Home Office

Public Health England

NHS England

Partnership Agreement between:

Home Office Immigration Enforcement, NHS England and Public Health England 2018-21

DRAFTING VERSION CONTROL

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Introduction

This is an update of the agreement first published in October 2013. It sets out the shared strategic intentions, joint corporate commitments and mutually agreed developmental priorities of NHS England, the Home Office Immigration Enforcement (HOIE) and Public Health England (PHE). Whilst the Department of Health and Social Care, CCG's and Local Authorities are not party to this agreement we recognise that there is a need to support joint working with them to secure the best health outcomes for individuals who are moved from an Immigration Removal Centre (IRC) but still detained under immigration powers to support continuity of services and continued good health, as far as appropriate.

It is a tripartite agreement between PHE, Immigration Enforcement and NHS England to commission and deliver healthcare services and improve the health of people to the extent possible in Immigration Removal Centres (IRCs), Pre-Departure Accommodation (PDA) and Residential Short Term Holding Facilities (STHF) across England.

We recognise our respective statutory responsibilities and independence. This document defines how we work together and co-operate at all levels within our organisations to achieve the joint delivery of our commitments to the work schedule for 2018-21 as described in the document. This approach will serve to improve the health and wellbeing of people during their stay in immigration detention, ensuring safe and effective care supporting earlier diagnosis and treatment of illnesses which will protect the wider population and contribute towards our respective statutory responsibilities to reduce health inequalities.

Collaboration must be embedded into the way in which we work together as a tripartite partnership. This includes nationally, regionally and at the appropriate local level, where NHS England Health and Justice teams are responsible for commissioning health services within IRCs and other immigration detention settings.

1 Organisational contexts:

1.1 Home Office Immigration Enforcement

The main aims of Immigration Enforcement are to reduce the illegal population and prevent harm from foreign nationals. As part of its responsibilities, Immigration Enforcement provides secure detention facilities for:

- People who have just arrived in the UK and who are subject to examination by an immigration officer to decide whether or not they can be granted entry to the UK.

- People who have entered the UK illegally (for example, in the back of a lorry or using false documents), who are waiting for a decision as to whether they will be granted leave to enter, and who are waiting for removal if leave to enter is refused. This category may include people who have applied for asylum.

- People who have overstayed their limited leave to remain, or who have breached conditions attached to their leave to remain, and who are waiting for a decision about whether they are to be removed from the UK, or pending their removal.

- People against whom the HOIE is taking deportation action. Most people in this position will be foreign national offenders who have completed their criminal sentence.

Immigration Enforcement is responsible for:

- Provision of safe, decent and secure detention;
  Management of the detained population and decisions on capacity;
- The safety and security of all staff (including healthcare staff).

Immigration Enforcement operates both residential and non-residential STHFs, IRCs and PDA, which is used for some families whose departure from the UK is being enforced.

Detention and removal are essential elements of effective immigration controls. The statutory purpose of the detention facilities is to provide secure but humane accommodation of detained persons whilst case owners take action to process asylum cases or seek to remove from the UK. Home Office Immigration Enforcement seeks to ensure the safe, secure and efficient running of the detention estate and escorting services, including removal.

1.2 NHS England

NHS England is a non-departmental public body which operates within the wider health and social care system. Its overarching role is to ensure that the NHS delivers continuous improvements in outcomes for patients within the resources available. NHS England fulfils this role through its leadership and assurance of the commissioning system and continuing to develop working relationships with clinical commissioning groups (CCGs) and a wide range of stakeholders.

NHS England's legal responsibility for healthcare across the immigration detention estate in England was enacted by the Health and Social Care Act 2012. NHS England therefore has both the legal and financial responsibility for commissioning the provision of healthcare across the estate.

NHS England also holds responsibility for the transfer of patients to secure hospitals from secure and detained environments under the Mental Health Act 1983 and for commissioning clinical reviews to support the Prison and Probation Ombudsmen (PPO) in addition to its responsibilities for funding primary and secondary healthcare services within the secure and detained estate.

NHS England's overarching organisational intentions are; to secure better outcomes, as defined by the NHS England Five Year Forward View and the Health and Justice strategic direction; actively promote the rights and standards guaranteed by the NHS Constitution and secure financial control and value for money across the commissioning system.

NHS England published its strategic objectives for the commissioning of healthcare in health and justice settings in its *Strategic Direction for Health Services in the Justice System: 2016-2020.*[1] The strategy sets out seven priority areas for NHS England over the next four years:

1. A drive to improve the healthcare of the most vulnerable and reduce health inequalities;
2. A radical upgrade in early intervention;
3. A decisive shift towards person-centred care that provides the right treatment and support;
4. Strengthening the voice and involvement of those with lived experience;
5. Supporting rehabilitation and the move to a pathway of recovery;
6. Ensuring continuity of care, on reception and post release, by bridging the divide between healthcare services provided in justice, detained and community settings;
7. Greater integration of services driven by better partnerships, collaboration and delivery.

