Service Specification – LC

## Open Advert Project Number –

**For young person who requires an OFSTED/CQC ONLY registered solo Residential Children’s Home.**

**If you are interested and would like further discussions with the care team, please email;** [**Placements@durham.gov.uk**](mailto:Placements@durham.gov.uk)

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| **Age** | 17 |
| **Gender** | Female |
| **Current Placement Type** | Unregulated |
| **Geographical location required** | North East only/within County Durham – A local area where LC can go to shops/amenities and go for walks. As close to Stanley as possible. |
| **Needs and presentation.** | **Matching**  The social worker recommends that this search be made for a single child home only for residential options, I appreciate supported living searches may be multiple occupancy and would be open to exploring this. If LC is placed in a residential, due to her vulnerabilities and the complexities of her mental health needs, it is felt she needs a single child home.  **Search**  LC is currently in an unregulated placement, we are searching for a registered provider for her and potentially somewhere she could remain post-18 that would support her care needs and mental health needs.  **Pen Picture**  LC is a fantastic young lady with a hilarious personality! LC has a great sense of humour and loves to make people laugh.  LC has ambitions for her future to complete an apprenticeship.  LC has had excellent feedback on her written work form previous apprenticeship.  LC can say what’s on her mind very clearly and when in secure she has worked so hard with her coping strategies and putting these in place.  LC engages very well with all support in place.  LC has a diagnosis of ASD which may help her understand herself a little more.  LC is seventeen years old and is currently staying in an unregulated home whilst her social worker searches for a permanent placement for her.  **Education**  LC would like to do a course in hair and beauty or health and social care. The Send team are re referring her to Durham Works to look at options.  LC currently works at McDonald's at the Arnison Centre, this is part-time and she has changeable shifts.  LC has applied to Springboard, an alternative education further education college in County Durham, however, they've advised that the courses are full for this year and they cannot offer LC a place.  LC has a Durham Works worker assigned now, they are looking for employment opportunities for her, and she is happy about this.  LC attended an apprenticeship interview on 18th March 2024, this went well however she was not offered a place, she is going to keep applying.  **Health**  Physical  LC has declined to attend her last 2 dentist appointments. LC is now registered at her local GP.  Ashley Parker, the LAC health nurse, is looking into getting replacement insoles as LC's have been misplaced.  LC attended the hospital on 31ST March, this was due to drinking two bottles of Calpol, which meant she had overdosed on paracetamol. LC attended Sunderland Hospital, notes on the Ambulance services referral suggest LC was monitored and discharged but did not receive treatment for this as such.  LC continues to be offered weekly CAMHS appointments, she has missed some of these appointments, however, she most recently attended on 8.4.24 and reportedly engaged well. CAMHS have not made the social worker aware of any changes to her medication.  LC attended the hospital on 8th April due to knee pain, the doctors said this was due to period pain, she has a blood test booked for 18.4.24 for a blood test about her hormone levels as they want to explore if this may be linked to her period pain.  Medication  LC is currently taking medication as of 15.2.24 as per Dr Grimwade:  CONTINUE Promethazine has been used x1 per day at night, rarely twice  DISCONTINUED Zopiclone is now finished – 7 tablets – was given at 10pm but still not sleeping till morning.  DISCONTINUED Diazepam – 5 tablets now finished  Option of starting melatonin again if there is some agreement from LC to maintain sleep hygiene however no script currently  **Identity**  LC has spent time in the care of the local authority from the age of 13, including foster care and residential care settings. LC has previously been admitted to a secure centre under a Section 20 Welfare Order following concerns around vulnerabilities linked to self-harming behaviours, suicide attempts, absconding, and putting herself at risk. LC was initially admitted to Aycliffe Secure Centre (ASC) on 2 March 2021 under a Section 25 Welfare Order following concerns around absconding behaviour and posing a risk to herself and others. Upon transition from the centre, LC was later re-admitted on 29 January 2022 following an increase in risk. LC has previously made allegations against family members, these have been investigated and no further action taken, rescinded or both.  LC has previously stayed in residential, supported accommodation, secure and family placements whilst looked after. LC has a diagnosis of autism spectrum disorder, anxiety disorder and PTSD; she also has an IQ of around 86. LC has complex mental health needs and this often presents as emotional dysregulation and self-harming behaviour. LC has been known to attempt to self-harm in significant ways, especially tying ligatures and jumping out of windows. Her carers need to be always mindful of her emotional state and the opportunities available to her to self-harm to keep her safe.  Worries around LC remain high and that she may harm herself by tying ligatures around her neck, stating she has ingested detergents, overdosing on paracetamol/medication and assaulting staff. LC can become unregulated and when this does occur the behaviours above do present. We know that LC has a recent diagnosis of ASD we are trying to understand how she becomes unregulated and so heightened. LC is also undergoing genetic testing for a chromosome abnormality.  