Healthcare Standards for Children and Young People in Secure Settings

June 2019
Foreword

I am delighted to welcome this refresh of the Healthcare Standards for Children and Young People in Secure Settings.

The children and young people cared for in the secure estate are often some of our society’s most vulnerable. These are young people with high levels of complex needs, who become completely dependent on the system and those professionals working within it. As Children’s Commissioner I am proud to act as both a champion and a conduit for the views and experiences of children in England. My priority is to protect children’s rights and to give children the care and springboards they need to flourish in life. I feel it is our responsibility to give these young people a voice and ensure they can meaningfully input into the design of the systems with which they interact, which in turn is vital to those systems’ success.

The guiding principles of these standards show a commitment to a child-centred approach, while recognising the tension between children’s right to autonomy and the need to promote their welfare. Children in secure settings are more likely than other children their age to have additional healthcare needs, such as neurodevelopmental disorders, substance misuse and mental health disorders. These young people should never be disadvantaged in relation to their peers when accessing health services, and these standards reflect that.

All professionals working with these young people have a responsibility to ensure they are supported and cared for throughout their time in the secure estate, and their needs holistically met. It is refreshing to see this commitment to improving their experiences and ensuring that their rights are upheld. The refreshed standards will act as an important resource for those professionals already working hard to deliver better health and wellbeing outcomes for vulnerable young people. It is important that these standards are now implemented and monitored across the secure estate to ensure children get access to the healthcare that they need – care which, in many cases, can help a child to take a different pathway from that which led them to be placed in a secure setting.

Anne Longfield
Children’s Commissioner for England
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Introduction

Intercollegiate Healthcare Standards for Children and Young People in Secure Settings were first published in 2013 to support high quality healthcare provision for children in secure settings. Six years on, the standards have been refreshed to align with changes to regulation, legislation and professional guidance.

Importantly, as with the 2013 standards, the refresh was developed through extensive engagement with healthcare and operational staff in secure settings, children with experience of living in them, and a range of Royal Colleges and Faculties. This has enabled the learning from half a decade of implementation to be captured and drive further improvement in services.

Why the standards were introduced

The standards were developed to help improve the quality and consistency of healthcare available to children in secure settings.

Around 1,000 children are held in secure settings in England at any time. These children have significantly greater, and often previously unidentified and unmet, physical, mental and emotional health, and speech, language and communication needs and neurodisabilities than other children their age. This includes but is not limited to a prevalence of mental health disorders, neurodisabilities, learning difficulties, long-standing physical complaints including respiratory problems, musculoskeletal complaints, nervous system complaints, skin complaints, dental health problems, blood-borne viruses, sexually transmitted infections, substance misuse and epilepsy. Many have been victims of crime or abuse. They are twice as likely to have been subject to serious maltreatment as the population as a whole.

Research has highlighted the difficulties in adequately meeting the health needs of children in secure settings: 4,5,6

- Children have often missed out on early attention to their health needs,
- Many children may not have qualified for help because each of their problems was not in itself serious enough to attract attention even though the combination of needs put them at risk,
- Many children are only in secure settings for short periods of time and are often placed outside their home area, creating problems in ensuring continuity of care when they enter and leave.

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1 Whilst the standards are entitled Children and Young People in Secure Settings, the Children Act 2004 uses child/children for those under 18 years of age and therefore reference to child/children and not children and young people is used throughout this document.
2 See Appendix One: Refresh of the standards.
3 Health needs of young people in secure settings – summary drawn from evidence about the health and wellbeing needs of children and young people in contact with the youth justice system (Ryan, M and Tunnard, J, Healthy Children, Safer Communities programme, 2012).
4 I think I must have been born bad, Office of the Children’s Commissioner, 2011.
The United Nations Convention on the Rights of the Child states that every child has “the right to the enjoyment of the highest attainable standard of health”. This includes children in secure settings. Time spent in a secure setting provides an opportunity to attend to the child’s physical, mental and emotional health and wellbeing needs and plan for their continuing care on transition to the community.

**Purpose and application of the standards**

The Royal Colleges and Faculties play a leading role in setting and ensuring the highest standards of care for patients. They were instrumental in the development of the standards and therefore were asked by NHS England and NHS Improvement to actively support this refresh, to guide and champion the provision of healthcare for children in secure settings.

The standards are intended to be a tool and resource for healthcare professionals, service planners and providers, governors/directors/managers and regulators to help plan, deliver and quality assure children’s health services in secure settings. They do not replace relevant policy documents or clinical guidelines but are intended to consolidate in one place all the requirements on health services and to empower local teams to work together effectively to improve outcomes.

These standards apply to all children under the age of 18 years held in secure settings appropriate for those under 18 years of age. The standards apply to children on both welfare and justice placements in secure settings (which include Secure Children’s Homes (SCHs), Secure Training Centres (STCs), Young Offender Institutions for under 18 year olds (YOIs). This includes those held on 72 hour welfare orders and placements made under the Police and Criminal Evidence Act (PACE 1984). They cover all healthcare services (including physical health, mental health, neurodisabilities and substance misuse) and, where relevant, interfaces with non-health agencies. These standards do not cover Tier 4 secure inpatient beds.

The standards provide a model for delivering services, while recognising that an individualised approach focusing on the needs of the child will be necessary to take account of the often complex and multifaceted needs of this particularly vulnerable group. Continuity of care is essential as children move between community and secure settings, between secure settings and hospitals, and clear planning and sharing of information is needed to sustain health gains made.

The standards are broadly arranged in sections that follow the care pathway of a child in a secure setting, with overarching service-related standards brought to the forefront.

NHS England and NHS Improvement Health and Justice commissioning teams will monitor compliance with and performance against these standards as part of a wider ambition to improve the quality of health services and health outcomes for all people in secure settings. These standards will be refreshed in 2022.

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Glossary

**Adverse Childhood Experiences (ACEs)**
The term ACEs incorporates a wide range of stressful events that children can be exposed to whilst growing up. While the types of adversities defined as ACEs may vary across contexts, typically, they include harms that affect the child directly, such as neglect and physical, verbal and sexual abuse, and harms that affect the environment in which the child lives, including exposure to domestic violence, parental separation or divorce, or living in a home with someone affected by mental illness, substance abuse, or who has been incarcerated. A study across England estimated that 47% of adults have experienced ACEs (Bellis et al, 2014).

**AssetPlus**
An assessment and planning interventions framework developed by the Youth Justice Board (YJB) to replace Asset and its associated tools. AssetPlus has been designed to provide a holistic end-to-end assessment and intervention plan, allowing one record to follow a child or young person throughout their time in the youth justice system.

**Care plan**
The plan led by the managers of the secure setting which sets out all the actions that should be taken to ensure the child or young person is being safely and effectively managed and supported while their liberty has been restricted.

**CHAT**
The Comprehensive Health Assessment Tool (CHAT) is an evidence-based, validated health assessment tool for children and young people aged 10-18 years in contact with the Youth Justice System (YJS) and welfare secure system. There are two versions of the tool, one for the Children and Young People Secure Estate (CYPSE) and one for the community.

**CHAT Care Plan**
A collection of all health needs to be shared with those directly involved in the care of the child.

**Community Forensic CAMHS**
Community Forensic Child and Adolescent Mental Health Services.

**CYPSE**
The Children and Young People Secure Estate (CYPSE) is the collective term for three types of residential placements where 10-17 year-olds sentenced or remanded to custody can be placed by Her Majesty’s Prison and Probation Service Youth Custody Service (HMPPS)

- Secure Children’s Homes (SCHs)
- Secure Training Centres (STCs)
- Young Offender Institutions (YOIs)

SCHs may provide care and accommodation for children placed by local authorities under a Secure Welfare Order for the protection of themselves and/or others (welfare placements), under Section 25 of Children Act 1989. It is important to remember these children are not offenders. Some SCHs are ‘welfare only’, while others take a mixture of these children and those placed by the Youth Custody Service.
YOIs and STCs hold young people who are:

- On remand
- Serving Detention and Treatment Order (DTOs), or
- Serving longer periods of detention under section 90 of the Powers of Criminal Courts Sentencing Act 2000 (i.e. are detained during Her Majesty’s pleasure) or under section 91 of that Act (for certain serious offences – mainly those punishable by 14 years imprisonment or more in the case of an adult)

**CPA**

Care Programme Approach. A package of care for people with mental health difficulties.

**Dental emergency**

Dental emergencies include: Trauma including facial/oral laceration and/or dento-alveolar injuries (e.g. avulsion of a permanent tooth), oro-facial swelling that is significant and worsening, post-extraction bleeding that the patient is not able to control with local measures, dental conditions that have resulted in acute systemic illness or raised temperature as a result of dental infection, severe truisms, oro-dental conditions that are likely to exacerbate systemic medical conditions (e.g. diabetes).

**FGM**

Female Genital Mutilation

**Formulation**

The shared, jointly agreed, understanding of a child’s needs which underpins all their care and healthcare in a secure setting.

**FP10**

NHS prescription form for medication.

**Framework for Integrated Care**

Framework for delivering integrated care that supports secure settings to develop environments that are relationally-based, trauma-informed, and that support staff to provide consistent, therapeutic care that enables children and young people to thrive.

**Healthcare**

The term “healthcare” and “health” to refer to all aspects of health and wellbeing, including physical, mental and emotional health, neurodisabilities and the impact of substance misuse.

