, what happens when you place a children's nurse in an environment to work with children and young people who have been thoroughly neglected, either by the birth parents or in a system that is set up to try to look after them but who really can't in the same way a lobbying, nurturing supportive family system can. This is perhaps best reflected by JT's quote.

> Let's not be polite – it's shit. Madness. No parents, life in a mental hospital, and some of the nurses have been horrible: it's like they enjoy seeing you in pain because it is keeping them in a job. Like, so uncaring and rude... rude man… like, 'Get up! Get washed!' Not like, 'Morning, how are you? Can I help you?' My foster carer wasn't horrible, but she avoided me and that was quite hurtful. Do you know what she used to do at breakfast time? She would place the cereal boxes [between us], so she didn't have to look at me.
>
> JT, Interview 2

JT's narrative towards the end of his interview tells me that even the nurses can't be good not all the time and reminds me poignantly of the utter aloneness and neglect some Looked After Children and Care Leavers experience. Whilst I was horrified hear JT's words about his foster carer and the cereal boxes, perhaps this is a genuine reflection of how feel Looked After Children and Care Leavers within societies and organisations. This led me to thinking about is there a possibility that the LAC nurse can transcend some of these experiences where they looked-after child is an overlooked or defences aren't put up because the nurse can just be with the looked-after child.

5.8 Summary

This chapter has brought to life the case narratives of each young person and presented an analytical reflection based on the dominant emotional themes that were most pertinent and present in each young person's narrative.

The dominant emotional themes and the dynamics that shaped the analysis set the path for further discussion and key findings which will be explored in subsequent chapters. They also assisted with looking at the data from a much deeper perspective, uncovering the underlying and sometimes hidden emotions and experiences that the young people found difficult to talk about.

In this chapter I have set out some initial ideas that relate to the young people's experience of professionals, systems and organisations which – as the data showed though the case narratives – played a huge part in their experience and well-being. There were key commonalities with themes across all the young people's experiences. As an example, the narratives around loss may be different, but they are parallel across every interview and were the hardest hitting findings in such a population. This thesis will progress to discuss and present the findings.

Chapter 6: Leave to Remain: Domain Findings

6.1 Introduction

In the previous chapter I presented the case narratives and dominant emotional themes that came across in each young person's interview and started to illustrate the compelling emotional nature of their experience. In this chapter I present the findings from critiquing the data in their entirety.

Some of the themes set out in this chapter are striking in their obvious nature, given the experiences of the children and young people I interviewed.

Although some of the detail within the themes might have been predictable from what we already know about Looked After Children and Care Leavers and what we know about nursing already, what grounds these themes in this chapter is their authenticity children and young people rather than a hypothesis of thought, or professional practice wisdom. These themes are real, first-hand and very much relevant, as they are the foundation from which the more difficult and less obvious themes were generated.

This section sets out the findings that arose from the domains, that is, the commonalties and outcomes of the in-depth analysis undertaken. Whilst the domains concerning young people and the system had distinct findings, the nurse and relationship domains had merged and included findings that were all related in some way (see Appendix D). As such, this section is presented as a discussion of domain thematic findings in relation to young people, a joint section of the nurse, the relationship and the system and a summary across all the domains' thematic findings.

6.2 The young people

6.2.1 The young person's life

Except for Dinar and very limited accounts from Narisa, none of the young people talked about their very early experiences and life history. The differentiation between these young people's narratives is obvious, in that both Dinar and Narisa had a memory and recollection of a warmth and positivity about their early life, and the other young people quite simply did not articulate any. The sense of not knowing or being able to recount was striking and radiated throughout the analysis of all their accounts. Similar words were used frequently: "I can't remember", "I don't know", and "I've never had" featured heavily. However, what could not be conveyed in words but did come through the synthesis and my experience of being with the young people as a researcher, was the bleakness and utter despondency in their narratives. Even JT's graphic and disturbing account of being born on the floor of a psychiatric ward was told in a detached and disconnected way. There were two underlying factors in this phenomenon: one is that the young people really didn't have a narrative, and the other being that there was one, but that it couldn't be recalled.

6.2.2 Early experience

Our early experiences are so important and shape and contribute to who we are and become. Bion (1962) states that the ability of a baby to survive the intense frustrations of early life and to thrive and develop the skills to think about their position in relation to others in the world is the early dependency experience. Waddell encapsulates this idea:

> the mother brings not only her straightforwardly nurturing and loving qualities to the baby, but also her thinking self, the mental and emotional states which, in encompassing the chaos of her infant's psychic life,

> establish a precondition for more integrated capacities, for a more integrated self.
>
> Waddell (2002, p. 30)

Due to the very nature of the young people having been in care, there are questions about the quality and availability of the mother figure in their lives. This corresponds with my practice knowledge and the findings of many reviews and researchers (DSCF, 2000; Munro, 2001; Triseliotis, 2010; Meltzer et al., 2002). What the young people were able to state about their early experiences was having little-to-no sense of them. Parents and mothers were barely mentioned at all, and whilst it could be argued that I had not asked the young people to tell me about their early experiences, they all – without exception – told me about their younger selves and early life and in a chronological order. I felt it important to try and tease the important elements out of the analysis and think about this in relation to its relevance to the young people. I found that Klein (1946) and Bion (1962) were helpful when thinking about this. The importance of early development and the mind is summarised by Loshak (2013) as enabling the mind "to recognise good and bad in one's relationships, and oneself, without forming harsh judgements". This contrasts with the 'paranoid-schizoid position', which surfaces when progress through early infant development is disturbed. This can be depicted by splitting the world into 'good' and 'bad', leaving little space for anything in between. Aspects of both positions are likely to exist in all of us at different times. However, for children who have experienced much turbulence and disruption in their early development, there is likely to be an impact on their ability to understand and function in relationships in the same way as we would, or might expect others who have experienced less.

It could be argued that all children and young people in the care system will have experienced less than ideal early experiences by the fact they have been removed from parental care for reasons of abuse and neglect. In this study, the early experiences of parenting for the majority couldn't even be recalled, and this was both sad and striking. The impact of this could be felt in the interviews, and Isla's quote illustrated this to me in a profound way:

> But there in my head, like, there's nothing concrete or real I can pick up and say like, 'This was my baby blanket, or this was my picture I drew on my first day at school'.
>
> Isla, Interview 2

Klien (1946) argues that the later strategies for dealing with loss are dependent on the early primitive experiences and these infantile feelings are evoked at every parting. We are never truly alone, but alone with our internal world, either with feelings of helplessness, fear, terror and misery or, on the other hand, some hope of inner security founded on the expectation of love and goodness. At the time of the interview I felt immensely overwhelmed and couldn't think about what to do next. I also felt quite humbled that JT had shared some of this experience with me. I also felt angry with the foster carer and very tearful. This radiated through JT's interview, but lead to my thinking more analytically.

6.2.3 Abandonment and absent parents

Abandonment followed as the next theme, as in all the narratives there was much communication about being abandoned within the care system and losing contact with birth parents in a tragic way. A painful severed connection was the reality for the children and young people. They all had absent mothers: five were dead and one mother (Fleur's) was alive but had very little contact. For three young people their father was also dead: Dinar, Isla and Luna. For the others their father was completely missing from their narrative, which would

suggest they were absent from their lives. JT states quite clearly that no one knew who his Dad was, not even his mother.

> I don't know anything about my dad, and I doubt my mum did.
>
> JT, Interview 1

The starkness of this statement shows JT trying to communicate something of his own sense of abandonment. This phenomenon was present in the narratives of all the young people but only named so honestly by JT. The young people all talked at some stage about "being left, alone", and referred often to their experiences as "just me".

Whilst the young people have some sense of birth mothers and fathers, apart from Dinar and Narisa, none have a powerful recollection or vocabulary about their parents. The four young people who were born in this country and known to safeguarding services prior to being looked after all have striking gaps in their experience of parenting and contact with family members. In all cases there is very little dialogue about early history or memory and where there is, these are referred to in fragments of recollection: the odd, fleeting reminiscence referred to in their narratives. In trying to gain some understanding of this, the next theme that emerged was 'being taken away'.

6.2.4 Being taken away

All these children have been taken away from their parents. Even Dinar and Narisa were taken by traffickers from their homes. Whilst they may have had some motivation to leave and the others perhaps did not, it is still a fact within the case characteristics that all the children and young people were taken. Whilst this might be quite obvious to the reader what was communicated through the research was how being taken away had an impact on the children and young people. Whilst it could be argued that they are in a better or safer

place this does not take away the fact that they have all been through a level of separation. All had been taken from an environment which was known to an environment that was unknown. None described any feelings of safety or relief. This concept was difficult to disaggregate from the theme of abandonment and absent parents initially, but the layers of analysis and thinking around the contexts of the young people's experiences lead to this connection. Contextualising this back to Bion (1962) and Klein (1946)'s ideas about early experiences and being able to manage separation and loss and the importance of early relationships in setting the pathway for understanding future relationships is important to this part of the analysis as, whatever the relationship was, or how successful or unsuccessful it may have been for the young people, it became relevant to them now in the context of their narratives:

> I don't understand what they're saying about my mum not being able to prioritise my needs. She gave birth to me, so she must have prioritised me that day.
>
> Fleur, Interview 1

Fleur's words came across emotionally in the interview, and the enormity of what she was articulating seemed to be conveyed in her tone and expression in a way that cannot be captured in this piece of writing. Therefore, I have used my own observation from the interview to try to illustrate the narrative and give feeling to the words:

> Fleur looked hurt and angry in equal measure. She had a deep frown and looked distracted, looked out of the window and then to the door, then became tearful. Was not sure where this anger was placed or if it was frustration at not being able to understand.
>
> Fleur, Interview 1 notes

Fleur's words and my own observations at the time facilitated an understanding of the theme of abandonment that resonated across all the young people's narratives.

6.2.5 Loss and being lost

From the data, it was possible to extract that loss took many forms and meanings. Some young people were able to articulate their losses very clearly; others were unable to name loss but talked about it in a different way. Linking in with this there is another: the central narrative of grief. From Dinar's obvious narrative of loss, to the less subtle yet striking sense of loss in Fleur's narrative, it seemed that these themes permeated across all these children's lives.

Dinar spoke about loss in terms of bereavement and how it affected his memory, yet I witnessed a very powerful description of his memory of being taken from his village and his eventual arrival in the UK. This included Dinar recounting his story in not only words but descriptions of events, sights, smells and feelings. This gave me the first glimpse of what it was like to get beneath the surface as a researcher. Loss went much further than bereavement and parental loss for Dinar, as whilst I was undertaking the research, Dinar was taken into custody in relation to his immigration status. Dinar not only lost his liberty at this point, and as he said, "my freedom"; Dinar also lost his leave to remain in the UK. Something of Dinar's loss got located in this research, as it felt more important than ever to write about the multifaceted loss experienced by Looked After Children and Care Leavers.

JT talked about the loss of any early identity and spoke about his birth history in a very matter of fact way. It almost felt as though he wanted to shock me, suggesting to me that there was a need for me to offer empathy towards his

situation. JT also went on to talk about the loss of any physical object that would remind him of his early childhood.

What I understood here was the underlying internal expression of a child's need for a mother. JT had nowhere to locate his feelings and spoke very little about his mother, almost as if she were an unknown entity to him. But within the data it was very clear that what JT really wanted was parenting. JT spoke of his rejection by his foster carer and his own concerns for his mental health. What I was getting from the data were that JT's need for a stable relationship where he wouldn't feel rejected. There was a very sad and poignant moment during the interview, when JT described himself as unadoptable:

> I mean, who would want me? Can go bonkers at the drop of a hat, unadoptable me.
>
> JT, Interview 2

There is something about being able to hear this sense of loss, but also being able to interpret the sense of loss in its many forms. All the young people talked about not having a place to be or belong, and a sense of nothing being permanent or enduring.

6.2.6 Missing

There is multilevel maternal deprivation in all the histories. Not just at an early age or by birth parents, but across the continuum of care. There are many examples of the dearth of any maternal warmth the young people experience in care and most shockingly in foster care. The overriding theme with this is the concept of being missing. Intertwined with the theme of loss, the case narratives all relate how loss and missing are inextricably linked. This related to both internal and external aspects of missing, as in something that is lost, and the very real and present reality of the constant state of missing a parent or parental influence that the young people could relate to.

There was a very strong message in all the transcripts about the need for acknowledgement about experiences and relationships that were missing. This extended to the need for physical objects from childhood, like baby records and mementos and photos. There was a real sense of a missing early identity throughout all the narratives and the emotional context of the words the young people were using. Dinar states clearly that he feels that he was always missing, or without. It was also possible to see within Fleur's narrative her need to know her history. Whole parts of her life were not known, and she couldn't hold on to any understanding about the reasons she was a Looked after Child. Fleur also felt compelled to physically go missing herself, leaving her placements and staying away, but she couldn't give a reason for doing this.

The questions which arose across all of the narratives about being missing were compelling, as there was a strong sense that the young people understood that there were elements of their lives, histories and identities that were missing, but there was another phenomenon that they were unable to articulate clearly: the sense that they knew they were also missing something else, but they were not quite sure what it was, or how to describe it. This sense of not knowing what's missing but sensing there is this phenomenon fits with the recent literature on ambiguous loss. Boss (1999) defines ambiguous loss as a feeling of grief or distress combined with confusion about the lost person or relationship. Boss (1999) relates this factor in relation to many situations of familial life and life experiences of losses in different contexts. An interesting aspect of the theory has been considered in adoption and foster care (Boss et al., 2003) in which the authors state that, for children placed in foster care, this type of loss tends to happen repeatedly and is incredibly hard to process. This

was helpful to consider when trying to understand the factors about the phenomenon of being missing described by the young people.

The concept of ‘missing’ in the young people’s narratives was stark and seemed to relate to all aspects of their lives, experiences, care and trajectories. What the young people described in the data were how throughout their lives, relationships with key people were transient, and they felt different feelings towards them at different times. Many of the young people articulated how their social workers, carers and sometimes parents were physically with them but emotionally absent and unable to think about them even when they were present.

Whilst all young people may experience loss, grief and a sense of ‘missing’, whether that was ambiguous or not for the young people in this study the pattern was repetitive, and it seemed relentless and inevitable.

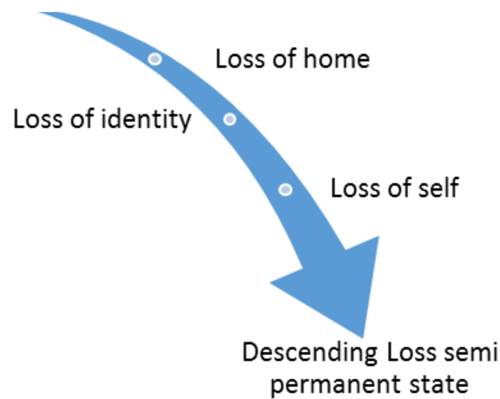
6.2.7 Deprivation and loss

The overriding feeling, I was left with was that these are still children and young people who need looking after and the striking absence of anything maternal to relate to was profound.

It is impossible not to talk about absent parents and bereaved children as this factor was present and continued across all the case narratives, as I have referred to earlier. From the data, it was possible to extract that loss took many forms and meanings the young people. This can all be summed up into an overarching finding: layers of loss.

This finding was constructed not only around the theme of loss but the sub-themes within it and the intensity of the multifaceted spectrum of loss. The diagram in Figure 1 represents the losses that were articulated by the young people in relation to how they described their trajectories.

Figure 1 Loss



This ranged from grief and bereavement derived from loss of a parent or family member by death to a lack of contact brought about by being in the care system. There was also an idea in the minds of the young people that they knew they had lost lots, or that they were missing something. They were unable to identify exactly what that was, and numerous parts of their narratives covered this concept. This experience of not knowing what is lost fits with the concept of (Boss, 1999), and is not an unusual presentation in young people who have experienced fragmented care (Boss et al., 2003).

What was apparent from the narratives is that there was a full trajectory of loss across the lifespans of these young people, who carried that sense of loss into the present, and they expected that it would follow them, or at least the experience would follow them, into adulthood.

For some of the young people it was evident that loss was being experienced so frequently that nothing seemed permanent. In Fleur's striking example, she came to expect that loss would be the status quo. Mixed in with loss, young people were also articulating how fragmented their lives were, so that even what they remembered could somehow become confused and separated. All young people spoke very powerfully about how being with the nurse brought about these ideas to their minds, enabling them to express these thoughts, talk about and in turn think about them. What did surface across all

the narratives was how this constant experiencing of loss had left them feeling a deep sense of insecurity.

Fleur and JT end the interviews on their terms, and leave when things get difficult, trying to control some sense of an ending. This made me wonder about their overall experiences of separation and loss, and how they have come to deal with life and its everyday occurrences by taking some control over how they deal with loss. Canham (1998) related this concept to residential care, and how young people who have experienced such frequent separation and loss find it extremely difficult to think about and carry out any type of task that might relate to an ending of any kind. The permanent existence of loss in the lives and experiences of all the young people permeates the narratives in every sense of its meanings and connotations. How loss is defined and centralised in the young people's narratives is the central finding.

6.3 The nurse and the relationship

6.3.1 Nurse

Describing the nurse was something all young people tried but struggled to do, other than simply referring to the nurse as "the nurse". However, when the transcripts were analysed, there were many examples of how the young people placed great importance on the behavioural traits and characteristics of the nurse that were not only important for being able to talk to the nurse, but fundamental to being able to engage and interact. This domain explores this concept in depth and examines the subtleties and nuances of the data around associations and meaningfulness of the role of the nurse. Isla's narrative was particularly poignant in relating to the aspects of the nurse and nursing, so in this chapter there are more of Isla's quotes than the other young people,

however the essence of what was captured by Isla so eloquently was found across all the narratives and within the coding of the data.

6.3.2 Defining nursing

Henderson (1964, p. 62) states “It is evident that an occupation and especially a profession, whose services affect human life, must define its function. Nursing’s attempt to do so, has long and still unfinished history.” Not knowing how to describe “the nurse“ is reflected in the literature, as even the discipline of nursing has struggled to define what nursing is, offering various definitions through the ages (Schlotfeldt, 1987) and to the present day (RCN, 2014). Despite this evidence, which clearly demonstrates the need for nursing to define itself, it would appear from the literature that nursing is constantly defining and redefining itself. This may be in part due to the need of nursing to evolve and be responsive to the changing needs of patients and society, as humans develop and aspects of heath and illness, disease and recovery all develop and influence the scope of nursing and how the nurse needs to nurse. The context of nursing today has been critiqued in Chapter 2, and the reflections of the young people in this study demand a closer examination of the conception of nursing.

The World Health Organization (WHO, 2017) defines nursing as encompassing autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people. This definition is interesting and relevant to this research, as it specifically mentions care of the well and all communities and settings, as opposed to just sick. This offers some acceptance of all populations without explicitly mentioning the social care contexts of nursing care, which is where

this study is focused. There is no specific literature on the role of LAC nursing and the impact it has on young people, but increasingly there are more specialist LAC nursing teams in the UK.

Girvin et al.'s (2016) study of contemporary conceptions of nurses identified that although there is evidence of robust public trust, this does not stem from an understanding of nursing and its impact: it seems to come from the respect held for the traditional, more sentimental stereotypes of selfless, hardworking young females. To some extent there was an acknowledgement of this within the research too, however there was also the real-life world of the LAC nurses, who embodied some of these traits, which reinforced this view.

> The nurses are all nice ladies, fun and caring.
>
> Narisa, Interview 2

Throughout the study it became apparent that the young people were very clear that the LAC nurse couldn't really be described, but what they were recounting were the tasks, or the way in which the nurses undertook their work, that made a positive difference to them.

Whilst the young people didn't make any specific reference to the different definitions of nursing or nurses, they all alluded to some interesting concepts, and it is likely that some of the concepts of nursing they had in mind were from the societal perception of what nurses are, do, or represent. These definitions were present in all the narratives, and there was a selection of words that featured heavily in all the transcripts*:* 'kind', 'genuine' and most frequently, 'friend(ly)'.

What was new in this research was the nurse being referred to as something akin to a female family member. This links with not knowing what label to give to the nurse, but hints at an underlying close or familial relationship associated with the nurse. Getting near to this as part of the analysis was

difficult, as I struggled and over-analysed what was being articulated, but there was a genuine affection towards the nurses. This is perhaps in part due to the public perception of nurses and how they are portrayed in society that the young people identified with, but there was also a desire to stay in touch with the nurses: the young people had, like most children and young people in the care system, fragmented and often little contact with birth families and extended family members, so part of this communication from them may have to do with a wish for something like that, or it may have been just based on their need to have someone they could stay in touch with and the nurse fitted that mould, where others in their care network perhaps did not.

As much as I could get from the data that there was a warmth and closeness that was spoken, there was an underlying narrative that was moving towards a maternal type of association. Without mentioning directly, the concept of the nurse as a mother figure was a subtle, underlying account present in all the narratives of the young people. In a very delicate way, all the young people described aspects of mothering or parenting as part of their experiences and associations with the nurse:

> I don't have a family, but it felt like the nurse was the family I would choose if I could! Everyone needs a nurse Aunty.
>
> Isla, Interview 2

Where these associations came from was not clear in any of the narratives, which lead me to look more retrospectively at the role of the nurse in a historical context.

The historical concept of nursing relates back to the wet nurse: the act of breastfeeding other people's children, a task that would usually be performed by the mother. There is a very primitive idea here in this very early image of nursing that also served to meet the most basic need of a baby or infant to be

fed. Within this image we have the representation of the female meeting the most basic but necessary function for a baby to survive. Is this an image or concept that has been internalised by society and linked to nursing being able to meet the needs of infants?

Slightly later in history we have the children's nurse working in foundling hospitals and workhouses where they cared for society's unwanted, neglected and abandoned children. There is an obvious link with the history of children's nurses working with what were effectively Looked After Children since the Victorian age, and the present-day statutory requirement to have LAC nurses. Is it possible that there is an unconscious influence from times gone by and the embracing of nurses by young people in this research? To ask this question of the data seemed to assist in trying to define nursing in this setting and research study. Whilst it would be impossible to answer the question unequivocally, there are some interesting ideas put forward in the analysis and synthesis of the data which support the idea of the LAC nurse in caring for unmet needs of the young people that help to define nursing in a social care context.

6.3.3 Caring

Nursing has long been known as the caring profession (Watson and Thompson, 2000) and in its early years it was considered a vocation that could only be undertaken by the truly devout (Dolan, 1968); giving one's life to nursing was considered essential and non-negotiable. This is perhaps where the 'patient first and always' message of today's media campaigns about the NHS stem from (NHS England, 2013). But this slogan suggests that the nurse is the epitome of all things caring, and that they will care for patients forsaking even their own needs. Nursing literature all agrees with this aspect of nursing as a caring profession throughout its history to present day (Rhodes et al., 2011). There

has been some literature suggesting that present-day nursing is more task- than care-oriented, and that nursing has become too academic and desk-oriented (Chapman and Martin, 2013)

However, most of the nursing literature is quick to refute this (Benner et al., 2009; RCN, 2014; NHS, England 2009). Within this research, the word 'caring' was used to describe the nurses many times and was used interchangeably with the word 'kind'. However nursing care was defined by the young people as different to other types of care:

> The LAC nurse made my care experience more about caring. Like, I felt she cared for me… not like in a lovely-dovey or like gushy way… more just like she was part of my life, but apart from it, and like she cared about me and about parts of all our lives, not just me.
>
> Isla, Interview 2

Isla's narrative from the transcript describes how she felt the nurse cared for her in a way that was different to love or affection, but she also states that it was care of 'us' – Looked After Children, so there was an idea in her mind that the nurse was a helpful and necessary part of the experience of all the young people. This also suggests that the care didn't feel intrusive or overwhelming. "[P]art but apart" suggests that care was at a safe distance, or a distance that could be not just tolerated, but maintained in a helpful way. This links to the idea of the nurse in society, in that nurses will be there when you need them and are accessible and available whenever needed (Maben and Griffiths, 2008).