LC has an IQ of 86 and this does impact on her understanding in some areas, specifically on relationships with adults and how to keep herself safe. She has had contact with an adult of concern PL (social worker to share details in person), who has been contacting her via social media, attended her home address, and it is believed he has been following her in the community. From what we understand he has been asking LC to provide information to him regarding the local authority.  **Family and relationships**  LC has contact with her parents and siblings as and when she wants to, there are no restrictions on this. LC has been going to the gym with her mam which is having a really positive effect. LC has had contact with her grandparents for the first time since October which has gone well.  Historically, LC has experienced feelings of rejection from her family. Her close family is her mum, dad, older sister, and younger brother. LC was voluntarily accommodated under S20 initially before the Care Order was granted. During her time in care, LC has felt that her family do not want her or that they do not feel they can look after her. LC has had periods where she returns home or to live with her maternal grandparents, however, these arrangements have broken down. LC’s family have sometimes said they do not feel able to see her, this included when she was in secure twice, and this has caused her upset. LC has a close relationship with her siblings and wishes to see them a lot, she is also close with her mum and she sees her weekly at present, unsupervised. LC has said she is afraid of her dad and has said she was abusive to her and her mum during her childhood, she maintains the allegations of sexual abuse against him she made during proceedings, although the police investigation was NFAd in relation to this. LC has very little contact with her dad as far as the social worker is aware and he has not seen her during any recent family time. Family time is very positive for LC and improvements in her mental health can often be seen when she is seeing them more regularly, she wants to feel like part of her family unit and she is conscious that she cannot live with them.  **Communication and Social presentation**  In terms of LC’s developmental history it appears that there were some early concerns in her functional use of language. She was described as ‘not talking much’ and being a ‘late talker’, often letting her sister do the talking for her. LC was approximately 4 years old when she started speaking in three-four word sentences. LC also struggled to comprehend spoken and written language. She will often watch the TV with subtitles on and prefers texts or instructions to be written down. When younger LC would often repeat words she has head in a similar sentence but often getting the meaning wrong. Parents describe her calling them and using all the care-home terminology, acronyms and jargon etc but not having the understanding to accompany these words. In care meetings LC would use these stereotyped phrases but later when in a 1:1 situation did not have the understanding of what she was saying or was able to follow what had happened in these meetings. There were early pronunciation difficulties and LC’s speech was not always clear even to family members. It was thought that this was due to excess saliva and LC would often soak her jumpers with this excessive saliva. LC did not have a speech and language assessment until August 2022. LC has always struggled to have a reciprocal back and forth conversation. She does not like being asked questions and often responds ‘I’m fine’ but would then text later. LC does not like talking on the phone and will say “I don’t do verbal communication”. She will often make socially inappropriate statements “I’m having a phone, I’m going to commit burglary and get one”. LC was banned from social youth clubs when younger as she often would start inappropriate sexualised conversations. There are some unusual aspects to the way in which LC speaks in that she cannot whisper or speak quietly. Her parents describe her volume as loud without appropriate varying intonation. There are no apparent early concerns around her use of gesture. LC’s eye contact when younger was described as variable, in that sometimes she would look, but would quickly ‘zone off’ and was described as ‘staring through you’. LC would not always respond to the smiles of other people, or even her parents. Her parents report that she wouldn’t really display any emotion coming out of nursery or school.  There is consistent evidence across contexts that LC has significant social communication difficulties. LC’s social approaches and responses are often inappropriate, one sided and naïve. LC struggles to modify her behaviour according to the needs, interests, and responses of the other person. In the past LC’s surface sociability and attempts not to draw attention to herself, as she wants to fit in with her peers, has meant that she has been able to mask some of her difficulties. LC, like many girls on the Autism Spectrum are more able to follow social actions by delayed imitation i.e. observing others and copying them in a way that often masks her social communication difficulties. However, as the social demands outweigh her abilities, this strategy is no longer working in all situations. It is important to note that LC uses a lot of stereotyped language, which sounds like it has been ‘borrowed’ from elsewhere (for example, a social worker, or a tv programme).  **Emotional and mental health needs**  As discussed, LC has a number of complex mental health needs and this often presents in terms of prolonged periods of crisis in which she will make multiple attempts at self-harm, including significant suicide attempts, such as tying ligatures, drinking bleach, taking overdoses of medication and jumping into the road/trying to jump out of windows. LC mood can be unpredictable and it’s not always possible to assess her mood based on her presentation which can make the management of her mental health challenging. LC has input from CAMHS and a psychologist in relation to her mental health needs. LC has a diagnosis in relation to mental health of depression, anxiety, and PTSD.  