Healthcare Standards for Children and Young People in Secure Settings

Updated April 2023

Faculty of Public Health
Royal College of General Practitioners
Royal College of Nursing
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists
Royal Pharmaceutical Society
The British Psychological Society

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

Healthcare Standards for Children and Young People in Secure Settings

Updated April 2023

A web version of this document is available at **www.rcpch.ac.uk/cypss**

Foreword

As Children's Commissioner for England my role is to promote and protect the rights of children. I have a particular duty towards those children living away from home, including those in secure welfare and justice settings. These children are some of the most vulnerable in the country, who have faced great difficulties and need the right care and treatment to help them develop and rebuild their lives. They also often have very significant mental health and neurodevelopmental needs.

Wherever possible, I want children to be getting the right help and support early on in their lives which will mean they are diverted away from youth justice or welfare systems. But when that doesn't happen it is vital that those who are caring for them look out for them as any loving parent would, to advocate tirelessly for them to get the very best care possible, including ensuring that all their healthcare needs are met.

I am particularly pleased in these refreshed standards to see the emphasis on trusting relationships, as time and again the children I speak to in secure settings tell me that it is the quality of the relationships they have with those caring for them that make all the difference in their lives.

I am equally pleased to see the language updated to refer to 'children' throughout, rather than young people. This may feel like a small detail, but it is a crucial and fundamental change. Every child, no matter what else is happening in their lives, must be seen first and foremost as a child.

It is now down to all of us to ensure that these standards are embedded throughout the system and become a reality. Because I believe that they have the potential to transform the life chances of this group of children.

Rachel de Souza
Children's Commissioner for England

Contents

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[1] in secure settings. Since their creation the standards were reviewed in 2019 and have most recently been refreshed in 2023 to consider changes to regulation, legislation, and professional guidance.

As in previous refreshes healthcare staff in secure settings played a key role in the standards refresh providing extensive feedback to update and improve the standards. Stakeholders included representatives from providers, the inspectorates, the Royal Colleges and Faculties, clinicians, and commissioners. Alongside this, young adults with experience of the CYPSE supported children currently placed in the CYPSE to share their experiences of secure settings, and to use their voice to shape the standards and how they are put into practice.[2]

The outcome of this is the newly refreshed standards which places a greater emphasis in building trusting relationships with children, continuity of care, listening to their thoughts and wishes and including them in decisions about their care. The refreshed standards also incorporate The Framework for Integrated Care in the CYPSE (SECURE STAIRS) which emphasises the importance of providing integrated care which is trauma informed.

Why the standards were introduced

The standards were developed to help improve the quality and consistency of healthcare available to children in secure settings. The standards support the need to ensure that children receive healthcare provision that is at least equivalent to that available to their peers living in the community.

In 2019 there were approximately 1,000 children held in secure settings in England. During the response to the COVID-19 pandemic this fell, and as at the start of 2023 there are approximately 550 children in the CYPSE.. Children placed in secure settings are some of the most vulnerable in our society. They are more likely than their peers to have additional healthcare needs, mental health difficulties, neurodevelopmental disorders, and speech, language and communication need and a range of physical health conditions, all of which are often previously unidentified and unmet.[3] Many have been the victims and/or the perpetrators of crime or abuse, including gender and/or racial trauma. They are twice as likely to have been subject to serious maltreatment as the population.[4] It must be remembered that children coming into secure settings may have found the experience of being taken from their community and placed in the setting deeply traumatising and steps must be taken to ensure that the child feels safe and cared for.[5]

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.[6]

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 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/registered managers/principal director 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. The newly refreshed Standards are complemented by a revised set of service specifications published by NHS England, the statutory commissioner for children held in secure settings. The standards are also designed to be complementary of other inspection frameworks used by the Care Quality Commission (CQC), Ofsted, and HMIP (His Majesty's Inspectorate of Prisons).

These standards apply to all children under the age of 18 years held in secure settings and are appropriate for children aged 10- to 17-year-old. 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), and Secure Schools). They cover all healthcare services (including physical health, mental health, 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 transition 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 will be supported in their assurance of their role a statutory commissioner by monitoring compliance 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.

Footnotes:

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.
5. *The health of children and young people in secure settings*, Mooney, A, Statham, J and Storey, P, 2007.
6. *Healthy children, safer communities*, HM Government 2009.

Glossary

Abuse
Any action that violates a person's human or civil rights. It can take many forms and involve several factors. It can occur anywhere and the abuser could be a stranger, a carer, a family member or someone else in a position of trust.

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.

Autism spectrum condition
A condition where an individual experiences difficulties in social communication and may show restricted and repetitive patterns of behaviour, such as motor mannerisms, insistence on routine, sensory sensitivity and obsessive or unusual interest. Another way of understanding autism is as a natural part of 'neurodiversity'.

Caldicott Principles
Eight principles to ensure people's information is kept confidential and used appropriately.

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.

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

Care, Education and Treatment Review
Care (education) and treatment reviews (C(E)TRs) are part of NHS England's commitment to transforming services for people of all ages with a learning disability and autistic people. C(E)TRs are for people who have been admitted to a mental health hospital or for people who are at risk of admission.

C-card (Condom Card)
The C-Card scheme is a free and confidential service offering free condom and sexual health information and support to all young people aged 13–25 years.

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.

Child/CYP/Children and young people
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 the standards document. The term 'children and young people' are used in the specifications that support the standards.

Constant care and supervision practices
Also known as constant watch or constant observation, constant care and supervision involves allocating a staff member (or in some instances more than one staff member) as a protective measure for a prescribed time to a child who is deemed at immediate risk of harm to self or to others so that they can be watched, supervised intensively, and provided with care at all times.

Complex needs
If a child has been diagnosed with an illness, disability or sensory impairment and needs a lot of additional support on a daily basis, they're described as having complex needs. A child might have complex needs from birth, or after an illness or injury.

Co-production
A partnership approach between a practitioner and young person that allows each to learn from the other, draws on the strength and knowledge of both and allows all to experience a more balanced power dynamic within the relationship. This can enhance the child's ownership of services, create a vested interest and respond to their needs.

CYPMHS/CAMHS
Children and young people's mental health services (CYPMHS) is used as a term for all services that work with children and young people who have difficulties with their mental health or wellbeing. You may also see the term children and adolescent mental health services (CAMHS) used. This is an older term for the main specialist NHS community service within the wider CYPMHS that may be available locally.

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)
- Secure Schools (first due to open 2024)
- 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 such as diabetes (that is lead to acute decompensation of medical conditions such as diabetes).

DHSC
Department of Health and Social Care

Disability/ies
Any condition of the body or mind (impairment) that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions).

Duty of Candour
The intention of the duty of candour legislation is to ensure that providers are open and transparent with people who use services. It sets out some specific requirements providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

Enhanced Support Service/Enhanced Support Team (ESS/EST)
The service encompasses nursing and psychological approaches. It offers short-term outreach and support to individuals who are experiencing emotional dysregulation and associated behavioural problems linked to personality.

Equality Act 2010
The Equality Act 2010 ensures individuals have equal treatment in employment and access to private and public sector services regardless of age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

Extended Duty Dental Nurse (EDDN)
A dental nurse with additional training to provide extended clinical duties, including dental and oral health promotion, assisting in the treatment of patients with special needs, and providing fluoride treatment as prescribed by a dentist, amongst other skills.

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

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 (SECURE STAIRS)
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.

GDPR / Data Protection Act
The Data Protection Act 2018 controls how your personal information is used by organisations,
The Data Protection Act 2018 is the UK's implementation of the General Data Protection Regulation (GDPR).

Gender dysphoria
Gender dysphoria is a term that describes a sense of unease that a person may have because of a mismatch between their biological sex and their gender identity.
This sense of unease or dissatisfaction may be so intense it can lead to depression and anxiety and have a harmful impact on daily life.

Gillick Competency and Fraser Guidance
Gillick competence is concerned with determining a child's capacity to consent. Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.

Governor/director/registered manager
The individual who is responsible for the residential care of children within a secure setting.

GP
General practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment.

Harm minimisation
The International Harm Reduction Association (IHRA) defines harm minimisation as the policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. This focuses on the prevention of harm, rather than on the prevention of drug use itself and focusses on people who continue to use drugs (Stone & Shirley-Beavan, 2018)

Health Promotion
Giving people the information or resources they need to improve their health. As well as improving people's skills and capabilities, it can also involve changing the social and environmental conditions and systems that affect health.