6.3.4 Kindness

Linked very closely with care was an extensive narrative in all the transcripts about the concept of kindness and being kind. I have separated the words 'kindness' and 'kind', as within the narratives they were described differently:

> We went into a room in the hospital and she gave me the comfortable seat and introduced herself again and then she goes, 'I am sorry if that conversation with Hannah made you feel uncomfortable,' and then she said a whole load of other stuff about the health assessment and signing stuff, but I didn't really take it in. She had me in it, she was kind and nice and I thought she had stuck up for me, so I didn't have any issue talking.
>
> Dinar Interview 1

These words from Dinar sum up this point very well, in that 'kindness' referred to the feelings and the emotional space the young people felt was available to them and 'kind' was the physical act of the nurse doing something for him. This interaction also allowed Dinar to feel both supported and cared for in the immediacy of the situation and interaction.

A broad distinction may be drawn here, linking traditional nursing as 'caring for patients' with caring for a young person in any setting. The emphasis here is on the nurse carrying out a caring role. Although this could be considered as overly simplistic, one could certainly describe the key aim of the nursing role as 'being there for the patient, offering them care'. In the context of the young people's narratives in this research, kindness is about paying attention to them and acknowledging their situation and experience. It suggests sincerity and consideration and respects the individuality of the young person. Without exception all the young people describe this process throughout their narratives, most commonly early in their interviews, which suggests that it was at the forefront of their thinking within the research.

6.3.5 Being understood

Linked in with kindness and care, there was a prominent narrative around being understood.

> The nurse tried to understand my point in it, like where I was coming from and what was going on in my life at the time. And they had the time, like when she came to see me she wasn't in a rush.
>
> Fleur, Interview 1

There are also very extensive sections of dialogue in all of the young people' narratives about being understood and the nurse being understanding. However, what interested me within this, was how the young people experienced understanding and not just the statements they made about it. When the deeper analysis was undertaken what transpired was that the young people were describing quite a sophisticated process. This process started before the young people had met the nurse and there was a thought in all the young people's minds that the nurse would be understanding, even before they had met them.

Luna states that the nurse was, as she expected her to be and within the meeting Luna felt understood, but there is a suggestion in Luna's narrative that the niceness and the expectations about the nurse being understanding of her needs and situation were in her mind long before the nurse arrives.

Luna's words were "it was nice they were coming to see me". Apart from the fact that it was anticipated that they would be nice to her, Luna is already positive about the potential engagement and finds some understanding that the nurse is making herself available to Luna. All the young people had similar accounts in relation to understanding and had preconceptions that the nurse would be understanding. This fits with the previous discussion about how nurses are perceived, but in this research the young people are articulating that this is also how the nurse is experienced by them in the context of their life in care.

Being understanding was also fundamental and core part of the nurse's ability to be with the young people and get alongside their experience.

There is a strong message conveyed in all of the data about understanding. There is also an appreciation by the nurse that something was needed other than asking questions to support young people. The image and support the nurse conveys is very poignant and there is a deeper dialogue in the data, that the nurse is able to get across to the young people that even when things may feel messy, they can still be ok and also can be overcome. Fleur expresses this eloquently in her narrative and all the young people articulate similar views and all the narratives agree that the nurse is understanding but furthermore, there is a sense in all the analysis that the nurse can understand when something else needs to happen for the young person, for understanding to be experienced. From Dinar's example from the case narratives, to JT's discussion of the nurse being able to understand his sense of fear, and Isa and Luna citing past memories of how the nurse did something physical, either sitting down, or meeting them where they wanted to be seen, all convey a strong and powerful sense of the nurse being able to adapt their approach to facilitate an understanding response to the young people.

6.3.6 Humour

Tremayne (2014) suggests that the appropriate use of humour is an asset in nursing practice and an early study by Åstedt-Kurk (1994) found that humour can be described as, *joie de vivre*, which is manifested in human interaction in the form of fun, jocularity and laughter. It was both humorous to me as a nurse researcher and interesting that all the young people described the nurse as fun or funny, and they also recounted the use of humour in their interactions. Humour was a meaningful factor for the young people and the nurse's ability to

be humorous whilst also being sensitive to the young person's needs, feelings and experience was very present in all the narratives.

Knowing how and when to interject some humour into the situation is not an easy thing to do, but all the young people were able to describe examples of this in detail.

The data also states that's there is an underlying premise that there is an understanding between the nurse and the young people that it is okay to talk in this way and that it has become "our way". There is a powerful message in the data that young people experience that the nurse is concerned about them but by using humour the nurse can move young people out of being defensive and think about their situations by using humour.

6.3.7 Maternal

There is a very clear finding in relation to maternal deprivation across the narratives of all young people. There is also an absence of a mother figure in the lives of all the young people at the time they were interviewed. For some young people, their birth mother has been absent for most of their lives and others had memories that could be recalled with warmth. I have previously discussed the impact this had on the young people, however, in the findings section what is evident is the need of the young people within this research to narrate an idealisation of the maternal figure in relation to the nurse. How this represented as the relationship between the nurse and the young person was that the nurse had some sort of function within the relationship as a maternal reference point. How this then came out within the system varied in the young people's responses. There was clear appreciation of the role of the nurse within the social care system, yet an acknowledgement of the fact that the nurse was really a part of social care anyway. There was a contradiction in the narrative

the young people as to whether the nurse was part of the system or not. In some respects, this question may not be important, but what it may represent is: does this then reflect their view on the maternal representation not being available within the system to such a point they seek this out in their relationship with the nurse?

Maternal reference points cannot be referred to just across the domains: it's very clear that maternal reference relates to the sense of loss that the young people were articulating and a deep-seated and unsettling feeling about this being missing from not only the lives of the children young people, but within their care networks and particularly within the system. Not having this maternal reference point and this sense of loss and missing lessens the function of advocacy within the system, particularly the maternal perspective. Most children and young people have a mother, or maternal presence in their life that can advocate on their behalf. The young people in this study indicated that for the most part, for them this role was undertaken by the LAC nurse. This was evidenced in the way the young people described how the nurses were able to keep hold of and tell the individual's stories in the way a mother would about the child.

6.3.8 Advocacy

All the young people articulated that they felt the nurse truly advocated for them. This related to not only their care, but also aspects of their lives. There are examples of young people recollecting their memories of the young person's review and the nurse being the only one in the room to speak on their behalf. There is also a collective response from all the young people that they felt a key aspect of their relationship with the nurse had a strong and powerful advocacy remit. The young people all stated that the nurse was not only able to speak on

their behalf but was able to put the young person's needs before all else, including statutory tasks. How this related to the system was the professional advocacy that the nurses were able to bring to the system in terms of health and well-being. There were numerous references to and examples of this put forward by the young people. How this relates across the domains is the link to the maternal reference point in the sense of this being missing and lost to the young people, but somehow found within their relationship with the nurse.

6.3.9 Loss and empathy

The correlation between the experiences of the nurse being a maternal reference point to the young people, the advocacy function of the role and was some of the aspects experiencing empathy within the relationship was a key commonality across all narratives. Within the system the young people related to this phenomenon as being a care that they didn't experience within the system, that it was different to what was offered to them or at least it was thought about in this way. This does raise questions about the availability of empathy within the system and the system's ability to be empathetic to the young people. The idealised image of a mother would encompass the fundamentals of what we understand to be empathy, yet this is missing from the narratives of the young people and missing from the system which looks after them. What was most striking to me as the researcher was the trajectory of loss across the lifespan of the children young people in a way that cannot be quantified young people struggle to articulate what it meant them and as the researcher I had to look beyond the overwhelming sense of loss that resonated across all the narratives to try and find an understanding of what the overall findings might be. In order to be able to do this and as part of the overall methodology of the analysis it is clear that the young people's all loss of being a

core part of nursing and as such they were able to think about it with the nurse but also in the context of the research they were able to do this because I was a nurse and there were key references to the importance of this for them as enabling loss to be thought about. This moves into the context of the relationship and the fundamentals of the core part of the nursing allowing loss to be named and talked about there was also a question in relation to the nurses role in the system in it having this role attends to some of the loss and grief within the system in that the nurses in post somehow some of this unconscious very unprocessed raw grief and loss can be parked with their role and somehow attended to in the statutory functions of their duties. Whilst this might be oversimplifying a very complex process around grief and loss it does originate from the data analysis and perhaps was the only way the young people could find words to describe their experience and feelings in relation to this. Whilst this is a very thought provoking and difficult to define concept there was the beginnings of a very clear argument put forward by the young people about this role being missing from the system but was something that they experienced with the nurses. This correlates to the other domains in terms of the maternal aspect of the nurses identification by the young people the empathy they felt in the relationship and the ability of the nurses role to advocate for them within the system and somehow represent their experiences in this example is loss and how the young people felt the nurse was able to think about and process this with them it also indicated in many young people's narratives. The ability of the nurse to work in the system with them and stay with them throughout their care journey was highly articulated by all young people. This was also stated in a way that was an exclusive role that young people felt no one else had done or could do within their care network. This finding alone gives an important

understanding to the place of the nurse within lives of young people and also gives the nurse a significant place of importance in the system around young people. When analysing this more, the role of the nurse seemed to be able to attend to some of their grief and losses, not least by being there, being present and representing the maternal, but by instinctively and intuitively knowing what to say, how to say it, when to say it, when to be quiet and listen but overall just by being present for them.

What emerges from the analysis of all the transcripts is how the nurse is "caring" in the context of social care and is experienced differently by the young people to other types of care within their experiences. The use of the nurse's ability to portray that they care deeply, understand, can be kind and have a sense of humour, is all part of what the young people identified as defining nursing in their care context. What was interesting was there was much more of a focus from young people on what this meant and how this supported them not just that the nurses were undertaking tasks that related to care. This leads to the why-questions of what were the active task's that the nurses were undertaking and how were they undertaking that were important to the young people but also meant that they were fundamental to the relationship and the provision of care in the context of the young people's care journey.

It was very clear all the young people's narratives that they felt whole parts of the self and identity were missing and being with the nurse allowed this to be seen and experienced within the relationship. The nurse's role was able to fill some of the missing aspects and voids in their experiences. However, what was clear from the narration, is that this was fleeting and at times when the young people felt able to access it. This might be in part due of the type of appointments the young people had with the nurse and the fact that she was

not present all the time. However, there was a thought in young people's minds even if the nurse was not their physically, she was thinking about them. This summed up me as researcher the real impact of maternal reference points being lost and the need for this to be recognised.

6.3.10 The importance of trust and honesty

All the narratives described and gave examples of how the nurse would always be honest even when it was something they didn't want to hear, and this was one of the factors that seemed to inspire the young people's trust. Trust was also talked about versus the mistrust they felt towards other professionals and systems.

> Yeah man. There is a bit of me that tries, but like, I'm so mistrusting of social services. Not even my social worker… just like social services [in general].
>
> Fleur, Interview 2

This points to what is being offered within the relationship that leads to this offer data describes two important factors; being seen and being heard.

There are whole sections of narrative for each young person's transcript which relate to being seen and being heard. The dynamic which exists in the interaction of the nurse and the young people somehow enables this to be in the interaction and exist as an ongoing engagement. This led to looking beyond the theme of being seen and heard to trying to analyse what was important that enabled this to happen. This is further explored in the next section on systems.

6.4 The system

6.4.1 Systems

Throughout the narratives there is a conversation about 'the system', which far outweighs the occurrence of the terms 'social worker' or 'social care'. There is a

collective narrative that suggests care is something that is done to them, as part of a system, and they are treated as objects rather than young people. A comment of Isla's was most powerful when she says, "I am a tick-box, needs met". The dialogue changes when young people are discussing the nurses and their interactions with them, as if the nurse is seen as a separate part of the care system.

6.4.2 Reactionary care

All the young people spoke about their experiences of being in care as reactionary rather than planned. They would highlight that if they exhibited a specific behaviour then that would become the feature of their care, rather than being placed in the context of their lives. They also described their behaviour and communication and symptomatic of their experience rather than a wish to be different, yet the system only saw their behaviour, and their care would then revolve around that specific behaviour:

> All I heard was, 'Fleur ran away this many times… Fleur broke down this many placements…' I wish they would try and understand why I was doing that rather than list everything I've ever done wrong.
>
> Fleur, Interview 2

Except for Dinar and Isla, all the young people described aspects of their care as interventions, a very task-orientated word that excludes the humanness and perhaps more importantly the child focus of what their needs were.

> It's like I'm a demon I don't belong anywhere or with anyone.
>
> Fleur, Interview 1

6.4.3 Products of a system

As well as care being reactionary within a system, there was also an underlying narrative about care being an expendable commodity, separate to parenting. Young people referred to high-cost placements and breakdowns and used this

terminology to describe this as outcomes of their behaviour. These was a sense that they were talking about expendable products and not the lives of children and young people. This carried on to their experience of being Care Leavers, as if somehow there was a graduating process and a label of Care Leavers that defined who you were. There was an incredible sadness about this narrative, and a fatalistic acceptance given by most of the young people that this was their fate:

> The LA, they put on a consolation event for the Care Leavers.
>
> Isla Interview 2

It was Isla who describes the nurses as “There’s a way in which nurses communicate that isn’t social worky”. This was very striking at the time as the nurses are part of the system that cares for the young people, but they are not seen as, or experienced as a statutory service. This theme was strongly evident in every narrative and even when the nurses were referred to as being with social care they were a kinder, nicer, younger people centred part of the system. Even though the nurse’s visits are statutory and regulatory in minimum number- the human response was what the young people articulated rather than the care by systems narrative they had identified in all their interviews.

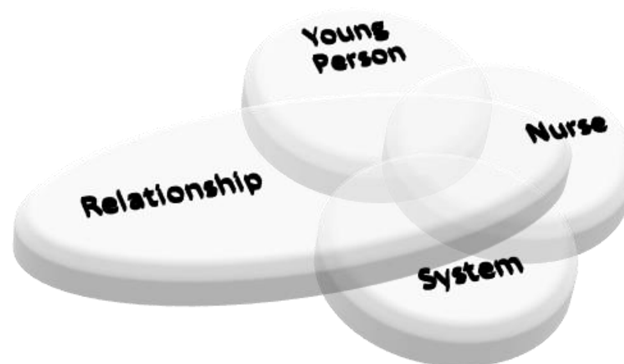
6.4.4 Disconnected

Across all the young people’s narratives there was a sense of disconnect with their care network in social care. It was talked about as an entity that they didn’t have a real relationship with; rather a phenomenon that was present in their lives. The young people were unable to talk about it in a concrete way, and referred to social are as ‘them’, ‘they’ or ’the management” often. No one spoke of individuals above the level of social worker by name. There was a sense that young people had positive relationships with their social workers, but they also

spoke of this being transient, as social workers moved on, left and sadly in Dinar's case his "favourite" social worker dies. There is an impression from the data that there is no sense of permanence available to young people from the system, and that part of their association with the nurse is some feeling of continuity, if not permanence.

There was a very clear suggestion in all the interviews that nursing sits outside of the corporate sphere and is seen as 'not social work'. The relationship with the nurse was the dominant discourse in all the narratives. The diagram in Figure 2 demonstrates the connectivity of the four domains in terms of interrelationships.

Figure 2 Interrelationships



The nurses are seen by the young people as outside their social care network but are somehow integral to it. The young people identified in their narratives that the nurses are not representative of social care, even though that is where they work. However, there was evidence within the young people's narratives that the nurses were important and relevant to the social care system. They seem to be saying the nurses were a part of the system, but apart from it too. There was a certain amount of distancing in the minds of the young people in terms of the nurse's role and position within the system. Health and social care are expected to function in partnership and the good intentions of parenting are the foundation from which the concept of corporate parenting was constructed

in policy. However, what the young people described in this study is how they felt the system was uncaring and didn't attend to their needs but only served to meet the needs of the system. This fragmentation and separation within the system could be a reflection of the young person's experience of the system as being unable to meet their needs all the time. It is also suggestive of an unachievable parenting task, when the system accommodates so many children and young people with so many needs. However. the narratives of the children young people placed emphasis on corporate parenting being more akin to a business with tasks and functions rather than a model of care.

The young people articulated quite clearly that they thought the corporate aspect of parenting rather than the parental aspect had been internalised by the organisation, and somehow the role of the nurse was more a parenting-type care delivery than the other roles within the care network. There is some sense that the young people recognised the relationship with the nurse was not regulated in the same way as the statutory obligations of social care, and this allowed for some creativity and innovation, enhancing the relationship and providing some sense of internal regulation to young people at times of emotional stress when they felt the system didn't know how to offer them any sense of regulation in relation to the pain they were experiencing.

6.4.5 Bearability and tolerance

Where the findings also merge across the domains is in relation to the nurses being able to bear and tolerate the aspects of the young peoples lived experiences from a place other than a statutory or professional position.

There was further narrative about the nurse being able to see and hear difficult experiences, and to bear them long enough to be thought about. The young people articulated a genuine sense of relief that the nurse could tolerate

any adverse experiences in the context of the interaction or care that was being given to a young person that would not change their ability to stay with the young person. This included Care Leavers feeling this long after they had left care and/or ceased regular contact with the nurse:

> I'd like to think I could still stay in touch with the nurse well into my 40s, even when I have my own children.
>
> Isla, Interview 2

The behaviours and characteristics of the nurses described in the experiences of the young people are all very close to the maternal aspects of a good mother that most people would recognise within contemporary British society. How nurses are experienced by the young people is a theme within all the narratives. As discussed, the young people had an expectation before meeting the nurse that they would be kind, helpful and able to support them. There was also a narrative that referred to it being "okay for the nurse to hear anything" without being judged, or without negative consequences. There was some expectation from the young people that their relationship with the nurse wouldn't change, and that she would always be around and a constant in their lives. I was very interested in this concept: that even when the nurse was not physically with them they had a sense that the nurse was thinking about them and holding them in mind.

There was substantial narrative about the nurse being able to see and hear difficult experiences and support the young person in acknowledging they had a difficult or traumatic time. Also, the way in which past losses were able to be spoken about and brought into the context of the relationship the young people had with the nurses was striking. All the young people articulated this in many ways: from something as simple as acknowledging that it might have been difficult to get to the appointment to something as far reaching as the

young person talking about undergoing female genital mutilation (FGM), seeing their house blown up or recognising symptoms of mental illness in themselves.

Linked to kindness, care, trust and honesty there was a softer, less obvious narrative around empathy and understanding. Whilst none of the young people used the word empathy, empathy was a theme that covered most of the examples that were given about the nature of the relationship and the type of understanding and emotions that were experienced:

> I had the feeling that I was understood… I felt lighter after I had told the nurse.
>
> Isla, Interview 2

Forrest (2011) poses that in nursing, being kind requires us to be vulnerable ourselves, whilst acknowledging distress and vulnerability in others. At times when we cannot offer any solution to another person's problems, kindness lets them just be as they are, offering companionship and acceptance of their feelings. This seemed to fit the description that most young people describe in the relationship with the nurse. I was interested in thinking about this more, and a key theme in the relationship domain may now seem obvious: that nurses see the young people as a patient, so whilst the young people may not see or describe themselves as a patient, they become one both in the nurse's mind.

6.4.6 Empathy

What was being described in all the narratives was the experience of care based on empathy:

> Wow, that hit me like a wave… like someone had, like, an understanding of my situation… like the nurse always felt connected with my experience. I started to cry… [sniffs and looks tearful] I know that sounds really over the top and a bit gushy, but it was like one of those moments like a reality check… it's not often anyone can do that.
>
> JT, Interview 1

What JT was expressing was his need to be understood: his situation, his life and why he behaved the way he did. From this understanding he experiences that someone was able to empathise with his situation. Empathy is suggested as being intrinsic to nursing practice (Scott, 1995) and empathising with the needs of patients is the essence of what makes a nurse. Empathy is, at its most basic level, a perception of and connection with someone else's feelings or situation. It involves compassion, responsiveness and understanding (Cunico et al., 2012). There were many more examples of the nurses being empathetic to the young people – this ranged from the way in which choice was offered to being sensitive to the young people's choice to the way in which the nurses introduced themselves, talked or approached each young person's difficult situation. All the young people articulated that the nurse understood what it was like to be them or be in their situation in some way.

Therapeutic relationships can take many forms, and in this research, the therapeutic range of behavior's and engagements was extensive and ranged from the nurse being funny to the nurse being empathetic. The narratives the young people articulated bore testimony to this fact and provided first-hand examples of this. Some were obvious and some less so, with meanings constructed from the examples. What was indisputable was the authenticity of the young people's testimony and the conviction with which they narrated the positive aspects of the relationship and the supportive facets of the nurse's interpersonal skills. The narratives also spoke of how in touch the nurses were with the young person's experience and situation and were able to relate to this in a way the young people felt supported and not judged:

> When no one was able to see I was in pain, even though I was literally cutting myself to pieces, the nurse just put her hand over the wound and said, 'You must be really hurting on the inside.'

JT, Interview 2

However, what developed as a finding from the narrative is how the nurse becomes a ‘mother’ archetype as they are spoken of in very motherly terms by the young people. There were many different examples of this across the narratives. When analysing this concept, it became obvious that there was a clear link to the concept of neglect and neglected children and young people and the association with the nurse as somehow being able to empathise with the neglectful situation of the young people. This was also seen as alive and present in the narratives of the young people currently. There were numerous examples of this: from the very practical empathy on offer in the conversations young people had with the nurses to a very physical empathy they felt. All of this pointed to the fact that the young people are cared for by the nurse’s key findings in relation to Domain 2, that the young people find nursing in their care context to be empathetic. This finding suggests that whilst there is contradictory reporting in the literature about empathy and clinical nursing, empathy in LAC nursing is key and fundamental to the success of the relationship the nurse can form with the young person within the context of nursing in a social care setting.

6.5 The nurse, the young person, the relationship and the system

Within this chapter I have presented the findings in relation to the domains and have presented the interrelating factors across each. What remains and is unanswered thus far is the underlying and more nuanced narrative that was difficult to extract from the young people’s experiences and their analysis. When the domains are brought together, and the totality of their shared findings is presented there is a missing part of the picture: the difficult and perhaps more challenging aspects of the young people’s experiences and how these are

attended to within the system. The more difficult aspects of the young people's behavioural responses to their experiences was submerged in the data and missing from their initial responses to the interviews. It is not in dispute that the young people have had experiences that led to them presenting difficult and anxiety-provoking behaviours and traits, which is well-known, researched and documented extensively in the literature (Meltzer, 2003). As the researcher, I get a glimmer of this in Fleur's difficult, awkward and sometimes defiant presentation during her interviews. There are hints of this in a less obvious way with the other young people: Dinar is very set in his way of giving information and often alluded to there being different versions of his story, when all that was needed was his account, whether that be somewhat based on his memory or not. Luna, Isla and JT all dictated the end of their interview and left when they had had enough and although this was absolutely their right to do, I was left wanting to know more and also with a feeling of being dumped or left. Narisa is very protective about certain details, and this was a frustration in the analysis. All these experiences and observations gave me a taster of what it might be like to be in a more intense relationship with the young people. It also bears a striking similarity to the intensity of the relationship the young people have with the nurse.

