Service specification

Dental service

for immigration removal centres in England

2020

NHS England and NHS Improvement Publishing Approval Reference: 001181

Contents

Note to local commissioners
This section is for guidance to assist you and does not form part of the final specification. It should be removed prior to publishing.

1. How to use this document

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 and 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:

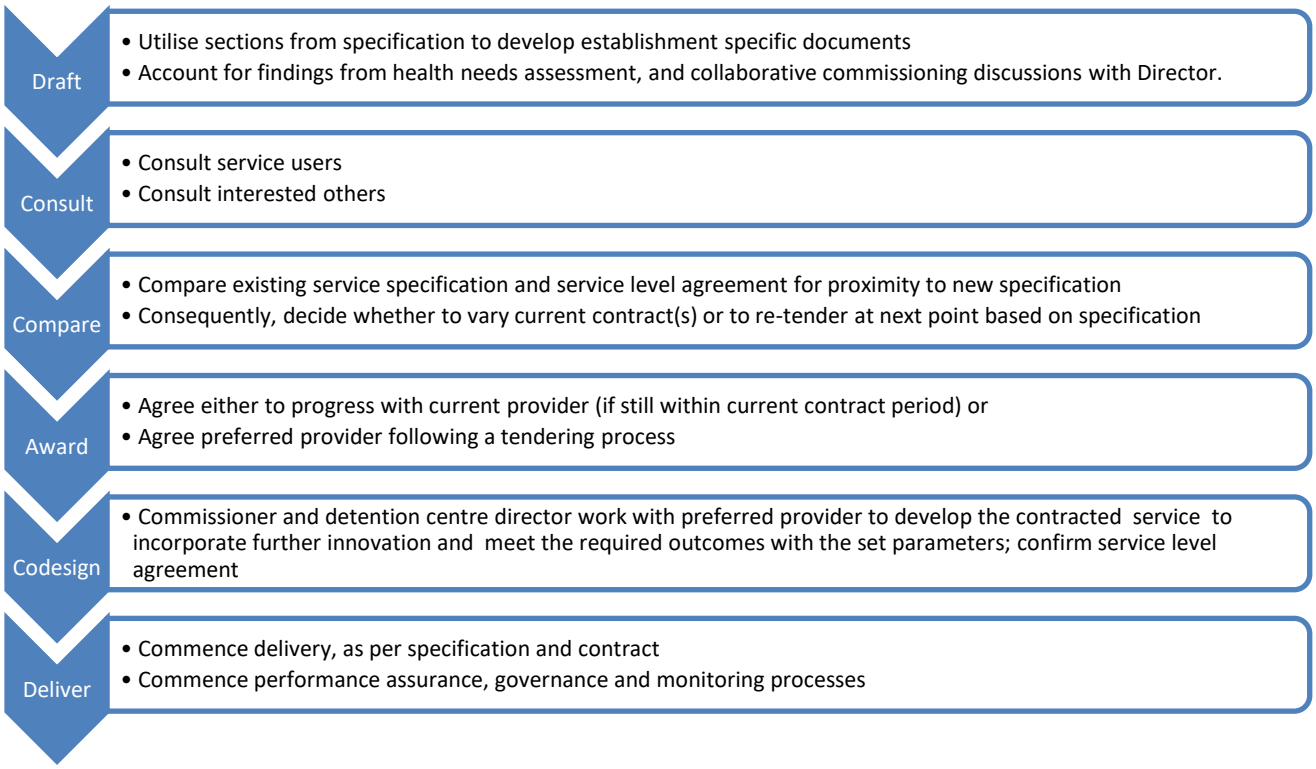
- areas of focus that nationally, providers are expected to prioritise
- the outcomes that are expected from any provider, and examples of how evidence of their ability to deliver those outcomes may be demonstrated
- the freedom for regional commissioners to tailor the specification to their needs and the needs of the detained 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:

