East London
NHS Foundation Trust

Primary Care Services

Repeat Prescribing Policy

Version 1.0

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Name and Job Title of Author	Quynh Nguyen, Lead Pharmacist – Primary Care
Executive Director Lead	Mohit Venkataram
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Contents

Introduction

The purpose of a repeat prescription is to allow patients to receive their medications without the need to attend for a consultation with a prescriber each time. The repeat prescribing process involves the setting up of prescriptions, ordering and producing prescriptions and the review of medication.

Repeat prescribing plays a significant part in the supply of medicines to patients in primary care. Two thirds of prescriptions generated in primary care are for patients needing repeat supplies of regular medicines and these account for nearly 80% of medicines costs in primary care. A well organised and managed repeat prescribing system will save time and energy for prescribers, staff and patients. Other benefits include improved quality of prescribing, improved patient safety and better use of NHS resources.

Any system for issuing repeat prescriptions should take full account of the obligation to prescribe responsibly and safely. The legal responsibility for prescribing lies with the prescriber who signs the prescription and is the same whether it is a first or repeat prescription. The person who signs the prescription will be held accountable should something go wrong. Therefore before authorising a repeat prescription the prescriber must be satisfied that it is safe and appropriate to do so and that secure procedures are in place to ensure patients are issued with the correct medication, each prescription is regularly reviewed and not issued if no longer required.

Purpose

The purpose of this policy is to set out the process for prescribing medications on a repeat basis.

- To standardise repeat prescribing processes and protocols within the Primary Care Directorate
- To enable staff to understand their roles and responsibilities around repeat prescribing
- To provide guidance on good repeat prescribing process and procedures
- To ensure safeguards are in place to minimise error and reduce risk

The policy includes all activity within the ELFT GP surgeries by all staff involved in the repeat prescribing process both clinical and non-clinical.

The policy will be reviewed and updated annually by the directorate. All relevant staff (including doctors, nurses, receptionists, prescription clerks, clinical pharmacists, pharmacy technicians, practice managers and independent prescribers) will be involved the review of this policy.

This policy should be read in conjunction with:

- Medication Monitoring in Primary Care Policy
- Prescription Security Protocol
- Non-medical prescribing Policy
- Medicines Policy

General Prescribing Guidance

All prescribers are to follow the information and guidance provided in the British National Formulary (BNF), whilst also taking into consideration the guidance published by NICE (England) and local prescribing guidelines (BLMK for Bedfordshire practices, and NEL for London Practices).

If prescribers have any uncertainty regarding strength, dosage, interactions or other elements of prescribing, they are to seek the appropriate guidance from suitably experienced colleagues, a pharmacist or a prescribing adviser.

Recording prescriptions

All prescriptions whether (acute or repeat) are issued and printed electronically using the practice clinical system (that is SystmOne for the Bedfordshire practices or EMIS for the London practices). This information is retained in the patient's electronic healthcare record and ensures that all staff involved in the care of the patient are aware of current medications and are able to avoid prescribing any medication that may be contraindicated.

Handwritten prescriptions are not routinely used unless circumstances dictate otherwise, for example in case of power failure, home visits, or other noteworthy events.

Handwritten prescriptions must be entered onto the patient's electronic healthcare record at the earliest opportunity to reduce inadvertent duplication of prescribing, to reduce the possibility of unintentional drug interactions and to provide an adequate audit trail.

Any alterations to a patient's condition or medication, outside of a practice consultation, (e.g. home visit), must be updated in the patient's medical record at the earliest opportunity by the doctor.

When recording the prescription on the practice clinical system, the prescriber will ensure that the prescribed medication is recorded as acute or repeat.

1. Authorisation Process

Initiating Repeat Prescriptions

When initiating a new medication, the prescriber must be satisfied that drug treatment is appropriate and necessary. This should usually be added to the patients' electronic healthcare record as an acute item. The prescriber should consider an initial prescription for up to 4 weeks in case the medicine does not suit the patient.

