BROOKHOUSE INQUIRY

First Witness Statement of Nicholas Watkin

I provide this statement in response to a request under Rule 9 of the Inquiry Rules 2006 dated 13 October 2021. I have been authorised by NHS England to provide this witness statement.

I, Nicholas Watkin will say as follows:-

1. I am the Head of NHS England Health and Justice, in the South East. NHS England Health and Justice is responsible for commissioning healthcare for children, young people and adults across secure and detained settings, which includes prisons, secure facilities, police and court Liaison and Diversion services and immigration removal centres.

2. My role is to develop and secure a commissioning strategy for the South East region that is consistent with the commissioning strategy for NHS England. I also work closely with the Contracts and Performance team to ensure that effective contract management processes as set by NHS England and the South East team are in place for Health and Justice services, ensuring that services are delivered within budget and developing strategies and operational policies within national guidelines for promoting innovation across the responsible area.

3. My role encompasses the Gatwick cluster of IRCs, which includes Brook House IRC and Tinsley House.

4. I have been in this role since April 2020. Prior to this role, I was the Senior Commissioning Manager for the South East region. The role was similar to the duties described above, but for a smaller regional area which included Kent, Surrey and Sussex. In April 2020 NHS England reorganised and consolidated its regions and I

took on responsibility for the whole South East region.

5. In April 2018, I was seconded to work for Her Majesty's Prison and Probation Service in their ministerial drug task force team for 2 years.

6. I understand that the request to NHS England has been made in order to progress the Inquiry's investigation and, in particular, to assist the Chair in understanding the role of NHS England in relation to Serious Incident referrals and the oversight of Immigration Removal Centre ("IRCs").

Role of NHS England

7. NHS England is the operational name for the statutory body the NHS Commissioning Board, which was established on 1 April 2013, pursuant to the amendments made to the National Health Service Act 2006 ("NHS Act 2006") by the Health and Care Act 2012.

8. Under the NHS Act 2006 and associated secondary legislation, NHS England is responsible for commissioning all health services (except emergency services, which are commissioned by clinical commissioning groups) for those detained in prescribed IRCs. This includes Brook House IRC.

9. NHS England discharges its commissioning role in partnership with the Home Office and Public Health England. The National Partnership Agreement between NHS England, Home Office Immigration Enforcement and Public Health England (2018-21) sets out that these organisations will work together to commission healthcare services in IRCs across England. A copy of the Partnership Agreement has already been provided to the Inquiry, as part of the documentary disclosure submitted on 21 October 2021.

10. As a commissioner of health services, NHS England is responsible for making arrangements for the provision of the services in question. However, it does not

provide them or involve itself in operational arrangements of provision at individual sites, other than by way of monitoring the provider's performance in accordance with the contractual agreement between the provider and NHS England. At Brook House IRC, the provider of health services was G4S during 1 April 2017 to 31 August 2017 ("the Relevant Period"). Under the terms of the contract between NHS England and G4S, G4S was responsible for putting in place relevant policies and procedures.

Oversight of immigration removal centres

11. The Alternative Provider Medical Services Contract ("APMS") between NHS England and G4S Facilities Management (UK) Ltd forms the basis of the commissioning arrangements between NHS England and the provider. G4S is responsible for providing Services, in accordance with the Service Specification and to such standards described in the Service Specification. The role of NHS England is to continuously review and develop the service specification to take note of emerging best practice, advances in approach and service user feedback.

Patient Complaints

12. The Patient Complaint Policy dated 15 September 2015 and subsequently updated on 12 June 2017(copies have been provided to the inquiry as part of documentary disclosure), applies to the handling of complaints or concerns relating to directly commissioned services by NHS England where such complaints are made directly the NHS England. In addition, individuals can also complain to the provider, who are contractually required to have their own complaints procedure. These two options exist in tandem and the NHS England complaints process is not an appeal or review process from the provider's process.

13. A complaint can be made by telephone, email or post, no later than twelve months after the date on which the matter occurred. Complaints will be acknowledged no later than three working days after the day the complaint is received and an offer should be made to discuss the handling of the complaint, timescales for responding and expectations and desired outcome, if unclear. The case officer will capture relevant information about the case and ensure this is accurately recorded.

14. Complaints should be responded to within 40 working days, unless a different timescale has been agreed with the complainant. If the timescale has not been met, the complainant should receive an update every 10 working days. Where complaints involve more than one body, discussions will take place between the bodies concerned about the most appropriate body to take the lead in coordinating the complaint. However, this is dependent on the complainant providing their consent for this to happen. Where a complaint relates to a third-party provider and consent for NHS England to involve the provider is withheld or not provided, NHS England may not be able to fully investigate the complaint and the complaint would be closed. As explained in paragraph 15 below, NHS England will be made aware of any complaints, at the Quarterly Quality Meetings.