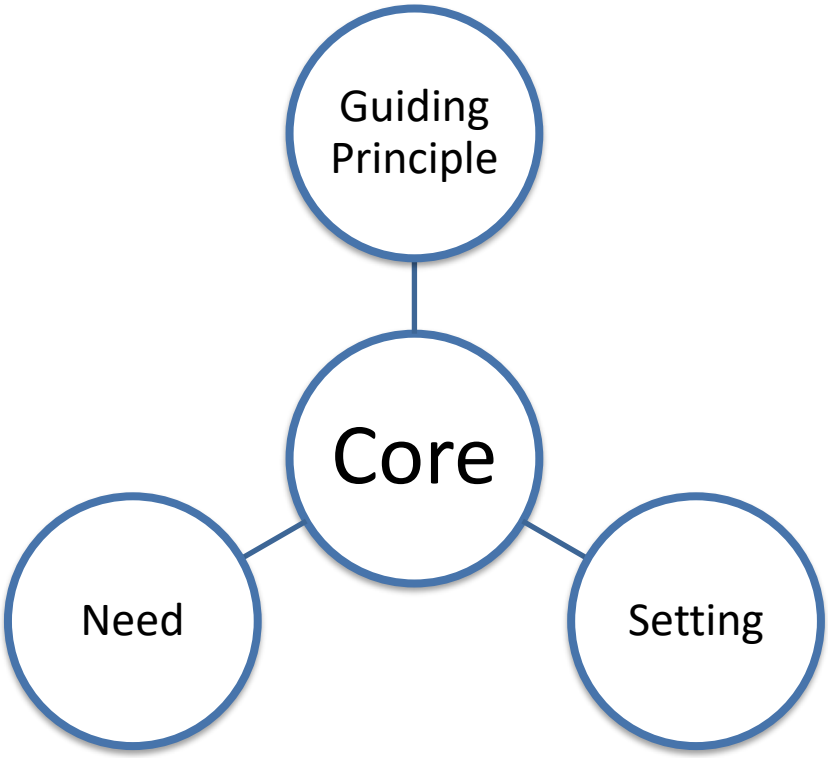


The specification also has appendices relevant to all health and justice specifications and are not all service-specific. These appendices form part of the overall specification and ensures that providers within an establishment, and nationally, are working to the same standards.

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, setting and regional / local approaches); further details of these will be included in other documents, such as the Personal Dental Services (PDS) Agreement.

2. The model

The dental service for immigration removal centres in England 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, recovery focused, 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 (The Shaw reviews of 2016 LINK and 2018 LINK).

Localised elements of the specification:

Full account of the **setting** within which delivery takes place should be taken.

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 establishment's needs*, 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 detention

- the different physical and mental health needs of women in detention and their social and family circumstances
- 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 mental health services are commissioned and provided as services that are fit for purpose and take account of the detained estate.

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 prisons and other places of prescribed detention. As such, this specification describes the standard requirements for dental services that need to be delivered in these environments, ensuring that the principle of 'equivalence'[1]. 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 person's physical circumstances. There is a full definition of this principle of equivalence on page 15 of this document. Enabling patient's access to physical and mental health care as required in line with services offered in the community, working towards agreed health outcomes and being supported to manage their ongoing health care needs.

This service specification outlines what should be included in a dental service being offered to patient populations in detention centres 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, physical impairments, including sight and hearing loss and broader cognitive impairments. It is an integral part of any healthcare of a person in detention that such vulnerabilities are brought to attention of the detaining authorities and delivery should support the mechanisms in train for identifying individuals who, because of their physical or mental health needs, should not be detained. 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.

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 detained environments. This document does not aim to replicate these guidelines but provide a description of the minimum service requirements for a detention centre dental service. 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 the responsibility of the dental service provider, there is a strong need to work collaboratively with local authority social care teams and other healthcare providers. Appropriate support must be provided to people in detained environments with an identified or suspected learning disability or difficulty to enable them to cope better within the environment and ensure that their health needs are met. The dental service provider also has a role in providing general support and advising other agencies within a detention centre of their respective responsibilities to support those detained in their daily life.

[1] 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 person's physical circumstances. There is a full definition of the principle of equivalence on page 16 of this document.

For ease of reference, throughout this document, the term ‘Learning Disability’, unless otherwise stated, encompasses individuals with learning disabilities, autism, neuro-disabilities and other cognitive impairments.

This specification aims to build upon existing positive relationships between healthcare services, the Home Office (HO), detained settings 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, therefore elements of this specification may be subject to review in response to variations.

IT and the Health and Justice Information System

All healthcare services in a detained setting will use the national IT solution provided by NHSE/I Health and Justice Information System (HJIS) as the primary medical record for the patient. Persons will be clearly identified as superusers for the current medical system (HJIS) and the right level of training accessed to support this role throughout the secure settings healthcare service. The superuser will be able to assist the healthcare staff in accessing and using HJIS effectively.

All dental providers must ensure they have an accredited dental software solution to support clinical decision making and the electronic submission of FP17 in line with the regulations all contracts need to be added to the BSA COMPASS system. This includes sub-contractors.

The provider will ensure there are standardised procedures and processes in place for the use of all clinical software solutions and that all clinicians and administrators receive thorough training in the correct use.