The patient should be given an explanation of what is being prescribed and why, how the medicine is to be administered, and whether the drug is an addition or replacement for current medication. If the medicine is being used 'off-label' or is an unlicensed drug the patient should be informed of this and documented in electronic healthcare record.

Patient sensitivities, allergies and significant interactions should be considered. Drug allergy status should be recorded as drug allergy, other allergy or none known. If a drug allergy is recorded; information should be included about the drug involved, type of reaction including severity and when the reaction occurred.

Common adverse effects of the medication should be discussed; consider if the patient might be concerned by the manufacturer's patient information leaflet. The patient should be advised on what actions should be taken if problems arise.

Authorisation to repeat

The decision to transfer a drug from an acute prescription to a repeat prescription must always be made by a **prescriber.** The patient should be reviewed at least once before granting a prescription repeat status.

The new treatment should be reviewed after 1-2 months, where the prescriber should take into consideration whether the treatment:

- Has been effective
- Is well tolerated
- Is required long term

The patient should be consulted with to ascertain the above and to check compliance. It is the duty of the prescriber at this stage to ensure that the patient understands the repeat prescribing process and what is required of them.

When a medication is first added to a repeat prescription, it should be noted clearly why it was started in the first place. The medicine prescribed should be linked to a medical condition (READ/SNOMED code) within the patient's electronic healthcare record and where necessary flagged for appropriate monitoring including blood tests.

The prescriber will also determine the number of repeat authorisations before a review is required; this may be dependent on the clinical needs of the patient; the frequency of monitoring required for that medication, the clinical stability of the patient, or any other relevant clinical factors.

For example, a patient on a high risk medicine (see medication monitoring in primary care policy) who requires blood tests every 3 months should have their repeats authorised for no more than that time. This will prevent the patient from ordering more medications without having the required monitoring carried out. A patient who is clinically stable and requires no further monitoring, may have their repeats authorised for 6 or 12 months. The prescriber should consider the patient's need and use their clinical judgement to determine most appropriate timeframe.

When authorising/re-authorising repeat prescriptions, the prescriber should note in the patient's health record what is required by the next re-authorisation; this will provide a clear plan for the next clinician to aid carrying this through.

Care should be taken to ensure the repeat record is accurate, quantities for each drug are synchronised (to reduce waste medicines), and the appropriate review dates are entered.

Items not suitable for repeat

Most prescription items will be suitable for repeat status, but there are certain medicines which are not routinely appropriate. These include: antibiotics/antifungals, hypnotics and anxiolytics, potent topical corticosteroids and dressings. A list of medicines that should remain as “acute“ can be found in appendix 1.

If a request is received for a drug that is not authorised as a **repeat** item, a prescription must **not** be generated. The request should be referred to a doctor, nurse or clinical pharmacist as a medication query via task on SystmOne or EMIS. This is to ensure an audit trail and items are followed-up.

Number of Days Supply

The majority of prescriptions should be for **28** days’ supply. The prescriber can use their discretion to allow up to **84** days’ supply if deemed appropriate, this might include patients who are on stable long term medication. (Exceptions to this include HRT and oral contraceptives which may be prescribed for up to 3-6 months). Prescribers should ensure that the issue duration is correct and that all items are synchronised to run out at the same time.

The supply of schedule 2 and 3 controlled drugs (CDs) should be limited to a maximum of 28 days.

Prescriptions for durations of seven days should only be issued to patients where there is a clinical need for this, for example if there is risk of abuse, or the patient would struggle to manage larger quantities. This is also applicable to those patients who have medicines dispensed in a compliance aid (dosette box), where it is inappropriate for the patient to receive more than one compliance aid at a time for clinical reasons.

If seven day prescriptions are considered appropriate, the reason for this should be documented in the patient’s medical record. Ensure that items not supplied in the compliance aid, such as inhalers, are only issued as often as needed and not on a weekly basis. For most patients with a compliance aid (dosette box) 28 day (i.e. 4 x 7 days) prescriptions are appropriate.

