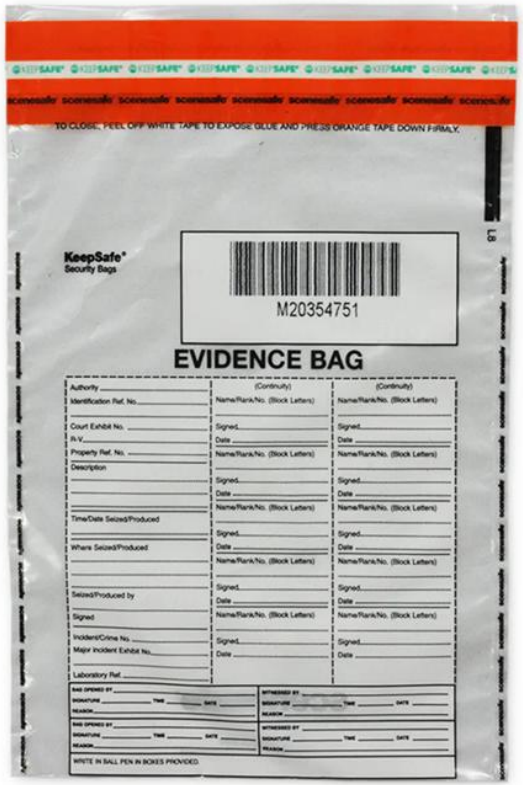
Tamper-Evident Bags

- Secure bags for medicines in transit providing a clear audit trail
- Process required due to increase in inter-prison movements due to schemes such as SDS40
- Site visits & PPG pilot site, information gathering from providers who already use this process
- Briefing
- Task and Finish Group – carefully selected stakeholder group including HMPPS and PECS representatives
- Benefits of using tamper evident bags:
    - Safe transfer of medicines
    - Auditable trail
    - Medicines stored in one place



NHS England

Continuity of Medicines in Detained Estates – Using tamper evident bags for medicines in transit to court and on transfers

Tamper-Evident Bags

	Regional Average Monthly Cost	Regional Average Annual Cost
East of England (5)	£590.89	£7090.68
London (4)	£472.71	£5672.52
Midlands (7)	£827.25	£9927.00
North East & Yorkshire (8)	£945.42	£11,345.04
North West (4)	£472.71	£5672.52
South East (8)	£945.42	£11,345.04
South West (3)	£354.53	£4254.36

- Procurement of tamper evident bags – single source (Scenesafe) same provider as HMPPS so recognisable across all stakeholders
- Approximate national and regional costings **based on HMPPS figures for courts and transfers** using number of sites in region and a variety of different sized bags - **£55307.18**
- Funding – no additional funding, if struggling can request
- Assurance required sites are using process after three months – support from regional pharmacy advisors

Next Steps

- Comms to commissioners and HMPPS by end of Nov '25
- Agree with commissioners/HMPPS re assurance

Project Plan for improving IP medication

HMPPS training for importance of medicines and medicine queue supervision- linked to Justice Select Committee recommendations

Develop template for IP spot checks and/or good practice guide- as above

Review current IP risk assessment tool- to increase IP- small group Dec 2025

Reception template – are there any adjustments required for transfers to enable continuity of IP and increase in IP in Cat C/D

Data review of current levels of IP- if possible!

Cat D programme: Clarification and actions required- to work closely with individual Cat D providers to enable consistent access to non-IP (Sch 2 CDs and Bup only) and IP medicines (all others including Sch 3 and 4 CDs).