4. Guiding principles

The purpose of health care in detained settings is to provide an excellent, safe and effective service to all, ensuring that a detained person has access to a dentist and that their dental treatment is of a quality that would be expected if they were in the community. Services should meet the objectives and outcomes of several frameworks and priorities and are expected to develop and implement measures to monitor these outcomes.

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.

Dental services in detained settings should assist patients to achieve oral health and to be able to continue to maintain their oral health either within the detained setting

or in the community following release. People in detained settings should generally be able to access the same (NHS) healthcare services as the rest of the population. The way people in detained settings access dental services will differ from those in the community. However, as an overarching aim, it is expected that people in detained settings should experience an overall improvement in their oral health while they are detained.

The World Health Organisation describe oral health as:

'a state of being free from chronic mouth and facial pain, oral and throat cancer, oral infection and sores, periodontal (gum) disease, tooth decay, tooth loss, and other diseases and disorders that limit an individual's capacity in biting, chewing, smiling, speaking, and psychosocial wellbeing." [2]

Achieving oral health will require provision of the following:

- Initial assessment and oral health advice
- Getting people out of pain
- More intensive oral hygiene instruction and behaviour modification to ensure clinical/surgical interventions are successful
- Stabilisation of the dentition/mouth
- Definitive treatment dependent on time constraints (due to length of stay in each setting) and patient compliance with oral hygiene (as advanced treatments may not be appropriate if plaque control is poor)
- Equipping people with necessary skills to maintain oral health on release.

The National Partnership Agreement between HO, NHSE/I and Public Health England (PHE) for people in detention centres is a tripartite agreement between PHE, Immigration Enforcement and NHSE/I 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.[3]

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

- Detainees should receive high quality dental 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).

[2] World Health Organisation. Dental diseases and oral health [Internet]. 2003. Available from: http://www.who.int/oral_health/publications/en/orh_fact_sheet.pdf

[3] This Partnership Agreement is subject to review. Any review will not materially change the purview of this specification.

It is understood that the detained population is not a stable population. Detainees should have urgent dental needs identified and managed appropriately. 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 from the UK.

All of these objectives are relevant to dental services.

Provision of dental services in detained settings offers a real opportunity to reduce health inequalities in a population who may not normally access dental services. Improving oral health increases the chances of improving better overall health and confidence. Supporting people to access dental services post-detention is important in maintaining any oral health improvements.

Integration with other healthcare services is essential in achieving health and oral health.

Healthcare for people in detained estate is influenced by a wide range of policy areas and developments. The provider will deliver detention community care 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

The 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.

NHS Long Term Plan

The NHS Long Term Plan (LTP) 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/.

Reconnect

Health and justice services are provided to some of the most vulnerable members of our society**.** Many people in detention experience greater problems than the rest of the population but do not regularly access timely dental care. The NHS is already working with partners across government to improve the wellbeing of people in detention and reduce.

A priority in services for this group of patients is improving continuity of care. The care after detention service, Reconnect, will incorporate work with people in detained settings starts and where appropriate will help to make the transition to community-based dental services that will provide the dental health support that they need.

5. Core service delivery

5.1 Service vision

Note to local commissioners
If the lead provider can deliver the dental services themselves, via the PDS contract alongside the main contract; or If the lead provider cannot deliver the dental services, NHSE/I will contract directly with the dental provider via a PDS contract alongside the main contract with the lead provider, with the additional requirement for an alliance contract to be in place between the lead provider and the dental provider.

This service is commissioned as part of the overall detained settings health pathway and as such this model will ensure an integrated treatment system, both within the detained settings and onwards into the community. The service will focus on delivering person-centred care within seamless and integrated clinical services in detention settings and facilitating arrangements through the gate into the community where appropriate to ensure effective continuity of care. Close joint working with other healthcare services, as well as other departments within detained settings to support holistic care.

The service is to be made available to all people 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.

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 Mental Capacity Act (2005), Mental Health Act (2007) and the Care Act (2014) and include such considerations into the overall approach taken and any plans made.

The dental service will adhere to the requirements within the PDS Agreement specified by NHSE/I. This specification and the PDS Agreement should both be read in conjunction with oral healthcare in prison and detained settings in England (BDA Feb 2012 LINK). 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.

