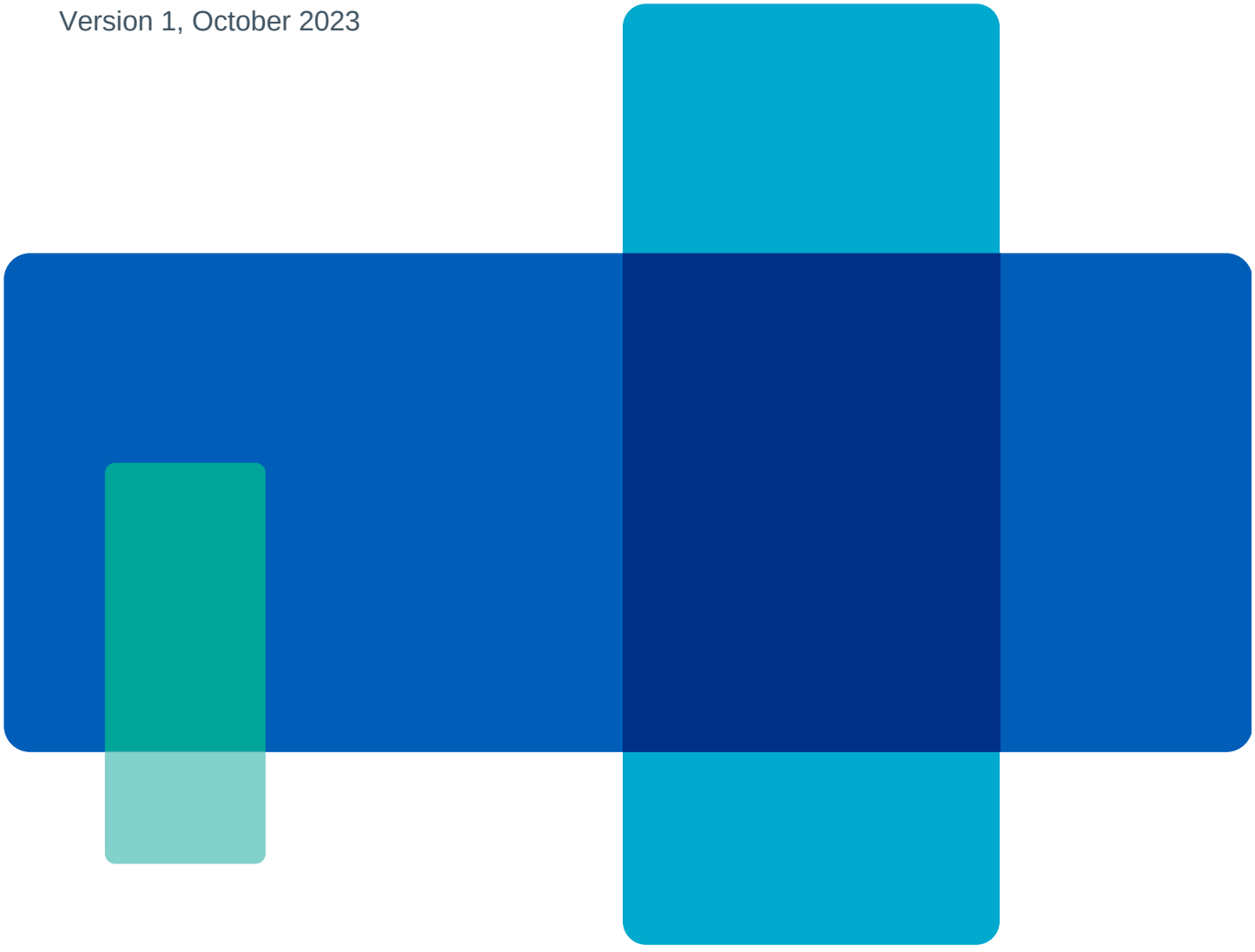
NHS England

Overarching healthcare specification

For children and young people in secure settings (CYPSS)

Version 1, October 2023



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SERVICE SPECIFICATION

NHS England is the commissioner of healthcare services for children and young people secure settings (CYPSS). NHS England regional commissioners may retain the structure of this model service specification template or determine their own in accordance with the Standard Contract Technical Guidance. Integrated care systems (ICSs) must not amend it.

