Healthcare Standards for Children and Young People in Secure Settings

June 2013
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Foreword

We are delighted to welcome the Healthcare Standards for Children and Young People in Secure Settings. Young people in secure settings are some of the most troubled and vulnerable in our society and these standards provide a landmark opportunity for all those who work with them to make a real improvement to their health outcomes and life prospects. We expect these standards to apply to all children under the age of 18 years held in centres appropriate for children and that no child should be held in an adult establishment.

As UK Children’s Commissioners, we have a responsibility to ensure the UK government and devolved governments discharge their duties under domestic legislation and uphold their international obligations under the United Nations Convention on the Rights of the Child (UNCRC) and other international standards. Research clearly indicates that young people who lose their liberty in secure settings have high levels of physical, mental and emotional health needs, often previously unidentified and unmet. It is their right to receive the highest standard of healthcare attainable. It is in the best of interests of young people and society as a whole that we ensure they receive the best possible support and treatment to help rehabilitate them and reduce the future risks that they might otherwise pose to themselves or others. We should all be concerned by the variance in the quality of healthcare currently received by young people in secure settings.

What is unique about these standards is that they are built, not around a service or a system, but around the young person and their journey through any secure setting. This document sets out clear service standards for the healthcare of young people and calls on us to see the young person first and to uphold their rights enshrined in the UNCRC.

We commend the Royal Colleges on the involvement of young people in the development of these standards. Quotes from them on their experiences are a powerful testament to the need for improvement across the UK.

We urge all healthcare professionals, governments and regulators to adopt these healthcare standards. It is time for everyone concerned to join the Royal Colleges in working together to ensure every child and young person under 18 years of age, held in any type of secure setting anywhere in the UK, receives the best possible healthcare. We cannot stress enough the urgency of seizing this window of opportunity to support and fulfil our duty of care to some of society’s most vulnerable children and young people.

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1. Safeguarding and risk of harm
Everyone working with or in a secure setting has a responsibility to safeguard and promote the welfare of the young people sent there. Healthcare professionals have a duty to ensure that any risks of harm are identified and to provide care and support to young people, particularly at difficult times, for example, on entry or after a restraint. Officers and care staff must be supported by healthcare professionals to ensure that they are able to recognise warning signs and take appropriate action.

2. Window of opportunity
Young people in secure settings have significantly greater physical, mental and emotional health needs than their peers in the non-secure community. Any time spent in a secure setting is an opportunity to reach out to this vulnerable population and a chance to improve their health outcomes. An early and accurate assessment of health needs must be followed by prompt care and intervention and services must, at least, be equivalent to those available in the community.

3. Continuity of care
Young people are often only in a secure setting for a short period of time. There must be an emphasis on preparing for their return to the community and ensuring that they will receive the right care and support there. Planning for release must begin at entry and be taken into account in healthcare plans and referrals. All interactions with healthcare professionals are an opportunity to develop confidence and trust and build a strong foundation for self-care and effective use of health services in the future.

4. The voice of the young person
Young people must be involved in decisions about their healthcare. Their views need to be listened to and incorporated into their healthcare plan for it to work. Every young person must be treated as an individual, with respect, in a professional and caring manner. The standards should be applied using a developmentally sensitive approach; the needs of a 12 year old girl on a welfare placement will be significantly different from the needs of a 16 year old boy presenting a high risk to others.

5. Working together
Services must work collaboratively, in the best interests of the young person. Information must be shared to ensure that the team around the young person has the information they need to meet the young person’s health and wellbeing needs. A named lead healthcare professional takes responsibility for each young person’s healthcare but all staff need a shared understanding of the key factors affecting young people’s health and wellbeing.

6. Health promoting environment
Healthcare professionals, alongside everyone working in a secure setting, have a responsibility to ensure that the secure setting actively promotes the physical, mental and emotional health and wellbeing of the young people there. This includes supporting young people to make positive choices about their health and lifestyle and ensuring that they have access to healthy food, a gym and fresh air. Every secure setting must be a young person centred, therapeutic and health promoting environment.
Introduction

The Royal College of Paediatrics and Child Health (RCPCH), the Royal College of General Practitioners (RCGP), the Royal College of Nursing (RCN), the Royal College of Psychiatrists (RCPsych), the Faculty of Public Health (FPH) and the Faculty of Forensic and Legal Medicine (FFLM) have worked together to develop these standards which we believe will facilitate the provision of equitable and high quality health services for young people in secure settings across the UK.

The case for change

Over 2200 young people are held in secure settings in the UK at any one time and over the course of a year an estimated 9900 young people will spend time there (based on figures from 2011/12). These young people have significantly greater, and often previously unidentified and unmet, physical, mental and emotional health needs than other young people their age.

Health needs of young people in secure settings - summary drawn from ‘Evidence about the health and well-being needs of children and young people in contact with the youth justice system’ (Ryan, M and Tunnard, J, Healthy Children, Safer Communities programme, 2012):

- Over a quarter of young men and a third of young women in secure settings have a long standing physical complaint including respiratory problems, musculo-skeletal complaints, nervous system complaints, skin complaints, dental health problems, blood-borne viruses, sexually transmitted infections and epilepsy.

- The prevalence of mental health disorders is over three times greater in young people in secure settings compared to the general population. The most common disorders are conduct disorders, anxiety and depression. Prevalence rates of personality disorder, psychosis, attention disorders, post-traumatic stress disorder and self-harm are also high.

- Significant numbers of young people in secure settings are diagnosed with attention deficit hyperactivity disorder (10 per cent of males and five per cent of females), an estimated 50 per cent have learning disabilities, there is a high prevalence rate of traumatic brain injury (at least 50 per cent and up to 90 per cent1) and over half have difficulties with speech, language and communication.

- A very high proportion of young people in secure settings have a history of substance misuse. Before they entered custody over 83 per cent were regular smokers, over 60 per cent drank alcohol daily or weekly, with 66 per cent reporting binge drinking once a week, and over 80 per cent had used an illegal drug once a month.

- Young people in secure settings are more likely to be victims of crime, have a parent in prison, have been exposed to bullying and to be a young parent. The proportion of young people in secure settings who have experienced serious maltreatment is twice that of the population as a whole and many have been in contact with children’s social care or have been looked after.

1 Repairing Shattered Lives, Williams, H, 2012
A number of recent reports have highlighted the difficulties in adequately meeting the health needs of young people in secure settings. These young people have often missed out on early attention to their health needs. They may not have qualified for help because each different problem they had was not in itself serious enough to attract attention, even though the combination of needs put them at risk. Most young people are only in secure settings for short periods of time and many are placed outside their home area, creating problems in ensuring continuity of care when they enter and leave.

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 and young people in secure settings, as for all others. Any time spent in a secure setting provides an opportunity to attend to the young person’s physical, mental and emotional health and wellbeing needs and to plan for their continuing care on release.