In IRCs, Residential STHFs and PDAs, NHS England is specifically responsible for providing high quality and timely healthcare to all detainees to meet their needs. NHS England is responsible for commissioning all healthcare services in the detained estate with the exception of urgent care services (which are the responsibility of CCGs).

Non-fixed minor capital equipment (for example: medical instruments) are also commissioned by NHS England and both parties will work with the Home Office on emergency and contingency planning.

[1] Available at: https://www.england.nhs.uk/wp-content/uploads/2016/10/hlth-justice-directions-v11.pdf [Accessed 2 November 2016]

Primary healthcare facilities are provided at residential STHFs, PDA and IRCs. All detainees are seen for a healthcare screening by a nurse within two hours of arrival at a residential STHF, IRC or the PDA to identify any issues of concern. In IRCs and PDA, all detainees are enabled to have an appointment with a GP within 24 hours either through a 'new reception drop in clinic' or given an appointment unless they say they do not wish to be seen by a GP. Detainees can then access health care facilities on demand, subject to a triage service similar to those found in GP surgeries in the community.

1.3 Public Health England

PHE is an executive agency of the Department of Health and Social Care. PHE's mission is working with national and local government, industry and the NHS, is to protect and improve the nation's health and wellbeing, and reduce health inequalities.

Functions delivered by the National Health and Justice team in Public Health England include disease surveillance, response to communicable disease incidents and outbreaks (in partnership with PHE Centre Health Protection Teams, who will lead the response at a local level), production of evidence-based guidelines, and advice to policy makers, commissioners and service providers on addressing public health issues, including substance misuse services. Specifically this includes:

- Developing the evidence-base to support commissioning and service provision through primary research, audit, collection and analysis of data, publication and dissemination of information, reports and research studies;
- Identifying emerging health threats to detainees and staff working in IRCs and providing advice on their management or mitigation;
- Producing evidence-based guidelines and advice on all aspects of public health in IRCs, including health protection, health improvement and healthcare public health;
- Developing resources and tools to enable commissioners and service providers to assess the quality of services and how well they meet the needs of the people who use them (including supporting the development of new information systems and Health and Justice Indicators of Performance (HJIPs));
- Leading the development of disease surveillance and alerting systems to detect outbreaks of infectious diseases in IRCs
- Leading the management and control of outbreaks of infectious diseases;
- Supporting partner organisations in developing and delivering appropriate screening and immunisation programmes according to the needs of the population and consistent with PHE's role in the wider community;

- Supporting emergency preparedness, resilience and response through development of training and exercise resources as well as providing 'structured debriefs' for incidents to capture learning for the wider system;
- Supporting partners in conducting health needs assessments or other formal public health activities to assess the health and wellbeing of people in IRCs, including developing 'toolkits' and information resources which can be used by those undertaking work with IRCs;
- Working with partners to ensure continuity of care across the IRC detention estate and where individuals are released back to the community whether or not given permission to stay in the UK;
- Supporting both Home Office Immigration Enforcement and NHS England in the performance of their statutory functions as appropriate.
- Supporting collaborative working for health across the Devolved Administrations of the UK and with the Republic of Ireland through the Five Nations' Health & Justice Collaboration, thus supporting the arm's length support PHE and NHS England offer across the detained settings in Northern Ireland and Scotland.)

While Public Health England has a key role in providing expert public health advice to Home Office Immigration Enforcement and NHS England which supports commissioning, it does not have any direct responsibility for commissioning or performance management of services, nationally or locally.

2 Information Sharing

The three organisations will co-operate fully in relation to the disclosure and exchange of information, intelligence, evidence, policy formulation and documentation in accordance with relevant legislation and case law.[2]

It is possible that one of the organisations will receive information which may be relevant to the statutory responsibility of one of the other organisations. Given the overriding need to protect the interests of patients and the public, it is important that the three organisations have complete trust and confidence in each other and are willing to share relevant information subject to any legislative constraints.

The interests of patients and the public remain paramount and where issues relate to the fitness to practise of healthcare professionals, this information should be referred to the appropriate regulatory body for further investigation. Nothing in this framework seeks to preclude HOIE from taking relevant action as necessary to safeguard detainees and staff.

[2] Detention Services order 1/2016 sets out information sharing arrangements and can be found at https://www.gov.uk/government/publications/medical-information-sharing

NHS England will ensure that all commissioned services are aware of the requirement to share appropriate information with HOIE and, where appropriate, PHE so that they can carry out their statutory responsibilities in line with the Data Protection Act 1998.