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.

ICO and Data sharing checklist
This checklist provides a step-by-step guide to deciding whether to share personal data.
You should use it alongside the data sharing code and guidance on the ICO website ico.org.uk.
It highlights what you should consider in order to ensure that your sharing complies with the law and meets individuals' expectations.

Infection Control
Infection control prevents or stops the spread of infections in healthcare settings.

Intermittent care and supervision
Intermittent care and supervision involves allocating a staff member (or in some instances more than one staff member) as a protective measure for a prescribed time to a child who is deemed at immediate risk of harm to self or to others so that they can be watched intermittently, supervised intensively, and provided with care.

Lead healthcare professional
The healthcare professional responsible for leading a particular category or work stream of health or care activity in the secure setting.

Learning difficulty
A learning difficulty is a type of Special Education Needs, which affects areas of learning, such as reading, writing, spelling, mathematics etc.

Learning disability
A learning disability affects the way a person learns new things throughout their life.
A learning disability is different for everyone. No two people are the same.
A person with a learning disability might have some difficulty:
- understanding complicated information
- learning some skills
- looking after themselves or living alone

Local Authority
The local authority is responsible for a range of vital services for people and businesses in defined areas. Among them are well known functions such as social care, schools, housing and planning and waste collection, but also lesser known ones such as licensing, business support, registrar services and pest control.

Looked After Child/ren
A child or young person who is being cared for by their local authority is known as a 'looked-after' child. They might be living in a children's home, or with foster parents, or in some other family arrangement.

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

Neurodevelopmental Conditions
Neurodevelopmental disorders are behavioural and cognitive disorders that arise during the developmental period that involve significant difficulties in the acquisition and execution of specific intellectual, motor, language, or social functions. Although behavioural and cognitive deficits are present in many mental and behavioural disorders that can arise during the developmental period (e.g., Schizophrenia, Bipolar disorder), only disorders whose core features are neurodevelopmental are included in this grouping. The presumptive aetiology for neurodevelopmental disorders is complex, and in many individual cases is unknown.

Neurodisability
Neurodisability is an umbrella term for disabilities resulting from congenital or acquired long-term conditions. These problems are generally due to impairment in the nervous or musculoskeletal systems and can be static or progressive in nature.

Neurodiversity
Neurodiversity is a term used to describe a variation in normal human evolution which means some people think different to others. Neurodiverse conditions include autism, attention deficit hyperactivity disorder (ADHD), dyslexia, dyspraxia, Tourette syndrome and complex tic disorders.

Next of Kin
There is no legal definition of next of kin. Children can nominate a next of kin to keep informed about their care. In identifying a next of kin, the child is giving permission to keep them informed.

NICE
National Institute for Health and Care Excellence.

Nicotine/tobacco products
Nicotine is a highly addictive chemical compound present in the tobacco plant. Use of products containing nicotine can cause nicotine addiction to products containing tobacco, which is harmful to the health of those using it and those around the user.

NRT
Nicotine Replacement Therapy used in stop smoking programmes.

Nutritional status
The state of a person's health in terms of the nutrients in his or her diet.

Oral Health
A state of being free from chronic mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing.

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.

Regulatory bodies
Regulators exercise regulatory or supervisory authority over a variety of endeavours. Some examples within secure settings are the Care Quality Commission (CQC) and the Office for Standards in Education, Children's Services and Skills (Ofsted)

Residential / operational staff
Non-healthcare staff members working in a Secure Children's Home, Youth Offender Institution, Secure Training Centre or Secure School providing care to children in these settings. These members of staff work alongside healthcare teams but are often employed by a different employer.

Restraint
Restraint, or restrictive intervention, is the use of reasonable force to stop a person from hurting themselves and / or others. Restraint can take many forms, such as physical, mechanical, medication (chemical) restraint, withdrawal (imposed and autonomous) and seclusion. It is known to be traumatising to those who carry it out and have restraint used on them, therefore should be avoided and proactive, preventative, non-restrictive approaches adopted in respect of behaviour that challenges. Where restraint and restrictive interventions are used they should be used appropriately, only where necessary and for the minimum time required, by trained staff and in line with the Human Rights Act 1998, relevant international obligations such as the UN Convention on the Rights of the Child and the UN Convention on the Rights of People with Disabilities, core values and key ethical principles.

RPI
Restrictive Physical Intervention. A system of restraint used in secure settings for children and young people.

Safeguarding
Safeguarding means protecting a citizen's health, wellbeing and human rights; enabling them to live free from harm, abuse and neglect. It is an integral part of providing high-quality health care. Safeguarding children, young people and adults is a collective responsibility.Those most in need of protection include:

- Children and young people
- Adults at risk, such as those receiving care in their own home, people with physical, sensory and mental impairments, and those with learning disabilities.
- All staff, whether they work in a hospital, a care home, in general practice, or in providing community care, and whether they are employed by a public sector, private, or not-for-profit organisation, have a responsibility to safeguard children and adults at risk of abuse or neglect in the NHS.

SARCs
Sexual assault referral centres, or SARCs, provide a safe space and dedicated care for anyone who has been raped, sexually assaulted, or abused.

Secure setting
A secure centre holding children under 18 for welfare or justice reasons: Young Offender Institutions (YOI), Secure Training Centres (STCs), Secure Schools and Secure Children's Homes (SCH).

Self-harm/harm to self
An intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act and is an expression of emotional distress.

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).

Separation in STCs
Refers to the removal of children from association, Rule 36 (Secure Training Centre Rules 1998, Statutory Instruments) – www.legislation.gov.uk/uksi/1998/472/made

Separation in YOIs
Refers to the removal of children from association, Rule 49 (Young Offender Institution Rules 2000, Statutory Instruments) –

Smoking Cessation
Smoking cessation refers to activities that aim to support people who smoke to stop smoking

Standard Operating Procedures (SOP)
A SOP is part of the risk assessment exercise itself and provides a written means to instruct employees on how a particular procedure should be carried out and lays out boundaries of responsibility. It can be used to satisfy legal compliance requirements too.

STOMP / Voluntary Organisations Disability Group
STOMP stands for stopping over medication of people with a learning disability, autism or both with psychotropic medicines.

SystmOne
Example of an electronic patient information record system

The Children Secure Estate National Partnership Agreement
The aim of this agreement is to enable a more fully integrated approach to the commissioning and delivery of excellent health services, and through this, to improve the health and wellbeing of those within the children and young people secure estate in England. The Agreement is between a group of six organisations, a mixture of arms-length bodies and government departments, all with a key role to play in ensuring high quality, outcomes based health services for this group of children and young people: Department for Education, Department of Health and Social Care, Her Majesty's Prison and Probation Service- Youth Custody Service, Ministry of Justice, NHS England, Public Health England.

Therapeutic plan
See care plan

Transition(s)
Transition is defined as a purposeful and planned process of supporting young people to move from children's to adults' services (Transition: getting it right for young people Department of Health and Department for Education and Skills).

Universal Health Service
Universal health service is a service that ensures all children and young people have access to the full range of high quality health services they need, when and where they need them, without discrimination. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. It focuses not only on preventing and treating disease and illness, but also on helping to improve well-being and quality of life.

Wellbeing
'Wellbeing' is a broad concept, and it is described as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society

YOI
Young Offender Institute

YOT (Youth Offender Team)
Youth offending teams work with young people that get into trouble with the law. They look into the background of a young person and try to help them stay away from crime.

They also:

- run local crime prevention programmes
- help young people at the police station if they're arrested
- help young people and their families at court
- supervise young people serving a community sentence
- stay in touch with a young person if they're sentenced to custody

1 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. All staff within secure settings strive to make every interaction positive and matter in line with the Framework for Integrated Care (See 3.2).

1.1.1 Healthcare staff are able to build trusting and non-judgemental relationships with children in secure settings.

1.1.2 Children in secure settings receive healthcare that addresses their individual health and wellbeing needs. Healthcare staff recognise children in secure settings may have experienced healthcare inequalities in line with the protected characteristics (See 15.1).

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

1.1.4 The personal information of children in secure settings is held securely and shared in accordance with the safeguarding and information sharing standards to enable the delivery of high-quality care. If information is shared without consent to support reduction of risk, the child will be informed of this as long as this would not create or increase the risk of harm (See 3.2.2 and 3.3.2).

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 health and wellbeing of children in their care. This covers all needs, such as physical, mental, emotional health, speech and language therapy and neurodevelopmental. There are also processes in place for continuous improvement of these services (See 12.5).