Purpose and application of the standards

The Royal Colleges play a leading role in setting and ensuring the highest standards of care for patients and were asked by the Youth Justice Board to develop standards to guide and support the provision of healthcare for young people in secure settings.

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

We expect these standards to apply to all young people under the age of 18 years held in centres appropriate for young people and that no young person should be held in an adult establishment. The standards are applicable to young people on both welfare and justice placements in secure settings (including young offender institutions, secure training centres, secure children’s homes and their equivalents) across England, Wales, Scotland and Northern Ireland. They cover all healthcare services (including physical health, mental health, neurodisabilities and substance misuse) and, where relevant, include interfaces with non-health agencies.

The standards provide a model for service delivery whilst recognising that an individualised approach focussing on the needs of the specific young person will be necessary to take account of the often complex and multifaceted needs of this particularly vulnerable group. Continuity of care is essential as young people move between community and secure settings and clear planning and sharing of information is needed to sustain health gains made.

The standards are arranged in sections which follow the care pathway of a young person in a secure setting, with overarching service related standards in the later sections.

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2 I think I must have been born bad. Office of the Children’s Commissioner, 2011
4 Healthy children, safer communities. HM Government. 2009
**Development of the standards**

The standards have been designed with a focus on the needs of young people in secure settings and have been developed by those with expertise in the system, including young people themselves. The work was overseen by a project board with representation from the Royal Colleges, Department of Health, Youth Justice Board and staff working in the secure estate.

**Stage 1 – Analysis**

Firstly, existing standards and guidelines relating to the healthcare of young people in secure settings were identified. A literature review to identify recommendations of best practice was also conducted. Visits were carried out to secure settings across the UK and a stakeholder meeting was held in July 2012 to seek inputs and recommendations. Focus groups were held with young people in secure settings to understand what they thought about the healthcare they received and how it could be improved.

Analysis of the existing standards and the literature review generated a database of over 600 standards and recommendations from over 60 source documents.

**Stage 2 – Expert working groups**

Expert working groups were established for each section to review the standards and recommendations from the analysis stage. Since many of the standards were duplicated, the working groups combined those that were similar to keep the document concise and edited the wording to ensure consistency and improve flow. Where gaps were identified, new standards were drafted and agreed by the working groups.

**Stage 3 – Consultation**

The standards were widely circulated as part of the consultation process. An online consultation was held for four weeks alongside two consultation meetings in March 2013 to review the draft standards.

The standards were also tested in eight secure settings across the UK to ensure that they meet the needs of young people in secure settings.

The standards were then refined by the Project Board incorporating valuable feedback from the consultation prior to full endorsement by all participating organisations.
Children and young people’s participation

‘The healthcare we get inside should be the same as the healthcare outside’

The Royal Colleges recognise that young people in secure settings are not only beneficiaries of healthcare but also key stakeholders with invaluable insights and experiences. The Project Board was committed to the meaningful participation of young people in the development of the standards and commissioned the RCPCH to lead on their participation in the project.

The RCPCH held a series of focus sessions across the UK (see Appendix 1) with a diverse group of fifty young people, male and female, aged between 12 and 17 years from across the UK and from a range of secure settings, including secure children’s homes, secure training centres and young offender institutions. The key principles, outlined in ‘Not Just a Phase, A Guide to the Participation of Children and Young People in Health Services’ 6, provided a core framework for the involvement of young people in the development of the standards.

The RCPCH worked strategically with the Project Board to ensure the insights of the young people meaningfully influenced the development of the standards from the outset; it was crucial to understand and explore the young people’s perspective on what healthcare is currently being received, their thoughts about it and how it could be improved.

‘We don’t know about healthcare standards, we need people like you to tell us’

The young people in secure settings shared some positive experiences of healthcare, including caring and confident staff, healthcare records being passed on during transfers, clear and informative information about substance misuse and mental health and good complaints procedures. They also raised a number of concerns, including a lack of clear systems to access health staff, a lack of information about the healthcare available, issues about confidentiality, and problems with the management of medication.

Their insights and key messages are echoed throughout this document as direct quotes. A poster has also been designed based on their insights and experiences (see Appendix 2).

On behalf of the young people who participated, we would like to extend our thanks for taking into account their insights and experiences and working together to uphold the right to the highest attainable standard of healthcare for all children and young people (UNCRC, article 24).

6 Not just a phase, a guide to the participation of children and young people in health services, RCPCH, 2010
# Key terms and definitions

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<td>Healthcare</td>
<td>Throughout the standards we use 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.</td>
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<tr>
<td>Healthcare practitioner</td>
<td>A person trained to provide some type of healthcare service, including, for example, substance misuse staff.</td>
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<tr>
<td>Healthcare professional</td>
<td>A clinically qualified person, who is working within the scope of practice as determined by their relevant professional body and who is registered with that body as competent to practice, for example, the General Medical Council or Nursing and Midwifery Council.</td>
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<tr>
<td>Parents/carers</td>
<td>To identify and acknowledge those who hold parental responsibility but who may not be the biological parent.</td>
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<td>Secure setting</td>
<td>A secure centre holding children and young people under 18 for welfare or justice reasons. This includes: young offenders institutions, secure training centres, secure children’s homes, juvenile justice centres and secure units.</td>
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<td>Young person</td>
<td>A child or young person under the age of 18.</td>
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‘Give us information about health, tell us when we come in, what’s available, how to access it’

‘I get why they have to ask if you’re pregnant on arrival but the way we are asked is rude’

‘It was good to receive a full health assessment on arrival’
Young people are treated as at risk of harm until the reception health screen and a risk assessment are completed.

A reception health screen is completed for each young person before their first night following admission and ideally within two hours of their arrival.

**Note:** In exceptional cases and where it is in the best interests of the young person, for example, late arrivals or if the psychological state of the young person is temporarily impaired, temporary arrangements to manage risks may be implemented until it is appropriate for the reception health screen to occur. The reason for any delay is clearly documented and reviewed by a healthcare professional.

**Guidance:** Particular attention is given to known risks linked to: looked after children, long term conditions, disabilities, previous history of abuse, ethnicity and culture, diverse needs, those undergoing trial, young people facing long sentences, and young people in secure settings for the first time.

Consent is sought by the healthcare professional carrying out the reception health screen (see 2.3). If the reception health screen is refused, the reason why is recorded and repeated attempts are made to complete the process.

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

The reception health screen is completed using recognised and reliable tools for young people.


Consent is sought by the healthcare professional carrying out the reception health screen (see 2.3). If the reception health screen is refused, the reason why is recorded and repeated attempts are made to complete the process.

The reception health screen is completed by a healthcare professional trained to screen for health needs in young people in secure settings.

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

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

There is a written protocol for the observation of young people at risk of harm, including those showing signs of withdrawal symptoms or at risk of suicide.
1.2.3 An immediate healthcare plan is written and put in place for young people with urgent health concerns. **Guidance:** The healthcare plan sets out the actions, timescales and responsible person, arising from the reception health screen.

