Service specification

Primary care service – medical and nursing for immigration removal centres in England

2020

NHS England and NHS Improvement

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Contents

The purpose of health care in detained settings is to provide an excellent, safe and effective service to all detainees ensuring access to and the quality of services delivered is equivalent to that of the community, taking into the particular needs of people detained**.**

1 How to use this document

1.1 This service specification represents something of a departure from earlier iterations of health and justice service specifications. In previous specifications, the text has very much provided a clear steer as to:

- exactly what should be provided, in what context
- how to go about providing it and
- how much of it to provide.

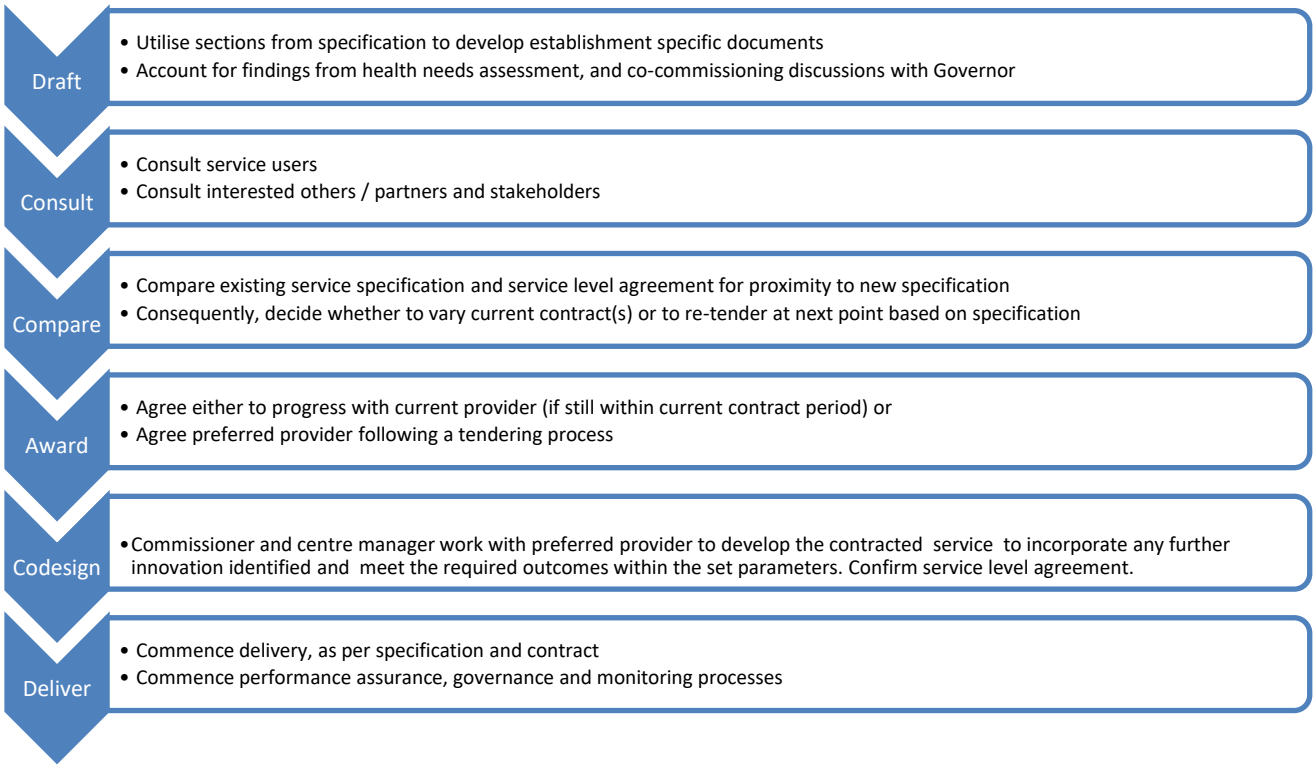
What is presented in this document is a modular approach taking account of:

- areas of focus that nationally providers are expected to prioritise
- the outcomes that are expected from any provider, and examples of how evidence of their ability to deliver those outcomes may be demonstrated
- the freedom for regional commissioners to tailor the specification to their needs and the needs of any specific population.
    - Where the following box is used, commissioners should insert local establishment/contract specific information or follow the instructions noted and delete the 'Note to local commissioners'.

Note to local commissioners
Insert local additions required to suit the individual establishment

- The opportunity for providers to show their skill, experience and creativity in developing service models that will deliver the required outcomes.

The expectation is for the following process to take place:

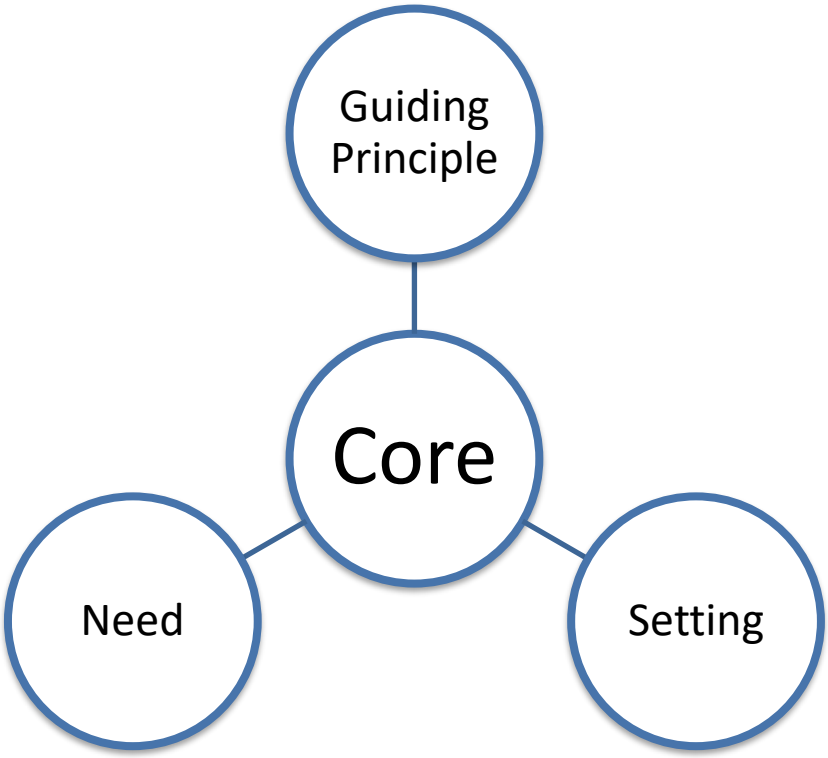


1.2 The specification also has an annex which is relevant to all health and justice specifications and is not service-specific. This annex forms part of the overall specification and ensures that providers within an establishment, and nationally, are working to the same standards.

1.3 As a part of the process of exploring the specification, co-design and agreements between parties, a number of documents will need to be in place (which will vary according to commissioner, provider, IRC and regional / local approaches); further details of these will be included in other documents, such as the standard contract.

2 The model

The integrated primary care service specification is structured to enable the flexible use of the following concepts presented through four main considerations:



National specification

- At its centre – a **core framework** that clearly outlines the required objectives, outcomes and standards of the service and the expected minimum levels of governance.

- An overarching **guiding principle**, that defines the basis upon which activities in the specification are delivered (i.e. safe, patient centred, integral peer approaches, and provided within a cohesive multi-disciplinary framework). The guiding principle element of the specification will also include signposting towards pre-existing reviews and recommendations.

Localised elements of the specification

- Full account of the **specific issues of immigration removal centres (IRCs)** and how this can impact on the type or duration of intervention that can be offered.

- A thorough examination of **need**, including (but not limited to) quantitative analysis, consultation and patient involvement. A comprehensive understanding of need is a cross-cutting issue across all elements of the specification. The flexibility offered by this specification places the emphasis

on *an establishment-based service designed around the needs of the patient population*, as evidenced through needs assessment.

The updated specification and its implementation from 2020 onwards provides an important opportunity to take into account:

- the profile of people in IRCs
- the different physical and mental health needs of women who are detained
- service users, and their full and active involvement in the design and planning of services, service delivery, peer support and service evaluation
- the need for all parties to ensure all primary care health services are commissioned and provided as services that are fit for purpose and take account of environmental factors and the additional stresses experienced by this patient population related to detention.

It is proposed that the central core specification is the primary document – prefaced by the guiding principle statement – with guidance, signposting and links made to appendices/annexes/external sources to cover need, setting, and standards. These can then be utilised as appropriate by commissioners and providers in specifying the required service and evidencing delivery.

This model should ensure:

- requirements are delivered, whilst allowing for local flexibility and personalisation
- existing standards (e.g. clinical guidelines) are not repeated or interpreted for the specification, instead they are signposted to
- rather than telling providers how they should be doing their job, commissioners will be able to look for competence, creativity and innovation in evidencing ability to deliver the required outcomes. Once assured of the ability of the provider to deliver effectively against the 'must do' elements of the specification, commissioner / governor and provider can work in a process of co-design to develop a bespoke service tailored to the setting, focussed on achieving the desired outcomes

3 Introduction

The 2012 Health and Social Care Act mandates NHS England and NHS Improvement (NHSE/I) to commission 'health services across IRCs and other places of prescribed detention'. The immigration removal estate constitutes places of prescribed detention, as such, this specification describes the required degree of primary care services that need to be delivered in these environments, ensuring that the principle of 'equivalence' is adhered to, enabling patients access to physical and mental health care as required in line with services offered in the community.

This service specification outlines what should be included in a primary care service being offered to patient populations in IRCs and Short-Term Holding Facilities. It also includes guidance for the support that should be offered to individuals with learning disabilities and other vulnerabilities (such as identifying people with a history of trauma, mental health presentations, physical impairments including sight and hearing loss and broader cognitive impairments - learning disabilities, autism, neuro disability or acquired brain injury).

It is an integral part of the primary care of a person in detention that such vulnerabilities are brought to attention of the detaining authorities. Delivery of the healthcare services should support the mechanisms in train for identifying individuals who, because of their physical or mental health needs may not be suitable for remaining in detention and need to be considered in relation to the Adults At Risk Policy[1].

Compassionate care needs to be delivered to patients at all times mindful of the previous trauma a person may have received at the hands of others.

The specification could be integrated with the secondary mental health specification and needs to reference the relevant Public Health Section 7a specifications and other health support provisions (as per the specific specifications detailing required provision for these areas).

There are numerous clinical guidelines and best practice documentation that describe clinical practice and processes to steer best practice in the delivery of physical healthcare for people in secure and detained environments. This document does not aim to replicate these guidelines but provide a description of the minimum service requirements for a primary care service delivering services to a patient population being held in immigration removal settings. For specific clinical interventions please refer to the appropriate clinical guidance.

People in detained environments may require additional health and social care support generally. Whilst social care is not legally the responsibility of NHSE/I commissioning arrangements and therefore the detail for this lies outside the scope of this specification, there is a strong need to work collaboratively with local authority social care teams and other healthcare providers.

[1] HO AAR Policy see p 85 for link to policy document.

A safe and secure detention setting cannot be successfully delivered without effective primary care which has an understanding of and a commitment to supporting the needs of patients with learning disabilities and other vulnerabilities. In turn, such services cannot be delivered without the full support and partnership of the establishment regime and its staff. Both the physical environment within which a person lives and receives care and the service provided, contribute towards general physical and mental wellbeing within the detention facility.

This specification aims to build upon existing positive relationships between healthcare services, the Home Office and patients and the vast body of work already successfully in place.

It is recognised that this is a significant time of change and transition in terms of NHSE/I commissioning pathways and the Home Office review of detention enforcement policies Therefore elements of this specification may be subject to review in response to variations. NHSE/I and Home Office commissioners will fully engage with the service provider during the initial service co-design period and then for the lifetime of the contract to ensure this specification remains relevant and meets the needs of the population.

4 Guiding principle

The purpose of health care in detention facilities is to provide an excellent, safe and effective service to all detainees ensuring access to and the quality of services delivered is equivalent to that of the community[2]. Services should meet the objectives and outcomes of national frameworks and priorities and are expected to develop and implement measures to monitor these outcomes.

Services should operate from a position of 'Making Every Contact Count'. Wherever a patient presents to any health service, or via some other intervention, it is incumbent upon providers to meet immediate needs and bring appropriate provision to the patient and not 'send' them to another intervention.

Screening, assessment and treatment should be holistic and encompass physical and mental health conditions, learning disabilities and other vulnerabilities. They should be appropriately levelled to the patient and address the wide range of other, often related mental and/ or substance dependency needs identified. It should have a public health perspective and focus on reducing harms and promoting recovery and rehabilitation. It is critical to the care of a patient that liaison with secondary care and especially specialist services, is in place to support continuity and specific care as required to meet a patient's needs.

Care should be person centred and delivered by professionals and allied staff who are suitably competent, well led, properly supervised and operating within a clear quality and clinical governance framework supporting safe and effective delivery.

[2] For NHSE/I the principle of equivalence across the detained estate does not mean 'the same as' but supports an approach where access to services is not compromised by a persons physical circumstances. There is a full definition of this principle of equivalence on page 15 of this document.

Every patient should have a treatment and care plan, which should be regularly reviewed with the patient.

There should be access to suitable psychosocial and clinical interventions, as well as a focus on health promotion and supporting positive health and well-being. Where medication is indicated, its provision should be suitably safe, particularly in those with difficulties achieving stability and with clear shared care between prescribers.

Clinicians should be able to adapt evidence-based treatments from the wider community to the IRC estate and regime and be able to work with security staff and systems to reduce harm and to manage risk, particularly the risk of fatalities and self-inflicted harm as well as other risks to consider such as abuse and exploitation. They should also have established links with other providers serving the detention facilities and engagement with the third sector providers supporting individuals, where appropriate, to ensure a holistic package of care and support.

5 Frameworks and priorities

Healthcare for people in the detention estate is influenced by a wide range of policy areas and developments. The provider will deliver services to meet the objectives and outcomes of the various frameworks and priorities and will be expected to develop and implement measures to monitor these outcomes. These include but are not limited to:

NHS Outcomes Framework

NHS Outcomes Framework sets out the framework and indicators used to hold NHSE/I and commissioned services to account for improvements in health outcomes. The outcomes and indicators can be found here: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework.

The NHS Outcomes Framework cuts across a number of specific elements of patient care, not all of which apply to the patient population in an IRC.

It is therefore important to consider the outcomes described in Appendix One of this document to ensure that relevant focused outcomes for this patient population are considered.

Public Health England Strategic Plan: Better Outcomes by 2020

Public Health England's strategy sets out priorities for health, which can be found here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/516985/PHE_Strategic_plan_2016.pdf.

6 NHS Long Term Plan

The NHS Long Term Plan published in January 2019 sets out the vision for the NHS over the next decade. The document can be accessed here: **https://www.longtermplan.nhs.uk/.**

While the principles of the entire LTP apply to all health and justice commissioned services, priorities relating specifically to health in detained settings include:

- **Additional investment in services for people experiencing a mental health crisis will make a real difference for people who need support and will help ease pressures on police services.** Adults, children and young people will receive health screening on entering detention and a follow-up appointment within seven days, or sooner as required. This will be supported by the full roll-out of the health and justice digital patient record information system across all adult prisons, IRCs and secure training centres for children and young people. This will include the digital transfer of patient records where possible (including from the community to the establishment and between establishments). Where appropriate these records would be transferred to the registered GP in the community.
- **Health and justice services are provided to some of the most vulnerable members of our society.** Many people within detained environments experience greater problems than the rest of the population but do not regularly access timely healthcare. The NHS is already working with partners across government to improve the wellbeing of people who have been detained and reduce inequalities. A priority in services for this group of patients is improving continuity of care. The care after detention service, RECONNECT will start to work with the most vulnerable people before they are released from detention and will help them to make the transition to community-based services, where this is appropriate for individuals likely to be returned communities in England, that will provide the health and care support that they need. Over the next five years, RECONNECT will engage and support more people post detention per year.

7 Core service delivery

7.1 Service vision

Note to local commissioners
(Delete as appropriate and include local governance arrangements) This is as a part of a wider integrated model of commissioning, e.g. prime provider model, this document represents the primary care 'module' (inclusive of learning disabilities) of that wider commissioning activity and should be read in conjunction with the other related elements. This is part of a 'lead provider' model, where the service provider must work collaboratively and flexibly with the lead provider to deliver integrated services. This service is a standalone service; however, the provider must work collaboratively with other healthcare providers. Consider cultural issues that may impact on an individual's choice to access services.

NOTE: As the commissioner is contracting an integrated healthcare service this specification should be read in conjunction with the other specifications attached to this contract (especially substance misuse, medical and mental health) for the full service model to be fully understood.

This service is commissioned as part of the overall IRC health pathway and as such this model will ensure an integrated treatment system both within an establishment and onwards into the community. The service will focus on delivering person-centred care within seamless and integrated clinical services in IRCs and facilitating arrangements to ensure continuity of care where appropriate. Close joint working with other healthcare services, as well as other departments within the establishment, such as education, case management, and physical education, is imperative to the success of the delivery of this service.