1.2.1 Children in secure settings receive services that are at least equivalent to their peers in the community. It is recognised these children will often require enhanced support and personalised responses, including reasonable adjustments such as adjustments to neurodevelopmental needs (language, learning, social communication differences), trauma informed approaches, interpreting services, to achieve equivalence and increase chances of achieving equitable outcomes (See 5.4.1 and 15.1).

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

1.3 Healthcare staff in secure settings recognise and demonstrate that their paramount 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. Staff trained in quality improvement ensure that feedback from children, families and professionals is sought.

1.3.2 Healthcare professionals work closely with staff across the secure setting to develop and implement joint healthcare strategies to enable the achievement of the best possible health outcomes.

1.3.3 Healthcare professionals work closely with staff across the secure setting 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.

1.4 Healthcare staff should work collaboratively with the child to support them to communicate their views, wishes, and feelings, in line with their level of understanding and competency. This should be taken into account by healthcare professionals, alongside their professional judgement to make informed decisions that are in the best interests of the child.

Guidance: Mental Capacity Act 2005, Gillick Competency and Fraser Guidelines

1.5 Healthcare staff in secure settings understand the value of health promotion activities as being essential to children's health, and actively engage children in them.

2 Safeguarding

"Not just doing a job but doing it to help you."

"They take our problems and suggestions seriously."

"Understand that we are kids in a secure unit."

2.1 Safeguarding children is of critical importance. Secure settings must meet the requirements of the Children and Social Work Act 2017, along with Working Together to Safeguard Children 2018 and the NHS Standard Contract. These requirements are a minimum. Where there is other pertinent legislation or local safeguarding policies, their requirements must also be met, or any updates made thereafter.

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, which may include care, education and night staff and takes action in line with local safeguarding and risk management procedures.

The identifier should inform the child's social worker, YOT worker and parents/ carers/ next of kin as appropriate. If risks remain high and cannot be managed, an urgent meeting should be called between relevant professionals to agree next steps.

2.2.1 Information is effectively shared between healthcare staff and staff across the secure setting for safeguarding purposes to reduce the risk of harm to self and/or/from others.

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

Guidance: United Nations Convention of the Rights of the Child 1989. Where there is other pertinent legislation, their requirements must also be met, or any updates made thereafter.

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 and communicated to healthcare staff for them to support where appropriate. 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 custody, all aspects of behaviour management, use of enhanced care and supervision, public protection, staff recruitment, suspension and training, allegations against staff, information sharing, use of separation/ segregation, restraint, searching and the duty of staff to see and act on warning signs. The policy should be compliant with their duties under section 11 of the Children Act 2004 and the relevant principles of the Working Together arrangements to Safeguard Children 2018.

2.3.2 The safeguarding policy is regularly reviewed and monitored and all departments in the secure setting are made aware of any changes to the policy.

2.3.3 All staff are aware of and act in accordance with current safeguarding statutory guidance and the secure setting's 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 setting's safeguarding lead or the designated nurse/doctor for safeguarding children in the locality or Freedom to Speak Up Guardians within NHS trusts).

2.3.4 The Governor, Director, Principal Director or Registered Manager of the secure setting is accountable overall for the safeguarding policy and procedure and is aware of the setting's need to meet standard 2.3.3.

2.4 Each child has access to a trusted member of staff who they can go to with issues, including concerns regarding their safety and/or wellbeing within the setting. The member of staff understands the appropriate routes for reporting these concerns.

3 Information sharing

"Young people shouldn't be expected to repeat their story over and over again to lots of different people for no eason."

"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 at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional well-being.

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 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).

Guidance: ICO Data Sharing Checklist

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, young people, parents and carers, 2018.

Guidance: Caldicott Principle 7

3.1.3 All staff receive regular training in the appropriate management of children's health information, as per professional guidance, including standard Information Governance and Records Management Training, and should understand how and when to share information and with whom (See 14.10).

3.2 The Governor, Director, or Registered 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.

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, such as a sharing agreement or processing arrangements.

3.2.2 Wherever appropriate, staff should seek consent from the child to share their information. It should be explained to them what information will be shared, why, with whom and how.

Privacy and consent information should be available and explained in an accessible format to the child and their parent/carer/next of kin where appropriate. Staff should seek clarity that the child, and parent/carer/next of kin where appropriate, has understood (See 1.1.4).

3.2.3 Healthcare staff should be sensitive to presumed capacity when seeking consent to share information and consider how the age and neurodevelopmental profile of the child could impact their ability to consent.

Guidance: Gillick Competency and Fraser Guidelines

3.3 Decisions to share information without consent should be based on considerations of the safety and well-being of the child and others who may be affected by their actions (See 3.1).

3.3.1 Information shared should be necessary, 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, ensuring decisions are defensible (See 1.1.4).

Guidance: ICO: Data Sharing Checklist

3.4 Healthcare staff must ensure that a child's healthcare information is obtained when they are admitted to a secure setting and key needs 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 multidisciplinary 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 they leave the secure setting and are transferred to the community, another secure setting, secure mental health provision or the adult justice setting. This must be completed within 7 days of transition. This information should include their Comprehensive Health Assessment Tool (CHAT) assessment, immunisation record, and details of medications and allergies as well as a summary of their healthcare needs at the point of exit / discharge, including details on any ongoing interventions / treatment (See 4.3.1 and 10.5).

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. This includes Regulation 44 Visitors (Children Act 1989), Ofsted and CQC Inspectors.

3.4.4 Subject to consent, the parents/carers/next of kin 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.

Guidance: Gillick Competency and Fraser Guidelines, DHSC: Reference guide to consent for examination or treatment (second edition), 2009.

4 Entry and Assessment

"Staff can speak professionally, but can also speak to young people."

"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."

4.1 Children with immediate health needs, vulnerabilities or who are at risk of harm to self or others are identified promptly on arrival at the secure setting.

4.1.1 Children are treated as at risk of harm to self and others 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 health professionals are not available on site 24 hours per day, standard operating procedures are developed to support other staff in the setting to identify any immediate and urgent health concerns and decide what action to take (See 6.3.2).
Particular attention is given to known risks linked to: Looked After Children, 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.

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.

4.1.3 The CHAT reception health screen includes life threatening and immediate health needs, identifies anyone on prescribed medication and includes documentation 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 the setting's constant care and supervision practices of children at risk of harm, including those showing signs of 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 prompt further assessment and support from health professionals for children at risk of harm or with urgent health concerns, and to ensure healthcare professionals in the secure setting are aware of local referral and consultation routes, including out of hours. Timeframes should be monitored including any serious incidents due to delays in accessing further assessment and treatment.

4.2.4 Children should be informed in an age and developmentally appropriate way about the setting's constant care and supervision practices, including reasons why and when this may need to be used, and what to expect when placed on constant care and supervision.

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, in line with 1.1.4 (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 custody 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,
- Recent or open paediatric or child mental health assessments
- 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 the records, or the information usually contained on healthcare records as quickly as possible. The child's GP, parents/carers/next of kin 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. This should be done by the following:

- The assessor checks that the child understands the purpose of the assessment and possible outcomes as fully as possible before it is conducted.
- Explaining any jargon and giving the child enough time to respond.
- During assessment the child's views are actively sought and recorded.
- 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 ten days of their arrival).

4.5.1 The assessment is completed by a healthcare professional with specialist input where appropriate, such as a substance misuse specialist and/or a speech and language therapist trained to assess health needs in children in secure settings. Best practice is that this should be completed by the staff member(s) listed at the start of each CHAT assessment. Any deviations from this should be decided by the healthcare team and should be formally agreed between the provider and commissioner.

4.5.2 All children should be assessed for experience and impact of current or past violence or

abuse, both as the victim and/or the perpetrator, (to include, but not limited to: racially motivated violence, gender-based violence, domestic and non-domestic violence and abuse; criminal and sexual exploitation; physical, emotional and sexual violence and abuse and female genital mutilation (FGM) child exploitation, grooming and trafficking). Healthcare staff should also consider previous undisclosed traumatic experiences (See 8.1).

4.5.3 Secure settings should create an environment where children feel they can disclose any form of previous abuse (See 14.3).

4.5.4 All CHAT 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. Assessments should be repeated if the child's presentation and needs has significantly changed since last assessment.