1.2.4 There is an agreed pathway to facilitate prompt further assessment and to ensure healthcare professionals in the secure setting are aware of local referral and consultation routes, including out of hours. **Guidance:** There are named individuals for points of contact within local services, including a GP, accident and emergency department, child and adolescent mental health service, substance misuse specialist and looked after children health professional.

1.3 **Information is shared on entry and health assessments are effectively coordinated with other agencies so that young people are not repeatedly asked to give the same information.**

1.3.1 The healthcare professional carrying out the reception health screen and health assessment seeks and reads the young person’s available health information including any previous health assessments (as appropriate: looked after child health assessment, pre-sentence report, Asset, community CHAT, escort report), record of regular medication and significant past medical history prior to carrying out the screen and assessment.

1.3.2 If previous health records are not available at time of entry, every effort is made by the healthcare professional to obtain them as quickly as possible. The young person’s GP, parents and any relevant care agencies (including looked after children health professionals where appropriate) are contacted, with appropriate consent (see 2.3), to provide relevant information within seven days to ensure continuity of care.

1.3.3 Information from health assessments undertaken is drawn together into a single onsite health record for the young person.

1.3.4 Once consent has been obtained (see 2.3) relevant information is shared with staff working with the young person to ensure that all agencies (health and others) are fulfilling their responsibilities to promote health and wellbeing (see 10.3). Any health issue that would have an impact on restraint is shared with relevant staff (see 3.7).

1.4 **Young people understand and are fully involved in their health assessments.**

1.4.1 Consent is sought for each assessment by the assessor (see 2.3). If part or all of the assessment is refused, the reason why is recorded in the young person’s health record and repeated attempts are made to complete the process if considered essential.

1.4.2 The assessor checks that the young person understands the purpose of the assessment and possible outcomes as fully as possible before it is conducted. During assessment young people’s views are actively sought and recorded and the young person receives feedback on the outcome of their assessment and the next steps at the end of the assessment.
Young people receive a timely, comprehensive and holistic health assessment with an emphasis on integrated personalised needs assessment and care 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).


1.5.2 The assessment is completed by a healthcare professional with, where appropriate, referral to a substance misuse specialist or other identified specialist, trained to assess for health needs in young people in a secure setting.

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

1.5.4 The mental health assessment includes: depression, self-harm, suicide, anxiety, post-traumatic stress, psychoses, and eating disorders.

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

1.5.6 The neurodisability assessment includes: traumatic brain injury, speech, language and communication impairment, attention deficit hyperactivity disorder, learning disabilities and educational needs, and autistic spectrum disorder.

1.5.7 All health assessments are reviewed annually and the mental health assessment is reviewed within three months of arrival to ascertain whether the young person’s needs have changed and if the assessment should be repeated with a view to adapting the care plan to meet altered needs. Guidance: The health assessment is not a one-off event, but part of a continuing action plan to ensure the young person’s health needs are being met effectively.

1.6 There is a clear pathway for managing referrals where a health need is indicated.

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

1.6.2 Referrals can be received from anyone working with the young person, including officers, care staff, education staff, health staff, parents/carers, youth offending teams, social services and young people.
2 Care Planning

‘My healthcare plan needs to be based on my individual needs and care’

‘They don’t take us seriously, they don’t care’

‘Listen to what we are saying, we should be involved’
2.1 Each young person has a named lead healthcare professional who coordinates their healthcare.

2.1.1 The lead 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, and substance misuse specialists.

2.1.2 The young person’s lead healthcare professional ensures that the young person’s health assessment and healthcare plan are completed and acts as the key contact point in relation to the young person’s health.

2.1.3 The lead healthcare professional, and other healthcare practitioners involved in the young person’s care where appropriate, attends the young person’s initial planning meeting and, where required, subsequent review meetings.

2.2 Each young person has a comprehensive and holistic healthcare plan within ten days of their arrival in the secure setting, demonstrating an integrated approach to physical health, mental health, substance misuse and neurodisability. The healthcare plan is not an isolated event, but part of a continuous process, with emphasis placed on ensuring actions in the healthcare plan are being taken forward and monitored at regular intervals.

2.2.1 The healthcare plan is integrated and aligned with, where applicable, the young person’s looked after child, education, sentence, care and transition plans. **Guidance:** There is a collaborative approach to care planning and delivery and healthcare plans are developed and reviewed by the multidisciplinary team of professionals and agencies working with the young person.

2.2.2 Healthcare plans are informed by the young person’s health assessment and set out the objectives, actions, timescales (appropriate to length of stay) and the responsible person.

2.2.3 The healthcare plan is developed in collaboration with the young person and, where appropriate, with the young person’s parents/carer.

2.2.4 The healthcare plan takes account of what happens to the young person both before and after their time in the secure setting as well as the time spent in the secure setting.

2.2.5 The young person’s lead healthcare professional meets with the young person 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 young person’s health needs.

2.3 There are clear procedures for gaining consent to health assessments and interventions.

2.3.1 Consent is sought and reviewed on a regular basis for each proposed assessment and intervention by the healthcare practitioner who will carry it out. This is documented in the young person’s health record.
Assessments of young people’s capacity to consent are made in accordance with the relevant legal principles and recorded in their health record. **Guidance:** Young people aged 16 and 17 are presumed in law to have capacity to give consent for themselves, unless it is established that they lack capacity (the Mental Capacity Act 2005 (England and Wales) and Adults with Incapacity Act 2000 (Scotland) apply to young people over 16).

Young people under 16 can give consent, but only if they are able to fully understand what is proposed (in Scotland, anyone aged 12 or over is legally presumed to have such competence). An assessment of capacity to consent must be undertaken when a young person is under the age of 16 and does not want to involve parents/carers. Where young people are not able to give consent, their views are ascertained as far as possible and taken into account, and the legal basis for giving the proposed treatment is recorded, for example, consent from someone with parental responsibility or treatment in the young person’s best interests. Where a young person lacks the capacity to make decisions for him or herself, someone with parental responsibility should, wherever possible, be involved in decision-making on the young person’s behalf.

**2.3.2** Assessments of young people’s capacity to consent are made in accordance with the relevant legal principles and recorded in their health record.

**2.3.3** Healthcare practitioners are proficient in assessing a young person’s ability to consent and are aware of possible cultural issues and communication difficulties.

**2.4** Young people receive prompt healthcare and intervention to improve their health outcomes.

**2.4.1** Access and waiting times following referrals of young people in secure settings take into account the length of time the young person is in the secure setting and are at least equivalent to those experienced by young people in the local population.

**2.4.2** Young people are not unnecessarily restricted by security procedures to attend healthcare appointments (internally or externally) or receive emergency care (see 3.3). Security measures are appropriately risk-assessed and proportionate.

**2.5** Young people experience collaborative and consistent healthcare.

**2.5.1** All health interventions are delivered by healthcare practitioners trained to deliver the intervention.

**2.5.2** Young people have regular discussions with healthcare practitioners about their progress and these are recorded in their health record. **Guidance:** Young people are asked about how they feel they are doing in relation to their goals and any problems with interventions are addressed and recorded.