Dosage instructions

All new drugs added to the patient’s electronic healthcare record must have clear dosage instructions, which includes liquid feeds, creams, nasal sprays and other external products. 'As directed' is not sufficient information to ensure the patient uses their medicines appropriately. This is particularly important for patients whose medicines are being administered by a carer or relative. Exceptions to specific directions may include dressings, test strips, and appliances.

Some prescription items may require some more detail for example:

- Steroid creams - apply sparingly once a day
- Warfarin - take as directed in yellow book

- Sildenafil - do not take more than one dose in 24 hours
- Drops for ear, eyes and nose - instil (number of) drops (number of) times a day to the
- ……. state right/left/both eye, ear or nose. Always add the dose given in the ophthalmologists' letter for eye drops.

Recommended drug choices and generic prescribing

In general medicines should be prescribed using the generic name as specified in the BNF. Choice of medicines should be in accordance with national guidelines as well as locally agreed by the local joint formulary.

Exceptions to generic prescribing are:

- Drugs specified in the BNF as unsuitable for generic prescribing, or highlighted by the clinical system
- Where branded prescribing has been recommended locally to optimise cost savings
- Where there is a high risk of introducing dispensing errors by prescribing the generic name, the prescriber may use their judgement and/or seek advice from the local prescribing advisors

2. Requesting Process

Requesting a repeat prescription

Where a patient is capable of ordering their own medication, they should be encouraged to do so as much as possible.

Patients should be advised to speak to a clinician if they have concerns about taking any of their medicines, or if they do not take them as prescribed. This will allow the repeat prescribing system to be updated to accurately reflect the medicines the patient is taking.

Requests for repeat prescriptions can be made by the following personnel:

- Patient
- Carer
- District and specialist nurses
- Community pharmacist offering managed repeat ordering service (MROS)
- Care home staff
- Dispensing appliance contractor

Where a third party requests, practice staff must ensure:

- Patient confidentiality is maintained
- The correct information is accurately exchanged, when those making the request are not fully aware of the patient's medications / health condition
- The request is genuine. The practice should be confident that the person making the request has the patients' permission to do so.

Requests can be received by the following routes:

- Counterfoil (issued with prescription)
- Online via SystmOne online or Patient Access (web-based or app), or via the surgery website
- Email
- Post
- Telephone (vulnerable patients only)

Written and online requests are preferable because they are more likely to be accurate, and there is a reduced opportunity for errors and misunderstandings. Telephone requests may only be taken by the prescription clerks who have access to the patient's repeat medicines list while taking the call.

For requests via email, post and telephone, the patient must provide the following information:

- Patient's name
- Date of birth or address
- Details of the medication required including name, strength and dosing information

Prescription boxes are located in each practice for patients to post their written requests. The boxes will be checked daily. Requests by other routes will be received throughout normal practice hours.

Repeat prescription requests should be sent to the practice no earlier than 7 days in advance of supply being due except in exceptional circumstances e.g. patient is going on holiday (see section on prescription requests for travel). An explanation of the early supply should be documented in the patient's medical record.

Period of notice

Patients should allow at least 3 working days' notice for repeat prescriptions to be processed by the surgery. Where it has been requested that the prescription is sent to the patient by post, the turnaround time should be one week.

Patients must be advised that requests for "all repeats" or requests with insufficient information are likely to result in a delay in the process. In such instances, staff will need to contact the patient to discuss their exact requirements.

Urgent medication requests

All urgent repeat prescription requests for items normally on repeat will aim to be processed within 24 hours (i.e. either on the same day or by the following day after receiving the request). The urgent request should be raised as an urgent task on SystmOne or EMIS.

Medications that would usually be considered as part of an urgent request are:

- Insulins
- Inhalers for respiratory conditions
- Medicines for pain
- Medicines for epilepsy
- Antidepressants
- Anticoagulants
- Antipsychotics

- Adrenaline
- GTN spray

Please note this list is not exhaustive and each urgent request should be considered on a case-by-case basis.

