Classification: Official

NHS England

Annex 1 – Primary care minimum service requirements

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Healthcare	
1.	The provider is to deliver healthcare services which work collaboratively and in partnership with all establishment professionals to deliver an integrated and patient-centred service.
2.	The healthcare workforce must possess and provide evidence of the appropriate professional registrations, competencies and skills including relevant and current qualifications for their specific role.
3.	Access to a prescribing learning environment managed by designated prescribing practitioners is to be in place to support and mentor the ongoing development of registered healthcare professionals to achieve non-medical prescribing qualifications. GPs will be required to support healthcare professional training and development alongside other clinical colleagues.
4.	The service must meet the establishment's specific requirements for healthcare input as stated in detention service orders (DSOs).
5.	The provider must develop a community equivalent multi-professional primary care service to patients that meets the needs of the population in the IRC, to that which is available in the community.
6.	Provide clinical input into the needs of detained individuals with substance use and mental health needs.
7.	Provide care and treatment that is consistent with national standards and professional and clinical guidelines, eg Quality outcomes framework (QOF) and NICE guidelines.
8.	Develop effective interfaces with community and secondary care providers to ensure continuity of care when people leave IRCs. This includes following local and national NHS clinical prescribing and treatment policies.
9.	Adhere to and implement the number of healthcare clinics, as specified in the contract, that will be delivered across the commissioned establishments.
10.	Agree formal arrangements for the monitoring of medicines prescribed and reviewed by specialist prescribers (eg mental health and hospital clinicians) in line with local and national arrangements.
11.	Use clinical IT systems including health and justice information services (HJIS), telehealth and integrated clinical environment (ICE) pathology reporting to effectively and accurately record patient information.
12.	Monitor patients with long-term conditions or on medication in accordance with an agreed personal care plan and in line with QOF, NICE guidance and other nationally accepted standards of best practice.

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13.	Provide assessment and management of minor injuries for patients who require medical attention but not a visit to Accident and Emergency (A&E).
14.	Actively participate and input into the local health improvement plans.
15.	Attend and actively participate in multi-disciplinary team reviews including assessment, care in detention, and teamwork (ACDT) reviews.
16.	Visit and carry out mental and physical health assessment on each patient as often as their individual health needs require.
17.	Adhere to the Patient safety incident response framework (PSIRF) which sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
18.	Involvement in safeguarding procedures.
19.	Provide all relevant medical reports where a medical opinion relating to the patient's health is required and the patient has given their consent to sharing the information.
20.	Attend and actively participate in the relevant local meetings. Local Delivery Boards (LDBs) are led by the Home Office service delivery managers and include providers of detention services, healthcare and healthcare commissioners; and Centre Partnership Boards (CPBs) are led by healthcare commissioners.
21.	Represent and participate in designated meetings where clinical input is required.
22.	Participate in emergency planning for epidemics and pandemics.
23.	Ensure notification of communicable diseases to the UK Health Security Agency (UKHSA).
Prescribing and medicines management for IRCs	
24.	The provider has an IRC medicines policy that complies with the Royal Pharmaceutical Society (RPS) professional standards for secure environments Edition 1[1]. This is delivered and overseen using the medicines management committee or equivalent forum.
25.	Prescribers will comply with the IRC's in-possession policy and local IRC formulary (which is based on the local ICB formulary). An exceptional case process is used when prescribing outside of these policies.
26.	Timely and thorough in-possession risk assessments using a national template will be undertaken on admission and during detention to ensure prescribed medication is safe and appropriate for the detainee.

[1] Optimising Medicines in Secure Environments (rpharms.com)

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27.	Medicines reconciliation is completed within 72 hours of arrival.
28.	Prescribers will work in conjunction with secondary care and pharmacy services to ensure the continuous issuing of prescriptions within agreed timescales and to avoid delays in access to medication for shared care.
29.	Clinicians effectively request, record and document medicine reviews to ensure a complete audit trail. Details for the medication type and due date should be clear to enable the practitioner to sort requests by urgency and due dates.
30.	Admission using the national template and in line with best practice patient group direction.
31.	A supply of medicines is provided on discharge from the IRC so that: - those released to the community have a minimum of 28 days' supply or a community prescription - those removed/deported have up to 3 months of supply and the supply meets the legal requirements of the receiving country.
32.	All prescribers must be certified in Royal College of General Practitioners (RCGP) certificate to at least Level 1 in the Management of Drug Use and the RGCP Certificate in the Management of Alcohol Problems or must gain both these certificates within 12 months of employment under the contract. Any prescribers or clinicians working directly to deliver the clinical substance misuse service must as a minimum be working towards Level 2.
33.	There are clear written protocols outlining prescribing and monitoring responsibilities when sharing care between hospital clinicians, psychiatrists, GPs and non-medical prescribers. Clinicians must refer to 'Safer prescribing in prisons: guidance for clinicians, second edition' (RCGP, 2019).
Healthcare staff requirements	
34.	GPs: • must undertake an IRC specialist peer-led appraisal at least every two years to supplement their annual appraisal as a GP • at least one GP in each of the IRCs must hold a Royal College of General Practitioners (RCGP) Level 2 for the management of substance misuse and work in that IRC at least once a week • GPs must have experience of working in a community practice setting or have access to a GP mentor and be linked into GP professional networks. This ensures the principle of equivalent care. New GP recruits must receive robust induction, mentorship and ongoing training by the provider.