15. NHS England will send a formal response in writing to the complainant which will be signed by the National Director or Nominated regional sign off. If the Complainant has not been provided with a response after six months from receipt of the complaint, we will notify the complainant of their right to go straight to the Parliamentary and Health Service Ombudsman.

16. The provider is also expected to provide quarterly updates to NHS England as the commission of trends in complaints. This is done by way of Quarterly Quality meetings to monitor and quality assure the complaints system, which will include the ability to identify and address common issues, themes and concerns and address these accordingly, review and monitor the timelines for responses, assess the appropriateness of replies, and assess the overall quality of the resolution. Similar issues are also discussed with Commissioners during the Strategic Partnership meetings. A copy of these meetings has already been provided to the Inquiry, as part of documentary disclosure on 19 and 21 October 2021. I attended these meetings in my capacity as the Senior Commissioning Manger for Gatwick IRC, at the time.

17. In terms of complaints specifically relating to referrals, complaints or concerns raised relating to nursing practitioners, these would have been referred to the provider for consideration and a response, consistent with the contractual framework within which

the provider operates. The reason for this is that NHS England does not employ any of the health and care staff engaged by a provider in order to deliver the commissioned services. Any disciplinary measures or regulatory referrals that needed to be taken as a result of a complaint or concern raised about a nursing practitioner would, therefore, have been managed by the provider.

18. NHS England would have been made aware of any such issues as part of the quarterly complaints monitoring process described above but would not have played a direct role in relation to managing them

Serious Incidents

19. The Serious Incident Framework dated March 2015 (copies have been provided to the inquiry as part of documentary disclosure) describes the process and procedures to help ensure serious incidents are identified correctly, investigated and learned from. This is the process all providers, including G4S are expected to follow.

20. Serious incidents or suspected serious incidents must be declared internally as soon as the healthcare provider is aware, and no later than 2 working days. The serious incident must be reported on the NHS serious incident management system (STEIS). However, there are incidents that should be reported immediately upon identification:

    a. Incidents which activate the NHS Trust or Commissioner Major Incident Plan;
    b. Incidents which will be of significant public concern; and
    c. Incidents which will give rise to significant media interest or will be of significance to other agencies such as the police or other external agencies.

21. Other regulatory, statutory, advisory and professional bodies should be informed about serious incidents, depending on the nature and circumstances of the incident. The report must clearly state that the relevant bodies have been informed.

22. An initial review should be undertaken and uploaded on the STEIS within 3 working days of the incident being identified. The purpose of the initial review is to identify

and provide assurance that any necessary immediate action is in place, assess the incident in more detail and propose the appropriate level of investigation.

23. Where a serious incident indicates an issue or problem that has or may have significant implications for the wider healthcare system, or widespread public concern, the relevant commissioner must consider the need to share information with NHS England sub-regions and regions and other partner agencies as required.

24. The provider declaring the incident must ensure that an appropriate investigation team is established. The team will identify what information/evidence is needed and how this will be obtained. The team will then review the information and agree the priority problems, following which they will analyse the problems to identify the underlying cause before recommendations are developed. The investigation will conclude with a report and action plan, which must be submitted to the relevant commissioner within 60 working days of the incident being reported, unless an independent investigation is required, in which case the deadline is 6 months from the date the investigation commenced.

25. The nature of the serious incident largely determines who has a role to play and what that role is. As NHS England is a commissioner of health services, it manages serious incidents by overseeing investigations that are led and resourced by the provider of care. However, NHS England is expected to develop and agree procedures for the management of the investigation process, where any concerns are raised to them.

26. In certain circumstances, NHS England may be required to lead a local, regional or national response, including the commissioning of an independent incident investigation. For example, incidents relating to mental health homicide.

27. The serious incidents process is managed by NHS England's Nursing and Quality Directorate and professionally qualified staff within that directorate would review incidents as part of the Quarterly Quality meeting process. NHS England are also required to formally sign-off serious incident investigations once complete and would

continue to play a role in monitoring any associated improvement measures. In my role, I did not have access to the details relating to any serious incidents (because these include patient identifiable information) but I would have been informed about any trends or similar high-level issues, as part of my contract management role.

Serious Incident involving Ms Joanne Buss

28. NHS England were not notified of a Serious Incident involving Ms Joanne Buss specifically. However, NHS England were aware of the wider investigation carried out by the provider following the *Panorama* show allegations. This is evidenced within the Quarterly Quality Minutes already disclosed (see 31 October 2017, 28 January 2018 and 18 May 2018).

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

I am content for this witness statement to form part of the evidence before the Brook House Inquiry and to be published on the Inquiry's website.

Name:

Nicholas Watkin

Signature:

Signature

Date;

15th November 2021