CYPSS Healthcare Provision Overarching Specification

Secure Settings for Children and Young People

(Under 18s)

NHS England and NHS Improvement

CYPSS Healthcare Provision Overarching Specification Secure Settings for Children and Young People (Under 18s)

Publishing approval number: 000566

Version number: 1.0

First published: January 2020

Prepared by: Sue Sylvester and Emily Nicol

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Emily Nicol at Emily.nicol@nhs.net.

Introduction

The overarching specification incorporates Healthcare Standards for Children in Secure Settings[1] considered cross-cutting and that must be considered by **all** providers in tandem with specialist specification documents (such as physical healthcare, mental health or substance misuse). *[NHS Commissioning Intentions]*

[1] CYPSS standards 2019

Standards

Standard 1: Overarching Principles for Delivering Healthcare to Children in Secure Settings

1.1 Healthcare in secure settings is centred on the child and all staff within secure settings strive to make every interaction matter and be positive. (See 3.2).

1.1.1 Healthcare staff are able to build relationships of trust with children in secure settings.

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

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

1.1.4 Children in secure settings are confident that their personal information is held securely and shared in accordance with the safeguarding and information sharing standards to ensure they receive the best possible care. (See Standards 2 and 3).
Guidance: Data Protection Act, (2018); Information Sharing, Advice for practitioners providing safeguarding services to children, young people, parents and carers, HM Government, (2018).

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

1.2.1 Children in secure settings are entitled to services that are at least equivalent to the services available to their peers in the community. It is recognised these children will often require enhanced support and personalised responses to achieve equivalence and increase chances of achieving best possible outcomes. Reasonable adjustments must be made to ensure access to these services by children with a disability. (See 5.4.1).

1.2.2 Healthcare staff offer children in secure settings, where possible, 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.

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

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

Relevant section of the CYPSS standards (summary of detailed standards below, the full detailed standards are at https://www.rcpch.ac.uk/resources/healthcare-standards-children-young-people-secure-settings)	**Requirements of the service**
Standard 2: Safeguarding **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, 2018 and the NHS Standard Contract. **2.2** When a child is identified as at risk of harm to self or others, the identifier informs and shares information with the relevant staff, including care, education and night staff, and takes action in line with local safeguarding and risk management procedures. **2.3** Children are protected from abuse through clear safeguarding policies and procedures.	To meet these standards all secure settings must comply with the requirements of the NHS Standard Contract [2]and have current safeguarding policies and procedures, which are subject to appropriate monitoring and review by a safeguarding committee and are legislatively compliant. Local safeguarding partners and senior staff from all departments including healthcare in the secure setting sit on the committee and are involved in approving and reviewing the policies and procedures. Settings have access to a 'Named Safeguarding Professional'. Staff should be trained (Standard 14) and information shared (Standard 3) in accordance with the requirements of the safeguarding standard. How you will evidence compliance with the standards: Effective safeguarding policies and procedures in place. Requirements of the Children Act 2004, Children and Social Work Act 2017, along with Working Together 2018, are met. Information shared according to relevant legislation, guidance and procedures. Inspection and audit results and evidence of addressing open issues. **Outcomes**: Risk of harm to children minimised. Safeguarding incidents reduced. **Indicators of Performance:** N/A

[2] https://www.england.nhs.uk/nhs-standard-contract/

Enabling:
The governor/director/manager of the setting:

- Is accountable (2.3.4) for ensuring that current safeguarding policies and procedures are in place and compliance monitored, and is aware of the setting's need to meet standard 2.3.3: *"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 local safeguarding partners' policies and procedures, through the secure setting's safeguarding lead or the designated nurse/doctor for safeguarding children in the locality)";*
- Champions effective and appropriate sharing of information between healthcare and non-clinical staff across the secure setting in the best interests of the child and to reduce the risk of harm.

Standard 3: Information sharing **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 or individual at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional wellbeing. (d) The common law duty of confidence, and the rights within the Human Rights Act 1998, must be balanced against the effect on children at risk if they do not share the information. **3.2** The governor, director or manager of the secure setting and their senior management team should support and encourage staff working in healthcare and those working outside healthcare to share information to support the needs of the child and underpin the Framework for Integrated Care (SECURE STAIRS).[3] **3.3** Decisions to share information without consent should be based on considerations of the safety and wellbeing of the child and others who may be affected by their actions. (See 3.1). **3.4** Healthcare staff must ensure that a child's healthcare information is obtained when they are admitted to a secure setting and key characteristics shared internally to assist in the integrated approach to formulation-based care planning. (See 3.1.1 and 4.3.1).	To meet these standards the setting must facilitate appropriate, timely and effective sharing of information to enable integrated and formulation-based care planning. The setting should embed the principles of the Framework for Integrated Care (SECURE STAIRS). Compliance with these standards requires a strong element of pro-activity with staff both actively seeking out information when a child is admitted to a secure setting and sharing information as appropriate with new providers when the child transfers to an alternative setting or into the community. Where requests for information regarding a child's healthcare records (and other relevant information such as Education, Health and Care plans) receive no response, this should be escalated through appropriate channels (e.g. the safeguarding lead in a hospital or community setting, or social worker in the local authority). The establishment of password-protected generic nhs.net accounts for each setting is recommended to ensure that effective sharing of information is not compromised when there are changes of personnel or instances of individual absence. **How you will evidence compliance with the standards:** Compliant with all relevant legislation and guidance. No complaints to or adverse rulings by Information Commissioner's Office. No safeguarding issues or serious incidents due to information not being shared. Staff training records and audit outcomes. Evidence of liaison with primary care/Looked After Children health teams. Accurate records kept of documentation disclosed and received. **Outcomes**: All staff aware of and acting appropriately in accordance with legislation, guidance and procedures on information sharing.