Recently, LC has been crisis and some of her previous behaviours had returned but this has settled in the last few weeks. This included assaulting staff, property damage and repeated attempts to self-harm. This was the use of ligatures, overdoses, attempts to ingest toxic substances, jump out of windows.  LC has settled a lot but still needs her sleep pattern to be restored as she has gone back to sleeping all day and being awake at night. She is on medication from CAMHS to support a better sleep routine, this is being kept under review during her weekly appointments with them.  LC has had one self-harm incident in the last month, this was on 31.3.24 when she drank two bottled of Calpol whilst at work, this has been the only self-harm incident.  LC had a missing episode on 1.4.24, she left her free time to meet the child JL, another looked after child, and they went to the Quayside and bought alcohol and got drunk. LC travelled to her maternal nan's and then was picked up by Police and was returned home, she was missing for around eight hours between 3-11pm.  LC's free time has been suspended as of w/c 1.4.24, due to her missing episode and her buying Calpol whilst out without staff, this is being kept under weekly review.  **Physical needs**  LC has no sensory needs. LC has some health needs as discussed above, including having one leg shorter than the other and having painful periods, she does not have diagnosis around these conditions, however, she is having ongoing health input for this. LC is in generally good health, although her sleep routine is poor and this impacts her mental health. LC has a diagnosis of ASD, although this is not a disability as such.  **Dietary needs**  LC has normal health needs for a child her age, she is in relatively good physical health and carers are encouraging her to eat a balanced diet. LC struggles to cook for herself and dislikes planning and making health meals, usually eating ready meals or takeaways, we’re trying to encourage her to eat more healthily and cook for herself.  **Cultural needs**  LC celebrates Christian holidays such as Christmas, however, he does not practice any religion.  **Self-care**  LC can do some of her basic care such as washing and dressing herself, she is able to plan his daily routines and outline activities she would like to do and share this with his carers. LC has very limited life skills and sometimes lacks motivation to build her skills. LC dislikes public transport and will get ubers as needed if staff won’t drive her, this is linked to her anxiety. LC has free time, however, she rarely uses this which leads the social worker to believe she lacks confidence in going out on her own.  LC enjoys activities such as going to the gym and going shopping and out for meals with carers. She also enjoys spending time with friends and family, and doing arts and crafts, she is a very talented painter.  **Search outline**  We want LC to have a home in which she can settle. She benefits from consistent routines and boundaries as well as positive relationship with carers who will get to know her and that take an interest in her life and history, LC can be ‘closed off’ when she first meets new people and it can take her a long time to open up to new people, however, when she does, she can be very chatty and caring.  LC would benefit from being in a home on her own as she has previously had issues with settling with other young people due to her own vulnerabilities. We want a home for LC near to Stanley, Durham, so she’s near her family as these are her support network. We want carers who can provide care for her until she transitions to adulthood and that would help teach her self-care and life skills to help prepare her for adulthood. We would want a home that could respond to LC’s more challenging behaviour in a calm and measured way to help settle her and prevent escalations of her behaviour.  We want carers that would build strong and stable relationships with LC as loss/rejection is a significant trigger for her getting upset and becoming low/withdrawn and seeing breakdowns in her mental health which can escalate to aggressive behaviours. LC would need a regular carer team who were able to build relationships with her and provide her with nurturing.  We also want LC to be able to access therapeutic support to address the trauma she has experienced during her childhood and that a therapeutic approach to parenting was undertaken to meet LC’s needs and to help understand her behaviour.  In summary, we would like a stable placement for LC, and a therapeutic approach to her care, and somewhere that can support her mental health needs and help her build her life skills. LC requires support with anxiety and some self-confidence setbacks. Local Authority would like LC to be supported back into education as this is something she wants. A supportive environment with a stable staff team is essential.  LC will be 18 in July and we are therefore looking for somewhere for her where she could remain post-18. Ideally, we would be looking for a placement that specialises in support children with autism and or complex mental health needs. We would be open to exploring a placement for LC that is CQC registered. At the present time, it is unclear if LC will receive psot-18 funding from Adult Services and this may limit the options open to her for supported housing. LC could potentially live in a setting with others, if there were staff on hand 24/7. LC needs support in doing life skills and maintaining a tenancy and any provision that could help her do household tasks would be something she would benefit from. |
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**What we require:**