The service is to be made available to all detainees within the establishment. The provider must meet the unique needs of the establishment and take into account the needs of the population within that establishment.

- The NHS Standard Contract is mandated for use by clinical commissioning groups (CCGs) and NHSE/I when commissioning non-primary medical services NHS-funded healthcare services. Where primary medical services are being commissioned, the appropriate form of primary medical services contract must be used in accordance with the relevant Regulations and Directions.

- In certain circumstances, commissioners may wish to commission a package of services including both primary and secondary care elements from a single provider. An example of this would be the commissioning of IRC healthcare

services (for which the NHS Standard Contract must be used) and GP services (for which a general practice contract must be used). In those circumstances neither the NHS Standard Contract nor any form of primary medical services contract may lawfully be used on its own to commission that package of services. Various contractual structures may be used to deal with this. The use of Schedule 2L of the NHS Standard Contract offers a relatively simple solution, for use in appropriate circumstances.

- If the package of services includes primary medical services and services for which the NHS Standard Contract is the mandated form of contract, commissioners may include provisions in Schedule 2L of the NHS Standard Contract to make the Contract compliant with the APMS Directions in relation to the provision of primary medical care services. In other words, to ensure that the contract is both an NHS Standard Contract and an APMS contract.

- Schedule 2L is based very closely on NHSE/I's model form of APMS Contract, which is available at: https://www.england.nhs.uk/commissioning/gp-contract/.

Services should be familiar with the legal duties placed upon them by both the Equalities Act (2010) and the Health and Social Care Act (2012), as well as the Care Act (2014) and Mental Health Act (1983) and any other pertinent legislative duties as described, include such considerations into the overall approach taken and any plans made.

The service provider will establish and run a primary care service for the establishment, delivered to an equivalent standard and quality as services in the community. Primary care services should be delivered as part of an integrated healthcare service (as described within the full range of health and justice service specifications). The service provider must ensure that the workforce is able to provide high quality, safe, effective, caring, responsive and well-led care to patients and that 'the right staff in the right place at the right time' are available to achieve better outcomes, better patient and staff experiences and effective use of resources.

The provider will ensure staff capacity and capability is consistent with operational and strategic planning processes. The provider will ensure that the workforce is able to work flexibly and provide cover where required and appropriately manage shortfalls in staff cover. The provider is expected to have a workforce contingency plan in place, which should include provision for supporting locum staff induction and training.

The appropriate skill mix of healthcare staff in the establishment will include the use of practitioners from a variety of disciplines, e.g. nursing, paramedic, support workers and assistant/associate practitioners. The workforce must have the essential and relevant qualifications and competencies to carry out their roles and responsibilities and have access to regular clinical supervision.

The provider must ensure there is a robust system in place to monitor compliance with all statutory and mandatory training requirements for all healthcare staff, clinical and non-clinical. This must also include training for IRC specific mandatory requirements; i.e. Rule 35 training.

The provider must ensure that there is a rolling training programme to ensure staff have access to preceptorship and mentorship skills training to maintain skills in supporting trainees and newly appointed staff.

The service must meet the establishment's specific requirements for healthcare input as stated in Detention Service Orders (DSOs).

7.2 Days and hours of operation

Note to local commissioners
Local determination required but minimum offer must consist of service provision for 52 weeks per year. The provider will ensure that cover is provided for bank holidays.

7.3 Service availability

Note to local commissioners
Local determination required, but at a minimum must include: • Emergency referrals – within two hours Urgent referrals – within one working day with protocols in place with out of hours (OOH) to manage any emergency/ urgent cases that rise during the OOH period through CCG commissioned services or specialist services. Where 24/7 health cover is to be commissioned local management of this should be described. • The medical service must provide the patient population with the opportunity to book appointments more than 48 hours in advance, up to a period of six weeks in advance. • An appointment system will be designed to meet the needs of the establishment's population • Where GPs are not on site there must be a system, in place to access advice and/or a consultation with a GP.

7.4 Inclusion criteria

In carrying out the Services the Provider will be 'exercising public functions' for the purposes of section 149(2) of the Equality Act 2010. As such, the service provider must pay due regard to the Public Sector Equality Duty under section 149(1) of that Act and to deliver the services accordingly. The Equality Act 2010 relates to service users and employees.

7.5 Exclusion criteria

- Private procedures and practice - this is outside of the scope of this specification. If a patient wishes to obtain private treatment this can only be

achieved if there is agreement with the healthcare provider, commissioner and centre operator. Any private work must occur outside of the agreed sessions detailed within this specification and the patient must bear all costs for treatment including security procedures to be implemented.

- Treatment of all establishment staff and visitors (unless in an emergency arising at the centre)
- Exclusions in the management of minor injuries outside the competencies of staff includes injuries that require emergency hospital treatment and/or are outside of the competence of the onsite healthcare team at the time.

7.6 Equivalence

As required and described in the HSCA 2012 patients within detained settings should receive the same level of healthcare as those people in the community – both in terms of the range of interventions available to them which meet their needs, and the quality and standards of those interventions.[3]

'Equivalence' is the principle by which the statutory, strategic and ethical objectives are met by the health and justice organisations (with responsibility for commissioning and delivering services within a secure setting) with the aim of ensuring that people detained in secure environments are afforded provision of or access to appropriate services or treatment (based on assessed need and in line with current national or evidence-based guidelines) and that this is considered to be at least consistent in range and quality (availability, accessibility and acceptability) with that available to the wider community in order to achieve equitable health outcomes.

Taking into account the substantial health inequalities likely to be faced by most, if not all, patients within detained settings, it is imperative that any provision is not only equitable to community provision, but that it takes bold and innovative steps to improve the health of the most vulnerable and reduce health inequalities. As such it would be imperative that services provide:

Note to local commissioners
Local additions will be required to suit the individual establishment.

7.7 Setting

Note to local commissioners
Consider cultural issues that may present barriers to patients engaging with health care provision.

[3] RCGPSEG Statement of Equivalence: https://www.rcgp.org.uk/about-us/news/2018/july/prison-health-is-public-health`.aspx

Note to local commissioners
Within the ethos of collaborative -commissioning and maintaining the flexibility of this specification to be adapted to local need, this section is where you would consider and iterate the specific needs of the setting within which the service is to be provided. The impact of the different settings should help providers to consider their service model and the needs to be met through their service offer in collaboration with other services provided in the establishment and subsequently help commissioners and providers with co-designing the service. Considerations of setting should also include the appropriateness of the estate to facilitate effective treatment and recovery interventions, such as a healthcare setting which actively promotes recovery, calm, safe and appropriate dispensing facilities, confidential and secure delivery of treatment and care. Please insert local setting requirements here, e.g. size, healthcare facilities and establishment regime.

7.8 Referral criteria and route

- Following referral, appropriate patients must be scheduled into clinic(s) through a robust triage process.
- It is expected that a receiving healthcare organisation (e.g. acute or mental health NHS trust/FT) must accept any reasonable referral and redirect referrals within the trust where appropriate
- There is an expectation that referrals are manged in line with NICE pathways

7.9 Demand management

The healthcare provider will proactively manage keeping waiting times to a minimum by:

- proactive management of demand and capacity and implementation of a flexible reactive appointment system that is responsive to need.
- accessible access to urgent care during contracted hours.
- taking advantage of developments in technology to enhance access to care.

7.10 Access requirements

- First night reception/transfer health screening - screening **must take place** within two hours of first arrival at an establishment or after a transfer into another establishment.
- Rule 34 assessment **should be offered** within two hours and delivered within 24 hours of arrival at a centre (this offer should be part of the screening assessment) and all outcomes recorded. Detainees should also be made aware that should they not take up the offer of the Rule 34

assessment, they can approach healthcare for an assessment at any time thereafter during their stay in the IRC for a health assessment.

- The Rule 34 assessment (according to the currently extant IRC rules) is a physical and mental examination with a GP. It is separate from the reception screening.[4] The findings from this assessment will contribute to the subsequent Treatment and Care plan which may be raised with an individual following their comprehensive health review carried out within seven days of their arrival at the IRC[5]. The findings from this assessment will contribute to the subsequent treatment and care plan which may be raised with an individual following their comprehensive health review carried out within 7 days of their arrival at the IRC.
- Rule 35 assessment offered to all detainees who answer 'yes' to the arrival assessment question regarding whether they have been tortured or otherwise give an indication that they may have been a victim of torture; suicidal thoughts or are assessed that their health may be deleteriously affected by detention. If there are concerns that the individual is otherwise vulnerable, healthcare should alert the Home Office. A Rule 35 assessment should be carried out within 24 hours of healthcare staff becoming aware of the issue (jurisprudence for the time line is set out)
- General health assessment completed within seven days of arrival to include BBV and other appropriate screening.
- Healthcare to express contact a patient's community GP (where there is one) to request a patient summary be sent securely to the healthcare department as soon as possible.
- All patients are examined by an appropriately skilled and qualified healthcare practitioner during the 24 hours prior to discharge release or removal where they are made aware that such a course of action is taking place.
- Healthcare to identify patients due for release back to UK where possible, who do not have a community GP and to work with the patient to ensure they are pre-registered with an appropriate community GP prior to release.
- Discharge plans for all patients on release where possible. The RECONNECT programme will eventually streamline continuity of care approach for the most vulnerable. Should also include at least one-month (maximum three months) supply of medication, paper copy of medical record including discharge summary and a HC2 certificate if eligible.
- Patient summaries to be sent securely (by email) to the patient's community GP on release where appropriate.
- Detainees identified as an adult at risk must be given and appointment with a GP within 24 hours of admission to an IRC.
- Medical emergencies/urgent care – immediately via the emergency service routes commissioned by CCGs (Blue light services).

[4] Rule 34 (i) Requires every detained person to be given a physical and mental examination within 24 hours of admission. The examination should not be carried out without the persons consent. If this consent is not given at the time of arrival the detainee will be entitled to an examination at any subsequent time upon request.

    - Urgent referrals - within 24 hours.
- All patients on the ACDT process –reviewed within the required 24 hours and MUST include heath engagement.
- Healthcare staff attend ACDT reviews.
- Where appropriate, medical holds need to be considered and reported to the regime.

It is the responsibility of the healthcare provider to ensure all activities take place within the timescales specified by a suitably qualified member of staff, within available capacity and to prioritise accordingly.

7.11 Clinical governance

Clinical governance arrangements and structures will be in place which facilitate continuous service improvement by the utilisation and analysis of key information sources such as patient safety incidents, risk registers, complaints, best practice and clinical audit, audit of Deaths in Detention, Serious Case Reviews, Care Quality Commission (CQC) and Her Majesty's Inspectorate of Prisons (HMIP) action plans. There should be evidence of communication of these improvements across the range of organisations and partners operating within the IRCs. Clinical governance concerns both clinical and non-clinical staff and acknowledges everyone's contribution to the patient's experience. Good integrated governance should combine and create consensus around the concerns of clinical staff, removal centre staff and managers, patients and their families. Key to effective governance is the availability of information sources on which to base decisions.

The provider will use a variety of methods to ensure that a high-quality service is provided. These will include, but not be limited to:

- Patient questionnaires
- Waiting time surveys
- Clinical audit
- Audit of prescribing and medicine usage
- Activity information.

The provider will supply regular reports and relevant metrics/ performance data any other reasonable additional information to enable the commissioners to monitor performance targets. This could be subject to change negotiation.

7.12 Safeguarding

Details of expected safeguarding can be found in ***Appendix 3.***

7.13 Information governance

Details of expected information governance, data protection, security and confidentiality can be found in ***Appendix 4.***

7.14 Information management and technology

Details of expected information management and technology can be found in ***Appendix 5.***

7.15 Pharmacy and medicines optimisation

Details of expected medicines management and optimisation can be found in ***Appendix 6.***

8 Health and justice objectives, outcomes and standards

The service provider will work in partnership with the commissioners and other stakeholders to contribute towards the following objectives and outcomes and will consider all opportunities to enhance the aims of the service.

8.1 National collected outcomes

Each overarching objective has a few specified measures that will be nationally mandated and collected nationally for national assurance purposes. The guidance on the national indicators will come out annually in information schedule will which will be sent to providers by regional commissioners.

8.2 Regional collected measures

All services should be commissioned to achieve the four objectives and their respective outcomes. However, how these are achieved will depend upon the service model provided within an establishment. Different establishments with differing functions will focus their service on achieving the most relevant outcomes for the need of the population. For example, this may mean that a local reception establishment will have a greater focus on screening and assessment and through the gate working, rather than long term treatment interventions. This will require local determination by commissioners and providers on priorities based on the health needs assessment and the current population.

To assist with the evaluation against the objectives below, the specification incorporates proposed regionally driven outcomes that cover the following four domains:

- PROMs: Patient Reported Outcome Measures
- PREMs: Patient Reported Experience Measures
- CROMs: Clinical Reported Outcome Measures
- PATOMs: Partnership Reported Outcome Measures.

*In the table in **Appendix 1,** there are examples of possible service outcome measures and ways in which providers can evidence that each of the outcomes have been achieved. These examples are not exhaustive and should be locally agreed to fit the need of the establishment and patient population utilising data and information that is already in place in services. There is not an expectation that all these examples will be implemented but are provided to assist in determining the type of evidence that may be available.*

It is not anticipated that providers will report on each outcome routinely, these simply provide a mechanism by which providers can evidence they are achieving the outcome measures to commissioners when appropriate, for example, this may be part of an audit cycle or a thematic contract review.

This is for local determination and should not create an additional reporting burden but enable providers to demonstrate how their service meets the required outcomes for the populations they serve.

In ***Appendix 2*** there are **service standards**, which are the expected minimum service requirements for the IRC primary care service.

Appendix 1 – objectives and outcomes for regional contract assurance

Objective: **To improve the health and wellbeing of people in IRCs and reduce health inequalities**	
Outcomes	**Examples of how this could be evidenced *(local determination required)***
PROMs: Patients can access healthcare and healthcare information in different languages. All patients are involved in, and have access to, their own care plans. Patients have an improved understanding of their healthcare conditions and know how to access healthcare in the community or in their country of origin. Patients being released, discharged or removed are discharged with sufficient quantities of essential medications or FP10 to cover period between discharge and community GP registration. Patients are made aware of their healthcare rights on discharge to the community and are supported in how to register with a GP and how to receive specialist care (where applicable). Patients should be in receipt of HC2 form on their discharge. Healthcare is delivered in a safe and confidential environment, and documented escalation processes are in place for staff to raise concerns. Patients know how to engage with community healthcare services on release.	PROMs: Translation services are provided for all who were identified to those who need it; healthcare leaflets are available in different languages. Patient forum feedback sessions; patient questionnaires. National measures or local audit. DHSC 'healthcare entitlements for former detainees' leaflet is provided to patients released to the community. Records kept of cancelled /late clinics due to IRC regime. Including secondary care and outpatient appointments. Pre-registration and regular and shared recording of healthcare contributions to discharge planning where appropriate.

Sexual health, including historic sexual trauma is explored and incorporated into the Treatment and Care Plan (where appropriate).	
PREMs: I am able to access healthcare services and information in my own language. I am involved in a regular review in my health. My medical confidentiality is protected but information is shared to keep me safe. The services around me work together in my interest and enable me to express my health needs. I can request and use health services and I know what is available including out-patient services (as appropriate). I am supported to care for myself and maintain/improve my health and wellbeing. I understand my sexual health needs and I am able to access support to make good decisions My care was compassionate, respectful and kind and took account of my previous and current circumstances.	PREMs: Translation services are utilised when necessary; evidence of multi-lingual medication information leaflets. Evidence of patient engagement (e.g. patient forums, questionnaires).
CROMs: Care is informed by histories of trauma and does not re-traumatise. Patients receive an initial healthcare screen that identifies risks and immediate needs within two hours of arrival at an IRC. Patients receive an in-possession medication risk assessment and medicines reconciliation. Patients receive a follow-up health assessment by the GP, or an appropriately qualified member of the nursing team should the rules change to accommodate such an option, which could identify their wider health	CROMs: All staff have received Trauma Informed Care training. Activity levels captured through health and justice information system (HJIS) and reported into national measures. National measures or local audit. Pathways are in place to support patients undergoing removal methadone, meds, medical information etc).

needs and would result in a co-developed Treatment and Care Plan that would build on the health findings from the rule 34 assessment. This subsequent (3rd) assessment should be carried out within seven days of the persons arrival at the IRC. All staff are trained to recognise Adults at Risk. Health promotion activity is tailored to the needs of the establishment's population. Long term conditions are managed appropriately through pathways and/or in-reach services.	All staff receive training in identifying Adults at Risk. QOF Screening services and appropriately trained staff are in place.
PATOMs: Patients have access to Rule 34 and 35 assessments to determine fitness for detention. Healthcare staff contribute to the assessment and provision of evidence for detainees deemed as an adult at risk. Patients are prepared for release and resettlement and supported to obtain and NHS number and register with a GP practice. The provider works with centre staff to support patients to prepare for removal or return to the community. Information sharing agreements are in place locally to support appropriate sharing of patient information. IRC healthcare support sending prison healthcare in relation to time served FNO who will need assurance that established care pathways can continue to be delivered. A trauma informed approach is employed across the estate by healthcare staff. All healthcare staff to receive Trauma Informed Care training within three months of starting and refresher every two years.	PATOMs: Staff receive training on Rule 34/35 assessments. Staff receive training on the Adults at Risk Policy. Pathways are in place for patients released to the community. Information is made available to patients being deported. Localised ISPs in place with providers, commissioners, governors and other partners who work with healthcare providers. IRC healthcare engage with sending prison healthcare in relation to transferring time served FNO to a suitable IRC establishment.