[3] Ref: Mental Health Care and Intervention specification (SECURE STAIRS)

	Information being shared appropriately and according to legislation, guidance and procedures to ensure children receive effective health and care services. Information being shared appropriately and according to legislation, guidance and procedures to ensure children are safeguarded from risk of harm. No information breaches. All complaints are dealt with effectively and within a timely manner. There are no upheld investigations by the Information Commissioners Office or Ombudsman. **Indicators of Performance:** N/A
Enabling: The governor/director/manager of the setting: • Is accountable for ensuring that current information-sharing procedures are in place and are being actively followed and monitored; • Champions the effective and appropriate sharing of information between healthcare and non-clinical staff across the secure setting in the best interests of the child and to reduce the risk of harm to the child, other children or staff; • Supports healthcare staff in the setting to obtain healthcare information when children enter the setting and provides appropriate support to escalate and unblock instances where requests for information are ignored or left unmet.	

Standard 4: Entry and Assessment **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. **4.2** 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. **4.3** Information is shared on entry and health assessments are effectively co-ordinated with other agencies so that children are not repeatedly asked to give the same information. (See Standard 3 above) **4.4** Children understand and are fully involved in their health assessments. **4.5** All children receive a timely full secure CHAT assessment, which includes an assessment of physical health (within three days of their arrival), mental health (within three days of their arrival), substance misuse (within five days of their arrival) and neurodisability (within 10 days of their arrival). **4.6** There is a clear pathway for managing referrals where a health and/or wellbeing need is indicated.	To meet these standards the service must complete a reception health screen, which is a recognised and reliable tool for use with children. This is the CHAT (Comprehensive Health Assessment Tool). The assessment should incorporate life threatening and immediate health needs, identify prescribed medication and record visible injuries. A trained healthcare professional should complete the tool. The CHAT Reception Screen can be completed by a Registered General Nurse (RGN), Registered Nurse (specialising in children: RNC) or Registered Mental Health Nurse (RMN). If healthcare is not available 24 hours a day, a Standard Operating Procedure (SOP) should be in place to support care staff to identify any health concerns and decide what action to take. Unless there are extenuating circumstances (such as detention under the Police and Criminal Evidence Act, 1984 (PACE)), reception CHAT assessment should, be completed before the child's first night and ideally within two hours. Consent should always be sought and clearly documented. In situations where the reception CHAT assessment is delayed, immediate threats to health should still be assessed. Urgent needs are identified, action taken and information shared appropriately where there is risk of harm to self or others in order to safeguard the child, other children in the secure setting, and staff. Staff should be proactive in accessing existing healthcare records, including from electronic systems such as NHS spine and the child's originating area (primary care (GP), Youth Offending Team (YOT) and Education Health and Care Plans (EHCPs) from the originating local authority. Information is drawn together on reception and staff should be afforded the time needed to do this. If available, previous health records are read and relevant information is collected into a single record and shared with other staff. Any health or wellbeing issue likely to impact on the child's engagement with the setting's broader regime, including restraint, is shared with appropriate staff. Reasonable adjustments within the secure setting should be considered where required to ensure engagement is maximised.

	Where it has not been possible to find or access existing records, attempts to do so should be recorded so that the setting can be assured that all reasonable efforts have been made to do so. Note: all secure setting staff should be aware that a disproportionately high number of children in secure settings suffer from Learning Difficulties and/or are on the autistic spectrum, and under-diagnosis is common prior to their arrival at the setting. The health assessment is reviewed regularly (at least annually and the mental health assessment is reviewed within three months of arrival) and is not a one-off event (See 4.5.8). The Children and Families Act 2014 makes far-reaching reforms to the special educational needs system, including introducing the 0-25 education, health and care plan (EHCP) which will replace statements of special educational needs and Learning Difficulty Assessments. It also covers children with long-term conditions. The EHCP will focus on improved outcomes for the child in education, health and care and the support they will need to help them meet those outcomes. The EHCP will be underpinned by a duty on local authorities and their partner CCGs to jointly commission the education, health and social care provision required by children with special educational needs (SEN) in their area. Statutory guidance on the SEN reforms, including how the process should work in custody, is set out in the 0-25 SEN Code of Practice. https://www.gov.uk/government/publications/send-code-of-practice-0-to-25 The Act places new duties on health service commissioners to arrange appropriate health provision if a child with an EHCP is detained in youth custody. (Appropriate health provision is defined as the health provision set out in an EHCP or, if that is not practicable, provision as close as possible to that in the EHCP if it is still appropriate for the child). The Act also gives a right to children in custody to ask the home local authority to arrange an assessment of their education, health and care needs. **How you will evidence compliance with the standards:** All children have a healthcare plan developed within defined timescales and in response to health needs. The setting has a written protocol for observing children at risk of harm.

Referral pathways are clear, including during “out of hours” periods.
The setting can demonstrate how every effort was made to ensure receipt of children’s EHCP when arriving at the secure setting.
There is evidence that the child’s EHCP is adhered to in their healthcare plan.

Outcomes:
Children receive a comprehensive health assessment(CHAT) in accordance with Standard 4 and further assessment that covers all aspects of their health including physical health (within three days), mental health (within three days), substance misuse (within five days), neurodisability (within 10 days).