3 Governance

This agreement sets out the basis of shared understanding both for the way in which NHS England, PHE and HOIE will work together and also for the work which we carry out unilaterally on a day-to-day basis in support of the commissioning of health services in IRCs.

3.1 National Governance

The National IRC Assurance Group has responsibility for the oversight and on-going management of this agreement. The Group is chaired by NHS England and manages the delivery of the shared priorities. It will also monitor delivery against the priorities set out above. In addition it will:

- Resolve disputes;
- Oversee and ensure that any agreed inspection recommendations in respect of healthcare are being implemented as reported through our local governance structures;
- Manage system wide partnership risks and their mitigation;
- Act as the final stage of dispute resolution (see below);
- Discuss areas of mutual interest or concern and provide a forum for the debate of any areas of divergence;
- Review working practices;
- Where required, review and amend this Agreement.

Immigration Enforcement, PHE and NHS England are committed to ensuring that there is excellent communication between the organisations. The IRC Assurance Group meets quarterly, feeding information up through organisations as required and manages information flow. Where issues arise that require escalation or urgent dispute resolution any partner can call for an extraordinary assurance meeting

3.2 Regional partnerships

Regional Partnership Groups provide local assurance of this agreement and will monitor performance against agreed key performance indicators. The meetings are currently scheduled monthly in the first instance and thereafter, if appropriate, will move to quarterly meetings. NHS England's local teams should hold regular local

partnership boards which act as performance management meetings with locality based IRC establishment health leads, HOIE and PHE representatives. These groups will consider the interfaces and dependencies between healthcare and wider detention custodial functions, including the effectiveness of enabling services and any issues which may impact on improving health outcomes.

Regional Partnership Groups will report on a quarterly basis to the National IRC Assurance Group through their regional reports. The reports will provide an update on any, risks and issues, and any points of escalation to the IRC Assurance Group which requires resolution.

See Appendix B for the IRC Assurance Group Terms of Reference

4 Complaints and dispute resolution

4.1 Making a Complaint

Concerns originating from detainees, their families or carers for healthcare services received in IRCs in England should be dealt with as a complaint.

Complaints which relate to both clinical and non-clinical healthcare matters can be raised via the HOIE complaint system in place at the IRCs or via the NHS England complaints procedure, details of which are available at www.england.nhs.uk/contact-us/complaint. Each individual area (Home Office, healthcare) will be responsible for sending an acknowledgement letter to the complainant setting out how the aspects of the complaint for which they are responsible will be handled and the anticipated target for a response to be provided. This includes information about how to make a complaint to the independent Parliamentary and Health Service Ombudsman (PHSO), where the NHS England complaints procedure has not resolved the complaint.

Complaints that relate to NHS funded care between 2003 and 2013 and pre-date NHS England should also use this procedure.

Some healthcare services are not commissioned by NHS England and there is a different procedure for making a complaint. For example, for NHS 111, out-of-hours GP services and ambulance services, a complaint would need to be made to the healthcare provider, or relevant clinical commissioning group.

The procedure for handling complaints relating to immigration detention, agreed by the Home Office and NHS England, can be found in Detention Service Order 3/2015.

4.2 Dispute Resolution

Concerns which relate to operational or resourcing disagreements between commissioners or providers of healthcare services or detention services, including performance and contract management issues, should be dealt with as a dispute if they cannot be resolved at a regional level. The partners agree that, where at all possible, concerns should be addressed locally in the first instance and use of

escalation processes should only occur if local resolution has not been possible. Dispute processes should not be used to deal with individual concerns by detainees or their representatives and these should be dealt with under complaints procedures (see above).

Where a dispute emerges between providers of healthcare services in an IRC and the management of the wider establishment, these should always be raised in the first instance and at the earliest opportunity directly with the other party. Issues should ideally be put in writing and discussed as part of a regional Partnership Board and any resolution similarly recorded in writing.

Where a dispute between a provider of healthcare commissioned by NHS England in IRCs and an establishment cannot be resolved satisfactorily at the regional Partnership Board level, this should be raised with the NHS England Health and Justice central team and Home Office Immigration Enforcement Head of Detention Operations.

The National IRC Assurance Group's decisions will be recorded in writing and a decision made on a dispute will be considered final.

5 Communication Strategy

NHS England, PHE and Immigration Enforcement will maintain a joint approach to communications to support and underpin the shared principles and priorities in this agreement. In relation to specific incidents and outbreaks, media enquiries will be managed by the Immigration Enforcement with reference to the PHE outbreak plan.[3]

Where there are media enquiries, correspondence or Parliamentary questions in respect of health management in IRCs, disseminated by the Department of Health and Social Care, we will ensure that these are handled appropriately through the respective organisational communications systems and shared between the organisations, including wider stakeholders.