In the context of this research the young people see the nurse a minimum of twice a year, some young people who the nurse will be working with more intensely due to a health concern may see the nurse more, but typically this would be for a short period whilst the work is undertaken. Much less contact is had with the nurse than the rest of the care network, yet the young people in this research had the idea that the nurse was integral to their lives and the relationship was highly prized and valued. This raises questions

about the relationship being idealised in the young person's mind. What purpose this serves is not articulated, but from the data there is a collective and agreed sense that this relationship must be preserved, and nothing bad can be said about the nurse. This gives a sense of fragility to the relationship and how the young people view the nurse. It could be argued that the nurses have no real reason to challenge or change this assumption, as they may be unaware of the unconscious nature of the idealised relationship, and if the relationship is meeting the health needs of the young people then there would be no need, wish or desire to challenge it. It does raise the question; would the relationship be the same and go unchallenged if the frequency of interaction was more than is currently provided and offered? There is a compelling assumption that the relationship needs to be preserved and functions as a comforting ideal for the young people and – I would argue – the nurse.

Within the system this then raises another question: does the nurses role attend to the more idealised, caring part of parenting that cannot be found elsewhere? Is this helpful or not? I would argue that the anxiety held in the system about these very vulnerable and needy children and young people simply cannot attend to and hold all the very complex behaviour, undertake every task of caring and be attuned to every need of every child and young person. This is supported by the work of Woodhouse and Pengelley (1991). Whilst the authors didn't look at LAC nursing specifically, they draw poignant conclusions from their work and state that the totality of caring gets split between different professionals and others in the care network. The essence of this theory is portrayed in that data, but rather than anxiety being split, the task of caring gets split up into different dimensions, with the nurses being seen by the young people as the more caring part of the system.

The question that arises out of the findings is: does this split serve a helpful function within the system or not? Certainly it demonstrates that the nurse role or function as defined by the young people in this study has the capability to be helpful in a caring and potentially therapeutic way, in ways which the system cannot, and offers the young people who find it difficult to access the support on offer a clinical or structured alternative. Being part of the system but apart from the centrality of the parenting aspect, was something the young people struggled with. However, with the nurses this level of closeness was not something the young people found uncomfortable. This raises the question of how difficult it may be for nurses to occupy this type of parenting role as it feels not only tenuous by nature but fragile as it is isolated from the system, which could give rise to anxiety about the nurse's role. Whilst this hasn't been articulated in the research, it could be an unintended consequence of this type of splitting. This makes the relationship both tolerable and bearable for the young person as it is not experienced as overwhelming. This model of LAC nursing permits a therapeutic, developmentally aware, empathy-based approach. Within the overall system and the place of the nurse in it, it could be argued that the role and function serve as more of a conduit in the system that's not overly clinical but is accessible and able to find a way to work with young people who are difficult to support. Nursing is not overbearing or constant in the same way that social work and foster care might be experienced, and its boundaries are different.

From the young person's perspective, there is a strong desire to preserve the relationship in a positive way, given all their adverse experiences so far. The nurse's fit for this is enhanced by the young people's view of them as a maternal archetype. This relationship and ideal can be held due to the

frequent nature of contact, so this fragile fantasy can be preserved on both sides with real purpose. Therefore, you don't see the more troubling behavior that the system may see in other aspects and caring/parenting roles. It is also possible that the nurse's role in the system is more of a conduit to social care and the social worker. There were instances of this and its impact within the research process, where I undertook a piece of work with Fleur and her social worker and enabled a dialogue to enable Fleur to question why she was in care. Thus, the nurse's role may sometimes be split, but the evidence from the research suggests that the nurse's role is to bridge that split by acting as a conduit between the young person and their social worker, foster career or other workers from the system.

Chapter 7: Findings The nurse helped me think of some of the questions to be answered

7.1 Introduction

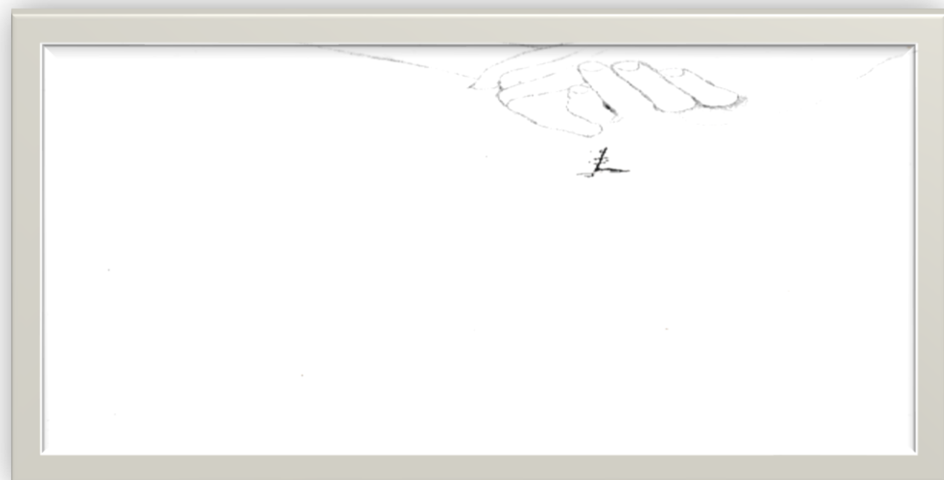
The overall findings are derived from the following sources:

- case characteristics
- case narratives
- domain findings.

In drawing all these together, I searched for the underlying meaning and narrative to form conceptualised findings. Two key areas were identified, which I go on the present in this section: the concepts of lost and being found and an adverse childhood experiences (ACE)-centric approach to Looked After Children's (LAC) nursing.

7.2 Lost and being found

Figure 3 'Hold my Hand' by Dinar



There were several ways in which the young people described the concept of being found. This theme started with reflection on the theme of loss and the

previous meta-themes that developed out of this. There was then further analysis of the relationship and the role of the nurse. Narratives of being lost and being found supported the presence and relevance of each other, as it seems entirely logical that to be found one must first be lost. There were some powerful examples of this in the case narratives and across all the thematic analysis presented so far. Thus, I start this chapter by exploring the concept of being lost, which is the hidden narrative that all the young people alluded to. I then progress to present two key concepts that underpinned this finding for being found: being seen and being heard.

7.2.1 Being lost as a young person

Throughout all the narratives there is a theme of loss which has been critiqued in depth and is indisputable given the gravity of loss experienced by the young people. However, when this is examined in the context of the young people's experience, the narratives are expressive of the young people's experience of being lost.

All the young people have experienced instability in their lives on a scale not usually experienced by young people who are not a part of the care system. This instability is well documented in the literature (Stein, 2006; Bielah et al., 1996; Broad, 1998; Broad, 2005; Children's Commissioner, 2017; Munroe and Hardy, 2006; Rock et al., 2003). How this manifested itself in the data were profound. The young people used the word 'lost' frequently in their narratives in relation to both their lives and how they felt and described themselves. From early experiences of childhood through to the present day their narratives all talked of being misplaced and missing. Whole chunks of childhood memories were absent for many and couldn't be recalled. They also spoke of not feeling they belonged anywhere and there was a sense of them being adrift in life.

Even Narisa and Isla, who were perhaps of the most grounded in terms of their education, employment and accommodation, spoke of feelings of confusion and bewilderment, all pointing to how they felt lost.

There could be an argument that most young people will at some stage feel lost, or at a loss to understand their lives and experiences. But what was different and striking with the young people in this study was the frequency with which they articulated feelings and experiences related to being lost and a profound sense of disconnection with society and the care network. Only Narisa and Dinar spoke of having a home, and this was in the past tense and about their countries of origin. None of the other young people articulated any reference to a home or a place to belong and be part of. There was a sense that this was completely lost and out of reach.

All the young people spoke about placements as a place to stay. There was no reference to any firm sense of belonging anywhere, and I was left with a strong sense that there was a longed-for place for the young people to feel that they could call home.

The pathway of the young people's lives though the care system and into Care Leaver territory and adulthood was described by them in phrases and expressions that further supported this sense of being lost. They used words like, 'alone', 'by myself', 'making my own way'. There was the obvious fact that none of the young people had any contact with their birth parents. This may have contributed to the phenomenon of being lost, but underneath this there was also a narrative that there was no one available to them and they were unwanted in some way.

JT talks about his placement and foster carer and how he felt physically and emotionally the weight of this experience. JT was unable to return to his

foster care placement and then felt lost amongst a chaotic adult mental health system. There is a profound and desperately sad reality in all the young people's narratives that they are unwanted, and this further exacerbated their sense of being lost.

7.2.2 Lost and the relationship with the nurse

There is a consistent theme and narrative account in the data that what the young people were articulating most was the loss of and need for a parental-type relationship. The responses I heard during my research provided very nuanced evidence to suggest some of this want and need to be 'found' was filled by the LAC nurses:

> It's like you know the LAC nurse can't be like a mum… but I am sure some of the kids – not me – maybe wanted the nurse to be their mum, as they are kind and generous, but like, they wouldn't let you come to any harm.
>
> Isla, Interview 1

There is also the possibility from what is known from the nursing literature that the nurse role often generates this type of dynamic in the needy (Peplau, 1952; 1962). It is likely that there was a tendency on behalf of the LAC nurses to unconsciously simulate a maternal role to the young people. All the young people expressed a need for the maternal reference point and were in many ways bereft of any female role model within their care network as no one referred to any other female in the same terms, showing how significant and consistent the nurse had been in their lives.

What was very clear from all of the narratives was that the nurse's presence in their lives reminded them of what was lost and brought it to the surface – their feelings could now be spoken about.

There is something familiar for the young people about the nurses, whether this is the maternal connotations and feelings the relationship brought out or a predetermined unconscious ideal that the young people ascribed to the relationship. It would seem without saying anything, the nurses were off to a winning start in terms of trust, communication and support for the mere fact of being a nurse:

> The LAC nurse came to see me and convinced the staff to let her take me for a milkshake, just to the café on the corner. I thought, 'Great escape plan!' but then I didn't want to escape from her, just the situation and the voices. She talked to me calmly and just, like, I said to her 'My head speaks in a language I don't understand. It's like there's all these other things going on and sometimes it's too much. She just like sat and, yeah, just sat with me… no look of panic or like, 'Oh shit, I'm with a mad boy!' She said something like 'You must feel very on your own and isolated here away from your carer,' or something like that. I said, 'I hear voices, I'll never be lonely.' It was funny at the time.
>
> JT, Interview 2

JT's quote supports this sense of lostness and being able to cope with difficulty as the nurse was with him. Even though there hadn't been a long-term established relationship, JT's sense was he could trust the nurse and he didn't feel the need to run, to get lost, or go missing. JT's words also convey powerfully how the relationship is more than just a health appointment or health intervention. The young people define the relationship in a way that nursing theory cannot, regardless of which nursing model of theorist that is referenced. The young people's narratives are raw, powerful and emphatic, opposed to theorical.

7.2.3 Lost within a system

Further analysis of the narratives takes the concept of feeling lost into the system that cares for the young people, and it is clear from the young people's narratives and the way in which they express themselves that the system takes

them from being lost and having experiences of loss and struggles with the dynamic. This takes the shape of the system not being in touch with their emotions and feelings, further contributing to their sense of being lost.

There were also very concrete examples in the data of the young people recounting that social workers were carrying out tasks and that there was a very set way in which they communicated with them and heard their emotions and issues:

> I feel like I am an appointment in someone's diary.
>
> Isla, Interview 2

As is evidenced in the data, that the system struggles to understand the young people and most poignantly their behaviour, as Fleur articulated so eloquently in relation to her own experiences of going missing and the system's response to that.

This is reinforced in other young people's narratives about the system reacting to behaviour such as going missing. Such behaviour meant there would be a meeting about going missing and interventions and plans would be put in place to try to manage that, instead of looking at the underlying behaviour and who would be best placed to support the young person with this. This was what they all seemed to be alluding to: that it was the person they felt they had a connection with who was best placed to advise them on this and support them.

One reason why this might have been the case is that all the young people also gave examples of where they felt they had been moved or passed on whenever they had an issue or a difficulty that the system couldn't hear, see or manage. The young people all stated that the nurse didn't do this and stayed with them to try and understand what the crux of the problem was and why they might be reacting in that way. Fleur speaks quite movingly about how she felt

whenever she spoke to her social worker, stating that before she had even finished talking, her social worker was already generating a referral to Child and Adolescent Mental Health Services (CAMHS) in her head. There were also very concrete examples in the data of the young people recounting that social workers were carrying out tasks and that there was a very set way in which they communicated with them and heard their emotions and issues.

The young people articulated that the system would see and react to their behaviour as a way from them to be chastised, punished or placed outside of the thinking of the organisation. This is rather than their behaviour being an expression of how they were feeling, and is also supported by Fleur's narrative and related to the concept of reactionary care in the domain's meta-themes.

There is comprehensive data in all the narratives about the nurse not being part of the system and that way of thinking. The young people also acknowledge how the nurse can work with and be with them and understand their behaviour in a way that the system simply cannot. Although they do not offer any narrative, and as previously stated, none of the young people related any of the system's behaviour to specific social workers, there is an idea in the minds of all the young people that the system is 'above' the role of the social worker. None of them define what the system is, as if it's unknown or unimaginable; there is nothing tangible in the data to reveal any real concept of this. However, it is striking that there is also no narrative from the young people about parenting within the system, and there may be a link to the idea that corporate parenting is simply something they cannot conceptualise or understand.

There is a strong sense of the system itself being at a loss and not knowing how to meet the needs of all the young people and the overwhelming lostness and loss of their situations.

Much of the data spoke on many levels to the fact that the system does not have a place to value the importance of relationships, that it is task-oriented and -driven, as Luna's narrative demonstrated so poignantly.

7.2.4 Being found

All the narratives describe how the nurse was able to seek out and find the young people, and not only when they were due to be seen for a health appointment. This was as simple as offering to be seen in a time and place of their choosing, to accompanying Narisa to an appointment about female genital mutilation (FGM) surgery, or at Dinar's last appointment, flying a kite with him. Young people were very clear that the nurse was able to prioritise them and their needs well and above all else made them feel safe. All these factors contributed to the theme of being found.

By their own histories and narrations, all young people were (to some degree) lost, some more so that others – Dinar was literally lost when he was found he was on a beach and didn't even know what country he was in. His first memory of someone in this country was a nurse telling him he was safe. Both Luna and Isla describe the actions of the nurse as helping them and helping them find things out that were important to them and helped build their own health histories, which contributed to their life narratives and sense of self. Narisa describes how she didn't even know how to bring up the subject of FGM but the nurse "helped her find her way", and JT tells me it was the nurse who could see him as a vulnerable child in the very distressing situation of being in

police protection. All are examples of how the young people narrated being ‘found’ by the nurse.

The contexts that were important to the young people and aided this sense of being found was the consistency and continuity with having the same nurse and how important this was. This concept on its own gives some validation to the significant impact the nurse’s role can have in the lives of children and young people in the care system.

7.2.5 Being seen, being heard

In the search for an understanding of how the nurses specifically found the young people, two main areas of the relationship where highlighted: being seen and being heard. This was described in many ways that included both passive and active tasks. There were real examples of active listening, which one would expect in a nurse-patient relationship, but there was something beyond and deeper than simply being heard. The young people were able to name, and give examples in context that showed they felt they had been heard in a way they didn’t feel heard in their care context. The first example of this is offered by Luna: “not social worky” (Interview 2).

There’s a way in which nurses communicate that isn’t ‘social worky’ – even though the visits are statutory – the young people all gave examples of how they felt the nurse’s response was human rather than statutory. There were also very concrete examples in the data of the young people recounting that social workers were carrying out tasks and that there was a very set way in which they communicated with them and heard their emotions and issues.

The was a different narrative in all the accounts about the nurse, further supporting that the young people felt heard in a way they didn’t experience in their care network. All the young people articulated that there was a way in

which the nurses were able to work with them in a supportive way that gave them the message they were heard and an understanding that they needed an opportunity to voice their feelings in a different way. How the nurses did this ranged from being very tenacious in meeting young people to undertaking activities.

There was a way in which the nurses communicate with the young people which JT describes as "talking my language".

All the young people spoke about the nurse's ability to know how to talk to them in a way that was not intrusive or uncomfortable but helped them to find the words they needed to describe what they were struggling with.

The nurse's ability to see and hear young people's concerns was also carried to other professional settings, as the young people felt the nurses were able to convey and articulate their understanding of them and their needs to other audiences in their care network.

There is an additional dynamic within the findings and that is the nurse's ability to see the young person in context:

> You could have, like, a childlike conversation with her. It seems silly saying this, no but like, 'Oh, I fell out with my best friend at school today…' If I had said that to my carer or social worker you can see the report now… it would have said something like 'Luna is struggling relating to her peers and finds the school setting challenging…' Most kids fall out with their friends at some stage don't they?
>
> Luna, Interview 2

There was a thread in all the young people's waiting to be found, like they expected that they would be somehow found in some way by the nurses and were waiting. Canham (1998) in one of his writings about young people in care describes his observation of visiting residential units and he was struck by the way in which young people hung around in the reception area or just outside the

front door, seemingly without purpose or agenda. Canham (1998) likened this to a waiting room, where someone was waiting to be collected or taken home. This powerfully resonated with my own practice experience and struck a chord with many of the narratives and the way in which the nurse was described.

7.2.6 Summary

The young people in this study had varied experiences of adults in their lives and the professionals involved in their care networks. What this chapter has illustrated is a poignant finding in relation to how the nurse's role is seen by the young people. Their narratives describe poignant aspects of this relationship. The centrality of being lost and found crystallises the collective narrative and experience of the young people.

7.3 An ACE approach to nursing

Figure 4 'War' by Dinar

7.3.1 Introduction: ACEs

The lives of young people in this study have been interspersed by trauma, abuse and maltreatment – all of which I have collectively described and defined

in the context of this study as ACEs. There are various debates in the literature about how to define both trauma and ACEs (Dube et al., 2001). This chapter sets out the ACEs the young people describe in their narratives and progresses to present and discuss the young people's trauma narratives.

The narratives of the young people in this study are referred to in the literature as chronic and multifaceted (Triesman, 2017). What was evident in this study was that the ACEs for all the young people began early in their lives and continued throughout their care experience. The impact of the ACEs can be seen in the data, and develops into a narrative about their trauma experience. From the data it is possible to plot the ACEs experienced by the young people. Table 27 demonstrates a trajectory. It charts the journey of the young people, starting with familial ACEs and progressing to ACEs in the CL phase of their lives. There is also a significant ACE around bereavement and stability.

Tables 28 and 29 chart the ACEs for the young people and demonstrate the historical and current ACEs. Table 30 charts the familial ACEs and the young people's shared experiences and Table 31 illustrates the ACEs that were identified in the data and attributed to each young person that were non-familial but occurring in their narratives

Table 26 ACEs

Familial	Bereavement	Stability	Pre-care	In care	Leaving care
• absent mother • absent father • history of parents in care • parent with history of childhood maltreatment or neglect • domestic violence or abuse in childhood (witnessed)	Death of: • a parent; mother • a parent; father • a sibling • extended family • friends • someone from care network.	• more than: ○ 3 placement moves ○ 3 social workers ○ 3 primary carers. • separated from siblings	• neglect • psychological or emotional abuse • criminality • going missing • child sexual exploitation • co-existence of mental ill health, family violence, substance misuse • threat of physical violence • threat of sexual violence • threat of torture • physical violence • actual sexual violence • actual torture • persecution arrest/ imprisonment FGM • physical destruction of home /community • trafficking	• accommodation temporary or homelessness • neglect • psychological or emotional abuse • criminality/ offending • going missing • child sexual exploitation • sexual exploitation • self-harm/suicide • trafficking • gang affiliation • persecution • arrest/ imprisonment	• more than 3 changes in placement/care • temporary accommodation or homelessness • neglect, emotional, physical or sexual abuse • incarceration • imprisonment • self-harm • more than ○ 3 social workers ○ 3 primary carers. • separation from siblings • going missing

Table 27 Familial ACEs, respondents identified by first initial

ACE event	Historical	Current
Absent mother	D, I, J	All
Absent father	D, I, L, J	All
History of parents in care	I, F	
Parental history of childhood maltreatment/neglect	I, L, F	
Domestic violence/abuse in childhood (witnessed)	F	
Death of a parent (mother)	D, N	D
Death of a parent (father)	D, N	D
Death of a sibling	D	
Death of extended family	D	D
Death of friends	D	D

Table 28 Non-familial ACEs, respondents identified by first initial

ACE EVENT	Historic	Current
Neglect	I, L, J	
Psychological or emotional abuse	I, L, J	
Criminality/offending		F, J
Co-existence of mental ill health, family violence, substance misuse	I, L, F, J	J
Threat of physical violence	D, N	D
Threat of sexual violence	D, N	
Threat of torture	D, N	D
Actual physical violence (FGM)	N	
Actual sexual violence	D, N	
Physical destruction of home/community	D, N	D, N
Trafficking	N	D
Death in care network	D	D
More than 3 changes in placement/care	I, L, N, J	D, F, J
Temporary accommodation or homelessness	I, L, N, J	D, F
Neglect, emotional, physical or sexual abuse	L	
Incarceration or imprisonment		D, J
Self-harm		F, J
More than 3 social workers	I, L, N, J	All
More than 3 primary carers	I	All
Separation from siblings	N	F, N
Going missing	F, J	F, J
Gang affiliation	D	
More than 3 changes in placement/care	D	All
Temporary accommodation or homelessness	D, N	All
Neglect, emotional, physical or sexual abuse	D*	J
Incarceration	D	D

Table 28 Non-familial ACEs, respondents identified by first initial

continued

Imprisonment	D	D
Self-harm		J
More than 3 social workers	D	All
More than 3 primary carers	D	All
Separation from siblings		
Gang affiliation	D	

The impact of these ACEs began early in life and therefore the young people deal with all types of adversity.

Whilst I have stated the young people in this study were exposed to many ACEs, they were in fact exposed to significantly more than in the ACEs study (Felliti et al., 1998). The original study devised a scorecard that divided ACEs into three groups: abuse, neglect and household challenges. The ACE score calculator developed from the ACE study asked 10 questions about experience of childhood trauma relating to ongoing physical abuse, emotional abuse, contact sexual abuse and physical and emotional neglect. The questions also include the presence of a substance misuser in the home, the presence of a depressed, mentally ill or suicidal family member, domestic violence, loss of or separation from a parent or parents and/or the imprisonment of a family member. All the young people would score in all the categories and would also have additional factors which have been set out in Chapter 4, but this includes more than three changes of placement, separation for siblings and going missing to name a few that are particularly pertinent to their experiences of being in care and commonplace to being in the care system (Children's Commissioner, 2017). By contextualising the young people's experiences and narratives as ACEs, a new way of seeing the data emerges and the level of ACEs the nurses are working with in the context of LAC nursing is clearer.