Indicators of Performance:

Indicator	Description
D02K01	The % of children with a CHAT reception health screen completed within two hours of admission
D02K02	The % of children with a CHAT physical health assessment completed within three days of admission
D02K03	The % of children with a CHAT mental health assessment completed within three days of admission
D02K04	The % of children with a CHAT substance misuse assessment completed within five days of admission
D02K05	The % of children with a CHAT neurodisability assessment completed within 10 days of admission

Enabling

The governor/director/manager of the setting:

- Has an awareness of the timescales required for assessment, aids healthcare staff's access to children to allow them to meet these timescales, and facilitates healthcare staff in accessing healthcare records whether through providing sufficient time to do so or acting as a point of escalation where the information is not forthcoming;
- Allows healthcare staff access to the whole secure setting and to case management systems outside those used specifically for healthcare;
- Allows access to children by healthcare or associate staff at any time in case of an urgent medical need or to ensure medication can be dispensed appropriately.
- Actively facilitates the sharing of a child's EHCP throughout the entire setting and works with healthcare staff to monitor adherence to these plans.

Standard 5: Care Planning **5.1** Each child has a named healthcare professional who co-ordinates their healthcare. **5.2** Each child has a comprehensive and holistic care plan, which is formulation-based, within 10 days of their arrival in the secure setting. This plan demonstrates a whole system approach to the care of the child integrating the approach to physical health, mental health and wellbeing, substance misuse, neurodisability and any speech, language and communication needs. The healthcare plan is not an isolated event, but part of a continuous process and should be revised at regular intervals taking into consideration revisions to the formulation and formulation based care planning. There should be an emphasis placed on ensuring actions in the healthcare plan are being taken forward and monitored at regular intervals. **5.3** 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. **5.4** Children receive prompt healthcare intervention to improve their health and wellbeing outcomes. **5.5** Children experience collaborative and consistent healthcare.	Care planning for each child should be comprehensive, holistic and formulation-based. Staff across the secure setting work as a multiagency team to place the child at the centre of their care (See 13.3). The named healthcare professional is trained in child and adolescent health and has access to a network of healthcare professionals and specialists. They are the coordinator of the healthcare plan and attend initial and follow-up meetings about the child, reviewing the plan regularly with the child. The healthcare plan is joined up to LAC (Looked After Child) plans, EHCP (Education, Health and Care plans), transition plans, education, sentence and care plans to tell a coherent and comprehensive story about how the child's health needs in relation to accessing education are being met. It references the child's history as well as their current status. The child and their parents/carers are involved in its development and it contains objectives, timescales and actions. The lead healthcare professional needs to engage in sentence planning/case management. Staff understand when consent does not apply to safeguarding priorities and how it is underpinned in GDPR. Access and waiting times are reasonable and take account of the child's length of stay. Children are not unnecessarily restricted by regime or education measures to attend healthcare appointments. Concerns regarding access should be escalated through appropriate governance arrangements. Staff are appropriately trained to give the interventions they are providing. Children consistently see the same health practitioner for an intervention (where possible and unless clinical need demands otherwise). Staff have regular discussions with children about their progress. **How you will evidence compliance with the standards:** A named health professional co-ordinates healthcare. There is a comprehensive health plan developed within the timescales described above.

The setting has evidence that the healthcare plan is joined up to LAC (Looked After Child) plans, EHCPs, transition plans, education, sentence and care plans.
Data is collected and analysed on access and waiting times and on the objectives and actions in the healthcare plan.

Outcomes:
Children receive the healthcare, care and other support that they need.

Indicators of Performance:

Indicator	**Description**
D10K01.1	No. of outpatient appointment escorts scheduled during the reporting period
D10K01.2	No. of children requiring an emergency escort during the reporting period
D10K01.3	No. of cancellations that resulted in an escort being reorganised for any reason
D10K02	No. of bedwatches provided within the reporting period
D10K03	The % of children urgent referrals seen by a GP
D10K04	The % of children seen by GP
D10K05	The % of children seen by a dentist
D10K06	The % of children seen by an optician
D10K10.1	Wait time to see a GP
D10K11.1	Wait time to see an optician
D10K12.1	Wait time to see a dentist

		D10K22	DNA Rate: GP
		D10K23	DNA Rate: Optician
		D10K24	DNA Rate: Dentist

Enabling

The governor/director/manager of the setting:

- Understands the duty of care on the secure setting to enable children's ability to access healthcare appointments and in particular the potential for improvement to their mental health and behaviour gained from accessing Children and Young People Mental Health Service (CYPMHS) appointments;
- Should be approached to find solutions where the regime impacts on access and waiting times for healthcare appointments.