This overarching specification details elements that pertain to all commissioned CYPSS healthcare services and each core (service specific) specification must be used in conjunction with it. All commissioners and providers must use this overarching specification in conjunction with each of the specialist specifications: (physical healthcare, mental health, dental and oral health, and substance misuse) when commissioning or re-commissioning services.

1.1 Service name	• Overarching healthcare specification for children and young people in secure settings
1.2 Service specification number	• XXX • *Insert the existing specification number where the specification is being amended. If it is a new specification, the new number will be assigned by xxx.*
1.3 Date published	• XX/XX/XXXX • *Insert the date the new or revised specification was published on the NHS England website.*
1.4 Accountable Commissioner	• XXX • *Insert regional commissioner title e.g., South West Health & Justice commissioner*

2. Service overview
Children in secure settings are entitled to service provision that is **at least** equivalent to that available for children living in the community. To offer children equivalent care, services need to work with children in secure settings to develop safe, trusting relationships. The standards for CYPSS healthcare services are: • Standard 1: Overarching Principles • Standard 2: Safeguarding • Standard 3: Information Sharing

- Standard 4: Entry and Assessment
- Standard 5: Care Planning
- Standard 6: Universal Health Services
- Standard 7: Physical healthcare and intervention (see specialist service specification)
- Standard 8: Mental Health and Neurodevelopmental Care and Intervention (see specialist service specification)
- Standard 9: Substance Misuse Care and Intervention (see specialist service specification)
- Standard 10: Transition and Continuity of Care
- Standard 11: Healthcare Environment and Facilities
- Standard 12: Planning and Monitoring
- Standard 13: Multiagency Working (including dental care – see specialist service specification)
- Standard 14: Staffing and Training
- Standard 15: Equality and Diversity

To enable the healthcare provider to meet these standards and optimise outcomes for these children, the governor/director/manager/principal director should themselves meet the 'access to healthcare' requirements for each standard.

The governor/director/manager/principal director retains a duty of care to the children in the setting and, as well as the provider, should consider how health outcomes impact on the overall performance of the secure setting.

3. Demographics & evidence base

3.1 Population covered

- Age: Children aged 10 to 17 years old placed in the Children and Young People Secure Estate (CYPSE)[1] on justice or welfare grounds.[2]
- Gender: The CYPSE is an all-gender service.

[1] Throughout these specifications we will refer to the both the Children and Young People Secure Estate (CYPSE) and secure settings; this covers Young Offender Institutions, Secure Training Centres and Secure Children's Homes inclusively and the Secure School in the future.

[2] Grounds for placement:

- Sentenced to a Detention and Training Order (DTO) – under section 100 of the Powers of Criminal Courts (Sentencing) Act 2000 (PCC(S)A.
- Sentenced for a serious offence – under section 90 or 91 of PCC(S)A or section 226, 226b or 228 of the Criminal Justice Act 2003 (CJA).
- Remanded by the court to custody – under section 91(4) of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPOA).
- Placed in a secure children's home on welfare grounds under Section 25(6) Children Act 1989.

3.2 Minimum population size

This service is available to all children placed in the CYPSE.

3.3 Evidence base

This section is for commissioners to complete based on Health and Wellbeing Needs Assessment and information from electronic health records (such as SystmOne) for their own local population.

4. Service aims and outcomes

4.1 Service aims

The service aim is to deliver an integrated healthcare offer for children in secure settings.

We recognise that children who are placed in secure settings are some of the most vulnerable in our society. They are more likely than their peers to have additional healthcare needs, such as neurodevelopmental conditions, substance misuse and mental health disorders.

Care within secure settings is underpinned by the Framework for Integrated Care, which NHS England and partners are committed to delivering.

This includes:

- Developing a whole setting, holistic, integrated care approach to address the health and emotional wellbeing needs of children, in collaboration with healthcare, education and secure setting staff
- Maximising opportunities to support children and their families/carers/next of kin (where appropriate) to address their needs, including understanding their condition, promoting their health and wellbeing, and promotion of “making every contact count”[3]
- Increasing awareness of the impact of trauma on children in secure settings
- Providing a holistic package of care that supports children who display harmful sexual behaviour[4]
- Ensuring effective information sharing systems are in place between those providing all types of care within secure settings including mental health, neurodevelopmental and emotional wellbeing interventions, physical health,

[3] See https://www.england.nhs.uk/wp-content/uploads/2016/04/making-every-contact-count.pdf
[4] See NICE Guidelines – NG55 https://www.nice.org.uk/guidance/NG55

dentistry, substance misuse, and those providing other types of interventions in the secure setting

- Ensuring that the secure setting receives continuity of care that is:
  - Clinically safe, and evidence-based
  - Delivered in accordance with relevant national and local quality standards
  - Efficient, equitable, and economical
  - Prioritised based on need and in accordance with the secure setting's risk management approach.