7.3.2 ACEs in narrative

> I walked home, bumping into people running away from me; it didn't enter my head to wonder why they were all going the other way. I turned a corner and just stood still, it was like I knew the place, but I didn't. It took a few minutes to realise the rubble on the floor was my house.
>
> Dinar, Interview 1

Dinars whole narration could be classed as an ACE narrative, but Dinar's excerpt gives a powerful visual representation of this memory. Whilst this was very striking, there were other less subtle yet powerful accounts across all the narratives, and when all the data is analysed alongside the case characteristics in Chapter 4, it is possible to see how interrelated and overlapping ACEs are in the lives of the young people.

Whilst the original ACEs study didn't include all the possible variables that I identified with the young people in this study, it does give a compelling and valid theory of the effect and impact of ACEs. The tables presented at the beginning of this chapter set out the ACEs that were articulated in the young people's narratives, and if I apply a similar scorecard approach to each young person, the following scores are set.

Table 29 Number of possible ACEs

Name	ACEs
Dinar	19
JT	14
Narisa	13
Fleur	10
Isla	9
Luna	9

Table 30 ACEs at time of interview

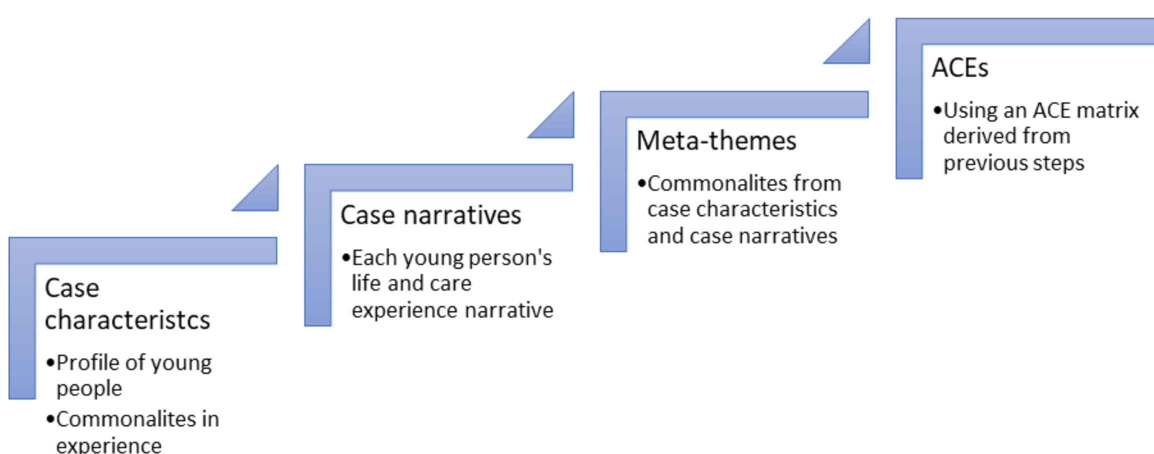
Name	ACEs
Dinar	18
JT	12
Fleur	12
Narisa	7
Isla	6
Luna	6

Table 31 ACEs related to loss

Name	Score
Dinar	16
Narisa	11
JT	8
Fleur	7
Luna	6
Isla	4

Tables 29–31 clearly state the ACE score ranges, but show both Dinar and JT as having higher ACE scores than the others and Narisa having a higher score on ACEs related to loss. The scores correlate with the case charateristics and would be a starting point to thinking about how ACE scores could be made more relevant for Looked After Children and Care Leavers in the context of their life expereinces. ACE narratives is the term I developed from bringing together the case characteristics, case narratives, and analysis thus far, incorporating the ACE framework. The process map in section 7.4 summarises the systhesis that was undertaken to arrive at this finding.

Figure 5 Thematic ACEs



From all that I have presented thus far in this thesis (and unlike the definition in fig 5), the experiences and frequencies with which the young people

experienced ACEs made them a commonplace event rather than an unusual one.

With the three young people who had been in care the longest, this impact manifested in their inability to recall memories and a lack of knowledge about themselves. Both JT and Fleur didn't even have basic knowledge of their parents and only articulated very loose details and would talk about this aspect in a way that was detached. Fleur really struggles with trying to recall and understand her experiences:

> For a very long time I have tried to understand the exact reasons why I've been in care… why I was taken from my family and out all over the place.
>
> Fleur, Interview 1

It was as if something in the first interview and what had been articulated reminded Fleur of her early sense of loss and adverse experience, and the only way she could cope with the feelings was to be demanding and ask for more of what she had got from the interview space. Whilst this might have been related to the need for a type of maternal contact, there is also an underlying unresolved sense of trauma. Fleur had recognised her own vulnerability and the need for help:

> Helpful? Are you having a laugh? How can that be helpful to anyone? I just felt like my social worker at the time just wanted to pass me on… me and my problems. Send them to CAMHS and they can think about them. I also thought they might think that they would find the magic solution to fix me.
>
> Fleur, Interview 2

For Fleur, her experience was that this support, understanding and help couldn't be found within her social care setting and had to be thought about elsewhere. Fleur's own internal belief system was that her memory was so distorted she

couldn't remember early experience, or even the reason she came into care. It is possible that, given Fleur's experiences, this presentation of struggling to think and recall are linked to early experiences which impact on the way information is recalled and recollected (Perry, 1999). There is no doubt that all the young people have experienced significant emotional turmoil and upset. Music (2011, p. 120) states that "Children who are traumatised also find it harder to put feelings into words or to organise their memories." It is possible the lack of the kind of parenting that gives rise to narrative capacities in children intersects with the impact of trauma, leading to even less likelihood of forming and processing memories. It is also clear that the young people in this study experienced a range of parental relationships and parental-type relationships, and there was a narrative from them about how confused they were about this and unclear on how to make sense of it. This illuminates why they couldn't explain entirely what the nurse did for them, as they were unclear and confused about how to define relationships.

There are various debates in the literature about how to define ACEs (Felitti and Anda, 2010). Whilst the debate may continue, within this study I would argue that it is defined by the young person's account and not limited to a list or scorecard. I have gone into detail about each young person's narrative in the case narratives and have also continued to articulate throughout this thesis the impact of some of these experiences on their lives and how they themselves have defined their own experiences in this way. What has developed without any prompting from me as a researcher is an ACE narrative as told by the young people. This includes how they have described their experiences and given their views, details events in a way that sets out how they have dealt with repeated ACEs and trauma.

What was evident from the data is that the young people's experiences do not occur within a vacuum: they are influenced by the care system around them, as well as relational and contextual factors. Therefore, the impact of these experiences is very likely to remain on a continuum. There were factors within the narratives of the young people and there were trauma variables, and each young person coped with and dealt with their traumas in different ways. The behavioural responses were discussed in relation to these.

7.3.3 The ACE nurse: trauma nursing redefined

There are many ways to define trauma and its many meanings. Within nursing there is a dedicated specialism of trauma nursing, which dates back as far as the origins of nursing and Florence Nightingale in the Crimean War (Beachley, 2005), to present-day nursing. Nurses are au fait with working with trauma and pain (Alzghoul and Manal, 2014) as to work with a patient is to work with a person who is in pain, distress or suffering of some kind. Bibi et al. (2018) state that nurses caring for those with severe physical injuries were more concerned about providing psychological support than physical care. Thus, describing the many dimensions there are to nurse. Nurses working in trauma settings is commonplace and has been since antiquity (Beachley, 2005). Whilst many studies describe trauma nursing settings as war zones and emergency departments to name a few (Sharpe, 2004). The young people were able to relate the role of the nurse to working in a chaotic environment.

> The nurse came out and sorted out the chaos that was the reception [in social care] and just like, went straight to the person who was hurt.
>
> Isla interview 1

Isla's narration speaks to a visual representation of a trauma setting that is the nurse working in social care. I can, as an experienced professional in this field vouch for the regular occurrence of these type of situations and the frequency

with which the nurse intervenes. Whilst this might not be a scene of physical injury, it does convey some of the meaning of working in an emotionally turbulence and traumatic environment. Just as the trauma nurse might work in an environment of injury, there is some link within all the narratives about the young person's view of the nurse being able to fix, or attend to some of their emotional trauma, in the same way you would expect a nurse to deal with physical injury.

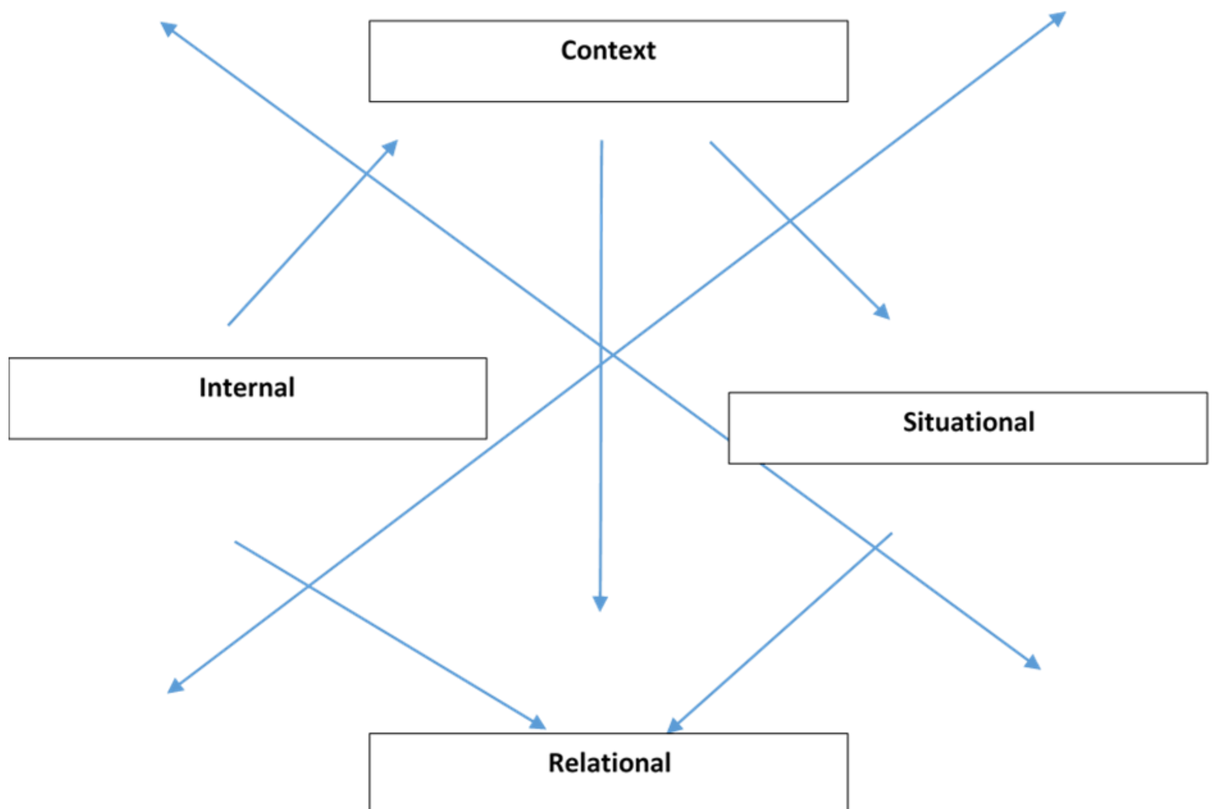
The nurses focus on the "wound" the ability to see amongst the chaos and confusion of the situation and get to the centrality and location of the injury and pain is what defines the nurse (Rudge, 2008). The narratives of the young people relate the emotional wounds they carry and arguably the after effect of early trauma and the important asset they were able to describe about the nurse's ability to see this in the way Rudge describes:

> But the nurse came out and like, it was calm and she helped the kids that were hurt. I would have called them all tossers and slung them out, but she was like, 'You can't fight each other,' and, 'That's not okay,' and they did listen. They had, like, kicked each other stupid.
>
> Isla Interview 1

All the people were able to articulate that the nurse is someone who is able to bear witness to painful experiences. The association between pain and trauma has already been discussed, but there was a dialogue in all the narratives about the nurse being able to see things differently. This was particularly evident in things that they found it hard to talk about and in doing so to name feelings and touch on painful experiences in depth that they were unable to do in any other setting, or with any other person. The diagram in Figure 6 details the context of the nurse and trauma in the context of the young people's narratives.

> Sometimes when I'm with the Looked After Children's nurses it helps me to think of some of the answers or even some of the reasons for the questions.
>
> Dinar, Interview 2

Figure 6 ACE nursing



The young people's narratives gave a picture of the nurse being able to work in their context, however emotional that might be, whilst being sensitive to their current situation. They state clearly that the nurses were able to do this in the context of their relationship with them which gave some connection with their internal state at the time.

There was an articulation about the nurse being able to assist the young people to recover from their painful experiences. This bears a stark resemblance to the reality of the specialism of recovery nurses who work in an acute hospital setting. The recovery nurse looks after the patient post-surgery, in a dedicated area called 'recovery'. Some aspects of this role were being

reflected in the way young people described their relationship, in a similar way to a patient having an operation, here was a pattern that was described by the people about the nurse being with them in their situation, whatever that might be, but with an emphasis on being able to help.

There were numerous examples of how the empathy-based approach to their care gave them the experience of being cared for. This response could be broken down into expressions of care – not just the way in which the nurse spoke to the young people and the physical actions that were taking place, but also the subtleties and nuances – for example the use of humour in the appropriate time, place in setting. Comforting injured minds, memories and bodies is another way to describe this element of care. Pain, hurt and injury was spoken about in the context of the situation and in a rational way. The nurses were able to tap into and touch on the internal worlds of the young people at the point of them being able to articulate, and the nurse being able to access, the interaction.

Seeing trauma, hearing trauma and responding to trauma in a way that was supportive and helpful to the young people was something that they all describe in every narrative, and sums up what the young people experienced with LAC nursing. I would suggest that trauma nursing is part of the role of the nurse in a social care setting, as defined by the young people and the findings of this study.

7.3.4 The ACE system

There is also a question about the system's ability to deal with this level of trauma and traumatised children and young people. As Fleur so eloquently states, she felt her narrative "couldn't be thought about and had to be sent to another organisation [CAMHS] to be thought about" and in Fleur's terms,

“fixed”. There are many similar examples and the young people related the system as being unhelpful and unable to meet their needs. Their frustrations and angst in relation to this radiated across all their experiences. To be able to look after these children and young people the system itself must able to tolerate them manage huge amounts of trauma and loss. Young people described how the system had stopped listening to them or was unable to hear their voices and what their needs were. In most of the narratives this led to a splitting, and the young person seeing the system as an inadequate parent. Anger, blame and shame all featured as parts of the young people’s reflective accounts. This portrayal by the young people links to their own traumatic experiences. The system caring for them must in turn deal with their traumatic experience and its manifestations.

There was strong evidence from the young people’s narratives in relation to the entire system around them becoming organised around the recurring and intense trauma responses they have. Fleur’s continual need to run away and be absent, Dinar’s overview well-meaning anxiety about his leave to remain are two examples of how the system became organised around managing their behaviours rather than looking at the source of the original trauma. The young people gave examples of complex interactions they had with the system which often occur between traumatised young people and overwhelmed workers, where pressured organisations and trauma response results in the young person re-experiencing the trauma (Bloom, 2010). A stark example of this was Isla referring to herself as a “tick box needs met checklist”. Her own early experience of not being seen or heard was echoed in the system’s response to her trying to retell her own narrative. One could argue that the system and its workers not being able to think about and hold in mind its young people is a

defence against unbearable psychic pain (Menzies-Lyth, 1960) and a symptom of a trauma-sensitised system. It is possible that the role of the nurse within this system and setting is to accommodate and bear some of the trauma-linked pain and its effects.

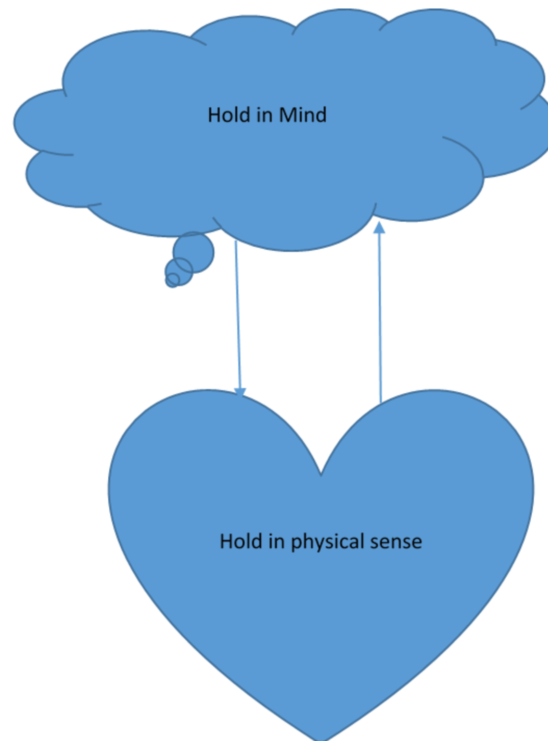
Bloom (2010) also states how trauma systems can become both hyper-reactive or hyper-aroused and dissociated. This relates to many examples the young people gave about not being seen or heard within the system.

Whilst not suggesting that any of the young people's challenges were minor to social care, this does resonate with how the young people articulated their own sense of how their problems were deal with. To Fleur, her behaviour was not a big deal, but she had internalised that the system couldn't deal with her and treated her as a "list of everything I've ever done wrong".

The psychodynamic perspective of organisational defences (Menzies-Lyth, 1960) is also helpful to this finding as Menzies-Lyth (1960) observed hospital settings and how nurses referred to and related to their patients. From this research she surmised that organisations construct themselves to prevent the workers within them from having to be in painful contact with the distress of their patients and the intimacy of personal care. In the setting of social care, the young people were kept constantly experiencing and visiting their own trauma. The young people were suggesting that the system was keeping them at a distance and was out of touch with their issues and struggles and failed to understand their needs. The nurses, however, responded in a different way, or from a different contact that allowed, or at least saw the behaviour and needs in a way that was not stressed and anxious, but in a way that permitted thinking and an empathetic response.

Nurses are not trauma-averse, whereas organisations can be (Bloom, 2010), and the young people in this study certainly articulated that as a reality in their experiences. This ability to be with the young person, bear and contain trauma was instilled and situated in their experience. Figure 7 illustrates this concept:

Figure 7 ACE nursing as defined by young people



7.3.5 ACEs in current practice

The use of an ACE approach to health assessments and working with young people in care from a nursing perspective, has not been developed. There are two standard tools which are currently used to assess health and well-being; both are pro formas (Merredew and Sampeys 2015). The general health form sets out a format for asking questions and checking the current health of the young person. It is very much an assessment based approach of asking questions which can rely on the skills of the person undertaking the assessment (Eichler 2009) and also becomes more of a check list, that can be impersonal

and takes away thinking. The other is the Strengths and Difficulties Questionnaire (SDQ). This asks questions about the young person's behaviour to the parents/carer, and the young person fills in a section. A score is then calculated, and this informs both the health assessments and care planning for the young people. The SDQ form does not contain any reference to ACE, or the history and experience of the child or young person, it only asks questions about their current behaviour. Both the health assessment and the SDQ is part of a statutory reporting framework, thus it is compulsory and must be done. So little consideration is given to using an alternative, which could include some thinking or questioning about ACE. There is criticism of the SDQ tool and its appropriateness to Looked After Children's health and well-being (Richards and Wood 2006) and also mixed reports on the outcome of continued monitoring of scores rather than engaging in a narrative way with young people who are looked after (Whyte and Campbell 2008). The Social Care Institute for Excellence published a report on improving mental health support for Looked After Children and Care Leavers in 2017. Care Leavers were intimately involved in the report and wanted an ecological approach to their support network, supporting a model that considered ACE.

There is an awareness of ACE in children's social care and an approach to thinking about working with children who are in care (Treisman 2017). However, at the time of writing, the literature reviewed related more to a practice based awareness rather than using ACE as a tool, assessment criteria, or approach to direct working with young people. There is international evidence of the negative impact on health and wellbeing for young people in care on the ACEs occurring earlier in the life course and with a greater intensity than the general population (Felleti et al 2010).

The ACE data and discussion generated in this thesis will offer a different perspective on how the impact of ACEs are viewed within the context of the life course of children and young people. Detailing how talking with the nurse as part of the statutory health processes can be thought about and ACE considered. This being part of the assessment and care planning process, rather than set pro formas with headings that ask set questions. This promotes a thinking and informed way of understanding ACE and a trauma informed assessment and subsequent care planning.

Finkelhor (2018) argues that it is still too early to start widespread screening for (ACE) in health care settings until we have understood the answers to significant questions:

1) What are the effective interventions and responses we need to have in place to offer to those with positive ACE screening?

2) What are the potential negative outcomes and costs to screening that need to be buffered in any effective screening regime?

3) What exactly should we be screening for?

Yet, to date there has been no research, or enquiry into using an ACE approach to health assessments. What is evidenced in this chapter is how an ACE approach to working with LAC and CL could be thought about and what additional factors would be included opposed to the traditional model of an ACE score card, considering an ACE approach to health assessment.

The concept of nursing in the care system moves out of a statutory framework, as the young people articulated in their narratives. This role then becomes a caring one of nurse and patient. Whist this is a different context to what we understand the traditional model of nurse and patient to be, the research proposed that in the young peoples' view the core skills of the nurse and the

caring role are not limited to a health care setting but extended to the setting in which the nurse is working, in this case social care. Whilst there might be maternal reference points from the young people to the nurse, the nurse is primarily functioning in an established role, even though the setting and the context of the care is giving is different.

The process map in 7.4 outlines the process young people stated happened in the approach taken by the LAC nurse in their care setting and describes how an ACE relationship-based approach would work in practice.

7.4 Process map

1. **Come from a position of trust**

   Pre-existing ideals and ideas about the person you will be and how useful you can be. This is in part a known entity and part of the accepted societal context of nursing.

2. **Confirm status in the mind of the young person**

   You are who I thought you would be.

3. **Enact the fantasy/reality in the first contact**

   The young people all had idealistic and positive first contacts with the nursing team.

4. **Be empathetic**

   The maternal aspect of the empathy-based approach secured the positive relationship.

5. **Tell it as it is**

   Naming and framing experience, explaining, interpreting and being helpful.

6. **Provide a containing space or function**

   Give time and space to allow dialogue and support the young person.

7. **Be consistent**
8. **Be there and alive in the patient's mind even when you're not**
9. **Maintain a position of trust (even when things are going wrong)**

From the data, the young people were stating that each profession seems to have its own conceptual and practice framework, rather than seeing the young person and working around that. The nurse's way of working was different to that of others and they were able to see and work with the young person in the context that they needed at the time. A finding from this study is that a conceptual framework is needed that draws all professionals together around understanding the young person's experience and responding to that in a way that is described in the process map in 7.4.

Children's service professionals see and understand children in different ways. To have different professionals seeing children in the same way and using a language that all professionals understand is no easy task. The issue of professional conceptualisation appears entrenched due to the "process of enculturation" (Easen et al., 2000, p. 357) and the "complexity of interaction and social practise" (Todd, 2007, p. 84). Different conceptualisations that professionals have across the key children's services can lead to dysfunction in a system. Practitioners could benefit from a common conceptual framework that is used across agencies to help understand and respond consistently to children's difficulties (Axford, 2006, p. 163).