4.6 There is a clear process and protocol 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 support and response. The criteria include what triggers a more detailed assessment, based on clinical need and risk; 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, community health services, on site operational staff, on site education staff, other staff, parents/carers/next of kin, youth offending teams, and social services. In certain settings peer referrals may also be made by children and these will be responded to as per usual referral pathways.

5 Care planning

"They take our problems and suggestions seriously."

"They don't sit you down and go through things with you – I didn't know what was going on."

5.1 Each child has a known, named registered healthcare professional who co-ordinates their healthcare.

5.1.1 Healthcare staff must work with secure setting staff and leaders to ensure care planning, whole-system interactions and interventions are based upon individual formulations as part of the Framework for Integrated Care and (for Secure Children's Homes) in accordance with the Care Planning, Placements and Review Regulations 2010 (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 the child's CHAT assessment and healthcare plan are completed. The named healthcare professional acts as the key contact point for parents/carers/next of kin (if appropriate) as well as professionals 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 subsequent review meetings.

5.2 Each child has a comprehensive and holistic healthcare plan, which is formulation-based and co-produced with the child, underway within 10 days of their arrival in the secure setting. This plan demonstrates a whole-system approach to the care of the child by integrating the approach to physical health, mental health and wellbeing, substance misuse, neurodevelopmental needs and any speech, language and communication needs. The healthcare plan is part of a continuous process and should be revised and monitored at regular intervals by a multidisciplinary team. The plan is shared with the child and, if the child consents, with their family/carer/next of kin (where appropriate).

5.2.1 The healthcare plan is integrated and aligned with the child's education, care and transition plans and, where applicable, their Looked After Child Care Plan and/or Pathway Plan and/or sentencing.

Guidance: Promoting the health and well-being of looked-after children. Statutory guidance for local authorities, clinical commissioning groups and NHS England, Department for Education and Department of Health 2015.

Looked-after children, quality standard, National Institute for Health and Care Excellence 2013.

5.2.2 Healthcare plans are 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/next of kin. The healthcare plan takes into consideration, where possible, the child's choice, regarding support, treatments, and interventions, including recording verbatim statements of choice and/or preference as appropriate. The plan is shared with the child's consent.

5.2.4 The healthcare plan takes account of what has happened to the child before their time in the secure setting as well as the time spent in the secure setting and plans for transition (See 10.1).

5.2.5 The child's named healthcare professional meets with the child, and their trusted member of staff if they would like, on a regular basis to monitor and review the healthcare plan – a minimum of every three months and prior to transfer, or more frequently as required to meet the child's health needs or reflect the changes from the multidisciplinary review of formulation-based care. This may include reference to the child's summary care record and previous health assessments (See 4.3).

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 is recorded, and repeated attempts are made to complete the process.

5.3.1 Assessments of the child's capacity to consent is made in accordance with the relevant legal principles and with consideration of the specific healthcare situation 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, autism spectrum condition or communication difficulties (See 14.10).

5.3.4 When obtaining consent, 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 views, a trusted staff member should be sought out to support them. It should be discussed with 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 timely healthcare and intervention to improve their health and wellbeing outcomes, now and in the future.

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 and, where possible and appropriate, healthcare staff work with local community services to negotiate expedited relevant health appointments.

5.4.2 Children are not unnecessarily restricted by security procedures to attend healthcare appointments (internally or externally) or receive emergency care (See 6.3). Security measures are appropriately risk-assessed and proportionate.

Guidance: Expectations: Criteria for assessing the treatment of children and conditions in prisons, Her Majesty's Inspectorate of Prisons, 2012
Children's Homes Regulation (Health and Wellbeing Standard), 2015.

5.5 Children receive collaborative and consistent healthcare, which is responsive to their individual needs.

5.5.1 All health interventions are delivered by staff trained to deliver the intervention.

5.5.2 Children have regular discussions with healthcare practitioners about their progress and ongoing health needs. These are recorded in their health record.

5.5.3 Children consistently see the same specialist healthcare practitioner for intervention to provide continuity of care, unless their preference or clinical need demands otherwise.

6 Universal Health Services

"I got this one tooth that's a bit messed and so the dentists gave me all the options and respected what I wanted to do."

"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 a universal health service that is tailored to meet their health and wellbeing needs.

6.1.1 Children in secure settings have access to primary care provision which is at least equivalent to the services available to children in the community. This includes (but is not limited to): general medical services, general dental services and general optical services (See 5.4.1, 7.1 and 8.1).

6.1.2 Such services may directly provide, or ensure appropriate referral to, services including but not limited to:

- Routine immunisations;
- Sexual and reproductive health services;
- Substance misuse services;
- Child and adolescent mental health and wellbeing services including emotional wellbeing services;
- Physical disabilities services;
- Neurodevelopmental conditions services;
- Psychological services and counselling;
- Community health services, including allied health professional services (including physiotherapy, podiatry, audiology, occupational therapy, medicines optimisation and review, optical services and speech and language therapy);
- Services for the management of long term conditions, blood disorders and chronic disease;
- Health promotion and lifestyle advice services (including nutritional support, smoking cessation, and physical activity). Note that these services may be co-designed and co-delivered with residential/operational staff; and
- Acute services for assessment, diagnosis and follow-up.

6.1.3 Children with gender dysphoria need additional support for mental health and wellbeing and should have support and access to specialist services (See 15.4.1).

6.1.4 All staff within the secure setting should be aware of any child experiencing gender dysphoria.

6.1.5 The secure setting has procedures in place to prevent the risk of bullying and harassment and the need to protect vulnerable children, and procedures to follow should this arise.

6.1.6 Care should be given taking into account 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, and are enabled to, access health and wellbeing services while they are in the secure setting (See 12.5, 13.5).

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

6.2.2 An effective appointment system is in operation, which ensures appointments are accessible and available at reasonable times and locations that are convenient for the child and are facilitated by health and residential/operational staff. The number of "was not brought" are monitored and reviewed to identify where access difficulties exist.

6.2.3 Children are treated with respect and dignity in a professional, friendly and caring manner.

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

6.3.1 A member of staff trained in first aid and cardiopulmonary resuscitation is 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 by both healthcare staff and residential/operational staff 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 Healthcare staff should work with external healthcare services to plan visits, ensuring services are aware that the child will be accompanied by staff, arranged by the setting, 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 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 jointly developed, comprehensive medicines management policy in place detailing the key responsibilities for residential/operational staff and healthcare staff.

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. Settings are committed to stopping the over-medication of people with a learning disability, autism spectrum condition or both (STOMP).

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

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;
Professional guidance on the safe and secure handling of medicines, Royal Pharmaceutical Society, 2018.

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 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
- Eye drops

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.

Guidance: Drug misuse and dependence: UK guidelines on clinical management, Department of Health, 2017;
Improving Medicines Use for Care Home Residents, Royal Pharmaceutical Society, 2016;
Health and Justice Mental Health Services, Safer use of mental health medicines, NHS England, 2017;
Overview: Depression in children and young people: identification and management, Guidance, NICE;
Overview, Attention deficit hyperactivity disorder: diagnosis and management, Guidance, NICE;
Overview, Psychosis and schizophrenia in children and young people: recognition and management, Guidance, NICE.

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 health improvement strategy should:

- Be linked to the secure setting's overall health and wellbeing strategy (See 12.1).
- Use evidence-based and age-appropriate approaches to encourage behavioural change.
- Include strategies and access to services to detail how the service will (a) improve mental health and wellbeing and social and emotional skills (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 social and 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/ next of kin (as appropriate) and senior management.
- Be an integral part of the secure setting's 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 appropriate. Materials and activities are tailored to meet the needs of children with communication or learning needs.

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, 2020.

6.5.4 Healthcare staff provide advice as to whether practice and policies, when reviewed, are adversely affecting or benefitting, 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. This includes support for physical, mental and emotional wellbeing as well as education on childcare and infant and child development. Referral to local parenting support should be made to midwife/health visitors, family hubs and infant mental health teams, where appropriate, ahead of transition to the community.

6.7 Children receive support from a registered healthcare professional after restraint procedures, who attend to the physical and emotional impact of restraints as appropriate. If support is refused, the reason why is recorded, and repeated attempts are made. Note: Healthcare staff have duties and responsibilities in regard to safety of a child during and following restraint. The setting's local policies will determine the role of healthcare staff in restraint (See 14.5).

6.7.1 All staff are informed and updated by the child's named healthcare professional of any relevant health 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 or placed on intermittent or constant care and supervision. 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 (including removals or interventions) occurring within normal working hours and out of hours when healthcare staff are onsite.