Standard 6: Universal Health Services	
6.1 Children have access to the services and support they need to meet their health and wellbeing needs including physical health, mental health, substance misuse, neurodisability and speech, language and communication. All interventions are delivered at a level that the child can access, including tailoring the intervention to meet any speech, language and communication needs the child may have.	Children have access to primary health services which are at least equivalent to the services available to children in the community including general medical services, general dental services, general optical services and relevant health promotion materials. Settings recognise the importance of promoting good physical, mental and emotional health.
6.2 Children know how to access health and wellbeing services while they are in the secure setting.	Children are treated with respect, understand what healthcare services they can expect and how to access them, and are informed of their rights regarding confidentiality subject to limits imposed by safeguarding. Appointments are available at reasonable times.
6.3 Children have access to 24-hour emergency medical services (physical and mental health, and including medical emergencies of dental origin).	There is access to emergency medical and dental services 24 hours a day.
6.4 The secure setting has a comprehensive medicines management policy in place, and is committed to stopping the over-medication of people with a learning disability, autism or both (STOMP). **Guidance:** STOMP: Stopping the over-medication of people with a learning disability, autism or both, Voluntary Organisations Disability Group.	The setting appropriately supports children whose individual circumstances mean they require additional support. This includes young parents, those who have suffered adverse childhood experiences (ACE), those starting to identify with a gender other than the one they were assigned at birth, radicalised children, and foreign nationals.
6.5 There is a comprehensive whole system approach to improving health and wellbeing across the secure setting, which includes a health improvement strategy.	Attending accompanied external healthcare appointments places additional stress on a child. The setting understands this and works with the external healthcare service to plan the visit to minimise additional stress to the child from being under public scrutiny.
6.6 Effective systems are in place to identify and support all children who are parents or expectant parents, including young men and women. This includes support for physical, mental and emotional wellbeing.	Prescribing is risk-assessed for each child and children are given information about their medicine in a format they can understand. There is adequate governance for management of medicines, in line with NICE guidance[4], and access to specialist pharmacy support and advice. Prescribed medication is documented on both healthcare and secure setting administrative records and is normally taken under supervision in line with the standards.
6.7 Children receive support from a healthcare professional after restraint procedures. If support is refused, the reason why is recorded and repeated attempts are made. Note: Healthcare staff do not restrain children but do have duties and responsibilities in regard to safety of a child during and following restraint. (See 14.5).	Settings recognise that, during instances of restraint and separation, the safety and emotional security of the child are of paramount importance. All staff are kept informed by the named health lead of any issues that might impact a child's health and wellbeing if they are restrained or separated from others. Advice is sought from healthcare staff, when
6.8 Children receive support from a healthcare professional after periods of separation from their peer group. 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.	available, before planned restraint and children are encouraged to see a healthcare professional as soon as possible afterwards. Healthcare staff should take account of the child's ability to consent at such times, and should ensure risks are assessed to effectively safeguard the child. **How you will evidence compliance with the standards:** Evidence of children receiving information/education about healthcare standards as part of their induction to the setting "Did Not Attends" (DNAs) are monitored and reviewed through collaborative working across the setting to identify problems. A member of staff trained in first aid and resuscitation (CPR) is always in the setting. There is an "access to emergency services" plan. There is a comprehensive medicines management policy. A qualified person (pharmacist or qualified nurse) documents and monitors a monthly medicines audit. There is a comprehensive health promotion strategy in place linked to the overall health strategy. There is an education programme in place on parenting for all young parents or expectant parents There is a clear and accessible policy and process for both children and adults to make complaints, including about 'Persons in a Position of Trust'. Injuries due to restraint are always fully documented. Incidents during or following separation are recorded and lessons learnt to present the incident from occurring again in the future. **Outcomes**: Children are health-literate and can identify needs and request health and wellbeing support when they need it Children always have access to primary care and urgent care when they need it. Prescribing data is collated and available for analysis to aid service improvement. DNAs are reduced. Injuries due to restraint are reduced. Incidents during or following separation are reduced

[4] 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)

Indicators of Performance:

Indicator	Description
D04K01	No. of supervised medication appointments that were Did Not Attend (DNA)
D04K02	No. of missed supervised medication appointments (excluding DNAs)
D04K05	The % of transfers received with a minimum of seven days' supply of prescribed medicine
D04K06	The % of children discharged with a minimum of seven days' supply or FP10
D04K07	The % of children with restraint vulnerability identified and shared with custody/care staff
D04K08	The % of planned restraints where a healthcare professional was present
D04K09	The % of unplanned restraints where the children were seen by a healthcare professional within 30 minutes of the restraint

Enabling:

The governor/director/manager of the setting:

- Encourages development of a "whole setting" approach to health promotion, including mental health;
- Ensures systems are in place to make sure care staff are aware of any child's physical and mental health problems that may impact them if restrained or separated from others;
- Where children are subject to restraint or separation, the governor/director/manager must ensure the requirements of CYPSS Standard 6.7 and 6.8 are fully met by both care staff and healthcare professionals.