A partnership is in place with a local SARC (sexual assault referral centre) for any patients who report sexual trauma.	

Women in IRCs

Outcomes	**Examples of how this could be evidenced *(local determination required)***
PROMs: Reduced levels of self-harm. All patients are treated with respect and dignity, especially following an incident of self-harm. Sexual health, including historic sexual trauma is explored and incorporated into the care plan where appropriate. Appropriate contraceptive services to be available.	PROMs: Audit and benchmarking. Access to SARC services in order to receive support, counselling and where possible (as abuse may have occurred in their home country) forensic engagement to enable a prosecution.
PREMs: Healthcare understands what has happened to me. I feel able to talk to healthcare. I feel that healthcare is a safe environment. My care plan recognises me as a carer and acknowledges my carer responsibilities. I feel understood and supported by healthcare when I self-harm	PREMs: Patient questionnaire. Patient For a. Easily accessed feedback system.

I understand my sexual health needs and am able to access support to make good decisions.	
CROMs: All pregnant women should be identified as soon as practically possible and maternity pathways established prior to a woman's discharge into the community in recognition that women who are pregnant should not be held on detention. Screening services – breast and cervical cancer screening are offered to all eligible patients. Women are provided with support for termination of pregnancies or where pregnancies have failed. Contraception and reproductive health care appropriately offered to women during their detention and prior to release.	CROMs: Monitoring through HJIS. Outcome measures captured through relevant data reporting sets. Women who have been pregnant have access to support pathways to help them manage their experience.
PATOMs: A trauma informed approach is employed in the women's estate by healthcare staff. All healthcare staff to receive Trauma Informed Care training within three months of starting and refresher every two years. A partnership is in place with a local SARC (sexual assault referral centre) for women who report sexual trauma.	PATOMs: All staff in women's IRC estate undertake Trauma Informed Training as required. Agreed clear pathway with local SARC.

Appendix 2 – Service Standards

General practitioner (GP) and advanced nurse practitioner (ANP) service		
No.	**Standard**	**Type**
	The provider will deliver GP and ANP services which work collaboratively and in partnership with all establishment professionals to deliver an integrated and patient-centred service.	
	GPs and ANPs must possess the appropriate competencies and skills mix including relevant and current qualifications in line with their specific role, which should be evidenced.	
	GPs will support and mentor the ongoing development of nurses to achieve non-medical prescribing qualifications. GPs will be required to support nurse training and development.	
	The service must meet the establishment's specific requirements for healthcare input as stated in Detention Service Orders (DSOs).	
	Provide and develop a community equivalent GP / ANP service to patients that meets the needs of the population in the IRC.	
	Provide medical input into the needs of detainees with substance use and mental health needs.	
	Provide care and treatment that is consistent with national standards e.g. Quality Outcomes Framework (QOF) and NICE guidelines.	
	Develop effective interfaces with community and secondary care providers to ensure continuity of care.	
	Adhere to and implement the specified number of GP and ANP clinics that will be delivered across all establishments.	
	Agree formal arrangements for the continued prescribing and monitoring of medicines prescribed and reviewed by specialist prescribers (e.g. mental health and hospital clinicians) in line with local and national arrangements.	
	Utilise the clinical IT systems including SystmOne, telehealth and Integrated Clinical Environment (ICE) pathology reporting to their full functionality to effectively and accurately record patient information.	
	Monitor and review patients with long-term conditions and/or under medication in accordance with an agreed personal care plan and in line with QOF, NICE guidance and other nationally accepted standards of best practice.	
	Provide assessment and management of minor injuries for patients who require medical attention but not a visit to A & E.	
	Provide minor surgery, in line with current directed enhanced services.	
	Actively participate and input into the local health improvement plans.	

	Attend and actively participate in multi-disciplinary team reviews including Assessment, Care in Detention, and Teamwork (ACDT) reviews.	
	Visit and carry out mental and physical health assessment on each patient as often as their individual health needs require and at least daily when located on the separation and care unit or in cellular confinement/under restraint.	
	Attend Death in Detention Inquests as requested by HM Coroner.	
	Assist with investigations into patient safety incidents where required.	
	Involvement in safeguarding procedures.	
	Provide all relevant medical reports where a medical opinion relating to the patient's health is required and the patient has given their consent to sharing the information.	
	Attend and actively participate in the relevant local delivery Board.	
	Represent and participate in designated meetings where medical input is required.	
	Participate in emergency planning for epidemics and pandemics.	
	Ensure notification of communicable diseases to Public Health England.	
	Prescribing and medicines management	
	GPs and ANPS will comply with the national IRC formulary.	
	GPs and ANPS will undertake timely and thorough risk assessments to ensure prescribed medication is safe and appropriate within a detained environment.	
	GPs and ANPS will use their discretion in prescribing using the detained settings healthcare exceptional case processes.	
	GPs and ANPS will provide medical input for the development of Patient Group Directions as required.	
	GPs and ANPS will work in conjunction with secondary care and pharmacy services to ensure the seamless sign off of prescriptions within agreed timescales and to avoid delays in access to medication.	
	GPs and ANPS will use SystmOne task templates to effectively request, record and document medicine reviews to ensure a complete audit trail. Details for the medication type and due date should be clear to enable the practitioner to sort requests by urgency and due dates.	
	GPs and non-medical prescribers will be the principal prescriber for shared health care for patients and the ongoing prescriber for treatment requirements along any clinical mental health care pathway	

GP and ANP workforce requirements		
No.	**Standard**	**Type**
	GP core competencies	
	Have full GMC registration and discharge their professional responsibilities in line with professional standards, regulations and code of practice and conduct.	
	Are registered on NHSE/I's Medical Performer's List.	
	Undertake an IRC specialist peer-led appraisal at least every two years to supplement their annual appraisal as a GP.	
	Take part in GP revalidation, agree an annual personal development plan with their appraiser and undertake relevant CPD.	
	Have substance misuse qualification/training within the first year of this agreement (please see section 3.9 substance misuse).	
	At least one GP in each of the establishments will hold a Royal college of General Practitioners (RCGP) level 2 for the management of substance misuse and work in that IRC at least one session per week.	
	GPs have had experience in a community practice setting or have access to a GP mentor and link into GP professional networks. This ensures the principle of equivalent care. New GP recruits to receive robust induction, mentorship and ongoing training.	
	Have a right to work in the UK.	
	Have appropriate indemnity insurance.	
	Who are in the process of attaining any accredited qualifications, have access to mentorship and support at all.	
	Are competent in the 13 key areas derived from the core RCGP curriculum statement 'Being a GP', using RGCP's Workplace Based Assessment.	
	Follow and are competent in the 'RCGP Curriculum: Clinical Modules 3.10 Care of People with Mental Health Problems'.	
	Are competent to carry out Rule 35 health assessments.	
	Have the attitudes, skills, expertise and competencies as described in the RCGP Curriculum: Core Curriculum Statement.	
	Receive training and ongoing refresher training to ensure high level of competence in responding to medical emergencies and resuscitation.	
	The workforce are skilled in and have an understanding of this patient population and the particular health related presentations their experiences may leave them with.	
	Are competent in the use of SystmOne and functionalities to ensure that all clinical contacts are correctly recorded.	
	Have a certificate from the Joint Committee of Professional Training in General Practice (JCPTGP) or a recognised equivalent certificate or a certificate of exemption.	

	Utilise the RCGP Safer Prescribing in IRCs: (Link). and the Orange Book [6]	
	Ensure their IRC based work is represented proportionally within their annual GP appraisal.	
	Take part in GP revalidation, including an annual appraisal and agreeing an annual personal development plan with their appraiser. This will be undertaken as part of the contract.	
	Work regular sessions within a community practice setting – the frequency of which is to be agreed with the commissioners.	
	Have appropriate support to take the necessary study leave in order to develop the necessary skills and to keep up-to-date for working in secure environments e.g. RCGP Substance Misuse Certificate, Rule 35 training and updates STIF training, RCGP Secure Environment Group organised training days.	
	Security training.	
	Have and maintain appropriate security clearances.	
	Advanced nurse practitioners (ANP) core competencies	
	The provider must ensure that all ANPs can demonstrate the core competencies as detailed in the RGCP General Practice Advanced Nurse Practitioner Competencies Framework (2015) and the RCN's 'Advanced nurse practitioners an RCN guide to advanced nursing practice, advanced nurse practitioners and programme accreditation'. All ANPs must hold a current non-medical prescribing qualification or be training towards this qualification.	
	All ANPs must be able to demonstrate they have achieved the competencies required to practice autonomously and are self-directed. Their practice should encompass direct clinical practice, education, research and management.	
	Any nurses who are developing or undertaking training to become an ANP must be supported by an experienced and qualified mentor and have appropriate membership, regular supervision, an annual appraisal and ongoing continual clinical practice.	
	All prescribers must be certified in or complete the RCGP certificate to at least Level 1 in the Management of Drug Use and the RGCP Certificate in the Management of Alcohol Problems and gain their certificates within 12 months of commencement of the contract and as a minimum be working towards level 2.	

[6] https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk- guidelines-on-clinical-management

Primary care nursing and administration service		
No.	**Standard**	**Type**
	The IRC based nursing team will include registered and unregistered roles to ensure the patients are seen by the right person with the right skills.	
	All nurses and HCSWs must possess the appropriate competencies and skills mix; including relevant and current qualifications in line with their specific role, which should be evidenced.	
	The workforce will be supported by a practice educator. The provider will appoint to this post in collaboration with an academic institution. The role of the practice educator will include the initial completion and annual review of training needs for the nursing and HCSW workforce.	
	Leadership - This should sit outside any role specific sections and may not be PC clinician	
	Each establishment will have a **provider nurse manager (PNM)**. This post will be minimum Band 8a (or equivalent Grade) and can be a clinical or non-clinical employee. The PNM will be the registered CQC manager.	
	The PNM will take the lead and responsibility for the following: • Providing effective management support and professional leadership to staff. • Ensuring healthcare services are integrated. • Attending the IRC SMT meetings and linking with key strategic meetings. • Leading on reporting any issues/incidents through appropriate channels. • Ensuring patient engagement and consultation activities are undertaken. • Developing and delivering service improvement plans • Participating in and supporting any inspections, audits, performance reviews and service reviews. • Coordinating services and care with all service leads, sharing operational issues across providers and ensuring their teams work together collaboratively.	
	Each IRC will have a clinical l**ead nurse**. This lead is responsible for the day to day management and leadership of primary health care and coordinating care for those with long term conditions. During those times when the lead or equivalent is not present within the establishment, a registered nurse must be on site during agreed healthcare hours.	
	The lead nurse will take responsibility for the following: • Coordinating all nurse triage and nurse led clinics.	

	• Improving the quality of patient care through the implementation of clinical governance activities. • Managing duty rotas and ensure adequate and appropriate staffing levels to fulfil service responsibilities • Ensuring safe, responsible and clinically and professionally appropriate practice within the scope of nursing code of conduct. • Leading on infection control within their establishment • Providing clinical supervision to other nursing staff • Providing expert nursing advice as appropriate to patients and to colleagues from other disciplines within the establishment. • Ensuring compliance and that care plans are developed, maintained and monitored.	

	Reception / first night screening	
	All detainees must undergo an initial health screen on receipt into the establishment by a registered nurse member of staff, to identify any immediate health needs or risk - particularly in relation to issues such as suicide or self-harm, mental health, learning disability, trauma related presentations, substance misuse (drugs and alcohol), infectious diseases and the needs of the older or younger adult or those presenting with other vulnerabilities.	
	All patients must be offered a healthcare screen under the requirements of Detention Services Rule 34.	
	Consent must be sought by the healthcare professional carrying out the reception/first night screen. If the reception health screen is refused, the reason why must be recorded, and repeated attempts made to complete the process. Where practicably possible, a detainee should be offered a choice in the gender of the healthcare professional carrying out interventions.	
	It is expected that any patient identified at reception as either: • already participating in a substance misuse treatment programme • already under the care of mental health services will be referred to the substance misuse / mental health service the same day.	
	Patients presenting at reception, or general health assessment stage, who are not currently on a substance misuse clinical programme, but who identify an active substance misuse, need will have to undertake a drugs test. Systems must be agreed with the substance misuse team to enable this to be undertaken in a timely fashion.	
	Systems must be in place to ensure that patients arriving at the establishment with medication are able to maintain access to this in line with their treatment regime. This should usually include completion of an in-possession risk assessment in line	

	with healthcare provider medicines management policies (see section 8 below). Under no circumstances should patients be denied access to their critical medication or be made to have an enforced break in their medication regime, unless it would be unsafe to continue access. Where patients arrive at an IRC without their prescribed medication, steps must be taken to rectify this position as a matter of urgency.	
	Within one working day of reception, the healthcare provider will initiate contact with external services used by the patient prior to their admission to establishment e.g. GP and community mental health team (CMHT), where it is possible to verify patient engagement. Any patient entering the establishment with an on-going medication requirement must have their prescription validated with the initiating prescriber.	
	The health screening service must be available at reception. When a patient is identified as at risk of harm to self or others, the healthcare provider must inform and share information with the relevant agencies and take action in line with local safeguarding and risk management procedures.	
	An immediate healthcare plan must be written and put in place for any patient with urgent health concerns.	
	Health assessment screen	
	All patient populations must be offered a more in-depth health assessment which, if accepted, must be completed within 72 hours of reception. The healthcare provider will ensure systems are in place, which actively encourage detainees to accept this assessment. All detainees' reception screening information should be recorded on SystmOne in line with the National Clinical Template (SEAT).	
	The healthcare provider will advise the patient of the range of health services available within the establishment and will give information about: • how healthcare services can be accessed • current waiting times • how to make a complaint or submit a compliment (internally and externally) • how to get involved in patient engagement activities. Information must be provided in a format and language that the patient can understand.	
	The patient population should be provided with information about the Health Trainer scheme (*see the Health Promotion/Prevention Service Specification*) and referred to see a health trainer where indicated. This will compliment a process of self-referral to the health trainer programme and enable a proactive approach that targets new entrants into the establishment.	