**2.5.3** Young people consistently see the same specialist healthcare practitioner for intervention, unless their preference or clinical need demands otherwise.
3 Universal Health Services

'A nurse comes in everyday, so you can access healthcare very easily, if you have a problem'

'Access to a gym helped me to learn more about being healthy'

'They think a paracetamol solves everything'

'I know I have to have handcuffs on when I go to hospital but everyone's looking at you. They should have a room for us to wait in so people can't look at you'
### 3.1 Young people have access to the services and support they need to meet their health and wellbeing needs including physical health, mental health, substance misuse and neurodisability.

#### 3.1.1 Young people in secure settings have access to primary care provision which is equivalent to the services available to young people in the community. This includes: general medical services, general dental services and general optical services.

#### 3.2 Such services may provide directly, or ensure appropriate referral to, services for:

- routine immunisations;
- sexual and reproductive health services;
- substance misuse services;
- child and adolescent mental health services;
- disabilities services;
- psychological services and counselling;
- community health services, including allied health professional services (including physiotherapy, podiatry, audiology and speech and language therapy);
- health promotion and lifestyle advice services (including nutritional support, smoking cessation and physical activity); and
- acute services for assessment, diagnosis and follow-up.

### 3.2 Young people know how to access health services while they are in the secure setting.

#### 3.2.1 During induction, young people are informed how to access health services while they are in the secure setting, in a format and language they understand.

*Guidance:* Staff check that the young person has understood the information given to them and the young person has the opportunity to ask for clarification or help in understanding it.

#### 3.2.2 Young people are informed of their right to confidentiality and the limits of this under safeguarding and child protection to protect the young person and others from harm (see 10.3 and 10.4).

#### 3.2.3 An effective appointment system is in operation, which ensures appointments are available at reasonable times and locations that are convenient for the young person. ‘Did not attend’ are monitored and reviewed to identify where access difficulties exist.


#### 3.2.4 Young people are treated with respect in a professional, friendly and caring manner.
3.3 Young people have access to 24-hour emergency medical (physical and mental) and dental services.

3.3.1 A member of staff trained in first aid and cardiopulmonary resuscitation is present in the secure setting at all times.

3.3.2 Out of hours and emergency cover is well organised, responsive and effective.

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

3.4 The secure setting has a comprehensive medicines management policy in place.

3.4.1 The policy includes processes to ensure:
- medicines are prescribed safely and in line with current evidence-based practice and local protocols, including disease management guidelines;
- all medication prescribed to young people is recorded on their health record and the secure setting’s medication log;
- all supervised medicines are administered safely and in line with professional accountabilities appropriate to the secure setting but always by individuals with appropriate medicines management training and overseen by a qualified nurse;
- adverse effects are monitored and any interactions identified are responded to promptly; and
- all medicines are stored, handled and disposed of safely and securely with safe pharmaceutical stock management and use.

3.4.2 There is a documented risk assessment of the medication and the young person before self-administration of medication is considered. Young people 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 young people.

3.4.3 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; and
- the secure setting has access to specialist pharmacy support and advice.
3.5 There is a comprehensive health promotion strategy in place across the secure setting.

3.5.1 The strategy:
- is linked to the secure setting’s overall health strategy (see 9.1);
- includes: (a) mental health promotion and well-being (b) smoking cessation/reduction (c) healthy eating and nutrition (d) healthy lifestyles including sexual health and relationships (e) drugs and alcohol (f) exercise (g) oral health (h) coping with being in a secure setting;
- is overseen by a group which includes health, education, facilities and catering, physical education, young people and senior management;
- reflects current practice and includes a mechanism for review, evaluation and feedback; and
- facilitates an individual, less formal and opportunistic approach to health promotion, responding to young people when they are receptive to health messages across the secure setting.

3.5.2 Health promotion materials are up to date and developmentally and age appropriate.

3.6 Effective systems are in place to identify and support all young people who are parents or expectant parents.

3.6.1 Education on childcare and child development is provided for all young parents and potential young parents.

3.7 Young people receive support from a healthcare professional after restraint procedures.

3.7.1 Officers and care staff are informed and updated by the young person’s named lead healthcare professional of any relevant issues (physical or psychological) including those arising from a young person’s personal and medical history that may have an impact on a young person’s safety and wellbeing if they are restrained.

3.7.2 The advice of a healthcare professional is sought before all planned restraint procedures occurring within normal working hours and out of hours when healthcare staff are onsite.

3.7.3 Young people subject to restraint procedures are encouraged to see a healthcare professional as soon as possible after restraint and any injuries sustained are fully documented.
4 Physical Health Care and Intervention

"It's hard to get access to healthcare, a doctor, to the dentist; it's difficult to access a doctor in the weekends."

"Waited three months to see doctor about my acne and then three weeks for cream."

"The dentist comes every two weeks; put my name down and no one calls you."

"I'm allergic to peanuts; they tried to stop me from doing cookery. I'm not stupid, I won't have peanuts again."

Healthcare Standards for Children and Young People in Secure Settings
4.1 Each secure setting has a comprehensive physical health strategy outlining the contributions of all staff to supporting and improving the physical health and well-being of young people and acknowledging the close relationship between mental and physical health.

4.1.1 The strategy incorporates a multi-disciplinary approach and is part of the secure setting’s health strategy (see 9.1).

4.2 The secure setting has access to, and receives support from, a multidisciplinary physical healthcare team appropriate to the needs of the young people.

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

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

4.3 Before intervention begins, physical health need is assessed (see 1.5), a healthcare plan is developed (see 2.2) and consent is sought (see 2.3).

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

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

Guidance: Young people have access to specialist clinics for long term conditions, for example, asthma, diabetes and epilepsy.

4.4.2 There are formal arrangements with local health and social care agencies for the loan of occupational therapy equipment and specialist advice to ensure young people are able to access mobility, communication and health aids.

4.4.3 Pharmacological treatment is delivered in accordance with clinical guidelines and local protocols and prescribing of drugs is audited annually.

4.4.4 Young people with skin conditions, including acne, dry skin, dermatitis and eczema, receive appropriate advice and treatment from healthcare professionals.

4.4.5 Young people’s physical health is monitored including growth and nutrition and screening for defects of vision or hearing.

Guidance: The weight, height and body mass index of young people are monitored, looking for physical signs of nutritional deficiencies and young people who are under or overweight.
4.5 Young people are cared for by a dental health service that assesses and meets their needs.

4.5.1 Young people have timely access to dental checks and treatment including orthodontics where appropriate.

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

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

4.6.2 Young people are offered vaccinations appropriate to their age and need, as set out under national guidance for immunisations and vaccinations. *Guidance: UK routine childhood immunisation programme, ‘Immunisation Against Infectious Disease: the Green Book’ Department of Health, 2013.*

4.7 Young people have access to confidential advice and education about safer sexual practices and contraception within the context of relationships.