For patients who repeatedly request urgent repeats, the practice manager is to be informed.

Urgent requests which are for items not normally on repeat should be referred to a prescriber (usually the clinical pharmacist or doctor) as a medication query via task on SystmOne or EMIS.

3. Processing Repeat Prescriptions

Processing repeat requests

All staff involved in the repeat prescribing process should be suitably trained and understand their roles and responsibilities and the processes to be followed.

Only prescribers can sign prescriptions.

Non-clinical staff must have specific training to be authorised to **generate** repeat prescriptions (see section on Training)

A counterfoil must be generated with every paper repeat prescription. Counterfoils will be printed by the community pharmacy for electronic prescriptions.

Prescriptions should not be "directed" to any particular pharmacy or appliance contractor. Where repeat prescription collection services are in place, the pharmacy or appliance contractor used should be chosen by the patient. Practice staff should not influence the choice of pharmacy for prescriptions to be sent to.

Generating a Repeat Prescription

The staff member should confirm the patient's details to ensure they access the correct patient record.

The repeat prescription can be generated if it complies with the following rules:

- The item is not on the list of medicines not suitable for repeats
- The item requested has repeat status
- The form, strength and dosage instruction of the item is the same as on the repeat screen
- The item has current authorisations available (as indicated by the review date)
- The item is not being ordered earlier or later than expected unless there is a valid reason, as this may indicate over or under usage and requires review as the patient may not using the medication as intended

- The item has been ordered within the last 6 months, exceptions to this include as required medicines or medicines which are used seasonally
- The patient's medication review is not overdue (if a review is required, the patient should be advised to make this appointment and attend before any further scripts are generated)

If the medicine requested is a controlled drug, the member of staff may generate a repeat prescription if all the rules apply. In addition, they must also ensure a query note is added to the prescription to alert the prescriber that there is a controlled drug that requires clinical oversight before it is signed.

All requests that do not fulfil the rules outlined above or requests where there is any doubt as to whether a repeat prescription is appropriate must be referred to a prescriber as a medication query. The referral should be actioned as a task on SystmOne or EMIS in order to maintain an audit trail and ensure these items are followed-up.

When the quantity of repeat medicines has been changed the clinical pharmacist or doctor should be alerted.

Although the member of staff generating the repeat prescription is responsible for making sure these checks are made, ultimately the responsibility for the prescription itself lies with the prescriber that signs it.

Signing Repeat Prescriptions

Repeat prescriptions should only be signed by a prescriber who has direct access to the patient's clinical records at the time of signing the prescription.

The doctor is responsible for signing repeat prescriptions, and must have an allocated time set aside each day for signing / reviewing repeat prescriptions.

Non-medical prescribers may sign repeat prescriptions within their scope of practice.

Before signing the repeat prescription, the prescriber should be satisfied:

- The item is still needed
- The item is effective (look for objective evidence)
- The patient is concordant and able to take the medication i.e. (inhaler)
- The patient is not experiencing problems with adverse effects
- Any interactions with other medication have been considered and reviewed
- The patient's condition is still stable enough to warrant a repeat prescription without further examination or assessment

The prescriber should check the following:

- Drug name, strength, form and dose
- Indication for each drug
- Whether appropriate monitoring has been undertaken, and if an adjustment to medication is required in response to results of monitoring
- Date of next review

Requests for 'High Risk' Drugs

High risk drugs include those that have a narrow therapeutic index, require unusual dosing or closer monitoring, for example under a Shared Care Agreement. Please refer to the "Medicines Monitoring in Primary Care Policy" for further information on managing repeat prescriptions for this group of medicines.

4. Patient receives prescription

Collection and Management of Prescriptions

Electronic prescriptions (via EPS) are the preferred method for transmitting prescriptions from the GP surgery to the community pharmacy, and the majority of prescriptions will be handled this way.