**Healthcare plan**

The plan led by the secure settings healthcare team which sets out all the interventions and actions that should be taken to improve, protect and promote the child or young person’s physical and mental health.

**Healthcare practitioner**

A person trained to provide a healthcare service, including, for example, substance misuse staff.

**Healthcare professional**

A clinically qualified person who is working within the scope of practice as determined by their relevant professional body, for example the General Medical Council, Nursing and Midwifery Council or General Pharmaceutical Council, and who is registered with that body as competent to practice.
Lead healthcare professional
The healthcare professional responsible for leading a particular category or work stream of health or care activity in the secure setting.

MDT
Multi-Disciplinary Team

MMPR
Minimising and Managing Physical Restraint. A system of restraint used in secure settings for children and young people.

Medicines reconciliation
The process of identifying an accurate list of a person's current medicines and comparing them with the current list in use, recognising any discrepancies, and documenting any changes, thereby resulting in a complete list of medicines, accurately communicated. The term “medicines” also includes appliances and over-the-counter or complementary medicines, and any discrepancies should be resolved.

Named healthcare professional
The healthcare professional assigned to each individual child or young person in the secure setting

NICE
National Institute for Health and Care Excellence.

NRT
Nicotine Replacement Therapy used in stop smoking programmes.

Out of hours
Outside the contracted hours of the NHS England and NHS Improvement commissioned provider.

Parents/carers
Those who hold parental responsibility who may or may not be the biological parent.

Prevent
Part of the UK’s Counter Terrorism Strategy which works to stop individuals from getting involved or supporting terrorism or extremist activity.

PSHE
Personal, Social, Health and Economic education.

RPI
Restrictive Physical Intervention. A system of restraint used in secure settings for children and young people.
Secure setting
A secure centre holding children under 18 for welfare or justice reasons: Young Offender Institutions (YOI), Secure Training Centres (STCs) and Secure Children’s Homes (SCH).

SECURE STAIRS
The response developed to roll out the Framework for Integrated Care to Young Offender Institutions, Secure Training Centres and Secure Children’s Homes.

Separation in YOIs

Separation in STCs

Separation in SCHs
Refers to the Guide to the Children’s Homes Regulations including the Quality Standards, Department for Education, April 2015:
- Elected (where a child chooses to stay in their bedrooms) or
- Direction (staff direct a child to their bedroom to calm down) or
- Enforced (staff send and lock a child in their bedroom for a short period because the child’s behaviour is a danger to themselves or others.
Overarching principles for delivering healthcare to children in secure settings

“Listen to what we’ve said to you about healthcare and listen to our concern.”

“Healthcare staff should be like normal people. Come in here, do what you need to do, but still be normal you know.”
1.1 Healthcare in secure settings is centred on the child and all staff in secure settings strive to make every interaction matter and positive. (See 3.2).

1.1.1 Healthcare staff are competent in building relationships of trust with children in secure settings.

1.1.2 Children in secure settings are confident that healthcare professionals are focused on addressing their individual health and wellbeing needs.

1.1.3 Children in secure settings feel able to speak freely with healthcare professionals about a wide range of issues related to their healthcare and wellbeing needs. The preferences and opinions of children are listened to and considered respectfully.

1.1.4 Children in secure settings are confident that their personal information is held securely and shared in accordance with the safeguarding and information sharing standards, to ensure they receive the best possible care. (See Standards 2 and 3).

Guidance: Data Protection Act, 2018; Information Sharing, Advice for practitioners providing safeguarding services to children, young people, parents and carers, HM Government, 2018.

1.2 Healthcare staff in secure settings deliver high quality services to support the physical, mental and emotional health and wellbeing of the children in their care. There are also processes in place to continuously improve these services. (See 12.5)

1.2.1 Children in secure settings are entitled to services that meet all their identified needs. Reasonable adjustments are made to ensure access to these services by children with a disability. (See 5.4.1).

1.2.2 Healthcare staff offer children in secure settings choices, where possible, about their individual healthcare, and about how treatment and interventions are delivered.

1.3 Healthcare staff in secure settings recognise, and demonstrate, that their responsibility is the health and wellbeing of the children in their care.

1.3.1 Healthcare staff in secure settings recognise, and demonstrate, that they are accountable for improving health and wellbeing outcomes for the children in their care.

1.3.2 Healthcare professionals work closely with staff across the secure setting in caring for children to achieve the best possible health outcomes.

1.3.3 Healthcare staff work closely with staff across the secure setting caring for children to develop a shared, psychologically informed, multi-factorial formulation for each child. This facilitates a shared understanding of need and informs and guides every aspect of the child’s care within the setting.
2 Safeguarding

“They take our problems and suggestions seriously.”

“Not just doing a job but doing it to help you.”

“Understand that we are kids in a secure unit.”


2.2 When a child is identified as at risk of harm to self or others, the identifier informs and shares information with the relevant staff, including care, education and night staff, and takes action in line with local safeguarding and risk management procedures.

2.2.1 Information is effectively shared between healthcare staff and staff across the secure setting to reduce the risk of self-harm.

2.3 Children are protected from abuse through clear safeguarding policies and procedures.


2.3.1 The secure setting has a written safeguarding policy which is compliant with statutory duties, Government guidance and has been agreed by the local safeguarding partners. The policy covers the following but is not limited to: Child protection, suicide and self-harm prevention, bullying and violence reduction, children who struggle to cope in detention, all aspects of behaviour management, public protection, staff recruitment, suspension and training, allegations against staff, information sharing, use of separation, restraint, searching, and the duty of staff to see and act on warning signs.

2.3.2 The safeguarding policy is jointly reviewed and monitored by a safeguarding committee which meets regularly and includes representation from local safeguarding partners and senior staff from all departments including healthcare in the secure setting.

2.3.3 All healthcare practitioners are aware of and act in accordance with current safeguarding statutory guidance and the secure settings safeguarding policy, and feel competent, confident and safe to raise concerns in confidence without prejudicing their position (following local safeguarding partners’ policies and procedures, through the secure settings named safeguarding lead or the designated nurse/doctor for safeguarding children in the locality).

2.3.4 The governor, director or manager of the secure setting has overall accountability for the safeguarding policy and is aware of the settings need to meet standard 2.3.3.
Information sharing

“I think they stick to confidentiality too much, like I am always being asked to answer things I already told someone.”

“There’s no communication within that team. Sometimes you have to educate them on things that they should know about.”
3.1 Secure settings must have due regard to the relevant data protection principles in The General Data Protection Regulation (GDPR) and the Data Protection Act (2018), which allow them to share personal information. They should be aware that:

   a) The Data Protection Act (2018), includes “safeguarding of children and individuals at risk” as a condition that allows practitioners to share information without consent.

   b) Information can be shared legally without consent if a practitioner is unable to, or cannot be reasonably expected to, gain consent from the individual, or if to gain consent could place a child at risk.

   c) Relevant personal information can be shared lawfully if it is to keep a child who is at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional wellbeing.

   d) The common law duty of confidence and the rights within the Human Rights Act(1998), must be balanced against the effect on children at risk if they do not share the information. (See 14.10.1)

3.1.1 Information is shared by healthcare staff and staff across the setting to enable integrated and formulation-based care planning, to protect children from harm, to prevent them harming others and to ensure they receive appropriate healthcare. (See 5.1.1).

3.1.2 All staff in secure settings should understand and apply the guidance in Information Sharing: Advice for practitioners providing safeguarding services to children, parents and carers (July 2018).

Guidance: Caldicott Principle 7

3.1.3 All staff should understand how and when to share information and with whom. (See 14.10.1)

3.2 The governor, director or manager of the secure setting and their senior management team should support and encourage staff working in healthcare and those working outside healthcare to share information to support the needs of the child and underpin the Framework for Integrated Care (SECURE STAIRS).

Guidance: Framework for Integrated Care

3.2.1 Secure settings should have arrangements in place which set out clearly the processes and the principles for sharing information within the secure setting and for sharing information with other external organisations and practitioners.

3.2.2 When necessary, staff should seek consent from the child to share their information beyond those providing direct care. Any sharing beyond those directly involved in care delivery should be explained to them: explaining what information will be shared, why, with whom and how. This should be explained in plain English, and staff should seek clarity that the child has understood and consented to the sharing. All consent should be recorded in the notes.

3.2.3 Healthcare staff should be sensitive to presumed capacity when seeking consent to share information.
3.3 Decisions to share information without consent should be based on considerations of the safety and wellbeing of the child, and others who may be affected by their actions. (See 3.1).

3.3.1 Information shared should be necessary and proportionate, relevant, adequate and accurate, and shared in a timely and secure manner.

3.3.2 Where a decision to share information without consent is made, a record should be kept of what has been shared and the reason for sharing it.

3.4 Healthcare staff must ensure that a child’s healthcare information is obtained when they are admitted to a secure setting and key characteristics shared internally to assist in the integrated approach to formulation-based care planning. (See 3.1.1 and 4.3.1).

3.4.1 Healthcare staff must engage in multi-disciplinary meetings to collaboratively develop formulations for all children and ensure care planning and whole-system interventions are based upon those individual formulations to support trauma-informed care and evidence-based approaches to creating change. (See 5.1.1 and 13.1.2).