	• GPs must be registered on NHS England medical performer's list and have full GMC registration and discharge their professional responsibilities in line with professional standards, regulations and code of practice and conduct • GPs must be competent in the 13 key areas derived from the core RCGP curriculum statement 'Being a GP', using RGCP's workplace-based assessment • must be competent to carry out Rule 35 reports • must have a certificate from the Joint Committee of Professional Training in General Practice (JCPTGP) or a recognised equivalent certificate or a certificate of exemption • must be allowed to take study leave to develop the necessary skills and to keep up-to-date on working in secure environments, e.g non-medical prescribing, RCGP Substance Misuse Certificate, Rule 35 training and updates STIF training, RCGP Secure Environment Group organised training days.
Healthcare staff	
35.	Any member of healthcare staff that is in the process of attaining any accredited qualifications must have access to mentorship and support.
36.	Registered medical and non-medical prescribers must prescribe medicines based on the national prescribing competencies: Prescribing competency framework - RPS (rpharms.com)[2].
37.	Must follow and be competent in the 'RCGP Curriculum: Clinical Modules 3.10 Care of People with Mental Health Problems'.
38.	Must have the attitudes, skills, expertise and competencies as described in the RCGP Curriculum: Core Curriculum Statement.
39.	Receive initial and regular refresher training to ensure a high level of competence in responding to medical emergencies and resuscitation.
40.	Use the RCGP safer prescribing in prisons as this is relevant for other secure settings including IRCs: Secure environments group (rcgp.org.uk[3]) and the Orange Book [4].
Advanced nurse practitioners (ANP) core competencies	
41.	The provider must ensure that all ANPs can demonstrate the core competencies as detailed in the RGCP general practice advanced nurse practitioner competencies framework (2015) and the RCN's 'Advanced nurse practitioners an RCN guide to advanced nursing practice, advanced nurse practitioners and programme accreditation'. All ANPs must hold a current non-medical prescribing qualification or be training towards this qualification.

[2] Prescribing Competency Framework - RPS (rpharms.com)
[3] https://www.rcgp.org.uk/about/communities-groups/secure-environments
[4] Drug misuse and dependence: UK guidelines on clinical management - GOV.UK

42.	All ANPs must be able to demonstrate they have achieved the competencies required to practice autonomously. Their practice should include direct clinical practice, education, research and management.
43.	Any nurses who are developing or undertaking training to become an ANP must be supported by an experienced and qualified mentor and have appropriate membership, regular supervision, an annual appraisal and ongoing continual clinical practice.
Nursing leadership	
44.	Each establishment will have a provider nurse manager (PNM). The PNM will take the lead and responsibility for the following: • providing effective management support and professional leadership to staff • ensuring healthcare services are integrated • attending the IRC senior management team meetings • leading on reporting any issues/incidents through appropriate channels • ensuring patients are consulted with on their own care • developing and delivering service improvement plans and ensuring patients are given the opportunity to provide feedback • participating in and supporting any inspections, audits, performance reviews and service reviews • coordinating services and care with all service leads, sharing operational issues across NHS providers and ensuring their teams work together collaboratively.
45.	The lead nurse will take responsibility for the following: • coordinating all nurse triage and nurse-led clinics • improving the quality of patient care • managing duty rotas to ensure adequate and appropriate staffing levels to fulfil service responsibilities • ensuring safe, responsible and professionally appropriate practice within the scope of the Nursing Code of Conduct • leading on infection control within their establishment • providing clinical supervision to other nursing staff • providing expert nursing advice as appropriate to patients and to colleagues from other disciplines within the establishment • ensuring care plans are developed, maintained and monitored.
Reception/first night screening	
46.	All detained individuals must undergo an initial health screen using the IRCAT suite/templates (IRC Assessment Tool) on arrival at the IRC by a registered nurse member of staff, to identify any immediate health needs or risk - particularly in relation to vulnerabilities such as suicidal