6.7.3 Children subject to restraint procedures are seen as soon as possible and in line with the timescales identified by the secure setting's procedures Any injuries sustained are fully documented and escalated in line with local safeguarding procedures where appropriate.

6.8 Children receive support from a trusted healthcare professional after periods of imposed separation from their peer group. If support is refused, the reason why is recorded, and repeated attempts 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. See 'Separation in SCHs / YOIs / STCs' in the glossary for further guidance.

6.8.2 Healthcare professionals should retain access and proactively monitor the health and wellbeing needs of a child who is separated from their peer group or placed on intermittent or constant care and supervision. 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 is refused, the reason why is recorded, and repeated attempts 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 multidisciplinary team, to address their needs and be safeguarded against ongoing exploitation. Care should be taken by all staff to safeguard other children in the setting from radicalisation.

7 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 an appropriate, comprehensive physical health strategy outlining the contributions of all staff to support and improve the physical health and wellbeing of all children. The strategy includes confirmation that reasonable adjustments are made in the provision of health services for those with an identified need. The strategy incorporates a multidisciplinary approach based on the Framework for Integrated Care. It forms part of the secure setting's health strategy (See 6.5 and 12.1).

7.1.1 The strategy incorporates a multidisciplinary approach and is part of the secure setting's health strategy (See 12.1).

7.2 The secure setting has access to, and receives support from, a multidisciplinary 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 (See 8.2.3).

7.3 Before planned physical healthcare intervention begins, physical health need is assessed (See 4.5) and a healthcare plan is developed (See 5.2).

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

7.4.1 Staff are appropriately trained to manage, provide effective treatment and regular review of children with long term conditions, in line with evidence-based practice.

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, when needed, 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, treatment from healthcare professionals and timely referral to specialist services where clinically indicated.

7.4.4 Children's height and weight is measured on arrival, as clinically indicated and as a minimum on an annual basis. Children's nutritional status should be assessed on arrival, and as clinically indicated throughout their stay, using validated screening tools to guide intervention and timely referral to services.

7.4.5 Children's vision and hearing should be assessed on arrival, and as clinically indicated throughout their stay, using validated screening tools to guide intervention and timely referral to services.

7.5 Children are cared for by a dental health service that assesses and meets their needs.

Guidance: Oral health promotion: general dental practice, NICE, 2015, Delivering Better Oral Health, PHE, 2017.

7.5.1 Children have access to comprehensive dental care including oral health education and prevention, check-ups, diagnostics, and urgent care.

7.5.2 Children have timely access to dental checks and treatment. Orthodontic care is offered where appropriate and should be continued where it has been started.

7.5.3 A comprehensive discharge summary following any dental examination or treatment should be completed, these should be sent to the child's new dental provider upon transition.

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

7.6.1 The policy includes an outbreak, acute respiratory illness (including COVID and flu), and vaccination plan.

7.6.2 Children are offered and educated on vaccinations that are appropriate to their age and need, including previously missed childhood vaccinations, as set out under national guidance for immunisations and vaccinations.

7.7 Children have access to confidential advice and education about relationships, safer sexual practices, and contraception, which is delivered by a trained professional (See 3.1).

7.7.1 Children have access to advice and appropriate contraception in the secure setting, including emergency contraception if necessary.

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

7.8 Sexual health services are available to all children. Specialist services are 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 or use other products containing nicotine, 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 children who are pregnant and after delivery.

7.10.1 Pregnant children have access to a midwife.

7.10.2 Pregnant children are supported through non-judgemental counselling around the options for continuing with pregnancy and termination of pregnancy, where appropriate and within relevant legislation.

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

7.10.4 Pregnant children should receive appropriate care while in secure settings which ensures the wellbeing of parent 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. On transition, they should be referred to appropriate local services.

7.10.5 Pregnant children should receive advice and support about feeding options (including formula and breastfeeding) for their baby, both prior to and after birth. On transition, they should be referred to appropriate local services.

7.10.6 Children giving birth while in a secure setting or recently having given birth should have access to postnatal services. On transition, they should be referred to appropriate local services.

7.11 Support should be given to girls in the setting to ensure good menstrual health. This should include education on the menstruation cycle, the range of menstrual products available and the possible implications on their physical and emotional health. Girls should be supported to access sanitary products and to manage the impact of symptoms linked to menstrual health problems, including but not limited to pain and heavy menstrual bleeding. If appropriate, girls should be referred to the GP and/or gynaecology for diagnosis and treatment of possible conditions linked to menstrual health, including but not limited to endometriosis and PCOS.

8 Mental Health and Neurodevelopmental 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 an appropriate, comprehensive mental health and neurodevelopmental conditions (including speech, language and communication) strategy outlining the contributions of all staff to support and improve the mental health and wellbeing of all children. The strategy includes confirmation that reasonable adjustments are made in the provision of health services for those with an identified need. The strategy incorporates a multidisciplinary approach based on the Framework for Integrated Care. It forms part of the secure setting's health strategy (See 6.5 and 12.1).

8.1.1 All healthcare staff work to the principles of the Framework for Integrated Care to deliver consistent, trauma-informed, formulation-driven, evidence-based care.

8.2 The healthcare team includes a multidisciplinary Children and Young People's Mental Health Service (CYPMHS) offer appropriate to the needs of the children.

8.2.1 The secure setting seeks consultation, advice, supervision, support and training from the integrated CYPMHS team in line with the mental health strategy and agreed pathway.

8.2.2 All children will have a psychologically underpinned formulation, from a multi-disciplinary team with a mental health practitioner embedded.

8.2.3 Dedicated and timely access to psychiatric and psychological input is available from the integrated CYPMHS team, through which access to other professional input may include occupational therapists, speech and language therapists, primary mental health workers, a clinician with neurodevelopmental expertise and Community Forensic CAMHS (Community F:CAMHS) (See 3.4.1, 10.3.1).

8.2.4 There is a lead mental healthcare professional responsible for overseeing mental health provision within the secure setting (See 7.2.2 and 8.2.3).

8.3 Before planned healthcare intervention begins, mental health and neurodevelopmental need is assessed (See 4.5) and a healthcare plan is developed collaboratively (See 5.2).

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 diagnostic thresholds) takes place within the appropriate site-specific arrangements, for example Enhanced Support Services (ESS) integrated care framework on site at YOIs. If a child comes to the setting on a Care Programme Approach (CPA), the setting should support this and transition the CPA to the relevant process.

8.4.2 Practitioners actively engage parents/carers/next of kin in assessment, 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 Children who present with highly complex needs are supported with specific, timely, and appropriate interventions. (See glossary for definition of complex needs)

8.4.5 Mental 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).

8.4.6 Specific evidence-based interventions are offered for addressing the root cause of and managing harmful sexual behaviour.

Guidance: Research in practice: Children and young people with harmful sexual behaviours, 2014.

8.5 A range of evidence-based neurodevelopmental support and interventions are offered and delivered according to individual needs. 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;
- Educational needs; and/or
- Autism spectrum condition. "

8.6 Children at risk of self-harm or suicide are provided with individual care and support in line with current evidence-based best practice in this area.

8.6.1 Known personal factors or significant events which may be a trigger to self-harm and / or suicidal ideation / intent are identified in the child's healthcare plan and discussed with all staff.

8.6.2 Evidence-based interventions are offered and delivered to address the underlying causes of self-harming behaviour and / or suicidal ideation / intent. Where a child is placed on constant care and supervision, there should be clear explanations in child and age appropriate ways about what this involves, and its purpose.

8.6.3 All incidents of self-harm or attempts to self-harm are recorded and routinely referred to the safeguarding lead and, as appropriate to the secure setting safeguarding team (See 2.3).

8.7 For any child thought to require inpatient specialist mental health treatment, it is essential that they are identified, assessed and, if clinically appropriate transferred to hospital as early as possible (under the Mental Health Act 1983, amended 2007). A Care, Education and Treatment review (C(E)TR) should be undertaken ahead of the move, if appropriate.

Guidance: Transfer guidance under Mental Health Act 1983 for children detained on youth justice and welfare grounds

8.7.1 The supporting CYPMHS team is aware of the referral criteria and process for access to the adolescent mental health in-patient services, and any potential referrals are discussed at the earliest opportunity. The child's community professionals and parents/carers/next of kin (as appropriate) are consulted to draw on previous knowledge of the child and their difficulties.

