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A Pharmacy Service for Prisoners

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Executive Summary

At present there are wide variations in the approach to, and quality of, pharmacy services provided to prisoners. There is no accepted framework for the delivery of pharmacy services, and the health needs of prisoners are not adequately reflected in the services provided.

Health services provided within prisons are essentially primary care services. The pharmacy services required to support the delivery of health care in prisons should, therefore, be predominantly primary care based, be closely linked with Primary Care Trusts (PCTs), and meet legal requirements and professional standards.

The partnership between the Prison Service and the NHS is now well established. The recent transfer of funding for prison health from the Home Office to the Department of Health will support further developments in all aspects of prison health care, including the implementation of wide ranging changes to the delivery of pharmacy services to prisoners.

This report sets out a way forward in the development of more patient focused, primary care based pharmacy services to prisoners based on identified need.

The report sets out 30 recommendations; a full list of these can be found in Section 13. Some of the recommendations can be easily incorporated within the local development of pharmacy services to prisoners, others will require further work and increased partnership working with local PCTs. The principal conclusions of the report are as follows:

Service Provision

- Pharmacy services to prisoners should be patient focused, be based on identified patient needs, and support and promote self-care.
- Developments in medicines management in the NHS, including repeat dispensing and medication review, should be reflected in pharmacy services provided to prisoners.
- All prisoners should have appropriate access to a pharmacist or pharmacy staff.

- Medicines in use should normally be held in the possession of prisoners unless there are clearly indicated individual factors why this should not be the case.
- All prisons should have, or be covered by, a Drug and Therapeutics Committee responsible for the development of evidence-based local formularies, disease management guidelines and medicine-related policies and procedures.
- Pharmacy leadership roles should be established on a regional basis to help drive forward the required programme of change locally.
- An IT system delivering the same level of information and support for the prescription and supply of medicines that is widely available in the NHS should be introduced.

Training & Continuing Professional Development (CPD)

- An analysis of the training needs of pharmacy staff should be carried out, and a training programme developed to meet identified needs.
- All pharmacy staff should have a personal development plan (PDP).
- Learning and CPD opportunities available to staff in the NHS should be available, where relevant, to staff providing pharmacy services to prisoners.
- All pharmacists should be enabled to meet the CPD requirements of the Royal Pharmaceutical Society of Great Britain (RPSGB).

The Pharmacy Workforce

- Local assessments of staffing requirements, in terms of skills and grades, should be undertaken to establish an appropriate workforce to deliver the proposed patient-focused pharmacy services.
- The full range of pharmacist, medical technical officer (pharmacy technician), and assistant technical officer (pharmacy assistant) grades, used in NHS pharmacy services, should be available to prisons to enable an appropriate pharmacy workforce to be achieved.
- The NHS approach to job evaluation should be adopted for pharmacy staff working within prisons, ensuring equality of pay and responsibility, as well as opportunities for career progression.
- The temporary movement of qualified pharmacy staff, including joint appointments, between prison health care and other areas of NHS practice should be encouraged in order for staff to gain wider experience.
- Existing and future developments in the practice and use of pharmacy staff should be introduced in prisons as for the wider NHS.

Section 1: Introduction

Background

- 1.1** When the Prison Health Policy Unit and Task Force came into being in April 2000 it quickly became clear that for too long prison health care including pharmacy services, has been separated from the NHS. Professional isolation and poor communications have been all too common, resulting in enormous variations in the provision of pharmacy services across the prison estate.
- 1.2** To address these problems, the Prison Health Policy Unit and Task Force published a development work programme to bring about improvements in the healthcare delivered to prisoners within the next 2-3 years. One of the projects commissioned, as part of this programme, was to critically examine and evaluate pharmacy services, and to make recommendations as to how pharmacy services to prisoners should be delivered in the future.
- 1.3** A steering group was formed, and a wider reference group was also convened to help explore the project's key priorities and reflect on its findings. A questionnaire was sent to all 137 prison establishments in England and Wales. One hundred prisons responded, providing a detailed picture of how pharmacy services are delivered in prisons.
- 1.4** This report sets out the recommendations and key findings of the project, including a framework for future provision of pharmacy services to prisoners.

Partnership with the NHS

- 1.5** On 25th September 2002, the Secretary of State for Health and the Home Secretary announced that funding responsibility for prison health services in England would be transferred from the Home Office to the Department of Health from April 2003.
- 1.6** This is the first step in a process over the next five years which will see prison health become part of the NHS, with Primary Care Trusts (PCTs) becoming responsible for the commissioning of health services to prisoners in their areas.

- 1.7** Representatives of the Welsh Assembly Government were consulted in the drafting of this report, and the Assembly will now give fuller consideration to the adaptation and adoption of the recommendations within the Welsh context.
- 1.8** Much progress has already been made through the partnership between prisons and the NHS. The funding transfer marks a natural next step in the partnership and will support further developments in health services to prisoners.
- 1.9** In terms of pharmacy services to prisoners, the partnership with the NHS will provide the opportunity to deliver the wide ranging programme of changes discussed in this report; in particular it will:
- maximise the use and effectiveness of available resources and expertise;
 - address the previous professional isolation;
 - deliver standards of care equivalent to the NHS; and
 - ensure more patient-focused services and improved continuity and consistency of care.
- 1.10** Pharmacy services are already delivered to prisoners by NHS providers, such as hospital departments in NHS Trusts and community pharmacies, as well as by pharmacists and support staff employed by the Prison Service and by private contractors. Cementing the partnership with the NHS should facilitate the improvement and development of pharmacy services to prisoners, by whichever means of provision.

Section 2: Essentials of a Pharmacy Service to Prisoners in the Future

- 2.1** Following, firstly, the establishment of partnership between the prison service and the NHS and, perhaps more significantly, the development of prison health needs assessments, a clearer picture has emerged over the delivery of health care services for prisoners. Essentially, health care in prisons is primary care based, with referral to secondary services as required.
- 2.2** As a result, it is clear that the pharmacy services, required by establishments to support the delivery of prison health care, should be predominantly primary care based and closely linked with PCTs. There is a need to support some areas of specialist and intermediate care, for example for substance abuse and mental health. Whilst these latter services may be provided by, or under the direction of, specialist NHS staff, they are often delivered within the prison setting. Service providers will need to provide the appropriate clinical, professional and technical support.
- 2.3** Fuller definition of pharmacy services to prisoners and a framework for delivery are developed later within this report. However, the key essentials are:
- A more patient-focused pharmacy service, based on identified patient needs
 - A pharmacy service that is more accessible to the patient, and which enables direct contact between patients and pharmacy staff
 - A pharmacy service which supports self-care and patient self-management
 - A more efficient service delivery system, in particular in the supply of medicines
 - A service that utilises the full range of skills and expertise of pharmacy staff
 - Integration of pharmacy services into the overall delivery of health care services. For example
 - i) Providing pharmacist run minor ailment and general medication advice clinics
 - ii) Multi-disciplinary clinics e.g. smoking cessation, asthma, diabetes etc
 - iii) Availability of telephone advice from pharmacists (e.g. pharmacy “helpline”)

- A pharmacy service that supports other health care staff and the establishment as a whole
- A pharmacy service that promotes value for money through both the clinical and cost effective use of medicines and the effective utilisation of staff resources.
- A service that participates in and supports quality improvement through clinical governance (including clinical audit and continuing professional development (CPD)).

2.4 From this clarified position, it is possible to make appropriate comparisons with similar pharmacy services, operating in equivalent practice areas. In doing so, it is essential to consider health needs and health care delivery from the patient's perspective, so that patients are involved in their own care and are able to make choices about access to care, as is typical of primary care in the NHS.

2.5 Working from the basis of what is normal for the public and patients in the community, requirements specific to the prison setting can then be taken into account. The type of pharmacy service which results from this consideration is markedly different, in the main, from that which is currently operating within the prison system.

Section 3: Current Position

The prison population

- 3.1** Approximately 140,000 prisoners pass through the prison system annually. At the time of publication the prison population is over 71,000, the majority of whom are adult males.
- 3.2** In general, prisoners tend to have poorer physical and mental health than the population at large. Mental illness, drug dependency and communicable diseases are the dominant health problems among prisoners.
- 90% of all prisoners have a diagnosable mental health problem, substance misuse problem, or both
 - 80% of prisoners smoke (of whom, 69% would welcome help to quit)
 - 24% of prisoners report having injected drugs
 - 13% of the prison population has diagnosed asthma
 - 8% of a representative sample of prisoners tested positive for Hepatitis B, 7% for Hepatitis C and 0.3% of male prisoners and 1.2% of females were HIV positive.

Pharmacy Services

- 3.3** At present, the 137 prison establishments obtain pharmacy and related services from a number of different suppliers:
- “In house” – Pharmacy staff directly employed by the prison service (25%)
 - As a “satellite unit” served by an “in house” prison pharmacy department (50%)
 - Contracted in “in house” service – services provided on site but by a contracted in provider (5%)
 - Contracted out service provided from a local NHS Acute Trust Hospital (10%)
 - Contracted out service provided by a local community pharmacy or pharmacy company (10%)
- 3.4** Within the establishments served by Prison Service pharmacy departments, there are a number of “key” sites where the central pharmacy department serves several establishments (a “cluster” group). Three of these establishments

(HMP Glen Parva, HMP Rochester and HMP Featherstone) cover almost 25% of the total prison estate in terms of pharmacy service provision.

- 3.5** Historically, there has not been a clear definition over the practice area in which prison pharmacy operates. Different pharmacy departments and pharmacy service providers have adopted varying approaches, some based on a community style of practice, some on NHS hospital practice and some an, at times uneasy, amalgam of the two. Whilst there are many examples of good practice there are no formal links between these varied service providers, each group or individual provider essentially operating in isolation from the others.
- 3.6** The rationale behind the approach adopted appears to have been based on a number of factors:
- Response to other operational systems being used within the establishment;
 - Adoption of the system perceived most appropriate by pharmacy staff
 - Use of a practice system, in which pharmacy staff were experienced; a reflection in many cases of the practice area from which the staff were recruited.
- 3.7** In many ways, this also reflected a lack of clarity of the overall practice area in which prison health care services operated.
- 3.8** The outcome of this was, at times, an unhappy alliance of different operating practice, and confusion, not just within pharmacy, but also in the wider health care setting. On occasion this has led to apparent incompatibilities between pharmacy and other health care operating systems.

Section 4: The Vision

- 4.1** Our vision, as detailed throughout this report, is for patient-focused pharmacy services to prisoners, with patients involved in their own care, as for primary care services in the NHS. This case study clearly illustrates the effects that the proposed changes can bring to a patient's health and well being.

Before Changes

Steve is a 50 year old insulin-dependent diabetic requiring daily insulin injections to control his condition. He also takes regular daily oral medication. Despite his medication being stable, the ordering of Steve's Insulin can be sporadic (on one occasion an urgent request was received in pharmacy late on a Friday requiring a special, and potentially costly delivery from suppliers). This is largely because health care staff have responsibility for ordering and controlling Steve's medication, but as a result of their heavy workload this is done on a less than regular basis. His oral treatment is dispensed on a weekly basis as seven individual daily packs. His prescription is usually written for a 28-day duration.

Steve, along with other diabetics, has to be escorted to the health care centre twice a day to be observed by healthcare staff as he goes through his blood-sugar level testing and injecting routine. These visits have to be fitted in around the other duties that have to be carried out, both by health care and discipline staff. Although not a lengthy procedure, the additional requirement to collect regular oral medication prolongs the whole process.

On one occasion recently, Steve became hyperglycaemic (necessitating health care staff attending his cell urgently) because changes in staff resulted in his escort being forgotten and his injection being delayed. Subsequently, Steve (along with other diabetic inmates) has been regarded by wing staff as a potentially "problematic" or "demanding" inmate.

After Changes

The prison service now has a policy of allowing prisoners to have the medicines they are taking in their possession, unless the risks identified in an individual risk assessment are such that they are unable to do so. Since coming into prison, Steve has been assessed as able to store his medication and injecting equipment in his cell and can therefore manage his diabetes in largely the same way as he did before he entered prison. His oral medication is provided as a monthly supply. Steve is also able to obtain further supplies of medication through a repeat prescription system in the same way as he would have done with his local GP. And as repeat dispensing by community pharmacists is introduced in the NHS there are plans for similar arrangements in the prison.

Steve now attends a chronic disease management clinic on a quarterly basis where his treatment plans and regimes are reviewed and he has the opportunity to discuss relevant issues, including with pharmacy staff, who also have input to these clinics. Additionally, now that pharmacy staff are supplying Steve directly with his medication, they utilise this regular contact to give advice on taking medication and on techniques to help control various conditions.

With these arrangements in place, staff are aware that he has regular contact with pharmacy staff and health care staff see him in the chronic disease management clinic on a quarterly basis, but otherwise he is treated no differently to other prisoners on the wings. Now that regular escorting to health care is no longer necessary, Steve is no longer regarded as a problem or demanding prisoner.

The above example shows improvements, which result from a patient-focused service that supports self-care. Patients having access to their medication (where safe and appropriate) means that medication can be taken at the appropriate time, reduce wastage of medicines and improve efficiency. Health Care staff are also able to use their full range of skills and expertise. Many of these points were discussed in Section 2, Essentials of a Pharmacy Service.