	ideation or self-harm; mental health, learning disability, trauma related presentations; substance misuse (drugs and alcohol), infectious diseases, continuity of prescribed medicines or any acute, urgent medicines and the needs of the older or younger adult or those presenting with other vulnerabilities.
47.	All patients must be offered a healthcare screen in a manner they understand under the requirements of detention centre rules using translator or interpreter services if needed.
48.	It is expected that any patient identified at reception will be referred to the substance misuse or mental health service the same day if they are either: • already participating in a substance misuse treatment programme • already under the care of mental health services • presenting with any substance misuse or mental health needs.
49.	Patients presenting at reception or at the general health assessment stage, who identify an active substance misuse and are not currently on a substance misuse clinical programme, must take a drugs test. The substance misuse team must undertake this in a timely fashion.
50.	Provider must ensure that patients arriving at the IRC with medication can access a continued supply unless no longer clinically indicated. This includes completion of an in-possession (IP) risk assessment in line with provider IP policies. Access to critical medicines should be continued to avoid harm from delayed and omitted doses. Where patients arrive at an IRC without their prescribed medication, steps must be taken to access the medicines urgently using local procedures.
51.	Within one working day of arrival at the IRC, the provider will initiate contact with external services used by the patient prior to their admission, e.g. GP and community mental health team (CMHT), where it is possible to verify patient engagement.
52.	The health screening service must be available at reception. When a patient is identified as at risk of harm to themself or others, the provider must inform and share information with the relevant agencies and take action in line with local safeguarding and risk management procedures.
53.	An immediate healthcare plan must be written and put in place for any patient with urgent health concerns.
Health assessment screen	
54.	All patients must be offered a more in-depth health assessment which, if accepted, must be completed within 72 hours of arrival. The provider will ensure systems are in place which actively encourage detained individuals to accept this assessment. All detained individuals' reception screening information should be recorded using the IRCAT suite/templates.

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55.	The provider will advise the patient on the range of health services available within the establishment and will give information about: • how the range of healthcare services can be accessed (including medicines) • current waiting times • how to make a complaint or submit a compliment (internally and externally) • how to get involved in patient engagement activities[5] • information must be provided in a format and language that the patient can understand.
56.	Patients should be provided with information about the health trainer scheme (see the Health Promotion/Prevention Service Specification) and referred to see a health trainer where indicated. This will compliment a process of self-referral to the health trainer programme and enable a proactive approach that targets new IRC arrivals.
57.	The health assessment must be based on best practice and use recognised screening tools which include assessments for: • physical health problems including urine test and blood pressure • mental health problems • trauma-related presentations • drug or alcohol abuse • risk of suicide or self-harm • learning disabilities or neurological conditions • immunisations in line with UKHSA guidance and national vaccination programmes.
58.	A full assessment in accordance with current and future national IRCAT suite/templates is carried out with referrals and care pathways, as per the outcomes of the assessment with ongoing monitoring including: • reception health screen • secondary full health screen • In-possession risk assessment • medicines reconciliation • release or transfer planning template.
59.	The provider will ensure that patients have NHS-equivalent access to a range of diagnostic services according to level of need within each IRC.
Telehealth	

[5] NHS England - Engaging patients and carers

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60.	The provider will ensure that in IRCs where telehealth equipment is available, it is used in line with national guidance [6].
61.	The telehealth equipment should be used by staff for clinical supervision and training across IRCs. Telehealth should be used to facilitate inter-establishment consultations, such as between a health provider in one establishment and a client in another or other similar consultations. The NHS commissioner will procure and maintain all telehealth equipment.
62.	The provider must ensure that relevant staff receive training in the use of equipment and are competent and confident to use the equipment. Use of telehealth needs to be delivered in line with professional standards and best practice, i.e. GMC guidelines.
63.	Telehealth can be used to supplement the management of specific long-term conditions. A healthcare support worker (HCSW) or nurse must always be present with the patient whilst a tele-consultation is taking place to ensure patient confidentiality and clinical governance.
64.	Medicines prescribed as part of a telehealth consultation must be issued, signed and recorded in the IRC clinical record (HJIS) in line with legislative and best practice requirements. The provider must arrange for these prescriptions to be dispensed and delivered to the IRC in line with local policy and pharmacy services.
65.	The provider must ensure that there are clear eligibility criteria and referral protocols in place, shared with all staff (GPs, nursing and administration). The provider must work with the telehealth provider and local providers to minimise delay in the patient care pathway. In addition, the provider will avoid duplication of appointments and diagnostic tests.
Consent, assessments and care planning	
66.	Information obtained at reception and general health assessment stages must be shared with other agencies where appropriate and health assessments effectively coordinated - with the patient's consent so that patients are not repeatedly asked to provide the same information. The patient can refuse to allow information sharing, unless there is an exception such as risk of harm.
67.	Staff should discuss with and seek consent from the patient regarding completion of an assessment and intervention. The patient should receive easy to understand information about the assessment and its purpose including their legal and privacy rights. Translation and pictorials should be offered if appropriate, either before or at the start of the assessment. If a patient declines an assessment or withdraws from an intervention, the reason should be documented.
68.	Patients must understand and be fully involved in their health assessments.
Planned care	