* To open a discussion with providers about a solo, Ofsted/CQC registered Children’s Home provision in County Durham or in the surrounding area within the Northeast of England to meet the specific needs of an identified young person.
* A provider will already have a registered children’s home with a highly experienced Registered Manager and be able to provide a solo provision.
* Providers that have well established knowledge and experience of working with children with complex needs and within Ofsted and CQC’s Regulatory Frameworks.
* Providers that have a track record of achieving positive outcomes for children / young people and who provide consistent good quality care and who demonstrate stickability.

**Environmental Considerations:**

* A good size outdoor space, ideally a garden area.
* Links to local routes.
* The environment needs to be calm, minimally furnished and not overstimulating.
* Some areas of the house need to be made secure for the storage of sharps and other objects that the child can cause harm to themselves or others.
* Separate room for staff to go to when the young person needs less stimulations or more space.
* A breakout room or low stimulation space would be needed.

**Rural/Urban Location:**

* This young person would benefit more so from a rural location to allow some freedom in movement, but with realistic distances to amenities and entertainment. This young person can become quite heightened when in social situations and out in busy communities and therefore a quieter home where he can be taken away from busy/social situations would be most beneficial.
* Careful consideration needs to be given to how rural a home could be as not to isolate the young person too much.
* Urban opportunities need to be planned carefully and antecedents/triggers mitigated as much as possible. This needs a positive risk-taking approach and reflective approach to risk events.

**Single tenancy or share with others:**

* This young person would need to be in bespoke single occupancy accommodation.

**Noise Issues and the impact on neighbours:**

**Technology:**

**Current level of support including night (staff to complete daily support needs timetable):**

* **To be discussed as part of care planning and transition into the home**

**Transport:**

* **Accessible transport links considering the needs of the child.**
* **Far enough away from direct transport links such as train stations, bus stations and links that could pose a risk to child.**

**Staff Specification:**

* **Provider to have staff trained to a minimum level 3 qualification in children and young people’s service.**
* **Evidence of ongoing staff training including Safeguarding, basic mental health awareness, trauma informed.**

**Staff Training**

**We would like to see evidence of the model of care you would provide (e.g., PACE, Therapeutic, Trauma informed)**

**What we will offer as a Local Authority:**

* Tailored multi-agency planning about additional support and resources that can be offered in line with the needs of the young person.
* A letter of support for the change of use SOP.
* A dedicated point of contact.
* Access to an advocacy and independent visitor service.

**If you are interested and would like further discussions with the care team, please email** [**CYPSResidential@durham.gov.uk**](mailto:CYPSResidential@durham.gov.uk)