	The health assessment must be based on best practice and utilise recognised screening tools which include assessments for: • physical health problems including urine test and blood pressure • mental health problems. • trauma -related presentations • drug or alcohol abuse. • risk of suicide and / or self-harm. • learning disability / difficulties.	
	A full assessment in accordance with SEAT templates is carried out with referrals and care pathways, as per the outcomes of the assessment with ongoing monitoring covering: • Reception health screen • Secondary full health screen • In possession risk assessment • Medicines reconciliation • Release/transfer planning template • Release transfer template.	
	The provider will ensure that patients have NHS equivalent access to a range of diagnostic services according to level of need within each IRC.	
	Telehealth	
	The provider will ensure that in IRCs where telehealth equipment is available it is used to its maximum potential where appropriate.	
	The equipment will also be used by staff for clinical supervision and training across establishments. Telehealth will also be used to facilitate inter-establishment consultations, such as between a health provider in one establishment and a client in another or other similar consultations. The commissioner is responsible for the procurement and maintenance of all telehealth equipment.	
	The provider must ensure that relevant staff receive training in the use of equipment and are competent and confident to use the equipment.	
	Telehealth can be used to supplement the management of specific long-term conditions. A HCSW or nurse must always be present with the patient to ensure patient confidentiality and clinical governance.	
	Telehealth must not be used as a triage tool. The provider will ensure that there are clear eligibility criteria and referral protocols in place, shared with all staff (GPs, nursing and administration). The provider must work with the telehealth provider and local providers to minimise adding delay/extra steps into the patient care pathway. In addition, the provider will avoid duplication of appointments and diagnostic tests.	
	Consent, assessments and care planning	

	Information obtained at reception and general health assessment stages, must be appropriately shared and health assessments effectively coordinated - as per the specified consent by the patient unless there is an exception - with other agencies so that patients are not repeatedly asked to provide the same information.[7]	
	Consent must be sought for every assessment and intervention and if the patient refuses (in full or in part), the reason why must be recorded in the patient's clinical record and repeated attempts made to complete the process if considered essential. Consent must be fully documented in the patient's clinical record.	
	Assessment of a person's capacity to consent must be made in accordance with the relevant legal principles and recorded in their health record.	
	Patients must understand and be fully involved in their health assessments.	
	Triage	
	Robust triage systems and referral pathways must be implemented to enable all healthcare applications / appointment requests to be screened on a daily basis and patients referred to the most appropriate healthcare service / professional, including mental health and substance misuse services. (Included sub contracted services). These systems must be structured to support the achievement of national access targets.	
	For patients already under the care of a primary care clinician the practice of ensuring direct access, rather than resubmitting an application, is to be adopted.	
	Planned care	
	The service must provide specialist healthcare advice and treatment for a range of specific health conditions. The volume, location and range of nurse led services must be appropriate to the needs of the patient population as described in the health needs assessment.	
	All clinics must be provided to the same standards as those delivered within the community and in line with the requirements of the NSFs and published NICE guidelines or equivalent current national standards. Nurses must operate regular review clinics and coordinate primary and secondary care referrals.	
	The healthcare provider is responsible for: • ensuring the establishment provider has provided the NHS appropriate clinical and cleaning facilities and the	

[7] See Appendix 4 (p53) for details on information governance.

	establishment provider has ensured all required equipment is available to enable all clinics to take place • ensuring effective follow up arrangements • scheduling appropriate patients into clinics • monitoring the time between receipt of request and appointment date.	
	Unplanned / emergency care	
	The aim of this service is to minimise the requirement for external escorts by ensuring that any interventions that can be safely delivered within the establishment are done so. Exclusion criteria of the service include those whose injuries or illness(es) require medical or emergency intervention beyond the scope and practice of primary care nursing or general medical practice.	
	The provider will develop and implement protocols, specific to each IRC, for responding to and managing situations in which a person's health quickly deteriorates, or in a health emergency such as accidents and self-harm or suicide.	
	The provider will work with the IRC to establish the effective triage and management of emergencies that meet the requirements set out within 'emergency response in detention'. This will include the use of a paramedic service where appropriate and they can be supported and supervised as required, as part of the contract of delivery.	
	The provider will ensure that all registered nursing and medical staff are trained to manage acute clinical emergencies and that an annual training plan is developed within six months of the contract.	
	The service must offer: • initial assessment and triage of minor injuries and illnesses using a recognised algorithm. • treatment for injuries and illnesses. • liaison with the Home Office regarding unexplained injuries.	
	Management of injuries, including self-harm and minor illnesses.	
	Exclusion criteria of the service include those whose injuries or illness(es) require medical or emergency intervention beyond the scope and practice of primary care nursing or general medical practice.	
	Treatment time for minor injuries and illness(es) must be an appropriate response within the context of initial assessment/screening of the referral by a suitably qualified Nurse or GP.	
	Risk assessments should be completed where there is potential significant exposure to blood and bodily fluids.	
	Appropriate details of assessment of injury/illness as well as interventions outcomes (including referrals made or follow up arrangements) and outcomes must be documented in the patient's records.	

	When a patient is hospitalised from an IRC the arrangements must include: • documented outcomes • information explicitly given regarding self-care including infection, prevention and control • any follow up or referral to other service including the GP.	
	Responding to emergencies	
	The service will respond to requests for emergency clinical assistance for detainees including: • accidents • self-harm and suicides • acute intoxication and medical emergencies	
	Nursing support for coded calls will be provided in line with DSOs whilst healthcare staff are on site. Healthcare staff will be alerted through a coded call in accordance to local policy/protocol and as appropriate by telephone or radio call from other areas within the establishment.	
	The healthcare provider must ensure that this service is undertaken immediately and by a suitably qualified member of staff.	
	Care options when responding to onsite emergencies include: • initial triage and assessment of whether more intensive treatment and care from external health services is required • co-ordinate with the IRC to allow escort out to secondary care if clinically necessary • resuscitation including defibrillation • support the safer custody policies within the establishment in response to risk assessment and response to acts of self-harm • support staff as a result of incident.	
	Healthcare staff must be trained and competent in managing non- fatal strangulation cases.	
	Appropriate detailed patient records must be maintained, and all appropriate paperwork must be completed according to relevant DSOs, GMC Good Medical Practice (2006 and 2013) and NMC Code of Conduct and record keeping guidance.	
	Mental health	
	The foundation stage of the mental health Stepped Care Model is a whole IRC approach to mental health promotion and primary prevention with particular attention being paid to potential trauma-related illness / presentations. As such the healthcare provider will provide: • mental health promotion and wellbeing activities in collaboration with the centre operator and mental health team • signposting and information provision • guided self help	

	• referral of patients using an appropriate tool (e.g. Threshold Assessment Grid (TAG)) • attendance at case conference meetings, as required so that a clinical overview of the potential deleterious impact of continued detention can be recorded and acted upon.	
	People with learning disabilities, autism neuro-disability or acquired brain injury (ABI)[8]	
	General principle: It is understood that it is not usual or desirous for a person with LD, autism, neuro-disability or ABI to be detained within an IRC. It is however, acknowledged that there may be some individuals who have a degree of LD, autism neuro-disabilities or ABI who are resident in an IRC for periods of time and for these individuals it is important that health care services are aware and supportive of their vulnerabilities and ensure the Home Office case workers are also kept informed of any issues these vulnerabilities may cause in relation to their detention. In conjunction with the required primary care interventions for individuals who present with additional LD, autism neuro-disabilities or ABI the provider must enable the following activity below.	
	The provider will ensure that a robust pathway to appropriate community-based services where appropriate is developed and implemented for the management of the health of people with learning disabilities, autism neuro-disabilities or ABI. All healthcare providers should be aware of the Adults At Risk Policy and adhere to its requirements in the identification and assessment of vulnerable people. Should an individual be released from the IRC back to a community in England they may be eligible to be referred into the RECONNECT service, depending on the level of their vulnerabilities. Reconnect services supports the most vulnerable people, to engage with community healthcare post release. The provider should identify an LD or autism champion or lead nurse amongst the establishment healthcare team.	
	Healthcare providers must ensure that the centre staff are made aware of an individual's presentation so that any social care support that might be required can be provided.	
	The healthcare provider must ensure a suitable assessment of need is completed should someone with a known or suspected learning disability, autism or both be detained.	

[8] Accompany guidance concerning the implementation of the relevant Objective for individuals with learning disabilities, autism or both is available. See list of all guidance documents.

	The healthcare provider will liaise with the establishment who will make appropriate reasonable adjustments to enable detainees with a learning disability, autism or both access to the full range of regime activities.	
	For people with learning disabilities, autism neuro-disabilities or ABI providers must consider: • screening for learning disabilities, autism neuro-disabilities or ABI where this is suspected in an individual, using an appropriate screening tool where available (for example, a non-verbal tool to overcome language barriers) • if the healthcare provider is concerned that an individual has a moderate to severe learning disability then the individual's Home Office caseworker must be made aware of their condition, their ability to cope and their level of vulnerability as continued detention would be unsuitable for someone with that level of presentation • a care plan should be produced for any individuals with learning disabilities, autism, neuro-disabilities or ABI to ensure any health and care needs are met. • ensure individuals have the appropriate reasonable adjustments to fully access healthcare services and interventions.	
	Suicide / self-harm	
	IRCs have an established, multidisciplinary approach to managing a detainee at risk of suicide or self-harm known as the ACDT Process (Assessment, Care in Detention, and Teamwork). The ACDT process ensures that any detainee who is causing concern or who needs to be kept safe receives immediate support, multidisciplinary review and care planning. Please refer to Home Office Adults at Risk Policy for more information and healthcare requirements which require all individuals who are assessed as vulnerable and /or who are at risk of suicide to be identified to the centre staff and case managers with a recommendation for release.	
	The desired outcomes of engaging someone in the ACDT process is: • reduction in the number of incidents of self-inflicted death and self-harm • vulnerable individuals are provided with positive care and support that gives them coping mechanisms other than self-harm.	
	The current ACDT process for use across detention sites provides a suitable multidisciplinary crisis response service, which signposts for resolution of crisis issues to the appropriate departments.	
	Where patients under ACDT are identified as requiring an additional health assessment and mental health assessment by the nursing team, this must be undertaken within 24 hours.	

	Where a clinical causation has been identified through a clinical assessment as underpinning an individual's self-harming behaviour or ideation, and the patient has been placed under constant supervision, the Home Office will be responsible for funding this. The constant supervision may be undertaken by clinical staff or Detention Officers but in all cases, staff must be appropriately trained, ensure there are therapeutic benefits to the constant supervision and have regular breaks.	
	In the event of a Death in Detention: • healthcare staff should take appropriate action after a Death in Detention in accordance with the guidelines. • the provider director on call must be notified immediately. • the commissioner should be advised no later than the next working day. • an initial review should be completed within 48 hours, the findings of which are shared with the commissioner. • quarterly action plan updates where recommendations have been will be provided to the commissioner (and through them to the local Health Partnership Board) regarding how Death in Detention recommendations have been implemented to improve patient care. An exception report is required where recommendations have not been implemented.	
	Older people	
	The provider will ensure that a robust pathway is developed and implemented for the management of the health of older detainees. All healthcare providers should be aware of the Adults at Risk Policy and adhere to its requirements in the identification and assessment of vulnerable people.	
	The healthcare provider must ensure a suitable assessment of need is completed.	
	The healthcare provider will liaise with the establishment who will make appropriate adaptions to enable older detainees or those with a disability to access the full range of regime activities.	
	For patients aged 50 and over, the healthcare provider must consider: • medication reviews if required • depending on individual presentation, there should be the completion of an assessment to assess overall general health morbidities.	
	Food and fluid refusers	
	The healthcare provider will work with the mental health team and the centre operator on the agreement of a protocol for the management of food refusers. This will include access criteria and pathways for acute inpatient beds, communication and referral links with acute secondary care services and systems	

	for the regular assessment of mental capacity. Members of the primary care team must be trained in relation to the Mental Capacity Act and the use of Advanced Directives. The delivery of services to patients who are refusing food and fluids must abide by the appropriate DSO 2019 'Management of detainees refusing fluid and/or food'.[9]	
	Escorts and bedwatches	
	The Home Office have responsibility for the escort and bed watch budget.	
	The healthcare provider will adopt a pro-active approach to working with the commissioner to develop innovative alternative solutions to external secondary care services. This would include: • effective communication with A&E regarding waiting times to be seen prior to transferring the patient to A&E. For example, should a patient need to go to A&E could this could be arranged on an appointment basis, i.e. if there is a four hour wait in A&E then three hours of this wait could be completed within the establishment thereby reducing stress to the patient. The patient would first need to be assessed and triaged within IRC healthcare by a clinician. • charcoal should also be stocked in healthcare to enable administration to the patient in the event of an overdose. • nurse practitioner posts (suturing etc) • pre-operative and post-operative observations and care carried out within the establishment where appropriate (on a case by case basis) • follow up supported by GPs working under the consultant's direction, on an agreed shared care management plan • effective channels of communication between healthcare and secure unit.	
	Proactive management of demand and a flexible reactive appointment system according to patient need including: • all appointments filled on day of clinic, referring to the waiting list where possible to fill appointments to capacity • accessible urgent care during the contracted hours • take advantage of developments in technology to enhance access to care.	
	Proactive management of long-term conditions, including multi-disciplinary team working; pro-active promotion of service and healthcare facilities to secondary care providers and the wider community, to raise awareness of the level of skills and capabilities and also the security procedures required when treating detainees.	

[9] DSO 03/2017 Care and management of detainees refusing food and/or fluid https://www.gov.uk/government/publications/detainees-who-have-refused-to-eat-or-drink

	Having a named contact in each secondary care setting with whom to deal with appointments and/or cancellations where feasible.	
	Actively scrutinising the number, reason and cost implications of cancellations.	

Public health		
No.	**Standard**	**Type**
	All new receptions to places of detention should be provided with an 'opt-out' offer for blood-borne virus (BBV) testing, covering Hepatitis B, Hepatitis C and HIV. Acceptance of the opt-out offer should be strongly encouraged, and assertively followed up in the case of refusal. After reception, detained individuals should be offered repeat testing every three to six months.	
	The provider needs to carry out screening for TB at the point of reception, using recognised screening processes recommended by NICE and Public Health England.	
	The provider is required to support the delivery of the full range of public health programmes appropriate to the needs of the patient populations and will provide a localised service using nationally recognised values and behaviours with information flowing between local and national teams contributing to the key outcomes and improvement areas.	
	Where results received from screening indicate further intervention is required, this must be progressed without delay.	
	The provider will ensure that arrangements are in place to manage the treatment and care of patients with a long-term condition such as HIV.	
	Abdominal Aortic Aneurysm (AAA) programme: screening offered to all men in their 65th year. Men with aneurysm measuring over 3cm will require further screening or treatment dependant on size.	
	Bowel Cancer Screening programme: screening every two years for all men and women aged 60 to 69; in some areas the programme is being expanded to include people up to the age of 75 years. The Faecal Immunochemical Test (FIT) test will be proactively sent to eligible patients.	
	Cervical Cancer Screening programme: screening from the age of 25 years every three to five years dependent on age and history of screening results.	
	Breast Cancer Screening programme: screening every three years between the ages of 50 and 70 years in females only[10].	

[10] The lower age limit may change to 47 years but at the time of writing it is 50 years. The required approach would have to be altered to reflect the new age range if and when this is approved.

	This can be extended passed the age of 70 years at the request of women.	
	Vaccination and immunisations	
	All patients are made aware of, and fully understand, the benefits of vaccination.	
	All people in places of detention are offered vaccinations appropriate to their age and need in accordance with the national schedule/programme, specifically covering Hepatitis A, Td/IPV (Tetanus, Diphtheria and Polio) Tuberculosis, Pneumococcal, MMR, Meningitis, Hepatitis B (see sexual health/BBV service section), completion of childhood vaccinations and flu vaccinations. Where evidence of previous vaccination is not available, this should be offered.	
	An immunisation register is maintained.	
	Vaccination details are recorded in the individual's clinical record (including decline of offer), data is submitted as per national requirements and uptake rates reviewed and reported to support high levels of compliance.	
	Provider must consider effective management of communicable diseases within the establishment. This may mean testing for immunity to such diseases as close to reception into an establishment as possible.	
	Sexual and reproductive health	
	All new receptions should have their sexual history taken as part of the general health assessment and screening process.	
	All new receptions to places of detention should be provided with an 'opt-out' offer of a test for HIV, Hepatitis B, Hepatitis C, and syphilis, chlamydia and gonorrhoea.	
	The provider is required to align the sexual and reproductive health and chlamydia screening needs of the patient population to the PH sec 7a specification 29 requirements.	
	The provider will work with the Chlamydia Screening Programme in their local area and offer screening according to the needs of the IRC populations. The regional sexual health/BBV service will offer assistance and advice when needed / available, though health and justice retain responsibility for ensuring that this is carried out.	
	Identify a named chlamydia lead in each establishment to communicate with the local chlamydia screening service.	
	Display the relevant national and local sexual health and chlamydia screening materials.	
	Provide those testing for chlamydia with an information leaflet as part of the consent process.	
	Be responsible for ensuring timely onward referral for those people who they are not able to manage.	
	Be responsible for undertaking a satisfactory system of audit in line with the annual requirements to audit key performance indicators of the programme.	

	Provide information about chlamydia and other sexual health promotion including the benefits of testing, specimen collection, management of results and access to free treatment.	
	Refer patients declaring symptoms suggestive of sexual ill health to the IRC sexual health clinic. Healthcare staff need to be mindful of the support that might be required following a disclosure of sexual assault during R35 interviews.	
	Provide information and advice about safer sex practices and, in line with local policies, ensure that condoms and lubricants are available.	
	Provide information and advice about sexual health including the benefits of screening and treatment of infection.	
	Samples and forms should be collected for analysis in a timely manner, as defined by local operational guidance.	
	Mechanisms must be developed to identify under 25s who are appropriate for offering a chlamydia screen, including repeat offers for those already resident in the IRC.	
	NHS Health Checks	
	Due to the average time spent in a detention facility, NHS Health Checks will not follow the schedule of offer made elsewhere in the NHS. Specific individuals identified as meeting age criteria (35-74) can be offered a health check, but there is no blanket requirement to do so.	
	Health promotion and prevention	
	All healthcare services within the establishment must work in partnership with the centre to ensure that there is effective coordination a delivery of health promotion activities and interventions.	
	An IRC specific Health Promotion and Prevention plan will be developed within six months of the contract commencement. This will be owned and monitored by the Local Delivery Board. This will include but not be limited to: • leading IRC-wide Health Promotion Action Group with development and monitoring of a Health Promotion Action Plan` • delivery of health education, promotion and preventative care programmes • supporting patient self-care • auditing health education and preventative care and formulating an action plan to monitor areas for improving outcomes • liaising with voluntary sector organisations to support delivery of health promotion activities • prevention of re-infection (e.g. following successful treatment for Hepatitis C) • training of healthcare peer mentors to support the delivery of consistent health improvement messages, programmes and interventions across the IRC. This will include group and individual support.	