Section 5: Professional and Technical Components of a Pharmacy Service to Prisoners

5.1 The requirements of a modern primary care based pharmacy service are far beyond the “supply only” function that has prevailed in much of the prison service to date. The medicines supply function has its roots in the traditional role of pharmacy; that is the safe and effective preparation and provision of medicines. Whilst still an essential component of modern pharmacy services, this has been supplemented over recent years by development and utilisation of the clinical and professional skills of pharmacists in the use and management of medicines, supported by extension in the role of pharmacy technicians and other pharmacy support staff. These developments have become an integral part of patient focused pharmacy services within health care delivery in the wider NHS and involve close interaction between pharmacy staff and patients, healthcare staff and the wider organisational setting within which the service is delivered. This level of interaction is not a general feature of the current pharmacy service to prisoners.

Figure: Frequency of Pharmacist visits to establishments without an on-site pharmacy



At least a quarter of prison establishments without an on-site pharmacy have direct pharmacist input less than once a month.

- 5.2** Pharmacy services can be described under two headings – professional and technical. It is difficult to make a clear distinction between the two, because they are intrinsically linked in the overall delivery of service. However, there are certain aspects of each that, when separated out, give a much clearer picture of how pharmacy should operate and where pharmacy presence and input can underpin appropriate patient care. Furthermore, the roles of pharmacists, pharmacy technicians and other pharmacy support staff tend to be differentiated according to the two main components. However, there is cross-over, with some pharmacy technicians taking on a more clinical role.

Professional services

- 5.3** Examples of the aspects of a pharmacy service, which would be classed as professional, are listed below. The list is not exhaustive, but gives an indication of those areas involved. In the main, these are services that require direct pharmacy contact with patients and the health care team. In future, however, alternative and innovative approaches may be used to provide more appropriate or effective ways of delivering services (e.g. “pharmacy helplines”, video links etc.)

- 5.4** For patients:

- Clinical assessment and validation of prescriptions prior to dispensing;
- Counselling, education and advice on the safe and effective use of medicines, prescribed or purchased;
- Advice on medicines for minor conditions;
- Pharmacy-led clinics;
- Monitoring and review of treatment, particularly in chronic disease management, to ensure the medication remains appropriate and any difficulties in taking the medicines are identified and addressed, including as part of repeat dispensing;
- Pharmacists supplying medicines to patients without a prescription under patient group directions;
- In the future, pharmacists prescribing medicines for patients as supplementary prescribers.

- 5.5** For health care staff:

- Advice on treatment options, risk management and audit of care;
- Information relating to medicines and related devices;
- Training, support and updating on medicines;
- Involvement in the multi-disciplinary care of patients.

5.6 For the organisation:

- Involvement in the development of local and wider policy in relation to prescribing, medicines management and usage;
- Provision of management information;
- Participation in the assessment of health care and pharmacy needs and audit of services.

Technical services

5.7 Technical aspects of the service are primarily concerned with the safe effective supply of medicines, and support the delivery of professional services. Whilst medicines must be dispensed under the supervision of a pharmacist, technical aspects of the pharmacy service are routinely delivered by pharmacy technicians and other pharmacy support staff. This has developed to the point where, once the pharmacist has clinically assessed the prescription, the prescription can be dispensed and an accuracy check undertaken by a pharmacy technician, provided they are appropriately trained and accredited. Many of the technical aspects do not necessarily require direct contact between pharmacy staff and the service users. It follows that the location of this component of pharmacy service provision is not so critical. Technical services can, for the most part, be delivered from a distance, provided the necessary professional oversight and logistical support is provided.

5.8 The technical supply of medicines includes:

- Accurate dispensing and supply of medicines in appropriate containers, correctly labelled with patient information
- Preparation and supply of medicines held as stock within health care
- Procurement of medicines and contract monitoring
- Stock control of medicines in the pharmacy
- Ensuring proper storage and stock control of medicines in other health care settings
- Logistical support

5.9 As previously stated, neither the professional nor the technical components can exist totally in isolation. They are inherently linked in the overall delivery of pharmacy services. What can be identified, however, are those services which need to be conducted in close proximity to the point of delivery, unless modern, innovative communication technology can be utilised, and those which may be provided from a more remote location and which might

support the delivery of local services at a number of different sites. We will return to this later in considering a framework for service delivery.

- 5.10** Recognising the components of a pharmacy service is also important in identifying potential developments in the utilisation of the pharmacy workforce, to maximise the contribution pharmacists and their staff can make. This includes the continued extension of the role of pharmacists in supporting patients with their medicines, for example, through medicines management schemes, medication review and supplementary prescribing, as well as parallel development of the role of pharmacy technicians and other support staff to provide improved patient services, as outlined in *Pharmacy Workforce in the New NHS*¹.

¹ Pharmacy Workforce in the New NHS: Making the best use of staff to deliver the NHS Pharmacy Programme: A Discussion Paper. Department of Health, London, 2002.

Section 6: Professional Leadership

Pharmacy services to prisoners, and the staff that provide them, currently tend to be isolated, resulting in fragmentation and variation. Whilst the professional leadership arrangements within the Department of Health and the NHS will support and advise on pharmacy services to prisoners, additional professional leadership resource will be needed to drive forward the change management programme required to deliver the recommendations in this report.

- 6.1 Many pharmacists and their staff providing pharmaceutical services to prisoners tend to be isolated, both from the health care staff within the establishments they serve and other prison pharmacy service providers. We need to build on the links between prison pharmacists and their colleagues in the NHS, including community pharmacy providers. At present, where these links occur it is more often on the basis of individual networking, rather than more formal relationships.
- 6.2 As a consequence, pharmacy services are fragmented and have largely pursued an individual, independent and largely uncoordinated course. Service development tends to be restricted to pockets of excellence rather than spread across the service. Also, changing practice in the NHS is not readily applied to the prison service when appropriate. As a result, there is a risk of duplication of effort, as well as widening variation in pharmacy provision, both within the prison service and as compared to the NHS.
- 6.3 Implementation of the patient-centred pharmacy service we propose, as well as the report's other recommendations, will require strong professional leadership and effective networks, to share good practice and support service development. At the local level this can be achieved through proper communication and liaison between pharmacists providing pharmacy services to prisoners and their NHS colleagues, for example through the Primary Care Trust (PCT) pharmaceutical adviser. However, there is also a need for input at the regional and national level, in keeping with arrangements post "Shifting the balance of power"².
- 6.4 At the Department of Health, the Chief Pharmaceutical Officer, together with his team, are responsible for advising on pharmacy and medicines management issues across all relevant policy developments, including pharmacy services to

² Shifting the balance of power with the NHS – Securing Delivery. Department of Health, London, 2001.

prisoners. Whilst medicines management and pharmacy services to prisoners will be encompassed within NHS professional leadership and advisory arrangements, we consider there is a need, at least in the short to medium term, for additional pharmacy advice and leadership resource, to support the implementation of the changes proposed.

6.5 We recommend that new pharmacy leadership roles be established on a regional basis to drive forward and support the implementation of this pharmacy strategy locally. (Recommendation 1)

The Pharmacy Leadership role

6.6 The precise pharmacy leadership requirements will vary according to local needs. We view the following as core issues:

- Providing pharmacy advice and leadership, particularly regarding the provision of pharmacy services to prisoners, including meeting legal requirements and professional standards;
- Ensuring drug and therapeutics committees are in place and functioning effectively;
- Advising on the training and continuing professional development of pharmacy staff and making sure local NHS organisations include pharmacists and their staff providing pharmacy services to prisoners in their educational activities;
- Advising on the clinical governance of pharmacy services and medicines management;
- Promoting the development of professional pharmacy networks and promoting pharmacy involvement in wider clinical networks, to facilitate the sharing of good practice;
- Ensuring developments in pharmacy practice and the use of the skills of pharmacy staff in the NHS are reflected within health care to prisoners;
- Advising on pharmacy staffing requirements and skill mix;
- Advising on the recruitment and retention of pharmacy staff;
- Ensuring professional input to the appraisal of pharmacy staff;
- Facilitating interchange, joint training and shared posts for both student and qualified pharmacy staff across different practice areas;
- Professional input into the modernisation of prescribing and pharmacy IT systems.

Section 7: Prescribing

Prescribing, in general, varies greatly across the prison service. Although there are individual examples of good prescribing practice at the establishment level, very few links exist across groups of establishments, prisons with similar populations or with the NHS. Inconsistency of approach results. There is also a lack of reliable, easily accessible data on medicines usage.

Lack of evidence based prescribing

- 7.1** Generally, prescribing does not appear to be highly evidenced-based. Although many establishments have formularies (79%)³, limited prescribing lists (46%) and prescribing policies and protocols (60% and 56% respectively), there is less evidence that accepted sources of information have been used in their construction. Only half of prisons or less use National Institute for Clinical Excellence (NICE) guidelines (38%), Committee on the Safety of Medicines (CSM) Current Matters (45%), and Chief Medical Officer (CMO) letters and guidance (50%) to inform prescribing policies and decisions. Furthermore, links with the local NHS on prescribing issues are poorly established. Just over a third (37%) of establishments say such links exist and only half (50%) use local NHS policies and guidelines to inform prison prescribing.

Inconsistency of prescribing

- 7.2** Patterns of prescribing vary greatly from prison to prison. This is illustrated by the small study reported at Annex 3. Whilst prescribing policies have been developed locally by some prisons, reflecting individual establishment need, there appears to be poor communication and collaboration between neighbouring prisons or establishments with similar prison populations, such as Young Offenders Institutions. Information sharing and joint working is similarly poor between prisons and the NHS. Some examples do exist, but these are neither structured nor widespread. Collaboration across the prison service and with the NHS would reduce unnecessary variation, avoid duplication of effort and facilitate continuity of care.

³ The figures appearing in brackets within the report are drawn from the questionnaire results.

Expenditure on medicines

- 7.3** The prison service spends in order the of £7 million per annum on medicines. Expenditure per prisoner varies widely.
- 7.4** The study of prescribing in 2000 across five prisons at Annex 3 shows a range in average annual cost per prisoner of between £78 (in a male category C training prison) and £273 (in a male local prison). Within England as a whole in 2000, NHS prescribing in primary care accounted for the equivalent of eleven prescription items for each member of the population at a cost of £110 per person, per annum.
- 7.5** Based on invoice data over a 3 month period, variation in prescribing costs between prisons was also found in a study of nine prisons in the Northern and Yorkshire Region in 2001⁴. In addition, this study found differences in prescribing costs by British National Formulary (BNF) category and also as compared to prescribing by general practitioners in England.
- 7.6** These variations need to be examined further before concrete conclusions can be reached. This will require good quality aggregated electronic prescribing data, a subject we return to below.
- 7.7** In comparing the budgetary situation, between prisons and the wider NHS, it is well accepted within the NHS that expenditure on medicines tends to rise faster than the rate of inflation. As treatment effectiveness improves and widens in scope, there is a year-on-year increase in the costs associated. The prison service generally has seen no comparable change in budgetary application. This will need to be addressed as the NHS takes over the commissioning of health care for prisoners.

Drug and Therapeutics Committees

- 7.8** Many prison establishments (59%) have drug and therapeutics committees (DTCs) . However, their remits and methods of working appear to be variable. In the NHS, DTCs⁵, or their equivalent, often have a remit beyond the development of local formularies. This may include disease management guidelines, the managed entry of new medicines and more general prescribing policies, such as the use of unlicensed medicines. Indeed, the DTC may provide the mechanism by which all prescribing and medicine-related policies and procedures are agreed and monitored, drawing on specialist expertise as necessary, such as microbiology and communicable diseases expertise in the case of antimicrobial prescribing policies.

⁴ 'Pharmacy services and medicines management in prisons – an initial report' Northern and Yorkshire regional Prison Health Task Force, December 2002.

⁵ PCTs tend to have prescribing fora/subgroups or medicines management committees. The term 'drug and therapeutics committee' has been used in this report for simplicity.

- 7.9** Ensuring prescribing and medicine use is safe through raising risk awareness is also important. This can be supported by the DTC considering safe medication practice, alongside the clinical and cost effectiveness of medicines, or, for example, through a sub-group of the DTC.
- 7.10** We envisage DTCs, having access to the prison service, fulfilling this wider remit and becoming the primary avenue through which prescribing and medicine-related policies and procedures for prisoners are agreed and monitored. This would include responding to medicine-related targets in National Service Frameworks (NSFs) and guidance from the National Institute for Clinical Excellence (NICE), for example following a technology appraisal. In doing so, the DTC would need to consider the particular needs of the prison population, in collaboration with other prisons, local Primary Care Trusts and NHS Trusts and other prison bodies, such as the suicide awareness team or the communicable diseases team, and establish appropriate working arrangements.
- 7.11** Medicine taking has an influence on the prison regime as a whole. It is therefore important for prison staff to understand the rationale for prescribing and medicine-related policies and procedures and to have the opportunity to input to their development, where appropriate. Furthermore, to be effective, the DTC will need the necessary authority of prison health care and general management, underpinned by clear lines of accountability.
- 7.12** Pharmacists are key members of DTCs, and often the Chair – providing assessments of the clinical and cost effectiveness of medicines and awareness of medicine usage throughout the organisation. They also have expertise in the legal and professional requirements surrounding medicines, which is critical in developing medicine policies and procedures. However, importantly, their role extends beyond the work of the DTC itself to the provision of advice and monitoring, in support of DTC policies and guidance.
- 7.13** There are many examples of good practice within the prison service and the NHS, which could usefully be drawn together in guidance to inform the development of DTCs into this wider role.
- 7.14** **We recommend that all prisons, in conjunction with their local PCT, are covered by a drug and therapeutics committee or equivalent. This should draw on specialist expertise, and be responsible for the development of evidence-based local formularies, disease management guidelines and medicine-related policies and procedures. (Recommendation 2)**

Access to prescribing trend and expenditure data

- 7.15** Ready access to data on current prescribing trends and expenditure is necessary to provide feedback to individual doctors on their prescribing practice, to inform clinical audit and to underpin the work of the DTC. Although a great deal of data is collected and held on pharmacy computer systems about prescribed medication in prisons, it is difficult to make effective use of it due to the limitations of the operating systems in place, as the example below clearly illustrates.

