



## Health & Justice, Armed Forces and SARCs in the Long-Term Plan for the NHS

Response submitted by the Royal College of  
Paediatrics and Child Health

September 2018

## Overview

Thank you for your letter of 10 September inviting the Royal College of Paediatrics and Child Health (RCPCH) to share our thoughts on the populations of Health & Justice, Armed Forces and SARCs in the long-term plan for the NHS.

As you are aware, promoting children and young people's mental health and wellbeing is a priority area for the RCPCH. In January 2017, the RCPCH published ['State of Child Health 2017'](#) which covers 25 indicators of child health. To inform the report we consulted 326 children and young people. Mental health was a major area of concern; many children and young people told us that they had a lack of knowledge around mental health, with specific anxieties around how to deal with mental health concerns in themselves and others, as well as questions about who they should turn to for guidance.

In our response to your questions we have focused on the needs, support and services that are available for the 0-25 age group, as this is where the expertise of our members lies.

The health of children and young people is crucial to the future well-being and prosperity of our nation. We look forward to the developments of the plan and would welcome the opportunity to participate in future conversations to contribute to the transformation of services for these populations.

In developing this response, we have consulted with our Child Protection Standing Committee, which draws on expertise from across both paediatrics and forensics, and also that of our colleagues at the NSPCC. Based on the committee's feedback we have split our response into two; firstly focusing on SARCS and the Health & Justice populations; and secondly on the Armed Forced population.

### **For more information, please contact:**

Alison Firth, Policy Lead  
alison.firth@rcpch.ac.uk | Tel: 020 7092 6093

## SARCs & Health and Justice – NHS long-term plan

This response heavily references current NHS England strategies for these populations: the *Strategic Direction for Sexual Assault and Abuse Services 2018-2023* [report](#) (referred to as SARC strategy) and the *Strategic Direction for Health Services in the Justice System 2016-2020* [report](#) (referred to as Justice strategy).

### 1. What are your top three priorities for meeting the health needs of people (in our populations of Health & Justice, Armed Forces and SARCs) of all ages in England?

RCPCH recommends that any priorities should take a holistic view of children's health, acknowledging both the physical and mental health needs of patients. It is important that wellbeing and resilience are considered, to ensure that children and young people can achieve their life goals. We also recommend that all areas of the long-term plan take a life course approach, supporting integrated models of care which combine health promotion, prevention, early intervention, service transformation and provision, and evaluation, all within a continuous cycle of quality improvement. In addition, we recommend that NHS England's strategy for sexual assault and abuse services should be aligned to the Maternity Transformation Programme<sup>1</sup>.

Our top three priorities are:

1. **Mental health.** Ensure that mental health assessments for both adults and children adequately look for an underlying neurodevelopmental disorder which might impact upon mental health and behavioural presentations, including those around violent crime and substance misuse.
2. **Workforce.** Ensure true multiagency working around the needs of that child and family. Equip the children's health workforce with appropriate resources, competencies and support to build resilience. The medical workforce in SARCs is a foreseeable gap in the near future in paediatrics.
3. **Early intervention and prevention.** Ensure improved recognition and quality early intervention for adverse childhood experiences under five years old. Invest in trauma-informed care and building understanding of the long term mental and physical health effects that early trauma can have on the developing brain and body.

### 2. What gaps in service provision currently exist, and how do you think the NHS should address them (these can overlap with Q1 but may include a longer list)?

To identify gaps in service provision, RCPCH recommends that NHS England uses service delivery standards to audit services, via health inspectorates (such as Care and Quality Commission). RCPCH has produced a suite of *Facing the Future* [standards](#), covering acute care, community care, emergency care, and care of children with ongoing healthcare needs – including specific safeguarding and child protection standards. Jointly with the Faculty of Forensic and Legal Medicine (FFLM), RCPCH have also produced a [service specification](#) for the clinical evaluation of children and young people who may have been sexually abused, which outlines the standards that should inform the establishment of these services. RCPCH recommends that NHS England's strategy for improving sexual assault and abuse services

---

<sup>1</sup> NHS England Maternity Transformation Programme <https://www.england.nhs.uk/mat-transformation/>

is expanded to incorporate how evaluation of RCPCH standards leads to service improvement and ultimately improved child health outcomes pertaining to health, wellbeing, experience and vocational outcomes. Also, RCPCH suggests that the role of education inspectorates (such as Ofsted) is considered within this framework, in order to ensure an integrated care model.