Standard 10: Transition and Continuity of Care **10.1** Early planning for transfer to the community or to another secure setting is crucial, beginning as soon as children are admitted to the setting. Continuity of healthcare is ensured to the greatest possible extent as children transition between secure settings, hospital settings or to the community. Transition arrangements should be captured in a health transition plan, which feeds into the overall transition plan for that child. **10.2** 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 or 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. **10.3** Referrals and arrangements are made to ensure that children are offered continuity of care when they move between health services on transition. **10.4** The secure setting records any instances where transition practices compromise the health and wellbeing of the child and these records are passed to the relevant host and reviewed with safeguarding partners, regulatory body or health commissioner/service planner. **10.5** A summary of the child's healthcare record, including a list of current medication with the indication for each one and any recommendations for future care (CHAT discharge summary), is sent to the child's GP and any other relevant agencies (including Looked After Children health and care professionals and youth offending team where appropriate). The child and, where appropriate, their parents/carers are asked whether they would like a copy of the healthcare record at the time of leaving. **10.6** The child and, where appropriate, their parents/carers are provided with information about how and why to register with community health services, including (but not limited to): GP, dentist, optician, sexual health services, substance misuse services and other community health services on transition to the community.	Transition planning starts as early as possible and is captured in a transition plan. The transition plan is informed by the healthcare plan, co-ordinated by the named health professional, and developed with the child and family or carers where possible. This may involve practitioners liaising directly with their community-based counterparts to refer children on or liaise with the originating GP. At other times it may be appropriate for the home youth offending team to broker how a health need will be met. The named health professional attends case management and transition meetings or provides written information to ensure an integrated approach to transfer. Sometimes the named healthcare professional will need to proactively promote engagement with community provision by supporting in-reach before release. The roles of agencies involved in follow-up care are documented and there is agreement about procedures in the case of DNAs. Information is shared effectively to ease transition between secure settings and shared with the child (or their carer) if they are transferred to the community. Additional support is offered before transition based on the child's needs and transition plan (such as harm minimisation programmes). Children with complex needs (such as those who have suffered adverse childhood experiences) are signposted to agencies and services that can offer continuing support after they leave the secure setting. Children understand what to expect on transition, know whom to contact if there is a problem and have an adequate supply of medication (including special arrangements if discharged with controlled drugs). **How you will evidence compliance with the standards:** There is a comprehensive transition plan in place for each child covering all health needs, that is shared with the young person's YOT worker, YOT nurse, GP and carer where appropriate. Instances where transition practices compromise the health and welfare of the child are recorded and the local and originating CCG is informed.

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

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

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

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

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

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

Outcomes:
Children understand why they need to register with health services on their return to the community and that general practice is the doorway to accessing services.
There is improved continuity of care to meet mental health, physical health, substance misuse and neurodisability needs (follow-up to measure how many children are registered with appropriate services after discharge).
Children stay off drugs.
Children continue to take their medications as prescribed on transition.

Indicators of Performance:

Indicator	Description
D08K01	The % of children with a CHAT discharge plan on discharge
D08K02	The % of children registered with a community GP practice on discharge
D08K03	The % of children with a CHAT discharge plan sent to their community GP

Enabling
The governor/director/manager of the setting:
- Understands the benefits of a comprehensive health transition plan, including the potential this has to impact on reducing reoffending (where appropriate), and is committed to working with healthcare staff on a transition plan that is combined with educational, sentencing (or a court order for children placed under the Children Act) and other needs.

Standard 11: Healthcare environment and facilities **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. **11.2** All health equipment is safe, appropriate and meets standards laid down by the regulatory bodies. **11.3** There are comprehensive infection control procedures in place. **11.4** There is a systematic and planned approach to the management of health records on site. **Guidance:** Health and Justice Information Service, NHS England.	There is a dedicated room available for healthcare in a location that is child-friendly. Privacy and confidentiality are assured. The room is accessible to those with disabilities and should be suitable for both physical and mental healthcare as well as the supply of medicines. Where clinically appropriate, and safeguarding of the child and staff can be assured, children should have a choice of where to be treated. Staff can access help in an emergency and readily accessible equipment is available at key locations, which is maintained in line with manufacturers' guidelines (See 11.2.2). Health equipment and supplies are checked and maintained as they would be in the community. Comprehensive infection control procedure is in place including adequate systems for disposal of clinical waste. This should be underpinned by an infection prevention policy. **How you will evidence compliance with the standards:** There is a defibrillator in the setting that is checked and maintained in accordance with guidance from the suppliers. There are regular infection control audits in line with nationally defined standards (See 11.3.3). Cleaning is in accordance with national standards for health facilities. Audit and inspection findings confirm health equipment is safe, appropriate and meets regulatory standards and that non-compliance from previous audits/inspections has been addressed. **Outcomes:** Children are satisfied with healthcare facilities (measured through questionnaire, focus group etc.). Healthcare equipment (and cleaning of healthcare equipment) meeting regulatory standards. Results of infection control audits are acted upon to aid service improvement. **Indicators of Performance:**

	N/A

Enabling

The governor/director/manager of the setting:

- Works with healthcare providers to ensure the healthcare facilities in the setting are fit for purpose, in a suitable location and that fixed fittings are adequately maintained (moveable equipment relating to health treatment and intervention is the responsibility of NHS England). Healthcare facilities provided should be used solely for clinical tasks.
- Works with healthcare providers to ensure that cleaning of healthcare facilities and equipment is to the same standard as health settings in the community.

Standard 12: Planning and Monitoring **12.1** There is a clear role for health and wellbeing services in the secure setting that is set out in a comprehensive health strategy for the secure setting. **Guidance:** A resource providing guidance on the strategies can be found on the NHS England intranet for commissioners. **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. **12.3** Service planning/commissioning is responsive to the needs of the children in the secure setting. **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. **12.5** 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.	The health strategy contains short and long-term plans and reflects national guidance and best practice. It incorporates all the relevant strategies and policies named in the standards and links to the secure setting's safeguarding and information sharing policies. Implementation of the strategy is reviewed annually. Service planners/providers/commissioners and the director/governor/manager of the setting are aware of their respective responsibilities under legislative and regulatory frameworks. The director/governor/manager ensures that the whole setting is involved in strategic health planning. Views of children are taken into account and incorporated into planning and improving services. Special health and wellbeing services provided should be outlined and any healthcare needs that cannot be met within the setting should also be outlined. Skill mix is regularly reviewed in accordance with population needs and there is adequate administrative support. There is adequate time provided for continuing professional development. There should be clear and accessible mechanisms for children to raise concerns or complaints. The secure setting should have a learning culture that welcomes feedback and makes it easy for children to provide it. **How you will evidence compliance with the standards:** A comprehensive health strategy for the secure setting will be prepared and reviewed annually. A health and wellbeing needs assessment for the secure setting will be completed and reviewed every two years using a structured assessment tool suitable for use with children. A health delivery plan is developed and agreed by heads of settings, providers and commissioners. Gaps between capacity of service and demand on service are monitored and reported to service planners. Clinical outcomes are monitored and outcomes evaluated.