Any queries of this nature for all the organisations will go to the respective relevant central team. These are then allocated to the appropriate organisation. It is expected that, irrespective of who leads on providing a response of this nature, the other partners would be consulted prior to the final response being made.

It is anticipated that site specific and overall healthcare questions in relation to the commissioning and provision of health care will be for NHS England to respond to. Issues in respect of communicable disease and wider public health matters would sit

[3] The PHE Outbreak Plan can be accessed at: https://www.gov.uk/government/publications/multi-agency-contingency-plan-for-disease-outbreaks-in-prisons [accessed: 2 November 2016]

with PHE and Immigration Enforcement will be responsible for any issues in relation to any decisions to detain both generally and case specific.

Announcements and communications, in which the other parties to the agreement have an interest, will be consulted on in advance of issue, particularly where these have contractual, financial or reputational implications.

5.1 Independent Scrutiny and Inspection

Healthcare services delivered in IRCs are subject to a range of independent scrutiny and inspection, the high level function and responsibilities for which are set out below.

5.2 Care Quality Commission

The CQC is the independent regulator of all health and social care services in England. Their role is to ensure that services meet national standards of safety and care. This remit includes the inspection of IRC healthcare services and providers are required to register their services with the Commission. The CQC has a memorandum of understanding with HM Inspectorate of Prisons (HMIP) to ensure that checks are not duplicated. This includes mapping all of CQC's regulations to HMIP's expectations and inspection methodology. The role and independence of CQC remains unchanged by this agreement.

5.3 Her Majesty's Inspectorate of Prisons

Her Majesty's Inspectorate of Prisons (HMIP) is an independent inspectorate, which reports on conditions for and treatment of those in prisons, young offender institutions and IRCs. HMIP has a memorandum of understanding with the CQC to ensure alignment of inspection and regulation expectations. Where HMIP has inspected healthcare and found satisfactory performance, CQC will not normally undertake further checks. HMIP may also undertake thematic inspections which relate to health functions. These may be undertaken individually or in conjunction with CQC and others. The independence and role of the inspectorate remains unchanged by this agreement.

5.4 The Prisons and Probation Ombudsman

The Prisons and Probation Ombudsman (PPO) is appointed by the Secretary of State for Justice to investigate complaints from detainees in IRCs as well as prisoners and those subject to probation supervision. The PPO is also responsible for investigating all deaths in custody and detention and producing Fatal Incident Reports. The PPO publishes 'Learning Lessons' bulletins which draw together lessons for improving practice based on investigations. The PPO is independent of HOIE, NHS England and PHE; although, all three organisations work together with

the PPO. The role and independence of the PPO remains unchanged by this agreement.

5.5 Coroners

Under the Coroners and Justice Act 2009 a coroner must conduct an investigation into deaths which occur in custody or otherwise in state detention. This may include the coroner holding an inquest. The 2009 Act introduced a duty for coroners to issue a report to prevent other deaths. Additionally, Regulation 28 of the Coroners (Investigation) Regulations 2013 provides that a report must be sent by the coroner to the Chief Coroner and any other relevant parties, in order to prevent future deaths. Where relevant parties receive Regulation 28 reports, they have a duty to provide a written response.

As NHS England has full commissioning responsibility for healthcare in IRCs, Regulation 28 reports will be sent to both NHS England and HOIE. Both organisations have individual and co-ordinated systems for both responding in a timely manner and to ensure that learning is captured and disseminated to all relevant staff. The role and independence of coroners in undertaking these duties remains unchanged by this agreement.

5.6 Independent Monitoring Boards

Every IRC has an Independent Monitoring Board (IMB). IMB members are independent and unpaid individuals, appointed by the Home Office to monitor day-to-day life in the IRC to which they have been appointed and ensure that proper standards of care and decency are maintained. This remit includes healthcare provision. The role and accountability of IMBs remain unchanged by this agreement.

5.7 The Parliamentary and Health Service Ombudsman

Parliamentary and Health Service Ombudsman (PHSO) comprises the offices of the Parliamentary Commissioner for Administration and the Health Service Commissioner for England. The Ombudsman is responsible for considering complaints made by the public that their experiences at the hands of Government departments, public authorities and NHS England were not of an acceptable standard. The PHSO is independent of both Government and the Civil Service and annually to both Houses of Parliament. The role and accountability of the PHSO remains unchanged by this agreement.

5.8 The National Audit Office

The National Audit office (NAO) scrutinises public spending for Parliament which ensures that Parliament can hold the Government to account and improve public services and their use of public spend. They also investigate practice, produce

reports to the Committee of Public Accounts and support other select committees. The role and accountability of the NAO remains unchanged by this agreement.

