



A Survey for children and  
young people who have  
additional support.



**This survey is for:**

Children and Young People who have extra support and may have an Education Health and Care Plan, also known as an EHCP.

**An Education Health and Care Plan:**

Is the plan that describes what is important to a child or young person, their needs and says what support they should get.

**The survey is being carried out by:**

The local authority and a charity called ['In Control'](#).

**Who wants to know:**

How helpful your support is to you, to help improve things for other children and young people who need support.

**The answers may be read by:**

Your Local Authority, school or health service. But they will not know who wrote them. In Control will also read your answers. People who read your answers will not know who wrote them.

**The answers will be used to:**

Help improve the way that people get support where you live and across the country. The answers will also be used to write reports that will be made public.

**Someone you trust can help you complete the questions:**

If you need help to answer the questions you can ask a member of staff, a friend or family member to help you.

**If you do not want to take part then that is absolutely fine:**

You can also choose to answer some or all of the questions. If you do answer them we will only use them in the way we have described.

**If you are under the age of 16:**

You must have agreement from your parent or guardian to complete this questionnaire

## Questions about you and the support you get

1. How old are you:

2. Are you:

A boy       A Girl       Prefer not to tell us

3. What is the main reason you need support? Please tick all that apply to you

- |  |                          |  |                          |
|--|--------------------------|--|--------------------------|
| Speech, language and communication needs       | <input type="checkbox"/> | Social, emotional and mental health difficulties | <input type="checkbox"/> |
| Cognitive or learning disability or difficulty | <input type="checkbox"/> | Sensory (hearing, sight) or physical disability  | <input type="checkbox"/> |
| Autism (including Asperger's syndrome)         | <input type="checkbox"/> | Don't know                                       | <input type="checkbox"/> |

Other

**4. What type of education, work or training do you do:**





- |   |                          |  |                          |
|---|--------------------------|--|--------------------------|
| Pre-school or nursery                                       | <input type="checkbox"/> | Special school   | <input type="checkbox"/> |
| Mainstream school   | <input type="checkbox"/> | Home schooled  | <input type="checkbox"/> |
| College: mainstream, including 6 <sup>th</sup> form college | <input type="checkbox"/> | College: special needs, including 6 <sup>th</sup> form college | <input type="checkbox"/> |
| University  | <input type="checkbox"/> | Apprenticeship/internship /work based training                 | <input type="checkbox"/> |
| Paid work   | <input type="checkbox"/> | Volunteer work   | <input type="checkbox"/> |
| None of these   | <input type="checkbox"/> | Other  | <input type="text"/>     |

**5. What additional paid support do you get: Please tick all that apply to you**

- |                                   |                          |  |                          |
|-----------------------------------|--------------------------|--|--------------------------|
| Education health care plan (EHCP) | <input type="checkbox"/> | Special Education Need support (SEN support) | <input type="checkbox"/> |
| Personal Budget                   | <input type="checkbox"/> | Transport                                    | <input type="checkbox"/> |
| Social care                       | <input type="checkbox"/> | Health Care                                  | <input type="checkbox"/> |
| Don't know                        | <input type="checkbox"/> | None of these                                |                          |
| Other                             | <input type="text"/>     |  |                          |

## Questions about your experience of the support you get

6. Over the past year, what do you think about these areas of the help and support that you get:

Poor	OK	Good	Don't know
			

The quality of my support:

Having choice and control about my support: I can choose and change my support if I need to..





Having the right help and support to meet my needs:

Practitioners who help and support me work well together:

Flexibility of help and support as my needs change:




## Questions about how the support you get has helped you

7. Over the past year, how well has the support you get helped you:




	Poor 	OK 	Good 	Don't know 
Take part in school, learning, work or training: I do the best I can at school, college or work...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel happy with your quality of life: I'm happy and enjoy life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Develop independence and the skills to be ready for the next steps of your future:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Be as fit and healthy as you can be:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Be part of the local community: I can do things in my local area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enjoy relationships with family and friends: I enjoy time with family and friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Questions about your support planning

8. Were your views included when your support was planned?

Yes	Mostly	No	Not sure
			?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Were the views of close family members included when your support was planned?




Yes	Mostly	No	Not sure
			?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Who was involved in the planning? Please tick all that apply

- |                        |                          |  |                          |
|------------------------|--------------------------|--|--------------------------|
| Class teacher          | <input type="checkbox"/> | Classroom assistant  | <input type="checkbox"/> |
| SENCO                  | <input type="checkbox"/> | Education Specialist (educational psychologist)                          | <input type="checkbox"/> |
| Social worker          | <input type="checkbox"/> | Health specialist (nurse, occupational or speech and language therapist) | <input type="checkbox"/> |
| Family member          | <input type="checkbox"/> | Planning co-ordinator  | <input type="checkbox"/> |
| Voluntary organisation | <input type="checkbox"/> | Support worker   | <input type="checkbox"/> |




Other

11. Does the plan explain what you find difficult and what help you need?




Yes	Mostly	No
		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Questions about your outcomes




12. Do you know what the outcomes are in your support plan?

Yes	Some	No
		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>




13. Do the outcomes in your support plan represent your views and the things that you want to do?

Yes	Mostly	No
		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Are you happy with the progress towards your outcomes?




Yes	Mostly	No
		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Do people who support you know what the outcomes are in your support plan?




Yes	Some	No
		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



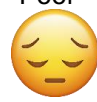



16. Do you know how you are going to achieve your outcomes?

Yes	Mostly	No
		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. Have you achieved your goals with the support that you get?

Yes	Making progress	No
		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. Over the past year, how well has the support you get helped you:

	Poor 	OK 	Good 	Don't know 
<b>Have fun:</b> I have fun and enjoy my spare time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Feel safe:</b> I feel safe at home and out and about	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>At home:</b> I enjoy life at home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

19. Did you have help to complete this questionnaire?

No, I answered it on my own

Yes, someone helped me answer

Yes, someone else answered for me

Thank you for answering these questions.

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