In the SARC strategy, it is good to see Accountable Care Organisations and Integrated Care Systems mentioned, as they have a key role to play in large scale system service transformation, as well as meeting local needs. To achieve the vision of true partnership working, other sectors need to have more prominence, including the Education sector, and the Home Office.

We recommend that there needs to be a cross government strategy and framework if a truly integrated model of care will be effective which has a clear reporting structure and accountability framework. There also needs to be a much larger profile for the education sectors right through from nurseries to colleges/universities in building important awareness and resilience, and the health sector should be involved in co-production of health education through PHSE. NHS England must acknowledge and plan for effective cross-sector collaboration, co-production and partnership between health and education services to ensure commissioning responsibilities are joined up. We also want to emphasise the importance of having a key worker as part of the multiagency approach, and recommend that this is continued.

With regard to secure settings, we emphasise the need for the key messages and recommendations in the Healthcare Standards for Children and Young People in Secure Settings<sup>2</sup>, published by RCPCH, to be met and adopted in full to ensure that there are no gaps in service for this vulnerable group.

**3. There are some significant inequalities in how our populations access and experience care for their health needs, and in their outcomes, including but not limited to people who have ‘protected characteristics’ under the Equality Act 2010. What are your views on what practical steps the NHS should take to address inequalities in the services it provides?**

The impact of poverty and inequality on child health outcomes is well-evidenced. Recent child poverty figures show the number of children living in relative poverty in the UK (after housing costs) increased to 4 million in 2015/16. This is an increase of 100,000 over the previous year, and means that nearly a third of children in the UK are living in poverty. It is important to ensure services are developed to support the most vulnerable children, young people and families for whom the legislation and assessment process can be a “minefield”.

Commissioners have a responsibility to ensure the UK government discharge their duties under domestic legislation and uphold their international obligations under the United Nations Convention on the Rights of the Child (UNCRC). As part of upholding these rights, NHS England should ensure that there is effective engagement and involvement of children,

---

<sup>2</sup> RCPCH Healthcare Standards for Children and Young People in Secure Settings, 2013 <https://www.rcpch.ac.uk/resources/children-young-people-secure-settings>. Please note these standards are currently being updated and will be published in December 2018.

young people and families in the design and development of all healthcare services. This will ensure that the right modes of dissemination and communication are fully explored and implemented. NHS England should encourage all services to sign up and to adhere to the You're Welcome standards<sup>3</sup>, a set of quality criteria for young people friendly health services.

Child sexual abuse should not be considered in isolation from all other forms of physical and emotional abuse and neglect, and mental health needs. SARCs should therefore support children and their families by ensuring they are assessed with this in mind and in a timely, appropriate and empathetic way. However, it has been projected that only 33% of children and young people with mental health needs will receive treatment by 2020.<sup>4</sup> This leaves concerning gaps in service provision for children and young people who do not meet Tier 3/4 CAMHS thresholds, and are left to a system which the Care Quality Commission (CQC) have recently found to be fragmented to a degree that is an obstacle to progress.<sup>5</sup> It is unrealistic to expect that funding for specialist services will treble in order to increase this figure to 100%, but the support and care of the remaining 67% is important.

Service planners must ensure there is a pathway for the treatment of all children and young people with mental health problems of any severity in a local area. We support the CQC in recommending that local transformation plans (LTPs) are given statutory footing to set out a local offer for children and young people's mental health and wellbeing and recommend that this is supported by NHS England.