Individual care and treatment plans should be guided by a trauma-informed formulation, developed with the child or young person, family/carers/next of kin (where appropriate), and multiagency professionals in a culturally sensitive way to ensure a shared understanding and collaborative working.

Healthcare staff take the child's views, wishes and feelings into account regarding matters affecting their healthcare, in line with the child's level of understanding. This is balanced against what the healthcare professional judges to be in the child's best interests.

4.2 Service outcomes

Nationally collected outcomes

Key Performance Indicators will be nationally mandated by NHS England and collected for assurance purposes. The guidance on the national KPIs will be released annually via an information schedule which will be sent to providers by regional NHS England commissioners. The indicators will be based upon the Healthcare Standards for Children in Secure Settings.

Regionally collected outcomes

All services should be commissioned to achieve defined outcomes. However, how these are achieved will depend upon the service model provided within a secure setting, which should focus their service on achieving the most relevant outcomes for the needs of the population. This will require local determination by commissioners and providers on priorities based on the most recent Health and Wellbeing Needs Assessment (HWBNA) and the current population. Regionally collected outcomes should be determined locally, however consideration should be given to the burden of reporting whilst enabling providers to demonstrate how their service meets the required outcomes of the populations they serve. Outcomes may be collected as part of the following:

- Audit
- Contract management
- Inspection
- Key Performance Indicators
- Surveys (children or young people / staff)

When creating regionally collected outcome measures, the Intercollegiate Healthcare Standards for Children and Young People in Secure Settings should be consulted, and providers/commissioners should work together to determine the best way of assuring the standards.

5. Service

5.1 Service description

Service outline:

- Children have a named healthcare professional.
- Children have a shared trauma-informed formulation which includes:
  - Information from the Comprehensive Health Assessment Tool (CHAT)
  - Specialist assessment(s) for the child or young person
  - Speech, language, and communication needs
  - Outcomes for the child or young person with consideration given to transition pathways.
- Children are supported to contribute to the development of their trauma-informed formulation.
- Children have access to NICE recommended interventions for specific conditions and practitioners can refer them appropriately.
- Embedded mental health and neurodisability practitioners at each secure setting offering increased support to staff and children.
  Examples include:
  - Staff with health training are visible and available
  - A point of contact and a resource for residential staff and children at the secure setting
  - Providing informal support/reflection/training to residential staff through increased integrated multi-disciplinary team (MDT) working
  - Increasing confidence amongst staff in managing complex behaviours
  - Working collaboratively, knowing a particular group of children in detail
- Healthcare staff provide training, supervision, reflective practice and support to health and non-health staff to improve the mental health, resilience and wellbeing of all staff and children
- Continuity of care plans are in place for children both entering and leaving secure settings, ensuring that:

- All children are registered with a GP before leaving or having just left secure settings
- Completed CHAT discharge plans are all forwarded to the new registered GP
- There is a named healthcare lead(s) to coordinate pre-transition engagement with services
- There is effective communication with families/carers/next of kin (where appropriate) and youth justice services (e.g., Youth Offending Teams) to support improved health outcomes on transition
- For justice placements, effective communication with Liaison and Diversion takes place if the child or young person was assessed at arrest.

Record Keeping

The CHAT (Comprehensive Health Assessment Tool) should be used as a reception health screen for all children entering the secure setting to assess individual health need. For those needing a full mental health and neurodisability assessment, this should be undertaken within CHAT timeframes. The data from CHAT can also be used as a starting point for conducting a Health and Wellbeing Needs Assessment for the secure setting. The information from these assessments can be used to best inform the commissioning of health services in future. A plan should be in place to ensure staff who will need to access CHAT are trained to use it and that new staff are also trained as part of their induction.

Prescribing

Prescribing in secure settings should be based on national guidance but may need to be adapted for use in a secure setting where medicines are open to abuse or where they may pose a high risk of overdose.[5] There should be a medicines management policy.[6] Clinicians should clearly document their decision making regarding medications in the clinical record (e.g. the electronic health record) and if departing from guidance, the rationale for this must be recorded. Medication dispensing in secure children's homes is the responsibility of the residential staff. This means the provider should support the care staff employer and employees to develop and use standard operating procedures that describe a safe process for supplying substance misuse medicines in line with national medicines guidance.