3.4.2 Healthcare staff must ensure that a child’s healthcare information, obtained when they are admitted to a secure setting, is shared with new providers when the child leaves the secure setting and transfers to the community, another secure setting or adult secure estate. This information should include their Comprehensive Health Assessment Tool (CHAT) assessment, immunisation record, and details of medications and allergies. (See 4.3.1).

3.4.3 Children’s health records are readily accessible to all relevant professionals working with the child, subject to protocols and procedures in relation to confidentiality and the application of the Data Protection Act (2018).

Guidance: Health and Justice Information Services Clinical Information System.

3.4.4 Healthcare staff receive training in the appropriate management of children’s health information, in line with professional guidelines.

3.4.5 Subject to consent, the parents/carers of the child or other person designated by the child are informed of the state of health of the child on request, and in the event of any important changes in the health of the child, as identified by the healthcare staff.
Entry and Assessment

“We just helped the healthcare team to put together an induction video so that when new people come here they will know what services they can receive whilst they are here.”

“Staff can speak professionally, but can also speak to young people.”
4.1.1 Children are treated as at risk of harm until the CHAT reception health screen is completed.

4.1.2 The CHAT reception health screen is completed for each child before their first night following admission and within two hours of their arrival. In settings where healthcare professionals are not available on site 24 hours per day, standard operating procedures are developed to support other staff to identify any health concerns and decide what action to take (See 6.3.2).

**Note:** In exceptional cases where it is in the best interests of the child, for example if the psychological state of the child is temporarily impaired, the CHAT reception health screen can be delayed. However, a temporary health assessment must be carried out to identify any health risks and manage them appropriately to ensure the child is effectively safeguarded. The CHAT reception health screen should be carried out as soon as is appropriate and the reason for any delay is clearly documented and reviewed by a healthcare professional.

**Guidance:** Particular attention is given to known risks linked to: Being or having been a Looked After Child, long term conditions, disabilities, speech, language and communication difficulties, previous history of abuse, ethnicity and culture, diverse needs, those undergoing trial, children facing long sentences, and children in secure settings for the first time.

4.1.3 The CHAT reception health screen includes life threatening and immediate health needs (withdrawal symptoms and other immediate substance misuse needs including withdrawal from nicotine, allergies, psychoses, self-harm, risk of suicide, mental health, neurodisability, chronic health issues, any present pain, pregnancy, communicable diseases, HIV/Hepatitis B, care of children and other dependants, communication difficulties), identifies anyone on prescribed medication and includes documentation (body map) of any visible injuries or marks.

4.2 Where a child is identified as at risk of harm, or urgent health concerns are identified, immediate and continuing action is taken to safeguard the child.

4.2.1 There is a written protocol for observing children at risk of harm, including those showing signs of substance misuse withdrawal symptoms or at risk of suicide.

4.2.2 An immediate healthcare plan is written, shared with the secure setting and put in place for children with urgent health concerns.

4.2.3 There is an agreed pathway to facilitate prompt further assessment and to ensure healthcare professionals in the secure setting are aware of local referral and consultation routes, including “out of hours”.

4.3 Information is shared on entry, and health assessments are effectively co-ordinated with other agencies, so that children are not repeatedly asked to give the same information. (See 3.1.1)

4.3.1 The healthcare team is proactive in seeking, accessing and using the child’s previous health information. Information should be gathered as soon as it is known the child is arriving and should be used to inform the CHAT reception health screen, particularly for those arriving late at night.

Previous health information may include, but is not limited to:

- Health assessments (as appropriate: Looked After Child health assessment, liaison and diversion team assessment from detention or court settings, pre-sentence report, AssetPlus, community CHAT, escort report),
- Summary care records,
- A child’s registered GP records,
- Education, health and care plans,
- Record of regular medication and significant past medical history.
4.3.2 If previous health records are not available at time of entry, every effort is made by the healthcare professional to obtain them as quickly as possible. The child’s GP, parents/carers, and any relevant care agencies (including Looked After Children health professionals where appropriate) are contacted, to provide relevant information within seven days to ensure continuity of care.

4.4 Children understand and are fully involved in their health assessments.

4.4.1 The assessor checks that the child understands the purpose of the assessment and possible outcomes as fully as possible before it is conducted. This can include explaining any health terms and giving the child enough time to respond. During assessment the child’s views are actively sought and recorded and the child receives feedback on the outcome of their assessment and the next steps at the end of the assessment.

4.5 All children receive a timely full secure CHAT assessment, which includes an assessment of physical health (within three days of their arrival), mental health (within three days of their arrival), substance misuse (within five days of their arrival) and neurodisability (within 10 days of their arrival).

4.5.1 The assessment is completed by a healthcare professional with, where appropriate, referral to a substance misuse specialist or other identified specialist trained to assess for health needs in children in a secure setting. Where there are concerns about speech, language and communication needs, support from a speech and language therapist should be sought.

4.5.2 All children should be assessed for experience and impact of current or past violence or abuse (to include, but not limited to: Domestic and non-domestic violence and abuse; physical, emotional and sexual violence and abuse and female genital mutilation (FGM) child exploitation, grooming and trafficking).

4.5.3 Secure settings should create an environment for disclosing any form of previous abuse, by ensuring that healthcare staff are trained to ask children about their history, and that all staff are trained in complex trauma. (See 14.3).

4.5.4 The physical health assessment includes, as appropriate according to gender and developmental factors: Social circumstances, ethnicity and culture, weight, height, body mass index, measurement of vital signs, immunisation status, sexual health, pregnancy, and physical signs of self-harm or substance misuse needs, including nicotine withdrawal.

4.5.5 The mental health assessment includes: Depression, self-harm, suicide, anxiety, post-traumatic stress, psychoses, eating disorders, exploitation and other adverse childhood experiences.

4.5.6 The substance misuse assessment includes: Drug and alcohol use history, resilience, risk and protective factors (which may include parental or sibling substance misuse), previous treatment and assessment of motivation to engage and affect change.

4.5.7 The neurodisability assessment includes: Traumatic brain injury, speech, language and communication impairment, attention deficit hyperactivity disorder, learning disabilities and educational needs and autistic spectrum disorder.
4.5.8 All health assessments are reviewed at least annually and the mental health assessment is reviewed within three months of arrival to ascertain whether the child’s needs have changed and if the assessment should be repeated with a view to adapting the healthcare plan to meet altered needs.

4.6 There is a clear pathway for managing referrals where a health and/or wellbeing need is indicated.

4.6.1 There are clear and easy to follow referral criteria for further assessment and intervention, including criteria for varying levels of response. The criteria include what triggers a more detailed assessment, who carries out this assessment and by what method, how the findings are made known and to whom, and the actions that will result.

4.6.2 Referrals can be received from anyone working with the child, including the child themselves, healthcare staff, other staff, parents/carers, youth offending teams, and social services.
“They don’t sit you down and go through things with you – I didn’t know what was going on.”

“They take our problems and suggestions seriously.”

Care planning
5.1 Each child has a named healthcare professional who co-ordinates their healthcare.

5.1.1 Healthcare staff must work with staff within the secure setting to ensure care planning and whole-system interactions and interventions are based upon individual formulations, as part of SECURE STAIRS. (See 1.3.3).

5.1.2 The named healthcare professional has training in child and adolescent health and has access to a network of healthcare professionals and specialists, including GPs, paediatricians, child and adolescent mental health services, specialist nursing services, Looked After Children healthcare professionals, substance misuse specialists, and speech and language therapists.

5.1.3 The child's named healthcare professional ensures that the child's health assessment and healthcare plan is completed, and acts as the key contact point in relation to the child's health and wellbeing.

5.1.4 The named healthcare professional, and other healthcare practitioners involved in the child's care where appropriate, attends the child's initial planning meeting and, where required, subsequent review meetings.

5.2 Each child has a comprehensive and holistic care plan which is formulation based, within 10 days of their arrival in the secure setting. This plan demonstrates a whole system approach to the care of the child integrating the approach to physical health, mental health and wellbeing, substance misuse, neurodisability and any speech, language and communication needs. The healthcare plan is not an isolated event, but part of a continuous process, and should be revised at regular intervals taking into consideration revisions to the formulation and formulation based care planning. There should be an emphasis placed on ensuring actions in the healthcare plan are being taken forward and monitored at regular intervals.

5.2.1 The healthcare plan is integrated and aligned with, where applicable, the child's Looked After Child, education, sentence, care and transition plans.

Guidance: Promoting the health and wellbeing of looked-after children.

Statutory guidance for local authorities, clinical commissioning groups and NHS England, Department for Education and Department of Health, March 2015.


5.2.2 The healthcare plan is informed by the child's health assessment and collaboratively developed formulation. The plan sets out the objectives, actions, timescales (appropriate to length of stay) and the responsible person.

5.2.3 The healthcare plan is developed in collaboration with the child and, where appropriate, with the child's parents/carers. The healthcare plan takes into consideration, where possible, the child's choice regarding treatments and interventions, including recording verbatim statements of choice and/or preference as appropriate.

5.2.4 The healthcare plan takes account of what has happened to the child both before and after their time in the secure setting, as well as the time spent in the secure setting.
5.2.5 The child’s named healthcare professional meets with the child regularly to monitor and review the healthcare plan – a minimum of every three months and before transfer, or more frequently as required to meet the child’s health needs or reflect the changes from the multi-disciplinary review of formulation based care. This may include reference to the child’s summary care record and previous health assessments. (See 4.3.1).