“It took many hours of painstaking work for one establishment to manually collate and manipulate data, from their pharmacy computer system, for inclusion within the health needs assessment process. This was information which would have been readily available in the wider NHS, either from PACT (Prescribing And CosT) data in the primary care setting or within minutes from the computer systems in operation in NHS Trust pharmacies.”

- 7.16** Manual data input of prescribing information for analysis is also not practicable or viable, as the study of in the Northern and Yorkshire Region demonstrates⁴. Coding and input of data for nine prisons, covering a three month period of prescribing, took over 300 hours to complete.
- 7.17** This means doctors working within prison establishments, unlike their NHS GP colleagues, who receive regular data on their prescribing, which also indicates their performance, in comparative terms, with local (and national) colleagues, do not benefit from routine feedback on their prescribing patterns. This lack of IT capability is not a situation which can remain if clinical and cost effective prescribing is to be achieved within prisons.
- 7.18** **We recommend, as an urgent priority, the introduction of an IT system delivering the same level of information and support for the prescribing and supply of medicines that is widely available in the NHS (on an individual patient basis and to manage the overall clinical, cost effective, and safe use of medicines locally and nationally). (Recommendation 3)**

Access to medicines information

Similarly doctors, pharmacists and other health care staff do not receive or have ready access to the same level of medicines information as their NHS colleagues. In the NHS, health care staff could not imagine a situation, for example, where the British National Formulary was not freely available, where routine mailings of NICE guidance and bulletins from the National Prescribing Centre (NPC) were not received as a matter of course, or where

individual prescribing queries could not be easily resolved by a telephone call to the local or regional medicines information centre. However, prisons would not appear to be included on the mailing lists of many organisations involved in the dissemination of such information or have ready access to other resources they provide. This undermines both good clinical decision making by health care staff in prisons and the development of evidence-based prescribing and medicine-related policies and procedures through the DTC.

7.19 We recommend that prison health care staff, including pharmacy staff, be accorded equal access to the prescribing and medicines information available within the wider NHS, such as the British National Formulary (BNF), National Prescribing Centre publications and guidance and guidelines published by the National Institute for Clinical Excellence. (Recommendation 4)

7.20 Much of this information is accessible over the internet, as the NPC's Area Prescribing Committee guide⁶ illustrates, with a list of some 16 sources at national or regional level. It is therefore equally important for prison doctors, pharmacists and other healthcare staff to be able to have internet access. This should be built into the Prison Service's IT strategy.

⁶ Area Prescribing Committees – Maintaining effectiveness in the modern NHS: A Guide to Good Practice. National Prescribing Centre, September 2000.

Section 8: Medication Systems

There are wide variations in the ways in which prisoners access medication. There are a number of influences, many of which are not evidence based. As a matter of principle, in keeping with the community, prisoners should be given responsibility for their medicines, unless there are clearly identified individual factors why this should not be the case for that prisoner.

The responsible (“expert”) patient

- 8.1** A large number of patients within prisons are perfectly able to take responsibility for the storage and use of their medication. Many, with chronic health issues, have a significant insight into their medical condition. When in the community, they are used to managing many aspects of their own care.
- 8.2** Once their condition has stabilised, consultation with a doctor is reduced to periodic checks, every three to six months or so, or if there is cause for concern. Patients obtain a regular supply of their medication through a prescription repeat process, which they initiate. Similarly, some aspects of monitoring are undertaken by the patient, such as blood sugar levels for diabetics and peak flow monitoring for asthmatics. The patient is supported in these processes through ready access to a number of health professionals, such as the practice nurse and the community pharmacist, as well as the GP, who are able to give necessary advice.
- 8.3** Even for prisoners without ongoing medical problems, the majority will be quite conversant with self-treatment for minor ailments, the sources of advice and treatment available and, in many cases, the relevant treatment necessary.

“A prisoner who had a cold sore in the early stages of development and knew that the most appropriate form of treatment was Aciclovir cream, available for purchase in community pharmacies, had to wait 4 days for treatment, rendering it ineffective. They had to wait for a Medical Officer’s appointment and a prescription to be written before treatment was authorised!”

8.4 As a matter of principle, in keeping with the community and as advocated in the report of the Expert Patients Task Force⁷, we believe that prisoners should be able to retain greater responsibility for aspects of their care, including taking their medicines and the treatment of minor ailments, where appropriate. This will require a number of fundamental changes to the way prisoners access medicines, both prescription and over the counter medicines, underpinned by changes in culture and attitude amongst prison staff. Prisoners, themselves, will also need support and advice to ensure proper management of their condition and effective medicine taking.

Medication in possession

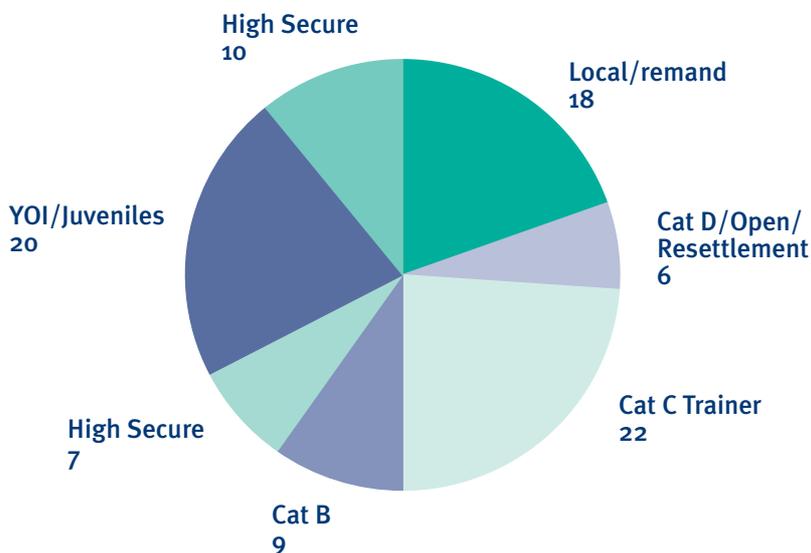
8.5 Historically, there has been unease amongst the prison service over prisoners being in possession of the medicines they are taking; a feeling which generally remains today. Whilst, in theory, this unease is understandable, with large amounts of medicines perceived as a vector for suicide, self-harm and abuse, this is not borne out in practice.

8.6 Nearly all establishments allow some degree of in-possession medication and in some virtually all medication is issued in this way. The levels of harm associated with medicines are low. Nationally, deaths associated with medication run at approximately one case per year (national statistics do not differentiate between accidental cases and deliberate intent). If in-possession medication was extended significantly, one might postulate higher levels of harm associated with medicines due to increased opportunity. The available evidence, as illustrated by the three establishments referred to below, would indicate that this is not so.

“Three establishments, a dispersal prison, one category B/C and one category C, allow virtually all medication on an in-possession basis. At none of these has there been a demonstrably higher level of harm associated with medicines. At all of these the time saved in supplying regular medication, has allowed the development and provision of health care service in other areas.”

⁷ The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century. Department of Health, London, 2001.

Number of establishments with in-possession policies by security type



Responses to the questionnaire indicate that over 90% of establishments responding have in-possession policies.

8.7 The majority of establishments of all types, as illustrated above, have a formal in-possession policy, describing which medicines can be issued in this format, how much can be supplied and the conditions under which the supply can be made. However, all too often, this means that “not in-possession” medication is the standard process. In effect, a negative approach is adopted and one in which risk management issues and processes are bypassed by default to what is perceived as the lowest level of risk. However, we believe, both for effective and efficient patient care, the level of risk should be correctly identified, assessed and managed in a more positive manner, taking full account of the risks and benefits of both in-possession and not in-possession medicines. Furthermore, we believe, this is likely to be most effectively achieved by adopting in-possession medication as the normal method of supply and requiring clear assessment for medicines to be supplied in any other way. We therefore conclude that, as a matter of principle, in keeping with the community, prisoners should be given responsibility for their medicines, unless there are clearly identified individual factors why this should not be the case for that prisoner. Special consideration will be required for juveniles.

8.8 Treatment times are operated at nearly all establishments. These are times when prisoners are required or able to attend to collect their medicines. This may be for prescribed medication and/or to request treatment for minor ailments. In general, frequent treatment times indicates a lower usage of “in possession” medication supply. The following diagram shows the variation at different establishment types

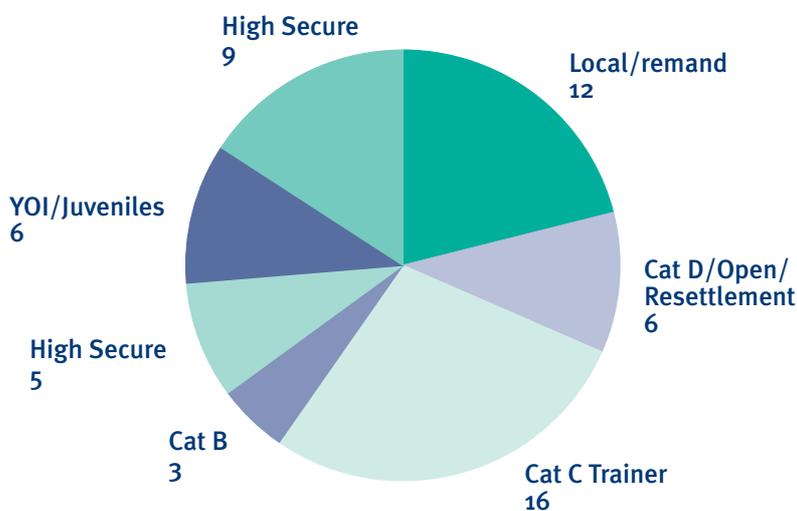
Figure: Range in the number of treatment times offered per day in different types of prison establishment

						Female
						YOI/Juvenile
						Remand
						High Secure
						Cat B
						Cat C
						Cat D
1	2	3	4	5	6	No of Treatment times

*There is a large unexplained variation in the number of treatment times.
A higher number of treatment times demands increased staff resources*

8.9 Likely improvements in quality and continuity of care for patients, together with workload benefits for pharmacy and health care staff, makes the case for in-possession medication systems a strong one. Indeed, many establishments already have successful ‘in-possession’ policies. Less time has to be spent by pharmacy staff in dispensing daily doses or by nursing staff in handing out medicines at treatment times; time which could be more productively utilised on other aspects of patient care. Treatment times can be less frequent, and thus easier to accommodate in the prison regime; it will also allow patients to take their medicines at the appropriate time. This is equally important for diagnostic tests used to monitor treatment and devices necessary to administer medicines properly, such as for diabetes, which prisoners should also be able to hold in possession. The following diagram is an example of the above.

8.10 Number of establishments allowing insulin pens in possession by security type



A wide variety of establishments allow insulin pens in possession. This should be consistent across the estate.

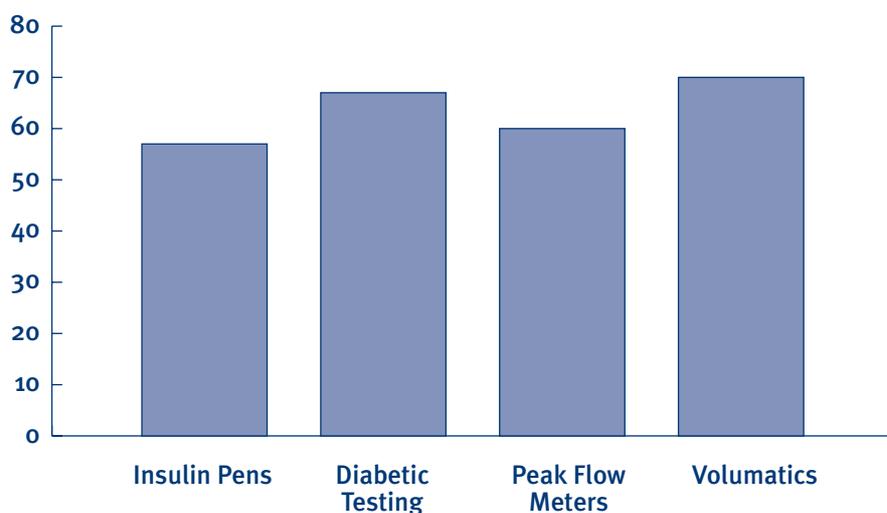
- 8.11** In moving to a position where medicines are routinely held in the possession of prisoners, consideration should be given to arrangements for the appropriate and safe storage of medicines to minimise risk to other prisoners and maintain the integrity of the medicine.