How each of the CYPSS standards (excluding 7, 8 and 9 – for these, see the relevant service-specific specification) could be met through the service model is described below.

[5] Please see Safer Prescribing in prisons, guidance for clinicians, RCGP, 2019, which can be used to inform secure settings for children https://www.rcgp.org.uk/getmedia/400e7a75-7b46-4a24-8151-d3ea4a2cf5a1/SPiP-Final-v10-20-Email-Friendly.pdf

[6] CYPSS Standard 6.4

Standard and its purpose	Approach	Relevant sections
1. Overarching principles for delivering healthcare to children in secure settings Sets out the overarching principles for delivering an integrated healthcare service for children in secure settings, notably the importance of a child-centred health approach.	All elements of service delivery should be underpinned by these principles.	Primary standards: 1.1, 1.2, 1.3, 1.4, 1.5 Additional linked standards: 3.2,3.3.2, 15.1
2. Safeguarding Safeguarding is the responsibility of all individuals working with children in the secure estate. Sets out the requirements to meet safeguarding responsibilities.	All secure settings must comply with the requirements of the NHS Standard Contract and have current safeguarding policies and procedures in place, which are subject to appropriate monitoring and review by a safeguarding committee and are legislatively compliant.	Primary standards: 2.1, 2.2, 2.3, 2.4 Additional linked standards: 3, 14
3. Information sharing Sets out principles and requirements for information sharing, as well as responsibilities in terms of consent and who to share information with.	All secure settings must facilitate appropriate, timely, and effective sharing of information to enable integrated and formulation-based care planning. Compliance with this standard requires proactivity; from staff in seeking information when a child or young person is admitted to a secure setting, and in appropriately sharing information with new providers when the child or young person transfers to an alternative setting or into the community.	Primary standards: 3.1, 3.2, 3.3, 3.4, Additional linked standards:

		1.1.4, 3.1.1, 4.3.1, 5.1.1, 10.5, 13.1.2, 14.10
4. Entry and assessment Defines what needs to happen when a child or young person is admitted to a setting, including assessments for early identification of needs.	The service must complete a reception CHAT (Comprehensive Health Assessment Tool) health screen. The assessment should identify life threatening and immediate health needs and prescribed medication needed, using a medicines reconciliation, and record visible injuries. Other than in extenuating circumstances (such as detention under the Police and Criminal Evidence Act, 1984 (PACE)), the reception CHAT assessment should be completed before the child or young person'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. Where the child or young person is considered at risk of harm to self or others, urgent needs are identified, action taken, and information shared appropriately, to safeguard them and all others in the secure setting, including staff. Staff should access existing healthcare records, including from electronic systems such as NHS spine and the child or young person's originating area (primary care GP), youth justice services, e.g., Youth Offending Team (YOT) and Education Health and Care Plans (EHCPs) from the originating local authority. Information is collated on reception and staff 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 or young person's engagement with the setting's broader	Primary standards 4.1, 4.2, 4.3, 4.4, 4.5, 4.6 Additional linked standards: 1.1.4, 3.1.1, 6.3.2, 8.1, 14.3

	regime, including restraint, is shared with appropriate staff. Reasonable adjustments within the secure setting should be considered where required to maximise engagement. All reasonable efforts should be made to and find any existing records. These efforts should be documented where records cannot be found or accessed. Assessment is not a one-off event. The health assessment is reviewed at least annually and the mental health assessment within three months of arrival.	
5. Care planning Sets out the ways in which care planning, including formulation, should be carried out by settings to ensure integrated care for the child or young person.	Care planning for each child or young person should be comprehensive, holistic and formulation based. Staff across the secure setting work as a multiagency team to place the child or young person at the centre of their care. The named registered 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 or young person, reviewing the plan regularly with the child or young person. The healthcare plan is joined up to LAC (Looked After Child) plans, EHCP (Education, Health and Care plans), transition plans, education, and sentence and care plans to tell a coherent and comprehensive story about how the child or young person'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 or young person and their parents/carers/next of kin (where appropriate) 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.	Primary standards: 5.1, 5.2, 5.3, 5.4, 5.5 Additional linked standards: 1.3.3, 4.3.1, 6.3, 10.1, 14.10