The appropriate skill mix of dental staff will vary according the setting. Successful models include teams using the full range of dentists, dental hygienists and therapists, and dental nurses including Extended Duty Dental Nurses (EDDNs) for oral hygiene instruction and health promotion. The workforce must have the essential and relevant qualifications and competencies to carry out their roles and responsibilities and have regular contact with other dental professionals working in detained settings. This should be supported through protected time allocation. This is particularly important for dentists working in detained settings due to the risk of professional isolation, and the need to address the particular challenges to providing equivalent dental surgery and care for patients in a detained setting. As a separate surgical specialty, dentists are generally less well integrated with other healthcare teams (e.g. medical and nursing) in secure settings. To ensure dentists can learn from each other, peer review should be a main component of protected sessions. Peer review is an important aspect of quality assurance where dental care is provided with little interaction with other dental professionals. It is also difficult for dentists new to providing care in detained settings to gain a suitable induction and peer support. Peer review/support sessions should take into account the needs of dentists new to providing care in detained settings. Appropriate Continued Professional Development (CPD) is required by the General Dental Council and differs for every dentist based on their Personal Development Plan. Whilst limited CPD specific to detained settings may be useful in these sessions, this would not be a main component of protected sessions and it should be clarified that these are not ‘CPD sessions’ as CPD is a separate requirement for individual dentists. Two sessions per year should be allocated for such peer support/peer review sessions. Where possible, this should include all members of the dental team. Organisation of peer support/peer review sessions should be agreed at the regional/local level. It is recognised that release of dentists for two sessions per year will impact on wait times. Where peer support/peer review sessions impact on wait times, then the procedure for dealing with extended wait times, as outlined in 5.8 below, should be followed.

5.2 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.

5.3 Service availability

Specific times when a dental service is available will need to be agreed locally. The relatively small populations in detained settings will mean availability of a dentist/dental team will differ to that in the community. This will require partnership working between the dental team and other healthcare providers to develop local protocols and commissioners should facilitate this. Access to urgent dental care can be particularly problematic. NHSE/I have published a commissioning standard for

urgent dental care which should form the basis of a locally developed protocol. This includes definitions of ‘emergency’, ‘urgent’ and ‘routine’ dental care, which should be used by all healthcare providers.

Note to local commissioners
Commissioners should use the following guidance to inform locally developed protocols in conjunction with other healthcare providers: https://www.england.nhs.uk/wp-content/uploads/2019/07/commissioning-standard-for-urgent-dental-care.pdf Local determination is required, but should be based on the above and at a minimum must include: **Dental emergencies** include the following conditions, which require contact with a dentist or other appropriate clinician within one hour and are treated in a timescale appropriate to the severity of the condition: • Trauma, including facial/oral laceration and/or dentoalveolar injuries, for example avulsion of a permanent tooth • Oro-facial swelling that is significant and worsening • Post-extraction bleeding that the patient is not able to control with local measures • Dental conditions that have resulted in acute systemic illness or raised temperature as a result of dental infection • Severe trismus • Oro-dental conditions that are likely to exacerbate systemic medical conditions such as diabetes (that is lead to acute decompensation of medical conditions such as diabetes). **Urgent** dental problems include the following conditions, which should receive self-help advice and treatment within 24 hours: • Dental and soft-tissue infections without a systemic effect • Severe dental and facial pain: that is, pain that cannot be controlled by the patient following self-help advice • Fractured teeth or tooth with pulpal exposure.

5.4 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.

5.5 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 IRC director. 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 establishment.)
- Dentists are expected to provide the skills commensurate with a General Dental Practitioner (GDP) under General Dental Council and NHSE/I regulations. Other dental services would need to be commissioned separately.
- Where a dentist feels that a patient would benefit from treatment that appears to be subject to exclusion, they should discuss this with the commissioner.

5.6 Equivalence for services in detained settings:

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.

'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 (detained) setting) with the aim of ensuring that people detained in secure (detained) 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.[4]

Equivalence here does not mean 'the same as'. For many, the detained setting may be the first time they access dental services regularly. Oral health is generally worse in people in IRCs. The aim should therefore be to ensure people in detained settings are supported to achieve better oral health than they experienced previously.

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

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

5.7 Setting

Providing dental services in detained settings presents particular issues due to the surgical nature of dentistry, requiring specific settings and equipment. Failure of key dental equipment (such as a dental chair or sterilisation equipment) can result in extensive delays to treatment. All such delays should be accurately recorded and reported to commissioners.

NHSE/I, as commissioners of services, do not hold responsibility for dental equipment. The HO are responsible for fixed, permanent dental equipment. This includes, for example (but is not limited to), a dental chair (plus compressor and suction), fixed sterilisation equipment and fixed radiography equipment. The dental provider must be confident that this equipment is fit for use and is responsible for reporting and escalating any issues. The dental provider is responsible for equipment which can be removed from the surgery. All parties should work together to facilitate a continuous service.