[6] NHS England - remote consulting and Remote consultations - ethical topic(gmc-uk.org)

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69.	All clinical services must be provided to the same standards as those delivered within the community and in line with published NICE guidelines or equivalent current national clinical and professional standards. The service must operate regular review clinics and coordinate primary and secondary care referrals.
70.	The provider is responsible for: • ensuring the IRC has NHS-standard clinical and cleaning facilities, including disposal arrangements for clinical and medicines waste. The provider must supply equipment to enable all clinics to take place • scheduling patients into clinics as needed • monitoring the time between receipt of request and appointment date.
Unplanned/emergency care	
71.	This service should minimise the requirement for external escorts by providing interventions on-site whenever they can be safely delivered on. The service excludes patients whose injuries or illnesses require specialist medical or emergency intervention beyond the scope and practice of primary care nursing or general medical practice.
72.	The provider will develop and implement protocols, specific to each IRC, for responding to and managing situations in which a person's health quickly deteriorates, or in a health emergency such as accidents or self-harm or suicide.
73.	The provider will work with the IRC to establish the effective triage and management of emergencies that meet the requirements set out within ‘emergency response in detention’. This will include the use of a paramedic service where appropriate, so the patient can be supported and supervised as required, as part of the contract of delivery.
74.	The provider will ensure that all registered nursing and medical staff are trained to manage acute clinical emergencies and that an annual training plan is developed within six months of the contract.
75.	Management of injuries, including self-harm and minor illnesses.
76.	Exclusion criteria of the service include those whose injuries or illness(es) require medical or emergency intervention beyond the scope and practice of primary care nursing or general medical practice.
77.	Treatment time for minor injuries and illness(es) must be an appropriate response within the context of initial assessment/screening of the referral by a suitably qualified healthcare professional.

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78.	Risk assessments and actions to manage identified risk where there is potential significant exposure to blood and bodily fluids.
79.	Appropriate details of assessment of injury or illness and intervention outcomes such as referrals made or follow up arrangements. These outcomes must be documented in the patient's records.
80.	When a patient is hospitalised from an IRC the arrangements must include: • documented outcomes • information explicitly given regarding self-care including infection, prevention and control • any follow up or referral to other service including the GP.
Responding to emergencies	
81.	The service will respond to requests for emergency clinical assistance for detained individuals including: • accidents • self-harm and suicide attempts • acute intoxication and medical emergencies.
82.	Nursing support for coded calls will be provided in line with DSOs whilst healthcare staff are on site. Healthcare staff will be alerted through a coded call, in accordance with the local policy/protocol and as appropriate by telephone or radio call from other DS areas within the IRC.
83.	The provider must ensure that this service is undertaken immediately and by a suitably qualified member of staff.
84.	Care options when responding to onsite emergencies include: • initial triage and assessment of whether more intensive treatment and care from external health services is required • co-ordinate with IRC staff to allow escort out to secondary care if clinically necessary • resuscitation including defibrillation • administration of emergency medicines in line with national standards[7] • support the safer custody policies within the establishment in response to risk assessment and response to acts of self-harm • support staff as a result of incident