	Access and waiting times are reasonable and take into account the child or young person'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 provide the interventions required of them. 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.	
6. Universal health services Children have access to primary health services that 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. There is access to emergency medical and dental services 24 hours a day.	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. 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. The setting appropriately supports children whose individual circumstances mean they require additional support.	Primary standards: 6.1, 6.2, 6.3, 6.4, 6.5, 6.6, 6.7, 6.8, 6.9 Additional linked standards: 5.4.1, 7.1, 8.1, 9.1, 12.5, 13.5, 14.5
10. Transition and continuity of care	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 or young person and family/carers/next of kin (where appropriate) where possible. This may involve	Primary standards: 10.1, 10.2, 10.3, 10.4, 10.5, 10.6,

Sets out how to support children to transition out of the secure setting as well as continue to access care in their new setting, whether back in the community or a different establishment in the Children Secure Estate or into the adult estate.	practitioners liaising directly with their community-based counterparts to refer children or young people on or liaise with the originating GP. At other times it may be appropriate for the home youth justice services e.g., 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 (Did Not Attends). Information is shared effectively to ease transition between secure settings and shared with the child or young person (and their family/carers/next of kin where appropriate) if they are transferred to the community. Additional support is offered before transition based on the child or young person's needs and transition plan (such as harm minimisation programmes). Health professionals should use the child or young person's formulation to take an active role in communicating strengths, needs and risks regarding the child or young person to the new placement/provider/family/carer in order to ensure continuity of care during and after the transition period. Children or young person 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 at least seven days' supply of medication (including special arrangements if discharged with controlled drugs).	10.7, 10.8, 10.9, 10.10, 10.11 Additional linked standards: 4.5.2, 5.2

12. Planning and monitoring Sets out the principles for planning a service, including the development of healthcare strategies as well as monitoring outcomes and service experience. There is also a focus on implementing improvements.	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/registered manager/principal director of the setting are aware of their respective responsibilities under legislative and regulatory frameworks. The director/governor/manager/principal director ensures that the whole setting is involved in strategic health planning. Views of children are considered 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.	Primary standards: 12.1, 12.2, 12.3, 12.4,12.5 Additional linked standards: 2, 3, 6.3, 6.4, 6.5, 7.1, 7.6, 8.1, 9.1, 13.5.4
13. Multiagency working Multiagency working is fundamental to delivering an integrated care offer for children within secure settings.	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.	Primary standards: 13.1, 13.2, 13.3, 13.4, 13.5

Sets out how different agencies should work together within the setting as well as outside the setting to meet the needs of children.	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 is embedded in the setting's ways of working. Children or young people, family/carers/next of kin (where appropriate), and allied health professionals know how to complain or raise questions and concerns. Responses are timely. Leaders from all organisations/departments within the secure setting should work together to ensure strong working relationships are formed and maintained between departments to ensure the best care is offered to young people.	Additional linked standards: 3.1, 3.4.1, 11.4
14. Staffing and training This standard outlines the expectation of staff working within secure settings. It outlines the training and support staff should receive to be able to deliver high-quality care.	All staff are aware of the key challenges around child and adolescent health and wellbeing for children in secure settings. 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, if a child needs to be restrained.	Primary standards: 14.1, 14.2, 14.3, 14.4, 14.5, 14.6, 14.7, 14.8, 14.9, 14.10 Additional linked standards: 3.1.3, 5.1.1, 7.2.1, 8.2.1, 9.2.1, 12.4.3

	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.	
15. Equality and diversity This standard outlines the ways in which healthcare services and staff are expected to deliver care that is equitable, respectful, trauma informed and supportive of each child's individual needs.	Healthcare services are delivered in line with the provisions set out in the Human Rights Act 1998 and the Equality Act 2010 to ensure children do not face discrimination. Healthcare staff work with residential/operational and educational staff as well as parents/carers/next of kin (where appropriate) to ensure medical, cultural, and dietary needs of all children are met. Healthcare staff respond to the needs of children, bearing in mind protected characteristics such as an ethnic minority background, children who are lesbian, gay, bisexual and/or identify with a gender other than the one they were assigned at birth and those with a learning disability, neurodevelopmental need or both. Healthcare staff are appropriately trained in equality and diversity. Opportunities are available to staff to reflect on their unconscious biases during guided reflective practice.	Primary standards: 15.1, 15.2, 15.3, 15.4, 15.5, 15.6 Additional linked standards: 1.1.2, 1.2.1, 6.1.4, 10.3.3, 11.1.4, 14.3, 14.10