- 8.12** Evidence shows that as many as half of patients in the wider community may not be taking their medicines as intended. Involving patients in their treatment facilitates more effective medicine taking⁸. That is why the Department of Health has established a joint Task Force to take forward a programme of work to achieve greater partnership between patients and health care professionals on medicine taking. In-possession medication is in keeping with this NHS development and will help prisoners take their medicines appropriately and gain the most from them, both whilst in prison and when discharged.

- 8.13** **We recommend that medicines in use, together with associated monitoring and administration devices, should normally, as a matter of principle, be held in the possession of prisoners. Each prison establishment should have a policy and risk assessment criteria, developed through the Drug and Therapeutics Committee, for determining on an individual basis when medicines and related devices may not to be held in possession of a prisoner. (Recommendation 5)**

- 8.14** **Furthermore, we recommend that the length of supply of medicines given in possession should move to be in line with local primary care practice in the NHS. (Recommendation 6)**

8.15 Percent of Establishments allowing items In-possession



⁸ From Compliance to Concordance – Achieving Partnership in Medicine-Taking. Royal Pharmaceutical Society of Great Britain, London, 1997.

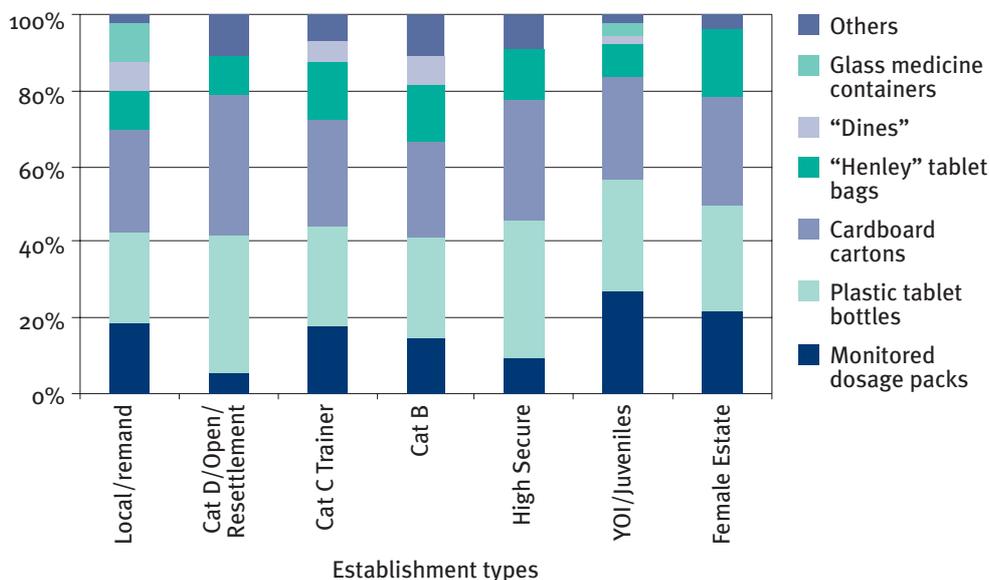
Use of patient packs and monitored dosage systems

8.15 As a consequence of the policies and approaches adopted in prisons, a wide variety of formats and containers are currently used to issue medicines to patients. Many of these are practically, ethically and technically either unacceptable or inappropriate. Many of them increase the difficulty in both supplying the actual medication and in ensuring the necessary information is provided to the patient, in particular patient information leaflets. Identification of the drug can be difficult. Many are costly, both in purchase terms and in the staff time necessary to prepare them, as indicated below.

Each Venalink card costs approximately 36p in the cold seal version compared to no cost at all if the original pack is used. Also, it would take approximately six times longer to prepare each drug in a Venalink pack. Widespread issue of in-possession medicines would allow greater use of patient packs (i.e. the packs in which medicines are supplied by the manufacturer to cover a normal course of treatment – usually a month). This, in turn, would allow labelling and patient information requirements under medicines legislation to be readily met. Overall, such an approach would bring significant benefits to patients, health care staff and the establishment.

8.16 Where the original manufacturer’s pack or patient pack is not used both additional cost and time resources are incurred in preparing and packaging medicines. An indication of the wide variety of alternative packaging currently in use at various categories of establishments is illustrated in the following figure:

Container Types



There is no consistency across the prison estate as to the containers used for medication. This is not affected by security status. Medicines supplied to prisoners should be packaged and labelled as in normal NHS practice.

- 8.17** Some patients experience difficulty in remembering to take their medicines. Dispensing medicines in specially prepared blister packs or other monitored dosage systems is one of a variety of aids available to help people take their medicines at the right time. Monitored dosage systems are not the only way of helping patients to take their medicines correctly. Simpler methods such as reminder charts also help many patients and are often more appropriate. In line with NHS policy⁹, patients' need for compliance aids should be individually assessed and the use of monitored dosage systems targeted accordingly.
- 8.18** **We recommend that the drug and therapeutics committee should ensure medicines are generally supplied in patient packs. Non-standard medicines packaging should be phased out. Monitored dosage systems should only be used following an individual patient needs assessment, as in the NHS. (Recommendation 7)**

Repeat prescribing and dispensing

- 8.19** At present, many aspects of health care within prison establishments, and in particular the supply of medicines, are encompassed within a single operational process. There is often little or no differentiation between acute and chronic care. In the wider NHS, the organisation and management of care for ongoing or chronic medical conditions, often with significant involvement of the patient in self-management, can be quite separate from that provided for acute conditions. Chronic conditions, although often variable or progressive, are generally more predictable and consistent in terms of need. Variation when it does occur may, again, be predictable or manifest itself over a protracted time period. Planning the care of patients with chronic conditions is, as a consequence, far easier to accomplish. Specific or specialist medical input is greatly reduced; the majority of on-going care being provided by other health professions, such as practice or community nurses and community pharmacists, or by the patient themselves.
- 8.20** With over 80% of NHS prescriptions in primary care being for on-going medication¹⁰, repeat prescribing systems are a matter of routine within GP practices. These are patient initiated and do not involve direct GP contact on each occasion.

⁹ Medicines and Older People – Implementing medicines-related aspects of the National Service Framework for Older People. Department of Health, London, March 2001.

¹⁰ Harris CM, Dajda R. The scale of repeat prescribing. Br J Gen Pract 1996; 46:649-653.

- 8.21** Within the NHS, this is being taken a step further, through the introduction of repeat dispensing. This allows patients to obtain prescriptions from their GPs, which they can then have dispensed in several instalments, rather than going back to the surgery each time for a new prescription. Community pharmacists then have an opportunity to check with the patient, when they collect their instalments, how they are progressing, confirm a further supply is required and answer any questions they may have. Evidence from pilots has shown that many patients with chronic conditions find repeat dispensing more convenient. It also reduces the waste of medicines. There is therefore a commitment within the *NHS Plan*¹¹ and the supporting programme for pharmacy, *Pharmacy in the Future*¹², for repeat dispensing schemes to be introduced into the NHS in 2002 and to become a nationwide feature by 2004. Thirty repeat dispensing pathfinder sites were announced in October 2002.
- 8.22** The NHS is also actively developing medicines management services within primary care, so that patients receive information and advice about their medicines, what they are for and how to take them and support where they find their medication difficult to take or hard to remember, particularly where a complicated regime of several medicines is involved. Monitoring progress and regular medication review are also important to ensure patients continue to gain benefit and their treatment remains appropriate. By 2004, all primary care trusts across the country are expected to have such schemes so that people get more help from pharmacists in using their medicines. The National Service Framework for Older People¹³ reinforces the importance of medicines management and highlights the need for regular medication review, especially for those taking four or more medicines and at higher risk of medicine related problems.
- 8.23** Pharmacists in the NHS can already supply prescription only medicines under a patient group direction, without the need for a doctor's prescription. Under the new supplementary prescribing arrangements, following diagnosis by a doctor and through a clinical management plan, pharmacists will be able to prescribe a wide range of medicines, themselves. Supplementary prescribing is defined as a voluntary prescribing partnership between an independent prescriber (usually a doctor) and a supplementary prescriber (currently a pharmacist or a nurse), to implement an agreed patient-specific clinical management plan with the patient's agreement. The first training and accredited pharmacists are expected to be prescribing in the NHS from the second half of 2003¹⁴.

11 The NHS Plan – A plan for investment. A plan for reform. Department of Health, London, 2000.

12 Pharmacy in the Future – Implementing the NHS Plan. A programme for pharmacy in the National Health Service. Department of Health, London, 2000.

13 Medicines and Older People – Implementing medicines-related aspects of the National Service Framework for Older People, Department of Health, London March 2001.

14 Further information on supplementary prescribing can be found at www.doh.gov.uk/supplementary-prescribing.

- 8.24** If prisoners are to receive the same level of care as in the community, it is essential that these developments are reflected within prison health care. There are already examples of good practice on which to build as illustrated below.

A category C establishment has started a chronic disease management clinic for the monthly assessment of relevant patients. This is backed up by allowing patients to have monthly supplies of their medication in their possession. The reduction in workload on a daily and weekly basis for both health care and pharmacy staff has been dramatic. By the same token the actual care delivered to the patients has been improved and enhanced.

- 8.25** There are also many other benefits, in terms of reducing medicines wastage and using pharmacy and other health care staff more effectively, which would accrue from reviewing systems to reflect the needs of patients.
- 8.26** **We recommend that the drug and therapeutics committee should ensure repeat prescribing and dispensing systems are put in place, in line with those in the NHS. These systems should be flexible to allow for the introduction of supplementary prescribing by appropriate health care professionals. (Recommendation 8)**

Self-care and minor ailments

- 8.27** As for the management of acute and chronic conditions, there is also the tendency to handle minor ailments within the same single operational process. This involves doctors in unnecessary patient consultations for conditions that can be more than adequately dealt with by pharmacists, nurses or patients themselves. Within the wider community, people access treatment for minor conditions to a large extent independently of the routes used for chronic or more serious acute conditions. Although a consultation with their GP is still an option, the general public routinely use other sources to access medicines for minor ailments and obtain advice. And this is something the NHS is seeking to encourage through the promotion of NHS Direct, walk-in centres and community pharmacies, as alternative routes to advice and treatment. Self-care and self-medication are both well established and account for the vast majority of care for minor conditions.

In the wider community, for a simple headache, a dose of an appropriate pain-killer is taken from the medicine cupboard or first aid box when needed or purchased at the local pharmacy.

In a prison establishment the patient has to:

- Wait
- Queue up at a hatch
- Explain why they needed a pain killer
- Wait for this to be verified and allowed
- Have the appropriate dose issued and checked by two members of health care staff.

8.28 The highly medicalised system, which to a large extent represents practice within the prison service, would appear to be inefficient, unstructured and inappropriate.

8.29 As in the community, prisoners should be able to care for themselves, through access to certain medicines. If professional advice is required this can be provided by a range of health professionals, including nurses, pharmacists and pharmacy technicians. Similarly, prisoners should be encouraged to seek advice from the most appropriate health professional, which may not necessarily be the doctor. Systems for assessment and prioritisation can support this approach.

8.30 In setting these policies, the D&T committee must ensure that the limited financial resources of prisoners are taken into account and that patients will not be disadvantaged in their access to necessary medication.

8.31 **We recommend that the drug and therapeutics committee ensures there are policies and procedures in place in each establishment for access to self-care, taking into account prisoners' ability to pay for such medication. This should encompass the full range of options normally available in the community, including the opportunity to purchase certain medicines and to seek the advice of a pharmacist or pharmacy technician. (Recommendation 9)**

Access to a pharmacist and other pharmacy staff

8.32 In order to provide the necessary levels of service, particularly for direct patient services, it is necessary for pharmacy staff to be both, accessible by the patient, and have access to the patient.

8.33 We recommend that, as in the community, all prisoners should have appropriate access to a pharmacist or pharmacy staff. (Recommendation 10)

8.34 Prisoners should also be made aware of when and how they can access the advice of a pharmacist and the range of pharmacy services available. This can be achieved through a pharmacy leaflet as well as other forms of communication.

Patient movement

8.35 There are frequent movements of people in and out of prison. Whilst, at any one time, the prison population amounts to over 71,000 people, the annual turnover is approximately 140,000 prisoners per year. The number of prisoners moving between establishments is also significant, at over 2,000 per week¹⁵. Many of these prisoners will have chronic medical conditions, which require continuing treatment. All too often patients are received at establishments, whether direct from court or on transfer from another establishment, without either their medicines or clear information regarding their medical history. Less frequently, but of equal importance, patients are released back into the community without adequate medication supplies or treatment history. Throughcare contacts between prisons and the community, although improving, remain inconsistent.

8.36 All of these situations can have a marked effect on the successful and effective medical care of patients. Indeed, improving continuity of care and medicine taking is an issue of particular concern to voluntary groups working with prisoners and their families and friends. It is important to ensure that disease management and medication within prisons, follows the same nationally agreed protocols, or the local PCT interpretation of these protocols, as operate within the wider NHS to avoid duplication of effort and to help joint working between prisons and the NHS.

8.37 We recommend that sufficient supplies of medicines be issued to prisoners to cover the whole period they are in court or on transfer. Furthermore, prisoners discharged into the community should receive sufficient medicines, usually a month's supply, to enable treatment to be continued until a further supply can be reasonably obtained through a general practitioner. (Recommendation 11)

8.38 Using the prisoners existing supply of medicines, where safe and appropriate to do so, can reduce waste and improve efficiency. This is common practice in the NHS when patients move between different sectors of care.