4.7.1 Young people have access to appropriate contraception in the secure setting.

4.7.2 Young people have access to screening and treatment programmes for sexually transmitted infections.

4.8 Young women are provided with a choice of sanitary products to meet individual needs.

4.9 Antenatal and postnatal services equivalent to those provided in the community are available for pregnant young women.

4.9.1 Pregnant young women have access to a midwife.

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

4.9.3 Pregnant young women receive information about avoiding substances (drugs, alcohol and smoking), healthcare professionals document in the young person’s health record if there is a history of substance misuse in pregnancy and appropriate interventions are offered.
5 Mental Health and Neurodisabilities Care and Intervention

‘Building bridges (CAMHS programme) is very good – you can either request it or have your case worker refer you’

‘Eye movement therapy was really helpful for my concentration’

‘Been asking to see CAMHS and been waiting a month’
| 5.1 | Each secure setting has a comprehensive mental health and neurodisability strategy outlining the contributions of all staff to supporting and improving the mental health and well-being of young people. |
| 5.1.1 | The strategy incorporates a multi-disciplinary approach and is part of the secure setting’s health strategy (see 9.1). |
| 5.2 | The secure setting has access to, and receives support from, a multidisciplinary Child and Adolescent Mental Health Service (CAMHS) team appropriate to the needs of the young people. |
| 5.2.1 | The secure setting receives consultation, advice and training from a CAMHS team. |
| 5.2.2 | There is timely access to dedicated CAMHS psychiatric and psychological input; and through CAMHS access to other professional input including occupational therapists, primary mental health workers and forensic CAMHS. |
| 5.2.3 | There is a named lead mental healthcare professional responsible for overseeing mental health provision within the secure setting. |
| 5.3 | Before intervention begins, mental health and neurodisability need is assessed (see 1.5), a healthcare plan is developed (see 2.2) and consent is sought (see 2.3). |
| 5.4 | A range of evidence-based mental health interventions is offered and delivered according to individual needs. |
| 5.4.1 | Care of young people on medication, with a diagnosis of serious mental illness and complex cases (taking account of accumulating or multiple needs which may not individually meet thresholds) takes place within the Care Programme Approach (CPA). The CPA is continued for those young people subject to CPA on entry to the secure setting. **Note:** Not applicable in Northern Ireland where care plans are used instead. |
| 5.4.2 | Pharmacological treatment is delivered in accordance with clinical guidelines and local protocols and prescribing of psychoactive drugs is audited annually, including drugs for attention deficit hyperactivity disorder and antidepressants. |
| 5.4.3 | Practitioners actively engage parents/carers in care and interventions, where appropriate. |
| 5.4.4 | Practitioners support young people to take responsibility for their actions and nurture their independence as part of their therapeutic plan. |
| 5.4.5 | Specific interventions are offered for managing severely difficult behaviour. |
| 5.4.6 | Specific interventions are offered for managing sexually disinhibited and harmful behaviour. |
5.5 A range of evidence-based neurodisability interventions is offered and delivered according to individual needs.

5.5.1 This includes interventions for:
- traumatic brain injury;
- speech, language and communication difficulties;
- attention deficit hyperactivity disorder;
- learning disabilities and educational needs; and
- autistic spectrum disorder.

5.6 Young people at risk of self-harm or suicide are provided with individual care and support.

5.6.1 Personal factors or significant events which may be a trigger to self-harm are identified in the young person’s healthcare plan and discussed with officers/care staff.

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

5.6.3 All incidents of self-harm or attempts to self-harm are recorded and routinely referred to the named safeguarding lead (see 10.4).

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

5.7 Young people with serious and complex problems are transferred (under the Mental Health Act 2007 (England and Wales), Mental Health (Care and Treatment) (Scotland) Act 2003 or Mental Health (Northern Ireland) Order 1986) if clinically indicated to inpatient units that meet their individual needs with effective continuing care.

5.7.1 The supporting CAMHS team is aware of the referral criteria and process for access to the Adolescent Forensic Mental Health In-patient Service, and have the contact details for their closest unit so potential referrals can be discussed at the earliest opportunity.

6 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’
6.1 Each secure setting has a comprehensive substance misuse strategy outlining the contributions of all staff to reducing the risk of substance related harm for young people.

6.1.1 The strategy incorporates a multi-agency approach and is part of the secure setting’s health strategy (see 9.1). **Guidance:** The strategy is developed in conjunction with the substance misuse commissioner/service planner.

6.1.2 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 young person.

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

6.2.1 The secure setting receives consultation, advice and training from substance misuse specialist staff.

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

6.2.3 There is a clear protocol which clearly states the roles and responsibilities of substance misuse specialist staff and other healthcare staff and details expectations around information sharing and transitions/handover (see 10.1).

6.3 Young people have access to substance misuse education, prevention activities and advice and information to reduce the risk of substance related harm.

6.3.1 A universal drugs education programme is in place covering legal and illegal drugs and substances (including alcohol, tobacco, and solvents) (see 3.5).

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

6.4 Before intervention begins, substance misuse need is assessed (see 1.5), a healthcare plan is developed (see 2.2) and consent is sought (see 2.3).
6.5 A range of evidence-based substance misuse interventions is offered and delivered according to individual need.

6.5.1 A range of psychosocial and pharmacological interventions from harm reduction to abstinence is offered with a focus on strengthening protective factors in order to improve resilience.
   **Guidance:** ‘Practice Standards for Young People with Substance Misuse Problems’ Royal College of Psychiatrists, 2012.

6.5.2 Pharmacological treatment is delivered in accordance with clinical guidelines and local protocols and prescribing for drug misuse is audited annually.

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

6.5.4 Practitioners actively engage parents/carers in care and interventions, where appropriate.
7 Transfer and Continuity of Care

‘Health records are passed on from previous institutions, which is good’

‘Transition to adult prison, big jump’
ALL TRANSFERS

7.1 The young person’s lead healthcare professional (see 2.1), in conjunction with other healthcare practitioners involved in the young person’s care, reviews the young person’s healthcare plan prior to transfer.

7.1.1 The review identifies any outstanding actions and ongoing or new health needs or risks of harm to self or others.

7.2 Each young person has a holistic health transition plan which includes physical health, mental health, substance misuse and neurodisability and is integrated with their overall transition plan.

7.2.1 The health transition plan is informed by the review of the young person’s healthcare plan and sets out the responsibilities of, and the services to be delivered by, the relevant health services post transition.

7.2.2 The health transition plan is developed in conjunction with the young person and, where possible, with their parents/carers and the young person understands the health transition arrangements that are in place.

7.2.3 The young person’s lead 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.

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

7.3.1 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 young person does not attend.

7.3.2 Information is shared effectively, with consent (see 2.3), to enable treatment to continue. Guidance: Full case histories are sent to the new service prior to the young person’s first appointment.

7.3.3 Young people and parents/carers are provided with information, in a format and language they understand, on what to expect after transfer to the new service and who to contact if there is a problem.