5.1 Service description (continued)

Access to healthcare

The governor/director/registered manager/principal director of the setting:

- **Standard 2 - Safeguarding**
  - Is accountable for ensuring that current safeguarding policies and procedures are in place and compliance monitored, and is aware of the setting's need to meet the standard
  - Champions 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**
  - Is accountable for ensuring that current information-sharing procedures are in place, followed and monitored
  - Champions the 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 and staff
  - Supports healthcare staff in the setting to obtain healthcare information when children enter the setting and provides appropriate support to escalate any instances where requests for information are not met
- **Standard 4 - Entry and Assessment**
  - Is aware of the timescales required for assessment, aids healthcare staff's access to children to meet these timescales, and facilitates healthcare staff in accessing healthcare records whether through providing them with 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 healthcare or associate staff access to children at any time in case of an urgent medical need or to ensure medication can be supplied appropriately
  - 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**
  - Understands the duty of care on the secure setting to enable children to access healthcare appointments, particularly those that could improve their mental health and behaviour
  - Should be approached to find solutions to any impacts the regime has on access to and waiting times for healthcare appointments
- **Standard 6 - Universal Health Services**
  - Encourages development of a "whole setting" approach to health promotion, including mental health
  - Ensures systems are in place to make care staff are aware of any child's physical or neurodevelopmental conditions, and mental health problems that could be exacerbated were they to be restrained or separated from others
  - Where children are subject to restraint or separation, ensures 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**
  - Understands the benefits of a comprehensive health transition plan, including their potential to reduce reoffending (where appropriate), and is committed to working with healthcare staff on a transition plan that includes educational, sentencing (or a court order for children placed under the Children Act) and other needs.
- **Standard 11 - Healthcare environment and facilities**
  - Works with healthcare providers to ensure the healthcare facilities in the setting are fit for purpose and in a suitable location, and that fixed fittings are adequately maintained (NHS England is responsible for moveable equipment relating to health treatment and intervention). Healthcare facilities 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 in health settings in the community
- **Standard 12 - Planning and Monitoring**
  - 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 and outside healthcare to support the needs of the child
- **Standard 13 - Multiagency Working**
  - Is committed to the concept of multi-disciplinary working which incorporates staff from substance misuse, safeguarding, healthcare, care and education teams
  - Is 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**
  - Is aware of the setting's requirement to meet CYPSS standards 14.1, 14.2 and 14.3
  - Is aware of the setting's requirement to meet the standard 14.8.2: healthcare staff can operate safely within the secure setting; and 14.8.6: healthcare professionals conduct their work within the same ethical and good practice codes as their colleagues in health services in the wider community
  - Is aware of the setting's requirement to meet the standard 14.9.2: healthcare professionals know where to go for advice and support following a major or disturbing incident and have access to a support system such as a support group or counselling service
- **Standard 15 - Equality and Diversity**
  - 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.

5.2 Additional vulnerabilities and health inequalities

Providers should be aware of the additional vulnerabilities and health inequalities facing children in their care and be able to evidence how they adapt their processes, policies, and interventions to meet the needs of all children. This includes Core20PLUS5.[7]

This should include making use of best practice and relevant statutory guidance for children who:

- Are looked after (LAC) or care leavers
- Have experienced child sexual exploitation (CSE) or child criminal exploitation (CCE)
- Have neurodiverse needs including learning disability, autism, ADHD, acquired brain injury (ABI), or Tic disorders (e.g., Tourette's Syndrome)
- Have speech and language needs
- Experience gender dysphoria
- Are addicted to drugs and/or alcohol
- Self-harm
- Display harmful sexualised behaviour
- Have been excluded from education and/or are at risk of becoming long-term Not in Education, Employment or Training (NEET)

A Health and Wellbeing Needs Assessment for the setting should be completed ahead of any new procurement cycles. This will provide data specific to the secure setting and will consider the needs of children with relevant protected characteristics.