Note to local commissioners
Within the ethos of collaborative-commissioning between health commissioners and the directors of detention centres 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 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 secure setting and subsequently help commissioners and providers with co-designing the service. Considerations of setting should also include the appropriateness of the detained estate to facilitate effective treatment and recovery interventions, such as a healthcare setting which actively promotes recovery, safe and appropriate dispensing facilities. Please insert details and size of the establishment.

5.8 Demand management

The dental provider will manage waiting times, keeping them to a minimum by proactive management of demand and capacity and implementation of a flexible reactive appointment system that is responsive to need. Extended wait times for dental services are often related to extraneous circumstances. There are no set time limits for routine dental care in the community. However, where wait times for routine dental care in any secure setting are consistently beyond eight weeks, the commissioner and provider should work together to address this. Eight weeks should be measured from the request for a non-urgent appointment to the initial appointment. This would allow a dentist to assess the patient and allocate future treatment appointments according to need. Although ‘time to treatment’ is assessed in other areas of healthcare, this generally relates to wait times in secondary care. If

wait times are extended and dental clinical time is not fully used, then the provider should work with the commissioner, healthcare staff and governors to resolve issues. Where dental clinical time is optimised and wait times are consistently extended, then discussion between the commissioner and provider is needed to establish whether a review of current levels of commissioned activity is required. The dental provider will support the commissioner, through the provision of health need, demand and capacity information, to undertake a review of commissioned activity.

5.9 Access requirements

- NICE guidance suggests that within seven days of arriving in a detained setting people should be given advice on how to access dental services.
- Dental appointments are not automatically transferred when someone is transferred between detained settings and this should be made clear on transfer.
- Medical emergencies – immediately (via blue light ambulance services commissioned by clinical commissioning groups).
- Discharge plans for all – on release with follow-up in community if relevant.
- Systems are in place for the detained setting healthcare provider to support access targets including 18 weeks from referral to treatment (consultant led activity) and 2 weeks from referral to first outpatient appoint (cancer referrals).

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. The dental provider has a responsibility to work with the healthcare provider and make sure that they are aware of any issues which may affect this. This is also important in reducing professional isolation of the dental team.

5.10 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 critical incidents, complaints, best practice and clinical audit, audit of Deaths in Detention, Serious Case Reviews 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 system. 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
- patient compliments/complaints
- clinical audit (including antimicrobial prescribing)
- waiting time surveys.

The provider will supply regular reports and any other reasonable additional information to enable commissioners to monitor outcome measures.

CPD of the dental team should include learning and learning objectives specific to secure settings.

Performers should take part in relevant networks to continually improve quality of dental care provision. Performers should engage with a peer review group or similar for dentists working in detained settings. This should ensure up to date knowledge of any relevant changes in procedures and any relevant guidance. Assuming performers are engaged on a sessional basis, a minimal number of sessions each year should be allocated for networking and/or quality improvement in protected time. Where protected time forms part of the contract, outcomes of these should be reported back to commissioners as a formal method of quality assurance.

5.11 Safeguarding

Details of expected safeguarding can be found in ***Appendix 2.***

5.12 Information governance

Details of expected information governance, data protection, security and confidentiality can be found in ***Appendix 3.***

5.13 Information management and technology

The provider must have in place appropriate, secure and well managed information management and technology (IM&T) systems, which properly support the efficient delivery of all healthcare services and which either includes or links with primary care and mental health. These must comply with specific requirements as specified in the PDS Agreement.

5.14 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.

Pharmacy service and medicines outcomes

- People in detained settings have prompt access to medication in accordance with clinical need.
- Systems enable the safe use and handling of medicines accessed by people in detained settings.
- 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 detention centre.
- Outcomes are underpinned by an on-site pharmacy workforce who are fully integrated into the healthcare team, provide services to people in detained settings that enable medicines optimisation and who are led by a senior pharmaceutical adviser or chief pharmacist.

IRC medicines and pharmacy standards

The dental services provider should collaborate with the healthcare and pharmacy services provider for the detained setting to deliver the dental service and use of medicines within it, in line with the Royal Pharmaceutical Society's Professional Standards for Optimising Medicines for people in IRCs (Link). This provides detailed information about medicines handling and optimisation in secure settings and should be read alongside the Royal Pharmaceutical Society (RPS) Safe and Secure Handling of Medicines 2018 (LINK), NICE guidance and other national clinical guidelines.

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.