#### **4. How best can we bridge the gap between children's and adults' services?**

As the adolescent brain is still developing up to 25 years, we recommend that children and young people's mental health services should be commissioned together up to age 25 years, with tailored services to meet needs according to age and development. This is already recognised by Education Health and Care Plans, which extend up to that age.

High-quality youth services are crucial for providing support and developing resilience in young people. However, availability and access to youth services has been reduced as a consequence of decreased funding within Local Authority budgets. This gap not only applies to assessment when in the Justice system but in the wider community too as the failure to adequately address it is likely to have an impact on the Justice system.

Commissioning services up to age 25 years ensures that any underlying neurodevelopmental disorder is identified and appropriately managed, thus reducing the risk for that individual of developing secondary mental health and behavioural difficulties which might lead them into contact with the Justice system. Such neurodevelopmental disorders include autism spectrum disorder which can present itself later in adolescence as the social demands upon that person become more complex. In many CCG areas currently,

---

<sup>3</sup> Young People's Health – You're Welcome 2017. <http://www.youngpeopleshealth.org.uk/yourewelcome/>

<sup>4</sup> NHS England Mental Health Taskforce. The Five Year Forward View for Mental Health. <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

<sup>5</sup> Care Quality Commission: Are we listening? Review of children and young people's mental health. March 2018. <https://www.cqc.org.uk/publications/themed-work/are-we-listening-review-children-young-peoples-mental-health-services>

it is not possible for an adult without known learning difficulties to obtain an assessment for autism.

Child and adolescent mental health services (CAMHS) also promote keeping children and young people safe by decreasing vulnerabilities and building resilience. This extension of services to age 25 should also include CAMHS, and some aspects of community paediatrics so that there is adequate knowledge and expertise applied in the assessment and management of emerging behavioural and mental health conditions.

We would recommend that NHS England ensure multi-disciplinary involvement in transition planning, including the active participation of GPs. We recognise that multi agency working is difficult to do in practice, both across children's services, and between child and adult services. True change for a family can only come about by addressing the needs of both the children and adults who may be involved in the Justice system or have needed to visit SARCs. Suggesting referral to adult services via GPs when neither the GP nor adult services, usually mental health services, are present at the multiagency meeting is not the most effective way of working and is less likely to lead to the engagement of the adult family member. To be able to address that in a time efficient way is a current challenge that needs attention.

Another concern is the lack of understanding in social care and education of the role that health can play in helping to identify root causes of family difficulties; with a focus on managing the behavioural symptoms rather than seeking the underlying cause of that behaviour (although we acknowledge that there is progress in this area in Youth offending teams). However, this service is not available to children who are on the edge of crime. Adequate funding for Early Help strategies is an important gap to be filled, and one that would help to support children and families at risk of further adversity.

#### **5. How can we recruit, train and retain the workforce to deliver the changes we need, particularly to meet your priorities (Q1 above)?**

Investing in the workforce should be prioritised. The medical workforce in SARCs is a foreseeable gap in the near future in paediatrics, and is a challenge RCPCH are already responding to. We recommend that NHS England look at other ways of working, including staff reward and recognition, workforce flexibility, psychological support for staff, joint job roles, and shared competencies between paediatric and forensic examiners.

There is also a gap in knowledge, expertise and confidence in general and community paediatrics as the SARCs have become so specialist. This has other knock on effects in treating more routine gynaecological conditions. Some areas have joint child protection and child sexual abuse services which work well together and may be more likely to support the confidence and expertise of other local paediatricians, in contrast to a separate service that paediatricians can't refer to (e.g. social care and police) and do not receive reports from. We recommend that NHS England review joint working between child protection and child

sexual abuse services to avoid widening of this gap, as recommended in our SARC service specification (2015).<sup>6</sup>

In order to meet the priorities outlined by RCPCH, workforce considerations should be expanded to consider the role of both the education sector and maternity / gynaecology services. Education plays a key role in identifying and managing children's healthcare needs, as children and young people spend a large proportion of their time in this setting (ranging from nursery to university / college age). To provide effective integrated healthcare, the education sector should be incorporated into the strategy with respect to its commissioning and provider roles. NHS England should work closely with the education sector in the commissioning and provision of their services so that its workforce are properly equipped to recognise the symptoms and signs, know where to signpost can give on-going support from a resilience building and educational perspective.