[7] Resuscitation Council UK website homepage

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85.	Healthcare staff must be trained and competent in managing non-fatal strangulation cases.
86.	Appropriate detailed patient records must be maintained, and all appropriate paperwork must be completed according to relevant DSOs, GMC Good Medical Practice (2006 and 2013) and Nursing Midwifery Council Code of Conduct and record keeping guidance.
People with a learning disability, autism, neuro-disability or acquired brain injury (ABI) [8]	
87.	**General principle (in line with the Adults at risk policy):** A person with a learning disability, autism, neuro-disability or acquired brain injury (ABI) should not be detained within an IRC unless there are exceptional reasons. Sometimes individuals who have a degree of learning disability, autism, neuro-disability or an ABI are resident in an IRC for short periods of time. For these individuals it is important that health care services are aware and supportive of their vulnerabilities. Home Office case workers must be kept informed of any issues these vulnerabilities may cause in relation to their detention.
88.	When individuals present with Learning Disabilities, autism, neuro-disabilities or ABI, the provider must, in conjunction with the required primary care interventions, provide a robust pathway to appropriate community-based healthcare services for people with learning disabilities, autism, neuro-disabilities or ABI. All providers should be aware of the Adults at risk policy and adhere to its requirements in the identification and assessment of vulnerable people. If an individual is released from the IRC back to a community in England, with consent (if eligible) ensure a referral is made to their local RECONNECT and ensure the individual has the contact details of the service on release. RECONNECT services support the most vulnerable people, to engage with community healthcare on release. The provider should identify a learning disability or autism champion amongst the establishment healthcare team.
89.	With consent from the patient, providers must ensure that the centre staff are made aware of an individual's presentation so that any social care support required can be provided.
90.	The provider must complete an assessment of need if someone with a known or suspected learning disability, autism or both is detained.
91.	The provider must liaise with the IRC to ensure reasonable adjustments are made so that detained individuals with a learning disability, autism or both can access the full range of activities available in the IRC.

[8] NHS England - Meeting the healthcare needs of adults with a learning disability and autistic adults in prison

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92.	For people with a learning disability, autism, neuro-disabilities or ABI, providers must consider: • screening using an appropriate screening tool (for example, a non-verbal tool to overcome language barriers) • prescribing and supply of medicines to reflect the clinical needs of the patient, avoiding sedation or mental health medicines being prescribed to manage behaviour: NHS England - stopping over medication of people (STOMP[9]) with a learning disability, autism or both. • if the provider is concerned that an individual has a moderate to severe learning disability then the individual's Home Office caseworker must be made aware of their condition, their ability to cope and their level of vulnerability, as continued detention would be unsuitable. The provider should produce a care plan for each individual with a learning disability, autism, neuro-disability or ABI to ensure their health and care needs are met.
Suicide risk and self-harm	
93.	IRCs have an established, multidisciplinary approach to managing detainees at risk of suicide or self-harm, known as the ACDT (assessment, care in detention, and teamwork) process. The ACDT process ensures that any detainee who is causing concern or who needs to be kept safe receives immediate support, multidisciplinary review and care planning. Please refer to Home Office Adults at Risk policy[10] for more information and healthcare requirements on how to identify and assess individuals as vulnerable or at risk of suicide. Centre staff and case managers should make a recommendation for release if a detainee is at risk.
94.	Where patients under ACDT require an additional health assessment or mental health assessment by the nursing team, this must be undertaken within 24 hours.
95.	Where there is a clinical cause underpinning an individual's self-harming behaviour or suicidal ideation, and the patient needs to be under constant supervision, the Home Office will fund this. The supervision may be carried out by clinical staff or detention officers but in all cases, staff must be appropriately trained so that the detainee receives therapeutic benefits from supervision and staff must have regular breaks.
96.	In the event of a death in detention: • healthcare staff should take appropriate action after a death in detention in accordance with the guidelines[11] • the provider's director on call must be notified immediately • the NHS commissioner should be advised no later than the next working day