Providers should consider at a minimum:

- How their assessment process supports effective identification of additional vulnerabilities
- What reasonable adjustments are made to screening/assessment or interventions, clinical and non-clinical environments to ensure all children can access and benefit from services equally
- How identified vulnerabilities are recorded to ensure continuity of care throughout a child or young person's journey, to reduce re-assessment
- How information is shared with wider support networks throughout the care pathway - but especially at the point of discharge - to ensure care and support

[7] See https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-cyp/

from all agencies is appropriate and co-ordinated in the best interests of the individual child or young person

- How the staffing model ensures that children are supported by professionals who understand and can meet their individual needs – e.g., through 'champions', Train the Trainer models, Lived Experience inclusion within the workforce, skill mixes within multi-disciplinary teams and/or access to peer support
- How the workforce is trained and supported to identify and respond to additional vulnerabilities.

CYPSS Standard 15 sets out the equality and diversity responsibilities.

5.3 Pathways

See the specific service specifications for pathway details.

5.4 Clinical networks

All providers will be required to participate in a networked model of care to enable services to be delivered as part of a co-ordinated, combined whole system approach.

The Managed Clinical Advisory Group (MCAG) is a specialist children health subgroup to the Health and Justice Clinical Reference Group. Membership is recruited from each secure setting.

This group meets, where possible, four times a year. The role of the MCAG is to:

- Support high-quality clinical governance and best practice
- Provide assurance and guidance on clinical matters relevant to the children and young people secure estate (CYPSE)
- Ensure the child or young person's voice is heard and support co-produced solutions by children with lived experience of the CYPSE
- Provide clinical input to policy development
- Support the continued implementation of the Framework for Integrated Care in the children and young people secure estate
- Support the implementation of the Framework for Integrated Care (Community) to bridge gaps for vulnerable/at risk children in the community as outlined in the NHS Long Term Plan

Members are expected to:

- Be clinical leaders from a broad range of professions in the CYPSE, whose core focus or lead responsibility is child and young person health and wellbeing
- Be supported by key non-clinical staff from secure settings to reflect and address wider relevant issues relating to delivery of health provision in a secure setting
- Have expert understanding of:
  - Clinical, operational, and safeguarding pathways and practice
  - Healthcare standards
  - Policy developments
  - Key reports, guidance and statutory responsibilities related to the CYPSE and the broader children's health and safeguarding field.

5.5 Staffing

For commissioners to complete:

- *List essential staff groups for provision of the service*
- *Include links to relevant, agreed, and applicable standards*

CYPSS Standard 14 sets out the requirements of staff working in a secure setting.

5.6 Essential equipment and/or therapeutic environment

CYPSS Standard 11 sets out the requirements for the therapeutic environment needed in a secure setting.

5.7 Inter-dependencies with other services

Detail other inter-dependent NHS services the service relies on for delivery. Include links to relevant, agreed, and applicable standard and proximity

This section is for commissioners to complete based on local provision.

Interdependent service	Relevant service specification / standard	Proximity to service

6. Appendices

Appendix 1 – Rights of the Child

The United Nations Convention on the Rights of the Child (UNCRC) should underpin the specification. This is international agreement protects the rights of children and provides a child-centred framework for the development of services to children. The UK

Government ratified the UNCRC in 1991 and, by doing so, recognises children's rights to expression and receiving information amongst other matters.

Children have said that they need:

- Vigilance: to have adults notice when things are troubling them
- Understanding and action: to understand what is happening; to be heard and understood; and to have that understanding acted upon
- Stability: to be able to develop an on-going stable relationship of trust with those helping them
- Respect: to be treated with the expectation that they are competent rather than not
- Information and engagement: to be informed about and involved in procedures, decisions, concerns, and plans
- Explanation: to be informed of the outcome of assessments and decisions, and reasons be given when their views have not met with a positive response
- Support: to be provided with support as well as a member of their family
- Advocacy: to be provided with advocacy to assist them in putting forward their views.

Appendix 2 – Safeguarding

Safeguarding children (Working Together to Safeguard Children, 2018)

Effective safeguarding arrangements in every local area should be underpinned by two key principles:

- Safeguarding is everyone's responsibility. For services to be effective, each professional and organisation should play their full part
- A child centred approach. For services to be effective they should be based on a clear understanding of the needs and views of children

Safeguarding is everyone's responsibility. Everyone who works with children has a responsibility to keep them safe. No single professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who meets them has a role in identifying concerns, sharing information, and taking prompt action.