Prescriptions that have been signed electronically are sent directly to the patient's nominated pharmacy via EPS (see section below on EPS) so no prescription collection is necessary. The patients will collect the dispensed medication from the pharmacy.

Handling of Paper Prescriptions

There will be some exceptions to electronic prescriptions, for example if a medicine is not able to be sent electronically (non-ETP compliant medications), or private prescriptions.

Paper prescriptions that have been signed are to be left with reception for collection by the patient or patient's representative.

Paper prescriptions can be collected by the patient or the patient's representative at reception, or via the community pharmacy offering repeat collection service.

In certain circumstances, paper prescriptions may be posted to the patient. This must be by **recorded delivery**. The need for prescriptions to be posted should be exceptional rather than routine practice and will need to be considered on a case-by-case basis.

The signed prescription should be stored in a secure, supervised place, out of reach of the public, as it contains confidential information about the patient.

The patient's name, address, and date of birth should be checked with the person collecting the repeat prescription to confirm the identity of the patient.

Controlled Drug prescriptions should be signed for when collected. This will facilitate any investigation should a problem or dispute arise.

Any prescriptions being collected by an outside agency i.e. a community pharmacy, will have been agreed with the patient and recorded in their medical notes. This should be checked if the receptionist is not aware of such an arrangement.

Children under 16 are not permitted to collect prescriptions unless a prior written agreement has been arranged between the parents or guardians of the patient and the practice manager/prescriber.

Uncollected Prescriptions

Prescriptions not collected 4 weeks after issue should be highlighted to the prescriber. They should be shredded, and the issue should be deleted from the issue record in the patient's medical notes. The READ/SNOMED code "prescription not collected" should be added to the patient's record.

The prescription collection "box" should be regularly cleared of uncollected prescriptions and occasional audits performed to determine the reason for non-collection.

5. Medication Reviews

Reauthorisation of Repeats and Medication Review

Re-authorisation is a good opportunity to assess whether the patient is taking the medication in line with the directions, to align quantities so they all run out at the same time and to assess whether the patient benefits from repeat dispensing.

Clinical responsibility for re-authorisation

Only clinical practice staff (that is a doctor, nurse, pharmacist or pharmacy technician) can add medications, or make changes to a patient's repeat medication template in the context of transcribing (with the exception of appliances). This ensures that the correct item is chosen from the picking list and that there is clinical input to the process.

Transcribing is defined as the act of making an exact copy, usually in writing of previously prescribed medicine details to enable their administration. For example transcribing medications from a discharge summary or hospital clinic letter onto the clinical system.

Only a qualified prescriber can authorise repeats, and indicate the number of repeats allowed.

Where possible the medication review should be aligned to the patient's birth month. A review date for reauthorisation is used (rather than number of issues). This allows one review date for all items and avoids different medicines having to be issued at different times.

Non-prescribing clinical staff who are clinical pharmacists or pharmacy technicians may re-authorise prescriptions depending on their level of competence and as agreed with their line manager and lead GP. The staff member must have access to a prescriber, and a route for escalation for queries.

Clinical staff who are non-prescribers may extend repeat medications for a **maximum** of 1 issue; this is solely for the purpose of allowing the patient to continue their medications without treatment break whilst they await a review appointment with a qualified prescriber. At this stage, the patient must have an appointment booked, and must be notified their medication supply has been extended for this purpose. This should be documented in the patient's medical notes. Medications excluded from this extension are controlled drugs and any medicines defined as high risk (see High Risk Drugs Monitoring Policy).

Patient must be informed that their medication cannot be extended further beyond this point until they have had their review.

Non-clinical staff must not re-authorise prescriptions; in the event that a medication has been requested by the patient and requires re-authorisation before it can be re-issued, then this must be referred to a prescriber via a task on the clinical system.

Medication Review

The review period for repeat medication rests with the prescriber, however medication reviews should be carried out **at least annually.**

The objective of a medication review is to optimise the use of medicines, reduce wastage and ultimately reach an agreement with the patient about what is required for their continued care. The review process maintains collaboration between the prescriber and the patient, allowing the patient to obtain further prescriptions for medicines at agreed intervals.