	Smoking cessation	
	The provider will be required to deliver smoking cessation services in order to promote a smoke free environment, including the provision of psychosocial programmes and NRT. This service must be delivered using a multidisciplinary approach and will take into consideration age and gender specific needs. The provider will comply with national guidance in relation to smoking cessation. The provider will make available pharmacotherapies that meet the needs of patient.	

Discharge and release planning		
No.	**Standard**	**Type**
	The provider must participate in the overall discharge planning for detainees being released from the establishment and returning to the community, returned to their country of origin, attending court or being transferred to another establishment. Insofar as this is possible.	
	Ensure continuity of care for all healthcare needs. This must include an extensive process of multidisciplinary planning to enable an effective and functional hand over of the patient to community health and where possible prior to their removal to their country of origin. (through e-records if possible)	
	Ensuring a) that a patient is registered with a GP prior to release as a requirement along with b) engaging with local RECONNECT / IRC discharge schemes and c) ensuring the sharing of information to support continuity of care where this is appropriate, and a person is remaining in the UK.	
	Establish a directory of information regarding local resources and foster a good understanding of the local patient care pathways to promote effective referrals.	
	Be responsible for ensuring that appropriate external services are advised of: a patient's release; the care they have received whilst in detention; any ongoing care required, and any medicines administered prior to leaving the establishment.	
	Ensure an appropriate discharge summary is provided to relevant community/home services on release.	
	Include provision of HC1 form to support the receipt of a HC2 certificate if eligible so as to enable access to free prescribed medication post release.	
	Provide advice to the patient on how to manage their healthcare needs on release, including provision of a discharge summary where required. This should include details of NHS 111 where a patient is returning to UK community services.	

	Ensure medication needs are fully included in the discharge planning process. This is particularly important where the patient has a specific medication need (e.g. a specially prepared or difficult to purchase medicine). Patients should be provided with advice regarding local pharmacies. Where appropriate patient consent should be obtained so that their medicines information can be sent directly to their community pharmacy or the patient should have adequate medicine supplies to ensure uninterrupted treatment where they are returning to their country of origin. Where required and possibly all patients who are being released from detention should be helped to access their medication post release.	
	Ensure patients have access to relevant and appropriate quantities of discharge medication or FP10s if returning to UK communities.	
	Ensure the patient is aware of the date, time and place of any community healthcare appointments in UK.	
	Appropriate contraception and advice on safer sexual practices should be offered and provided on discharge.	
	Where there is lack of access to 24-hour healthcare, ensure that the receiving detention facility is able to safely support the administration of patient specific medication.	
	Joint care planning with other healthcare providers	
	The healthcare provider must ensure that formal arrangements are in place for those with a dual diagnosis and/or complex needs and that the service offers a comprehensive, co-ordinated, and accurate approach to those needs. The healthcare service must ensure that all providers do so in a joined up, holistic manner, that is seamless to the end user.	
	Staff must work within local guidance for the management and disclosure of confidential information about service users, between different agencies and within multiagency teams. They will adhere to statutory and common law frameworks, allied to both government policy and best practice guidance, including, but not limited to: • information rights • The Data Protection Act • Consent and confidentiality • Using technology and information security • rights of access to information.	
	To support joint working with other partnership services and organisations, when appropriate nursing staff must support and facilitate representatives visiting the establishment to continue their supporting role.	

Detention Service Orders and centre regime		
No.	**Standard**	**Type**
	The healthcare service must provide healthcare advice through the formal and informal attendance at management meetings, forums and ad hoc requests.	
	The healthcare provider must fulfil all obligations and responsibilities applying to the application of Detention Service Orders (DSOs) as they relate to health provision.	
	Support and advice must be available to agencies and operational staff to support the health and wellbeing of patients within the context of local and national guidance for the management and disclosure of confidential information.	
	Input from healthcare must be provided in a number of IRC operational forums which include as examples the following (but not exhaustive list): • Daily directors meetings and senior management Board/ team forums. • Attendance at planned control and restraint interventions and incidents • Preparation of specific reports as required i.e. Death in Detention reports, patient safety incident reports. • ACDT reviews.	
	The healthcare service must work closely with other areas of the establishment regime and external agencies to ensure integration of patient focused care in line with IRC standards and mandatory obligations.	
	To attend the segregation/care and separation unit to see all detainees and complete a safety algorithm within two hours of an admission.	
	Daily clinical engagement and overview of any detainees held in segregation/care and separation unit.	
	As required provide constant supervision for patients at risk of harm to themselves where a clinical causation has been determined through a clinical assessment process.	
	Participation in the ACDT process.	
	Healthcare staff attend all planned use of force and where possible when unplanned use of force is used. Detainees must be seen within 24 hours of force being used.	
	Room share risk assessment.	
	Fitting for transfers - all detainees will receive medical screening prior to any movement.	
	Any request for Rule 35 assessment must be actioned within the required 24hr timescale.	
	Rule 34 assessment must be offered to all new receptions.	
	Completion of a range of IRC health specific administrative activities including writing medical reports on patients	

	answering solicitors' letters or independent medical examiners letters and complaints and the timely response to GDPR request in relation to removal or immigration hearing requirements.	

Management support and professional leadership		
No.	**Standard**	**Type**
	The healthcare provider must deliver effective management support and professional leadership to staff. The healthcare manager has day to day operational responsibility for **all** healthcare services delivered within the establishment.	
	All healthcare staff must have access to appropriate clinical and professional management and supervision.	
	The healthcare provider must ensure that effective management and leadership are reflected in the roles of senior leaders of the service.	
	The healthcare provider must ensure the management, administration and smooth running of all healthcare services and healthcare centre	
	Ensure all clinic rooms are properly equipped and equipment is fit for purpose and appropriately maintained in liaison with providers and in line with local protocol and statutory requirements. Any facility issues must be escalated to the establishment facilities manager in the Home Office.	
	Ensure working practice within the framework of local, national and best practice guidance on infection prevention control.	
	Ensure patients are informed about service available, waiting times etc in a suitable format	
	Ensure patient engagement and consultation activities are undertaken.	

Appendix 3 – Safeguarding

The Care Act (2014) sets out a clear legal framework for how systems should protect adults (18 years of age and over) at risk of abuse or neglect whilst the Working Together to Safeguard Children Statutory Framework provides statutory guidance relevant to safeguarding and promoting the welfare of children under the Children Act (2019, 2004). The provider must be able to demonstrate compliance with the requirements and principles of all relevant legislation, regulations and statutory circulars relating to safeguarding adults and children in so far as they are applicable

to all services. Age-disputed minors must be treated as vulnerable (under the Care Act 2014) as they may be children and must be provided with adequate safeguarding measures.

The provider must ensure they have up to date organisational safeguarding policies and procedures for children and adults and robust governance arrangements in are in place for safeguarding in line with the Home Office Adults At Risk Policy and relevant local authority safeguarding policies and procedures. They must have strong links with local Safeguarding Boards and any safeguarding issue must be managed through these policies and brought to the attention of the Local Authority Designated Officer (LADO).

Safeguarding policies and procedures must give clear guidance on how to recognise and refer safeguarding concerns both within the establishment and when necessary outside of these structures. All policies and procedures should be consistent with and make reference to safeguarding legislation, including in relation to mental capacity and consent, national policy/guidance and local multiagency safeguarding processes.

The Safeguarding Policy must also detail: safeguarding responsibilities and accountabilities within the service; whistle blowing procedures; safe recruitment; safe working practices; induction and training; complaints procedures; confidentiality and information sharing.

Staff must have access to these policies and procedures at all times and practice in accordance with these policies.

There must be a named designated lead within each establishment to champion the importance of safeguarding. These representatives must link in with the individual establishment safeguarding managers and attend and contribute to any safeguarding case conferences/protection meetings within the establishment and/or the relevant local authority.

There must be an effective system for identifying, recording, analysing and referring any safeguarding concerns, including potential neglect. Patterns and trends must be identified through governance arrangements including; risk management systems, patient safety systems, complaints and human resources functions and referred appropriately according to multiagency safeguarding procedures.

The provider must:

- review the effectiveness of its safeguarding policies, procedures and arrangements on an annual basis
- provide assurance through an annual safeguarding report to the Local Health Delivery Board and the commissioner
- implement robust audit programmes to provide assurance that safeguarding systems and processes are working effectively

- consider and implement the recommendations of any Serious Case Review and devise an action plan to ensure that any learning is implemented and shared.

All safeguarding concerns relating to a member of staff (including staff on fixed-term contracts, temporary staff, locums, agency staff, volunteers, students and trainees) must be effectively investigated and referred appropriately according to local multiagency safeguarding procedures. Disciplinary processes must be concluded irrespective of a person's resignation, and 'compromise agreements' must not be allowed in safeguarding cases.

Staff training
All staff must undertake safeguarding training appropriate to their role and level of responsibility. All new staff must undertake safeguarding training during their induction. The training needs analysis and training plan will determine which groups of staff require further safeguarding training, how often and at what level for both safeguarding adults.

Safeguarding training should include how to recognise and respond to abuse, how to report concerns, the principles of the Mental Capacity Act and consent legislation.

All staff must be confident to report any suspicions of abusive practice, without fear that they will suffer as a result and are aware of their rights under the Public Interest Disclosure Act.

All staff must be aware of and fully comply with guidance in the document:

- 'Safeguarding Adults: The Role of Health Service Practitioners' (DoH, 2011)
- Home Office 'Adults At Risk' Policy

Safeguarding vulnerable adults
To promote the safety and protection of vulnerable adults, staff should:

- be aware that vulnerable adults may encounter abuse
- take reasonable steps to protect vulnerable adults
- identify vulnerable adults within the service
- report any concerns or risks to a vulnerable adult.
- be alert to the risks that known abusers may pose to vulnerable adults
- ensure they are fully aware of the policy in relation to protecting vulnerable adults
- work in cooperation with all agencies involved in any investigation
- be aware of the referral procedures and refer as appropriate.

Plans must be in place from any Serious Case Reviews that are on-going or completed and implementation is monitored with a robust process to share lessons learnt.

Prevent is part of the UK's Counter Terrorism Strategy, known as CONTEST. Prevent works to stop individuals from getting involved or supporting terrorism or extremist activity; this includes people in detention and staff. Radicalisation is a

psychological process where vulnerable and/or susceptible individuals are groomed and become involved with criminal, terrorist activity. In April 2015, the Prevent Statutory Duty, under Section 26 of the Counter-Terrorism and Security Act 2015, was made a statutory responsibility for the health sector. The Duty stated the health sector needed to demonstrate 'due regard to the need to prevent people from being drawn into terrorism'. Within health, NHS trusts and foundation trusts are specifically mentioned in the Duty, however, Prevent is part of mainstream safeguarding and therefore all health staff must ensure vulnerable people are safeguarded. This is supported by the NHS Standard Contract (clause 32), which requires all NHS funded providers to demonstrate they comply with the requirements of the Prevent Duty. This includes ensuring there is a named Prevent lead in an establishment and there is access to quality training for staff in their organisation and embedded processes to identify and protect those who may be at risk of radicalisation. They must also have a clear process for escalating concerns regarding potential terrorist events to the police and/or IRC director/establishment pathfinder lead.

Appendix 4 – Information governance, data protection, security and confidentiality

The provider will ensure that they are fully compliant with the standards set out in the Data Security Protection Toolkit. This includes arrangements to ensure that personal identifiable information or information of a confidential nature is treated as such, including prisoners' records, and shall not be divulged to any unauthorised person. Evidence for the Data Security Protection Toolkit must be supplied and submitted as required by the predetermined submission dates to the NHS Digital and submissions must be available for external audit.

The provider will ensure that relevant legislation concerning confidentiality; data protection and freedom of information are complied with, along with compliance with Caldicott principles.

The provider will ensure the co-ordination of IT, data collection and quality assurance process to allow for timely and comprehensive reporting to the commissioner on agreed service parameters, HJIPs and external health and social care needs assessments.

Compliance
The provider will adhere to all appropriate governance and security for the IM&T Systems and paper records to safeguard person identifiable information as determined by the Commissioner and the prison establishments including appropriate security measures and access controls. This includes adherence to relevant PSO and PSIs.

The provider will demonstrate compliance with the Data Security Protection Toolkit Standards for prisons working towards a minimum of 'satisfactory' compliance in all requirements and will co-operate fully with the Commissioner in any submissions

The provider will provide evidence of any registration under ISO.IEC 27002 -2005; ISO 27001 – 2005 and BS7799-2 or other appropriate information security standards.

Legislation and guidance
The provider will adhere to all statutory obligations for the management of information and the operation of IM&T within the NHS, including, but not exclusively:

- Common law duty of confidence
- Code of Practice on Confidential Information 2014
- Confidentiality Guidance for Doctors GMC 2009
- Confidentiality and Disclosure of Information BMA 2008
- Code of Professional Conduct NMC 2004
- Caldicott Report 1997 and Caldicott 2
- Information – To Share or not to share? The Information Governance Review 2013
- National Data Guardian for Health and Care Review of Data Security,

Consent and Opt-Outs 2016 Data Protection Act 1998 European Directive 1995/46C
- Access to Health Records Act 1990
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- European Directive 2003/4 EC
- Computer Misuse Act 1990
- Mental Capacity Act 2005 and Code of Practice 2007
- Human Rights Act 1998
- Health and Social Care Act 2015
- Health and Social Care Act 2008
- Health and Social Care Act 2001
- NHS Act 2006
- Crime and Disorder Act 1998
- Regulatory and Investigatory Powers Act 2000
- Records Management Code of Practice for Health and Social Care 2016
- Public Records Act 1958 .

In addition to the statutory requirements, the provider must meet prevailing national standards and follow appropriate NHS good practice guidelines for information governance and security, including, but not exclusively:

- use of the Caldicott principles and guidelines
- appointment of a Caldicott Guardian
- policies on security and confidentiality of patient information;
- records management policies and procedures
- achievement of the data accreditation requirements.
- governance arrangements in line with the NHS Information Governance Toolkit
- risk and incident management system
- encryption standards in line with guidance from NHS Digital (formerly Health and Social Care Information Centre)
- for the avoidance of doubt, obligations apply in respect of information held in all formats including electronically and manually.

Data protection
The provider shall maintain the confidentiality of personal data entrusted to it in accordance with the provisions of the Data Protection Act 2018 (DPA), General Data Protection Regulation 2018 (GDPR) and any other relevant legislation.

The provider shall comply with the six principles of the Data Protection Act 2018 (the 2018 Act) and in particular the provider agrees to comply with the obligations placed on the commissioner by the data protection principles as set out in the 2018 Act, namely:

- To maintain technical and organisational security measures sufficient to comply at least with the obligations imposed on the commissioner.
- Only to process personal data for and on behalf of the commissioner, in

accordance with the instructions of the commissioner and for the purpose of performing the services in accordance with this agreement and to ensure compliance with the 2018 Act.

- To allow the commissioner to audit the provider's compliance with the requirements of this Clause on reasonable notice and/or to provide the commissioner with evidence of its compliance with the obligations set out in this Clause. Both parties agree to use all reasonable efforts to assist each other to comply with 2018 Act. For the avoidance of doubt, this includes the provider providing the commissioner with reasonable assistance in complying with subject rights requests (including rights to be forgotten, right to amend etc) served on the commissioner under Schedule 9 and 10 of the 2018 Act and the provider consulting with the commissioner prior to the disclosure by the provider of any personal data in relation to such requests. The provider will be registered for data protection with the Information Commissioner for all appropriate categories of processing of personal data. There is a statutory obligation to protect person identifiable data against potential breach of confidence when processing or sharing with organisations outside of the United Kingdom. No information under this contract should be processed outside of the UK without the prior written consent of the commissioner.
- The provider should be a signatory to a local ISP developed by the local commissioner for all partnerships relevant to the establishment(s) concerned.

Clinical information systems

To ensure the quality and safety of patient care, the IM&T systems must also support the following:

- Maintenance of individual electronic prisoner health records within an audit function to control access in line with registration authority guidance.
- Inter-communication or integration between clinical and administrative systems for use of patient demographics.
- Access to knowledge bases for healthcare, such as Map of Medicine, at the point of patient contact.
- Access to research papers, reviews, guidelines and protocols.
- Seeking the consent of every prisoner to have their clinical records on SystmOne or any subsequent clinical systems.
- Communication with prisoners, including seldom heard groups such as service users with mental health problems, learning disability problems, hard of hearing and detainees to support the provision of quality care, including printed materials.
- Agreed arrangements and time scales for multi-agency audit of clinical record keeping including data quality.

Clinical records management

The provider will at its own cost retain and maintain all the clinical records in accordance with:

- good practice
- The requirements of the contract (IM&T Schedule). The provider will at its own costs retain and maintain all the clinical records in chronological order and in a form that is capable of audit. Clinical records shall be retained and

maintained in electronic form in accordance with the Contract (IM&T Schedule). The provider will ensure that all staff are trained and understand their responsibilities and legal obligations in relation to person identifiable records. The provider will be expected to ensure that all records follow the principles of confidentiality and are in line with legislation and professional codes of practice. Clinical records will include as a minimum:

- A full account of the assessment.
- Relevant information about the prisoner's condition at any time.
- The measures taken to respond to the needs of the prisoner.
- Evidence that the duty of care has been understood and honoured.
- A record of arrangements for continuing care (care plan).
- Recovery and discharge plans including integration with resettlement.