5.3 There are clear procedures for gaining consent to health assessments and interventions. If the assessment and/or intervention is refused, the reason why it has been refused is recorded and repeated attempts are made to complete the process.

5.3.1 Assessments of the child’s capacity to consent are made in accordance with the relevant legal principles and recorded in their health record.

5.3.2 Healthcare practitioners are proficient in assessing a child’s ability to consent and are aware of possible cultural issues, learning difficulty, disability, autistic spectrum disorder or communication difficulties. (See 14.10.1)

5.3.3 When obtaining consent to any health intervention, if the child is not deemed to be the appropriate person to give consent, their views should still be sought. If they are not forthcoming in providing their view, this should be discussed with both the person giving consent and the wider healthcare team to determine that any action taken is in the overall best interests of the child.

5.4 Children receive prompt healthcare and intervention to improve their health and wellbeing outcomes.

5.4.1 After a child is referred for healthcare, the length of time they are expected to stay in the secure setting informs prioritisation of which services they access, and the length of time they wait to receive these (i.e. what is most important and then how care is sequenced to meet those needs). Access and waiting times are at least equivalent to peers in the community.

5.4.2 Children are not unnecessarily restricted by security procedures in attending healthcare appointments (internally or externally) or receiving emergency care (see 6.3). Security measures are appropriately risk-assessed and proportionate.


5.5 Children experience collaborative and consistent healthcare.

5.5.1 All health interventions are delivered by child specialist practitioners trained to deliver the intervention.

5.5.2 Children have regular discussions with healthcare practitioners about their progress, and these are recorded in their health record.

5.5.3 Children consistently see the same specialist healthcare practitioner for intervention to enable continuity of care, unless their preference or clinical need demands otherwise.
“When I was on the outside there were discussions about whether I had ADHD but it took for me to end up in a place like this for people to do something.”
6.1 Children have access to the services and support they need to meet their health and wellbeing needs including physical health, mental health, substance misuse, neurodisability and speech, language and communication. All interventions are delivered at a level that the child can access, including tailoring the intervention to meet any speech, language and communication needs the child may have.

6.1.1 Children in secure settings have access to excellent primary care provision due to the multiple vulnerabilities of this group of children. This includes, but is not limited to: General medical services, general dental services and general optical services. Reasonable adjustments must be made to ensure access to these by those with a disability. (See 5.4.1).

6.1.2 Such services may provide directly, or ensure appropriate referral to, services for:
- Routine immunisations;
- Sexual and reproductive health services;
- Substance misuse services;
- Child and adolescent mental health and wellbeing services;
- Disabilities services;
- Psychological services and counselling;
- Community health services, including allied health professional services (including physiotherapy, podiatry, audiology, optical services and speech and language therapy);
- Health promotion and lifestyle advice services (including nutritional support, smoking cessation and physical activity); and
- Acute services for assessment, diagnosis and follow-up.

6.1.3 Children identifying with a gender other than the one they were assigned at birth may need additional support for mental health and wellbeing and should have support and access to specialist services (e.g. referral to gender identity development services/clinics). (See 15.4.1).

6.1.4 All staff within the secure setting should be aware of any child questioning their gender or identifying or starting to identify with a gender other than the one they were assigned at birth.

6.1.5 The secure setting has procedures in place to prevent the particular risk of bullying and harassment in the system and the need to protect vulnerable children.

6.1.6 Children in secure settings receive the same range and quality of services irrespective of where they were born or their nationality. Care should be given to particular needs resulting from specific health and social factors associated with a child’s country of origin, their journey to the UK, their immigration status in the UK and the insecurity they may face as a result of this status.

6.2 Children know how to access health and wellbeing services while they are in the secure setting.

6.2.1 During induction to the secure setting, children are informed of what health and wellbeing care services they can receive, and how to access them while they are in the secure setting, in a format and language that they can understand.

6.2.2 An effective appointment system is in operation which ensures appointments are available at reasonable times and that locations are convenient for the child. “Did not attends” (DNAs) are monitored and reviewed to identify where access difficulties exist.
6.2.3 Children are treated with respect in a professional, friendly and caring manner.

6.3 Children have access to 24-hour emergency medical services (physical and mental), and dental services.

6.3.1 There is a member of staff trained in first aid and cardiopulmonary resuscitation present in the secure setting at all times.

6.3.2 Out of hours and emergency cover is well organised, responsive and effective. In settings where health professionals are not available on site 24 hours per day, standard operating procedures (SOPs) or care pathways for accessing out of hours healthcare advice and treatment must be developed collaboratively between local health services and the secure setting.

6.3.3 The secure setting has a 24-hour, seven-day-a-week emergency medical and dental plan in place which is developed jointly and regularly updated with local emergency and urgent care services, out of hours GP services, out of hours mental health services and out of hours dental services. The plan includes security arrangements and stipulates what information is sent with the child when accessing emergency care and what information is sent back.

6.3.4 Where possible healthcare staff should work with external healthcare services to plan visits, ensuring services are aware that the child will be accompanied by security personnel at all times. The service should be asked to be prepared to receive the child, aware of the higher than average level of stress the child may be experiencing from being in public under security supervision, and to ensure that they are treated with dignity and respect. Standard procedures for accessing emergency care are set out in a protocol agreed with the local emergency services.

6.4 The secure setting has a comprehensive medicines management policy in place, and is committed to stopping the over-medication of people with a learning disability, autism or both (STOMP).

Guidance: **STOMP: Stopping the over-medication of people with a learning disability, autism or both, Voluntary Organisations Disability Group.**

6.4.1 Medicines are prescribed safely and in line with current evidence-based practice and local protocols including National Institute of Health and Care Excellence (NICE) guidance.

6.4.2 Professional standards on handling medicines in secure environments are used to deliver best practice.

Guidance: **Professional Standards for Optimising Medicines for People in Secure Environments, Royal Pharmaceutical Society, 2017.**

**Managing medicines in care homes, National Institute of Health and Care Excellence, 2014.**

**Medicines Optimisation: The safe and effective use of medicines to enable the best possible outcomes, National Institute of Health and Care Excellence [NG5], 2015.**

6.4.3 All medication for children (including non-prescription and over the counter) is recorded on their health record and administration or supply of medicines is also documented in an electronic or paper based medication administration record.
6.4.4 Children should usually receive their medicines under supervision (i.e. not in their possession). When a child is able to manage their medicines independently, an in-possession risk assessment is completed. Suitability for a child keeping their medicines is also reviewed on an ongoing basis as part of their care, to identify any risks to the child’s safety or the safety of others. Medicines that can be managed independently could include, but are not limited to:

- Inhalers for asthma
- Epipens
- Externally applied medicines such as creams and ointments
- Or where those children are older adolescents

In cases where emergency medicines, such as epipens or asthma inhalers, are not held by children systems are in place so that these can be accessed quickly.

6.4.5 All supervised medicines are administered safely and in line with professional accountabilities appropriate to the secure setting. Where possible this should be overseen by a qualified nurse, pharmacist or pharmacy technician. All staff involved in the supervised administration of medicines should receive the necessary medicines management training and be assessed as competent to do so.

6.4.6 Mechanisms to access medicines, when needed, outside of healthcare team and pharmacy core hours are in place.

6.4.7 A medicines reconciliation is completed within 72 hours of admission to enable safe continuity of care.

6.4.8 Allergies to medicines are recorded and adverse effects and medicines interactions are identified and responded to promptly.

6.4.9 All medicines are stored, handled and disposed of safely and securely in line with legislation and best practice and with effective pharmaceutical stock management.

6.4.10 There is a documented risk assessment of the medication and the child before self-administration of medication is considered. Children are given information about the benefits and risks of self-administration of medication in a format they are able to understand. Self-administered medicines are dispensed appropriately and facilities are available for secure storage by children.

6.4.11 Governance systems are in place for the management of medicines and to ensure compliance with the medicines management policy including:

- Monitoring of prescribing trends;
- A pharmacist or qualified nurse undertakes and documents a monthly medicines audit, including psychoactive drugs and drugs for attention deficit hyperactivity disorder, and
- The secure setting has access to specialist pharmacy support and advice.


6.5 There is a comprehensive whole system approach to improving health and wellbeing across the secure setting which includes a health improvement strategy.
6.5.1 The strategy should:
- Be linked to the secure settings overall health and wellbeing strategy (see 12.1).
- Use evidence-based approaches to encourage behavioural change.
- Include strategies and access to services to (a) improve mental health and wellbeing (b) encourage smoking cessation/reduction (c) encourage healthy eating and good nutrition (d) promote healthy lifestyles including sexual health and relationships, and sleep (e) reduce drug and alcohol issues (f) increase physical activity and time outside of the child’s room (g) improve oral health (h) improve coping with being in a secure setting and (i) improve communication skills for building and maintaining relationships.
- Build on protective factors, focussing on improving resilience, encouraging a commitment to learning, improving self-esteem and creating a sense of purpose.
- Be led by a cross organisational group with representation from, but not limited to, health, care, education, facilities, catering, physical education, children, parents/carers and senior management.
- Be an integral part of the secure settings overall health strategy.
- Reflect current practice and includes a mechanism for review, evaluation and feedback.