In addition, there are specific medicines and pharmacy elements which will apply to dental services in detained setting. These elements along with any guidance referenced in them require delivery by the dental provider:

- Prescribing should be in line with the British National Formulary, including the prescribing in dental practice section and national dental practitioner's formulary.
- Dentists should prescribe pain relief in line with the national secure and detained pain management formulary and implementation guide (link) and in collaboration with the local healthcare provider to ensure a consistent approach is used.
- National guidance for the use of antimicrobials should be followed with regular audit. A toolkit can be found here: https://bda.org/about-the-bda/campaigns/antibioticresistance.
- The dental provider should support the healthcare provider to develop and use processes relating to the use of medicines for acute dental needs that present to healthcare when the dental team are not on-site.
- The dentist must prescribe medicines themselves directly onto the detained setting IT system (HJIS) including printing and signing the prescription forms in line with the local healthcare provider's processes.
- The dental provider should ensure that medicines needed in the event of a dental emergency are stocked and accessible by the dentist. This should be in line with national guidance: https://www.cqc.org.uk/guidance-providers/dentists/dental-mythbuster-4-drugs-equipment-required-medical-emergency.
- The dental provider will use medicines sourced by the healthcare provider so that the healthcare provider retains ownership of medicines used by the dental team. This simplifies the arrangements in order to comply with medicines legislation.
- The dental provider staff should comply with the healthcare provider's processes and policies relating to medicines handling, medication safety incident reporting and policy. This will require developing processes relating to dental practice in partnership with the healthcare provider's lead pharmacist and the detained setting's medicines management committee. Examples include:
    - Prescribing based on the IRCs in-possession policy
    - Disposal of pharmaceutical waste.
- Dental staff may be required to manage stock control (i.e. ordering and checking medicines held for dental use) and monitoring of fridges held in dental practice rooms. Clear accountabilities and responsibilities should be agreed with the healthcare provider and pharmacy team.
- Prescribing and use of any Controlled Drugs (CDs), in particular midazolam and other benzodiazepines, should be in line with regulatory and local operational requirements. This includes ensuring any CD incidents are reported to the healthcare provider, the dental provider's Controlled Drugs Accountable Officer (CDAO) if applicable and NHSE/I CDAO for the IRC.
- The dental 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 that are relevant for dental practice and that all necessary

actions are carried out and documented within the required timescale. The dental provider should liaise with the healthcare provider's pharmacist to confirm the actions taken.

5.15 Learning disabilities and other vulnerabilities

It is understood that it is not usual nor desirous for a person with high levels of learning disabilities (LD), autism or other serious cognitive impairments and vulnerabilities to be detained within an IRC. It is however, acknowledged that there may be some individuals who have a degree of LD, autism or other vulnerabilities for whom dental provision for the duration of their stay in the detention centre must be made available.

The number of adults with autism or Asperger's Syndrome in detention settings population is unknown. However, 1% of the general population have an autistic spectrum condition. People with learning disabilities are more likely to experience certain physical and mental health conditions and are less likely or able to access healthcare services[5]. People with other vulnerabilities such as autism, ADHD or acquired brain injury, may also experience associated health problems and have difficulty communicating their situation or symptoms.

Members of the dental team need to have a comprehensive understanding of learning disabilities and other vulnerabilities.

The dental team will support the role taken by healthcare staff in helping individuals with LD and other vulnerabilities, including autism, neuro-disabilities and other cognitive impairments, to access the care they need.

This is to involve:

- helping detention and healthcare staff to identify possible learning disabilities
- implementing pathways to enable patients with learning disabilities to be referred, where appropriate, to local or regional services
- ensuring the service has access to learning disability expertise to advise and have input into planning and support, as required
- liaising with social care regarding any detainees who require a social care assessment and ensuring that any outcome of such an assessment is embedded within the detained person's support plan
- raising awareness of LD across the detention centre
- working with the establishment operator and other healthcare services to manage specific detainees with learning disabilities, whose behaviour is causing considerable disruption or concern. This includes contributing to case conferences.

[5] The health Equality Framework (2013) www.ndti.org.uk/uploads/files/The_Health_Equality_Framework.pdf

The dental care team will also work with the primary care team in the development of learning disability registers that will enable an annual health check and health action plan to be completed. Dental teams should co-operate with this wherever necessary.

Individuals identified with a learning disability will be given a comprehensive physical and mental health assessment using an appropriate tool which healthcare staff are fully trained to use and which the detainee is able to fully comprehend and take part in. This should include an oral health examination.

Appropriate support must be provided to detainees with an identified or suspected learning disability in order to enable them to cope better within the detained environment and ensure that their health needs are met.

Patients identified with a suspected or confirmed learning disability must be clearly identified on a central establishment setting healthcare database and appropriate information shared with the establishment operator and other healthcare and detained setting services.

All detained patients with a learning disability should be able to access all relevant information via clear communication, including, translations, accessible, easy to read information that meets their specific needs, including Easy Read dental health literature.