Chapter 8: Conclusion

Figure 8 'Untitled' by Isla

8.1 Introduction

‘The nurse will see you now’ is a phase I’ve often heard in my career, but in this research, it seemed to sum up entirely what the young people were saying. The young people’s narratives tell of how the nurse was not only able to see them but hear them in a way they understood and felt comfortable with, and with a knowledge that they felt comfortable and supported by. In its most simple form, the research demonstrated the need for the role of the nurse within Looked After Children’s system from the young person’s definition. There were powerful narratives of loss, grief, being lost and the desperate need for some maternal reference point in the lives of the young people. Going missing was a dominant theme, and across all these aspects in the lives and experience of the young

people. This bears a striking parallel with the absence of the role of the nurse in policy, practice and literature in the field of Looked After Children's health and well-being, as the literature in Chapter 2 clearly demonstrated.

8.2 What sort of nurse are you?

The research may not have fully answered the thesis title, and in many ways has begun to ask more questions than it answers, but what is clear from undertaking the research is that young people's narratives have become a starting point from which to think further. Just as nursing seeks to redefine itself, so does the nature of human relationships and working with people at their most vulnerable and when crisis is never going to go away. What this research has done is to begin defining LAC nursing and its significance to both the wider nursing profession and children and young people. It's clear that as long as there are patients who need nursing, there will be a need to constantly review, refine and understand what nursing is. The questions this research raised were: how do nurses work with children and young people who are care experienced? What learning can be taken forward to improve both practice and understanding of the needs of this group and the needs of the nurses who undertake this type of work? What skills and training are necessary to work with such pain and trauma, which are experienced and played out in a very different context to what nurses are trained to do? Whilst post graduate courses are available, there is little to no post graduate training on working within Looked After Children and Care Leavers social care settings.

There is also a paucity of research in relation to nursing in a social care context, and into nurses working with Looked After Children and Care Leavers. However, it is hoped that this research might mark the foundation for future

studies and the beginning of a new direction in the nursing specialism and for further evidence-based practice.

All populations, well or sick, contain social care clients all in need of care. This research suggests there is a social care context in which LACs are nursed. Rather than nursing in a social care context, there should be an exploration of social care contexts of nursing, examining the contribution of nursing to social care practice, development and what really matters – improving and enhancing the lives and experiences of all in care, regardless of route of entry to social care or help and support. More and more, health and social care service providers are being asked or pressured by policy to become more integrated, yet no one has raised the important contribution nursing has made and can make to the social care and support of young people. This study has been the first stage of considering real world research and experience as the driver for more adverse childhood experiences (ACE) and trauma-aware approaches to providing nursing to what is a statutory requirement of a heath assessment to Looked After Children and Care Leavers.

This research demonstrates how nursing means so much more to the children and young people who took part in this study than a statutory duty or offer, and it could be argued that this is a reflection of shared views amongst other children and young people who are looked after.

Statutory guidance, intercollegiate documents and the standard approach to providing and commissioning health services for Looked After Children are all very helpful but none of them explain or even attempt to give guidance for how to work in practice with the level of separation, disruption, pain, loss and trauma that are inevitably encountered in this area. We talk a lot about trauma, but have we really explored the emotional impact of constant

sustained loss in the context of providing nursing to Looked After Children as a statutory requirement?

Perhaps the documents are not meant to do that, but a mention or even acknowledgement of this very difficult challenge would be helpful. Having completed this research and many years of practice in this area, I am left wondering if the policy documents do in fact act against anxiety, as if everything is split into tasks, allocations or resources, tools and checklists, we can as professionals distance ourselves somewhat from the reality of the experience for the children and young people.

This research suggests that a trauma-aware relationship model of practice is possible, sustainable and welcomed by young people if it can be accessed and if the nurse is able to be reflexive and responsive in their practice. This leaves the question of what skills, knowledge and experience nurses need to work in this area of practice, and what support do they need to stay with the young people on their care journey.

Absent parenting and the absence of a birth mother in the lives of children in care is commonplace. The extent to which the role of the nurse can and does attend to this void and the unconscious needs of the young people to fill the void with a maternal presence is immense, and the impact this has for both parties in this research has been positive, but also raises questions about the universal implications of this across the area of practice and young people's lives, which has yet to be explored though any of the literature I could identify. There is a deeper subtext to this too: society's need to hide neglected children and young people and let their needs be attended to by social care. In so much as nursing has provided some support to young people in social care, we are still in the same position as at the inception of children's social care and

children's nursing, with children who could not be cared for within a family context being taken away and cared for elsewhere.

In describing the nurse, the young people placed the most importance on the nurses' features of positive and pragmatic aspects of personality and professional temperament. These were vital to the young people and sustained and maintained dialogue in the most difficult of situations and life experiences.

This research has cemented in my mind the need for a very different understanding of the concept of the trauma nurse and trauma nursing. It is clear from the narratives of the young people that nursing trauma is not confined to the four walls of an emergency department.

The art of working with trauma is not limited to trauma specialists, and there is something deeply soothing about the presence of a nurse in traumatised minds. This research has started to evidence the huge contribution made by the relationship between young people and their nurses, and how this supports the emotional lives of young people. A small but significant example of this was the way the young people used the interview space and some of their feedback to me post-interview to echo the findings of how supportive they found it talking to a nurse in a place and space in which they felt at ease.

8.3 Impact of findings

The aims of this research were as follows:

1. To explore how relationships between and Looked After Children and Care Leavers the nurses who work with them are formed and developed in a social care setting.
2. To critically analyse the existing field of knowledge in this emerging, yet under-researched area of nursing.

3. To generate empirical data from interviews with Looked After Children and Care Leavers and formulate analysis that contributes to the body of professional knowledge.
4. To identify factors that are raised through the process of conducting research and being a researcher that also contribute to understanding the experience of Looked After Children and Care Leavers nursing.

8.3.1 Limitations of study

This group in this study may not reflect the national profile of Looked After Children and Care Leavers terms of age, gender and ethnicity. It was a local study that produced rich data that was previously unknown. However, the young people were volunteers who came forward and as such, I choose to proceed with the research rather than wait for a sample group that best reflected the population of the LA. A study that was more reflective of the population would possibly have given a different depth of data to be analysed, however I don't think it would have changed the main findings, as experience is relatable to others and in this case, with my findings there was a consistent narrative or conversation in all of the interviews, leaving me to suppose that the key findings were consistent.

I didn't find any data relating to addiction or substance misuse, learning difficulties or disabilities, or sexual abuse. Whilst no data were found from the research it cannot be excluded from the possible life experience of the young people – just that they didn't disclose these details as part of the interviews. There is a possibility that this was a hidden narrative that I didn't find evidence for.

This study was never intended to be a comparative study between nursing and social care. From the individual case narratives, a meta-analysis

was produced that developed into a thematic conceptual thread that crystallised across the analysis, discussion and findings.

8.3.2 Reflections

With hindsight, some aspects of the research would have been undertaken differently. I would have liked to have interviewed the social workers of the children and young people involved in the research. This would have produced significantly more data, however I am unsure if I would have obtained the same rich interview data from the respondents had I included their social workers.

As I was not involved in the recruitment and selection of participants, I gained a research group that did not accurately reflect the population of Looked After Children and Care Leavers I work with. In hindsight I might have left the recruitment phase open longer or canvassed more of my social care colleagues to talk to their caseloads about participating. This would however have meant I would have selected respondents rather than interviewing those who came forward initially, and this didn't feel ethically correct to me in the early stages of undertaking the research, as it felt wrong to take away an opportunity that had been offered. There is an argument that would suggest more reliable data would be produced by selected a group of participants that mirrors the Looked After Children and Care Leavers. However, having conducted the study I believe that the research data I gathered was valid and reflective of young people's situations and experiences and whilst it was personal to them there were correlations and commonalities within the data that I think are applicable to all . Looked After Children and Care Leavers. If I were to conduct a similar study I would give more consideration to the recruitment and selection of respondents.

Whilst I think the research undertaken is of great value and will make a significant contribution to my field of practice, it must be considered this is one study, in one setting, undertaken by a lone researcher. More research needs to be undertaken on a wider scale in similar settings to either support or refute my findings. I hope that similar studies will be undertaken and that any contribution I can make in the field will be a starting point focusing on Looked After Children and Care Leavers experiences of nursing in a social care context. I hope that the findings will inspire more reflective practice by practitioners and encourage more nurses working in social care to undertake research.

All young people involved in the study were interested in helping or assisting in decimating the findings and participating in further work – which is an opportunity to support ongoing involvement. I would like to take this forward and I plan to hold an informal consultation event to canvass views on the best method of moving forward.

Leeson (2012) states that quality relationships form the backbone of social work with children and their families. They are particularly relevant in the close, intimate work with Looked After Children who have identified how important it is to them that their relationship with their social worker is positive, warm and meaningful. It is accepted that to achieve and maintain successful and meaningful relationships, practitioners need to engage at an emotional as well as a professional level. All too often this requires a trade-off between organisational efficiency and the emotional work of caring for Looked After Children. Therefore, it would appear the role of the corporate parent is increasingly difficult, involving complex decisions about how practitioners might best spend their time, where their loyalties lie and the quality and direction of the final output. Using data from a series of interviews with practitioners, this

paper explores the difficulties of maintaining active emotional engagement with children using the sociological concept of emotional labour (Leeson, 2010). My research supports this view and places the nurse in a central position that can support young people who are looked after, in social care and in the system of corporate parenting.

Finally, over the course of the research and analysis, my views of the contribution of nursing to the emotional life of Looked After Children and Care Leavers evolved. I became far more aware of the myriad of factors that contributed to my own professional and perspectives. I acquired greater insight and depth of understanding of the Looked After Children and Care Leavers I worked with and, as a researcher, I was able to learn much from them. I became more knowledgeable about their beliefs and values. I was able to examine my own practice and professional values and assess how my knowledge impacted on the relationships. I had not really considered my own maternal attitude and the effect it had on Looked After Children and Care Leavers. I had not realised the breadth of unconscious processes around parenting, maternal and paternal roles that resonated with them in their relationships with key staff across key children's services, and the research gave me a salutary reminder as to the importance of the Department for Education (DfE), and the need to understand and respect each other's roles and responsibilities.

8.3.3 Future work

The importance of narrative and the spoken word cannot be underestimated: in any setting, working relationships are at the centre. Therefore, I hope to bring to life the narratives of the research respondents who took part in this thesis and research study through both the written word and the spoken word. I have

secured funding from my organisation for a short film to be made which will use child actors to portray the key narrative messages from this small piece of research. My rationale for these fits with my original aims of undertaking the research, that the voices of Looked After Children and Care Leavers should be heard. Having completed the research and having been the researcher in the room hearing the stories, I wanted to bring some of that powerful experience of being with, being alongside and understanding right to the heart of practitioners continued professional development. A film with children's voices will reach parts of people's understanding and resonate with their experiences in a way that written words cannot. I hope the persistence of the human voice will endure long after my thesis is gathering dust on a library shelf. Table 31 outlines the current status and plan for dissemination.

Table 31: Dissemination

Develop learning narratives from case narratives	Integrate into learning packages within workplace and an online medium	February 2020	Currently working on an e-learning package with my employers IT department
Short film	Film to be used in presentations and social media	September 2019	Completed and available as a pod cast
Sharing interdisciplinary knowledge	Present at own organisation learning and staff events Present at Local Authorities currently aligned with Enquire about presenting at Association of Directors of Children's Social Care	February 2020 February 2020	Currently in discussion with new Partnership for Safeguarding Currently in email correspondence with Chairperson

Table 31: Dissemination continued

Develop Bite sized patient experience learning	Use key quotes as opening/closing sections of team meetings and other meetings I chair	June 2019	Completed
Conference dissemination	Post Viva: Contact CoramBAAF RCN Looked After Childrens Forum Offer to present	January 2020	Currently in discussion with: • CoramBAAF • Childrens Staying Healthy Forum Chair of Royal College of Nursing

Table 31: Dissemination continued

Journal publication	Publication of initial data Future publications Draft articles for: Nursing Children and Young People Evidence Based Nursing Journal Adoption and Fostering	Adoption and Fostering publication March 2019 March 2020	In discussion with Editorial teams: • Adoption and Fostering CoramBAAF • Nursing Children and Young People • Evidence based Nursing

8.3.4 Recommendations

- To replicate research with both LAC nurses and social workers and triangulate outcomes and findings to gain an overall picture. This could also be extended to include carers and residential workers.
- To develop a narrative-based condensed training tool from each young person's case narrative.
- To further research an ACEs- and trauma-informed evidence base for LAC nursing.

- To use the findings as a basis for dispelling the practice myths around not asking young people to tell their stories – the young people in my study very much wanted to share their experiences.

8.4 Closing summary

I recognise the need to bring together shared knowledge and skills to best meet the emotional needs of Looked After Children and Care Leavers and will aim to do this via the research dissemination from a nursing perspective.

However, there is a need for conceptual framework professionals working across health and social care, particularly considering the proposed changes to health funding and the organisational structure of health and social care, as currently there is no literature or evidence base that brings this together other than policy and statutory guidance.

It is hoped that the research acts as a transdisciplinary learning agent in that it transcends disciplinary and multidisciplinary confines. As a nurse for Looked After Children and Care Leavers I am committed to trying to find a way to bring the people, professionals, and care network around Looked After Children and Care Leavers together. I hope to do this is by presentation and dissemination of the findings. I thought a very effective way to do this would be to share some of the stories from the research so professionals and any other interested party can hear first-hand the narrative of Looked After Children and Care Leavers rather than my opinion or analysis. I also thought this might be a better way of unifying and bringing people together and of facilitating relationships rather than segregating them into professional disciplines.

Absenteeism, in this context, refers to how absent the LAC nurse role is in primary legislation and cross professional policy. The Children and Social

Work Act (2017) has many references to multi-agency working, yet there is no mention of the designated LAC role.

This thesis submission contributes to the field of psychosocial studies, LAC nursing and nursing in social care settings. It is a piece of research that aims to transcend professional disciplinary boundaries by focusing on the voice of the child rather than professional discipline.

8.5 The research questions: conclusion

8.5.1 What are the experiences of LACs and young people of specialist nursing in a social care context?

All the children and young people spoke about all their interactions with the nurse in an overwhelmingly positive way. All spoke of how they felt relaxed, able to talk, and were valued and respected by the nurses. They attributed all of this to the nurse's ability to make them feel comfortable and talk to them on their level. The practical aspect of how the nurses delivered the service was the most important factor in determining how engaged the young people felt in making decisions about their health care. Of most value was choosing a place and ti and making the health assessment process about them rather than attending a health appointment with pre-set questions. Without exception, this describes how a conversational style with a nurse who didn't obviously fill in a form was the most important aspect of their engagement:

> There are no time limits. They don't have another appointment to go to or someone waiting to see them. They had made time and space to see us in our time.

8.5.2 What does it mean to Looked After Children and young people to work with nurses during their care journey?

All the young people spoke about the positive impact of having a consistent health professional involved with them throughout their care journey. They valued highly the idea that there was someone available to them to answer health questions, and saw this as being essential even after they left care:

> I'm leaving care. I've had 18 social workers, 1 nurse. I know who I'd go to if I needed help, and it's the nurse.

8.5.3 What meaning do Looked After Children and young people make of this experience?

What interested me most about the narrative and is consistent across all interviews was the amount of trust and positive regard there was for the nurses. There was an idea that even though you only saw the nurse once a year, the nurse was always available and accessible, and the young people placed great emphasis on this. The following quote best describes what's important:

> It's not about meaning or logic, just being there.

8.5.4 What can this tell us about the care experience and the role of nursing?

The emerging findings are fully supportive of the role of nursing in enhancing good relationships with health professionals and the care network. The following quote is in relation to a young person accessing their GP:

> You can't have a relationship with a form or a screen when you're 14 and in need of someone to listen. I didn't feel like I was just an appointment in someone's dairy, I felt like a person.

We are excellent at detailing the epidemiology of Looked After Children and Care Leavers and tangible measurable outcomes, but a future aspiration would

be to have as much narrative and qualitative data as we do quantitative information.

8.6 A note on quality assurance

Throughout my research and thesis journey I have often wondered if the most important part of quality assurance within organisations where there are high levels of anxiety is misplaced. More and more in today's health and social care landscape there is continued and relentless focus on targets and quantitative reporting. One could argue on one level that this is important, but many have counter-argued that the relentless focus on numbers distracts from what really matters to both patients and people working in human services.

From my own experience I can only support this counterargument and my own view is that quality assurance comes from qualitative information and research and is more related to how people experience being cared for rather than how many people were cared for and within what timeframe. I continually hear from commissioning bodies that they wanted more about inputs and outputs and thematic analysis. I have yet to be asked how LACs and young people are, or about their emotional well-being. I would like to pose the question at this stage and ask: 'Where is the 'you' in quality?' I would like to hear more practitioners and organisations asking their patients: 'What matters to you?' Can't we measure quality by users' experience of our service?

8.7 From young people

It seems only fitting and entirely appropriate that the closing statement of this thesis be from a young person. A token, relating back to founding hospital, where parents, usually mothers, left their babies with a memento in the form a

token. This poem was sent to me by Luna when the research had been completed:

> It can be about a courage but
>
> A token is a gift
>
> It might be to heal a rift
>
> A token is a thank you
>
> Often of great value
>
> A token is meant
>
> With heartfelt lament
>
> A token is a message
>
> To let you know
>
> That I no longer feel low
>
> And you have made it so
>
> Thanks, is not enough
>
> But you need to know
>
> My token to you all is
>
> My story warts and all

Luna, post-interview

Ultimately what was spoken about in this research was the power of another human having the time and capacity to connect with another, ably assisted by the skills, knowledge and label of 'nurse'.

References

Adams, M., Robert, G. and Maben, J. (2015) 'Exploring the legacies of filmed patient narratives', *Qualitative Health Research*, 25(9), pp.12–41.

Allen, G. (2011) *The Allen report*: *early intervention*: *the next steps*: *an independent report to Her Majesty's Government*. London: HM Government.

Allin, D.S. (2010) *The early years of the Foundling Hospital 1739/41–1773*. London: D.S. Allin.

Alzghoul, M.M. (2014) 'The experience of nurses working with trauma patients in critical care and emergency settings: a qualitative study from Scottish nurses' perspective', *International Journal of Orthopaedic and Trauma Nursing*, 18(1) pp. 13–22.

Appleby, J. and Devlin, N. (2004) *Measuring success in the NHS*: *using patient-assessed health outcomes to manage performance of healthcare providers*. London: Kings Fund.

Ashburner, C., Meyer, J., Cotter, A., Young, G. and Ansell, A. (2004) 'Seeing things differently: evaluating psychodynamically informed group clinical supervision for general hospital nurses', *Journal of Research in Nursing*, 9(1), pp. 38–48.

Åstedt-Kurk, P. (2014) 'Humour in nursing care', *Journal of Advanced Nursing*, 20(1), pp. 183–188. Available from: https://onlinelibrary.wiley.com/toc/13652648/1994/20/1.

Aust, P.H. (1981) ‘Using the life story book in treatment of children in placement’, *Child Welfare*, 60(8), pp 535-560.

Axford, N. (2006) ‘Developing a common language in children’s services through research-based, inter-disciplinary training’, *Social Work Education*, 25(2) pp. 161–176.

Bagnoli, A. (2002) ‘Beyond the standard interview: the use of graphic elicitation and arts-based methods’, *Qualitative Research*, 9, pp. 547–570.

Bains, M., Shortall, C., Manzuangani, T., Cornelius, K. and Russell, K. (2018) ‘Identifying post-traumatic stress disorder in forced migrants’, *British Medical Journal*, 361, p. 1608.

Barber, P. (1991) ‘Caring: the nature of the therapeutic relationship’, in Jolley, M. and Perry, A. (eds.) *Nursing*: *a knowledge base for practice*. London: Edward Arnold, pp. 230–270.

Barker, J. and Weller, S. (2003) ‘“Is it fun?” Developing children centred research methods’, *International Journal of Sociology and Social Policy*, 23, pp. 33–58.

Barker, P. (1993) ‘The Peplan legacy’, *Nursing Times*, 89(11), pp. 48–51.

Barnes, E. (ed.) (1968) *Psychosocial Nursing*. London: Tavistock.

Barr, H. and Ross, F. (2006) ‘Mainstreaming inter professional education in the United Kingdom: a position paper’, *Journal of Inter professional Care*, 20(2), pp. 96–104.

Baruch, G., Fonagy, P. and Robins, D. (2007) *Reaching the hard to reach*: *evidenced-based funding priorities for intervention and research*. Chichester: John Wiley and sons.

Bate, P. and Robert, G. (2006) ‘Experience-based design: from redesigning the system around the patient to co-designing services with the patient’, *British Medical Journal: Quality & Safety,* 15, pp. 307–310.

Bass, S., Shields, M.K. and Behrman, R.E. (2004) ‘Children, families, and foster care: analysis and recommendations’, *The Future of Children*, 14, pp. 4–29.

Beagley E., Hann G. and Al-Bustani, N. (2014) ‘Mental health needs of Looked After Children’s in one of the most deprived boroughs in England’, *Archives of Disease in Childhood*, 99: A69.

Beachley, M. (2005) ‘The evolution of trauma nursing and the society of trauma nurses: a noble history’, *Journal of Trauma Nursing*; *Philadelphia*, 12(4), pp. 105–115.

Benner, P.E., Tanner, C.A. and Chesla, C.A. (2009) *Expertise in nursing practice*: *caring*, *clinical judgment and ethics*. 2nd edn. New York, NY: Springer.

Beresford, B. (1997) *Personal accounts: involving disabled children in research social policy*. London: Stationery Office.

Berridge, D. (2012) ‘Educating young people in care: what have we learned?’, *Children and Youth Services Review*, 34(6), pp. 1171–1175.

Bibi, S., Rasmussen P. and McLiesh, P. (2018) ‘The lived experience: nurses’ experience of caring for patients with a traumatic spinal cord injury’, *International Journal of Orthopaedic and Trauma Nursing*, 30, pp. 31–38.

Biehal, N. and Wade, J. (1996) ‘Looking back, looking forward: Care Leavers, families and change’, *Children and Youth Services Review*, 18(4) pp. 425–445.

Bion, W. (1961) *Experiences in Groups*. London: Tavistock.

Bion, W.R. (1962) *Learning from Experience*. London: Heinemann.

Birheim-Crookall, L. (2016) ‘How social workers can track and boost the happiness of Looked After Children’s’, *Community Care,* March, p. 12.

Bisson, J.I., Cosgrove, S., Lewis, S.C. and Roberts, N.P. (2018) ‘Post-traumatic stress disorder’, *British Medical Journal*, 351: h6161.

Black, N. (2013) ‘Patient reported outcome measures could transform the NHS?’, *British Medical Journal*, 346: i167.

Black, S. (2008) ‘Project to restore care is transforming care?’, *Nursing Standard*, 22(48), p. 10.