We recommend that NHS England continue to support the updating of the document 'Safeguarding children and young people: roles and competencies for healthcare staff'<sup>7</sup>, which is published by RCPCH. This document sets out the core competencies for all healthcare staff who come into contact with children, and is an essential safeguarding document. There is a dedicated section at Level 3 for staff working in sexual health, and it is essential that NHS England remain committed to this and ensuring that all staff working in SARCs are assessed against these skills and competencies during their appraisals.

## **6. Do you think the NHS should be doing more to prevent ill-health / intervene early? If so, what should we do to improve this?**

The 2011 Munro Review of Child Protection<sup>8</sup> identified that there are two types of primary prevention: universal prevention, which addresses the entire population and aims to reduce later incidence of health issues, and selective primary prevention, which focuses on identified groups with a higher than average risk of developing health issues. We would recommend that NHS England should invest further in selective primary prevention services to reduce the burden on secondary and tertiary prevention services (which includes SARCs). The Department of Health and Social Care have done some analysis that shows the average life time cost to the health service for a child sexual abuse case which we would recommend NHS England review and consider in their prevention planning.<sup>9</sup>

We know that half of all mental health problems have been established by the age of 14 and 75% by age 24 years, and that mental health problems have higher incidence in the SARC and health and justice populations. We believe it is important to take a life course approach to all services; for mental health a key part of improving child mental health services is to have effective perinatal mental health services. It is therefore important to ensure that there is join up of mental health and wellbeing in the long-term plan with ongoing maternity

---

<sup>6</sup>RCPCH/FFLM Service Specification for the evaluation of children who may have been sexually abused.

[https://www.rcpch.ac.uk/sites/default/files/Service\\_Specification\\_for\\_the\\_clinical\\_evaluation\\_of\\_children\\_and\\_young\\_people\\_who\\_may\\_have\\_been\\_sexually\\_abused\\_September\\_2015.pdf](https://www.rcpch.ac.uk/sites/default/files/Service_Specification_for_the_clinical_evaluation_of_children_and_young_people_who_may_have_been_sexually_abused_September_2015.pdf)

<sup>7</sup> RCPCH/RCN Intercollegiate Competencies for Safeguarding Children

<https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competences-healthcare-staff>

<sup>8</sup> The Munro Review of Child Protection

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/175391/Munro-Review.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/175391/Munro-Review.pdf)

<sup>9</sup> Contact: Michaela Bartlett, Department of Health and Social Care

transformation plans. We also recommend that NHS England invest in engaging in developing a public understanding of child development and the long term mental and physical health effects that trauma from adverse childhood experiences (ACEs) can have on the developing brain and body.

Young people we have spoken to through our RCPCH &Us<sup>10</sup> network have been clear that improved communication by adults, and having their rights to information, healthcare and involvement in decision-making respected and acted upon when accessing services, were all key factors in improving their wellbeing. For example, if individualised crisis management is necessary, the child and their parent/carer should co-author their crisis care plan, which should be circulated with relevant agencies in health, education, social care, judiciary and the third sector.

### **7. People with more serious and complex problems do not always receive the care they need. Which groups would you prioritise and what extra help would you like to see developed by the NHS?**

Child sexual abuse should not be considered in isolation, and there is a need for stronger consideration that children and young people presenting to SARC services often have complex physical and mental health problems. We recommend that holistic approaches to care are prioritised to ensure the best long-term outcomes.

It is known that 75% of adult mental health difficulties have emerged by 25 years of age, therefore children and young people should be prioritised in these populations going forwards, in particular adolescents with emerging mental health problems. This urgent need for priority should be fed into the NHS Assembly as it develops.