¹⁵ Estimated from the questionnaire returns, which indicated there are 1,184 transfers a week from 70 establishments; and average of 17 per prison per week.

- 8.39** Similarly, it is important that patients have access to their medicines and any necessary monitoring or administration devices, whilst in transit, so they can take their medication at the appropriate time. Continuing the principle of in-possession medicines, we believe that prisoners in transit should retain responsibility for their medicines and related devices, unless there are clearly identified individual factors why this should not be the case for that prisoner.
- 8.40** **We recommend that the policy of in possession and risk assessment criteria, developed through the drug and therapeutics committee, should extend to those prisoners attending court or on transfer. (Recommendation 12)**

Changing the supporting infrastructure

- 8.41** The implementation of these changes to the overall medication system will need effective management, not least in reviewing the supporting infrastructure necessary to bring about and sustain this change. Current processes, procedures and paperwork, surrounding the prescribing, dispensing, supply and administration of medicines, unsurprisingly are based on the historical perception of prison health care and, as a consequence, do not support either the ethos or delivery of the proposed patient-focused approach.

“The current combined prescription and treatment sheets are based on a secondary care model. By their construction, they promote “not in possession” systems for supplying medicines and the consequent requirement for individual doses to be issued and recorded. They provide for only very limited repeat medication provision and, paradoxically, encourage the prescription of medicines for fixed treatment lengths, which do not necessarily reflect individual patient needs, particularly where medication is stable and long-term.”

- 8.42** **We recommend that the supporting infrastructure, including prescription forms and medicine administration records, are reviewed to reflect the proposed revised medication system. This should include enabling prescriptions for chronic medication to be written for a period of up to one year, with the supply of medicines made on a more frequent basis, underpinned by regular medication review. (Recommendation 13)**

Section 9: Maintaining and Improving Pharmacy Standards

Pharmacy services, both in terms of level and extent of service delivered, are unacceptably variable across the prison estate. The extremes range from virtually no pharmacy input into the care of patients up to a fully comprehensive pharmacy service, fully integrated into the health care provision to the establishment, with pharmacy staff providing clinical care directly to patients.

Legal requirements and professional standards

- 9.1** There are clear and indisputable legal and ethical requirements and professional standards associated with the delivery of pharmacy services. Although historically, and to a certain extent currently, the prison service and establishments might not fall within the enforcement capacity of the relevant legal processes, it is difficult to accept that the service, establishments and individuals working within them would willingly work or act in a way that is contrary to these laws. Furthermore, it is difficult to accept that professionals working within the service would either willingly, or through pressure, contravene their own codes of ethics or conduct. The fact that identification of non-compliance with these requirements still occurs within the prison service is, therefore, a cause for concern.

“Both the prisons inspectorate (HMCIP) and the internal standards audit teams continue to find procedures for medication supply and handling that are legally or ethically unacceptable. This is particularly the case at establishments where there is a low level of input and involvement from pharmacy staff.”

- 9.2** Under the Royal Pharmaceutical Society of Great Britain’s (RPSGB) standards of professional performance¹⁶, pharmacists assuming responsibility for any pharmacy function must ensure that they do not work in conditions that do not enable them to comply with the key responsibilities of a pharmacist, including complying with professional standards, accepted codes of practice and statutory requirements. Similarly pharmacist managers and superintendent pharmacists have a personal professional responsibility to ensure the observance of all legal and professional requirements in relation to the pharmacy service.

¹⁶ Medicines, Ethics and Practice: A guide for pharmacists, 25th edition. Royal Pharmaceutical Society of Great Britain, London, July 2001.

Key responsibilities of a pharmacist¹⁶

Pharmacists understand the nature and effect of medicines and medicinal ingredients, and how they may be used to prevent and treat illness, relieve symptoms or assist in the diagnosis of disease. Pharmacists in professional practice use their knowledge for the well-being and safety of patients and the public.

- At all times, pharmacists must act in the interests of patients and other members of the public, and seek to provide the best possible health care for the community, in partnership with other health professions. Pharmacists must treat all those who seek their professional services with courtesy, respect and confidentiality. Pharmacists must respect patients' rights to participate in decisions about their care and must provide information in a way in which it can be understood;
- Pharmacists must ensure that their knowledge, skills and performance are of a high quality, up-to-date, evidence based and relevant to their field of practice;
- Pharmacists must ensure that they behave with integrity and probity, adhere to accepted standards of personal and professional conduct and do not engage in any behaviour or activity likely to bring the profession into disrepute or undermine public confidence in the profession.

9.3 Management arrangements should therefore respect the professional autonomy of pharmacists and should not infringe the pharmacist's responsibility to ensure pharmaceutical services and the handling of medicines meet legal and ethical requirements, and reflect accepted professional standards.

9.4 **We recommend that the pharmacy service should be provided within a framework of proper professional control, so that legal requirements and professional standards are met. (Recommendation 14)**

Health Services for Prisoners Standard

9.5 Prison health care, including pharmacy, is subject to internal, audited standards. The Health Services for Prisoners standard is to provide prisoners with access to the same range and quality of services as the general public receives from the NHS. The required actions and key audit baselines for pharmacy do not fully reflect current pharmacy practice in the NHS and the patient-focused pharmacy service we propose for prisons, and will need to be amended.

¹⁶ Medicines, Ethics and Practice: A guide for pharmacists, 25th edition. Royal Pharmaceutical Society of Great Britain, London, July 2001.

- 9.6 We recommend that the Prison Health team at the Department of Health ensures that when the Health Services for Prisoners Standard is next revised the recommendations in this report, and especially the patient-focused nature of the pharmacy service, are fully reflected. (Recommendation 15)**

Clinical governance

- 9.7** Guidance on clinical governance, issued to the NHS in 1999¹⁷, defines it as:

“A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish.”

- 9.8** Clinical Governance is underpinned by a statutory duty of quality and applies across all NHS services, including pharmacy. Now that the prison service is in partnership with the NHS in the delivery of health care to patients, the requirements for clinical governance should equally apply.
- 9.9** Primary Care Trusts (PCTs) are responsible for clinical governance in primary care and much progress has already been made, in particular in implementing clinical governance in general practice. As PCTs represent both the formal and natural link point between prisons and the NHS, it would be appropriate for prisons to progress clinical governance issues in line with local PCTs.
- 9.10** In the NHS, the development of clinical governance in pharmacy services has progressed at varying rates. Practice within the secondary care sector is encompassed within the NHS Trust’s organisational framework for clinical governance and measures have been taken to address clinical governance, in respect of pharmacy and medicines management. The NHS Controls Assurance Standard on Medicines Management (safe and secure handling), which forms part of governance as a whole within the NHS, recognises the chief pharmacist as responsible for ensuring systems are in place to address the safe and secure handling of medicines across the entire organisation. The latest edition has been extended to cover primary care.¹⁸
- 9.11** Development of clinical governance in community pharmacy is at an earlier stage. Whilst much has been achieved by some, PCTs have varied greatly in the extent to which they have succeeded – or indeed attempted – to incorporate community pharmacy within their clinical governance frameworks. With the issue of guidance at the end of 2001, together with central resources to supplement local funds, progress is quickening, so that local frameworks for

¹⁷ Clinical Governance : Quality in the new NHS. (HSC 1999/065) Department of Health, London, 1999.

¹⁸ Further information on controls assurance can be found at www.doh.gov.uk/riskman.htm

clinical governance include both community pharmacy services themselves and the contribution pharmacists and their staff can make to the clinical governance of other services.

9.12 There is obviously a need to progress the development of clinical governance within pharmacy services for prisoners. The principal practice area is in the provision of primary care and this should be reflected in both the approach taken and the framework developed.

9.13 Work should be progressed within both the prison service arrangements for clinical governance and those of the local PCT in line with PSO 3100 'Clinical Governance – Quality in Prison Healthcare'. The Department of Health publication *Clinical Governance in Community Pharmacy – Guidelines on Good Practice for the NHS*¹⁹ also provides some useful pointers. This includes undertaking a baseline assessment and identifying the elements of a development plan. However, there are also some more specialist areas of practice, which operate within the prison service (eg mental health, substance abuse, and GUM), and it would be appropriate to seek input from specialist pharmacy NHS providers in these areas.

9.14 **We recommend that medicines management and pharmacy services for prisoners are fully integrated into local, multi-disciplinary arrangements for clinical governance, following existing and future clinical governance guidance and reflecting where appropriate the Department of Health's guidelines on Clinical Governance in Community Pharmacy. (Recommendation 16)**

Clinical audit

9.15 As part of clinical governance, it is important for pharmacy staff to participate in clinical audit, in fulfilling their commitment to assuring and improving the quality of care delivered to patients. In addition to supporting quality improvement in the organisation, clinical audit undertaken by pharmacists also contributes to meeting the RPSGB's requirements for continuing professional development, which are to become mandatory for continued registration. Most prison pharmacists and their staff have had few opportunities to participate in clinical audit and the Prison Service will need to provide suitable training for pharmacy staff and fund the development of clinical audit in a similar way to the NHS. There are a number of existing resources within the pharmacy profession and the NHS, which can be drawn on in supporting this development.

¹⁹ Clinical Governance in Community Pharmacy – Guidelines on Good Practice for the NHS. Department of Health, London, December 2001.

Support through good practice guidance and pharmacy networks

- 9.16** The majority of prison establishments (75%) receive services from either an on-site pharmacy (25%) or from another establishment with an on-site pharmacy (50%). However, there is little structured or regular communication between them. Furthermore, the remaining establishments receive pharmacy services from a number of, in many cases independent, providers, again with virtually no intra-professional contact.
- 9.17** Whilst legal requirements and codes of ethics and practice provide the framework for pharmacy services, individual pharmacists and pharmacy staff may have difficulties in translating these into practice, particularly in a different environment such as a prison establishment. Equally for those new to the prison environment or working externally, but supplying services, there may be uncertainty as to the best or most appropriate way to provide pharmacy services. In addition, we are proposing significant changes to the way medicines are handled in prisons, and the underpinning pharmacy service.
- 9.18** Many examples of good practice exist. However, due to the isolation of prison pharmacy staff, these are not always readily shared and spread. Examples of good practice need to be collated and disseminated to assist the implementation of the report's recommendations.
- 9.19** The prison pharmacists and pharmacy technicians fora provide a means of professional contact and support at a national level. However, it is often not easy for people to participate and they do not embrace all providers of pharmacy services. To sustain the continuing development of pharmacy services, encourage equality of service and a shared ethos of practice, we believe there is a need to establish local pharmacy networks. These would provide peer support, facilitate effective communication, including partnership working with the NHS, and effect shared learning.
- 9.20** **We recommend that systems be developed by the Prison Health team to facilitate the sharing and learning of good practice in medicines management and pharmacy services to prisoners. (Recommendation 17)**

Adverse patient incidents and medication errors

- 9.21** As previously indicated, within the prison service, many of the systems surrounding medication and treatment are based on a negative, often avoidance, culture. This means a reactive, rather than a pro-active, approach ensues, with poorly established risk management processes. Due to the perception of a "blame culture" within the prison service, there is also a reluctance to monitor,

report and audit negative outcomes. The opportunity to learn from mistakes and use them as a positive development driver is therefore lost. This is in direct contrast to the wider NHS where both positive and negative outcome monitoring is used to identify and focus development needs.

9.22 A new independent national body, the National Patient Safety Agency (NPSA), has been established in the NHS to implement, operate and oversee a new national reporting system for learning from adverse events and near misses – to improve patient safety by reducing the risk of harm through error²⁰. It will identify patterns and trends in avoidable adverse events so that the NHS can introduce changes to reduce the risk of recurrence. Given the implementation of clinical governance in the prison service, of which patient safety is a key component, we believe the prison service should develop local reporting systems in collaboration with the NHS and feed into the NPSA. Recognising that the Agency is a new body, the time-scale for implementation will need to take account of the Agency’s capacity and resources.

9.23 **We recommend that all prisons should have a local system for reporting and learning from adverse patient incidents, including medication errors. The drug and therapeutics committee should ensure that the forthcoming guidance on reducing medication errors in the NHS is reflected in medicine-related procedures and processes within all prison establishments. In time, health care to prisoners should be covered by the NHS system for reporting and learning from adverse patient incidents, including medication errors, through the National Patient Safety Agency. (Recommendation 18)**

²⁰ Building a safer NHS for patients – Implementing an organisation with a memory. Department of Health, London, April 2001.

Section 10: Pharmacy Service Delivery

There is currently neither an accepted framework for the delivery of pharmacy services, nor a readily identifiable approach of choice, as demonstrated by the wide variation in pharmacy services. The health needs of prisoners are not adequately reflected in pharmacy services. Accurate information on the cost of pharmacy services is also lacking.