Black, S. (2011) ‘Bury the bill NHS complexity, not bureaucracy, is issue in health bill’ (letter), *British Medical Journal*. 348(7963). Available from: https://doi.org/10.1136/bmj.d4725

Bloom, S. (2010) 'Organizational stress and trauma-informed services' in Levin, B. and Becker, M. (eds.) *A public health perspective of women's mental health*. New York, NY: Springer.

Boss, P. (1999) *Ambiguous loss*. Cambridge, MA: Harvard University Press.

Boss, P., Beaulieu, L., Wieling, E., Turner, W. and LaCruz, S. (2003) 'Healing loss, ambiguity, and trauma: a community-based intervention with families of union workers missing after the 9/11 attack in New York City', *Journal of Marital and Family Therapy*, 29, pp. 455–467.

Boucher, P.A. and Riggs, N.A. (2014) 'Practicing narrative inquiry: Chapter 11' in Leavy, P. (ed.) *The Oxford Handbook of Qualitative Research*. Oxford: Oxford Library of Psychology.

Braun, V., and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77–101.

Briggs, S. (2005) 'Psychoanalytic research in the era of evidence-based practice' in Bower, M. (ed.) *Psychoanalytic theory for social work practice*: *thinking under fire*. London, Routledge.

Broad, B. (1999) 'Young people leaving care: moving towards 'joined up' solutions?' *Children Society*, 13, pp. 81–93.

Broad, B. (2005) *Improving the health and well-being of young people leaving care*. Lyme Regis: Russell House Publishing.

Brosz- Hardin, S., Weinrich, S., Weinrich, M., Garrison, C., Addy, C.A. and Hardin T.L. (2002) 'Effects of a long-term psychosocial nursing

intervention on adolescents exposed to chronic stress', *Issues in Mental Health Nursing*, 23(6), pp. 537–551. doi:10.1080/01612840290052712.

Buchanan, A. (1995) 'Young people's views on being looked after in out-of-homecare Under The Children Act 1989', *Children and Youth Services Review* 17(5), pp. 681–696.

Bundle, A. (2008) *Cafcass Health and wellbeing review*: *The experiences of young people in care*. London: Cafcass.

Cameron, D. (2009) *David Cameron Speech*. [Online]. 11 May, RCN Congress. Accessed 31 May 2013. Available from: *http://www.conservatives.com/News/Speeches/2009/05/David_Cameron_Speech_to_the_Royal_College_of_Nursing.aspx*.

Campbell, M., Fitzpatrick, R., Haines, A. and Kinmonth, A.L. (2000) 'Framework for design and evaluation of complex interventions to improve health', *British Medical Journal*, International edition 321.7262 694–696.

Carnevale, F.A. (1997) 'The experience of critically ill children: narratives of unmaking', *Intensive and critical care nursing*, 13(1), pp. 49–52.

Care Leavers Association (2017) *Caring for better health*: *an investigation into the health needs of Care Leavers*. London: Care Leavers Association.

Canham, H. (1998) 'Growing up in residential care', *Journal of Social Work Practice*, 12(1), pp. 65–75.

Carter, B. (1998) 'Children – silent consumers of healthcare', *Journal of Child Health Care*, 2, p. 57.

Carter, B. (2002) 'Chronic pain in childhood and the medical encounter: professional ventriloquism and hidden voices', *Qualitative Health Research*, 12, pp. 28–41.

Carter, B. (2011) 'Ethical aspects of paediatric nursing research' in Brykczynska, G. and Simons. J (eds.) *Ethical and philosophical aspects of nursing children*. Oxford: Whiley-Balckwell, pp. 201–209.

Carter, B. and Ford, K. (2013) 'Researching children's health experiences: The place for participatory, child-centred, arts-based approaches', *Res. Nurs. Health*, 36, pp. 95–107. doi:10.1002/nur.21517.

Carter, B., Bray, A., Dickinson, M., Edwards, K. and Ford, A. (2014) *Child centred nursing*: *promoting critical thinking*. London: Sage.

Casey, A. (2015) 'An international comparison of children's nursing roles' chapter 3 in Hughes, J. and Lyte, G. (eds.) *Developing nursing practice with children and young people*, pp. 36–51. Chichester: Blackwell. doi:10.1002/9781119102342.ch3.

Critical Appraisal Skills Programme (CASP). http://www. casp-uk.net/ (accessed 01.02.20).

Chapman, J. and Martin, D. (2013) 'Nurses told, "you're not too posh to wash a patient": minister orders student nurses back to basics to improve compassion in NHS', *Daily Mail,* 25 March. Available from: www.dailymail.co.uk/news/article-2299085/Youre-posh-wash-patient-Minister-orders-student-nurses-basics-improve-compassion-NHS.html. (Accessed: 13 May 2012).

Children's Commissioner (2017) *Stability Index for Children in Care*. London: Office of the Childrens Commissioner.

Children leaving Care Act (2000) *Children Leaving Care Act*. London: Department of Education.

Clandinin D.J. and Connelly F.M. (2000) *Experience and story in qualitative research*. San Francisco: Jossey-Bass.

Chapman, J. (2002) *System failure*: *why governments must learn to think differently*. London: Demos.

Clarke, S. and Hogget, P. (2009) *Researching beneath the surface*. London, Karnac.

Coad, J. and Houston, R. (2007) *Involving children and young people in the decision-making processes of health care services*: *a scoping of the literature*. London: Action for Sick Children.

Coad, J. and Lewis, A. (2004) *Eliciting children's views.* Retrieved from http://www.ne-cf.org on 23 September 2007 Full version available from: DfES/ne-cf.

Coad, J.E. and Shaw, K.L. (2008) 'Is children's choice in health care rhetoric or reality? A scoping review', *Journal of Advanced Nursing*, 64, pp. 318–327. doi:10.1111/j.1365-2648.2008.04801.x.

Cooper, A. and Lousada, J. (2005) *Borderline welfare*: *feeling and fear in modern welfare*. London: Karnac.

Cope, S. (2015) 'Ensuring that 'hard to reach' young people agree to health assessments', *Nursing Children and Young People*, 27(10, December), pp. 26–31.

Hadley Centre for Adoption and Foster Care Studies (2015) *Children and young people's views on being in care*: *a literature review*. London: Coram Voice.

Corbin, J. (2008) 'Is caring a lost art in nursing?', *International Journal of Nursing Studies*, 45, pp. 163–165.

Cornwell, J. and Goodrich, J. (2009) 'Exploring how to enable compassionate care in hospital to improve patient experience', *Nursing Times*, 105, p. 15.

Crinson, P. (2007) *Illness as a social role.* Available from: http://www.healthknowledge.org.uk/public-health-textbook/medical-sociology-policy-economics/4a-concepts-health-illness/section2 (Accessed 19 June 2010).

Cossar, J., Brandon, M. and Jordan, P. (2011) *Don't make assumptions*: *Children's and Young People's Views of the Child Protection System and messages for change*. London: Office of the Children's Commissioner.

Cunico, L., Sartori, R., Marognolli, O. and Meneghini, A.M. (2012) 'Developing empathy in nursing students: a cohort longitudinal study', *Journal of Clinical Nursing*, 21, pp. 2016–2025.

Darbyshire, P., MacDougall, C. and Schiller, W. (2005) 'Multiple methods in qualitative research with children: more insight or just more?', *Qualitative Research*, 5, pp. 417–436.

Dartington, T. (2010) *Managing vulnerability*: *the underlying dynamics of systems of care*. London: Karnac.

Darzi, A. (2008) *High quality care for all*: *NHS Next Stage Review final report*. London: Department of Health.

Dawson, J., Doll, H., Fitzpatrick, R., Jenkinson, C. and Carr, A.J. (2010) 'The routine use of patient reported outcome measures in healthcare settings', *British Medical Journal*, 340:c186.

DCSF (2009) *Statutory guidance on promoting the health and well-being of Looked After Children's London*. London: Department for Children Schools and Families.

DfE (2012) *Children looked after in England (including adoption and Care Leavers) year ending 31 March 2012*. London: Department of Education.

DfE (2015) *Promoting the health and well-being of Looked After Children's*. London: Department of Education.

DfE (2017a) *Children looked after in England (including adoption)*, *year ending 31 March 2017*: *additional tables SFR 50/2017*. London: Department of Education.

DfE (2017b) *Children looked after in England (including adoption)*, *year ending 31 March 2017 SFR 50/2017*. London: Department of Education.

DfE (2018a) *Statistical Release*: *children looked after in England (including adoption)*, *year ending 31 March 2018*. London: Department of Education.

DfE (2018b) *Applying corporate parenting principles to Looked After Children and Care Leavers*: *statutory guidance for local authorities* London: Stationery Office.

DfE (2018c) *Promoting the education of Looked After Children's and previously Looked After Children's*: *statutory guidance for local authorities*. London: Department of Education.

DoH (1998) *The Quality Protects programme transforming children's services*. London: The Stationery Office.

DoH (2010) *Equity and Excellence*: *Liberating the NHS*. London: The Stationery Office.

DoH (2012) *Transforming care*: *A national response to Winterbourne View Hospital Department of Health review*: *Final report*. London: Stationery Office.

Dickson, K., Sutcliffe, K. and Gough, D. (2009) *The experiences views and preferences of Looked After Children's and young people and their families and carers about the care system*. London: Social Science Research Unit Institute of Education, University of London.

Dickinson, K. and Divencenzi, S. (2015) 'A new service for initial health assessments for 16+ young people across Kent Community Health NHS

Trust, UK', *Adoption & Fostering* 39(1), pp. 86–90. doi:10.1177/0308575915574470.

Dietze, E.V. and Orb, A. (2000) 'Compassionate care: a moral dimension in nursing', *Nursing Inquiry*, 7(3), pp. 166–174.

Dolan, J.A. (1968*) A History of Nursing*. 12th edn. Philadelphia: W.B. Saunders.

Driessnack, M. (2005) 'Childrens drawings as facilitators of communication: a meta-analysis', *Journal of Pediatric Nursing*, 20, pp. 415–442.

Dube, S.R., Anda, R.F., Felitti, V.J., Chapman D.P., Williamson D.F. and Giles W.H. (2001) 'Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span findings from the adverse childhood experiences study', *JAMA*, 286(24), pp. 3089–3096. doi:10.1001/jama.286.24.3089.

Dyson, A., Farrell, P., Kerr, K.I. and Mearns, N. (2009) *Swing*, *swing together*: *multi-agency work in the new children*'*s services.* Available from: http://www.education.manchester.ac.uk/research/centre/cee/publications (Accessed: 30 April 2016).

Easen, P., Atkins, M. and Dysen, A. (2000) 'Inter-professional collaboration and conceptualisations of practice', *Children & Society*, 14(5), pp. 355–367.

Eichler, H. (2011) 'Innovations in statutory health assessments of Looked After Children's: a service evaluation', *Paediatric Nursing*, 23(3), pp. 20–23.

Emery, P. (2006) '4 years on: lessons learnt from implementing and integrated care pathway to address promoting health in Looked After Children's', *Adoption and Fostering*, 30(20), pp. 81–83.

Fear, W. (2014) 'What is the story? The uniqueness paradox and the patient story in the minutes of the boardroom', *Management Learning*, 45(3), p. 317.

Felitti V.J., Anda R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V. and Koss, M.P. (1998) 'The relationship of adult health status to childhood abuse and household dysfunction', *American Journal of Preventive Medicine*, 14, pp. 245–258.

Felitti, V.J. and Anda, R.F. (2010) 'The relationship of adverse childhood experiences to adult medical disease, psychiatric disorders and sexual behaviour: implications for healthcare', in Lanius, R.A., Vermetten, E. and Pain, C. (eds.) *The impact of early life trauma on health and disease*: *the hidden epidemic*. New York: Cambridge University Pres, pp. 77–87.

Finkelhor, D. (2018) 'Screening for adverse childhood experiences (ACEs): Cautions and suggestions', Child Abuse & Neglect, 85, pp.174-179.

Fisler, R. (1995) 'Dissociation and the fragmentary nature of traumatic memories: overview and exploratory study', *Journal of Trauma and Stress*, 8, pp. 505–525.

Fitzpatrick, J.J. and Whall, A.L. (1983) *Conceptual models of nursing*, *analysis and application*. USA: Appleton and Lange.

Flatman, D. (2002) ‘Consulting children: are we listening?’, *Paediatric Nursing*, 14, pp. 28–33.

Ford, T., Vostanis, P., Meltzer, H. and Goodman, R. (2007) ‘Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households’, *British Journal of Psychiatry*, 190(4), pp. 319–325. doi:10.1192/bjp.bp.106.025023.

Forrest, C. (2011) *Nursing with kindness and compassion*.

Francis, R. (2013) *QC Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: The Stationery Office.

Gibson, F., Fletcher, M. and Casey, A. (2003) ‘Classifying general and specialist children’s nursing competencies’, *Journal of Advanced Nursing*, 44, pp. 591–602. doi:10.1046/j.0309-2402.2003.02849.x.

Gibson, F. (2007) ‘Conducting focus groups with children and young people: strategies for success’, *Journal of Research in Nursing*, 12, pp. 473–483.

Gibson, F. and Carson, Y. (2010) ‘Life story work in practice: aiming for enduring change’, *Journal of Dementia Care*, May/June’18(3), pp. 20–22.

Giger, J. and Davidhizar, R. (1999) *Transcultural nursing*. St. Louis: Mosby Year Book.

Gilmartin, J. (2008) ‘Psychodynamic sources of resistance among student nurses: some observations in a human relations context’, *Journal of Advanced Nursing*, 32(6), pp.1533–1541.

Girvin, J., Jackson, D. and Hutchinson, M. (2016) ‘Contemporary public perceptions of nursing: a systematic review and narrative synthesis of the international research evidence’, *Journal of Nursing Management*, 24, pp. 994–1006.

Glasper, E. (1995) ‘Preserving children’s nursing in a climate of genericism’, *British Journal of Nursing*, 4, pp. 24–25.

Glasper, E.A. and Mitchell, R. (2006) ‘Historical perspectives on children’s nursing' in Glasper, E.A. and Richardson, J. (eds.) *A textbook of children’s nursing*. Edinburgh: Churchill Livingstone, pp. 3–17.

Gonçalves-Bradley, D.C., Lannin, N.A., Clemson, L.M., Cameron, I.D. and Shepperd, S. (2016) ‘Discharge planning from hospital’, *Cochrane Database of Systematic Reviews*, 1(CD000313). doi:10.1002/14651858.CD000313.pub5.

Goreman, L. and Sultan, D.F. (2008) *Psychosocial nursing for general patient care*. Philadelphia: F.A. Davis company.

Graham-Ray, L. (2014) *The story so far*. London: Central London Community Health Care Trust (internal publication).

Healy, K. and Kennedy, R. (1993) ‘Which families benefit from inpatient psychotherapeutic work at the Cassel Hospital?’, *British Journal of Psychotherapy*, 9, pp. 394–404. doi:10.1111/j.1752-0118.1993.tb01240.x.

Hallam, J. (2002) ‘Vocation to profession: changing images of nursing in Britain’, *Journal of Organizational Change Management*, 15(1), pp. 35–47. doi:10.1108/09534810210417366.

Henderson, V. (1964) ‘The nature of nursing’, *The American Journal of Nursing*, 64 (8), pp. 62–68.

Hill, C., Daniel, S., Dunnett, C., Sampeys, C., O’Dell, S., Watkins, J., and Wright, V. (2002) ‘The emerging role of the specialist nurse in promoting the health of Looked After Children’s’, *Adoption and Fostering*, 26(4), pp. 35–43.

Hill, C.M. and Mather, M. (2003) ‘Achieving health for children in public care: new Department of Health guidance emphasises a rounded approach’, *British Medical Journal*, 326(7389), pp. 560–561.

Hill, M., Davis, J., Prout, A. and Tisdall, K. (2004) ‘Moving the participation agenda forward’, *Children and Society*, 18, pp. 77–96.

Hodgkinson, K. (2008) ‘What is the psychosocial impact of cancer?’ in Hodgkinson, K. and Gilchrist, J. (eds.) *Psychosocial Care of Cancer Patients*. Melbourne: Ausmed, pp. 1–12.

Holloway, W. and Jefferson, T. (2010) *Doing Qualitative Research Differently*. 2nd edn. London: Sage.

Hopkinson, G. and Hogarth-Scott, C. (2001) ‘“What happened was...” Broadening the agenda for storied research’, *Journal of Marketing Management*, 17:1-2, 27– 47. doi:10.1362/0267257012571483.

House of Commons Health Committee (1997) *Second*, *third*, *fourth*, *and fifth reports of session 1996–7*. London: House of Commons Health Committee.

House of Commons Education Committee (2006) *Mental health and well-being of Looked After Children: fourth report of session 2015–16.* Report, together with formal minutes relating to the report Ordered by the House of Commons to be printed 20 April 2016. Available from: https://publications.parliament.uk/pa/cm201516/cmselect/cmeduc/481/481.pdf

Howak, C., Brophy, G.H., Carey, E.T., Noll, J., Rasmussen, L., Searcy, B. and Stark, N.L. (1998) 'Psychodynamic Nursing Chapter 22' in Tomey, M.A. and Alligood, M.A. (eds.) *Nursing Theorists and their work*. 4th edn. St Louis: Mosby.

Hughes, L. and Pengelly, P. (1997) *Staff supervision in a turbulent environment*: *managing process and task in front-line services*. London: Jessica Kingsley.

Hunter, A.L., Minnis, H. and Wilson, P. (2011) 'Altered stress responses in children exposed to early adversity: a systematic review of salivary cortisol studies', *Stress*, 14(6), pp. 614–626. doi:10.3109/10253890.2011.577848 Ipsos MORI (2012) *Veracity Index 2017* London: Ipsos MORI.

Johnson, M. (2008) 'Can compassion be taught?', *Nursing Standard*, 23(11), pp. 9–21.

Jones, S. (1995) ‘The development of the paediatric nurse specialist’, *British Journal of Nursing*, 4(1), pp. 34–36.

Jones, R., Everson-Hock, E.S. and Papaioannou, D. (2011) ‘Factors associated with outcomes for Looked After Children and young people: a correlate review of the literature’, *Child*, 37(5), pp. 613–622. doi:10.1111/j.1365-2214.2011.01226.x.

Kelly, Á. (2016) ‘Growing up in care’, *British Medical Journal*, 352: i1085.

Kirk, S. (1998) ‘Trends in community care and patient participation: implications for the roles of informal carers and community nurses in the United Kingdom’, *Journal of Advanced Nursing*, 28, pp. 370–381. doi:10.1046/j.1365-2648.1998.00781.x.

Kisiel, C.L., Fehrenbach, T. and Torgersen, E. (2014) ‘Constellations of interpersonal trauma and symptoms in child welfare: implications for a developmental trauma framework’, *Journal of Family Violence*, 29, p. 579. doi:10.1007/s10896-014-9603-8.

Kitson, A., Marshall, A., Bassett, K. and Zeitz, K. (2013) ‘What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing’, *Journal of Advanced Nursing*, 69, pp. 4–15. doi:10.1111/j.1365-2648.2012.06064.x.

Knei-Paz, C. (2009) ‘The central role of the therapeutic bond in a social agency setting clients’ and social workers’ perceptions’’, *Journal of Social Work*, 9(2), pp. 178–198.

Kodner, D. and Spreeuwenberg, C. (2002) 'Integrated care: meaning, logic, applications, and implications – a discussion paper', *International Journal of Integrated Care*, 2(14) pp 12-14.

Laub, D. and Auerhahn, N. (1993) 'Knowing and not knowing massive psychic trauma: forms of traumatic memory', *International Journal of Psychoanalysis*, 74(2), pp. 287–302.

Leeson, C. (2010) 'The emotional labour of caring about looked-after children', *Child & Family Social Work*, 15, pp. 483–491.

Legg, M.J. (2011) 'What is psychosocial care and how can nurses better provide it to adult oncology patients', *Australian Journal of Advanced Nursing*, 28(3), pp. 61–67.

Lewin, S., Glenton, C. and Oxman, A.D. (2009) 'Use of qualitative methods alongside randomised controlled trials of complex healthcare interventions: methodological study', *British Medical Journal*. doi:10.1136/bmj.b3496 (Published 10 September 2009).

Lindsey, D. and Shlonsky, A. (2008) *Child welfare research*. Oxford: Oxford University Press.

Loshak, R. (2013) *Out of the mainstream*: *helping the children of parents with a mental illness*. London: Routledge.

Maben, J. and Griffiths, P. (2008) *Nurses in society*: *starting the debate*. London: National Nursing Research Unit, King's College.

Manning, J.C., Hemingway, P. and Redsell, S.A. (2017) 'Stories of survival: children's narratives of psychosocial well-being following paediatric critical illness or injury', *Journal of Child Health Care*, 21(3), pp. 236–252.

Mather, M. (2002) Promoting Clients Heath *Adoption and Fostering*, 26(4), pp. 20–23.

MacAuley, M. (2009) Emotional well-being and mental health of Looked After Children's in England. *Child and Family Social Work* 14, pp.147–151.

McDonald, L. *(2017) Florence Nightingale*, *nursing and health care today*. Canada: Springer Publishing.

Meltzer, H., Gatward, R., Goodman, R. and Ford, T. (2000) *Mental health of children and adolescents in Great Britain*. London: The Stationary Office.

Meltzer, L.J. and Mindell, J.A. (2006) 'Sleep and sleep disorders in children and adolescents', *Psychiatric Clinics*, 29(4), pp. 1059–1076.

Menzies-Lyth, I. (1960) *The functioning of social systems as a defence against anxiety*: *report on a study of the nursing service of a general hospital*. London: The Tavistock Institute of Human Relations.

Munro, E. (2001) *Empowering Looked After Children's*. London: LSE Research Articles Online. Available from: http://eprints.lse.ac.uk/archive/00000357/.

Munro, E. and Hardy, A. (2006) *Placement stability*: *a review of the literature*. Loughborough: Loughborough University.

Munro, E. (2011) *The Munro review of child protection*: *final report*: *a child-centred system*. London: Department for Education.

Music, G. (2011) *Nurturing natures*: *attachment and children's emotional*, *sociocultural and brain development*. Hove: Psychology Press.

Melnyk, A. Mazurek, B. Fineout-Overholt ,E. Gallagher-Ford, L. Stillwell, S. B Evidence-Based Practice, Step by Step: Sustaining Evidence-Based Practice Through Organizational Policies and an Innovative Model

American Journal of Nursing: September 2011 111 (9) 57-60

doi: 10.1097/01.NAJ.0000405063.97774.0e

NCB (2012) *NCB policy briefing*: *delivering the health reforms for Looked After Children's*. London: National Children's Bureau.

Neustatter, A. (2002) *Locked in*, *locked out*: *the experience of young offenders out of society and in prison*. London: Calouste Gulbenkian Foundation.

NHS England (2009) *6Cs*. Available from: https://www.england.nhs.uk/leadingchange/leading-change-adding-value/about/the-6cs/ (Accessed: 17 July 2012).

NHS England (2013) *Putting patients first*: *the NHS England business plan for 2013/14–2015/16*. London: NHS England.

NHS Scotland (2006) *Competencies and capability framework for nurses who care for children away from home*. Scotland: NHS Scotland.

NICE/SCIE (2010) *Promoting the quality of life of Looked After Children and young people*. London: National Institute for Clinical Excellence & Social Care Institute for Excellence Joint Publication.