	Appropriate audit data is collected and used to evaluate services. **Outcomes:** The service provided is based on a thorough assessment of need that is regularly updated. **Indicators of Performance:** N/A
Enabling: Service planners/providers/commissioners and the governor/director/manager of the secure setting are aware of their responsibilities and duty of care for the health and wellbeing of the children under current legislative, regulatory and quality frameworks. The governor/director/manager of the setting: • Is aware of the setting's need to meet CYPSS standards 12.2.1, 12.2.2, 12.2.3 and 12.5.3; • Ensures that service planners/providers/commissioners and the secure setting have a joint, short and long-term approach to health service delivery, development and resource management; • Ensures that the secure setting is involved in strategic health planning and decision-making; • Understands the need for information exchange between staff working in healthcare and those working outside healthcare to support the needs of the child.	

Standard 13: Multiagency Working **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. **13.2** Multiagency working is supported by systematic and robust management of health records. (See 11.4) **13.3** Children receive care from a multi-disciplinary team that works in a holistic way according to the individual child's formulation. (See 3.4.1). **13.4** Assessment, care planning and appropriate interventions for children with co-occurring conditions (substance misuse, mental health, neurodisability or physical) should be delivered in collaboration between healthcare and specialist services to ensure that all of the needs of the child are identified and supported. **13.5** Children, parents/carers and allied healthcare professionals understand how to provide feedback (including making complaints) about healthcare services.	Staff understand the setting's information sharing policy and hold a copy of it. Children understand the need for information sharing and what will happen if their confidentiality needs to be breached. Where consent for treatment is not given, the reasons for the refusal are documented. Staff feel competent and safe to raise concerns about safeguarding without prejudicing their position. A whistleblowing policy is in place and underpins this. Multi-disciplinary team (MDT) meetings ensure that children's co-occurring conditions are supported in a holistic way. This requires that the Framework for Integrated Care (SECURE STAIRS) is embedded in the settings ways of working. (Ref: The specification Mental Health Care and Intervention [SECURE STAIRS]). Children, family/carers and allied health professionals know how to complain or raise questions and concerns. Responses are timely. **How you will evidence compliance with the standards:** There are up-to-date, documented service level agreements or contracts with service providers for all services. There is regular documented dialogue through multidisciplinary meetings about a child's care. There is one health record for each child, readily accessible to all professionals and this is electronic. There is a setting-specific information sharing policy which has been negotiated across the disciplines and with the director/governor/manager to facilitate joint care planning and multidisciplinary care plan reviews. There is a clear complaints procedure that is understood by the children in the setting and their family/carers. There is a children's forum in the setting. **Outcomes:** Children and family/carers know how to complain and receive timely responses. Staff feel competent and safe to raise concerns about safeguarding.

	Children are protected from harm through effective multiagency working. There is evidence that safeguarding reports and complaints lead to service improvement. **Indicators of Performance:** N/A
Enabling: The governor/director/manager of the secure setting is: • Committed to the concept of multi-disciplinary working which incorporates staff from substance misuse, safeguarding, healthcare, care and education teams; • Aware that, although work may be managed through different systems in the setting, an MDT approach enables staff to work more effectively and share information.	

Standard 14: Staffing and Training **14.1** Staff working with children receive training in safeguarding and child protection. **14.2** Staff working with children know who to contact in an emergency, including for incidents of self-harm, violent behaviour and first aid. **14.3** Staff working directly with children receive training on child and adolescent development, attachment, trauma, bereavement, loss, adverse childhood experiences, violence counselling and other relevant key theories. **14.4** Staff are trained in and can implement the principles of the Framework for Integrated Care (SECURE STAIRS). **14.5** All healthcare practitioners are trained in the principles of the method of restraint where relevant to the setting (for example Minimising and Managing Physical Restraint awareness module (MMRP) or Restrictive Physical Intervention Training (RPI)), to support clinicians to understand potential risks and injuries. Healthcare staff only provide health advice which may inform any decision around restraint, and are not involved in the decision of whether to undertake a restraint or not. **14.6** All staff are aware of the Government's Prevent anti-terrorism strategy and the duty to comply with it within the NHS and secure settings for children. **Guidance**: Revised Prevent Duty Guidance for England and Wales, Home Office (2015). **14.7** Healthcare staff contribute to the recruitment, development and sustainability of an emotionally resilient staff able to work effectively and compassionately with highly challenging children. **14.8** There are appropriately qualified and skilled healthcare staff to meet the needs of the children in the secure setting. **14.9** Healthcare practitioners have an annual appraisal and receive clinical and managerial supervision.	All staff are aware of the key challenges around child and adolescent health and wellbeing and children in secure settings. Behaviours relating to heightened risk can be recognised. Healthcare practitioners are trained to work with children in challenging circumstances and can operate safely in the secure setting. All staff working in the secure setting are supported to help them remain emotionally resilient in the face of challenging behaviour or circumstances and to prevent vicarious trauma and burnout. This is underpinned by a supervision strategy. Roles and responsibilities are clear and understood by all staff, in line with NICE Guidance[5], in the event that a child needs to be restrained. Settings acknowledge that, in an ever-changing system, it is essential to comply with appropriate legislative changes and updates, and for all staff to maintain up to date knowledge as relevant to their role/profession. **How you will evidence compliance with the standards:** Healthcare practitioners are compliant with Looked After Children: Knowledge, skills and competences of health care staff, Intercollegiate Role Framework 2015 at level three and with Safeguarding Children and Young People: Roles and competences for health care staff, Intercollegiate Document 2014 at level three. This is underpinned by a comprehensive training strategy. There is pre-employment checking and monitoring every three years thereafter. Healthcare practitioners have clear job descriptions, lines of clinical and managerial responsibility are clear and they know where to go for advice and support following a major incident. Continued professional development includes training and guidance on evidence-based practice, consent and information sharing, children's rights, safeguarding, diversity and equality, communicating with children. **Outcomes:** Positive workforce indicators. Behaviour management of children is improved.