9 NHS England - stopping over medication of people with a learning disability, autism or both (STOMP)

10 Adults at risk in immigration detention - GOV.UK

11 Deaths in detention (gov.uk)

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	• an initial review should be completed within 48 hours, the findings of which are shared with the commissioner • if recommendations are made following a death in detention, quarterly action plan updates must be provided to the commissioner (and through them to the local Health Partnership Board) to demonstrate improved patient care. The provider must request/produce an 'exception report' where recommendations have not been implemented.
Older people and frailty	
97.	People over the age of 65 might be considered 'older people'. However, it is not easy to apply a strict definition because people biologically age at different rates so, for example, someone aged 75 may be healthier than someone aged 60. Instead of simply age, 'frailty' has a bigger impact on their likelihood to require care and support.
98.	The provider should develop and implement a robust pathway for the management of the health of older detained individuals. All providers should be aware of the Adults at risk policy and adhere to its requirements in the identification and assessment of vulnerable people.
99.	The provider must complete a suitable assessment of need.
100.	The provider will liaise with the IRC so that appropriate adaptions enable older detained individuals or those with a disability to access the full range of activities available in the IRC
101.	For patients aged 50 and over, the provider must consider: • adaptations to maintain independence in medicines taking, e.g. compliance aids (an intervention that is designed to support adherence to medicines) depending on individual presentation, assessing overall general health morbidities.
Food and fluid refusers	
102.	The provider will work with the mental health team and the centre operator on the agreement of a protocol for the management of food refusers. This will include access criteria and pathways for acute inpatient beds, communication and referral links with acute secondary care services and systems for the regular assessment of mental capacity. Members of the primary care team must be trained in relation to the Mental Capacity Act and the use of advanced directives. The delivery of services to patients who are refusing food and fluids must abide by the appropriate DSO 2017 'Management of detained individuals refusing fluid and/or food'.[12]
Escorts and bedwatches	

[12] DSO 03/2017 Care and management of detained individuals refusing food and/or fluid

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103.	The provider will adopt a proactive approach to working with the commissioner to develop innovative alternative solutions to external secondary care services.
104.	Proactive management of demand for escorts and bed watch staff and a flexible reactive appointment system according to patient need.
105.	Proactive management of long-term conditions through multi-disciplinary team working; pro-active promotion of the IRC service and healthcare facilities to secondary care providers and the wider community, to raise awareness of the level of skills and capabilities within the IRC and also the security procedures required when treating detained individuals.
106.	Having a named contact in each secondary care setting with whom to deal with appointments and/or cancellations where feasible.
107.	Actively scrutinising the number, reason and cost implications of cancellations.
Public health section 7a	
108.	All people newly received in places of detention should be provided with an 'opt-out' offer for blood-borne virus (BBV) testing, covering hepatitis B, hepatitis C and HIV. Acceptance of the opt-out offer should be strongly encouraged, and assertively followed up in the case of refusal. After reception, detained individuals should be offered repeat testing.
109.	The provider is to carry out screening for Tuberculosis (TB) at the point of reception, using recognised screening processes recommended by NICE and Office of Health Improvement and Disparities (OHID).
110.	The provider must support the delivery of the full range of public health programmes appropriate[13] to the needs of detained patient populations. They must provide access to a local team.
111.	The provider will ensure that arrangements are in place to manage the treatment and care of patients with a long-term condition such as HIV and sexual health diseases.
112.	Abdominal Aortic Aneurysm (AAA) screening should be offered to all men and trans women in their 65th year. If the aorta is more than 3cm wide, and therefore enlarged, the individual will require further screening or treatment dependant on size.[14]

[13] NHS England - Specification 29 section 7A: public health services for children and adults in secure and detained settings

[14] Abdominal aortic aneurysm screening: programme overview - GOV.UK (www.gov.uk)

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113.	People with diabetes over the age of 12 are eligible for diabetic eye screening (DES) except those with no perception of light in both eyes. The local screening programme should separate eligible people who are not invited into one of two categories: exclusions and suspensions. People who are suspended are under surveillance, assessment and/or treatment of their diabetic retinopathy by a clinician who has taken clinical responsibility for their care. People who are excluded (i.e. those who opt out or are medically unfit to receive and/or benefit from treatment due to another existing condition) are not invited for screening and are not screened or assessed for diabetic retinopathy.[15]
114.	Bowel cancer screening should be offered every two years to men and women aged 60 to 74. The programme is expanding to make it available to everyone aged 50 to 59 years. This is happening gradually over four years and started in April 2021.[16]
115.	All women and trans men between the ages of 25 and 64 should receive Cervical Cancer screening every three to five years dependent on age and history of screening results.[17]
116.	Anyone registered with a GP as female will automatically be invited for NHS breast screening every three years between the ages of 50 and up to their 71st birthday. If over 71, women can request screening every three years.[18]
117.	All patients to be made aware of, and fully understand, the benefits of vaccination.
118.	All people in places of detention are to be offered vaccinations appropriate to their age[19] and need in accordance with the national schedule and UKHSA guidance, specifically covering hepatitis A, Td/IPV (tetanus, diphtheria and polio), tuberculosis, pneumococcal, MMR, meningitis, hepatitis B (see sexual health/blood born virus (BBV) service section), completion of childhood vaccinations, Covid and flu vaccinations. Where evidence of previous vaccination is not available, this should be offered in line with the UKHSA Green Book[20].
119.	Eligibility of detained individuals for vaccinations should be checked on arrival and during seasonal or other national campaigns.
120.	Vaccination details must be recorded in the individual's clinical record, including decline of offer. Data should be submitted as per national requirements and uptake rates reviewed and reported to support high levels of compliance.