Medication reviews can be conducted by doctors, nurses, pharmacists and pharmacy technicians.

Annual Review

A full medication review must be carried out once a year. Medications reviews must take place **with the patient** and can be by face to face, telephone or video consultation.

More frequent follow up medication reviews can be undertaken on high-risk patients. This is dependent on the condition being treated as well as the stability of the patient.

Patients can request a medication review at any time however the surgery will aim to align the annual review with the patient's birth month. Patients will be contacted by SMS or letter to book their review appointment.
Reviews may also be done opportunistically for example if the patient is nearly due a review and it is convenient for this to be done if the patient is already visiting the surgery.

The individual undertaking the review must ensure:

- The prescribed medication is appropriate for the patient's needs

- The medication continues to be effective
- All monitoring and chronic disease reviews have been completed
- The patient remains compliant
- The review date is amended

The following are examples of what a patient's medication review may include:

- Health assessments such as BP, respiratory and pulse check, BMI etc
- Review of routine blood test results and any necessary intervention afterwards such as medication changes or lifestyle interventions
- Check patient's understanding of their medication (knowledge of dose, frequency and any other issues relating to administration)
- Any side effects, interactions or problems with taking the drugs
- Other non-prescription drugs being taken
- Any general queries they may have about their medication
- What quantity of each drug do they currently hold
- Patient's understanding of the repeat prescribing system
- Option to go on the repeat dispensing system
- Any other issues they currently have

Following the review, the action taken and any changes to the prescription are recorded in the patient's electronic healthcare record.

Depending on the patient, the condition being managed and the stability of the condition, an option of 6 monthly repeats will be offered to the patient. The maximum number of repeats that can be authorised is 12 months.

Medication review of patient's medical notes

Some patients may have review of their medication RECORDS after their repeats have expired following their full annual medication review.

Review of the notes is to be undertaken by either the clinical pharmacist or a doctor (preferably a clinician who regularly treats the patient) and must be coded as ***"Medication review of medical notes***".

Below are the requirements for this form of review to occur:

- The patient's condition and medication(s) must be stable after the full annual review.
- The patient only requires basic monitoring such as a BP, or simple blood test and pass the results to a clinician as part of the review

Depending on the results of the review, the prescriber will:

- Re-authorise the prescription for further repeats and record in the patient's notes that the prescription has been re-authorised
- Request that the patient attend a consultation if further intervention is required.

All GP Practices within the directorate will also have a recall system in place to ensure that patients who do not order their repeat medications are contacted and a review is arranged. This information is recorded in the patient's electronic healthcare record.

Structured Medication Review (SMR)

A Structured Medication Review (SMR) is a critical examination of all a person's medicines with the objective of reaching an agreement with the person about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste.

SMR differs from medication review in that they are much more comprehensive, and take into consideration all aspects of the patient's health. The clinician and the patient work as equal partners to understand and balance the benefits and risks and alternatives of taking medicines. The shared decision making conversation being led by the patients individual needs, preferences and circumstance.

SMRs can be undertaken by doctors, nurses and clinical pharmacists only.

There are groups of patients who will be identified to benefit from having an SMR. These groups include:

- Adults, children and young people taking multiple medicines (polypharmacy)
- Adults, children and young people with chronic or long-term conditions
- Older people with frailty
- Patients in care homes

When conducting an SMR the following are considered:

- Aim - What matters to the patient?
- Need - Identify essential drug therapy.
- Need - Is the patient taking unnecessary drug therapy?
- Effectiveness - Are therapeutic objectives being achieved?
- Safety - Is the patient at risk of ADRs or suffers actual ADRs?
- Efficiency - Is drug therapy cost-effective?
- Patient-Centred - Is the patient willing and able to take drug therapy as intended?

When undertaking medication review and SMR, opportunities for de-prescribing should also be considered. (De-prescribing is the process of tapering, stopping, discontinuing or withdrawing drugs, with the goal of managing polypharmacy and improving outcomes).