Guidance: Transfer guidance under Mental Health Act 1983 for children detained on youth justice and welfare grounds.

9 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 an appropriate 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 6.5 and 12.1.3).

9.1.1 The strategy incorporates a multi-agency approach, including where appropriate outside agencies, and is part of the secure setting's health and wellbeing strategy (See 12.1 and 13.1).

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

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

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

Guidance: **Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence, NICE CG115, 2011.**

Drug misuse prevention: targeted interventions, NICE NG64, 2017.

Guidance for the pharmacological management of substance misuse among young people in secure environments, DH NTA, 2009.

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 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, including preparation for integration into their communities or following transfer to other settings.

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

9.3.2 For children requiring individualised support there is a targeted substance misuse programme, as part of wider health programmes, that is up to date and has clear learning objectives and outcomes that are informed by the children's needs and the current evidence base including trauma-informed care.

9.4 Before planned intervention begins, substance misuse need is assessed (See 4.5) and a healthcare plan is developed (See 5.2). Reference should also be made to the Education, Health and Care Plan (if appropriate).

Guidance: **From harm to hope: A 10-year drugs plan to cut crime and save lives, HM Government, 2021.**

9.5 A range of evidence-based substance misuse interventions are offered and delivered according to individual need. Psychological and physical support is provided where needed for children adapting to substance misuse opportunities being removed.

Guidance: NICE CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence; NICE NG64 guideline Drug misuse prevention: targeted interventions; Guidance for the pharmacological management of substance misuse among young people in secure environments London DH NTA Gilvarry E and Britton J (2009).

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 or use other nicotine products (See 7.9).

9.5.4 Practitioners actively engage parents/carers/next of kin in care and interventions, where appropriate (See 10.1 and 10.2.1).

10 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 Continuity of healthcare is ensured as children transition between secure settings, hospital settings or to the community. Early planning for transfer to the community or to another secure setting is crucial, beginning as soon as children are admitted to the setting. Transition arrangements as well as healthcare needs and requirements stated within their Education, Health and Care Plan should be included in the health transition plan, which feeds into the overall formulation and transition plan for that child.

10.1.1 Healthcare staff are aware that children, particularly those with autistic spectrum condition, and/or learning difficulties or disabilities, and/or those with histories of trauma and significantly disrupted care, may find transitioning periods distressing and further preparation to increase predictability and provide support through the process may be necessary. This includes consideration of sensory and communication adaptations.

10.1.2 Transition in the lead up to a child moving to the adult estate due to 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 prior to transfer. Any outstanding actions and ongoing or new health and wellbeing needs or risks of harm to self and/or/from others are identified. The named healthcare professional leads this review in conjunction with other staff involved in the child's care, together with the child and, where possible, with their parents/ carers/ next of kin.

10.2.1 A holistic health transition plan is developed with the child which includes physical health, mental health and wellbeing, neurodevelopmental needs, speech, language and communication needs, substance misuse, allergies and the management of medicines. This is integrated with their overall transition plan. The child's named health professional should ensure that the child understands the health transition arrangements that are in place.

10.2.2 As a minimum, 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 F:CAMHS, where it is 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, where appropriate, parents/carers/next of kin 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 take into account the speech, language and communication and literacy needs of the child, their parent/carers/next of kin.

10.3.4 Children or their parent/ carer/ next of kin, where appropriate, 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 any medication they may be using and what to do in case of a problem. The provision of medication directly to the child upon leaving the setting is supported by a risk assessment undertaken by the team in the setting they are leaving. In the event of circumstances where a supply would be unsafe, robust arrangements are made by 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 receiver organisation and reviewed with safeguarding partners, regulatory body or health commissioner/service planner.

10.5 A summary of the child's healthcare record, including:

- Current diagnoses, including for those where medication isn't prescribed
- A list of current medication with the indication for each
- Any recommendations for future care (CHAT discharge summary) is sent to the child's GP and any other relevant agencies prior to transfer, and when this is not possible, no later than one week after transfer (including Looked After Children health and care professionals and youth offending team where appropriate). The child and, where appropriate, their parents/carers/next of kin are asked whether they would like a copy of the healthcare record at the time of leaving."

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

10.7 Pre-transition harm-minimisation programmes (use of products containing nicotine, 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 healthy relationships and safer sexual practices is offered and provided for children leaving the secure setting. Contraceptive cards should be used where available.

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 within seven days of the transition and confirmation of receipt should be sought. This should include any 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, such as for weekly or monthly medicines including injections.

Guidance: Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes, NICE, 2015. Keeping Patients Safe, Getting Medicines Right, RPS, 2012.

10.10 Consideration is given to a child's healthcare and any 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, or in the community, to ensure effective transfer of all healthcare services (physical health, mental health, neurodevelopmental and substance misuse), allergies and medicines. Cross-over working may also involve children being linked a mentor from the new transitional setting who can talk through the process of transition.

10.11 Children with a learning disability and/or autistic spectrum condition should be supported and have a Care, Education and Treatment Review (C(E)TR) which is updated when referred to hospital.

11 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 space that offers a confidential, therapeutic environment for physical health, mental health, neurodevelopmental needs and substance misuse (screenings, assessments, consultations, information, treatment and intervention, supply of medicines).

11.1.2 The locations where health services are delivered are child friendly, developmentally and age appropriate and ensure the child's privacy and confidentiality.

11.1.3 Healthcare staff provide advice to ensure children's rooms do not present a risk to their physical or mental health, helping to ensure rooms are clean and sensory friendly with fixed furniture and anti-ligature.

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

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

11.1.6 Where clinically appropriate, reasonably possible and safeguarding is assured, children should be offered the choice as to whether they wish to be assessed and/or treated in the secure setting's dedicated healthcare room(s) or in an alternative location.

11.2 All health equipment is safe, appropriate and meets standards set 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. All staff know the location of the defibrillator and are trained as appropriate.

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 to deliver healthcare undergo cleaning, infection prevention and control processes in line with the relevant nationally defined standards.

Guidance: Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance, Department of Health, 2015.

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

11.4 There is a systematic and planned approach to the management of electronic 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 audit on the quality of health record entries.

12 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 that is appropriate for the secure setting.

Guidance: a resource providing guidance on the strategies can be found on the NHS England Intranet for commissioners.

12.1.1 The health strategy sets out the secure setting's 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 setting's wider strategy and plans.

12.1.2 The health strategy incorporates the: physical health strategy (See 7.1), mental health and neurodevelopmental 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 links to the secure setting's 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 senior leaders, staff and children (See 13.5.4).

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, or Registered Manager of the secure setting are aware of their responsibilities and duty of care for the health and wellbeing of 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, or Registered Manager ensures that the secure setting is involved in strategic health planning and decision making. Governance at the secure setting level is provided through the development and operation of local partnership boards.

Guidance: The Children Secure Estate National Partnership Agreement. Working together to commission and deliver high quality services for children 2018-2021, NHS England, 2018.

12.3 Service planning and commissioning are responsive to the needs of the children in the secure setting.

12.3.1 The views of children and their parents/carers/next of kin are sought, listened to, and actioned wherever appropriate 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 is conducted by the service planners/ providers/ commissioners in conjunction with the secure setting, and reviewed as a minimum every two years using a structured assessment tool.

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 setting's health strategy and resource allocation.

12.3.4 The secure setting provides information to commissioners, children and other stakeholders about any special health and wellbeing services offered and about any health conditions that they are unable to care for. This is reviewed annually and recorded in the health strategy.

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), particularly 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 within the healthcare service 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, whistleblowing, best practice and clinical audits.

12.5.1 Healthcare practitioners monitor clinical outcomes and experiences at regular intervals, using recognised outcome tools where appropriate and relevant, and outcomes are evaluated using the views of the child, staff, and parents/carers/next of kin where appropriate. This should take place at a minimum at the beginning of treatment and upon transition out of the secure setting.

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

12.5.3 Healthcare staff support the development of local processes that outline clear communication pathways and organisational responsibilities in the event of any safeguarding and / or serious incident. This should be developed with all stakeholders including but not limited to: NHS Health and Justice Commissioning, the Governor, Director, Principal Director or Registered Manager of the secure setting and the Local Authority.

Guidance: Child Death Review Statutory and Operational Guidance (England), Cabinet Office, 2018. Patient Safety Incident Response Framework, NHS England.

12.5.4 Children are involved in reviewing and shaping healthcare provision in the secure setting.

13 Multiagency working

"They take our problems and suggestions serious."