Health needs assessment

- 10.1** The health needs assessment (HNA) process was introduced within prisons to highlight and evaluate the true health needs of the client population. As a result, it is possible to determine what services are needed, what services need improvement, the priority of these improvements and what changes need to be made in order to deliver these services. It is wholly appropriate that pharmacy should be part of this process and that service development and delivery is targeted to meet the identified needs. In doing so, this should consider and determine the needs of prisoners against the full range of pharmacy services, normally available in the community.
- 10.2** Hitherto, pharmacy has not been specifically identified as an area for inclusion in the health needs assessment process, although pharmacy and medicines management needs may have been given some consideration as part of a broader remit. Given the changes that are proposed within this report and the current state of pharmacy services within the prison service, it is necessary for pharmacy to be given greater emphasis within the future HNA process.
- 10.3** **We recommend that prisons and PCTs, as lead partners, ensure health needs assessments and action plans cover and inform the future development of pharmacy services to prisoners.**
(Recommendation 19)

A specification for a patient-focused pharmacy service

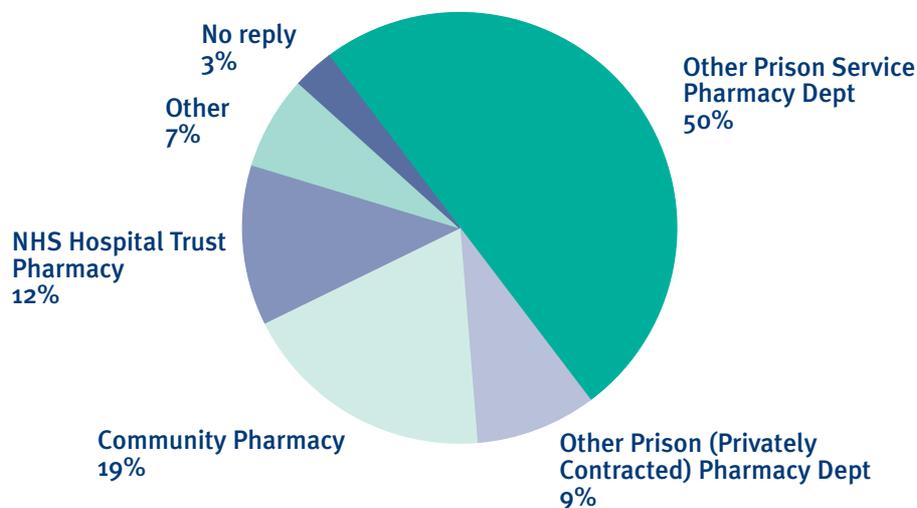
- 10.4** Whilst pharmacy services should take account of patient needs, as identified in the health needs assessment and otherwise, and reflect individual requirements of the establishment concerned, in general, there should be common core elements provided right across the prison service. These should reflect this

report's recommendations, in the provision of a comprehensive patient-focused pharmacy service, in line with the NHS.

10.5 Providers of pharmacy services to prisoners are also required to meet the criteria laid down within the Health Services for Prisoners Standard. In broad terms this currently requires that:

- The provider is a recognised source of pharmacy services, such as a prison pharmacy department, an NHS Trust pharmacy department or a community pharmacy;
- The service provided is safe, efficient, cost effective and meets all statutory legal requirements and professional standards, as set out in the Royal Pharmaceutical Society of Great Britain's code of ethics and standards²¹; and
- The service is comprehensive and meets the full needs of prisoners and the establishment.

Source of Pharmacy supply if not onsite



There is a wide variety of providers of pharmacy service to prisoners currently.

10.6 The development of an outline service specification would facilitate a consistent high quality pharmacy service for all prisoners. It could be used to inform local service level agreements or contracts for the provision of pharmacy services to prisoners. The experience of all types of current providers should be drawn upon in the development of the outline service specification.

²¹ Medicines, Ethics and Practice: A guide for pharmacists, 25th edition. Royal Pharmaceutical Society of Great Britain, London, July 2001.

10.7 We recommend that the Prison Health team at the Department of Health should utilise relevant available expertise and experience to develop an outline service specification for a patient-focused pharmacy service, in keeping with the other recommendations in this report. (Recommendation 20)

10.8 The service specification should include:

- Full professional control by qualified pharmacy staff
- Meet legal requirements and professional standards
- Direct pharmacy input into the care of prisoners
- Direct access by prisoners to pharmacy staff
- Prescribing advice and clinical input
- Patient counselling and advice
- Medicines management
- Monitoring and review of patients' medicines
- Pharmacist supply under patient group directions
- Prescribing by pharmacists
- Support to health care services
- Advice, and where necessary supply of treatment for minor ailments and assisted self-care
- Procurement of medicines and related items of high quality, fit for purpose, from reputable sources
- Stock control and storage of medicines
- Supply logistics
- Dispensing and supply of medicines and related requirements, including repeat dispensing and provision to meet acute, urgent medication needs, both in normal working hours and out of hours
- Medicines information services
- Participation in the work of the drug and therapeutics committee and provision of professional advice on medicine-related policies and procedures
- Clinical governance, including clinical audit and systems for monitoring and learning from medication errors and near-misses
- Monitoring and reporting

- Information technology
- Service development
- Training and staff development

Delivery of pharmacy services to prisoners

- 10.9** Earlier in this report, we clarified that, in line with health care generally in prisons, pharmacy services should be predominantly primary care based. The essentials of a modern pharmacy service have been highlighted, together with the elements of a service specification, in line with the NHS. The professional and technical components of a pharmacy service have also been identified and attention has been drawn to the possibility of delivering these components from separate locations. Put differently, most professional aspects require some direct contact with patients and the health care team, for example, through consultations, in clinics or through meetings.
- 10.10** However, this may be supplemented by the use of modern communication technology. In contrast, most of the aspects of the technical supply of medicines can be undertaken from a distance. This means that, whilst neither the professional nor the technical components of a pharmacy service can exist in isolation, the technical component could be located in a pharmacy outside a prison and provide services to more than one establishment. The professional component, on the other hand, would involve pharmacists and their staff visiting prisoners on the wings and working alongside doctors and nurses in healthcare.
- 10.11** It is important to tease out these possibilities for a number of reasons, including:
- Economies of scale – a pharmacy supplying a number of prisons, can reduce stock holding and may justify greater investment in modern technology, such as automated dispensing robotics.
 - Reducing security clearance – medicines procured by a pharmacy located within the prison walls have to be cleared by security. If that pharmacy supplies one or more satellite prisons, those medicines will need to be cleared by security on two further occasions before reaching the patient; on leaving the original prison and for entry to the satellite. For pharmacies located outside the prison walls, the medicines would only ever have to be checked by security once.
 - Efficient and effective use of pharmacy staff – concentrating the dispensing and supply of medicines can enable pharmacy technicians, assistants and accredited checking technicians to be more effectively deployed, releasing pharmacists to focus on supporting patients with their medicines.

- 10.12** These factors also have to be balanced against other considerations, such as the need to deliver an accessible, timely and convenient service and the lost time in pharmacy staff travelling between prisons. Achieving a co-ordinated pharmacy service is also important so that the clinical pharmacy input, such as clinical assessment and validation of prescriptions, patient counselling and advice, and medication review, links safely and effectively to the supply of the medicines.
- 10.13** In drawing out all these factors, it gives the opportunity for all possible options to be considered and examined so that the pharmacy service is delivered in the most effective, efficient and economical fashion, making best use of the skills of pharmacists and their staff, working as part of the overall health care team and focused on the needs of patients.

Financial controls and procurement

- 10.14** The current accounting systems within the Prison Service do not operate with sufficient discrimination to show the precise allocation and use of resources within health care. Consequently, they do not allow for the specific, accurate and effective control of expenditure on medicines and pharmacy services. In the majority of establishments, non-pharmaceutical items are purchased from the budget for medicines, such as first aid supplies (69% of establishments responding)²², minor items of medical equipment (65%), and reference sources i.e. books and journals (22%). It is essential that clear and unambiguous information is available relating to the use of medicines and the costs of that usage.
- 10.15** Pharmacy staffing costs are usually charged to the establishment where they are based. Where services are provided to satellite units, only the cost of medicines and related items is charged. The cost of the staff resources inherent in the provision of the pharmacy service is not routinely cross-charged, neither is any indication of the staffing costs given.
- 10.16** Pharmacist locum charges are often met from a general locum/agency staff budget. More often than not, no specific allocation is set for pharmacist locum costs, with the risk that the necessary cover cannot be financed. Furthermore, pharmacist locum charges are not linked back to the pharmacy budget, impeding quantification of the full cost of the pharmacy service.

²² The figures appearing in brackets within the report are drawn from the questionnaire results.

10.17 We recommend that the cost of medicines, related items and pharmacy services themselves are separately defined and transparent, facilitating appropriate resource allocation, comparison and monitoring, and the assurance of value for money. (Recommendation 21)

10.18 Against the context of the future transfer of prison health funding to the Department of Health from April 2003, and ultimately the transfer of commissioning responsibility to PCTs, it will be especially important that the full costs of service provision are identified for each establishment and subsequently reflected in PCT baseline allocations.

10.19 The financial year 2003/4 will provide the opportunity to monitor expenditure on pharmacy services and refine the full service costs by establishment/PCT.

Section 11: Information Technology

Modern health care practice within the wider NHS, including pharmacy, is supported by the full utilisation of appropriate information technology and associated computer based systems.

11.1 The prison service generally, and health care in particular, has been slow in adopting modern IT systems. Prison health care services have been hampered in both delivery and development terms as a result.

11.2 Pharmacy departments, of necessity, have been provided with pharmacy computer systems, primarily to fulfil the requirement for mechanically produced dispensing labels. Whilst including some additional essential functions, it can generally be stated that the systems are:

- of ageing design;
- use dated operating software;
- lack the capacity to handle the volume of work generated by patient turnover and movement;
- will not interface with other healthcare or prison systems; and
- cannot produce the necessary report data.

In short, they do not support the provision of modern and effective pharmacy services.

11.3 There is an urgent need to consider the provision of adequate IT support for prison pharmacy. Although most of the potential systems on offer are designed around pharmacy needs, serious consideration must be given to how these might interface with other IT developments, particularly in health care, taking place in prisons and also in the wider community. There is a need to ensure that where links are necessary, these are either in place or can be readily facilitated. Any new system should:

- Have adequate operating capacity
- Provide the essential features required for primary care pharmacy practice
- Be supported in terms of maintenance, upgrading and development to cope with changing needs

- Produce the necessary data reports to support cost effective prescribing and pharmacy service provision
- Be 'networked' ready to interface with other healthcare and prison systems
- Provide the additional essential functions that support modern practice e.g. internet access, email, direct ordering from suppliers via modem link etc.

11.4 *Any systems used must be mutually compatible and support the principles of practice outlined in this report. (see recommendation 3 which states: We recommend, as an urgent priority, the introduction of an IT system delivering the same level of information and support for the prescribing and supply of medicines that is widely available in the NHS (on an individual patient basis and to manage the overall clinical, cost effective, and safe use of medicines locally and nationally)).*

Section 12: Workforce, Education and Training

The delivery of high quality pharmacy services to prisoners is reliant on the recruitment and retention of sufficient pharmacy staff, utilised properly according to their skills, up-to-date and appropriately rewarded.

Recruitment and retention

- 12.1** In common with most other health care professions, there is a general shortage of pharmacists and to a lesser extent pharmacy technicians. With the extension of the undergraduate course from three to four years, in recent successive years there has been very few new pharmacy graduates followed by very few newly registered pharmacists.
- 12.2** All areas of pharmacy practice have been affected to a greater or lesser degree. The most acute problems have been in junior to middle grade pharmacist posts in NHS hospitals. However, some community pharmacies have also had to close on occasions as a result of failing to recruit a locum pharmacist.
- 12.3** Although, in numerical terms, prison pharmacy staffing is relatively small, it has not been immune from these difficulties. Where vacancies for pharmacists have been advertised, response has been poor. Prison pharmacists have great difficulties in organising appropriate locum cover for planned absence periods. Emergency cover, in general, is all but impossible to find. Recruitment and retention of pharmacy technicians, whilst presenting some localised problems, has generally been less troublesome.
- 12.4** Although this may be regarded as symptomatic of the general position, there are a number of factors within prison pharmacy, which further exacerbate the situation. Many establishments have hitherto sought little more than a very basic pharmacy service, ie the supply of medicines. This makes the prison service potentially less attractive and rewarding than other employment opportunities, such as the NHS, where a more patient-focused, clinical service prevails. Making better use of both pharmacist's and pharmacy technician's skills is a factor in improving recruitment and retention, but also in delivering a high quality, efficient pharmacy service. This includes such developments as pharmacist prescribing and the checking of dispensed prescriptions by accredited pharmacy technicians.

- 12.5 We recommend that existing and future developments in the practice and use of the skills of pharmacy staff be introduced in prisons as for the wider NHS. (Recommendation 22)**
- 12.6** Where pharmacy staff are employed by the Prison Service, pharmacy human resources are largely unstructured. There is no career structure and no clear definition as to how pharmacy in prisons relates to, or can be compared with, pharmacy practice within the wider NHS. Pharmacy staff in prisons are appointed, and largely remain, within very narrow grading ranges. Grading, numbers of staff and duties performed, even within this narrow structure, vary considerably. Whilst some of these variations are understandable, very many are not based on clear policy or evidence. There is little recognition of the full range of duties performed by, or required of, pharmacy departments and staff, and the appropriate range of staffing options and grades to fulfil these. All too often, non-pharmacy trained staff are being used to carry out pharmacy duties.
- 12.7** The patient-centred pharmacy service proposed will mean nurses can spend less time supplying medicines to patients. The complement of pharmacists, pharmacy technicians and other pharmacy staff required will also be different, both in terms of numbers and grades. The current position where only a limited range of pharmacist and pharmacy technician NHS Whitley Council grades are recognised by the prison service, with no recognition of the assistant technical officer (more often known as the pharmacy assistant) grade at all, is a barrier to effective skill mix and needs to be addressed.
- 12.8 We recommend that local assessments of staffing requirement be undertaken, in terms of skills and grades, to establish an appropriate workforce to deliver the proposed patient-centred pharmacy service. (Recommendation 23)**
- 12.9 We recommend that the full range of pharmacist, medical technical officer (pharmacy technician), assistant technical officer (pharmacy assistant) grades, used in NHS pharmacy services, is available to prisons to enable an appropriate pharmacy workforce to be achieved. (Recommendation 24)**
- 12.10** Although there will be an increasing number of pharmacists joining the overall pharmacy workforce in the future, it must be recognised that, in the short to medium term at least, such qualified staff may still be in high demand. It may well be necessary to consider ways in which the necessary skills required from these staff may be obtained from a limited finite pool.