NHS standard contract SC23 requires:

- The Provider must create and maintain Service User Health Records as appropriate for all Service Users. The Provider must securely store, retain and destroy those records in accordance with Data Guidance, Information Governance Alliance Guidance and in any event in accordance with Data Protection Legislation.

- At a Commissioner's reasonable request, the Provider must promptly deliver to any third-party provider of healthcare or social care services nominated by that Commissioner a copy (or, at any time following the expiry or termination of this Contract, the original) of the Service User Health Record held by the Provider for any Service User for whom that Commissioner is responsible. Note this includes a request after termination/expiry of the contract.
- The Provider must give each Service User full and accurate information regarding their treatment and must evidence that in writing in the relevant Service User Health Record.

Consent

The provider is expected to operate a Patient Consent Policy, having regard to the Department of Health Reference Guide to Consent for Examination or Treatment; Health Service Circular HSC 2001/023 and the Good Practice in Consent Implementation Guide – Consent for Examination or Treatment, or to any amendment or reissue of them from time to time. Difficult situations can arise for healthcare professionals within Prisons where concerns about an individual's capacity to consent are compounded by serious mental health issues and behaviour likely to result in self-harm. In such situations, the Provider will have in place robust procedures in-line with the Mental Health Act Guidance 2007 which enable extremely careful handling, and which contain guidance provided by the appropriate department of health on seeking consent. All actions taken in these circumstances will be fully documented.

The provider will follow the requirements of and procedures within PSI 64/2011(updated) ‘Management of prisoners at risk of harm to self, to others and from others (Safer Custody) and will share relevant information appropriately with all those managing such prisoners.

General contractual confidentiality
Subject always to the obligations of the Parties under statute or common law, in respect of Confidential Information it may receive from the other Party (the ‘Discloser’), each Party (the ‘Recipient’) undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser’s prior written consent provided that the Recipient shall not be prevented from using any general knowledge, experience or skills which are in its possession prior to the commencement of this Agreement.

The provisions of this Clause shall not apply to any Confidential Information which is:

- in or enters the public domain other than by breach of this Agreement or other act or omission of the Recipient
- obtained from a third party who is lawfully authorised to disclose such information
- authorised for release by the prior written consent of the Discloser.
- identified as no longer needing to be regarded as confidential in accordance with any relevant timescale relating to that class of information.

Nothing in this Clause shall prevent the Recipient from disclosing Confidential Information where it is required to do so by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable law or, where the provider is the Recipient, to the provider’s immediate or ultimate Holding Company provided that the Provider procures that such Holding Company complies with this Clause as if any reference to the provider in this Clause were a reference to such Holding Company. The Receiving Party shall indemnify the Disclosing Party and shall keep the Disclosing Party indemnified against losses and indirect losses suffered or incurred by the Disclosing Party as a result of any breach of this clause. The Parties acknowledge that damages would not be an adequate remedy for any breach of this clause 16 (Confidential Information) by the Receiving Party, and in addition to any right to damages the Disclosing Party shall be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause.

The provisions of this Clause shall continue following termination of this Agreement for any reason whatsoever and without limit in time.

Freedom of Information Act 2000 and Environmental Information Regulations 2004
The commissioner is a public authority for the purposes of the regulation and guidance and cannot contract for services in a manner which prevents it complying with its obligations. The commissioner also recognises the special circumstances and security issues arising from requests for information relating to offender establishments and would work with the Ministry of Justice where any conflict arises.

The provider will ensure that all applications for Freedom of Information will come through the commissioner or the respective prison.

The provider will acknowledge the requirements of the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 and shall assist and cooperate with the commissioner and/or the respective prison(s) (at their own expense) to enable them to comply with these information disclosure requests.

The provider will notify the commissioner and/or the governing governor receiving a request through Freedom of Information and shall where possible and appropriate:

- Transfer the request for information to the commissioner and/or the respective prison(s) as soon as possible after receipt and in any event within two working days of receiving a request for information.
- Provide the commissioner and/or the respective prison(s) with a copy of all information in its possession or power in the form that the commissioner and/or the respective prison(s) requires within five working days (or such other reasonable period as the commissioner may specify) of the commissioner requesting that information.
- Provide all necessary assistance as reasonably requested by the commissioner to enable the commissioner to respond to a request for information within the time for compliance as set out in the legislation and regulations. If the provider determines that information (including confidential information must be disclosed), it shall liaise with the commissioner and the respective prison(s) before this is approved. Public authorities who hold information (including the commissioner) shall be responsible for determining at its absolute discretion whether the information is:
    - exempt from disclosure under the Freedom of Information Act 2000 or is covered by an exception under Environmental Information Regulations 2004
    - to be disclosed in response to a request for information.

The provider will acknowledge that the commissioner and/or the respective Prison(s) may, acting in accordance with the Department of Constitutional Affairs' Code of Practice on the Discharge of Functions of Public Authorities under Part 1 of the Freedom of Information Act 2000, be obliged under the Freedom of Information Act 2000 to disclose information without consulting with the provider, or following consultation with the provider and having taken their views into account. The Freedom of Information Act 2000 provides an exemption for information covered by the Environmental Information Regulations 2004 and information within that category will be considered under that guidance.

The provider will acknowledge that any lists or schedules provided by it outlining confidential information are of indicative value only and that the commissioner and/or the respective prison(s) may nevertheless be obliged to disclose confidential information.

Appendix 5 – Information management and technology

The provider must have in place appropriate, secure and well managed IM&T systems which properly support the efficient delivery of all healthcare services and which either includes or links with dental and mental health. These must comply with specific requirements and the underpinning standards and technical specifications. This includes the following services:

- Direct access IT links to pathology laboratories for the requesting and reporting of pathology results (such as ICE).
- All secure setting healthcare services will use the national IRC IT solution provided by NHSE/I HJIS as the primary clinical record for the patient.
- National systems implementation – programme management support by planning the delivery of national clinical IT system (new or upgrades), implementation, training and business change for optimal use of IT to improve health and justice services.
- IT maintenance and local service desk - providing local service desk and technical support services to ensure continued availability of all hardware and software.
- Networking - enabling infrastructure through a local area network as required, connecting to the Health and Social Care Network.
- Hardware management - ensuring all hardware is up-to-date and serviceable including the operation of replacement and disposal programmes.
- Registration Authority - administration of appropriate access to clinical systems.
- Clinical safety and assurance - to assure safe use and deployment of clinical systems (adherence to Information Standards Notices).

The provider shall deliver a level of service equivalent to that delivered by an NHS Commissioning Support Unit (CSU) in line with the required outcomes as listed below;

Required outcomes

Efficient and effective management of the following:

- The Commissioner Mandated System and National Mandated IT systems Internal networks E-mail services and systems.
- External relations with the Health and Social Care Network.
- NHSE/I patient and information directorate.
- Any other service provider.
- The provision of technical liaison with internet site host providers and telecommunications service providers.
- The efficient and effective acquisition and installation of all software and hardware, appropriate technical support day to day across all relevant healthcare centres.
- The continued maintenance of the current IT equipment and when required the deployment of software upgrades and training.

- Establish and maintain a regional wide IM&T Disaster Recovery Policy and Procedure, ensuring appropriate back-up systems are maintained on a daily basis.
- Manage all hardware to achieve optimal performance.
- Set up IT systems for all new recruits and provide an introductory overview of the data protection, Information governance and NHS information standards.
- Manage the secure connection to the NHS.Net in collaboration with the appropriate authorities.
- Deploy and maintain an agreed security access control system, ensuring that all new recruits are provided with appropriate training.
- Manage the decision-making, acquisition and implementation process for all new hardware and software.
- Manage the day to day technical relationship with any outside IT staff or contractors, telecommunication service providers, building management maintenance contractors and other facilities contractors, as required.
- Maintain an asset register of all hardware and ensure security tagging has been set up on all the hardware.
- Maintain a software license register.
- Upgrade and implement new IT system following technological advancement, ensuring implementation is within Health and Social Care Network guidelines and any in-house security systems.
- Support the development and establishment of internal management information and records management systems including document management, liaising with external consultants as required.
- The provider will ensure that home based staff have access to relevant IT systems to ensure continuity of service.
- The provider must register details of their helpdesk with the commissioner for visibility and future planning of updates.
- The commissioner will guide the provider in obtaining access to NHS systems and services such as NHS mail, Health and Social Care Network, Spine services, clinical systems, but the provider will bear any charges for the use of these systems and services. The provider will be responsible for meeting any compliance requirements in setting up this access.
- The provider is expected to explore and innovate the use of technologies to improve health information.
- The IM&T systems that are part of the national provision include (not all the following are currently available in the IRC IM&T environment):
    - **E-referral:** use of the Directly Bookable Service (DBS) for all patient referrals into secondary care.
    - **Health and Social Care Network:** use of the national network for all external system connections to enable communication and facilitate the flow of patient information.
    - **Summary Care Record (SCR*)* Service**: use of the SCR to view recent medication and key safety information.
    - **NHS Care Records Service (CRS):** use of CRS to ensure that all patient records are kept in the national compatible format and when available to communicate with the national spine services.
    - **Electronic Transfer of Prescriptions (ETP**): use of the electronic prescribing service for supply, administration and recording of

medications prescribed and transmission to the Prescription Pricing Division (PPD).
    - **Patient Demographic Service (PDS):** use of the PDS to obtain and verify NHS numbers for patients and ensure their use in all clinical correspondence (both electronic and paper based).
    - **NHSMail:** use of the NHSMail email service for all email communications concerning patient-identifiable information.
    - **Calculating Quality Reporting System (CQRS)**: use of CQRS to demonstrate performance against QOF achievement targets to support quality improvements in services provided to patients or Quality Management and Analysis System (**QMAS**): use of QMAS to demonstrate performance against QOF achievement targets to support quality improvements in services provided to patients.

Maintenance and support
The provider will be responsible for ensuring that adequate and appropriate maintenance and support services and service level agreements are available and in place for all systems, infrastructure, hardware and software used in the delivery of the IM&T Services, including but not limited to:

- Service / helpdesk – provide the single access point for all ICT related issue and problem resolution.
- Desktop services – provide second level desktop services, including on-site support
- Infrastructure services – provide third level support for network, server and infrastructure, including security.

The provider will also be responsible for obtaining, installing and maintaining software that is required to enable the core clinical systems to function and that is required for the provision of contracted services; this includes software updates, licencing and on-going training requirements.

Other healthcare providers subcontracted or otherwise authorised by the IRC community care service provider or the commissioner (e.g. the dental and mental health service providers) may use the computers and network in order to provide services commissioned from the IRC community care service provider with the consent of the commissioner, or services commissioned directly by the commissioner. This will be dependent on assurances being received from the IRC community care services provider in respect of compliance with the contents of this document.

Management of clinical information
All secure setting healthcare services will use the national IRC IT solution provided (HJIS) as the primary clinical record for the patient.

Adequate and appropriate information must be recorded onto the national IT solution to enable continuity of treatment and care. This will include assessment, diagnosis, treatment, prescriptions and any on-going healthcare needs, using nationally approved clinical templates where available.

All clinicians are expected to comply with good record keeping practice, as defined by their professional body and the provider must undertake regular record keeping audits, the results of which must be shared in writing with the commissioner, within agreed timescales. The provider must adhere to standard record keeping practices mandated by NHSE/I, including the use of standard templates where appropriate (national clinical templates are currently being developed).

Clinicians are permitted, in certain circumstances, to maintain their own patient records, (paper or electronic) supplementary to the primary detainee clinical record e.g. when making arrangements for continuity of care from alternative offices or where the ordering of patient apparatus is required off site. The provider must request written permission from the commissioner, in advance of all instances where additional clinical records will be used and assure all relevant policies regarding patient records are strictly adhered to. The provider will be required to demonstrate that any additional patient records are being transported and maintained securely, and in accordance with their policies and procedures. NHSE/I will not be liable for any losses or breaches occurring under these circumstances.

The provider must receive copies of, and approve, the protocols and policies that the clinician will be following in order to transport and maintain patient records safely. Patient records must not contain easily identifiable patient information and must not record any patient's offence.

Patient medical records will be available to all appropriate medical staff involved in the care of an individual within the boundaries of confidentiality. Information sharing protocols are to be agreed and signed off with the establishment operator.

Patients will be granted access to their medical records, upon request, in line with current NHS and IRC service guidelines, ensuring compliance with GDPR.

Patient medical records should not be destroyed under any circumstances and retention of records must comply with all current NHS guidance on the retention of records.

Paper patient medical records, where they exist, must not be removed from the establishment unless required by the courts or through an agreed archiving schedule.

Internet access will be available within the establishment to healthcare service providers and sub-contractors. The provider is required to ensure all their employee's sub-contractors and other healthcare providers sign an 'internet access' agreement.

The provider will indemnify NHSE/I against any loss arising under the Data Protection Act 1998 caused by any action, authorised or unauthorised, taken by themselves, their employees, or sub-contractors.

All employees or sub-contractors involved in the delivery of services will be required to agree and sign a confidentiality statement should they require access to confidential personal and/or business information.

Please also refer to DSO 01/2016 The Protection and Use of Confidential Information in IRCs and Inter Agency Information Sharing.

Use of HJIS
The provider will ensure there are standardised procedures and processes in place for the use of HJIS and that all clinicians and administrators receive thorough training in the correct use. Persons will be clearly identified as HJIS Superusers and the right level of training accessed to support this role throughout the IRC Healthcare Service. The superuser will be able to assist the healthcare staff in accessing and using HJIS effectively. Effective use of HJIS will ensure:

- all tasks have a specific type and are managed effectively
- a standard Read Code Formulary to be used regionally and locally
- one overarching template linked to all other templates to indicate to clinicians and administrators the relevant templates to be completed. This process should be validated by the regional Change Control Team.
- adoption of national agreed clinical templates
- use of caseloads in place of waiting lists to minimise the potential of patients being deleted off waiting lists
- Medicine Use Reviews carried out using a task template on HJIS
- processing and triaging all incoming correspondence ensuring there is an electronic audit trail.

General system characteristics
The IM&T systems must in general support the following:

- Management of all clinical services including ordering and receipt of pathology, radiology and other diagnostic procedure results and reports.
- Prescribing and where appropriate dispensing and medication administration.
- Maintenance of individual electronic patient health records.
- Inter-communication or integration between clinical and administrative systems for use of patient demographics.
- Access to research papers, reviews, guidelines and protocols.
- Communication with patients, including hard-to-reach groups to support provision of quality care, including printed materials, telephone, text messaging, website, and email.

Clinical systems in addition to those specified by the health and justice programme may be used to provide contracted services with the written agreement of the commissioner.

Any such IM&T systems must comply with the following standards as appropriate to the services commissioned from the provider:

- NHS Terminology Service (NHS TS), NHS Classifications Service (NHS CS) and Healthcare Resource Groupings (HRG).
- New General Medical Services (nGMS) contract.

The provider's IM&T systems must be effective for referrals and bookings including appointment booking, scheduling, tracking, management and the onward referral of patients for further specialised care provided by the NHS, independent sector or social care and must be compliant with e-referral requirements. This may require the

provider to obtain, install and maintain systems other than the core clinical system and to enter into agreements with systems suppliers or their agents. These arrangements will be subject to approval by the commissioner and systems and services will need to comply with the requirements in this section.

The provider must comply with NHS TS, NHS CS and HRG including:

- Read Codes and migrate to SNOMED CT (UK Edition) when available
- NHS Dictionary of Medicines and Devices
- Office of Population Census and Surveys (OPCS) version 4.3
- National Intervention Classification Service (NIC)
- International Classification of Disease (ICD) version 10
- HRG) version 4.

IM&T support and management
The provider will be responsible for IM&T support and management which will include:

- backup of all data in a manner so that it can be retrieved easily and economically
- supply and regular updates of virus protection software for each server and workstation such that all data exchanged from or via the IM&T Systems are subject to regular virus checking procedures
- prompt handling of system configuration changes required by the arrival, change and departure of staff including user account maintenance.

The provider shall provide the IM&T services to their users in accordance with, amongst other requirements:

- good industry practice
- all applicable laws (including but not limited to the Computer Misuse Act 1990, the Copyright Designs and Patents Act 1988, the Regulation of Investigatory Powers Act 2000, Data Protection legislation and the Freedom of Information Act 2000)
- any reasonable policies or directions of the commissioner notified to the provider from time to time
- the Common Law Duty of Confidence
- Access to Health and Records Act 1990
- Health and Social Care Act 2001.

The provider shall provide the commissioner with reasonable access to the premises from which the IM&T services are provided in order to carry out an IM&T audit.

An IM&T audit is any audit or inspection carried out so as to:

- ascertain that the information which has been provided to the commissioner or other bodies as required by this agreement in respect of IM&T services is accurate; and/or
- determine whether the provider has complied with its obligations in respect of IM&T services.