5.9 HealthWatch

HealthWatch is an independent consumer champion for health and social care across England established by the Health and Social Care Act 2012 which came into existence on 1 April 2013. The network is made up of the nationally-focused HealthWatch England leading 152 community-focused local HealthWatch. Together they form the HealthWatch network, working closely to ensure consumers' views are represented both locally and nationally. At present HealthWatch does not perform a role in relation to immigration removal centres although that they do have a legal remit to enter and view any publically funded health and social care provision. Therefore it is possible following intelligence gathered from communities or partners, that HealthWatch could prioritise a review of an IRC and uses the findings to consider how it might contribute to the improvement of services across the estate.

SECTION TWO

6 Agreed Work Plan for 2018-21

6.1 Joint Outcomes, Principles and Priorities

As partners we have developed the following shared outcomes and joint principles. These contribute to our agreed approach to joint working and priorities. They are summarised as:

- Detainees should receive high quality healthcare services, to the equivalent standards of community services, appropriate to their needs and reflecting the circumstances of detention. These services are to be made available based on clinical need and in line with the Detention Centre Rules (STHF rules are currently being finalised).

- Health and wellbeing services in IRCs should seek to improve health and wellbeing (including parity of esteem between services which address mental and physical health), tackle health inequalities and the wider determinants of health.

It is understood that the detained population is not a stable population. Detainees should have urgent healthcare needs identified and managed appropriately. Where there are other more complex or chronic health problems diagnosed, again where possible these should be responded to by an active management plan which takes account of care pathways and which recognises limitations of continuity of care in those who may be removed or deported from the UK.

Detainees should expect continuity of care between establishments (both prisons and immigration removal) and with community services as permitted, if given leave to remain in the UK or otherwise released from detention. Those being deported who have been diagnosed and treated for HIV or tuberculosis infections should be clinically assessed and receive an appropriate supply of medication from the healthcare providers in their IRC to allow time for them to seek healthcare in their home country upon their return.

NHS England, Immigration Enforcement and PHE are working together to develop and establish robust data sets across the detained estate to ensure shared oversight of performance. Improved data promotes transparency and ensures standards are described and evidenced.

Immigration Enforcement and NHS England, supported by PHE, have a shared responsibility for the development of health and wellbeing to detainees to ensure that whilst in an IRC, a detainee's physical and mental health and general wellbeing are supported on the basis of a shared local assessment of need, patient involvement and evidence-based practice.

Immigration Enforcement, NHS England and healthcare providers have a shared responsibility for continuous service improvement supported, where appropriate, by PHE.

Immigration Enforcement, PHE and NHS England will jointly ensure the best use of available resources in line with public value-for-money principles and recognising the pressures on public spending, including exploring jointly funded solutions where appropriate.

Decisions by either Immigration Enforcement, PHE or NHS England which may have a detrimental impact on the services commissioned by the other party (for example, changes to establishment function or capacity or changes to availability of services) will be discussed at the earliest possible opportunity and, where possible, major changes will be co-designed.

Immigration Enforcement, NHS England and PHE will jointly identify and agree the management of shared issues and risks at relevant levels between the organisations.

NHS England and Immigration Enforcement will jointly engage with each other's major procurement exercises by jointly developing and sharing health needs assessments and agreeing service outcomes in the spirit of co-commissioning and ensuring alignment between respective providers and their services.

Services will be assessed on the basis of performance, public value and quality. In addition to performance managing services using contract measures, NHS England will introduce and continue to develop the IRC Indicators of Performance (IRCIPs) in order to promote shared understanding of service performance and quality alongside other existing process and assurance mechanisms.

Immigration Enforcement, NHS England and PHE will work together to manage outbreaks of infection and communicable disease control in IRCs, recognising respective responsibilities for advice, response, planning and delivering interventions with detainees and staff working in a detention setting.

Immigration Enforcement, NHS England and PHE will support the development of partnerships at all levels within and between our respective organisations and commissioned providers of services (see 'Governance'). We will enable this development through transparency of all relevant financial, performance and strategic planning information and documentation. Establishments and healthcare providers (with input from respective commissioners and managers) will be expected to work together to agree how best to deliver the commitments in this national agreement, including appropriate governance and setting this out through the local partnership board mechanisms

Services will continue to be subject to independent inspection and challenge by the Care Quality Commission (CQC), HM Inspectorate of Prisons (HMIP), Independent Monitoring Boards (IMBs), coroners, Parliamentary and Health Service Ombudsman (PHSO), National Audit Office (NAO) and the Prison and Probation Ombudsman (PPO). We will work together to facilitate and support complete transparency of the scrutiny of health services and collate and learn from best practice identified and implement recommendations where appropriate.

Immigration Enforcement, NHS England and PHE will work together to ensure that the health issues of detainees are appropriately reflected in the development and implementation of wider Government policies and initiatives.