6.5.2 Health promotion materials are up to date and developmentally and age appropriate. They are also tailored to meet the needs of children with communication or learning difficulties, or poor literacy skills.

6.5.3 Healthcare staff work with the secure setting to support delivery of personal, social, health and economic (PSHE) education in line with current government recommendations and guidance. Guidance: Personal, Social, Health and Economic (PSHE) Education, Department for Education, 2013. Please note this guidance is currently going through a consultation and due to be updated in 2020.

6.5.4 Healthcare staff provide advice on whether practice and policies, when reviewed, are adversely affecting, or there are opportunities to improve further, the physical or emotional health and wellbeing of children.

6.6 Effective systems are in place to identify and support all children who are parents or expectant parents, including young men and women. This includes support for physical, mental and emotional wellbeing.

6.6.1 Education on childcare and child development is provided for all young parents and potential young parents, including young men and women.

6.7 Children receive support from a healthcare professional after restraint procedures. If support is refused, the reason why it is refused is recorded and repeated attempts are made. Note: Healthcare staff do not restrain children but do have duties and responsibilities in regard to safety of a child during and following restraint. (See 14.5).

6.7.1 All staff are informed and updated by the child’s named healthcare professional of any relevant issues (physical or psychological) including those arising from a child’s personal and medical history that may have an impact on a child’s safety and wellbeing if they are restrained. This information should also be included within the child’s care plan.
6.7.2 The advice of a healthcare professional is sought before all planned restraint procedures occurring within normal working hours and out of hours when healthcare staff are on site.

6.7.3 Children subject to restraint procedures see a healthcare professional as soon as possible after restraint and any injuries sustained are fully documented, or as per policy.

6.8 Children receive support from a healthcare professional during or after periods of separation from their peer group. If support is refused, the reason why it is refused is recorded, and repeated attempts to provide support are made.

6.8.1 All staff are informed and updated by the child's named healthcare professional of any relevant issues (physical or psychological) including those arising from a child's personal and medical history that may have an impact on a child's safety and wellbeing if they are separated from their peer group.

6.8.2 Healthcare professionals should retain access to and proactively monitor the health and wellbeing needs of a child who is separated from their peer group. This includes access to medicine where required. Healthcare staff should also ensure any new healthcare or wellbeing needs which arise (physical or psychological) are identified and met. If support if refused, the reason why it is refused is recorded, and repeated attempts to provide support are made.

6.9 Healthcare staff work with the secure setting to ensure requirements of Prevent are implemented and that children at risk of being drawn into extremism and terrorism are identified and appropriately managed and supported.

6.9.1 Children already radicalised may have one or a combination of mental health, neurodevelopmental and social care needs. They should be supported, through the multi-disciplinary team, to address their needs and be safeguarded against ongoing exploitation.
Physical Health Care and Intervention

“Make it easier to make appointments to see healthcare professionals.”

“If it’s a proper emergency, then they take you to the hospital but if it’s not then it’s dealt in here or the response is delayed.”
7.1 Each secure setting has a comprehensive physical health strategy outlining the contributions of all staff to supporting and improving the physical health and wellbeing of children and acknowledging the close relationship between mental and physical health. This strategy should be reviewed annually.

7.1.1 The strategy incorporates a multi-disciplinary approach and is part of the secure settings health strategy. (See 12.1).

7.2 The secure setting has access to, and receives support from, a multi-disciplinary physical healthcare team appropriate to the needs of the children.

7.2.1 The secure setting receives consultation, advice and training from a physical healthcare team.

7.2.2 There is a lead healthcare professional responsible for overseeing physical health provision within the secure setting.

7.3 Before intervention begins, physical health need is assessed (see 4.5) and a healthcare plan is developed (see 5.2) which is consolidated in the CHAT care plan.

7.4 A range of evidence-based physical health interventions is offered and delivered according to individual needs.

7.4.1 Effective treatment and regular review, in line with evidence-based practice, are in place for the management of children with long-term conditions.

7.4.2 There are formal assessments and arrangements in place with local health and social care agencies for the loan of appropriate occupational therapy equipment, and specialist advice to ensure children are able to access mobility, communication and health aids.

7.4.3 Children with skin conditions including acne, dry skin, dermatitis, and eczema, receive appropriate advice and treatment from healthcare professionals.

7.4.4 Children's physical health is monitored including growth and nutrition and screening for defects of vision or hearing.

7.5 Children are cared for by a dental health service that provides all proper and necessary dental care and treatment to meet their needs.

7.5.1 Children have timely access to dental checks and treatment. Children have access to the dental specialist and secondary care services they need to meet their needs (including orthodontics).

7.6 The secure setting has a comprehensive policy on communicable disease control.

7.6.1 The policy includes an outbreak plan, pandemic flu plan and vaccination policy.

7.6.2 Children are offered vaccinations appropriate to their age and need as set out under national guidance for immunisations and vaccinations.

7.7 Children have access to confidential advice and education about safer sexual practices and contraception within the context of relationships.
7.7.1 Children have access to appropriate contraception in the secure setting as set out in the local secure setting policy.

7.7.2 Children have access to screening and treatment programmes for sexually transmitted infections.

7.8 Sexual health services should be available to support children who have experienced violence, abuse and/or adverse childhood experiences as clinically indicated. (See 4.5.2).

7.9 Effective stop smoking interventions should be offered to children who smoke, with Nicotine Replacement Therapy (NRT) provided to children over 12 who are dependent on nicotine. Behavioural stop-smoking support should be provided to all children prescribed NRT and staff providing behavioural interventions should be trained to National Centre for Smoking Cessation and Training standards or its updates.

**Guidance:** *Stop smoking interventions and services, National Institute for Health and Care Excellence, 2018.*

7.10 Antenatal and postnatal services equivalent to those provided in the community are available for young women who are pregnant, and after delivery.

7.10.1 Pregnant young women have access to a midwife.

**Guidance:** *Healthy Child Programme: Pregnancy and the first five years of life, Department of Health, 2009*

7.10.2 Non-judgmental counselling regarding options is provided for pregnant young women and, where appropriate and within relevant legislation, access to termination of pregnancy services.

7.10.3 Pregnant young women receive information about avoiding substances (drugs, alcohol and smoking). Healthcare professionals document in the young woman’s health record if there is a history of substance misuse in pregnancy and appropriate interventions are offered.

7.10.4 Pregnant young women should receive appropriate care while in secure settings which ensures the wellbeing of mother and baby, including food that meets the nutritional standards recommended, and additional healthy food or snacks if they are hungry between mealtimes or miss meals due to sickness.

7.10.5 Pregnant young women should receive advice and support about breastfeeding, both prior to and after birth.
Mental Health and Neurodisability Care and Intervention

“I was having trouble sleeping and they suggested sleeping pills, I refused and they were cool with it.”

“Suicide and self-harm support takes way too long!”
8.1 Each secure setting has a comprehensive mental health and neurodisability (including speech, language and communication) strategy outlining the contributions of all staff to supporting and improving the mental health and wellbeing of children. This strategy should be reviewed annually.

8.1.1 The strategy incorporates a multi-disciplinary approach and is part of the secure settings health strategy. (See 12.1).

8.2 The healthcare team includes a multi-disciplinary Child and Adolescent Mental Health Services (CAMHS) team appropriate to the needs of the children.

8.2.1 The secure setting receives consultation, advice, supervision, support and training from the integrated CAMHS team.

8.2.2 All children will have a psychologically underpinned formulation, from a multi-disciplinary team with a mental health practitioner embedded within the team. Dedicated and timely access to psychiatric and psychological input is available from the integrated CAMHS team, through which other professional services may be accessed. This may include occupational therapists, speech and language therapists, primary mental health workers, a clinician with neurodisability expertise, and Community Forensic CAMHS. (See 10.3.1).

8.2.3 There is a lead mental healthcare professional responsible for overseeing mental health provision within the secure setting.

8.3 Before intervention begins, mental health and neurodisability need is assessed (see 4.5) and a healthcare plan is developed (see 5.2) and consolidated in the CHAT care plan.

8.4 A range of evidence-based mental health interventions is offered and delivered according to individual needs.

8.4.1 Care of children on medication with a diagnosis of serious mental illness and complex cases (taking account of accumulating or multiple needs which may not individually meet thresholds) takes place within the Care Programme Approach (CPA). The CPA is continued for those children subject to CPA on entry to the secure setting.

8.4.2 Practitioners actively engage parents/carers in care and interventions where appropriate.

8.4.3 Practitioners support children to take responsibility for their actions and nurture their independence as part of their therapeutic plan.

8.4.4 Specific interventions or advice are offered for managing severely difficult behaviour.

8.4.5 Mental health services should be available to support children who have experienced violence, abuse and/or adverse childhood experiences. (See 4.5.2).

8.4.6 There is specific evidence-based screening, assessment and treatment available for managing harmful sexual behaviour.
8.5 A range of evidence-based neurodisability interventions is offered and delivered according to individual needs.

8.5.1 This includes, but is not limited to, interventions for the following:

- Traumatic brain injury;
- Speech, language and communication difficulties;
- Attention deficit hyperactivity disorder;
- Learning disabilities and educational needs;
- Autistic spectrum disorder.

8.6 Children at risk of self-harm or suicide are provided with individual care and support.

8.6.1 Personal factors or significant events which may trigger self-harm, are identified in the child's healthcare plan and discussed with all staff.