All those working with children should be alert to risk factors and signs and symptoms of child abuse and follow local safeguarding procedures where there is cause for concern. **Working Together to Safeguard Children** (HM Government 2018) sets out how

organisations should work together and the actions to be taken when abuse or neglect is known or suspected.

Safeguarding children in the secure setting is of critical importance. Secure settings must have current safeguarding policies and procedures in place, which are subject to appropriate monitoring and review by a safeguarding committee and are legislatively compliant.

Appendix 3 - Relevant Inspection Frameworks for secure settings

Providers 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.

Inspection of a Young Offender Institution

His Majesty's Inspectorate of Prisons (HMIP) is an independent statutory organisation which reports on the treatment and conditions of those detained in Young Offender Institutions. HMIP inspects according to the **HMIP Inspections for Young Offender Institutions framework** jointly with other inspectorates such as the Office for Standards in Education, Children's Services and Skills (Ofsted), the Care Quality Commission (CQC) and the Royal Pharmaceutical Society.

Joint Inspections of Secure Training Centres

The inspection of Secure Training Centres (STCs) is undertaken jointly by Ofsted, HMIP and the CQC in consultation with the Youth Custody Service for England and Wales, and the Ministry of Justice. The **Framework for inspections of Secure Training Centres** (last updated December 2022) includes evaluation criteria to describe what "good" looks like in the judgement of overall effectiveness.

Ofsted Inspections of Secure Children's Homes

Ofsted uses the **Social Care Common Inspection Framework (SCCIF)** for the inspection of Secure Children's Homes.

Inspections of Secure Schools

Ofsted and CQC are the inspectors for the new school. Details of these inspections has not yet been confirmed.

Appendix 5 - References for commissioners

- **Care, Education and Treatment Reviews for Children and Young People- Code and Toolkit (2017)**

- **Child and Maternal Health (2023)**
- **Children Act (1989)**

  Ensure compliance with **Children Act 2004 Section 10** duty to co-operate to improve wellbeing and to safeguard and promote the welfare of children.

  Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.
- **Core20PLUS5 for Children and young people**
- **Equality Act (2010)**
- **Future in Mind: promoting, protecting and improving our children and young people's mental health and wellbeing (2012)**
- **Guidance: Health protection in children and young people settings, including education (2017)**
- **Healthy Children, Safer Communities (2009)**

  Mental health problems in children do not manifest themselves as clearly as they do in adults. They can emerge in ways that are less easily defined or diagnosed – for example, through behaviour problems, emotional difficulties, substance misuse or self-harm. This can lead to underestimates of the extent of mental health problems in certain groups of children. The mental health needs of children in the youth justice system overall are three times greater than for their peers in the general population, with increasing severity and complexity of need for those in custodial settings.
- **Making Every Contact Count (MECC): Consensus statement Produced by Public Health England, NHS England and Health Education England (2016)**
- **Mental Health Act (1983)**
- **Mental Health Act Code of Practice (1983)**
- **Minimising and Managing Separation and Isolation in the Children and Young People Secure Estate**
- **National Standards for Youth Justice Services (2019)**
- **NHS Long Term Plan (2019)**
- **NHS England: Special educational needs and disability (SEND)**
- **NICE Guidance – Harmful Sexual Behaviour (NG55)**

- **Population health needs assessment: a guide for 0 to 19 health visiting and school nursing services (2021)**
- **Preventing suicide in England: A cross government outcomes strategy to save lives (2012)**
- **Health and Justice Children Programme national partnership agreement 2023-25**
- **The Children's Homes (England) Regulations 2015**
- **Guide to the Children's Homes Regulations including the quality standards**
- **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 are treated as looked after by the local authority designated by the court when remanded securely.
- **The Secure Training Centre Rules 1998**
- **The Young Offender Institution Rules 2000**
- **THRIVE Framework for Systems Change**

  One example of mental health services is the THRIVE model, which helps to implement a whole system approach. The framework outlines groups of children and the sort of support they may need, drawing a clearer distinction between treatment on one hand and support on another. The model conceptualised five needs-based groupings for children with mental health issues and their families:

  - Thriving – prevention and promotion;
  - Getting advice – signposting, self-management and one of contact;
  - Getting help – goals focused, evidence informed, and outcomes focused intervention;
  - Getting more help – extensive treatment;
  - Getting risk support – risk management and crisis response.

- **Working Together to Safeguard Children (2018)**

Appendix 6 – Glossary

Please see the CYPSS Healthcare Standards Glossary.