6.2 Priorities

NHS England, PHE and Immigration Enforcement will address the following five priorities during FY 2018-21.

6.3 Priority 1: Manage the mental health of people in detention

6.3.1 Background

Stephen Shaw's review into the welfare in detention of vulnerable persons identified a number of issues relating to the mental health needs of people in detention. These recommendations have been incorporated into the revision of the priorities across the

estate where applicable and confirm our focus on the management of mental health across the estate, improving well-being and reducing incidents of self-harm.

We are aligning the mental health priorities to the joint Department of Health and Social Care, Home Office and NHS England Mental health action plan, which can be found at the following link

https://www.gov.uk/government/publications/improving-mental-health-services-in-immigration-detention-action-plan.

There are significant levels of mental health presentations across the detained estate as identified in the national Health Needs Assessment overview published November 2014 and it is essential that there is timely and appropriate assessment and treatment of individuals who present with mental health needs. A mental health clinical analysis carried out in 2016, and published January 2017, (https://www.centreformentalhealth.org.uk/Handlers/Download.ashx?IDMF=5dae67a1-03a4-4687-936e-495b14708296) supported the requirement for more robust assessment and treatment to meet the mental health needs of people across the detained estate and to have a more consistent approach across the estate to improve the uptake of treatment for this patient population. It is important; in order to ensure the best outcomes for patients that Home Office staff and healthcare providers work collaboratively with a shared understanding of a patient's needs within the detained environment.

Further to the above, there is some evidence that the use of psychoactive substances (PS) across the estate is contributing to mental health presentations. Specific training for all staff in IRCs was commissioned by NHS England and undertaken in 2017.

6.3.2 Commitments

In support of this priority during 2018-21 we will:

1. Develop an agreed mechanism to ensure that where a mental health need is identified either through health care providers or from the security and other staff in the IRC that the appropriate clinical decisions are made to support the case workers' decisions regarding the on-going detention for the individual.

2. Ensure that we work together to implement the recommendations of the Centre for Mental Health's Needs Analysis and embed those of the Shaw Review into the detention of vulnerable adults and embed the joint Department of Health and Social Care, Home Office, NHS England Mental Health action plan in related activity.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf.

3. Ensure that there are appropriate processes in place to support effective and timely transfer into secure hospitals where required across the detained estate.

4. Support a tripartite approach to developing a training programme for identification of trauma and torture and ensure that this programme is embedded across the detained estate and the providers of healthcare.

5. Pilot the use of a screening tool for learning disability across the estate.

6.4 Priority 2: Improve the pro-active detection, surveillance and management of infectious diseases in IRCs and improve capability to detect and respond to outbreaks and incidents

6.4.1 Background

The greater prevalence of infectious disease, especially blood-borne viruses (BBVs) and tuberculosis (TB), amongst detainees and the ability to deliver active case finding programmes among traditionally under-served populations passing through the IRC estate provides an opportunity to make significant improvements to both the health of detainees, their families and social networks, as well as public health gains for the wider population (the community dividend).

Therefore it is necessary to improve the pro-active detection, surveillance and management of infectious diseases in IRCs; improve capability to detect and respond to outbreaks and incidents; and to acknowledge and address the pathway challenges that this patient cohort is presented with in respect of where they might access ongoing treatment particularly for Hepatitis C treatment (see HIV approach to treatment regimens where individuals are returned to countries where pathways are not accessible) and the active identification and management of active and latent TB within this population.[4]

By working together, PHE, NHS England and Immigration Enforcement can build on good partnership working to make a step change in the way we detect and manage infectious disease in IRCs. We have an ambition to improve services offered to this

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Treatment of HIV-1 positive adults with antiretroviral therapy 2012 (updated November 2013) British HIV Association (BHIVA)

patient population with better disease surveillance and emergency planning, resilience and response (EPRR), including detection and management of outbreaks to strengthen visibility of our tri-partite commitment and governance to oversee delivery.

6.4.2 Commitments

In support of this priority during 2018-21 we will:

1. Continue to improve the detection of TB at or near reception and improve treatment for those who are infected. This will include provision of Directly Observed Therapy (DOT) and treatment completion in detention, in the community and following removal or deportation through the appropriate provision of medication on removal.

2. Continue to implement an 'opt out' policy for testing for blood-borne viruses (BBVs) and development of care pathways for those found to be infected notwithstanding the particular challenges as described above in respect of treatment pathways for some of this patient population.

3. Strengthen the tri-partite commitment to resilience against infectious diseases including the development and testing of outbreak plans and improvement of disease surveillance including notification of infections and outbreaks to Health Protection Teams within PHE Centres.