For children detained under the mental health act or in custody, every effort should be made by CCGs, NHS England and the institutions in which the children are detained to ensure these children's health needs are identified and met, wherever they are living. We support continued and universal use of the standardised and validated Comprehensive Health Assessment Tool (CHAT) for young people in the youth justice system developed by the National Child and Maternal Health Intelligence Network to improve the assessment process.

For looked-after children, designated doctors and nurses have a very important role in promoting the health and welfare of looked-after children. In line with Working Together Guidance, CCGs should have appropriate systems in place for discharging their responsibilities for safeguarding and ensuring that these posts are filled. That includes securing the expertise of designated doctors and nurses for looked-after children.

### **8. Are there examples of innovative/excellent practice that you think could be scaled-up nationally to enhance the quality of care people receive, reduce costs and/or improve efficiency of delivery?**

---

<sup>10</sup> RCPCH Working with children, young people and families <https://www.rcpch.ac.uk/work-we-do/working-children-young-people-families>

To achieve better integrated care, it needs to be supported by better technology, for example a universal email system to ease communication in a local area. Other examples we support include investment in electronic patient health records and better joined up use of data sets (for example maternity and perinatal maternity data linking to the justice information system and to education). A specific example of improving technology to integrate care is Alder Hey Children's Hospital, who are developing a wide ranging artificial intelligence (AI) programme to imagine the most technologically advanced hospital, which will eventually oversee logistics, supply chains, and diagnostics<sup>11</sup>. These examples of better technology should all be considered as part of NHS England's digital strategy bringing together data to underpin effectiveness and evaluation.

NHS England must look to the experiences of localities and system wide service transformations in terms of developing and rolling out integrated services. The role of STPs and ICSs is key and they need to look to models of integration to do this. For example, as part of the Greater Manchester Health and Care plans, there is a child health and wellbeing framework which is being developed and implemented across the health, social care, education, youth justice and voluntary sectors in collaboration with children, young people and families.<sup>12</sup>

We believe that both the SARC and Health and Justice strategies should refer to the Lived Experience group and Disrespect nobody campaign, which are of grave importance in raising awareness and ensuring young people have input into service design and delivery.

## **9. What do you think are the specific challenges that will prevent the NHS from being able to deliver good care, and what should we do to overcome them?**

RCPCH recommends implementation of a fully integrated and interoperable data infrastructure, to enable improved sharing of essential patient information through electronic patient records. NHS England has committed to supporting the expansion of the Child Protection Information Sharing (CP-IS) programme within unscheduled care settings in the strategy. RCPCH recommends that the current target of 80% of unscheduled care settings is expanded to 100% by 2021. Furthermore, we recommend that NHS England commit to an evaluation of CP-IS to assess the impact for services and children, and outline opportunities for the programme to be expanded in other areas (e.g. FGM).

In addition, we recommend that increased investment is made into the workforce, ensuring a systems approach. This should include recognition of the value of clinicians in quality improvement, both locally and nationally, with specific time allocated in their job plans. We recognise that this will require initial increased resource but feel that this current funding opportunity will support longer-term, cost-effective change.

We would also suggest that further research into adverse childhood experiences (ACEs) and how to address their effects appropriately is commissioned to support these particular populations.

---

<sup>11</sup> Alder Hey's "cognitive hospital" aims to turn NHS use of AI on its head BMJ 2018;362:k3791 <https://www.bmj.com/content/362/bmj.k3791>

<sup>12</sup> Manchester and Salford CAMHS pathway [www.positivepracticemhdirectory.org/nccmh/manchester-salford-camhs-pathway-nccmh/](http://www.positivepracticemhdirectory.org/nccmh/manchester-salford-camhs-pathway-nccmh/)

## Armed forces – NHS long-term plan

This response has been developed in conjunction with the NSPCC and is largely based on research from their upcoming report ‘Early Support for Military Families’ due for publication in early 2019.

### 1. What are your top three priorities for meeting the health needs of people (in our population Armed Forces) of all ages in England?