Nightingale, F. (1857) ‘Letter to Sir Thomas Watson, Bart, London dated 19 Jan 1867’ in Gaffney, R., ‘Women as doctors and nurses’ in Checkland, O. and Lamb, M. (eds.) *Health care as social history*, pp. 134–148. Aberdeen: Aberdeen University Press.

NSPCC (2015) *Achieving emotional wellbeing for Looked After Children’s*. UK: NSPCC.

Obholzer, A. and Roberts, V. (eds.) (1994) *The unconscious at work*: *individual and organisational stress in the human service*. London: Routledge.

Ofsted (2010) *After care*: *young people*’*s views on leaving care*. *Reported by the Children*’*s Rights Director for England*. London: Ofsted.

Ollernshaw, J.A. and Creswell, J.W. (2002) ‘Narrative research: a comparison of two restoring data analysis approaches’, *Qualitative Inquiry* 8(3), pp. 329–347.

Olson, T. (2002) ‘Poems, patients, and psychosocial nursing’, *Journal of Psychosocial Nursing and Mental Health Services*, 40(2), p. 46.

Passarlay, G. (2015) *The lightless sky*. London: Atlantic Books.

Pearce, L. (2009) ‘A flair for innovation’, *Nursing Standard*, 24(10), pp.17–19.

Pearce, L. (2010) ‘Transforming the lives of children in care’, *Nursing Standard*, 25(1), pp.20–21.

Peplau, H.E. (1952) *Interpersonal relations in nursing*. New York: G.P. Putnam’s Sons.

Peplau, H.E. (1962) ‘Interpersonal techniques: the crux of psychiatric nursing’, *American Journal of Nursing*, 62, pp. 629–633.

Perry, B. (1999) ‘Memories of fear: how the brain stores and retrieves physiologic states, feelings, behaviours and thoughts from traumatic events’ in Goodwin, J.M. and Attias, R. (eds.) *Splintered reflections*: *images of the body in trauma*. New York: Basic Books, pp. 9–38.

Perry, B. (2009) ‘Examining child maltreatment to neurodevelopmental lens: clinical application of the neuro sequential model of therapeutics’, *Journal of Loss and Trauma*, 14, pp. 240–255.

Phillips, J.R. (1977) ‘Nursing systems and nursing models’, *Image*, 9(1), p. 6.

Pike, A.W. (1990) ‘On the nature and place of empathy in clinical nursing practice’, *Journal of Professional Nursing*, 6(4), pp. 235–240.

Popay, J., Roberts, H. M., Snowden, A., Petticrew, M., Arai, L., Rodgers, M., & Britten, N. (2006). *Guidance on the conduct of narrative synthesis in systematic reviews.* London, UK: Institute for Health Research

Powers, P. (2002) ‘A discourse analysis of nursing diagnosis’, *Qualitative Health Research*, 12(7), pp. 945–965.

Rahilly, T. and Hendry, E. (eds.) (2014) *Promoting the Wellbeing of Children in Care Messages from Research*. London: NSPCC.

RCN (2014) *Defining Nursing*. London: Royal College of Nursing.

RCN (2015) *RCN survey of nurses working with Looked After Children’s*. London: Royal College of Nursing.

RCN & RCPCH (2015) *Looked After Children's*: *Knowledge*, *skills and competences of healthcare staff Intercollegiate role framework*. London: Royal College of Paediatrics and Child Health.

Read, J., van O., J., Morrison, A.P. and Ross, C. (2005) 'Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications', *Acta Psychiatrica Scandinavica*, 112, pp. 330–350. doi:10.1111/j.1600-0447.2005.00634.x.

Reay, N. (2010) 'How to measure patient experience and outcomes to demonstrate quality in care', *Nursing Times*, 106(7), pp. 12–14.

Redman, P. (2014) 'What are psychosocial studies anyway? And do we need them?', *Paper given at the School of Applied Social Sciences*, Brighton University, 14 January.

Reed, P. G. (1987) 'Constructing a conceptual framework for psychosocial nursing', *Journal of Psychosocial Nursing and Mental Health Services*, 25(2), pp. 24–28. doi:10.3928/0279-3695-19870201-06.

Rhodes, M., Morris, A. and Lazenby, R. (2011) 'Nursing at its best: competent and caring', *The Online Journal of Issues in Nursing*, 16(2) DOI:10.3912/OJIN.Vol16No02PPT01

Richard, R., Philpot, T., and Walsh, M. (2005) *The child's own story*: *life story work with traumatized children*. London: Jessica Kingsley.

Robson, P. (2002) *Real World Research*. 2nd edn. Oxford: Blackwell.

Rock, S., Michelson, D., Thomson, S. and Day, C. (2013) 'Understanding foster placement instability for Looked After Children's: a systematic review and narrative synthesis of quantitative and qualitative evidence', *British Journal of Social Work*. doi:10.1093/bjsw/bct08.

Rose, W. Barnes, J. (2008) *Improving safeguarding practice*: *study of Serious Case Reviews 2001–2003*. London: Department for Children, Schools and Families.

Rudge, T. (2008) Beyond caring? Discounting the differently known body. *The Sociological Review* 56: 233–248. doi:10.1111/j.1467-954X.2009.00825.x.

Rushton, A. Dance, C. (2002) Quality Protects: A Commentary on the Government's Agenda and the Evidence Base. *Child and Adolescent Mental Health* 7: 60-65. doi:10.1111/1475-3588.00012.

Ryan, T. and Walker, R. (2007) *Life story work*: *a practical guide to helping children understand their past*. London: British Association for Adoption & Fostering.

Salmon, G. and Rapport, F. (2005) 'Multi-agency voices: a thematic analysis of multi-agency working practices within the setting of a child and adolescent mental health service', *Journal of Interprofessional Care*, 19(5), pp. 429–443.

Sartain, S.A., Clarke, C.L. and Heyman, R. (2000) 'Hearing the voices of children with chronic illness', *Journal of Advanced Nursing*, 32 pp. 913–921.

Schlotfeldt, R.M. (1987) ‘Defining nursing: a historic controversy’, *Nursing Research* 36(1), pp. 64–66.

Scott, P.A. (1995) ‘Care, attention and imaginative identification in nursing practice’, *Journal of Advanced Nursing*, 21, pp. 1196–1200.

Singh J.(2013) Critical appraisal skills programme. *Journal Pharmacology and Pharmacotherapy*, 2013;4:76-7

Sharp, D. (2004) ‘Five sides of trauma’ *The Lancet*, 363(9423), p. 1750.

Smith J, Noble H. Reviewing the literature. Evidence-Based Nursing 2016;19:2-3.

Stead, J., Lloyd, G. and Kendrick, A. (2004) ‘Participation or practice innovation: tensions in inter-agency working to address disciplinary exclusion from school’, *Children & Society*, 18(1), pp. 42–52.

Stein, M. (2006) ‘Research review: young people leaving care’, *Child & Family Social Work*, 11, pp. 273–279. doi:10.1111/j.1365-2206.2006.00439.

Summers, S. and Summers, H. (2015) *Saving lives*: *why the media*’*s portrayal of nursing puts us all at risk*. 2nd edn. Oxford: Oxford University press.

Tanner, C. (2006) ‘The next transformation: clinical education’, *Journal of Nursing Education*, 45, pp. 99–100.

Taylor, C. (1989) *Sources of the self*: *the making of modern identity*. New York: Left Coast Press.

The Childrens Act (1989) *The Childrens Act*. London: Stationery Office.

The Social Work Task Force (2009) *Building a safe*, *confident future*: *the final report of the Social Work Task Force*. London, Department for Education.

Thompson, R. (2010) 'Realising the potential: developing life story work in practice', *Foundation of Nursing Studies Dissemination*, 5(5), pp. 238–256.

Todd, L. (2007) *Partnership for inclusive education*: *a critical approach to collaborative working*. Routledge: Falmer.

Treisman, K. (2017) *Working with relational and developmental trauma in children and adolescents*. Routledge: London.

Tremayne, P. (2014) 'Using humour to enhance the nurse-patient relationship', *Nursing Standard*, 28(30), pp. 37–40. doi:10.7748/ns2014.03.28.30.37.e8412.

Tylee, A., Haller, D.M., Graham, T., Churchill, R. and Sanci, L.A. (2007) 'Youth-friendly primary-care services: how are we doing and what more needs to be done?', *The Lancet*, 369(9572), pp. 1491–1574.

Van der Kolk B.A. (2005) 'Developmental trauma disorder: towards a rational diagnosis for children with complex trauma histories', *Psychiatric Annals*, 35, pp. 401–408.

Viner, R.M. and Taylor, B. (2005) 'Adult health and social outcomes of children who have been in public care: population-based study', *Pediatrics*, 115, pp. 894–899.

Waddell, M. (2002) *Inside lives*: *psychoanalysis and the growth of the personality*. London: Karnac.

Watson, R. and Thompson, D.R. (2000) 'Recent developments in UK nurse education: horses for courses or courses for horses?', *Journal of Advanced Nursing*, 32, pp. 1041–1042. doi:10.1046/j.1365-2648.2000.1147a.x.

Wengaff, T. (2001) *Qualitative research interviewing*. London: SAGE.

Whitfield, C.L. (1995) *Memory and abuse*: *remembering and healing the wounds of trauma*. Deerfield Beach, FL: Health Communications.

White, K. (2002) 'Nursing as vocation', *Nurse Ethics*, 9(3), pp. 279–290.

WHO (2017) *Report on the history of nursing and midwifery in the World Health Organization 1948–2017*. Geneva: World Health Organisation.

Woodhouse, D. and Pengelley, P. (1991) *Anxiety and the dynamics of collaboration*. Aberdeen: Aberdeen University Press.

Woodward, V.M. (1997) 'Professional caring: a contradiction in terms?', *Journal of Advanced Nursing*, 26, pp. 999–1004.

Wright, S. (2004) 'Say goodbye to core values', *Nursing Standard*, 34, pp. 22–23.

Yam, B. (2004) 'From vocation to profession: the quest for professionalization of nursing', *British Journal of Nursing*, 13(16), pp. 978–982.

Zaner, R. (2004) *Conversation on the edge*; *narratives of ethics and illness*. Washington DC: Georgetown University Press.

Appendices

Appendix A: patient stories

Dinar's story extract

The first time I met the nurse her first question was how you are. No, what's your date of birth, how old are you, what's your leave to remain. I thought that was nice and it seemed genuine, and she waited for me to answer. I wanted to say not that good, but I just said OK. She explained what was going to happen and that it would be confidential. She asked if it was OK if she saw me on my own. The social worker, not mine some random from duty interrupted her, which I thought was quite rude and said no I need to stay. The nurse wasn't rude, but she asked her, and I remember this clearly, as she wasn't rude, but she was like what's the word? I think it's assertive. She goes to the duty "for what reason would you like to stay, as I will invite you in at the end once Dinar and I have agreed what health information can be shared". Then the duty like lost a bit a goes Dinar is subject to a home office age assessment and the nurse goes, yes thank you that was on the referral form, but this is Dinars health assessment and completely separate, this is where we assist him with health needs and well-being, you will get a report at the end with Dinars consent and I can assist you with making recommendations, but the information exchanged during the assessment is confidential and won't be shared. I just stood there and thought wow- R.E.S.P.E.C.T!

We went into a room in the hospital and she gave me the comfortable seat and introduced herself again and then she goes, I am sorry if that conversation with Hannah made you feel uncomfortable, and then she said a whole load of other stuff about the health assessment and signing stiff, but I

didn't really take it in, she had me in it, she was kind and nice and I thought she had stuck up for me, so I didn't have any issue talking.

Everything changed when I was 13, back at home suddenly I was no longer a child, there was this pressure to be grown up, some of the things I saw made you grow up fast. I remember the day, it was sunny a load of kids was flying kites and there was this red one high above the others. I wanted to fly my kite too, but couldn't I wasn't a child anymore I had to be a grown up. I was sitting on a rock just looking up and there it was my world had changed, boom. The first of many explosions. There was dust everywhere, red dust, people running screaming. I walked home, bumping into people running away from me; it didn't enter my head to wonder why they were all going the other way. I turned a corner and just stood still, it was like I knew the place, but I didn't, it took a few minutes to realise the rubble on the floor was my house. I think I saw a foot sticking out of the rubble, I just stared and then someone grabbed me by my collar and stared to run. I just went along I don't remember what they were shouting at me. All around me bombs were going off, it smelled dusty and burdened, the air smelled of burning and toilets, it was like a scene from some action movie. Now when I reply the picture in my head I want Arnie Swatz and Bruce Willis to arrive and save the day, but they don't, that's my little dream. The smell is bad. It was my mum, the foot. I am not sure how long later as maybe I don't really know it's all a bit blurred and difficult to remember. A man in uniform tells me my father too has been murdered, he was a senior police commander. They take me to my aunt a long way away in Israt (N-I have changed the name) I was taken in a car and I felt very small, looking at the land whizzing past the window, most things dust and rubble, the odd cat and goat, sometimes an old person sitting by the side of the road. Can we take them I

ask, shut up and keep your head down, you are sitting target? I didn't understand what that meant, I still don't sitting target, what is that anyways? I don't recognise the lady that is my aunt, I see the man give her money and then he leaves, he pats me over the head and says be good and do as your aunt says. I have no money, no clothes, nothing. The lady says come inside I show you your room. She doesn't say I am sorry your parents are dead, she doesn't give me a hug, I just follow, feel numb. Time goes by and she says you are going to marry your cousin. I don't reply just think right OK in it, it must be. Later men come to get me I think they are taking me to get married. This time we drive far. I arrive in village near the border. No one has spoken to me and we get out the car. Wait there I am told. I think sometimes I am mad, I have invented so many versions of this just so as I can try and live with it. When I tell the officials, they want to know times places, like they try to trick you trip you up, so to them I tell just facts, so I don't get upset. You know one report said I was clearly making it up as I showed no emotion to what I was saying. I was just trying to protect my mind. It wasn't to get married, sold, age 14, to be degraded and humiliated. Things they did were painful, painful to the mind too.

I was sitting in the yard and I saw a bit of red material float down, the kite I thought. I picked it up and put in my pocket, this was my hope. I was traded like fish from the market. You are going on holiday they say to me. I get little bit of hope. What happened was I was bought and sold, you call it here trafficked. I like to think of it was economic survival; it brought me to better place to, to here. I travelled in a lorry with many others. It was hot, and it smelled no food. no water, then that toilet smells again. I was one minute back in my home that day, the day of the first bomb. So long without food and water, no day light, one died I think, it was that smell. Then on the water in a boat I felt half dead anyway, my

mind it is seeing kites in the sky. I wondered if they were my family in heaven waiting to meet me. I am very weak a man drags me out and takes money from the boat man, he says to me go you are in Dover. I didn't know where Dover was? Go where, and then he runs away. I didn't know it then, but this man was trying to save me. I looked at a piece of paper he had thrown over his shoulder, it said, you were to be sold to men in Romania, go to police they help you. I collapse on beach and wake up in hospital. I don't understand anything at all, everyone is speaking English. I only understand Chelsea win Champions League. I think hope, I like Chelsea. On the side a cupboard is my piece of red material.

I tell the nurse all this in the health bit and she seemed very concerned, she says that must have been very difficult for you to tell me, I would like to try and help you. I say yes please. We go to many appointments together and she helps me a lot. Sexual health clinic, head person, scan and dentist. I thank her. When I became a care leaver at my last health thing we decide to go to a park near the office. The Nurse bought me a kite, a blue one with Chelsea on, she knows I like Chelsea. We chat, and she tells me how far I have come, how much she is proud of me. I feel like light in my stomach and butterflies, she holds my hand and we fly the kite, she is pretty rubbish at it and I laugh. It's a nice day; I take out the red material form my wallet and attach to my new kite. It must look mad man, an 18-year-old and a lady flying a kite. I feel new hope.

Luna's story extract

I guess the lingo different there's no lingo there's no set dialogue it's like you're treated as a person in your own right. Rather than a client and it wasn't like this is safeguarding this is statutory role this is what we do it was friendlier it was very laid-back, and it was on your own terms it's not like we are meeting in my office building and it wasn't in a corporate setting. Hit felt like we humans we can go for a hot drink we can engage in a conversation we can talk about other things other than health is, so I have come to speak about your health, but we can talk about whatever you want to talk about like are you happy? What makes you happy are you feeling well in yourself? You are important and it felt like the nurses always try to capture that in the health assessments and when we met them can sometimes you would see them outside of the health assessments it might be that like that coming to shoes you are really stuck with something, or they would always be at things that were going on in the community, or at corporate events hosted by the borough. I remember this one time at some marketplace event we went to as Care Leavers they had all different stalls, all giving nutrition information or advice about benefits all work, loads of different stalls that everyone was going to nurses one because they were the only one that had sweets, everyone was sitting around on the floor by the nurses… It was only later that I found out the sweets the nurses were giving 100 per cent fruit juice… We all really laughed

Can you tell me a bit more about that? That's interesting

Yeah, we thought it was funny because we saw typical nurses there are offering you a treat but it's something that is good for you. I suppose they as well didn't want to get into trouble with the dentists because they had a stall nearby. We weren't really sitting there for the sweets, so I suppose it was because it was

the store that was the most fun and people were laughing, and we knew them of all the people in the room the nurses were properly the only ones that had met us before apart from social workers may be. The other thing is the nurses have always given us their mobile numbers not just the office number to ring or a duty number. But there was a clear way that we knew who they were and how to get in touch with them and they've consistently been around the whole of the time through all the changes that you get around you never didn't see them I knew where to find them and I've always felt welcomed and never fell and welcomed them at how silly my question might be or even if there is nothing wrong this money to speak to one of them… To say hi… To see they would meet me for a coffee… That always felt very mature and grown-up and I really value that that I could sit in a coffee shop with the nurse and have a coffee and a muffin like probably everybody else does may be with their family? … And it's a pleasant experience every time I see the nurse they genuinely pleased to see me so overall it's been a good experience and everything's been positive and if I did have any issues I always felt I could tell the nurse and that I would be supported evening she didn't agree with me, that she would support me and she would help me find a way to voice how I was feeling.

It's interesting what you said about statutory as health assessments or statutory but there seem to be something different to the health assessments than regulated or statutory activities by social care. The what is it that the nurses do differently to everybody else

I remember in some meeting once about me, I can't remember if it was a professionals meeting or replacement meeting but I remember the nurse saying this is how we've been working with Luna and this is what we find helps her so perhaps we could think about that in the meeting and perhaps that would help

others to think about how they work with Luna.… And I remember thinking at the time yeah, yeah that's what I want. And then the chair of the meeting said we have statutory something or rather the protocol whatever and I just sat there and thought you know what not even interested any more in what you're saying… I think that shows the difference… Then as soon as they started filling in forms I went somewhere else in my mind… The nurse must have picked up on this as she bent over and touch my hand and said are you okay… And I said what is there to be okay about they've already made up their minds……………….

Isla's story extract

Even that though it's just like the nurses say it's Ok to say anything, but you know they mean it and it's not just like for effect or to make them look good… It's like there's always someone in the back ground…. infect I think the nurse has been the only consistent adult…professional in my life actually…. Because it's when I moved into care to now I'm a care leaver and like we are still in contact I've had x amount social workers I've counted 11-13 I try to keep track, so I think its 13 Erm Erm yeah and I think the nurse is the only consistent person. …. And quite protective of me and I liked that…I know no one can stay around for ever but it's like you know they would stay in touch and they would…..I would love to stay in touch having someone who stays with you though your teenage years, it's rare to have someone you've grown up with what s has such a good knowledge of you it's like a professional best friend that has knowledge and insight, attended meetings and my placements and watched me grow she kind of grew with me whereas other didn't ….I also think it's nice that she has seen me progress it's really nice…. There's lots of chance ways and we are not always in control of what happens so it's nice to have in the back of your mind that they are there…..I was really surprised that not all LAC nurses work the same like the other nurses ….like the Care Leavers in the Tri Borough don't get anything like that support well at least the ones I know of……..we get asked to give feedback at consolation (V powerful she meant consultation) events and I like told the Director of Children's services that he must never get rid of the nurses I don't want like some random new people sticking their noses in……I still want to know my LAC nurse is around when I'm like 40 who else is going to remember if I have had like mumps or something? I'm going like say that at the next meeting like we need to have this strand of

support always… It would be like terrible if we didn't and like it wasn't Ok… we need to know that our options are open it would be like sad beyond words if they liked just dropped us… Like GPs don't know you and like you can't talk to them about everything it's just like about what you are sick with at that point in your life…. I don't know the GP I don't know anything about her and she doesn't know anything about apart from what's written in my medical notes and that not what's like important not like me myself what I've experienced and my background. I remember seeing one GP and I had to explain that I was a young person with issues and her advice was to go to yoga…I mean yoga…what was she thinking it's like £10 a session what planet did she come from and here on earth did she get the idea that I could afford that or even like sit with all the posh ones at like David Lloyd…but like how out of touch with reality must you be…. Erm and I didn't see her after that and I suppose that's what I mean about you just don't have the same relationship with them……. eventually she referred me to physio, but it took ages and like your restricted to ten minutes. What can you say in tem minutes- here's a list of things that are wrong…just doesn't work does it….OK ready for the next one off you go…….and I feel old like I have lost of problems with my body…what I'm experiencing…she made me feel uncomfortable….I didn't want to see her again and I should have said but I dint want to get her into trouble. I wanted the nurse to do my physio but she said she's not trained properly so she can't…she did say she could write to my GP and ask them to refer me to a different physio and she would help me change my GP if I wanted to …I thought that was nice ….and it helped even though I didn't do anything in the end it was the fact the offer was there…..and always that someone was there to explain…..and she suggested something really helpful like swimming and she knows I can't afford it

so she did like a deal with the manager of the gym and I do some admin for them and get free swimming lessons and able to sue the gym…. I thought that was really like up there with top negotiations…. I said to her you should work for the Un and she said I already do I work in health and social care Laughs and I was like yeah right you work in a war zone……must be like that as I felt the nurse was always battling on my behalf so she must do that for others too….and I kind of know that she's not one to give up on us….she never gave up on me….

Fleur's story extract

Well it's like the way even now you've said hello and explained stuff it's like with the other nurse it's like to matter and they care about you… like you're interested in what I have to say, and you really seem to listen…. it's like you don't come in with a list of things you have a task you just like come in and make me feel like relaxed and not like you're going to be making me feel bad…. Also, what I was going to say first before I said this was that just it's like quite intimidating sitting in a room on your own or in like a big group and people are asking you direct questions………….

God yeah man like your life in care isn't your own your just a series of meetings and interventions isn't that what they call it … man what's an intervention when it's at home anyway…..I need help about why I'm angry and not an intervention to stop it……….that's what I mean about the nurse she didn't walk right into my life and say this is your problem and here's what we are going to do about it……..I told her that the whole CAMHS thing wasn't for me…….like review meetings and PEPS and all that the nurse sees you and it's just focused on you and how you're doing and how can I help you and we always laugh it's like the nurse will try and think about how to make the most of stuff…..

in my placement with the carer like hiding food away from me and the social worker like coming down and telling about obesity…. the nurse was like, so you aren't feeling comfortable about being so curvaceous shall we think about ways to help you…not like lock all the food cupboards baton done the hatches……. I… I was eating for emotional reasons and it was related to all that kind of stuff but the nurse still tried to support me…she said what do you like doing…I said I like doing after school clubs…so she looked into it for me and

spoke to my teacher and hooked me up with the samba classes….she phoned me and said I've found out about it is is something you might like? We can trial it? See how it goes...like all the time giving me choices…… I'd said I'd give it a go and she said... go and shake some booty and I laughed so much it made me go…. I had some… but it was a samba class… so the only thing I got to shake was my mental stick… as my bit was to play the triangle….