6.5 Priority 3: Strengthen multi-agency approaches to managing adult detainees at risk and continue supporting multi-disciplinary meetings with expected attendance by all relevant parties and the expectation that all parties will contribute to the Assessment Care Detention Teamwork (ACDT)

6.5.1 Background

There is a real need to recognise the value of partnership work in identifying and managing detainees who present at risk of serious self-harm. It is essential to ensure there is clarity across health and secure pathways including primary mental health intervention, appropriate and effective use of ACDT, constant supervision and assessment and treatment of identified vulnerable detainees. In building on practice sharing arrangements which support the safer management of a detainee we will ensure the best outcomes for this patient population.

6.5.2 Commitments

In support of this priority during 2018-21:

1. We will improve patient outcomes and ensure that there are clear processes agreed for connecting the agencies working across the detained environment.to support best care for an individual.

2. We will ensure patient care in both the detained setting and in their healthcare delivery is consistent and beneficial.

3. We will support providers across the estate to have a clear and shared understanding of each other's responsibilities which includes robust clinical governance and quality oversight in accordance with national best practice

4. We will strengthen the joint approach to quality assurance and governance of healthcare services delivered to people held in detention which includes the reporting, investigating and responding to serious incidents, deaths in detention and coroner Regulation 28 reports. Take part in lessons learned from serious incident (SI's) and deaths in detention (DID) and continue to further embed shared learning to continuously improve practice

5. Develop local partnership boards to oversee each site or cluster of sites, the membership of which will reflect representation of the agencies delivering services across the detained estate.

6. Ensure there is a robust mechanism in place to support the shared review and revision of current Detention Services Orders (DSOs) where health factors are prevalent.

7. Strengthen the commitment to the delivery of the ACDT across the detained settings and, if appropriate, to review and revise the ACDT process in relation to the national health specifications for IRCs.

8. Develop joint quality assurance governance and processes, through the NHS England Nursing and Quality Group and IRC Assurance Group, to ensure quality concerns, lessons learnt and best practice are shared and acted upon at a local, regional and national level.

6.6 Priority 4: Align NHS England and Immigration Enforcement commissioning systems and strategies to ensure quality

services which support health and Immigration Enforcement outcomes and support partnership working.

6.6.1 Background

We will continue to work together to ensure that our respective commissioning systems and strategies are aligned to deliver our shared outcomes and acknowledge where conflicts may arise. We will work together to support the delivery of the core IRC service specifications and continue to support the development of an information sharing protocol and shared governance approach. We have a collective understanding that the decision to detain or maintain detention is always made by HOIE. Nevertheless, healthcare have a key role in providing advice, where appropriate, to help inform this decision making.

6.6.2 Commitments

In support of this priority during 2018-21 we will:

1. Support the delivery of the core IRC NHS England service specifications for Health and Justice Services with the contract providers aligned to the IRC estate Health Needs Assessment.

2. Align our information governance and information sharing agreements to drive transparency and the continuous improvement of services.

3. Support further development of IRCIPs to support improved performance monitoring and management of healthcare delivery across the detained estate.

4. Continue to work with NHS England to support the roll out of a clinical IT system across detained settings as required to improve integration across establishments and with community based health settings.

6.7 Priority 5a: Ambition to implement a smoke free estate

6.7.1 Background

In line with the implementation of the smoke free prisons by the Ministry of Justice across the prison estate, Immigration Enforcement has an ambition to follow this lead for the detained estate, subject to scoping work to identify risks, benefits and likely costs.

6.7.2 Commitments

In support of this priority during 2018-21 we will:

1. Undertake a scoping exercise of benefits, risks and costs.

2. Subject to the outcome of the scoping exercise, agree clear delivery milestones and consider a pilot project to test smoke free in detention settings.

6.8 Priority 5b: To ensure there are effective interventions in the management of psychoactive substances (PS), alcohol and drugs (incorporating illicit, prescription and over the counter drugs)

6.8.1 Background

There has been a well-documented rise in the use of substances in the IRC estate and the partnership is committed to working together to support the established substance misuse interventions and the centre staff to be better enabled to identify and engage with people who are misusing substances.

6.8.2 Commitments

In support of this priority during 2018-21 we will:

1. Ensure that IRC substance misuse specifications are revised in line with the Substance Misuse specification development across the secure estate in 2018.

2. Support the roll out of PS training for centre staff and clinical staff across the estate in 2018.

7 Review

This Partnership Agreement will be regularly reviewed at intervals of no greater than two years.