8.6.2 A range of evidence-based interventions is offered and delivered to address the underlying causes of self-harming behaviour.

8.6.3 All incidents of self-harm or attempts to self-harm are recorded and referred to the named safeguarding lead. (See 2.3).

8.7 If clinically indicated, children identified with serious and complex problems, are transferred (under the Mental Health Act, 1983 (as amended, most recently by the Mental Health Act 2007)) to inpatient units that meet their individual needs with effective continuing care. Before transfer, a care, education and treatment review should be undertaken.

8.7.1 The supporting CAMHS team is aware of the referral criteria and process to access adolescent mental health in-patient services, and have contact details for their closest unit so potential referrals can be discussed at the earliest opportunity.
Substance Misuse Care and Intervention
Alcohol. Smoking. Drugs.

“We have a drugs worker that works with us, they’re alright.”

“There’s lots of posters about drugs.”
9.1 Each secure setting must have a comprehensive substance misuse strategy outlining the contributions of all staff to reducing the risk of substance related harm for children. This strategy should be reviewed annually. (See 12.1.3).

9.1.1 The strategy incorporates a multiagency approach and is part of the secure settings health and wellbeing strategy. (See 12.1).

9.1.2 When clinically indicated, drug testing is used as part of a therapeutic plan, and includes requirements for clearly communicating the purpose of any drugs test to the child. There is a written drug testing policy which clearly differentiates this from drug testing for the purpose of management and discipline.

9.2 The secure setting has access to, and receives support from, a substance misuse team appropriate to the needs of the children.

9.2.1 The secure setting receives consultation, advice and training from substance misuse specialists, including on new psychoactive substances and any other emerging substances, to ensure that staff are aware of signs that could indicate a child is experiencing problems with drugs or alcohol.

9.2.2 There is a lead for substance misuse responsible for overseeing substance misuse provision in the secure setting.

9.2.3 There is a clear protocol which clearly states the roles and responsibilities of substance misuse specialist staff and other healthcare staff and details expectations around information sharing and transitions/handover. (See 13.1).

9.3 Children have access to substance misuse education, prevention activities and advice and information to reduce the risk of substance related harm.

9.3.1 A universal drugs education programme is in place covering legal and illegal drugs and substances (including alcohol, tobacco and solvents). (See 6.5).

9.3.2 For children requiring an individualised programme of support there is a targeted substance misuse programme that is up to date and has clear learning objectives and outcomes that are informed by children’s needs and the current evidence base.

9.4 Before intervention begins, substance misuse need is assessed (see 4.5) and a healthcare plan is developed (see 5.2) and consolidated in the CHAT care plan.
9.5 A range of evidence-based substance misuse interventions are offered and delivered according to individual need.

9.5.1 A range of psychosocial and pharmacological interventions, from harm reduction to abstinence, are offered, with a focus on strengthening protective factors in order to improve resilience.

9.5.2 Pharmacological interventions are only offered alongside concurrent psychosocial support and mental health interventions to provide comprehensive care.

9.5.3 Effective stop smoking interventions should be offered to children who smoke. (See 7.9).

9.5.4 Practitioners actively engage parents/carers in care and interventions, where appropriate.
Transition and Continuity of Care

“Tell me what I need, give me dates and information in advance.”

“Health records are passed on from previous institutions, which is good.”
10.1 Early planning for transfer to the community or to another secure setting is crucial, beginning as soon as children are admitted to the setting. Continuity of healthcare is ensured to the greatest possible extent as children transition between secure settings, hospital settings or to the community. Transition arrangements should be captured in a health transition plan which feeds into the overall transition plan for that child.

10.1.1 Healthcare staff are aware that children, particularly those with autistic spectrum disorders and or learning difficulties or disabilities, may find transitioning periods distressing, and further preparation to increase predictability and provide support through the process may be necessary.

10.1.2 Transition between settings due to a child turning 18 years will be treated in the same way as other transfers.

10.2 A child’s healthcare plan (see 5.2) is reviewed before transfer. Any outstanding actions and ongoing or new health and wellbeing needs or risks of harm to self or others are identified. The named healthcare professional leads this review with other staff involved in the child’s care, together with the child and, where possible, with their parents/carers.

10.2.1 A holistic health transition plan is developed for the child, which includes physical health, mental health and wellbeing, neurodisability, speech, language and communication needs, substance misuse, and the management of medicines. This is integrated with their overall transition plan. The child understands the health transition arrangements that are in place.

10.2.2 The child’s named healthcare professional attends the pre-transition planning meeting and the final transition meeting to advise on healthcare issues that will require action and follow-up on transition.

10.3 Referrals and arrangements are made to ensure that children are offered continuity of care when they move between health services on transition.

10.3.1 The roles of the agencies involved in any subsequent care are agreed and documented and there is clarity about whose role it is to follow up if the child does not attend. Community Forensic CAMHS, where appropriate, should be involved to facilitate transition into and out of secure settings, providing support, advice and practical input as required.

10.3.2 Children who have experienced violence, abuse and/or adverse childhood experiences are referred to agencies and services that can provide support for them after they leave the secure setting. (See 4.5.2).

10.3.3 Children and parents/carers are provided with information in a format and language they understand on what to expect after transfer to the new service and who to contact if there is a problem. The format should consider the speech, language and communication and literacy needs of the child.

10.3.4 Children or their carers have a supply of current medication, including controlled drugs or a FP10 prescription, provided by the secure setting they are leaving. This ensures continuity of care and safety until the child can reasonably be expected to visit/register with a community GP or they access healthcare in the new setting. The supply or prescription provided will be for a minimum of seven days and usually a maximum of a month’s supply. They are informed about how and where to access medication they may be using, and what to do in case of a problem. In circumstances where a supply would be unsafe, robust arrangements are made by the child’s named healthcare professional so that the child does not miss any doses of their prescribed medicine.
10.4 The secure setting records any instances where transition practices compromise the health and wellbeing of the child and these records are passed to the relevant host and reviewed with safeguarding partners, regulatory body or health commissioner/service planner.

10.5 A summary of the child’s healthcare record, including a list of current medication with the indication for each and any recommendations for future care (CHAT discharge summary), is sent to the child’s GP through the GMS registration process and any other relevant agencies (including Looked After Children health and care professionals and youth offending team where appropriate) by SystmOne summaries. The child and, where appropriate, their parents/carers, are asked whether they would like a copy of the healthcare record at the time of leaving.

10.6 The child and, where appropriate, their parents/carers are provided with information about how and why to register with community health services, including (but not limited to): GP, dentist, optician, sexual health services, substance misuse services and other community health services on transition to the community.

10.7 Pre-release harm-minimisation programmes (smoking, substance misuse, sexual health and child sexual exploitation) are offered to children to raise awareness of these dangers post-transition. The healthcare team support and champion access to community based facilities and provisions before transition where possible.

10.8 Appropriate contraception and advice on safer sexual practices is offered and provided for children leaving the secure setting.

10.9 A summary of the child’s health record, including physical and mental health as well as any recommendations for future care (health discharge summary), is sent to the GP and healthcare manager at the new secure setting/adult secure setting and any other relevant agencies. This should include existing outpatient appointments.

Information shared about medicines should include:

• Known drug allergies;
• Changes to medicines and the reason for the change;
• Date and time of the last dose for weekly or monthly medicines including injections.

Guidance: Medicines Optimisation: The safe and effective use of medicines to enable the best possible outcomes, National Institute for Health and Care Excellence, March 2015.

10.10 Consideration is given to a child’s healthcare and assessments and treatment when a transfer between secure settings/to adult secure setting is planned. The named healthcare lead should liaise with the named healthcare lead at the future setting to ensure effective transfer of all healthcare services (physical health, mental health, neurodisability and substance misuse) and medicines.

10.11 Children with a diagnosis of learning disability and/or Autistic Spectrum Disorder should be supported and have a care, education and treatment review when referred to hospital.
Healthcare Environment and Facilities

“The environment isn’t suitable for the young people.”

“The rooms are ok, they look ok, like doctor’s rooms.”

“It can look whole way better – some posters or paint to brighten it up or something.”
11.1 Health and wellbeing services are delivered in locations which are safe, fit for purpose and have the necessary facilities to meet children’s needs.

11.1.1 Secure settings have a dedicated room that offers a confidential, therapeutic environment for physical health, mental health, neurodisability and substance misuse (screenings, assessments, consultations, information, treatment and intervention, supply of medicines).

11.1.2 The locations where health services are delivered are age and developmentally appropriate and are child friendly.

11.1.3 The locations where health services are delivered ensure the child’s privacy and confidentiality.

11.1.4 Healthcare staff provide advice to ensure children’s rooms do not present a risk to their physical or mental health. They help to ensure rooms are clean and sensory friendly, with fixed furniture and that the rooms are anti-ligature.

11.1.5 Locations used by health services are accessible to all children, including those who have disabilities.

11.1.6 There is a system in place so that healthcare practitioners can summon help in an emergency (medical and security).

11.1.7 Where clinically appropriate and safeguarding is assured, children should, where reasonably possible, be offered the choice of whether they wish to be assessed and/or treated in the secure settings dedicated healthcare room or in an alternative location.

11.2 All health equipment is safe, appropriate and meets standards laid down by the regulatory bodies.

11.2.1 All health equipment is regularly checked, logged and maintained and staff understand how to access and use it effectively.