6. 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.

All services should be commissioned to achieve the objectives and their respective outcomes. However how these are achieved will depend upon the service model provided within an establishment.

Clinicians are expected to work with patients to agree treatment plans which address individual needs. 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 objective, the specification incorporates 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 tables starting on page 24, there are examples of ways in which you 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 important to recognise where a service is working well so good practice can be shared. It is also important that commissioners can identify potential issues with clinical quality/concerns around clinical practice which require further investigation. This could come from a composite of the following sources:

1. Outcome measures as below
2. CQC inspections
3. HMIP inspections
4. Reports from IRC healthcare
5. Patient questionnaires
6. Patient compliments/complaints
7. Clinical audit (including antimicrobial prescribing)
8. Waiting time surveys (noting that wait times are due to a number of factors often outside the control of dental providers).

FP17s must continue to be completed and sent. However, Units of Dental Activity or 'UDAs' are inappropriate for monitoring and comparing dental activity in IRCs.

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.

Appendix 1 Objectives and outcomes for regional contract assurance

In the tables below there are examples of ways in which you 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. They are provided to assist in determining the type of evidence that may be available. Healthcare within each setting can arrange focus groups to develop specific questions on dental provision based on the below. Due to differences in settings, local agreement is likely to be needed for most questionnaire settings. However, it may be useful to develop some regional or even nationally agreed questions for comparison as the specific wording of questions influences responses.

Objective 1 **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: Patient views and feedback are regularly obtained, and their comments reflected in continuous service improvement All patients are involved in, and have access to, their own care plans	PROMs: Patient survey results with evidence of actions completed based on these Evidence for this could be agreed in peer review/peer support sessions.
PREMs: While I was in the waiting room I was informed if I would be unlikely to be seen that day The dental surgery was clean My confidentiality is protected but information is shared to keep me safe I got the care I needed	PREMs: Patient questionnaire (locally/regionally agreed) Patient questionnaire Patient questionnaire Patient questionnaire

I have been told what is next in my dental treatment plan I received an explanation when I raised a complaint I feel the service listens to me and hears my concerns	Patient questionnaire Evidence of patient engagement (e.g. patient forums) Patients inform the development of the service

PREMs: Oral healthcare information can be understood by people who do not speak English and by people who use sign language Dental services are physically accessible to all	PREMs: Translation services are available and utilised; oral healthcare leaflets in an appropriate format (diagrams may be useful due to the large number of languages needed) Compliance with relevant legislation, e.g. people with mobility issues
CROMs: Antimicrobial prescribing is as per guidance Oral health advice is in line with most recent guidance Radiographs are according to most recent guidance Peer review for example by case based-discussion Dentures (or other treatment requiring a dental laboratory) are provided where length of stay permits where appropriate	CROMs: Regular antimicrobial prescribing audits (AMR audits) Regular Delivering Better Oral Health (DBOH) audits Regular radiography audits Evidence of peer review, for example attendance at local or regional meetings plus an action plan Evidence in FP17s where appropriate to the setting

PATOMs: Providers work with partners to ensure reasons for clinic cancellations are accurately recorded and reported	PATOMs: Where this is the fault of the provider these are replaced, where these are not the fault of the provider (faulty dental chairs, etc) these are reported, and an action plan developed Accurate pressure reporting
Regular contact with other key partners including recording of issues with equipment/regime	Records of contact made with improvements/solutions suggested by provider for action by the responsible body
Close working with other healthcare professionals (including GPs and nurse practitioners) to ensure adequate care when no dental service is available	Development of a local protocol for urgent dental care and involvement in interdisciplinary clinical governance group (commissioners should facilitate this)
CPD relevant to secure settings	Completed CPD or included in PDP

Objective 2 **To support access to and continuity of healthcare through the IRC estate post detention into the community where appropriate and possible.**	
Outcomes	**Examples of how this could be evidenced *(local determination required)***
PROMs: Information/discussion on how to access dental services following release Where the release date is known to patients, personal, written oral health care advice is given at the final appointment	PROMs: Written information available/posters in the dental setting Information on discharge summary and through the gate services are available to support patients to access dental services after release from detention.
PREMs: I am engaged in planning the treatment needed before and after my discharge	PREMs: Questionnaire (only applicable where release date is known)
CROMs: Arrangements are in place to support continuity of care on transfer to another IRC Referral to Reconnect where required/possible	CROMs: Patients are aware that they will need to check any ongoing dental appointments are rebooked on transfer to another IRC Engagement with the Reconnect programme as appropriate