Signature 	Signature 	Signature 
Paul Baumann **Chief Financial Officer** **NHS England**	**Hugh Ind** **Director General** **Immigration Enforcement**	**Duncan Selbie** **Chief Executive** **Public Health England**

Appendix A

List of Key Personnel Contacts

Organisation	Role	Name	Telephone No.
Home Office Immigration Enforcement	Interim Director: Removal immigration Enforcement	Alan Gibson	020 8603 8098
	Head of Operations	Vacancy	07766 133755
	Deputy Director Commercial	Ann Smith	020 8603 8167
NHS England	Director of Health and Justice, Armed Forces and their Families, and Sexual Assault Referral Centre Commissioning	Kate Davies OBE	0113 8248990
	Assistant Head of Health and Justice Commissioning	Chris Kelly	07824124462
	Health and Justice Clinical Quality and Assurance lead	Fiona Grossick	07900 715338
PHE	Consultant in Public Health, Health and Justice Team	Jane Leaman	07748148295

Appendix B

Terms of Reference and Membership IRC Assurance Group

Purpose

The Health and Justice Oversight Group (HJOG) is NHS England's national executive leadership forum providing systematic assurance and performance oversight for NHS England's Health and Justice commissioning responsibilities for Prisons and other places of detention. This includes oversight of the quality, safety and patients experiences of these commissioned services with a focus on improving health outcomes and reducing variation across England.

NHS England must assure the system of its ability to deliver these responsibilities. As part of this agreement, NHS England has agreed to two key ambitions:

a. Improve quality and consistency by setting a pace of change for the implementation of the national service specifications ('pace of change')
b. Improve consistency and equity over time, by reducing the range of variation in local levels of performance as well as delivering to the priorities of the Home office Immigration Enforcement, Public Health and NHS England national partnership agreement.

HJOG will report into the NHS England Specialised Services Commissioning Committee which has authorised HJOG to take decisions on its behalf on matters relevant to the purpose of the oversight group. HJOG therefore has a crucial place as the national forum with a sole focus on the operational delivery and strategic framework within which NHS England will discharge its responsibility for the commissioning of qualitative healthcare across the detained estate.

Duties

The Assurance Group duties are:-

1. Assure the Oversight Group and partners that the collective duties in regards to Health care commissioning and management of the member organisations are being delivered according to NHS England's legal responsibilities as set out in the Health and Social Care Act 2012 in relation to finance, quality and agreed outcomes to support local delivery and capability and governance in line with priorities of the Home office Immigration Enforcement, Public Health England and NHS England national partnership agreement. The meeting will cover:

    - Reporting on Risk
    - Financial management
    - Identify and discuss national issues or resource requirement to reach acceptable performance floors, and to inform future national strategic planning.
    - Provide overview and scrutiny of local plans to address areas of poor performance as set out in the performance data once we have access to dashboards and quality assurance across the estate.
    - Disseminate information received through the agreed mechanisms (including independent inspection reports) to ensure better quality

services.

- Disseminate and discuss learning from serious incidents and deaths in establishments, seeking assurance regarding actions taken and those that are being put in place.
- General forum to pick up key issues relevant to specific areas of work particularly in light of reduced number of local commissioners.

2. Provide regular performance and assurance reports for internal and external purposes that will enable us to track variation at regional levels, look at issues that require further dedicated scrutiny in order to make improvements and make recommendations to the HJOG in relation to national action required.

- Receive granulated data to look at national trends and national issues and escalate to HJOG where necessary
- Undertake deep dives and seek assurance regarding areas that require national action
- Identify trends and early intervention requirements
- Review serious incidents and implement an appropriate action plan
- Ensure integration with existing reporting and performance monitoring activities as they are in place
- A quarterly review of performance against priorities set out in the partnership agreement.

Quorum	***Frequency***
At least four members of the total membership, or which one must be include an NHS England VSM with Health and Justice responsibilities. Members should aim to attend 100% of meetings.	The Assurance Group will meet on a quarterly basis. The Secretariat to the Assurance Group will agree the agenda with the Chair. The agenda and papers will be distributed to members and those in attendance not less than three working days in advance of the meeting.
Members	
Locality Director – NHS England – Midlands East	Vikki Taylor: CHAIR
Director: Returns (Interim)	Alan Gibson
Head of Health and Justice, Armed Forces and their Families and Public Health Commissioning (National Team)	Kate Davies
Local Health and Justice representatives x 3 from Regions to represent all Heads of Health and Justice for England and act as conduit	Claire Weston Martin White Nick Watkin
Health and Justice Central Team representation	Chris Kelly
Assistant Director: Supplier Relationship Management Lead	Ann Smith
Head of Detention Operations	TBC

Immigration and Border Policy Directorate	Simon Barrett
Lived Experience Representative	Aisha Kebbejja
Immigration Area Manager	Terry Gibbs
NHS England QA Lead	Fiona Grossick
Business change and implementation manager	Angie Whitfield
Department of Health	Angela Hawley
Public Health England	Jane Leaman
Also in Attendance:	
Secretariat	Hayley Mason
Attendance as required:	
NHS England Finance representative	To be determined as required