11.2.2 First aid and resuscitation equipment, and an automated external defibrillator are provided in key locations as appropriate, following completion of a risk assessment.

11.2.3 Medical supplies are regularly checked and logged with sufficient stocks maintained.

11.3 There are comprehensive infection control procedures in place.

11.3.1 There are regular infection control audits.

11.3.2 Systems are in place for the handling and disposal of waste to minimise risk to children and staff.

11.3.3 The locations used by healthcare undergo cleaning, infection prevention and control processes in line with the relevant nationally defined standards.


11.3.4 A lead professional from healthcare and a lead professional from the secure setting are jointly responsible for managing and implementing infection control procedures. Settings should ensure that the leads are clear to all staff.

11.4 There is a systematic and planned approach to the management of health records on site.


11.4.1 There is a health record of all assessments, medication, treatment, interventions and first aid given to a child during their time in the secure setting.

11.4.2 There is a regular management check on the quality of health record entries.
Planning and Monitoring

“There are no major issues but doesn’t mean there’s no need for improvement.”

“Listen to what we’ve said to you about healthcare and listen to our concern.”

“Make the changes, so that we see the changes.”
12.1 There is a clear role for health and wellbeing services in the secure setting that is set out in a comprehensive health strategy for the secure setting. This strategy should be reviewed annually.

Guidance: A resource providing guidance on the strategies is available to commissioners.

12.1.1 The health strategy sets out the secure settings health priorities with clear long and short term plans for service development, reflects national policy and guidance on best practice and is integrated with the secure settings wider strategy and plans.

12.1.2 The health strategy incorporates: Physical health strategy (see 7.1), mental health and neurodisability strategy including speech, language and communication needs (see 8.1), substance misuse strategy (see 9.1) and health promotion strategy (see 6.5) and links to the medicines management policy (see 6.4), communicable disease policy (see 7.6) and emergency medical and dental plan (see 6.3) and the secure settings safeguarding (see standard 2) and information sharing policies (see standard 3).

12.1.3 Implementation of the strategy is monitored and reviewed annually in consultation with staff and children.

12.2 Service planners/providers/commissioners, including those responsible for mental health, substance misuse, public health and children’s services, and the secure setting work collaboratively to ensure the provision of appropriate and high quality healthcare for children in the secure setting.

12.2.1 Service planners/providers/commissioners and the governor/director/manager of the secure setting are aware of their responsibilities and duty of care for the health and wellbeing of the children under current legislative, regulatory and quality frameworks.

12.2.2 Service planners/providers/commissioners and the secure setting have a joint, short and long term approach to health service planning, delivery, development and resource management.

12.2.3 The governor/director/manager ensures that the secure setting is involved in strategic health planning and decision making. Governance at secure setting level is provided through the development and operation of local health partnership boards.


12.3 Service planning/commissioning is responsive to the needs of the children in the secure setting.

12.3.1 The views of children and their parents/carers are sought and taken into account in commissioning, planning, delivering and improving health services in the secure setting. Formal procedures are in place to ensure their involvement and such involvement is documented accordingly.
12.3.2 A health and wellbeing needs assessment for the secure setting (reviewing physical, mental, substance misuse and neurodisability health including speech, language and communication needs facing the secure settings population) is completed and reviewed every two years, using a structured assessment tool, by the service planners/providers/commissioners with the secure setting.

12.3.3 The health and wellbeing needs assessment is used by the service planners/providers/commissioners and the secure setting to agree the secure settings health strategy and resource allocation.

12.3.4 The secure setting is clear about any special health and wellbeing services offered and about any health conditions that they are unable to care for.

12.4 Staffing levels are managed to ensure continuity of service by appropriate healthcare professionals and to meet the needs of the children in the secure setting.

12.4.1 Services are regularly reviewed (capacity, skill mix, activity, demands on the service) including when there are changes in service provision or population need. Services monitor and report to service planners/providers/commissioners any identified gaps between the demand on the service and the capacity of staff.

12.4.2 There are appropriately skilled administrative staff to support the effective running of the service.

12.4.3 Staffing levels support healthcare professionals’ commitments to provide training, supervision and consultation within the secure setting and to ensure the secure setting is a health promoting environment.

12.5 There are clear clinical governance arrangements in place which facilitate continuous service improvement by using and analysing information sources such as inspection reports, peer review, critical incident reports, complaints, best practice and clinical audits.

12.5.1 Healthcare practitioners monitor clinical outcomes at regular intervals, using recognised outcome tools where appropriate and relevant, and outcomes are evaluated from the perspective of children, staff and parents/carers.

12.5.2 Managers ensure that appropriate audit data is collected to facilitate regular and meaningful evaluations of service delivery and outcomes.

12.5.3 Healthcare staff encourage the development of local processes that outline clear communication pathways and organisation responsibilities in the event of a serious incident. This should be developed with all stakeholders including but are not limited to: NHS Health and Justice Commissioning, the manager/director/governor of the secure setting and the local authority.


12.5.4 Children are involved in reviewing healthcare provision in the secure setting.
“They don’t communicate with each other... e.g. a dental nurse doesn’t communicate with another nurse when I ask questions.”

“They take our problems and suggestions serious.”
13.1 The secure setting works closely with, and has access to, a range of services and agencies appropriate to the health and wellbeing needs of the children in the secure setting.

13.1.1 The secure setting has clear, up to date, documented service level agreements or contracts with health service providers and agencies that clearly state the roles and responsibilities allocated to each organisation and detail expectations and governance arrangements around information sharing.

13.1.2 Frequent multi-disciplinary team (MDT) formulation meetings are in place across the secure setting to meet the needs of all children.

13.1.3 Healthcare staff support staff throughout the secure setting with supervision and reflective practice.

13.2 Multiagency working is supported by systematic and robust management of health records. (See 11.4)

13.3 Children receive care from a multi-disciplinary team that works in a holistic way according to the individual child’s formulation. (See 3.4.1).

13.4 Assessment, care planning and appropriate interventions for children with co-occurring conditions (substance misuse, mental health, neurodisability or physical) should be delivered in collaboration between healthcare and specialist services to ensure that all of the needs of the child are identified and supported.

13.5 Children, parents/carers and allied healthcare professionals understand how to provide feedback (including making complaints) about healthcare services.

13.5.1 Complaints procedures are well-publicised and child friendly, and staff explain to all children how to use them.

13.5.2 Complaints may be made without the knowledge and involvement of the person being complained about and with the assurance that the child making the complaint will not be discriminated against.

13.5.3 Responses to complaints relating to health services are dealt with by a healthcare professional where appropriate. Responses are timely, easy to understand, deal directly with the child’s concerns, take account of the emotional needs of the child and reflect the “duty of candour”. Procedures regarding complaints, including timeframes for responses, are set out in the secure settings’ internal complaints policy.


13.5.4 The governor/director/manager of the secure setting and the Health and Justice Commissioner are made aware of all complaints relating to healthcare services on a regular basis.

13.5.4 There is a children’s forum that is representative of the secure settings population. Children who are representatives are supported by staff to ensure they can play a full and active role.
14 Staffing and Training

“The staff have to be approachable, easy to talk to, trust and will get the job done.”

“Give your staff more training.”
14.1 Staff working with children receive training in safeguarding and child protection.

14.2 Staff working with children know who to contact in an emergency, including for incidents of self-harm, violent behaviour and first aid.

14.3 Staff working directly with children receive training on child and adolescent development, attachment, trauma, bereavement, loss, adverse childhood experiences, violence counselling and other relevant key theories.

14.3.1 Staff are aware of the key factors affecting child and adolescent health and wellbeing and of the common health problems of children in secure settings.

This includes, but is not limited to: Impact of trauma, neglect, attachment theory, mental health problems, management of long term physical conditions, neurodisability, speech, language and communication difficulties, anti-bullying practices and policy, conflict management, de-escalation and restraint.

14.3.2 Staff are able to recognise behaviours that indicate a heightened level of risk, and know how to access health advice for children in the secure setting.

14.3.3 Staff are trained to understand the needs of children and the interactions and interventions appropriate for them.

14.4 Staff are trained in and can implement the principles of the Framework for Integrated Care (SECURE STAIRS).

14.4.1 Staff from across the setting are appropriately trained to contribute to the formulation for each child which underpins the development and implementation of their care plans. (See 1.3.3).

14.4.2 Staff are supported to be emotionally resilient and able to remain child-centred in the face of challenging behaviour.

14.4.3 Staff are trained and supported to deliver the interventions required by the children and work within the Framework for Integrated Care (SECURE STAIRS).

14.4.4 Healthcare staff are trained and enabled to support supervision and reflective practice for all staff throughout the secure setting.

14.5 All healthcare practitioners are trained in the principles of the method of restraint where relevant to the setting (for example Minimising and Managing Physical Restraint awareness module (MMRP) or Restrictive Physical Intervention Training (RPI)), to support clinicians to understand potential risks and injuries. (See 6.7).

Healthcare staff only provide health advice which may inform any decision around restraint and are not involved in the decision of whether to undertake a restraint or not.

14.6 All staff are aware of the Government’s Prevent anti-terrorism strategy and the duty to comply with it within the NHS and secure settings for children.