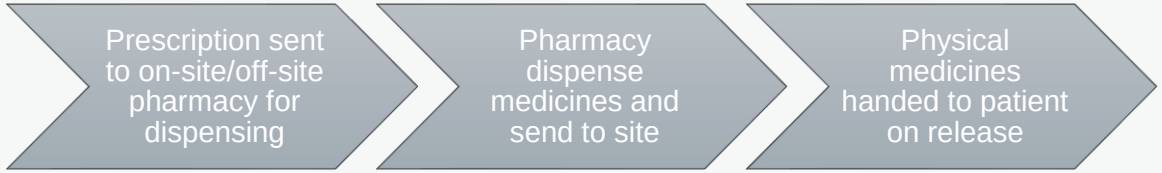
28-day discharge via EPS- overview

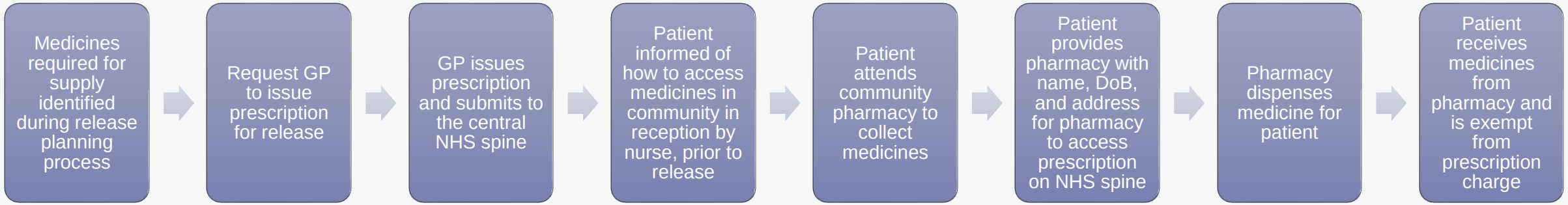
- Services are expected to supply at least 7 days of medicines on release- usually by providing a supply of the medicines. EPS FP10s can be used if the supply can't be provided before release. This has always been a challenge!
- We are changing the policy to provide a minimum 28-days of discharge medicines using EPS FP10 prescriptions- so the next repeat prescription can be accessed from a community pharmacy
- This has significant benefits to prisoners and primary care enabling more time for confirming GP registration and repeat request processes.
- Prisoners will leave prison with any medicines labelled for them in their possession or held in MAPs awaiting collection.
- Exceptions are
    - FP10MDA/OST supplies (where current BAU will apply)
    - High risk patients where an arrangement for weekly supplies in the community have been organised

28-day discharge using EPS

- Concerns about prisoners having this access: Prisoners will receive 28 days supply when accessing repeats from the GP as they do now post-release. There's no justification for restricting this on prison release- omitted doses can cause more harm
- Shifting to IP prior to release (i.e. as soon as possible during custody or for the final prescription/repeat) can be used to support prisoners to get used to managing their medicines- thus is underpinned by the principles of non-IP and IP already
- We will need to be smart about how we ensure prisoners know there will be a prescription they can collect:
    - How do we achieve this?
    - How do we identify and mitigate against the prescription not being issued?
- FP10 costs at the moment aren't recharged to the prescribing provider. This means funds may be released in costs for dispensing TTOs! We expect the funds and workforce capacity to support clinical pharmacy/SMR service delivery growth ☺

EPS Process





[Implementing the Electronic Prescription Service (EPS) for Improved Efficiency and Care Within the Detained Estate. on Vimeo]

Case Study – Medicines supply on release

1. Patient is seen for release planning is on prescribed medicines. Staff completing release planning tasks GP to prescribe TTOs.
2. GP prescribed TTOs via EPS and prescription is sent to the central NHS spine as it is non-nominated.
3. On release, the patient is provided with any named-patient medicines previously dispensed and advised to visit a community pharmacy in England for their TTO medicines to be dispensed.
4. Patient attends community pharmacy and informs them they have a prescription to collect providing their name, DoB, and prison address.
5. Community pharmacy pulls prescription from the central NHS spine and dispenses the medicines for the patient.
6. Medicines given to the patient and the patient is exempt from prescription charges for this prescription.

EPS Workshop

Think about the process used to identify people being released and for whom you would prepare a TTO supply

- When would you issue the 28-day prescription for those being released? Is the timing different than how prescriptions for TTOs are currently prepared?
- How would you ensure all named patient medicines in the medicines administration point are also sent with the patient on release?
- How can we make sure patients know there will be a prescription waiting for them after release?
- If needed, how could you issue a prescription later in the timeframe, up to 24-hours post release?