- Ensure prompt access for current and ex-serving personnel to adult mental health services specialising in the identification and treatment of post-traumatic stress disorder (PTSD) and other symptoms associated with combat experiences.
- Provide early help services to support the mental wellbeing of parents and children within the military, e.g. perinatal interventions and counselling.
- Ensure that children from military families with special educational needs and/or requiring specialist health care are not disadvantaged in their access to services through the requirement of military families to regularly relocate.

### 2. What gaps in service provision currently exist, and how do you think the NHS should address them? / 3. What are your views on what practical steps the NHS should take to address inequalities in the services it provides? / 4. Which groups would you prioritise and what extra help would you like to see developed by the NHS?

**PTSD among military personnel.** It is estimated that 4% of the armed forces are affected by PTSD. There is a link between paternal PTSD and emotional and behaviour difficulties in children, particularly boys and children under 11 years old (Fear et al, 2018). PTSD and other mental health problems among serving personnel also has a detrimental effect on the wellbeing of partners/main carers of children. The NHS was piloting enhanced services to the armed forces during 2016 in partnership with the MoD and military charities. What are the current plans/strategy? We recommend that this work is progressed.

**Mental wellbeing of parents and children in military families.** Mental health problems stemming from isolation and loneliness are a common issue amongst partners of military personnel. Longer deployment of serving personnel is associated with psychosocial problems for their partner/spouse and reported levels of anxiety among military spouses (exacerbated by relocation and the deployment cycle) is higher than within the general population in the UK (FAMCAS Tri-Service Survey 2017). Parental mental health, particularly that of the main care giver, significantly affects parenting ability and therefore child development and wellbeing. The NHS could extend perinatal and early help services in areas where there are large military populations.

**Children with SEN and/or complex health problems:** The NSPCC recently interviewed parents from military families and professionals who work with them. We also surveyed 137 parents attending drop-in services for parents and children under five located in or near army garrisons. The following paragraphs are taken from the draft NSPCC report<sup>13</sup>:

---

<sup>13</sup> NSPCC report. ‘Early Support for Military Families’ due for publication in early 2019.

“One negative aspect of relocation for children is the difficulties families experience in obtaining specialist health care. Workers described children who were on waiting lists for speech and language therapy or orthodontic work having to move before they ever reached the top the list and then being required to start again on a list in a different location. There were also concerns that relocation meant that the needs of some children are overlooked if the family move to a different health visiting team or services being unaware of children who are born abroad.

There were particular concerns about the impact of relocation for children with special educational needs and disabilities. In addition to problems accessing specialist services, changes in location and schools caused delays in information sharing and the completion of statements of Special Educational Need and Education, Health and Care Plans (EHCPs). There were also suspicions that families were being ‘fobbed off’ and delays were partly caused by a desire to protect limited resources and the knowledge that the families were likely to move on again before a referral needed to be made.”

#### **5. How best can we bridge the gap between children’s and adults’ services?**

The transition from child to adult services could be better planned for if the EHCP for children within military families refers to and plans for the circumstances of their family who are likely to be required to relocate on regular basis.

#### **6. Do you think the NHS should be doing more to prevent ill-health / intervene early? If so, what should we do to improve this?**

We recommend that NHS services should be extended to support perinatal mental and health visiting services.

#### **7. Are there examples of innovative/excellent practice that you think could be scaled-up nationally to enhance the quality of care people receive, reduce costs and/or improve efficiency of delivery?**

NSPCC Perinatal Interventions, e.g. BabySteps programme (Hogg et al, 2015). Evaluation of questionnaire responses showed that parents who had attended Baby Steps:

- showed an improvement in the quality of their relationship with their babies
- some parents had improved satisfaction in their relationships with their partners
- showed a decrease in symptoms of anxiety and depression
- showed increased levels of self-esteem.
- had a lower caesarean rate, higher birth weight and fewer premature babies compared to the general population.

NSPCC Drop-in Services to Military Families. A forthcoming evaluation report provides evidence of increased sources of support and social connections, happier parents with greater confidence in parenting abilities.