The provider shall comply with any audit recommendations arising from an IM&T audit and establish an effective issue tracking process to ensure that recommendations are implemented in accordance with agreed timescales.

Intellectual property rights
Any data relating to patients that is created by the provider as part of providing the service remains the intellectual property of the commissioner. The provider must provide access to this data:

- as part of regular performance reporting
- by electronic link to the commissioners' data warehouse when this is implemented and in electronic form when requested in the meantime
- as part of a handover to another provider at the end of the agreement term (see also section exit plan).

Patient information, system documentation, templates, standard reports and all other configured items will remain the property of the commissioner whether created by the provider or not.

This excludes financial data that is used by the supplier as part of their continuing operations.

Surveys
The provider shall cooperate with the commissioner in respect of the intermittent collection of data or information for the purposes of sharing and spreading best practice through the NHS ('Surveys'). Such data collection may include but not be limited to:

- collecting information on subjective patient health outcomes
- collecting information to allow benchmarks to be developed against which to judge the productivity of primary medical care providers (and other NHS providers)
- distributing and collecting NHS standardised patient questionnaires
- administering such data collection through existing systems or by distribution and collection of questionnaires.

The commissioner shall own the intellectual property rights in any data, information or results collected as a result of surveys. The provider shall provide any information relating to the services or to patients that the commissioner reasonably requires in a form reasonably required by the commissioner from time to time.

Disaster recovery
The provider must have an IM&T systems disaster recovery plan to ensure service continuity and prompt restoration of all IM&T systems in the event of major systems disruption or disaster. There should be evidence of testing of this continuity plan at regular intervals throughout the life of the contract.

Appendix 6 – Pharmacy and medicines optimisation

Pharmacy services and the optimisation of medicines within care pathways delivered by health and justice primary care providers are commissioned such that they:

- ensure patients get access to and a choice of the most effective treatments, and the outcomes that matter to them
- improve the quality (safety, clinical effectiveness, patient experience) of prescribing and medicines use
- make how we purchase and supply medicines more efficient, while ensuring the NHS retains its position as a world-leader in medicines
- provide clinical pharmacy services within health and justice services that deliver the services and pharmacy workforce expectations described in the Long Term Plan
- continuity of care processes should be completed in line with national guidance in a timely manner.

Pharmacy service and medicines outcomes

- Detainees have prompt access to medication in accordance with clinical need.
- Systems enable the safe use and handling of medicines accessed by detainees.
- A model of community pharmacy is provided with additional on-site clinical pharmacy services that support both patients and staff in optimising medicines. This includes arranging provision of a pharmaceutical supply service for the IRC.
- Outcomes are underpinned by on-site pharmacy workforce who are fully integrated into the healthcare team, provide services to detainees that enable medicines optimisation and who are led by a senior pharmaceutical adviser or chief pharmacist.

IRC medicines and pharmacy standards

The provider should consider this specification and deliver the service in line with the Royal Pharmaceutical Society's Professional Standards for Optimising Medicines for people in Secure Environments Link. This provides detailed information about medicines handling and optimisation in IRCs and should be read alongside the RPS Safe and Secure Handling of Medicines 2018, NICE guidance, and other national clinical guidelines, and the General Pharmaceutical Council (GPhC) and NHSE/I standards for the provision of pharmacy services from a registered pharmacy.

The domains in the RPS standards describe the standards needed within the detained person's time in custody, from admission to release or transfer:

- Domain 1: Arriving and meeting people's initial medicines needs
- Domain 2: Meeting people's medicine needs during their stay
- Domain 3: Continuing people's medicines on release and transfer
- Domain 4: Employing and training a competent workforce to underpin optimising people's medicines
- Domain 5: Maintaining a framework of safety and governance.

IRC pharmacy services and connecting with pharmacy services in integrated care systems and primary care networks

The NHS Long Term Plan described the development of integrated care systems (ICS) and local primary care networks (PCNs). In an ICS, NHS organisations in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. Within each ICS there will be local PCNs that serve between 30,000 and 50,000 people. The developments in pharmacy services within the ICS areas and PCNs within them include:

- clinical directors of pharmacy and medicines for each ICS
- clinical pharmacists within PCNs that can provide medication reviews and support for complex patients
- new services being delivered by community pharmacies such as medicines reconciliation- which could support released detainees who take high risk medicines or have complex medicines needs.

Collaboration and integration of the health and justice healthcare and pharmacy teams with pharmacy services in the new networks is essential. This is the case even if detained people are not being released into the local PCN. The reason for this is that providers can use their local PCN network to inform pharmacy leads in the community about the needs of people within the detainee pathway. This will develop blueprints to enable all PCNs to support all detained people and health and justice providers across England with continuity of and sustained outcomes from medicines.

To enable the access to pharmacy services within the ICS and PCN which a detained person is admitted from released into, the Provider will need to ensure that:

- the HJ service provision and pharmacy team form part of ICS and PCN pharmacy networks within which the health and justice site is located
- use PCN pharmacy teams to support medicines reconciliation and information sharing to support safe medicines continuity for people admitted into custody
- they collaborate with ICS clinical directors of pharmacy and medicines, community pharmacy network leads and local PCN pharmacists to agree pathways for referral of released detainees for clinical pharmacy services in the community.

In addition, there are specific medicines and pharmacy elements within the mental health and substance misuse service specifications. These elements along with any guidance referenced in them require delivery by the Provider.

Definitions

- The **provider** is the primary healthcare service provider who is responsible for the optimisation and safety of medicines use in the establishment.

- The **pharmacy service provider** arranged by the p**rovider** must provide a pharmaceutical supply services including
    - dispensing of individually named prescriptions issued at the IRC

- supply of bulk stock of medicines via a wholesaler (if this stock is not procured directly by the provider) if the pharmacy service provider has a wholesale dealer licence and Home Office Controlled Drug supply licence.

- **Pharmacy team**: This is the **on-site pharmacy team** delivering a medicines optimisation and governance service for the provider working within IRCs.

Aims and objectives of the pharmacy service and medicines optimisation services

The pharmacy and medicines optimisation service will be primarily concerned with patients and their safe and effective treatment with medicines from prescribing, supporting delivery of medicines reconciliation, getting access to a legal/prompt supply, to giving it to the person and disposing of un-used/expired medicines. All services must comply with statutory requirements, Detention Services Orders (DSO) and standing orders, national healthcare standards and professional and ethical codes/standards of practice.

The pharmacy service provider supplying, and dispensing medicines will be delivered by a pharmacy subcontracted by or delivered directly by the provider. This dispensing pharmacy will deliver a full pharmaceutical service to the IRC providing all essential services as detailed under the national pharmacy contract, undertaking services that optimise medicine use, and offering pharmaceutical products in usual packaging provided to community patients, information and advice to agreed consistent standards of quality within agreed budgets and defined areas. The pharmacy will comply with GPhC and professional standards. The pharmacy will comply with GPhC and professional standards whether the pharmacy is registered with the GPhC or not. Registration of the pharmacy with the GPhC may be required and should be confirmed by the **provider.**

Within the service provision, the provider will ensure pharmacy and medicines optimisation form a key part of the healthcare service. A senior pharmacist, directly commissioned or employed by the provider leads on the pharmaceutical elements of the IRCs healthcare, including the provision of information and advice, medicines management and the development of integrated advanced and locally developed services for patients. Pharmacy technicians will be expected to be active in a multi-disciplinary approach to delivering medicines optimisation including administering medications to detainees and delivering locally developed services

In providing a full medicines optimisation service to detainees, the provider will be responsible for:

- the provision of information and advice on medicine budgets and comparative costs, to ensure the rational and economic use of medicines
- establishing effective communication with detainees and access to a pharmacist, either directly or through healthcare staff, concerning medicines optimisation, in particular by ensuring that those who have

in-possession medication have sufficient understanding of how, when and why it is taken
- assuring all healthcare staff of the quality, safety and efficiency of pharmaceutical products, delivery systems and the medicines optimisation service as a whole
- delivering on-site support to the healthcare team and patients that is equivalent to the clinical pharmacy in GP practice service available in the community and described within the Long Term Plan
- contributing to and implementing actions arising from provider clinical governance and medicines management committees, the Regional NHS Medicines Management Committee (RMOC) and health improvement plans
- liaising with the security department within the IRC on all aspects of security concerning pharmaceutical products
- working closely with detention staff to ensure the pharmacy service, equipment and stock is managed safely and securely and with consideration to wider regime constraints
- working with the pharmacy service provider to ensure the pharmaceutical supply service is meeting the needs of the provider and detainees and is in line with the NHSE/I commissioned service and professional standards. Concerns that cannot be resolved locally should be escalated to the NHSE/I commissioner.

Service description

Medicines optimisation services can be organised into two distinct area of provision: medicines governance and services led by a pharmacy team including clinical pharmacy services that integrate medicines safely into care pathways and services.

Providing healthcare in a custodial setting where the highest priorities are maintaining order, control and discipline may pose particular challenges with respect to supply, storage, administration and transfer of medicines. The Care Quality Commission (CQC) and related controls assurance and risk management standards which apply to NHSE/I will also apply to healthcare in detained settings. These, and the RPS professional standards and medicines elements in all care pathways must be taken forward through the IRCs Medicines Management Committee. The Medicines Management Committee's advised membership is a lead pharmacist for the provider, healthcare managers, substance misuse representatives, non-medical prescribers, mental health providers, IRC GPs, a pharmacist from the external pharmacy service provider where this is different to the provider chief pharmacist and an IRC staff lead.

The commissioner requires a service that provides the following:

- Sourcing of medicines stock either via a pharmacy (which has the required licenses) or via alternative pharmaceutical manufacturers or wholesalers.
- Accessing dispensed medicines via a pharmacy directly provided by the provider or subcontracted - usually via a pharmacy external to the IRC.
- A pharmacy supply service that delivers dispensed medicines within agreed timeframes and in packaging that is usually provided for dispensed medicines supplied to people living in their own homes in the community. This is because the health and justice services are commissioned so that medicines

are provided in the same way as people living independently (i.e. not in a hospital or care home). Any variation in routine packaging must be agreed with commissioners.

- Medicine optimisation services including as a minimum: medicines reconciliation; medicines reviews; providing the pharmacist input for the development of Patient Group Directions; delivering clinical pharmacist support that is equivalent to pharmacist roles being delivered in community GP practices.
- Monitoring stock control directly within the IRC.
- Monitoring Controlled Drug administration systems by healthcare and substance misuse providers.
- Analysing and reviewing prescribing against national prescribing indicators for cost and clinical effectiveness.
- Delivering training on the use of medicines and clinical effectiveness to those health professionals handling or administering medicines.
- Actioning and implementing drug and patient safety alerts and actions required by pharmacy or healthcare service regulators.
- Medicines governance: Including development of a medicines governance framework underpinned by a medicines policy and procedures in line with RPS guidance and legislation.
- Nominates a medication safety officer (as described in national patient safety guidance) who provides a proactive role in managing medication safety.
- Routinely reports medication safety incidents via the provider's organisational process AND share these incidents with the healthcare teams via the Medicines Management Committee, the commissioner for contract monitoring AND enter relevant incidents onto the National Reporting and Learning System (NRLS) or any future national reporting process.
- Routinely clinically audit and benchmark prescribing practice and develop an action plan to address where outcomes suggest use is not optimised.

Out of hours

The provider is required to arrange and use a process for the dispensing of urgent medication from local pharmacies, or other urgent care or out of hours primary care services outside of core hours (including public holidays). This should be available on request although pick up/delivery of the medicines will need to be arranged by the IRC team.

Sourcing of medicines

The commissioner requires a service that includes the cost effective, legal sourcing and purchase of all required pharmaceuticals, and that ensures continuing patient treatment.

The provider will source stock medicines (including over-labelled stock for direct supply within the IRCs) cost effectively either via the pharmacy service provider or elsewhere. This will include from the outset centrally procured vaccines via Immform and payment by results (PbR)/NHS Tariff excluded High Cost Drugs that will be sourced via NHSE/I in line with regional and national arrangements. The commissioner reserves the right to organise cost effective routes of any medicine and will advise the provider of the required supply chain for the affected medicines.

Where a prescription for a pharmaceutical special is prescribed the provider is expected to follow professional guidance including:

- identify whether a licensed alternative is available and suggest this to the prescriber
- request that the pharmacy service provider shares the costs (ideally at least from three different sources/manufacturers) **in advance** to the prescriber or named healthcare lead

All medicines including Controlled Drugs should be prescribed on an individual named patient basis. Supply from bulk stock should be reserved for:

- initial supplies on admission until a named patient prescription can be dispensed
- injectables that are directly administered to people where stock needs to be available for prompt use (e.g. immunisations/vaccinations)
- medicines for emergency administration
- methadone, buprenorphine, where the number of people needing these medicines and storage requirements mean that individually named supplies would be at risk of administration error
- where additional medicines for substance misuse (e.g. chlordiazepoxide, diazepam) are stored in Controlled Drug cupboards and a high number of people have prescribed them
- over the counter genral sale list (GSL) and pharmacy medicines that can be supplied un-labelled.

The commissioner requires stock items to be available which are consistent with the IRCs individual usage.

The commissioner requires an agreed range of labelled pre-packed medication from a licensed provider to be available for use in an emergency for issue by the GP or healthcare staff against a prescription or for the supply of medicines using a Patient Group Direction. However, the commissioner reserves the right to source these from an alternative provider should this be more cost effective.

The provider shall liaise with the pharmacy service provider and agree an efficient and economic delivery service for both stock and dispensed prescriptions to the IRCs, which ensures the availability of medicines required by patients within an agreed timescale that avoids delays in treatment or omitted doses. The commissioner will support the resolution of any issues arising from this agreement.

Dispensing and delivery of prescription medicines

The commissioner requires the provision of a robust and cost-effective system for the transfer of signed prescriptions to the dispensing pharmacy, and their delivery to the healthcare department in the IRC within agreed timescales.

The provider may use their own initiative to devise the most appropriate systems to meet this requirement. The commissioner requires that any solution fully complies with the requirements of the Commissioner and is not unduly burdensome. Orders, delivery notes and invoices are required and should conform to the requirements of

regulatory and good practice standards. The commissioner therefore requires that the provider propose systems which are legally, professionally and financially compliant. The commissioner will retain the right to propose modifications and have the power to reject the proposals of the provider.

It will be the responsibility of the provider to consider whether the external dispensing pharmacy can remotely access the HJIS records for detainees. This ensures that a comprehensive clinical check against dispensed prescriptions against all supplied medicines can be made for the benefit of patient care. In the absence of this, the provider must ensure that clinical pharmacy checks are undertaken that considers the interactions between all prescribed and supplied medicines and clinical markers that inform the safety of the prescribed medicine.

The commissioner requires the provider to work with the pharmacy service provider to have clear communication systems where the Provider receives information via telephone as soon as possible after receipt of the prescription of any item that they are unable to dispense within two working days (within 24 hours for urgent medicines). Advice of delivery timescales should be shared with and recorded by the provider and followed up by the provider if the timescales are breached. Alternative medication should be agreed with the GP where the delay is considered potentially harmful to the patient.

The provider will be required to work/lead on initiatives such the on-going development of the IRC formulary, prescribing practice, policies and procedures for handling of medicines by the healthcare team and pharmacy team. Where a national formulary for IRCs exists (e.g. for pain) or national guidance for prescribing exists (e.g. The Royal College of General Practitioners Secure Environments Group (RCGPSEG) Safer Prescribing in Prisons may have relevance for IRCs), the provider must use these in local care pathways and formularies.

The commissioner requires that prescriptions written in the IRC by any prescriber is completed on SystmOne (HJIS) using the customised IRC prescription form. FP10s are only used for urgent medicines and unplanned releases.

Medicines prescribed for a patient by an external prescriber (i.e. at an outpatient or in-patient hospital treatment episode) should be added to SystmOne in line with HJIS procedures and administered using the HJIS electronic administration system/e-medication chart.

The commissioner requires that all medication is dispensed in containers, which are in line with those provided to people in their own homes in the community, professional standards and suitable for use in the IRC environment that meet the approval of the commissioner and the establishment security department. Monitored dose packs should be used for individually assessed patients only to support identified issues relating to self-administration of medicines.

Where the pharmacy service is subcontracted, the provider will have agreed remuneration and service fees for the pharmaceutical supply service from the subcontracted pharmacy service provider. The provider will share these costs with

the commissioner as part of contract monitoring thus assuring the commissioner that the service is value for money.

Medicines are to be supplied/dispensed for a maximum of 28 days unless when specified by the prescriber. Prescriptions for greater than 28 days should be queried/confirmed with the prescriber before submission for dispensing unless they form part of a repeat dispensing batch.

Medicines supplied or administered to a patient must be supplied safely in accordance with RPS and related professional standards and be recorded on the electronic medicines administration chart on SystmOne. This includes:

- the supply of not in-possession medicines by a registered healthcare professional
- the supply of Sch 2 and 3 Controlled Drugs and buprenorphine in the presence of a competent witness
- collaboration with detention staff so that the not in-possession medication is supervised by IRC officers to minimise the risk of medicines diversion.