"They don't communicate with each other... e.g. a dental nurse doesn't communicate with another nurse when I ask questions."

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, multiagency, trauma-informed working and medicines management.

13.1.2 Regular multidisciplinary team (MDT) formulation meetings take 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 Multi-agency working is supported by having a systematic and robust management of health records in place (See 3.1 and 11.4).

13.3 Children receive care from a multidisciplinary team that works in a holistic and trauma-informed 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, neurodevelopmental or physical) should be delivered and developed in collaboration with healthcare and specialist services to ensure that all of the needs of the child are identified and supported.

13.5 Children, parents/carers/next of kin (if appropriate) and allied healthcare professionals understand how, and are encouraged to provide feedback (including making complaints) about healthcare services, including in-reach and community services as well as health practice, systems and policies. Feedback mechanisms take into account how to adapt and accommodate populations' needs including speech, language and communication needs. This activity should provide opportunities for children to feel more empowered in terms of their experiences of healthcare as well as to develop transferable vocational skills in terms of their education and employment.

13.5.1 Complaints procedures are well-publicised, 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 assurance given to the child making the complaint that this will be dealt with sensitively. Follow up input to the child making the complaint should be offered by a senior member of the healthcare team, to provide reassurance and ensure that ongoing care is not affected. Complaints management should take into consideration GDPR principles and guidelines with regards to information sharing and retention.

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.

Guidance: The NHS Constitution, Department of Health, 2018.
Regulation 20: Duty of candour, Care Quality Commission, 2015.

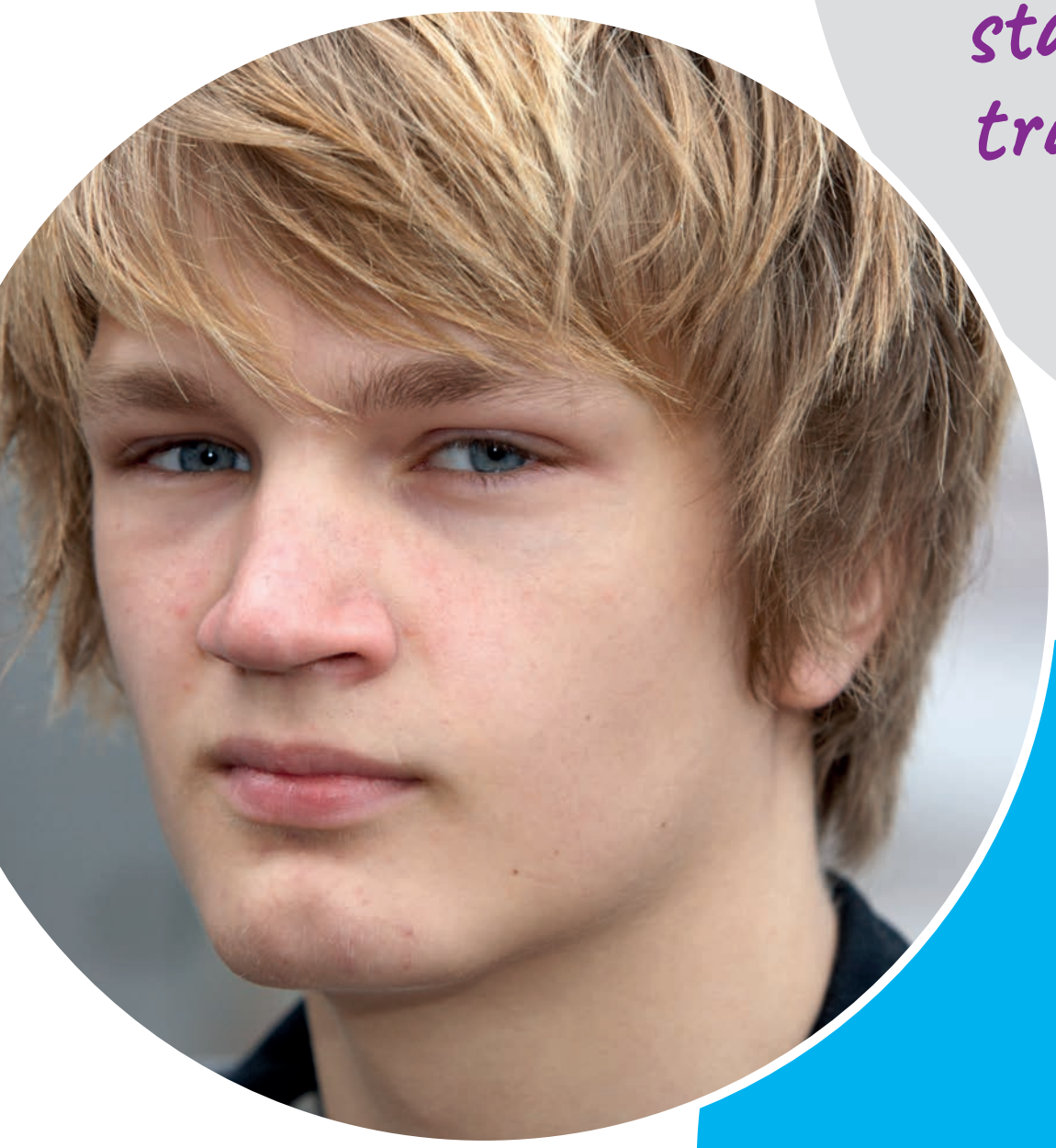
13.5.4 The Governor, Director, or Registered Manager of the secure setting and the Health and Justice Commissioner are made aware of all complaints relating to healthcare services on a regular basis.

13.5.5 There is a children's forum that is representative of the secure setting's population. Children who are representatives are supported by staff to ensure they are able to play a full and active role. Healthcare staff and commissioners should take a proactive role in using this forum to continuously improve the healthcare offer to children.

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 All staff working with children receive training in safeguarding and child protection (See 14.8.3 and 14.8.4).

14.2 All staff working with children know which services to contact in an emergency, including for incidents of harm to self, violent behaviour and first aid.

14.3 All staff working directly with children receive training on child and adolescent development, attachment, complex trauma, racial trauma, bereavement, loss, adverse childhood experiences, violence counselling and other relevant key theories. Where relevant, staff are trained on gender responsive needs and approaches.

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

This includes, but is not limited to, the impact of:

trauma, neglect, isolation, being placed in a secure setting, attachment theory, mental health problems, management of long term physical conditions, neurodevelopmental needs, speech, language and communication difficulties, anti-bullying practices, being in police custody, conflict management, de-escalation and restraint. Staff will also be sensitive to the significance of children's behaviour and how it can be an important way in which they communicate underlying distress."

14.3.2 Staff are able to recognise behaviours that indicate a heightened or escalating 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 all 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 within the setting.

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 and high levels of risk.

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

14.4.4 All healthcare teams have staff that 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 restraint where relevant to the setting (for example Minimising and Managing Physical Restraint awareness module (MMPR) or Restrictive Physical Intervention Training (RPI)), to support clinicians to understand potential risks and injuries. Training in restraint should be appropriate to the needs of the children the provision is set up to care for. Any restraint techniques the training promotes should be medically assessed to demonstrate their safety for use in a context of caring for children who are still developing, physically and emotionally.

Healthcare staff provide health advice which may inform any decision around planned restraint. Healthcare staff will advise on individual children who may have health related conditions that could cause a greater risk of harm if not considered during restraint (See 6.7)."

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 (See 6.9).

Guidance: Revised Prevent Duty Guidance for England and Wales, Home Office, 2015.

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, 2014.

14.7 Healthcare staff contribute to the recruitment, development and sustainability of an emotionally resilient staff able to work effectively and compassionately with vulnerable children displaying/presenting with challenging behaviours.

14.7.1 Healthcare staff ensure training on mental health and wellbeing awareness, child development, attachment and trauma awareness, neurodevelopment, and speech, language and communication needs are 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).

14.7.2 Healthcare staff provide appropriate support to staff working with children in the secure setting to foster a culture of multidisciplinary working and partnership, and ensure the whole secure setting operates as a health promoting environment.

14.8 There are appropriately qualified and skilled healthcare staff to meet the needs of the children in the secure setting.

14.8.1 Healthcare staff are trained and supported to work with children in challenging circumstances.

14.8.2 Healthcare staff are able to operate safely within the secure setting.

14.8.3 Healthcare staff are compliant with the level 3: Looked After Children: Knowledge, Skills and Competencies of Healthcare Staff Intercollegiate Role Framework, 2015.