- 12.11** As well as assessing the pharmacy staffing requirement, with appropriate skills and grade mix, consideration will need to be given to how best to recruit and retain that staffing complement. This factor should be taken into account in identifying the most appropriate service provider (whether in house or contracted in). Joint appointments between pharmacy service providers are also an option, which is discussed later.
- 12.12** There is also poor understanding of the nature of prison health care and the opportunities for pharmacy staff, a factor addressed later through the inclusion of experience of prison health care in the training of pharmacists and pharmacy technicians, as well as opportunities for qualified staff. However, there are other actions that can be taken to highlight the career opportunities for pharmacy staff within the prison service. These include publishing articles on pharmacy in prisons and service developments in professional journals and developing specific career literature.
- 12.13** **We recommend the Prison Health team at the Department of Health work to promote pharmacy careers involving the provision of health care to prisoners. (Recommendation 25)**
- 12.14** Other factors that impact on recruitment and retention are pay and the lack of opportunities for career progression.
- 12.15** **We recommend that the NHS approach to job evaluation be adopted for pharmacy staff working within prisons, to ensure equality of pay and responsibility, as well as opportunities for career progression. (Recommendation 26)**
- 12.16** A common grading and pay structure should also facilitate joint appointments and ease of movement between the Prison Service and the NHS. It is also in keeping with the NHS becoming responsible for the commissioning of health services for prisoners.

Induction

- 12.17** Induction programmes are important to staff new to any organisation. This is particularly so for staff working for the first time in a prison because the environment in which health care is provided is very different. Therefore, pharmacy staff new to the prison service or a particular establishment need adequate induction. The Workforce Programme is developing an induction programme for health care professionals and designed to be provided in addition to HMPS core induction which covers issues such as security and fire safety. The programme will be adaptable to different professional groups and will also take into account the needs of visiting and locum staff.

Maintaining competence

- 12.18** Most of the competencies required by prison pharmacists and pharmacy technicians are the same as those working in or for the NHS. However, there are also requirements specific to the custodial environment and the particular health needs of the prison population. This should be reflected in the appraisal and personal development planning process for pharmacy staff. Similarly, appropriate professional input is required to achieve the most from the process. That is not to usurp the role of a line manager from a non-pharmacy background, but rather to recognise the value of professional input in assessing performance, identifying learning needs and providing support and mentorship.
- 12.19** For pharmacy technicians working as part of a team, overseen by a pharmacist, this is likely to already occur. However, most pharmacists employed by the prison service tend to be the sole pharmacist in the department. With the developing partnership with the NHS, this is a role a local senior pharmacist may fulfil.
- 12.20** Although the prison service regards the training and development of staff as a priority, in practice little formal provision has been made available to pharmacy staff, particularly for pharmacy specific training. Furthermore, difficulties in obtaining relief cover, as previously highlighted, very often prevent participation, even when opportunities are given. It is therefore important that personal development plans not only identify the individual's organisational and professional development needs, but also how those needs are to be met. Not only does this need to be realistic, and reflect the range of learning formats available, ie work based and open learning, as well as face to face courses off site, but also commit the necessary resources. This includes securing protected time for such development.
- 12.21** Like other health professions, the professional body for pharmacists, the Royal Pharmaceutical Society of Great Britain, has signalled its commitment to the implementation of mandatory continuing professional development (CPD). By the end of 2002, some 5,000 pharmacists were expected to participate in the scheme voluntarily. The powers to require mandatory participation in CPD will be sought by government in due course as part of the overall modernisation of professional regulation. Like all other pharmacists, those working in the prison service will need to meet the Society's CPD requirements if they are to maintain their registration. There is already an ethical requirement placed on pharmacists to ensure that they undertake CPD. The suggested minimum requirement is 30 hours of CPD in each year.

12.22 We recommend that:

- i. The annual appraisal of pharmacy staff has appropriate professional input;**

- ii. **All pharmacy staff have a personal development plan, which identifies organisational and professional development needs and how those needs are to be met;**
- iii. **All pharmacists are enabled to meet the CPD requirements of the RPSGB, which will become mandatory for continued registration; and**
- iv. **Pharmacists and pharmacy technicians are granted protected time to maintain their existing skills and to develop new ones. This should be included in job descriptions as a matter of course. (Recommendation 27)**

Learning needs assessment and training provision

- 12.23** Whilst pharmacy staff will have many of the necessary skills to support the delivery of the patient-centred services to prisoners proposed, there will be individual and collective learning needs. A formal training and development programme will therefore be required to underpin this change management process.
- 12.24** **We recommend that the Prison Health team, in conjunction with the Head of Prison Health Training, commission an analysis of the learning needs of pharmacy staff to support the delivery of the patient-centred pharmacy service proposed and ensure a training programme to meet the identified needs is provided, using a range of learning methods, including work based learning, as appropriate. (Recommendation 28)**
- 12.25** Much of the learning needs and CPD required by pharmacy staff providing services to prisoners are the same as their NHS colleagues. Within the NHS, there are nationally funded programmes, which are relevant, as well as locally supported training and development commissioned through Workforce Development Confederations. For example, the National Prescribing Centre provides a range of publications and learning events for doctors, pharmacists, nurses and managers to support the clinical and cost effective use of medicines. There is also the Centre for Pharmacy Postgraduate Education, which provides a programme of learning materials, including print-based distance learning, electronic learning and face to face workshops, focused particularly on community pharmacists, but open to all pharmacists providing pharmaceutical services or advice to the NHS.
- 12.26** Whilst prison pharmacy staff access NHS training, it tends to be on an ad hoc basis, often through the goodwill of course providers. There is currently no access as of right.

12.27 Providing access to NHS training will not only help to meet learning needs, but also provide opportunities for staff to discuss issues of common interest, promote better understanding and share best practice.

12.28 We recommend that learning and continuing professional development opportunities available to pharmacy staff working in or for the NHS should, where relevant, be open to staff providing pharmacy services to prisoners, for example programmes run by the Centre for Pharmacy Postgraduate Education and the National Prescribing Centre, as well as local learning opportunities. (Recommendation 29)

Workforce Development Confederations

12.29 Furthermore, as well as gaining access to relevant NHS learning provision, it is important that the workforce, training and development plans of Workforce Development Confederations reflect the needs of staff providing pharmacy services to prisoners. The 24 workforce development confederations bring together NHS and non-NHS employers to plan the whole health care workforce, including medical staff, across wider communities, recognising that the NHS is not the only employer of health care staff – the Prison Service among others also employ such staff²³.

12.30 Workforce Development Confederations are increasingly working in partnership around prison health. The lead WDC for prison health is Kent, Surrey and Sussex and will work to ensure that the current and future needs of staff providing pharmacy services to prisoners are included in all WDC training and development plans, and as part of their overall workforce planning.

Interchange and joint training

12.31 A significant way in which the profile of prison pharmacy can be raised and greater understanding achieved is through the training of future pharmacists and pharmacy technicians. Whilst pre-registration pharmacy trainees often rotate through different areas of pharmacy practice, and indeed in the future will have to have experience of both community and hospital pharmacy, it is rare for them to spend any time in prison health care. Likewise, whilst some pharmacy technicians are trained within the prison service, others employed by the NHS or working in community pharmacy would gain from the experience of providing pharmacy services to prisoners. Such co-operation is likely to facilitate good relationships with the wider NHS and help develop future pharmacy staff with broader knowledge and experience, who could

23 Investment and Reform for NHS Staff – Taking forward the NHS Plan. Department of Health, London, February 2001.

more easily work in prisons in the future and may be more likely to do so. It would also demonstrate that providers of pharmacy services to prisoners are prepared to play their role in supporting the training of future qualified staff.

12.32 Similarly, there is much to be gained from qualified staff experiencing other relevant sectors of practice, both in terms of their own development but also in delivering high quality co-ordinated patient care. Staff providing pharmacy services to prisoners should spend some time in other areas of NHS practice and vice versa. Pharmacy staff could also broaden their experience and underpin collaborative working through spending time with different providers of pharmacy services to prisoners. There are a number of ways of achieving this, including through shadowing, rotation or job swaps.

12.33 We recommend that pharmacy leads should work with NHS and community pharmacy employers to:

- i. Provide some pre-registration pharmacy trainees and student technicians experience of the provision of pharmacy services to prisoners; and
- ii. Make arrangements for the temporary movement of qualified pharmacy staff between prison health care and other areas of NHS practice to gain appropriate wider experience, as well as joint appointments which will facilitate collaborative working. This should include temporary movement and joint appointments between different providers of pharmacy services to prisoners. (Recommendation 30)

Section 13: Summary of Recommendations

A significant number of recommendations have been made within this report as summarised below. We recognise that many of these require major change within the prison service either in terms of actual practice or in the ethos within which health care and pharmacy services are delivered. It is anticipated that the recommendations and associated change would be introduced over a period of time, although some prison establishments may be able to move forward faster than others. Publication of this report is accompanied by a Q&A document, including an action plan indicating, in general terms, how progress should be made.

- R1. We recommend that new pharmacy leadership roles be established on a regional basis to drive forward and support the implementation of this pharmacy strategy locally. (Paragraph 6.5)**
- R2. We recommend that all prisons, in conjunction with their local PCT, are covered by a drug and therapeutics committee or equivalent. This should draw on specialist expertise, and be responsible for the development of evidence-based local formularies, disease management guidelines and medicine-related policies and procedures. (Paragraph 7.14)**
- R3. We recommend, as an urgent priority, the introduction of an IT system delivering the same level of information and support for the prescribing and supply of medicines that is widely available in the NHS (on an individual patient basis and to manage the overall clinical, cost effective, and safe use of medicines locally and nationally). (Paragraph 7.18)**
- R4. We recommend that prison health care staff, including pharmacy staff, be accorded equal access to the prescribing and medicines information available within the wider NHS, such as the British National Formulary (BNF), National Prescribing Centre publications and guidance and guidelines published by the National Institute for Clinical Excellence. (Paragraph 7.20)**

- R5.** We recommend that medicines in use, together with associated monitoring and administration devices, should normally, as a matter of principle, be held in the possession of prisoners. Each prison establishment should have a policy and risk assessment criteria, developed through the Drug and Therapeutics Committee, for determining on an individual basis when medicines and related devices may not to be held in possession of a prisoner. (Paragraph 8.13)
- R6.** We recommend that the length of supply of medicines given in possession should move to be in line with local primary care practice in the NHS. (Paragraph 8.14)
- R7.** We recommend that the drug and therapeutics committee should ensure medicines are generally supplied in patient packs. Non-standard medicines packaging should be phased out. Monitored dosage systems should only be used following an individual patient needs assessment, as in the NHS. (Paragraph 8.18)
- R8.** We recommend that the drug and therapeutics committee should ensure repeat prescribing and dispensing systems are put in place, in line with those in the NHS. These systems should be flexible to allow for the introduction of supplementary prescribing by appropriate health care professionals. (Paragraph 8.26)
- R9.** We recommend that the drug and therapeutics committee ensures there are policies and procedures in place in each establishment for access to self-care, taking into account prisoners' ability to pay for such medication. This should encompass the full range of options normally available in the community, including the opportunity to purchase certain medicines and to seek the advice of a pharmacist or pharmacy technician. (Paragraph 8.31)
- R10.** We recommend that, as in the community, all prisoners should have appropriate access to a pharmacist or pharmacy staff. (Paragraph 8.33)
- R11.** We recommend that sufficient supplies of medicines be issued to prisoners to cover the whole period they are in court or on transfer. Furthermore, prisoners discharged into the community should receive sufficient medicines, usually a month's supply, to enable treatment to be continued until a further supply can be reasonably obtained through a general practitioner. (Paragraph 8.37)

- R12. We recommend that the policy of in possession and risk assessment criteria, developed through the drug and therapeutics committee, should extend to those prisoners attending court or on transfer. (Paragraph 8.40)
- R13. We recommend that the supporting infrastructure, including prescription forms and medicine administration records, are reviewed to reflect the proposed revised medication system. This should include enabling prescriptions for chronic medication to be written for a period of up to one year, with the supply of medicines made on a more frequent basis, underpinned by regular medication review. (Paragraph 8.42)
- R14. We recommend that the pharmacy service should be provided within a framework of proper professional control, so that legal requirements and professional standards are met. (Paragraph 9.4)
- R15. We recommend that the Prison Health team at the Department of Health ensures that when the Health Services for Prisoners Standard is next revised the recommendations in this report, and especially the patient-focused nature of the pharmacy service, are fully reflected. (Paragraph 9.6)
- R16. We recommend that medicines management and pharmacy services for prisoners are fully integrated into local, multidisciplinary arrangements for clinical governance, following existing and future clinical governance guidance and reflecting where appropriate the Department of Health's guidelines on Clinical Governance in Community Pharmacy. (Paragraph 9.14)
- R17. We recommend that systems be developed by the Prison Health team to facilitate the sharing and learning of good practice in medicines management and pharmacy services to prisoners. (Paragraph 9.20)
- R18. We recommend that all prisons should have a local system for reporting and learning from adverse patient incidents, including medication errors. The drug and therapeutics committee should ensure that the forthcoming guidance on reducing medication errors in the NHS is reflected in medicine-related procedures and processes within all prison establishments. In time, health care to prisoners should be covered by the NHS system for reporting and learning from adverse patient incidents, including medication errors, through the National Patient Safety Agency. (Paragraph 9.23)