14.10 Healthcare practitioners have access to an on-going and regularly updated programme of professional development.	Care staff understand the role and responsibilities of healthcare staff (including CYPMHS and substance misuse) and vice versa. **Indicators of Performance:** N/A
Enabling: The governor/director/manager of the setting: • Is aware of the setting's requirement to meet CYPSS standards 14.1, 14.2 and 14.3 (see above), "*that all staff should be aware of the key problems affecting child and adolescent health and wellbeing and the common problems of children in secure settings (14.3.1),"* and that *"staff should be able to recognise behaviours that indicate a heightened risk and know how to access health advice for children in the setting" (14.3.2);* • Is aware of the setting's requirement to meet the standard that *"healthcare practitioners are able to operate safely within the secure setting" (14.8.2)* and that *"Healthcare professionals conduct their work with the same ethical and good practice codes as bind their colleagues in health services in the community" (14.8.6);* • Is aware of the setting's requirement to meet the standard that "*healthcare practitioners know where to go for advice and support following a major incident and have access to a support system such as a support group or counselling service" (14.9.2).*	

[5] https://www.nice.org.uk/guidance/NG10

Standard 15: Equality and Diversity **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. **15.2** Healthcare services should work in partnership with parents/carers and professionals to ensure that the medical, cultural and dietary needs of all children are met. **15.3** Healthcare services in children's secure settings should seek to respond to the health needs of Black and Minority Ethnic communities. **Guidance**: NHS England response to the specific equality duties of the Equality Act, 2010. **15.4** Healthcare services seek to improve children's experience of healthcare in secure settings, particularly for children who are lesbian, gay, bisexual and/or identify with a gender other than the one they were assigned at birth. **Guidance:** NHSE Equality Objective Three. **15.5** Healthcare services seek to improve the experience of children with a learning disability, autism or both with a particular focus on removing the inequalities they will have already faced in accessing health care services. **15.6** All healthcare staff in secure settings for children are trained in equality and diversity.	Secure settings provide healthcare services to children that are at least equivalent to the services available to their peers in the community, and that are tailored to the child's healthcare plan and formulation. Care planning identifies specific medical, cultural, or dietary needs and how they will be met both in the setting and during transition, making reasonable adjustments where appropriate. All staff working in the setting have received equality and diversity training appropriate to their role. **How you will evidence compliance with the standards:** Demonstrable compliance with NHSE Equality Objective Three. No breaches of the Human Rights Act, Equality Act or upheld complaints of discrimination, harassment, or victimisation. Monitoring/audit/peer review shows that specific medical, cultural and dietary needs are identified and met with reasonable adjustments made where appropriate. Training records are up-to-date and include appropriate equality and diversity training. **Outcomes:** Children receive healthcare services that meet their individual needs. **Indicators of Performance:** N/A
Enabling: The governor/director/manager of the setting: • Is aware of the setting's duty to adhere to all relevant equality and human rights legislation and of their personal accountability for this; • Works with healthcare providers in the setting to facilitate healthcare services appropriate to the individual needs of the children, including access to interpreting and translating services to help ensure that children understand healthcare professionals and vice versa.	

Relevant Inspection Frameworks for secure settings	Alongside the Healthcare Standards for Children and Young People in Secure Settings (2019) (www.rcpch.ac.uk/cypss) providers also need to ensure compliance with the relevant inspection framework for the secure setting i.e. YOIs, STCs and SCHs. The relevant inspection framework should be frequently reviewed as part of all multi-disciplinary team meetings to address recommendations and ensure all areas for improvement are being progressed. Each secure setting is inspected on an annual basis. **HMIP Inspections for Young Offender's Institutions framework:** https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/03/INSPECTION-FRAMEWORK-2019.pdf Her Majesty's Inspectorate of Prisons is an independent statutory organisation which reports on the treatment and conditions of those detained in young offender institutions. HMIP inspects Young Offender Institutions for children under age 18 annually. HMIP works jointly with other inspectorates such as the Office for Standards in Education, Children's Services and Skills (Ofsted), Care Quality Commission (CQC) and the Royal Pharmaceutical Society. This joint work ensures expert knowledge is deployed on inspections and avoids multiple inspection visits. All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel Inhuman or Degrading Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) which monitor the treatment of and conditions for detainees. HMIP is one of several bodies making up the NPM in the UK. All HMIP reports include a summary of an establishment's performance against the model of a healthy prison. The four tests of a healthy prison are: • **Safety**: Children, particularly the most vulnerable, are held safely; • **Respect:** Children are treated with respect for their human dignity; • **Purposeful activity:** Children are able and expected to engage in activity that is likely to benefit them; • **Resettlement:** Children are prepared for their release into the community and helped to reduce the likelihood of re-offending. Under each test HMIP makes an assessment of outcomes for children and therefore of the establishment's overall performance against the test. In some cases this performance will be affected by matters outside the establishment's direct control which need to be addressed nationally. Further detail of the criteria under each of these tests for Young Offender Institutions for children under age 18 can be found online. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/11/Childrens-Expectations-FINAL-261118-2.pdf