7.3.4 Young people have an adequate supply of any current medication to last until follow-up can occur, together with information on storage of the medication. Arrangements are in place if the young person is to be discharged with controlled drugs.

7.4 The secure setting records any instances where transition practices compromise the health and welfare of the young person and these records are passed to the relevant host and home Local Safeguarding Children Board/Child Protection Committee, regulatory body or health commissioner/service planner.
TRANSFERS TO THE COMMUNITY

7.5 A summary of the young person’s health record including any recommendations for future care (health discharge summary) is sent to the young person’s GP and any other relevant agencies (including looked after children health professionals and youth offending team where appropriate) and a copy is given to the young person and, where appropriate, their parents/carers.

7.6 The young person and, where appropriate, their parents/carers are provided with information about how and why to register with community health services, including: a GP, dentist, optician, sexual health services, substance misuse services and other community health services on release.

7.7 Pre-release harm-minimisation programmes (alcohol, smoking and drugs) are offered to young people to raise awareness of the dangers of post-release drug use and the risks of overdose.

7.8 Appropriate contraception and advice on safer sexual practices is offered and provided for young people leaving the secure setting.

TRANSFERS TO ANOTHER SECURE SETTING OR THE ADULT JUSTICE SYSTEM

7.9 A summary of the young person’s health record including any recommendations for future care (health discharge summary) is sent to the GP and healthcare manager at the new secure setting/adult prison and any other relevant agencies.

7.10 Consideration is given to a young person’s healthcare and any assessments and treatment when a transfer between secure settings/to adult prison is planned.
There should be a different young people’s health section to the adults; obviously this would take time, money and years.

"If you tell them you’re not well then you’ll get stopped from using the gym - others will know."
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>8.1</td>
<td><strong>Health services are delivered in locations which are safe, fit for purpose and have the necessary facilities to meet young people’s needs.</strong></td>
</tr>
<tr>
<td>8.1.1</td>
<td>Secure settings have a dedicated room for healthcare (screenings, assessments, consultations, information, treatment and intervention).</td>
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<tr>
<td>8.1.3</td>
<td>The locations where health services are delivered ensure the young person’s privacy and confidentiality.</td>
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<tr>
<td>8.1.4</td>
<td>Locations used by health services are accessible to all young people, including those who have disabilities.</td>
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<tr>
<td>8.1.5</td>
<td>There is a system in place so that healthcare practitioners can summon help in an emergency (medical and security).</td>
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<tr>
<td>8.2</td>
<td><strong>All health equipment is safe, appropriate and meets standards laid down by the regulatory bodies.</strong></td>
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<tr>
<td>8.2.1</td>
<td>All health equipment is regularly checked, logged and maintained and staff understand how to access and use it effectively.</td>
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<tr>
<td>8.2.2</td>
<td>First aid and resuscitation equipment and an automated external defibrillator are provided in key locations as appropriate following completion of a risk assessment.</td>
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<tr>
<td>8.2.3</td>
<td>Medical supplies are regularly checked and logged with sufficient stocks maintained.</td>
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<tr>
<td>8.3</td>
<td><strong>There are comprehensive infection control procedures in place.</strong></td>
</tr>
<tr>
<td>8.3.1</td>
<td>There are regular infection control audits.</td>
</tr>
<tr>
<td>8.3.2</td>
<td>Systems are in place for the handling and disposal of waste to minimise risk to young people and staff.</td>
</tr>
<tr>
<td>8.3.3</td>
<td>The locations used by healthcare undergo cleaning in line with the relevant nationally defined standards.</td>
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9 Planning and Monitoring

'The healthcare we get inside should be like the healthcare we get outside'

'Cos we're young people they don't prioritise us as they only care about the mains, and the older lads, they don't listen to us'

'Listen to what we say, take it seriously'
9.1 **There is a clear role for health services in the secure setting that is set out in a comprehensive health strategy for the secure setting.**

9.1.1 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.

9.1.2 The health strategy incorporates the: physical health strategy (see 4.1), mental health and neurodisability strategy (see 5.1), substance misuse strategy (see 6.1) and health promotion strategy (see 3.5) and links to the medicines management policy (see 3.4), communicable disease policy (see 4.6) and emergency medical and dental plan (see 3.3) and links to the secure setting’s safeguarding and information sharing policies.

9.1.3 Implementation of the strategy is monitored and reviewed annually in consultation with staff and young people.

9.2 **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 young people in the secure setting.**

9.2.1 Service planners/providers/commissioners and the Governor/Director/Manager of the secure setting are aware of their responsibilities and duty of care for the health and wellbeing of the young people under current legislative, regulatory and quality frameworks.

9.2.2 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.

9.2.3 The Governor/Director/Manager ensures that the secure setting is involved in strategic health planning and decision making.

*Guidance: In England secure settings are linked with the Local Health and Wellbeing Board joint strategic needs assessment process.*

9.3 **Service planning/commissioning is responsive to the needs of the young people in the secure setting.**

9.3.1 The views of young people and their parents/carers are sought and taken into account in commissioning, planning, delivering and improving health services in the secure setting. Formal procedures are in place to ensure their involvement and such involvement is documented accordingly.


9.3.2 A health needs assessment for the secure setting (reviewing physical, mental, substance misuse and neurodisability health needs facing the secure setting’s population) is completed and reviewed every two years, using a structured assessment tool, by the service planners/providers/commissioners in conjunction with the secure setting.

*Guidance: Child and Maternal Health (ChiMat) Youth Justice Health and Wellbeing Needs Assessment Toolkit.*
9.3.3 The health 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.

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

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

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

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

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

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

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

9.5.2 Managers ensure that appropriate audit data is collected in order to conduct regular and meaningful evaluations of service delivery and outcomes. **Guidance:** England: substance misuse activity data is reported into the National Drug Treatment Monitoring System.

9.5.3 Young people are involved in reviewing healthcare provision in the secure setting.
'We have a very good complaints procedure which goes straight to the manager. We are told about the solution, even though that could be a month later.'

'How do you know what you share with healthcare won’t be talked about with others?'

'A complaints box that an independent person, like you, has access to'
10.1 The secure setting works closely with, and has access to, a range of services and agencies appropriate to the health needs of the young people in the secure setting.

10.1.1 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 around information sharing.

10.1.2 There is regular documented dialogue, such as case or multidisciplinary meetings, between representatives from all relevant agencies involved in the young person’s care.

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

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

10.2.2 Young people’s health records are readily accessible to all relevant professionals working with the young person, subject to protocols and procedures in relation to confidentiality and the application of the data protection act. 

   **Guidance:** There is an electronic records system.

10.2.3 Healthcare practitioners receive regular training in the appropriate management of young people’s health information.

10.2.4 There is a regular management check on the quality of health record entries.

10.3 Young people receive care from services that work collaboratively to ensure that the team working around the young person has all of the information they need to meet the young person’s health and wellbeing needs in a way that preserves the young person’s privacy and confidentiality.