- R19. We recommend that prisons and PCTs, as lead partners, ensure health needs assessments and action plans cover and inform the future development of pharmacy services to prisoners. (Paragraph 10.3)**
- R20. We recommend that the Prison Health team at the Department of Health should utilise relevant available expertise and experience to develop an outline service specification for a patient-focused pharmacy service, in keeping with the other recommendations in this report. (Paragraph 10.7)**
- R21. We recommend that the cost of medicines, related items and pharmacy services themselves are separately defined and transparent, facilitating appropriate resource allocation, comparison and monitoring, and the assurance of value for money. (Paragraph 10.16)**
- R22. We recommend that existing and future developments in the practice and use of the skills of pharmacy staff be introduced in prisons as for the wider NHS. (Paragraph 12.5)**
- R23. We recommend that local assessments of staffing requirement be undertaken, in terms of skills and grades, to establish an appropriate workforce to deliver the proposed patient-centred pharmacy service. (Paragraph 12.8)**
- R24. We recommend that the full range of pharmacist, medical technical officer (pharmacy technician), assistant technical officer (pharmacy assistant) grades, used in NHS pharmacy services, is available to prisons to enable an appropriate pharmacy workforce to be achieved. (Paragraph 12.9)**
- R25. We recommend the Prison Health team at the Department of Health work to promote pharmacy careers involving the provision of health care to prisoners. (Paragraph 12.13)**
- R26. We recommend that the NHS approach to job evaluation be adopted for pharmacy staff working within prisons, to ensure equality of pay and responsibility, as well as opportunities for career progression. (Paragraph 12.15)**

R27. We recommend that:

- i. The annual appraisal of pharmacy staff has appropriate professional input;**
- ii. All pharmacy staff have a personal development plan, which identifies organisational and professional development needs and how those needs are to be met;**
- iii. All pharmacists are enabled to meet the CPD requirements of the RPSGB, which will become mandatory for continued registration; and**
- iv. Pharmacists and pharmacy technicians are granted protected time to maintain their existing skills and to develop new ones. This should be included in job descriptions as a matter of course. (Paragraph 12.22)**

R28. We recommend that the Prison Health team, in conjunction with the Head of Prison Health Training, commission an analysis of the learning needs of pharmacy staff to support the delivery of the patient-centred pharmacy service proposed and ensure a training programme to meet the identified needs is provided, using a range of learning methods, including work based learning, as appropriate. (Paragraph 12.24)

R29. We recommend that learning and continuing professional development opportunities available to pharmacy staff working in or for the NHS should, where relevant, be open to staff providing pharmacy services to prisoners, for example programmes run by the Centre for Pharmacy Postgraduate Education and the National Prescribing Centre, as well as local learning opportunities. (Paragraph 12.28)

R30. We recommend that pharmacy leads should work with NHS and community pharmacy employers to:

- i. Provide some pre-registration pharmacy trainees and student technicians experience of the provision of pharmacy services to prisoners; and**
- ii. Make arrangements for the temporary movement of qualified pharmacy staff between prison health care and other areas of NHS practice to gain appropriate wider experience, as well as joint appointments which will facilitate collaborative working. This should include temporary movement and joint appointments between different providers of pharmacy services to prisoners. (Paragraph 12.33)**

Annex 1: Methodology

- 1 To deliver this project the following steps were put in place:
- 2 A steering group was formed to support this project. The group was chaired by the Deputy Chief Pharmaceutical Officer, at the Department of Health, and has met nine times. It included:
 - A pharmacist and pharmacy technician working within the prison service
 - Prison Health Medical Director
 - A Prison Lead Nurse/Health care Manager
 - A PCT Pharmacy Advisor
 - A Regional Pharmacy and Prescribing Advisor
 - A member of the Royal Pharmaceutical Society of GB/Prison Inspectorate.
- 3 Three meetings were also convened of a wider reference group, which included representatives with an identified interest in this project. The reference group helped to explore the project's key priorities and reflected on the findings and recommendations.
- 4 The project team held a meeting with representatives of patients, families and friends groups to discuss the aims and projected outcomes of the project as well as giving those represented an opportunity to input into the project. A number of useful points and suggestions were made (see Annex 2), which have been reflected in the report.
- 5 A questionnaire was sent out to 137 establishments in England and Wales to gain more information on how pharmacy services are delivered in prison. 100 prisons responded, providing us with a detailed picture of the diversity and inconsistency in the way pharmacy services to prisoners are provided. The figures appearing in brackets within the report are drawn from the survey results.

Annex 2: Meeting with Representatives of Patients, Families and Friends Groups

The project team held a meeting with representatives of patients, families and friends groups to discuss the aims and projected outcomes of the project as well as giving those represented an opportunity to input into the project. A number of useful points and suggestions for additional issues for the project are summarised below:

- Increasing the use of “in possession” medication was considered desirable but it was considered that certain medications should be excluded because of their toxicity and to avoid increases in undesirable trends (“taxing”, bullying, trading etc).
- Concerned that pharmacy services varied widely between prisons and that services should be standardised across the estate mirroring as far as possible pharmacy services in the community particularly in terms of accessibility and self-care. It was accepted that certain items might be made available for purchase by prisoners (mainly “cosmetic” and “non-essential” items), but given prisoners limited financial resources, all medically “necessary” items, should be provided free.
- It was felt that current systems for the exchange of information between relatives and prisons about the health and care of the prisoners on admission and discharge (and through-care issues) was limited. It was suggested that a leaflet could be provided for those attending court detailing the range of health care services available in prison to give reassurance to prisoners and their families that medical needs will be fulfilled. The leaflet should set out the information Prison health care staff would need in order to maintain levels of care and include a reminder to bring a (limited) supply of medication to court, a list of medications, GP name and address and any other relevant personal medical history information.
- Little provision was made at many establishments for simple health needs of visitors

Annex 3: Study of Prescribing within Prisons

Prescribing data within prison service is not universally available and significantly lags behind the quantity and quality of prescribing data within both primary and secondary care.

Some data has been obtained from five prisons. Within England as a whole each number of the population received eleven prescription items at a cost of £110 per annum²⁴ in the year 2000.

The data provided gives an interesting snap shot into prison prescribing. The following table outlines the average cost per prisoner for prescribed medicines for the year 2000. In some cases data was only available for 3 months and this has been multiplied up. This method will not allow for seasonal variations generally seen in prescribing data but will give an indication of current costs.

Prison	Range of prisoner population	Prison Type	Prescribing costs 2000	Average Annual Cost per prisoner
1	400 – 500	Low security	£38,000	£78
2	300 – 400	High security	£61,196	£167
3	600 – 700	Young offenders & remand	£67,244	£100
4	150 – 250	Local prison – remand	£59,920	£273
5	550 – 650	Training Prison	£53,584	£96

Top drugs by volume:

This section looks at the most frequently prescribed items.

Prison 1: The top 20 for prison 1 (Data only available April – June) shows high use of hay fever treatments with a range of other generally used items such as antidepressants, mild analgesics gastro-intestinal drugs and antibiotics. The profile has marked similarities with drugs commonly used in primary care.

Prison 2: The most frequently prescribed medicines is Aspirin 75mg this probably reflects the age and cardiac risk of the patients. Higher use of antidepressants and anti-psychotic drugs together with over 45,000 doses of mild analgesic combined annually.

²⁴ Statistical Bulletin 2001/19, Department of Health, August 2001).

Prison 3: High use of mild to moderate analgesics is apparent at prison 3 with Dihydrocodeine at the top (20,000/annum) Zopiclone (short acting hypnotic) is their third most frequently prescribed item, these items are a part of the drug detox regime and are not licensed for this use. Prescribing for mental illness, and antibiotics and treatment of skin conditions, such as acne are apparent in the top 20.

Prison 4: The number one item is Zopiclone with almost 2500 prescriptions being written (more than 10 per patient). There is an apparent higher use of medicine to treat mental illness than in other prisons and a notable use of Loperamide (to treat diarrhoea) with almost 200 prescriptions per annum.

Prison 5: High use of mild to moderate analgesics is seen at prison 5 with 92,000 doses/annum, however dihydrocodeine does not appear in top 20 prescribed items. Prescriptions for mental illness are notably less and treatment for constipation (Fybogel) appears in the top 20.

Top drugs by cost:

Drug expenditure by prisons are generally modest. Analysis of the top 20 by cost gives a clear indication of where cost pressures are present. The top 20 by cost accounts for some 25%-50% of the overall medicine budget.

Prison 1: Top items include treatments for gastrointestinal problems such as Omeprazole and Ranitidine, hay fever treatments and Hepatitis B vaccine.

Prison 2: Olanzapine is the top cost item for this prison with Nicotine patches as the second item. The third place item (goserelin implants) is for one patient and illustrates the influence of high cost low volume items on a budget. Unusual items in the top 20 include fentanyl patches for cancer pain and ethinyloestradiol 50mg.

Prison 3: Olanzapine is top item at prison 3 only just more costly than Citalopram for depressive illness. Hepatitis B vaccine appears at No. 5

Prison 4: Top four items are all for mental illness with Olanzapine again at No.1 seven of the top 10 are for mental illness.

Prison 5: Olanzapine appears as the top cost item here also with treatments for gastrointestinal problems running closely behind. Other notable items are treatments for asthma/hayfever and mild analgesics

Discussion

This small survey highlights a range of issues that need to be addressed.

Firstly effective medicines management relies on reliable data. The service needs a firm plan to move from current poor situation in terms of prescribing data to a system where drug use can be analysed at local area and national level.

It is apparent that patterns of prescribing vary greatly from prison to prison and there is scope for exploring the medicine requirements of different types of prison population. Policies for the use of unlicensed medicines and for medicines used outside their license should be considered.

These areas of prescribing highlighted by this work warrants active investigation by clinical pharmacists both to encourage good practice and discourage poor prescribing practice.

The top cost items indicate important trends, which if taken with previous years would help predict likely future spend on high cost items such as Olanzapine. Other high cost items such as Omeprazole may require a different approach such as checking the H.pylori status of prisoners if this has not already been done.

Conclusion

This brief section highlights the importance of good quality aggregated prescribing data. It is recommended that systems are put in place to ensure such data is available for every prison establishment to improve health care, inform clinical governance and demonstrate value for money.

Study undertaken by Phil Wiffen, previously Regional Pharmaceutical Adviser to South-East NHS Regional Office

Annex 4: Pharmacy Project Steering Group Members

Jeannette Howe	Deputy Chief Pharmacist	Department of Health
Dr Cliff Howells	Medical Director	Prison Health
John Reuben	Project Lead	Prison Health
Lyn Wibberley	Senior Policy Officer	Prison Health
Sinead O'Brien	Section Head; Primary Care	Prison Health
Paul Bedwell	Regional Co-ordinator	Prison Health
Alistair Monk	Principal Pharmacist	HMP Durham
Divna Young	Senior Pharmacy Technician	HMP Birmingham
Barry Sidaway	Health Care Manager	HMP Weare
Jill Williams	Professional Standards Inspector	Royal Pharmaceutical Society of Great Britain
Beryl Bevan	Pharmacy Adviser	Ealing, Hammersmith and Hounslow Health Authority
Phil Wiffen	Pharmaceutical and Prescribing Adviser	NHS Executive South Eastern Regional Office

Annex 5: Pharmacy Project Reference Group Members

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Jill Williams	Professional Standards Inspector	Royal Pharmaceutical Society of Great Britain
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Barry Greenbury	Governor	HMP Whatton
Rae Kettle		
John Stanley	Chief Executive	Essex Local Pharmaceutical Committee
Dana Tait	Principal Pharmacist	HMP Cardiff
Eileen Nelson		Royal Pharmaceutical Society of GB
Dr Brendan Carroll	Senior Medical Officer	HMP Armley
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Chris Frost		Lloyds Pharmacy Ltd
Linda Sloan	Principal Pharmacist	HMP Brinsford
Susan Manktelow	Deputy Chief Pharmacist	Kettering NHS Hospital Trust

Steve Churton		The Boots Company PLC
Andy Murdock	Director of Pharmacy and Superintendent Pharmacist	Lloyds Pharmacy Ltd
Elaine Hartley	Professional Services Executive	Moss Pharmacy
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Dr Peter Elton	North West Regional Prison Health Lead	North West Regional Prison Health Task Force
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Mr Lyndon Braddick	Pharmacy Adviser	Scottish Prison Service
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Mr Steve Crago	Principal Pharmacist	HMP Bristol
Mr John Burns	Principal Pharmacist	HMP Risley
Mr Colin Beacock		Royal College of Nursing
Mr Neil Mason		Prison Officers Association
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Lynne Bollington	All Wales Principal Pharmacist	
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