[15] Diabetic eye screening: cohort management - GOV.UK (www.gov.uk)
[16] Bowel cancer screening pathway requirements specification (gov.uk)
[17] Cervical screening: programme overview (gov.uk)
[18] Breast screening: programme overview (gov.uk)
[19] Public health commissioning in the NHS: 2022 to 2023 - (gov.uk) and NHS England - Specification 29 section 7A: public health services for children and adults in secure and detained settings in England, 2023-2024
[20] Immunisation against infectious disease (gov.uk)

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121.	The provider must consider effective management of communicable diseases within the IRC. This may mean testing for communicable diseases as close to reception i as possible to reduce the risk of transmission.
Sexual and reproductive health	
122.	All people newly received into IRCs should be offered sexual health screening as part of the general health assessment and screening process.
123.	All people newly received into places of detention should be provided with an 'opt-out' offer of a test for HIV, hepatitis B, hepatitis C, and syphilis, chlamydia and gonorrhoea.
124.	The provider is required to align the sexual and reproductive health and chlamydia screening needs of the patient population with the Public Health Section 7A Specification 29 requirements.
125.	The provider will work with the Chlamydia Screening Programme in their local area and offer screening and treatment according to the needs of the IRC populations. The local sexual health/BBV service will offer assistance and advice when needed. NHS England's health and justice commissioners retain responsibility for ensuring that this is carried out.
126.	Provide those testing positive for chlamydia with an information leaflet.
127.	Be responsible for undertaking a satisfactory system of audit in line with the annual requirements to audit key performance indicators of the programme.
128.	Provide information about chlamydia and other sexual health promotion including the benefits of testing, specimen collection, management of results and access to free treatment.
129.	Refer patients declaring symptoms suggestive of sexual ill health to the IRC sexual health clinic. Healthcare staff need to be mindful of the support that might be required following a disclosure of sexual assault during Rule 35 (R35) interviews, where someone may have been a victim of torture or is at risk of suicide.
130.	Provide information and advice about safer sex practices and, in line with local policies, ensure that condoms, lubricants and HIV PreP are available.
131.	Provide information and advice about sexual health including the benefits of screening and treatment of infection or post-exposure prophylaxis, e.g. HIV PreP.
132.	Samples and forms should be collected for analysis in a timely manner, as defined by local operational guidance.

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133.	Where results received from screening indicate further intervention is required, this must be progressed without delay.
134.	Mechanisms must be developed to identify under 25s who are appropriate for offering a chlamydia screen, including repeat offers for those already resident in the IRC.
135.	Enable supply of medicines in line with NHS clinical commissioning policies and provide clinical monitoring of any sexual health condition.
Health promotion and prevention	
136.	All healthcare services within the establishment must work in partnership with the centre to ensure that there is effective coordination and delivery of health promotion activities and interventions.
137.	An IRC specific health promotion and prevention plan must be developed within six months of the contract commencement. This will be owned and monitored by the Local Delivery Board. This will include but not be limited to: • leading IRC-wide health promotion action group with development and monitoring of a health promotion action plan • delivery of health education, promotion and preventative care programmes • supporting patient self-care • auditing health education and preventative care and formulating an action plan to monitor areas for improving outcomes • liaising with voluntary sector organisations to support delivery of health promotion activities • prevention of reinfection (e.g. following successful treatment of hepatitis C) • training of healthcare peer mentors to help deliver health improvement messages, programmes and interventions across the IRC. This will include group and individual support.
Smoking cessation	
138.	The provider will be required to deliver smoking cessation services in order to promote a smoke free environment, including the provision of psychosocial programmes and where needed, pharmacotherapies including Nicotine Replacement Therapy (NRT). This service must be delivered, usually over 12 weeks, using a multidisciplinary approach and will take into consideration age and gender specific needs. The provider will comply with national guidance in relation to smoking cessation e.g. those published by: • DHSC: Tobacco commissioning support: principles and indicators (gov.uk)