PATOMs: Where appropriate, dental teams should assist with patient information flows across the patient pathway	PATOMs: Engagement across delivery arms to be captured through partnership measurement mechanism
All CQC and relevant HMIP dental care recommendations and findings are responded to and actioned	Commissioners should facilitate dental providers input into wider secure setting leadership and initiatives and dentists should provide input/attendance when requested
Information sharing agreements are in place locally to support appropriate sharing of patient information	As appropriate
Contributions to multidisciplinary teams for complex cases where appropriate	As appropriate

Appendix 2 Safeguarding

The provider must ensure they have up to date organisational safeguarding policies and procedures for adults and robust governance arrangements in are in place for safeguarding in line with the local authority and the centre's safeguarding policies and procedures. They must work with detained settings partners to ensure there are strong links between the establishments and local safeguarding boards.

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 services must also abide by the HO Adults At Risk Policy[6] LINK in supporting safeguarding of patients. 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 healthcare lead within each IRC to champion the importance of safeguarding and the dental practice safeguarding lead would link into the designated healthcare lead. In turn these representatives must link in with the individual establishment safeguarding managers and attend and contribute to any safeguarding case conferences/protection meetings within the setting 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 quality assurance programmes to ensure that safeguarding systems and processes are working effectively

[6] Home Office Immigration Act 2016. Guidance on adults at risk in immigration detention

- 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 Primary Care Service Specification 57 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 children and 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 documents:

- 'Safeguarding Adults: The Role of Health Service Practitioners' (DoH, 2011)

- Home Office Adults At Risk Policy 2016 (scheduled for update)

- Public Health England have produced a toolkit entitled Safeguarding in general dental practice: a toolkit for dental teams.

- The British Dental Association have produced the following guidance: www.bda.org/safeguarding

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.

The provider will ensure that all staff recognise the risks of abuse to an unborn child.

Prevent

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 detainees 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 for the whole healthcare setting 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. The dental team must report relevant concerns to the healthcare Prevent lead. There must be a clear process for escalating concerns regarding potential terrorist events to the police and/or detention centre director pathfinder lead.

Appendix 3 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 detainees' 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 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 IM&T systems and paper records to safeguard person identifiable information as determined by the commissioner and the secure setting establishments including appropriate security measures and access controls. This includes adherence to relevant prison service order (PSOs) and prison service instructions (PSIs).

The provider will demonstrate compliance with the Data Security Protection Toolkit Standards for secure settings working towards a minimum of 'satisfactory' compliance in all requirements and will co-operate fully with the Commissioner in any submissions required by NHS Digital, Department of Health and NHSE/I.

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 confidentiality
- 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 2013
- 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’). 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 (including right to be forgotten, right to amend etc) requests 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 patient 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 detainee to have their clinical records on SystmOne or any subsequent clinical systems.
- Communication with patients, 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 the following:

- 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 patient's condition at any time.
    - The measures taken to respond to the needs of the patients.
    - 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.

For liability all records should be retained in line with the NHS Retention schedule LINK.

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 (LINK) Health Service Circular HSC 2001/023 (LINK) and the Good Practice in Consent Implementation Guide – Consent for Examination or Treatment (LINK) , or to any amendment or reissue of them from time to time. Difficult situations can arise for healthcare professionals within secure settings 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 patients at risk of harm to self (LINK), to others and from others (Safer Custody)' and will share relevant information appropriately with all those managing such people.

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
- is obtained from a third party who is lawfully authorised to disclose such information
- is authorised for release by the prior written consent of the Discloser
- is 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 setting.

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 detained setting(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

Secure setting(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 secure setting(s) with a copy of all information in its possession or power in the form that the commissioner and/or the respective secure setting(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 secure setting(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 secure setting(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 detained setting(s) may nevertheless be obliged to disclose confidential information.

Guidance and reference documents

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

- Standards for women in secure settings. PHE 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

- Immigration detention and HIV advice for healthcare and operational staff. BHIVA March 2019 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 LINK

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

- Detention Service Order LINK

  https://www.gov.uk/government/collections/detention-service-orders

- 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

- General Dental Council (2013) Standards for the dental team LINK

  https://www.gdc-uk.org/information-standards-guidance/standards-and-guidance/standards-for-the-dental-team/

- General Dental Council (2013) Scope of practice LINK https://www.gdc-uk.org/information-standards-guidance/standards-and-guidance/scope-of-practice

- NICE (2015) Oral health promotion: general dental practice LINK https://www.nice.org.uk/guidance/ng30

- PHE (2017) Delivering Better Oral Health LINK https://www.gov.uk/government/publications/delivering-better-oral-health-an-evidence-based-toolkit-for-prevention