The first thing is you don't have an appointment and then the second thing is like the duty workers busy….what kind of reception is that….you wouldn't get that anywhere else would you…especially in a family…god man these people are meant to be looking after me…….then the nurse walks by and she's like hi Fleur how you doing, where have you been…what did you bring me"…like straight away happy and laughing and like seems pleased to see me…like some mad old aunty that you can always call in on….I don't mean she was old….. or mad but just like that what I would imagine it to be like

Narisa's story extract

FGM is a horrible word

No, I just want to tell you because it is difficult for me to sit and not say once I have decided to tell it

No, it is important I want to say it's my choice, I want to say out loud how much better it is now than before, just when I visit the experience again it like it happening again

When I was small, very small I'm not sure how old I was taken to my aunties house….I don't think she was my real aunt but everyone they call her Aunty in my village… dint know at the time but some of the offer girls they were scared of her and I thought they were being respectful of an old aunty but now I learn why

The aunty cut me…that's what they called it…I was told I was going to be made to look pretty like a woman. I don't want to go over what happened and how and things, but you know don't do in this country you call it female circumcision...or FGM

The nurse helpfully said it's a crime in this country…it was a crime against me…to also pretends it was something nice to make it like this will make you pretty…like a woman…that was also a crime to lie and to miss-represent truth. FGM is a horrible word.

The nurse said "It is and it's also a horrible thing to do to someone and a horrible thing for someone to have inflicted on them. Yes is…very much……it took a while until it was physical problem for me…I had my initial health assessment with Dr and I didn't say anything…she was a nice Dr…female…Nigerian I think….very quietly spoken…always smiling and trying to help…I didn't get examination as I was older…she says quite a few times if

there's anything I wasn't to ask or anything troubling me….I keep to say no all the time……she as nice lady…very nice she had very white teeth and nice hair….

But I didn't feel able to tell her anything, I wasn't sure what her cultural belief was and I didn't know if she maybe had it done and it was acceptable to her but I think also she is Dr and not so easy to relax... and say…that is big factor in my decision…if I had of seen the Dr again…one more time I would have told her…just because also hospital and clinical environment…it feels how do you say…white and clean and like nothing should happen here about talking just medical procedure

I was a bit but also, I didn't feel I knew enough about the Dr to be at ease to say….

So when I first met the nurse I didn't tell her either…we just had chat about how I was doing and where I was going to school and exams and what I wanted to do with my life….it was less formal and more relax…I had been having pain and I wanted to tell her….she asked me some personal questions and I thought this was my opportunity…but I felt shy…I think she sensed or she knew as she said to me I don't need to see you again but if you want to get in touch before your next health assessment you can I and I can help you with anything…I just say yes OK and then a week or maybe two later I received my health care plan in the post and her phone number as on the bottom…I was going to call and then I changed my mind I said to myself you have to do this and to get help as it will become a bigger problem as I get older. I had been reading about the long-time effects of FGM...I hate that word…so I decided to text as its easier…I just put please can I see you soon I have something I need help with. Within ten minutes the text reply came and said sure yes Ok you free

now…I was very surprised I thought it will be like GP you have to wait one or two weeks and get appointment…I came into see the nurse here at Cobbs Hall, but we went for a coffee…I told her about my experience….

The nurse didn't say shock or anything…she just say thank you for sharing…how would you like me to help you and then she said I have choices and she told me…I thought that was kind and it made me not so scared…she gave me the choice of what to do next…not like hysterical and like I was a big problem. The nurse she was concerned and help me but not like Oh my Goodness we are going to have to tell social worker and police…she was more interested in me and my feeling and helping me…she did say that we will need to tell but in time not like right now and this minute…..wren start like I feel friendship…not like friend but more like professional…like I don't know…I know the nurse she can't be your friend as she is always nurse but she help you in a friendly way…….

Same like you…you just interested and you want to help that is your staring point with me and also other nurse…you don't have like a role inform anything other than to try and help and be helpful to Looked After Children's…you don't get paper work and things you just talk and listen and try to support us. Next thing she gave me some choices about what to do next and we agree that best thing is if she talk to a person she call local expert and try and get appointment with term…immediately I want to know if it's man or woman and where they are form…the nurse reassure me that have are lady and form African country…she asked if I had any problem with this and I say no but I don't want to go on my own…she ask me who I would like to come with me …foster carer…social worker…I say no you pleas first appointment you to come with me please…so she go away and make contact and get me an appointment

and then she also arrange for me to see her again…when we next meet she explain about the appointment and also she not say I have to but she advised me that it best to tell my social worker and my career. I say you come with me so she came to tell my foster career and I was surprised…that she, make time and also my foster carer was so nice about it and she understand why I find it difficult to talk about…she give me hug….We agree the nurse would tell my social worker and then we arrange meeting…so because nurse arrange meeting it's not so formal…just us siting the nurse explained what happened and I cried…everyone very nice. But the nurse was the only one who understood my feeling she knew I was embarrassed but the other just think I am sad…she sent them all out and we talk……the one week later we go to see the specialist my carer she came too and I went in with the nurse…the Dr I think you call them if they are a specialist Consultant explained everything ad make me feel very comfortable she's in a nice room and she made us all tea. It wasn't very nice tea…but it was nice she made it...she apologise but said she doesn't drink tea only coffee so she's not very good at making tea…the nurse say I wish you had of told me I would have made it…we all laugh and it seem to make us all relaxed…the nurse then went and made tea for us…this time we could drink it and she made the doctor a coffee…the Doctor joke and say we can come again especially if we make our own drinks…. The consultant and the nurse explain me everything and my option…. then it all felt OK I feel really…very much relief… Now like today I am in a very different place mentally I am much more settled in myself and I think that it because I was so much supported about his difficult experience….

I think also now as I have had surgery I feel physically different and I don't have pain. The nurse and me we had also I just remember a big turning

point…just before the surgery she met with me….and we were talking….she asked me some things that most people would think very personal but by this time we knew each other quite well and I felt able to discuss without shame or embarrassment…we were having tea and she aid Naris the one thing you haven't asked me about as if this will affect your reflation shops with boys….I nearly spit out my tea…but because I wasn't expecting so direct…I say you mean the s work…the nurse say yes the s word and not the one that ends with T the one that ends with X…I laugh but she knew I would be Ok with that….I felt OK ad it's our way we are able to laugh when something is difficult it has become our way…I say yes in future I worry like how I meet with a boy knowing that that part or me is so abnormal and not like woman…how I even meet an # boy…and she said and a lot of people will say this is not appropriate…she say well there's always match dot com…I laugh so much I nearly wet myself…the nurse laugh too…a lot…. It seems such a wrong thing to say but it was also so much of the right t thing to say at the time…not many people can do that…know exactly what to say at the right time and especially when it is something so….so difficult to talk about. So now you see I am in a very good place I can laugh, and I am happy tend that was the nurse helped me to do….

JT's story extract

I think its important professionals start off on the right walk with a young person and if you start using fancy worlds it's a real like downer….No no it was good but I kind a like set it up to be Ok I'm what you call a product of the system… so I know how to play stuff like about health I know my rights and s***

The system in it the health system the NHS…I've been in it all my life…if you think about it I was born in the NHS…and detained in it…so it's like a friend or that.

Well when I was sectioned first time I was detained under the mental health act so that's what I mean about detained. No, my mum had schitzo and I was born on a psychiatric ward. My mum went into labour with me quickly and the paramedic delivered me on the floor of the psychiatric ward.

So born on a psychiatric ward to a mother with mental health problems…no let's say it as it is schizophrenia and I don't know anything about my Dad and I doubt my mum did….my mums mum so my grandmother also had schizophrenia so hey its odds on I'm going to have issues…..in and out of foster care as I don't have any other family…social services tried to get me adopted but like who would take on a kid like me for life with the likelihood of me turning psycho at the drop of a hat….I don't remember a lot from being little until I went to long term foster care and there was some agreement that I could have like some status so I was not a LAC anymore…that went really well until two years ago so I would have been like twelve and I stared to have my friends round and like that was the start of the trouble don't know…like if it's painful or just like confusing like I know…. I do block a lot out…but then again there's a lot I don't know…

Yeah, I deal well with somethings… and not others but I've never really worked out what things I don't deal well with like why that is…my like psychiatrist has been trying to work that out too and those like talking groups you go too and individual therapy….no one's worked it out yet

I do though…. but it's like there's something inside that I don't get …I just don't understand………. like nothing makes any real sense I think that why my head might go somewhere else and tries to make sense of it all but in a mad way….

It goes back to what I was saying about my first assessment…I didn't want to see the Dr because I find the nurses easier to talk to …it's like they are softer. Kinder…as soon as I got to the nurse I was like…I've just self-harmed with a bit of glass…instead of panicking and like OMG safeguarding moment… call in the mental health lot. She just calmly said I'm sorry to hear that… you must be worried about something how can I help….and I was just like thanks…thanks for not judging me…..she said she could clean the wound and dress it and then asked about if I've had a tetanus….I said no so she like went and sorted all that….not like he needs to go to A&E and lets like pass him and his problems on! She went and found a doctor got him to prescribe the tetanus…. she apologised as it hurt me…she said I am sorry this will sting a bit…. I said I self-harm like a scratch isn't going to hurt…we both laughed and then she said. but on a serious note although it's a scratch… usually if someone doesn't feel pain on the surface its usually a sign that they are hurting on the inside….wow that hit me like a wave…like someone had like an understanding of my situation like the nurse always felt connected with my experience…I started to cry…I know that sound like really over the top and a bit gushy but it

was like one of those moments like a reality check…it's not often anyone can do that I suppose that's what I meant by therapist

Appendix B: UREC and NRES forms

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa

Quality Assurance and Enhancement

7 January 2015

Dear Lin ,

Project Title:	So what sort of nurse are you? Nursing in a social care setting: Looked after children's views and stories
Researcher(s):	Lin Graham Ray
Principal Investigator :	Lin Graham Ray

I am writing g to confirm that the application for the aforementioned NHS research study reference **14/LO/0845** has received UREC ethical approval and is sponsored by the University of East London .

The lapse dates for ethical approval for this study is **7 January 2019**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that you r study has current NRES ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sp ns your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS ethical approval.

Please confirm that you have conducted your study in accordance with the c onsent given by the NHS Ethics Committee by emailing researchethics@uel.ac.uk .

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With th e Committee's best wishes for the success of this project.

Yours sincerely,

Catherine Fieulleteau
Research Integrity and Ethics Manager
For and on behalf of
Professor Neville Punchard
University Research Ethics Committee (UREC)
Research Ethics
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Mrs Lin Graham-Ray
Nurse Consultant Looked After Children's
Central London Community Health Care Trust
Parsons Green Health Centre
5-7 Parsons Green Lane
Fulham London
SW6 4UL

Dear Mrs Graham-Ray

Study title: So what sort of nurse are you?Nursing in a social care setting: Looked After

Children's's views and stories REC reference: 14/LO/0845 IRAS project ID: 149570

Thank you for your letter of 22 August 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Libby Watson, at: nrescommittee.london-harrow@nhs.net

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study:

Looked After Children's 14+ and Care Leavers' PIS

The second sentence, 2nd point from the bottom of page 2, needs to be removed and the section titled 'Will my taking part in this study be kept confidential?' could be moved to just after the section 'What will happen to me if I take part?'.
The word 'total' in the first sentence needs to be removed from the section 'Will my taking part in this study be kept confidential?'.

Person with parental responsibility PIS

There is an issue with consent that needs to be clarified in this document. The Care Leavers aged 18 years and over will consent for themselves – there cannot be additional consent, as another adult cannot consent for anyone over the age of 18. Similarly, a young person less than 18 should be asked for their assent; the Committee would have thought that those 16 years to 18 years could consent for themselves, without involving parents or social workers, but if the researcher wishes to do so, then she should ask for assent in this group too. The PIS will need to be changed to refer to assent not consent.

There is a typo in the 1st sentence - please replace 'you're' with 'your'.

The second sentence, 2nd point from the bottom of page 2 (same sentence as in previous PIS above) needs to be removed.

Social Worker PIS

Again, the PIS needs to clarify, as above, regarding consent/assent and that consent is requested only for those aged up to and including those aged 17 years.

The same sentence needs to be removed as in the above points.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering letter on headed paper		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Certificate of Liability Insurance]	August 2013-July2014	
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Insurance]	1	03 May 2014
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [East London PI]	August 2013-July 2014	
Interview schedules or topic guides for participants [Topic guide]	3	20 May 2014
IRAS Checklist XML [Checklist_21082014]		21 August 2014
Other [Peer Review]		
Other [Topic Guides]	3	20 May 2014
Other [Cover letter Aug 2014]	1	21 August 2014
Other [Lone Worker Policy & check list]		
Other [Lone Worker Policy]	1	25 June 2014
Participant consent form [Consent young person]	5	21 August 2014
Participant consent form [Social worker consent]	5	21 August 2014
Participant consent form [Consent form LAC]	5	21 August 2014
Participant information sheet (PIS) [PIS Person with parental responsibility August 2014 version 5]	5	21 August 2014
Participant information sheet (PIS) [Info for LAC]	5	21 August 2014
Participant information sheet (PIS) [Social worker information]	5	
REC Application Form		05 May 2014
Research protocol or project proposal [Project protocol]	4	15 July 2014
Response to Request for Further Information		
Summary CV for Chief Investigator (CI) [Lin Graham-Ray]		
Summary CV for supervisor (student research) [Academic Supervisor CV]	3	03 May 2014
Summary CV for supervisor (student research) [Dr Gillian Ruch]		

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

14/LO/0845	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Dr Jan Downer Chair

Email: nrescommittee.london-harrow@nhs.net

Enclosures: "After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: *Professor Neville Punchard,*
Mr Frits Klinkhamer, Central London Community Health Care Trust

Appendix C: Patient consent forms

August 2014 version 5

Consent Form: Looked after Child or Care Leaver

Research Project: **Looked After Children's and Care Leavers experiences of nursing in a social care context**	Please tick eac box
I have read the project information sheet with Lin Graham-Ray and I have understood the information about the research project	
I understand that everything I say will be treated as strictly confidential unless it is outside the limits of confidentiality as described in the project information sheet	
The limits of confidentiality are fully explained in the project information sheet which I have read, understood and I agree to.	
I have been given the opportunity to ask questions.	
I agree to taking part in the project, and taking part will include:	
○ Being interviewed by Lin Graham-Ray on two separate occasions	
○ My Interview's on both occasions being audio-recorded	
○ My audio interview's being written up by Lin Graham-Ray	
○ Any art work I create will be photographed by Lin Graham-Ray and given back to me at the end of the research	
I agree to the interview being audio-recorded on the understanding that, once the data has been typed up the audio-recording will be deleted/destroyed	
I understand that Lin Graham-Ray will annonymise all the data to protect me identity and that of others participating in the study.	
I understand that my words may be quoted in the research report and any publication but they will be quoted anonumously	
I agree to take part in this study and understand that my part in it is my own choice and that I am free to change my mind about taking part at anytime and I won't have to give a reason and this will not affect the care I might receive now or in the future.	
I understand that I can have a full copy of the report and any publication	
I understand that Lin Graham-Ray will contact me and discuss anything outside this agreement, which may arise after the interviews that has not previously been considered as it could not have been foreseen.	

Name of Participant	Signature	Date
Name Principle Investigator	Signature	Date

- One copy to be kept by Lin Graham-Ray and one by the participant.
- Consent form from person with parental responsibility must also be signed and kept with this form. All forms must be securely stored and be password protected.

August 2014 version 5

Consent Form: Person with Parental Responsibility

Research Project: **Looked After Children's and Care Leavers experiences of nursing in a social** **care context**	Please tick eacl box
I have read the project information sheet with Lin Graham-Ray and I have understood the information about the research project	
I have been given the opportunity to ask questions.	
I understand that everything that is said during the interviews will be treated a strictly confidential unless it is outside the limits of confidentiality as describec in the project information sheet.	
The limits of confidentiality are fully explained in the Patient Information fo which I have read, understood and I agree with	
I agree to (Name) ………………………….taking part in the project, and taking part will include:	
○ Being interviewed by Lin Graham-Ray on two separate occasions	
○ Both Interview's being audio-recorded	
○ The audio interviews being written up by Lin Graham-Ray	
○ Any art work created will be photographed by Lin Graham-Ray and giv back to the young person at the end of the research	
I understand that even after agreeing to take part the young person is free to change their mind about taking part at anytime without giving a reason and th will not affect the care they might receive now or in the future.	
I agree to the interview's being audio-recorded on the understanding that, onc the data has been typed up the audio-recording will be deleted/destroyed	
I understand that Lin Graham-Ray will annonymise all the data to protect identity of (Name)………………………….and that of others participating in the study.	
I understand that quotes from the interviews may be used in the research report and any publication but they will be quoted anonymously	
I understand that I can have a full copy of the report and any publication	
I understand that Lin Graham-Ray will contact me and discuss anything outsi this agreement, which may arise after the interviews that has not previously been considered as it could not have been foreseen.	

Name Person with Parental Responsibility	Signature	Date
Name Principle Investigator	Signature	Date

- One copy to be kept by Lin Graham-Ray and one by the person with parental responsibility.
- All forms must be securely stored and be password protected.

CONSENT FORM: Social Worker
Consent to participate in qualitative research involving Looked After Children's and Care Leavers:

Project Title: **Looked After Children's's experiences of Nursing in a social care context**	Initials
I have the read the information leaflet relating to the above programme of research in which I have been asked to give parental responsibility consent to and I have been given a copy to keep.	
The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information.	
I understand what it being proposed and the process in which Looked After Children's and Care Leavers will be involved has been explained to me.	
I understand that Looked After Children's and Care Leavers involvement in this study, and that data from this research, will remain strictly confidential unless the limits of confidentiality are breeched as detailed in the project information sheet under sub heading-limits of confidentiality.	
I understand that all data collected will be completely anonymised so as none of the individuals or collective participants can be identified.	
I agree to (Name) ……………………….taking part in the project, and taking part will include:	
○ Being interviewed by Lin Graham-Ray on two separate occasions	
○ Both Interview's being audio-recorded	
○ The audio interviews being written up by Lin Graham-Ray	
○ Any art work created will be photographed by Lin Graham-Ray and given back to the young person at the end of t research	
I understand that they are free to change their mind about taking part at any time without giving a reason and this will not affect the care they might receive now or in the future.	
I agree to the interview's being audio-recorded on the understanding that, onc the data has been typed up the audio-recording will be deleted/destroyed	
I understand that Lin Graham-Ray will annonymise all the data to protect identity of (Name)……………………and that of others participating in the stud	
I understand that quotes from the interviews may be used in the research rep and any publication, but they will be quoted anonymously	
I understand that I can have a full copy of the report and any publication	
I understand that Lin Graham-Ray will contact me and discuss anything outsi this agreement, which may arise after the interviews that has not previously been considered as it could not have been foreseen.	

Name Person with Parental Responsibility	Signature	Date
Name Principle Investigator	Signature	Date

- One copy to be kept by Lin Graham-Ray and one by the person with parental responsibility.
  - All forms must be securely stored and be password protected.

Appendix D: Findings Matrix

1.	Code	Discussed/ referred in interview by: D, L, I, F, N, JT All	Frequency High (H) - More than 20 Medium (M) - More than 10	Discussed in group Yes/No	Theme/s	Primary Domain 1: Young people 2: Nurse 3: Relationship 4: System	Related to more than one domain Yes/No
2.	Secure base	All	H	Yes	Early history - missing	1	No
3.	Maternal deprivation	L, I, F, JT	H	Yes	Maternal	1	Yes
4.	Neglected	L, I, F, JT	H	Yes	History	1	No
5.	Without mum	All	H	Yes	Maternal Loss	1	Yes
6.	Without dad	All	H	Yes	Paternal Loss	1	Yes

Appendix D: Findings Matrix

7.	Without any parenting	L, I, F, JT	M	Yes	Loss	1	Yes
8.	No consistent adult in life	D, L, I, F, JT	M	Yes	Loss	1	Yes
9.	Someone knowing about me	All	H	Yes	Early history - missing maternal	1	Yes
10.	Messy experience	All	H	Yes	Loss	1	Yes
11.	Grief	All	H	Yes	Loss	1	Yes
12.	Loss	All	H	Yes	Loss	1	Yes
13.	Life trajectory of loss	All	H	Yes	Loss	1	Yes
14.	Loss across life span	All	H	Yes	Loss	1	Yes
15.	Fragmented memory	D, L, I, F, JT	M	Yes	Loss	1	No

Appendix D: Findings Matrix

16.	Going missing	F, JT	M	Yes	Lost	1	Yes
17.	Maternal representation	All	H	Yes	Missing Lost Loss	2	Yes
18.	Bearing with me	All	H	Yes	Maternal facet of relationship	2	Yes
19.	Staying with me	All	H	Yes	Maternal facet of relationship	2	Yes
20.	Knowing my story	All	H	Yes	Maternal	2	Yes
21.	History	All	M	Yes	Facet of relationship	2	No
22.	Feeling protected	All	H	Yes	Experience of relationship	2	Yes
23.	Experiencing empathy	All	H	Yes	Experience of relationship	2	Yes

Appendix D: Findings Matrix

24.	Vulnerability	All	M	Yes	Experience of relationship	2	Yes
25.	Fragility	All	H	Yes	Experience of relationship	2	Yes
26.	Consoled	D, I, L, JT	M	Yes	Experience of relationship	2	Yes
27.	Physical trauma	D, F, N	M	Yes	Trauma /traumatic	3	No
28.	Relational trauma	All	H	Yes	Trauma /traumatic	3	Yes
29.	Care not statutory	All	H	Yes	Trauma /traumatic	3	Yes
30.	Trauma language	All	H	Yes	Trauma /traumatic	3	Yes

Appendix D: Findings Matrix

31.	Pre-existing/ expected/anticipated relationship-transference	All	H	No	Experience of relationship	3	Yes
32.	Able to bear and alleviate pain	All	H	Yes	Experience of relationship	3	Yes
33.	Care without consequence	All	H	Yes	Experience of relationship	4	Yes
34.	Being Seen	All	H	Yes	Experience of relationship	4	Yes
35.	Being Heard	All	M	Yes	Experience of relationship	4	Yes
36.	Advocacy	All	M	Yes	Experience of relationship	4	Yes

Appendix D: Findings Matrix

37.	Empathy	All	H	Yes	Experience of relationship	4	Yes
38.	Compassion	L, I,N, JT	H	Yes	Experience of relationship	4	Yes
39.	Good intentions of “parents”	All	M	Yes	System indicators	4	Yes
40.	Splitting	All	H	Yes	System indicators	4	Yes
41.	Projection	All	H	Yes	System indicators	4	Yes
42.	Fragmentation reflective of children’s experiences	All	H	Yes	System indicators	4	Yes