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	• National centre for smoking cessation and training (NCSCT): NCSCT - National Centre for Smoking Cessation and Training • National Institute of Clinical Excellence (NICE): Smoking and tobacco - NICE Note that e-cigarettes or vapes are unable to be supplied as part of the service. The smoking cessation care plan will take into account an e-cigarette use by the patient to maximise the opportunity for them to reduce their dependence on nicotine and tobacco.
Discharge and release planning	
139.	The provider must offer a healthcare summary report on discharge to the detainee and the receiving clinician (if known) detailing the primary care, substance misuse or mental healthcare received whilst in detention. Discharge covers returning to the community, returning to their country of origin, attending court or being transferred to another IRC.
140.	Ensure continuity of care for all healthcare needs through provision of electronic patient record handover, where possible to community health. Where possible, prior to removal to their country of origin, a clinical handover should be provided to the removal escort. Provider to support the safety of the patient during the return process.
141.	Explain to the patient how to register with a GP, prior to their release and with consent (if eligible) ensure a referral is made to their local RECONNECT or IRC discharge schemes. When referred to RECONNECT ensure that the individual is provided with the correct contact details of the service prior to release. Share information, as appropriate, to support their continuity of care where a person is remaining in the UK.
142.	Include provision of HC1 form to support the receipt of an HC2 certificate if eligible to enable access to free prescribed medication post release.
143.	Provide advice to the patient on how to manage their healthcare needs on release, including provision of a discharge summary where required. This should include details of NHS 111 where a patient is returning to UK community services.
144.	Ensure medication needs are fully included in the discharge planning process. This is particularly important where the patient has a specific medication need (e.g. a specially prepared or specialist medicine). Patients should be provided with advice regarding local pharmacies and given information about how to access medicines in the community. Where appropriate patient consent should be obtained so that their medicines information can be sent directly to their community pharmacy. The patient should have adequate medicine supplies to ensure uninterrupted treatment if they are returning to their country of origin - up to three months' supply. The provider must help patients who need additional support, such as compliance aids to access their medication post release.

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145.	Give patients a minimum of 28 days' medication on discharge or FP10s if they are returning to UK communities.
146.	Ensure the patient is aware of the date, time and place of any community healthcare appointments in UK.
147.	Appropriate contraception and advice on safer sexual practices should be offered and provided on discharge.
Joint care planning with other providers	
148.	Staff must work within local guidance for the management and disclosure of confidential information about service users, between different agencies and within multiagency teams. They will adhere to statutory and common law frameworks, allied to both government policy and best practice guidance, including, but not limited to: • information rights • The Data Protection Act • consent and confidentiality • using technology and information security • rights of access to information.
149.	To support joint working with other partnership services and organisations, when appropriate nursing staff must support and facilitate representatives visiting the establishment to continue their supporting role.
Detention service orders (DSOs) and centre regime	
150.	The service will comply with all relevant DSOs.
151.	The healthcare service must provide healthcare advice through attendance at management meetings, forums and ad hoc requests.
152.	The provider must fulfil all obligations and responsibilities applying to the application of DSOs as they relate to health provision.
153.	Support and advice must be available to agencies and operational staff to support the health and wellbeing of patients within the context of local and national guidance for the management and disclosure of confidential information.
154.	Input from healthcare staff must be provided to any relevant IRC operational forum such as: • daily director's meetings and senior management Board/ team forums • attendance at planned control and restraint interventions and incidents • preparation of specific reports as required, i.e. death in detention reports, patient safety incident reports

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	• ACDT reviews.
155.	The provider must work closely with other areas of the establishment regime and external agencies to ensure integration of patient focused care in line with IRC standards and mandatory obligations.
156.	The provider is to make sure that relevant staff attend the segregation or care and separation unit (CSU) to check on all detained individuals and complete a safety algorithm within two hours of an admission, under rules 40 and 42 for IRCs.
157.	Fitting for transfers - all detained individuals will receive medical screening prior to any movement. Medical holds are used within national guidance.
158.	Any request for a Rule 35 interview in IRCs must take place within the required 24-hour timescale.
159.	Undertake the administrative activities associated with a healthcare provider.
Management support and professional leadership	
160.	The provider must deliver effective management support and professional leadership to staff. The healthcare manager has day to day operational responsibility for all healthcare services delivered within the establishment.
161.	All healthcare staff must have access to appropriate clinical and professional management and supervision.
162.	The provider must ensure that effective management and leadership are reflected in the roles of senior leaders of the service.
163.	The provider must ensure the management, administration and smooth running of all healthcare services and healthcare centre.
164.	Work closely with detention staff to ensure the pharmacy service, equipment and stock is managed safely and securely and with consideration to wider regime constraints and ensure that all equipment used in the provision of pharmaceutical services is maintained appropriately.
165.	Ensure working practice within the framework of local, national and best practice guidance on infection prevention control.
166.	Ensure patients are informed about service available, waiting times etc in a suitable format (for example provided in a different language or easy read document).

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