10.3.1 Healthcare practitioners have a copy of and understand the secure setting’s information sharing policy, including the young person’s rights to confidentiality, systems to ensure that appropriate consent is obtained from each young person in relation to the use of their confidential information, and the circumstances in which information can be shared with third parties, including those with parental responsibilities.


10.3.2 Healthcare practitioners clearly explain to young people what type of information will be shared and with who, seek their consent (see 2.3) and discuss with the young person what will happen in the event that they need to breach confidentiality.

   **Guidance:** Young people are informed when confidential information about them is to be passed on to other services and agencies, and the reasons why this is important to their continuing care are explained. Where there is concern that the young person may be suffering or is at risk of harm, the young person’s safety and welfare must be the overriding consideration.
10.3.3 Healthcare practitioners record, in the young person’s health record, the reason for sharing any information without consent.

10.3.4 Subject to consent, the parents/carers of the young person or other person designated by the young person are informed of the state of health of the young person on request and in the event of any important changes in the health of the young person.

10.4 Young people are protected from abuse through clear safeguarding policies and procedures.

10.4.1 The secure setting has a written safeguarding policy which is compliant with statutory duties, Government guidance and has been agreed by the Local Safeguarding Children Board (LSCB)/Child Protection Committee. The policy covers: child protection, suicide and self-harm prevention, bullying and violence reduction, young people who struggle to cope in custody, all aspects of behaviour management, public protection, staff recruitment, suspension and training, information sharing, use of separation/segregation, restraint, strip-searching and the duty of staff to see and act on warning signs.

10.4.2 The safeguarding policy is jointly reviewed and monitored by a safeguarding committee which meets regularly and includes representation from the LSCB/Child Protection Committee and senior staff from all departments including healthcare in the secure setting.

10.4.3 All healthcare practitioners 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 LSCB/Child Protection Committee policies and procedures, through the secure setting’s named safeguarding lead or the designated nurse/doctor for safeguarding children in the locality).


10.5 Young people understand how to make complaints about healthcare.

10.5.1 Complaints procedures are well-publicised and young person friendly and staff explain to all young people how to use them.

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

10.5.3 Responses to complaints relating to health services are dealt with by a healthcare professional and are timely, easy to understand and deal directly with the young person’s concerns.

10.5.4 There is a young people’s forum that is representative of the secure setting’s population. Young people who are representatives are supported by staff to ensure they are able to play a full and active role.
'Can always ask the doctor or nurse about health, if I need to'

'The midwife was easier to talk as it did not feel like she was part of the prison'

'They should just sit down for a cup of tea with us, chat and stuff, then they’ll find out how we are'

'There’s only a few people here we can talk to'
ALL STAFF WORKING WITH YOUNG PEOPLE IN SECURE SETTINGS

11.1 Staff working with young people receive training in safeguarding and child protection.

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

11.3 Staff working directly with young people receive training on child and adolescent development.

11.3.1 Staff are aware of the key factors affecting child and adolescent health and wellbeing and of the common health problems of young people in secure settings. Guidance: This includes: the impact of trauma, neglect, attachment theory, mental health problems, management of long term physical conditions, neurodisabilities, speech, language and communication difficulties, anti-bullying practices and policy, and conflict management and de-escalation.

11.3.2 Staff are able to recognise behaviours that indicate a heightened risk and know how to access health advice for young people in the secure setting. Guidance: Staff are aware of local health contacts and referral pathways.

ALL HEALTHCARE PRACTITIONERS IN SECURE SETTINGS

11.4 There are appropriately qualified and skilled healthcare staff to meet the needs of the young people in the secure setting.

11.4.1 Healthcare practitioners are trained to work with young people in challenging circumstances. Guidance: Healthcare practitioners have enhanced training in child and adolescent development and understand the particular health needs of young people in secure settings.

11.4.2 Healthcare practitioners are able to operate safely within the secure setting. Guidance: Healthcare practitioners understand the basic local security and emergency procedures.

11.4.3 Healthcare professionals are compliant with the ‘Looked after children: Knowledge, skills and competences of health care staff’ Intercollegiate Role Framework (2012) at level 3.

11.4.4 Healthcare professionals are compliant with the ‘Safeguarding Children and Young people: roles and competences for health care staff’ Intercollegiate Document (2010) at level 3.

11.4.5 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.

11.4.6 Healthcare professionals conduct their work within the same ethical and good practice codes as bind their colleagues in health services in the wider community.
### 11.5 Healthcare practitioners have an annual appraisal and receive clinical and managerial supervision.

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

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

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

11.6.1 This includes training and guidance, where applicable to the role and setting, on:
- Evidence based practice;
- Policies and procedures around consent, information sharing and confidentiality;
- Young people’s rights and legislation;
- Safeguarding children;
- Diversity and equality;
- Communicating with young people.

### 11.7 Healthcare practitioners provide appropriate support to staff working with young people in the secure setting to foster a culture of multidisciplinary working and partnership and ensure the whole secure settings operates as a health promoting environment.
Acknowledgements

We would like to thank all those who have contributed to the development of these standards, particularly the members of the Project Board and the Expert Working Groups and everyone who responded to the consultation or attended one of the consultation meetings.

We would also like to thank all the young people for sharing with us their insights and experiences of healthcare in secure settings. The young people’s participation would not have been possible without the help and support of the staff at the settings we visited – thank you.

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Naomi Black           Designated Nurse for Children in Care, Southern Health NHS Foundation Trust
Steven Boyd           Speech & Language Therapist, Hindley Young Offenders Institution
Dr Denise Carroll     Research and Development LAC Specialist Nurse, Kibble Education and Care Centre, LAAC Nurse Forum
Dr Lee Hudson         Consultant Paediatrician
Howard Jasper         Youth Justice Board
Dr Phil Mackie        Faculty of Public Health
Dr Elizabeth O'Sullivan  Consultant in Paediatric Dentistry, British Society of Paediatric Dentistry
Dr Rebecca Salter     Consultant Paediatrician
Dr Amanda Smith       Executive Director of Therapies and Health Science, Powys Teaching Health Board

Mental health and neurodisabilities care and intervention
Dr Adrian Worrell (Chair)  Royal College of Psychiatrists
Dr Nick Hindley      Child and Adolescent Forensic Psychiatrist, Adolescent Forensic Special Interest Group, Royal College of Psychiatrists
Dr Daphne Keen  Consultant Paediatrician
Lorraine Khan  Centre for Mental Health
Dr Paul Mitchell  Clinical Lead, Hindley Youth Custody Centre Mental Health Team
Dr Alison Shaw  CAMHS, Cwm Taf Health Board
Professor Huw Williams  Associate Professor in Clinical Neuropsychology, University of Exeter

**Substance misuse care and intervention**
Dr Adrian Worrell (Chair)  Royal College of Psychiatrists
Sam Cox  National Treatment Agency/Public Health England
Professor Éilish Gilvarry  Consultant Psychiatrist
Dr Jake Hard  Royal College of General Practitioners, Secure Environments Group
Dr Kah Mirza  Consultant Psychiatrist