### 14.6.1  All healthcare staff receive training in the Prevent strategy at a level appropriate to their role.

**Guidance:** *Safeguarding Children: Roles and competencies for healthcare staff, Royal College of Paediatrics and Child Health, 2019.*

<table>
<thead>
<tr>
<th>14.7</th>
<th>Healthcare staff contribute to the recruitment, development and sustainability of an emotionally resilient staff able to work effectively and compassionately with highly challenging children.</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.7.1</td>
<td>Healthcare staff ensure that training on mental health and wellbeing awareness, child development and attachment, and trauma awareness, is available for staff across the secure setting where required. This includes understanding of the need for psychologically informed practice and the benefits of case formulation. (See 1.3.3).</td>
</tr>
<tr>
<td>14.7.2</td>
<td>Healthcare staff provide appropriate support to staff working with children in the secure setting to foster a culture of multi-disciplinary working and partnership and ensure the whole secure setting operates as a health promoting environment.</td>
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<tr>
<td>14.8</td>
<td>There are appropriately qualified and skilled healthcare staff to meet the needs of the children in the secure setting.</td>
</tr>
<tr>
<td>14.8.1</td>
<td>Healthcare staff are trained to work with children in challenging circumstances.</td>
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<tr>
<td>14.8.2</td>
<td>Healthcare staff are able to operate safely within the secure setting.</td>
</tr>
<tr>
<td>14.8.3</td>
<td>Healthcare professionals are compliant with the Looked After Children: Knowledge, Skills and Competencies of Healthcare Staff Intercollegiate Role Framework March (2015) at level 3.</td>
</tr>
<tr>
<td>14.8.4</td>
<td>Healthcare professionals are compliant with the Safeguarding Children: Roles and Competences for Healthcare Staff Intercollegiate Document, Royal College of Paediatrics and Child Health, 2019, at level 3.</td>
</tr>
<tr>
<td>14.8.5</td>
<td>The service provider/secure setting undertakes pre-employment checks to ensure that healthcare professionals are registered with the appropriate bodies and on-going monitoring of this is carried out every three years.</td>
</tr>
</tbody>
</table>
14.8.6 Healthcare professionals conduct their work within the same ethical and good practice codes as bind their colleagues in health services in the wider community.

14.9 Healthcare practitioners have an annual appraisal and receive clinical and managerial supervision.

14.9.1 Healthcare practitioners have clearly defined job descriptions. There are clear and agreed lines of clinical and managerial responsibility for all healthcare practitioners.

14.9.2 Healthcare practitioners know where to go for advice and support following a major incident, and have access to a support system such as a support group or counselling service.

14.10 Healthcare practitioners have access to an on-going and regularly updated programme of professional development.

14.10.1 This includes training and guidance, where applicable to the role and setting, on:

- Evidence-based practice;
- Policies and procedures around consent, information sharing and confidentiality;
- Children’s rights and legislation;
- Safeguarding children;
- Diversity and equality;
- Communicating with children, including identifying and tailoring their approach to meet any speech, language and communication needs;
- Working effectively within the Framework for Integrated Care (SECURE STAIRS).
Equality and Diversity

“Not just doing a job but doing it to help you.”

“Just remember different things work for different people.”

“Assessing each young person as an individual.”

“I keep asking for coconut oil for my skin and hair and they never listen to me about [it]... I’m mixed race... so my skin and hair is different so I know what I need.”
15.1 Healthcare services for children in secure settings should be delivered within the provisions of the Human Rights Act (1998) and the Equality Act (2010) which protect against discrimination, harassment and victimisation.

15.1.2 Every child in a secure setting should have equal access to healthcare services that meet their individual needs, taking account of disability, gender reassignment, race, religion or belief, sex and sexual orientation.

15.1.3 No child should face discrimination in the provision of healthcare services in a secure setting.

15.2 Healthcare services should work in partnership with parents/carers and professionals to ensure that the medical, cultural and dietary needs of all children are met.

15.2.1 Healthcare services should help children to learn about healthy eating.

15.2.2 Healthcare services should seek to reduce language and communication barriers experienced by individuals and specific groups of children engaging with healthcare to reduce health inequalities and improve patient safety.


15.3 Healthcare services in children’s secure settings should seek to respond to the health needs of Black and Minority Ethnic communities.


15.4 Healthcare services seek to improve children’s experience of healthcare in secure settings, particularly for children who are lesbian, gay, bisexual and/or identify with a gender other than the one they were assigned at birth.

Guidance: NHSE Equality Objective 3.

15.4.1 Healthcare staff are aware of the appropriate healthcare pathways for children who may be questioning their gender identity or identifying with a gender other than the one they were assigned at birth. This may include psychological assessment and counselling, referral to the Gender Identity Clinic, and medication to block hormones.

15.4.2 Healthcare staff in secure settings are aware that children identifying with a gender other than the one they were assigned at birth may request to be placed in a male or female service (or part of service) that houses people of their preferred gender. However, the decision of where to place these children is informed by safeguarding, vulnerability and risk assessment in the first instance.

15.4.3 Healthcare staff use a child who is identifying with a gender other than the one they were assigned at birth’s preferred name and pronoun.

15.5 Healthcare services seek to improve the experience of children with a learning disability, autism or both with a particular focus on removing the inequalities they will have already faced in accessing healthcare services.

15.6 All healthcare staff in secure settings for children are trained in equality and diversity.
Appendix 1: Refresh of the Standards

In 2018, NHS England and NHS Improvement led a refresh of the standards to ensure they remain aligned to relevant regulation, legislation and professional guidance. This also presented an opportunity to assess the level of compliance with the standards and perceived effectiveness, as well as addressing omissions. This work was to refresh and not rewrite the standards.

Stage 1 – Secure setting engagement (stocktake)
Building on a 2014 audit on how the standards were being implemented, further engagement was carried out with secure settings in England – Young Offender Institutions (YOIs), Secure Training Centres (STCs) and Secure Children’s Homes (SCHs) – to baseline the current position. In total, 85% of settings completed an online survey and a further 60% participated in in-depth interviews.

This stocktake indicated high compliance with the standards across all secure settings in England. It also identified challenges and areas for improvement which have informed the standards refresh.

Stage 2 – Professional and expert engagement
An expert reference group (ERG) was established, comprised of clinical and non-clinical professionals including commissioners, providers and national bodies. The ERG considered the stocktake findings and subsequent engagement with service users as well as identifying changes in the regulatory, legislative and clinical environment that needed to be reflected in the standards.

The Royal Colleges and faculties were also engaged throughout the refresh, including through round table discussions and consultation on standards relevant to their respective areas of expertise.

Stage 3 – Engaging children with experience of secure settings
Children with experience of secure settings were actively involved in this refresh of the standards. A research company with expertise in engaging young people interviewed children across the secure estate and some now residing back in the community. Their voice permeates this refresh and is particularly present in the Guiding Principles with the focus on recognising the individual.

Stage 4 – Wider stakeholder engagement
Finally, before sign-off, wider stakeholder engagement took place, including with healthcare professionals, other agencies providing services in secure settings, and young people’s advocacy groups.

In total more than 120 comments were received from 20 individuals and organisations. This has resulted in amendments to more than 70 standards.
Key changes

1. A new standard has been added to the standards with “guiding principles” for delivering healthcare to children in secure settings. This places the voice of children at the centre of the standards.

2. Safeguarding and information-sharing have been pulled out into two single standards rather than distributed throughout the document.

3. A new Equality and Diversity standard has been developed.

4. The requirements for the reception health check have been updated to take into account of the increasing prevalence of children arriving at the setting during out-of-hours periods, and for short stays (i.e. overnight).

5. The standards on transfer and continuity of care – whether into a community setting or adult secure setting – have been strengthened.

6. Additional standards have been developed recognising differing or additional healthcare requirements of children identifying with a gender other than the one they were assigned at birth.

7. There is now a requirement that all children are assessed for current or past violence or abuse. This includes domestic and non-domestic violence and abuse; physical, emotional and sexual violence and abuse; female genital mutilation [FGM] and child exploitation and trafficking.

8. Additional standards have been included on the provision of care and support for pregnant young women.

9. The standards now specify the role of healthcare professions in providing expert healthcare advice and support if a child is to be or has been separated or radicalised.

10. The standards regarding multi-disciplinary working have been strengthened with adherence to the Framework for Integrated Care (SECURE STAIRS) embedded throughout the document.

There has been recent additional funding into secure settings for children, for the roll out of the Framework for Integrated Care, and a further impact assessment will be carried out for best use of financial uplift from 19/20 to support secure settings.

As a result there are no anticipated additional costs for implementing the refreshed standards. Throughout this project there was no declared conflict of interest from the project team, expert reference group or wider stakeholders.

The standards will next be refreshed in 2022, if you have any feedback on these standards please do send this through via the Royal College of Paediatrics and Child Health’s website (www.rcpch.ac.uk/contact-us).
Appendix 2: Acknowledgements

We would like to thank all those who have contributed to the refresh of these standards, particularly the members of the Expert Reference Group, the Royal Colleges and Faculties, all those from secure settings, and everyone who responded to the consultation or attended one of the consultation meetings.

We would also like to thank all the children who shared their insights and experiences of healthcare in secure settings with us. The children’s participation would not have been possible without the help and support of the staff at the settings and our engagement partner, Peer Power – thank you.
## The Expert Reference group

<table>
<thead>
<tr>
<th>Name</th>
<th>Position and Responsibilities</th>
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<tbody>
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