14.8.4 Healthcare staff are compliant with the level 3: Safeguarding Children: Roles and Competences for Healthcare Staff Intercollegiate Document, Royal College of Paediatrics and Child Health, 2014.

14.8.5 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.

14.8.6 Healthcare professionals conduct their work within the same ethical and good practice codes as their colleagues in health services in the wider community.

14.9 Healthcare professionals have an annual appraisal and receive regular clinical and managerial supervision. Where possible, clinical and management supervision should be provided by a different person to promote an open and transparent culture.

14.9.1 Healthcare professionals have clearly defined job descriptions and there are clear and agreed lines of clinical and managerial responsibility.

14.9.2 Healthcare professionals know where to go for advice and support following a major or disturbing 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. 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;
- Child and adolescent development."

15 Equality and diversity

"Everyone is entitled to be treated the same."

"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.

15.1.1 Every child in a secure setting should have equal access to healthcare services that meet their individual needs, taking account of any protected characteristics: disability, gender reassignment, race, religion or belief, being married or in a civil partnership, age, pregnancy, sex, and sexual orientation.

Guidance: Equality Act 2011.

15.1.2 Children do not face discrimination in the provision of healthcare services in a secure setting.

15.2 Healthcare services work in partnership with parents/carers/next of kin (where appropriate) and professionals to ensure that the medical, cultural and dietary needs of all children are met.

15.2.1 Healthcare services work with residential/operational and educational staff to help children to learn about healthy eating, taking into consideration religions, cultural, and dietary preferences.

15.2.2 Healthcare services are aware of the high level of developmental language disorders for children placed in secure settings and seek to optimise written and spoken communication to reduce health inequalities and improve patient safety.

15.3 Healthcare services in children's secure settings should respond to the health needs of ethnic minority communities, with a particular focus on reducing the inequalities they may have already faced in accessing health care services.

Guidance: NHS England response to the specific equality duties of the Equality Act 2010.

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

Guidance: NHS England Equality Objective 3.

15.4.1 Healthcare staff are aware of the appropriate healthcare pathways for children with gender dysphoria.

15.4.2 Healthcare staff in secure settings are aware that children with gender dysphoria 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 the child's preferred name and pronoun.

15.5 Healthcare services seek to improve the experience of children with a learning disability, neurodevelopmental needs (e.g. autism spectrum condition) or both, with a particular focus on removing the inequalities they may have already faced in accessing health care services.

15.6 All healthcare staff in secure settings for children are up to date with training in equality and diversity.

Appendix 1: Refresh of the standards

In 2023, NHS England led 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 2022 audit on how the standards were being implemented, further engagement was carried out with secure settings in England – Young Offender Institutions (YOIs) 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.
11. A new standard has been added outlining the support young people should receive in relation to good menstrual health and prompt access to treatment for gynaecological health issues including, but not limited to, endometriosis and PCOS.

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, the chairs and members of the Task and Finish Groups, and everyone who provided feedback on the standards.

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.

The Expert Reference group

Alexandra Lewis
Consultant Forensic and Child & Adolescent Psychiatrist
Royal College of Psychiatrists Representative

Alison Steele
Officer for Child Protection, Royal College of Paediatrics and Child Health

Alkmini Petraki
Assistant Director
Transformation Partners in Health and Care

Andrew Simpson
Deputy Head of Mental Health and Lead Commissioner CYPMH
National Specialised Commissioning Team, NHS England

Angela Dillon
LAC Nurse Forum representative / Designated Nurse Looked After Children and Care Leavers
Leeds Community Healthcare NHS Trust

Angus Mulready Jones
Lead – Children and Young Adults
His Majesty's Inspectorate of Prisons

Annie Rockson
Head of Co-production and Development
Peer Power

Caroline Twitchett
Children's Quality Lead
Health and Justice, Children Team, NHS England

Cassie Howe
Consultant
Transformation Partners in Health and Care

Claire Moser
Policy Adviser
Policy lead at Royal College for Speech and Language Therapists

Danielle Holden
Project Manager
Health and Justice, Children Team, NHS England

Denise Farmer
National Pharmaceutical Adviser
Health and Justice, Specialised Commissioning, NHS England

Brian Westbury
Academic Dean
Faculty of Forensic and Legal Medicine

Emmanouela Kritikaki
Offender Health Policy
Mental Health and Disability Directorate, Department of Health and Social Care

Fizz Annand
Programme Manager, Criminal Justice
Addiction and Inclusion Directorate
Office for Health Improvement and Disparities
Department of Health and Social Care

Francis N'Jie
Service Manager
Adel Beck Secure Children's Home and Chair of the Secure Accommodation Network-SAN

Heather Miller
Health and Justice Commissioning and Transformation Manager (CYP) East Midlands
NHS England – Midlands

Ian Darlington
Head of Assurance
Youth Custody Service, Her Majesty's Prison & Probation Service

Ian Lewis
National Children's Services Advisor Children and Young People's Mental Health Programme NHS England

Jennifer Frankish
Head of Strategy and Planning
Youth Justice Board

Jeremy Gleaden
Senior MHI His Majesty's Inspector
Ofsted

Jonathan Bacon
Deputy Director for Looked After Children
Department for Education

Joy Shacklock
RCGP Safeguarding Representative
Royal College of General Practitioners

Kenny Gibson
Deputy Director for NHS Safeguarding
NHS England

Kirsty Blenkins
Young People's Programme Manger
Addiction and Inclusion Directorate, Office for Health Improvement and Disparities, Department of Health and Social Care

Kloe Hampton
Senior Youth Engagement Co-ordinator
Peer Power

Fiona Corless
Association of Directors of Children's Services (ADCS) Representative Assistant Director Specialist and Complex Commissioning at Norfolk,
Association of Directors of Children's Services (ADCS) Norfolk County Council

Liz Gilbert
Consultant
Transformation Partners in Health and Care

Lizzie Fussey
Policy Lead - Child Protection and Ethics
Royal College of Paediatric and Child Health

Marina Maxwell
Junior Consultant
Transformation Partners in Health and Care

Melissa Beaumont
Lead Nurse and Clinical Lead for Children and Young People CNWL Health and Justice Services Directorate
Chair of the London Youth Justice CAMHS Forum
Royal College of Nursing representative

Naomi Gadian
Public Health Registrar
NHS England

Naomi Price
Senior Programme Lead
Secure CAMHS, NHS England

Nicola Thomas
Interventions, Health and Strategic Services Manager
Clayfields House

Nigel Thompson
Head of Inspections
Children's Health and Justice, Directorate of Primary Medical Services and Integrated Care, Care Quality Commission

Prathiba Chitsabesan
Consultant Child and Adolescent Psychiatrist
National Speciality Advisor and Co-chair of the Clinical Reference Group (Children and Young People's Mental Health Team) Visiting Professor
Pennine Care NHS Foundation Trust
NHS England

Rachel Swann
Consultant Clinical Psychologist & Lead for the Integrated Health and Emotional Wellbeing Service (IHEWS)
Lansdowne Secure Children's Home, CAMHS & Specialist Services, Sussex Partnership NHS Foundation Trust

Ruth Evans (chair)
Senior Consultant
Transformation Partners in Health and Care

Shaun Common
His Majesty's Inspector
Social Care Lead Secure Estate
Ofsted

Sophie Coates
Peer Engagement Worker
Peer Power

Sophie Mulvana
Clinical Psychologist and Clinical Lead for Health and Wellbeing
Clare Lodge In-Reach Health Team,
Cambridgeshire and Peterborough NHS Foundation Trust

Stephanie Roberts-Bibby
Chief Operating Officer
Youth Justice Board

Steven Malcolm
Offender Health and High Security Hospitals Team Leader
Mental Health and Disability Directorate, Department of Health and Social Care

Suzanne Clarey
Lead Physical Health Secure Nurse
Family Health, Aycliffe Secure Centre, County Durham and Darlington NHS Foundation Trust

Wing Tang
Interim Associate Director for Pharmacy and Membership Experience
Royal Pharmaceutical Society

Healthcare Standards for Children and Young People in Secure Settings

Updated April 2023

Royal College of
Paediatrics and Child Health,
5–11 Theobalds Road,
London, WC1X 8SH

www.rcpch.ac.uk

The Royal College of Paediatrics and Child Health is a registered charity
in England and Wales (1057744)and in Scotland (SCO38299)