Control of stock
The pharmacy service provider or wholesaler will retain ownership and risk of all stocks and dispensed medicines until such time as they are delivered to the IRC.

The commissioner requires a service which provides advice on the type and quantities of medication to be held in stock so that minimum stock, consistent with the ability to provide a caring, responsive and cost-effective healthcare service, can be maintained (i.e. to ensure availability and to reduce wastage). Stock requirements of the IRC should be reviewed on a regular basis to reflect any changes in prescribing trends and guidelines.

The commissioner requires monthly stock checks and a top up service to be carried out within the IRC, and a full detailed report to be provided.

The commissioner requires the maintenance of a safe, effective and secure storage system for medicines held in the IRC, and to provide advice regarding storage to healthcare staff. Advice should take into consideration the constraints of the IRC environment. Systems must meet current best practice and all applicable regulations (e.g. RPS Safe and secure handling of medicines 2018,). Medication storage audits are to be carried out in the IRC, using audit criteria to be agreed with the commissioner.

Items which are required for clinical emergencies, where required, should be in clearly marked and in tamper-proof emergency boxes, at accessible sites. Regular checks should be made by the provider on these boxes to ensure items are replaced after use or time expiry. All stock order lists will require countersignature by a prescriber.

The commissioner requires that appropriate arrangements are made for the secure storage and transportation of Controlled Drugs in accordance with relevant legislation and guidelines.

The commissioner requires that appropriate arrangements are made for the storage, daily monitoring of refrigerator temperatures and transportation of temperature sensitive medicines, and that procedures are put in place to validate and monitor storage and transportation systems. This includes ensuring procedures are in place and followed for refrigerators when temperature ranges fall outside those permitted.

The commissioner requires a system to be put in place to report any observed or identified incidences of poor practice with respect to prescribing, ordering, handling etc. of medicines with advice to be given on possible remedial action. The provider will retain a near miss log and report any Controlled Drug incidents to the accountable officer for the provider.

Towards the end of the contract there will be a requirement for the provider to decrease stock levels with an expectation that the incoming provider will purchase remaining stock at handover. Value of stock remaining may be assessed by independent valuation. A Wholesale Dealer Licence (WDL) is not required for this single transaction (i.e. the outgoing selling to the incoming provider) and the Home Office are able to provide a licence that permits this transaction for Controlled Drugs. This prevents the need to destroy Controlled Drugs and prevent stocks being decreased to levels that could result in delayed doses. The outgoing provider will need to apply to the Home Office at least three months before the contract changes to ensure permissions are in place for this transaction to occur.

Management of Controlled Drugs

The commissioner requires a service whereby the management of Controlled Drugs fully complies with the Misuse of Drugs Act 1971, and any appropriate guidelines.

The commissioner requires Controlled Drug stocks to be checked within each IRC in line with professional standards.

A registered doctor must have countersigned all orders (requisitions) for supplies of Controlled Drugs from wholesalers in line with Misuse of Drugs Regulations.

Any incidents, concerns or discrepancies related to Controlled Drugs must be brought to the immediate attention of the provider's Controlled Drugs accountable/responsible officer, the health and justice commissioner and the NHSE/I CD accountable officer.

Licence requirements

Healthcare providers in IRCs, no matter whether the IRC be government or privately run, do not have Crown Immunity and therefore must hold the appropriate Home Office licence for each schedule of Controlled Drugs held. This includes NHS organisations providing healthcare within the IRC.

In addition, following confirmation from the chief pharmaceutical officer, any supply of stock medicines on a commercial basis by a pharmacy service Provider requires them to hold a Wholesale Dealers' Authorisation (WDA).

If stock supplies of Controlled Drugs in schedules 2-5 are made by the pharmacy service provider, then they also need to hold the corresponding Home Office Controlled Drug supply licence. Supplies of medication including Controlled Drugs that are made on a named patient basis do not require WDA or the corresponding Home Office Controlled Drug licence.

Provision of drug /medical device alerts
The provider will be responsible for ensuring that they are aware of all drug and medical device alerts issued by the Medicines and Healthcare Regulatory Agency, and that all necessary actions are carried out and documented for the IRC within the required timescale. The provider's pharmacist will ensure that each IRC has actioned this.

Policies and standing operating procedures
These should be shared and agreed with healthcare teams. The commissioner requires a complete set of policies and operating procedures relating to the provider's medicines optimisation service and medicines policy to be in place at contract implementation and be part of a continuous review process. The commissioner may require copies of these at any time in support of clinical audits, inspections etc. The healthcare managers will advise the provider of any healthcare standing operating procedures that the provider must work to.

In-possession medication policy and assessment
The provider is expected to lead on the development, revision and implementation (including audit) of the IRCs in-possession medication policy as required by the healthcare teams and medicines management committee. The national health and justice in-possession risk assessment template should be used as part of this policy. Implementation and assurance of the policy may include:

- leading on the development/revision of the policy and using the national clinical In-possession template
- ensuring that prescriptions are in line with this policy at the point of prescribing and dispensing and intervening if not
- that healthcare staff supply medicines in line with the IP status of the medicine
- auditing prescription and/or medicines administration records to identify whether the policy is being adhered to.
- reporting on in-possession HJIP or equivalent as required by the commissioner.

Medicines reconciliation
The provider will deliver medicines reconciliation within 72 hours of admission to the IRC in line with NICE guidance and RPS standards. The provider should use the national health and justice clinical medicines reconciliation template to record this.

Medication review
The provider will liaise with the IRC healthcare teams to identify those patients that would most benefit from a review of their medication with the aim of improving adherence. Patients are to be invited to a pharmacy led clinic for a medicines optimisation review which will be undertaken in accordance with the service expectations that currently exist for the NHS Structured Medication Review and other relevant primary care or community clinical pharmacy services. The provider will be expected to develop a template for recording these interventions, and this information will need to be entered in to the detainee's records on SystmOne.

Development of Patient Group Directions
The provider will be expected to identify where PGDs are needed and develop and authorise Patient Group Directions in line with NICE guidance and legal requirements.

Prescribing analysis
The provider should produce reports or analyses of prescribed or dispensed medicines to allow monitoring of the use of medicines in the IRC against the formulary or national guidelines (e.g. NHSE/I, NICE; The National Patient Safety Agency (NPSA)) and to support financial governance.

Continuity of care
The provider will work with the pharmacy service provider to ensure the timely dispensing and supply of medicines to patients on release or transfer in line with local policy on the minimum quantity of at least seven days supply (and up to three months if appropriate) for such medicines.

In the event that a medicine cannot be supplied on release FP10/FP10MDA prescription forms should be available for use and supply to the detainees **who are released into the community** in line with professional standards for secure environments, so they can access the supply on release.

For detainees who are deported, additional planning will be needed to:

- ensure that doses needed during transit for critical medicines is enabled that avoids omitted or delayed doses that could cause harm
- ensure the supply of medicines take into account the regulatory requirements in the receiving country (see also Restrictions on Travelling with Medicines, Drug and Therapeutics bulletin | November 2018 | vol 56 | no 11)
- store medicines not required for doses during air travel in hold baggage.

Pharmaceutical waste
Systems should be in place that minimises the waste of medicines where possible and in line with national standards. The provider is responsible for medicines waste disposal arrangements within the IRC. A T28 exemption from the Environment Agency must be acquired by the provider to enable the denaturing of Controlled Drugs in line with requirements.

Pharmacy workforce
The provider will be expected to provide pharmacist and pharmacy technicians within the IRC. Pharmacy assistants are optional based on local skill mix requirements. The chief pharmacist employed or commissioned by the provider oversees the pharmacy workforce and their roles.

The provider should employ or commission pharmacists to deliver clinical pharmacy services and pharmacy technicians who are based in or visit the IRC. The skill mix of staff, e.g. the recruitment of pharmacy technicians versus pharmacists and nursing staff, will be agreed by the provider.

The role of the pharmacy technician can include the following:

- Deliver a service that checks and organises the replacement of bulk stock.
- Rotate stock cupboard to mitigate against expiry dates.
- Dispose of out of date medication.
- Flag where excessive stock is generated and take action to minimise its waste.
- Ensure that stock is stored under appropriate conditions.
- Review fridge temperature records and take appropriate action in the event that temperatures are not being appropriately maintained.
- Provide information on drug alerts and recalls and ensure that they are actioned within specified timescales.
- Reconcile stock against SystmOne ordering and alert the healthcare manager to any discrepancies.
- Ensure that all stock order lists have been countersigned by a prescriber in line with Human Medicines Regulations and ordering of prescription only medicines (POMs) across different legal entities. Pharmacy technicians with demonstrated competence can also administer and supply non-IP and IP medication; deliver medicines reconciliation, smoking cessation services and medicines use reviews.

The provider will be expected to participate in hosting undergraduate placements, pre-registration and foundation pharmacists and pharmacy technicians as part of regional pharmacy workforce development programmes. This includes ensuring development of pharmacist and pharmacy technician tutors to support this and minimising the disruption of training of pre-registration trainees who are in post during a change in provider. The skills and functions of the pharmacy workforce should align with the clinical pharmacy and governance roles outlined in the RPS standards and NHS Long Term and People Plans.

Generic substitution
Generic substitution policies which identify where generic substitution is not appropriate must be developed and agreed by the IRC Medicines Management Committee. The commissioner requires clinically equivalent generic products and reputable parallel imports to be supplied where they present the most economical option, when a proprietary brand is prescribed / ordered, except where a prescriber specifies that a proprietary brand must be supplied.

Pharmaceutical advice and formulary
The Provider will be responsible for securing pharmaceutical/medicines management advice for its employees and sub-contractors.

The provider will have responsibility for leading the development of an IRC wide formulary. The formulary will:

- be based on relevant local primary care, mental health, substance misuse provider formularies or national guidance where available (e.g. NICE guidance, NHSE/I prison pain management formulary, which will have relevance for IRCs)
- reflect the health economies antibiotic formulary and strategy for reducing antimicrobial resistance for implementation within a secure setting
- be developed in collaboration with mental health and substance misuse teams, as well as secondary care services (e.g. via the Area Prescribing Committee) so that it covers all aspects of the establishment healthcare
- developed in collaboration with all the IRC healthcare services and takes account of local secondary care services so that it covers all aspects of IRC healthcare.

Medicines governance and assurance
The provider shall, in partnership with all the pharmaceutical services provided for them, participate, in the manner reasonably required by NHSE/I and secure settings, in an acceptable system of clinical governance.

For these purposes, a system of medicines governance and assurance must comprise of a minimum of the following components:

- A requirement that the pharmacist should undertake an approved establishment satisfaction survey annually, in an approved manner.
- Monitoring arrangements for drugs or appliances owed to the IRC but which are out of stock.
- An approved complaints system which is acceptable to NHSE/I commissioners.
- Requirement that the lead pharmacist co-operates appropriately with the commissioner or provider and takes appropriate action following the outcome of any visits and meetings.
- A requirement that the pharmacy workforce co-operates appropriately with any reasonable inspection or review that the commissioner and IRCs wish to undertake.
- Prescription monitoring and discussion of prescription issues with staff - to include a full ‘clinical check’, where this is not completed by the dispensing pharmacy team (i.e. for items supplied from stock) and liaison with clinicians where required. A record should be kept of all issues raised (i.e. interventions made), and any changes made as a result of discussions with clinicians. Prescription monitoring should be carried out on a regular basis, the frequency of which should be agreed with each individual IRC according to their specific requirements.
- An assurance and risk management programme, which includes:

- arrangements for ensuring that all stock is procured and handled legally and in an appropriate way
- arrangements for ensuring that all equipment used in the provision of pharmaceutical services is maintained appropriately
- a nominated and proactive medication safety officer and an approved incident reporting system, together with arrangements for analysing and responding to critical incidents. Incidents should be reported to the commissioner in line with local arrangements
- never events and serious incidents: policy/process for management of including reporting arrangements and learning from, undertaking route cause analysis and developing/implementing/monitoring remedial action plans and identifying/responding to any trends identified
- risk management: up to date risk management policy in place, detailing how they reduce and manage risk
- audits of standard operating for all elements of the medicines pathway from prescribing, handling of received dispensed medicines, to supply, storage and waste management
- assurance of appropriate waste disposal arrangements (in addition to those required in Section 2) for clinical and confidential waste associated with the establishment contract
- the pharmacist's monitoring arrangements in respect of his compliance with the Health and Safety at Work etc. Act 1974
- arrangements for ensuring that appropriate advice is given by the pharmacy team in respect of medicines safety and handling to staff and detainees.

Pharmacy service and medicines access innovations

There are likely to be innovations in technology and workforce that provide opportunities for providers to review how pharmacy and medicines optimisation can be delivered to improve the safety, efficiency and patient experience. Any changes to the workforce or model by which the pharmacy service or medicines handling are delivered will need to be agreed via local/regional contract monitoring and variation processes and with IRC director support. Regional commissioners will usually gain national support for any innovations new to the health and justice setting. Examples include (but this is not an exhaustive list):

- Robotic/automated equipment for the dispensing of prescriptions in the on-site pharmacy (if applicable) or supply of medicines to detainees.
- Changes to processes for dispensing medicines by the pharmacy service provider that alters the packaging or other aspect of the delivered medicine that is not in line with the expected commissioned service as described in this specification.
- Access to a pharmacist or pharmacy staff by detainees using remote-access (tele-pharmacy).
- Using new types of registered or non-registered health professionals in the medicines pathway.

Guidance and reference documents

A number of sources of guidance and review have recommended multiple options for service outcomes and developments moving forwards, including:

- Guidance on learning disabilities and autism in IRC settings (NHS England and NHS Improvement, 2019) LINK
  https://www.england.nhs.uk/commissioning/health-just/hj-resources/

- Standards for women in secure settings - Public Health England LINK

  https://www.gov.uk/government/publications/women-in-prison-standards-to-improve-health-and-wellbeing

- Guidance for working with victims of torture in detention – FFLM - LINK

  https://fflm.ac.uk/wp-content/uploads/2019/07/HWVT_QualityStandards_May19-ONLINE-FINAL.pdf

- National preventative mechanism – isolation guidance LINK
  http://www.nationalpreventivemechanism.org.uk/app/uploads/2017/02/NPM-Isolation-Guidance-FINAL.pdf

- Immigration detention and HIV advice for healthcare and operational staff - British HIV Association LINK

  https://www.nat.org.uk/sites/default/files/publications/immigration_detention_and_hiv.pdf

- Inside Immigration Detention Mary Bosworth 2014 LINK

  https://www.oxfordscholarship.com/view/10.1093/acprof:oso/9780199675470.001.0001/acprof-9780199675470

- Detention Centre Rules – Legislation.gov LINK

  http://www.legislation.gov.uk/uksi/2001/238/contents/made

- Detention Service Orders below that reference health (all linked):-

06/ 2018 Accommodation

02/2019 Care and management of Post Detention Age claims

11/2012 Care and management of transsexual detainees

08/2014 Death in detention

01/2019 Detainee escort records

03/2017 Care and management of detainees refusing food and/or fluid

09/2016 Rule 35

01/2017 Pre departure accommodation arrangements for families.

03/2015 Handling of complaints

02/2016 LGB detainees

04/2018 Management of night state

08/2016 Management of adults at risk in immigration detention

07/2012 Medical appointments outside the detention estate

09/2014 Medical emergency response codes

01/2016 Medical information sharing

05/2016 Pregnant women in detention

06/2013 Reception, Induction and Discharge

02/2017 Rule 40/42

12/2012 RSRA

04/2017 Surveillance camera systems

07/2016 Use of restraints

04/2012 Visitors and visiting procedures

06/2016 Women in detention

- DSO 01/2016 on Sharing of Medical Information (the document is currently being reworked to ensure it is GDPR compliant but should be updated soon) LINK

  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/524505/DSO_01-2016_Medical_Information_Sharing.pdf

- Welfare in detention of vulnerable persons Stephen Shaw 2016 LINK

  Https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf

- Welfare in detention of vulnerable persons review Stephen Shaw 2018 LINK

  https://www.gov.uk/government/publications/welfare-in-detention-of-vulnerable-persons-review-progress-report

- Adults At Risk Policy 2016 LINK

  https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721237/Adults_at_risk_in_immigration_detention_-_statutory_guidance__2_.pdf (scheduled for update)

- MSO Smoking Cessation LINK
  https://www.england.nhs.uk/wp-content/uploads/2017/08/smoke-free-mso-national.pdf

- NAT guidance – Tackling Blood-Borne Viruses 2017 –LINK
  https://www.nat.org.uk/sites/default/files/tackling_BBVS_in_prison2017.pdf

- Partnership Agreement between the Home Office, NHS E/I and Public Health England

  https://www.england.nhs.uk/wp-content/uploads/2018/07/home-office-immigration-enforcement-partnership-agreement.pdf