Joint Inspections of Secure Training Centres.
The inspection framework for Secure Training Centres (STCs) is available at:
http://ofsted.gov.uk/resources/inspections-of-secure-training-centres-framework-for-inspecting
Please note the STC inspection framework is currently under review. A new framework will be published in April 2019.

The inspection of Secure Training Centres is undertaken jointly by Ofsted, HMIP and CQC in consultation with the Youth Custody Service for England and Wales, and the Ministry of Justice. Each Secure Training Centre in subject to an annual inspection in accordance with a service level agreement with the Youth Custody Service and Ministry of Justice, acting on behalf of the Secretary of State for Justice.

The timing of an inspection is influenced by an assessment of:

- Outcomes of previous inspections;
- Advice or information provided to the inspectorates by the Secretary of State, the Ministry of Justice and/or the Youth Custody Service;
- Other relevant information received by Ofsted, HMIP or CQC.

Where there are significant concerns about a Secure Training Centre between the annual inspections, an additional inspection may be carried out if requested by the Ministry of Justice and/or Youth Custody Service.

The inspection framework includes evaluation criteria for the following areas:

- To describe the characteristics of what is considered good in the judgement of overall effectiveness, taking into account:
    - Safety of children
    - Promoting positive behaviour
    - Care of children
    - Achievement of children
    - Resettlement of children
    - Health of children
    - Effectiveness of leaders and managers.
- The experiences and progress of children in all areas of their lives are central to the inspection.

Inspectors use the descriptors of good as the benchmark against which to grade and judge performance.

Inspectors will make their judgements on a four-point scale:

1. Outstanding
2. Good
3. Requires improvement
4. Inadequate.

Ofsted Inspections of Secure Children's Homes:

	Ofsted uses the Social Care Common Inspection Framework (SCCIF) for the inspections of Secure Children's Homes. https://www.gov.uk/guidance/social-care-common-inspection-framework-sccif-children-s-homes-including-secure-children-s-homes For full inspections of secure children's homes, Ofsted will be assisted by an inspector from CQC in Ofsted's evaluation of health services provided for children. For interim inspections of secure children's homes, Ofsted may request the assistance of a CQC inspector if there are health related matters where the inspection would benefit from CQC's input. CQC is responsible for regulating registered healthcare providers. Inspections under SCCIF make judgements on overall experiences and progress of children, taking into account: o How well children are helped and protected; o The effectiveness of leaders and managers; o Outcomes in education and related learning activities. Inspectors will use the descriptions of what "good" looks like as the benchmarks against which to grade and judge performance. The areas of required evidence and what "good" looks like is set out in chapter 5 of the SCCIF Inspectors will make their judgements on a four-point scale: 1. Outstanding 2. Good 3. Requires improvement 4. Inadequate. **Inspections of Secure Schools** At the time of creating these specifications the inspection framework for Secure Schools was not yet confirmed.
References and background for commissioners	**The Children and Young People Secure Estate National Partnership Agreement (2018)** https://www.england.nhs.uk/publication/the-children-and-young-people-secure-estate-national-partnership-agreement/ **Healthy Children, Safer Communities (2009)** http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_109772.pdf **Securing Excellence in Commissioning for Offender Health (2013)** http://www.england.nhs.uk/wp-content/uploads/2013/03/offender-commissioning.pdf **The Legal Aid Sentencing and Punishment of Offenders Act 2012 (LASPOA)** simplified the previous remand framework. All children aged 12-17 are subject to the same remand provisions and all remanded children treated as looked after by the local authority designated by the court when remanded securely. More details can be found here: http://www.justice.gov.uk/youth-justice/courts-and-orders/legal-aid-sentencing-and-punishment-of-offenders-act-2012 **The Young Offender Institution Rules 2000** http://www.legislation.gov.uk/uksi/2000/3371/contents/made

	The Secure Training Centre Rules 1998 http://www.legislation.gov.uk/uksi/1998/472/contents/made **The Children's Homes (England) Regulations 2015** http://www.legislation.gov.uk/uksi/2015/541/pdfs/uksi_20150541_en.pdf Guide to the Children's Homes Regulations including the quality standards https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/463220/Guide_to_Children_s_Home_Standards_inc_quality_standards_Version__1.17_FINAL.pdf **National Standards for Youth Justice Services** http://www.justice.gov.uk/downloads/youth-justice/yjb-toolkits/victims/national-standards-youth-justice-services.pdf **Human Rights Act (1998)** https://www.legislation.gov.uk/ukpga/1998/42/pdfs/ukpga_19980042_en.pdf **Equality Act (2010)** https://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf **Care, Education and Treatment Reviews for Children and Young People- Code and Toolkit (2017)** https://www.england.nhs.uk/wp-content/uploads/2017/03/children-young-people-cetr-code-toolkit.pdf