**Transfer and continuity of care**
Howard Jasper (Chair)  Youth Justice Board
Dr Marcus Bicknell  Royal College of General Practitioners, Secure Environments Group
Charlotte Levene  Young Minds
Dr Andrew Rogers  Consultant Clinical Psychologist
Dominic Stevens  Youth Justice Board
Ken Wilkinson  National Offender Management Service

**Healthcare environment and facilities**
Sue Eardley (Chair)  RCPCH
Cathy Cooke  Secure Environment Pharmacists Group
Fergus Currie  Care Quality Commission
Sally Handley  Senior Public Health Manager, NHS Nottinghamshire County
Ellie Lewis  National Children’s Bureau
Dr Phil Mackie  Faculty of Public Health

**Planning and monitoring/Multiagency working**
Dr Rosalyn Proops (Chair)  RCPCH
Julie Dhuny  North East Offender Health
Trish Dubrowski  Strategic Lead for Children and Young People, NHS South of England
Janet Finucane  
Strategic Deputy Head of Offender Health Commissioning, NHS Greater Manchester

Louise Hagger  
Designated Nurse Looked After Children/Named Nurse Safeguarding Children, NHS North East Essex

Pam Hibbert  
Standing Committee for Youth Justice

Dr Nick Lessof  
Consultant paediatrician

Gary Risdale  
Service Manager, Prison Child & Adolescent Mental Health, North Bristol NHS Trust

**Staffing and training**

Howard Jasper (Chair)  
Youth Justice Board

Dr Ann Lorek  
Consultant paediatrician, British Paediatric Mental Health Group

Dr Heather Payne  
Senior Medical Officer, Maternal and Child Health, Welsh Government

Ian Williams  
National Offender Management Service
Consultation responses

Birmingham City University
British Association for Adoption and Fostering
British Society of Paediatric Dentists
Centre for Mental Health
Kibble Education and Care
Lakewood Centre
Lifeline Eclypse, Children, Young People and Family Service
NHS Commissioning Board
NHS North Yorkshire and York: Designated Nurses and Designated Doctors for Looked after Children and Young People
Norfolk Youth Offending Team
Northumberland Tyne and Wear NHS Foundation Trust - Children and Young People's Specialist Services
Northumberland Tyne and Wear NHS Foundation Trust - Consultant Child and Adolescent Psychiatrist
North West Regional Healthy Care Partnership
Powys Teaching Health Board
Royal College of Psychiatrists (Child and Adolescent Psychiatry Faculty and Adolescent Forensic Psychiatry Special Interest Group)
Royal College of Speech and Language Therapists
Sheffield Children's Hospital NHSF Trust
South Eastern Health and Social Care Trust
South West Yorkshire Partnership NHS Foundation Trust Forensic CAMHS
St Mary's Kenmure Secure Unit
Young Minds
Youth Justice Board

Delegates at Consultation Meetings

Kirstin Barnes  Head of Reducing Re-Offending, HM YOI Wetherby
Dee Bunker  Healthcare Manager, Oakhill Secure Training Centre
Amanda Caldicott  Head of Health Services, HM YOI Cookham Wood
Dr Denise Carroll  LAAC Nurse Forum
Julie Constable  Lead Nurse, Hassockfield Secure Training Centre
Fergus Currie  Care Quality Commission
George Dodds  HM YOI Hindley
Nicola Ellis  Offender Health Commissioning Manager, Lancashire LAT
Rosalind Godson  Unite/CPHVA
Juliette Gregory  Speech and Language Therapist, Criminal Justice Clinical Lead, Leeds Community Healthcare NHS Trust
Louise Hagger  Designated Nurse Looked After Children/Named Nurse Safeguarding Children, NHS North East Essex
Amy Harker  The Communication Trust
Emma Herbert  Youth Justice Board
Pam Hibbert  Independent
Helen Hipkiss  Head of Adult and Child Safeguarding, Midlands and East Strategic Health Authority
Paul Houldey  Healthcare Contract Manager, G4S Secure Training Centres
Chris Jewesbury  NHS Commissioning Board
Gareth Jones  Association of YOT Managers
Abdullah Kraam  Royal College of Psychiatrists
Louise Large  Sheffield YJS/LAC care leavers
Dr Nick Lessof  Consultant paediatrician
Nicola Rabjohns  HM Inspectorate of Prisons
Dawn Rees  Office of Children’s Commissioner
Deborah Reilly  Deputy Designated Nurse - Looked after children, Leeds Community Healthcare NHS Trust
Wayne Sivyer  National Treatment Agency for Substance Misuse
Dr Clare Snodgrass  Clinical Lead, Mental Health, HM YOI Wetherby, Leeds Community Healthcare NHS Trust
Dr Lynn Snow  Designated Doctor Looked After Children, Sheffield Children’s Hospital NHS Foundation Trust
Kim Turner  Speech and Language Therapist, HM YOI Feltham
Neil Watson  YPSMS Manager, HM YOI Wetherby
Dr Oliver White  Consultant Child and Adolescent Forensic Psychiatrist, Southern Health NHS Foundation Trust
Louise Wilkinson  Child Brain Injury Trust
Rowena Williams  Offender Health Lead, NLIAH, NHS Wales
Appendix 1

Dates and locations of the focus groups held with young people in secure settings:

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 August 2012</td>
<td>Eastwood Park Young Offenders’ Institution</td>
</tr>
<tr>
<td>22 August 2012</td>
<td>Wetherby Young Offenders’ Institution</td>
</tr>
<tr>
<td>23 August 2012</td>
<td>Clayfields House</td>
</tr>
<tr>
<td>27 February 2013</td>
<td>Rainsbrook Secure Training Centre</td>
</tr>
<tr>
<td>1 March 2013</td>
<td>Parc Young Offenders’ Institution</td>
</tr>
<tr>
<td>8 March 2013</td>
<td>Woodlands Juvenile Justice Centre</td>
</tr>
<tr>
<td>15 March 2013</td>
<td>Kibble Secure Unit</td>
</tr>
</tbody>
</table>
Appendix 2

Poster for young people in secure settings

Your health matters to us!

This means:

You will have a health check-up when you arrive

You will have a nurse or doctor who you can talk to about your health

You know how to get an appointment with a doctor, nurse, dentist and optician

You will be listened to and involved in decisions about your health

You know how to get help about smoking, drugs, alcohol and mental health

You will be treated by respectful and caring staff that are properly trained to work with you

You can see a doctor or nurse after any restraint incident

You will receive the right medicines at the right time

You know how to raise concerns about your healthcare

You will be treated fairly and taken seriously


Royal College of Paediatrics and Child Health
Royal College of General Practitioners
Royal College of Nursing
Royal College of Psychiatrists
Faculty of Forensic and Legal Medicine
Faculty of Public Health

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