Medication reviews and mental capacity

Under the NHS constitution, patients have the right to be involved in discussions and decisions about their health and care, and to be given information to allow them to do this. This includes decisions about their medicines.

Consideration should be given to potential barriers to patients being able to take an active role in their medication review and management of their medicines. These include mental health problems, lack of (mental) capacity to make decisions, health problems (such as problems with vision and hearing) and difficulties with reading or speaking. Some illnesses can restrict the capacity of patients to be involved in a medication review and a patient's capacity to be involved in decisions about their medicine may vary over time.

Consideration should be given to adjusting the timing of a review to occur when the patient has the capacity to be involved, and potentially allowing time for them to recover from any acute illness before conducting the review.

If appropriate, family members and carers could be involved in the decision-making process. The views of the patient about who should and should not be involved in their care are important and should be respected. If the patient lacks the capacity to decide who should and should not be involved, health and social care practitioners must act in the patient's best interests, taking account of the provisions in the Mental Capacity Act 2005.

Patients who fail to attend for review

For patients who fail to attend for their medication reviews, every attempts should be made to contact the patient to determine the reason for their non-attendance, and re-arrange the review.

Several different means of contacting the patient should be tried. The approach will vary depending on the patient, but possible options include:

- Checking if the patient is still a member of the practice (they may have moved)
- Checking if the patient has been admitted to hospital
- Letter explaining the GPs obligation to ensure the welfare of the patient
- Phone call
- Visit to home
- Reducing the quantity of repeat medication issued (harder for inhalers). (It is difficult to stop a patient's medication altogether because this would effectively be withholding medication knowing that the patient may suffer harm as a result)
- Text message
- Using practice extended hours to offer appointments.
- Email
- Checking whether the patient has recently been reviewed by another health professional / organisation e.g. secondary care / mental health team etc
- Checking that it is appropriate to contact the patient using one of the methods above. It may be that the patient's carer should be contacted
- Checking that the patient is still resident at the registered address; it may be that the patient has moved, and the practice has not been notified, for example, students and patients living abroad for the winter months
- For patients that have co-morbidities, trying to co-ordinate reviews so that the attendances at the practice are reduced

All attempts to contact the patient or carer must be documented in the medical notes.

Non-compliance with medication monitoring

When a patient is identified as being overdue a blood test, it must be first established if they have already had their monitoring done elsewhere.

If no records of monitoring can be established the following actions should be taken depending which medications are involved:

High risk medications

- The patient should be contacted and informed that their monitoring is overdue and to arrange an appointment. The amount of medications supplied on should be reduced to 2 weeks.
- If after 2 weeks, the patient still has not attended for their monitoring, the supply should be reduced to 1 week.
- If the patient continues to be non-compliant with the monitoring, the patient must be discussed with the lead GP for the practice to establish an individualised strategy for the patient.

Other medications requiring monitoring

- The patient should be contacted and informed that their monitoring is overdue and to arrange an appointment. The amount of medications supplied on should 4 weeks.
- If patient fails to attend more than twice for their monitoring, the supply should be reduced to 2 weeks.
- If after this time the patient continues not to attend, the supply should be reduced to 1 week.
- If the patient continues to be non-compliant with the monitoring, the patient must be discussed with the lead GP for the practice to establish an individualised strategy for the patient.

For further details please see the “medicines monitoring in primary care policy”.

Medicines Reconciliation of Hospital Discharge / Outpatient attendance

Patients who have been discharged from hospital or seen in outpatients often have their medication changed. This can potentially lead to serious problems if the patient is not reviewed and followed up appropriately.

The discharge summaries and hospital letter must be reviewed and actioned by a clinical pharmacist, pharmacy technician or doctor **in conjunction** with details of the patient’s current medication. The patient’s electronic healthcare records must be updated accordingly.

Hospital communications should be made available in the practice computer system as soon as possible after receipt, and raised as a task or scanned document.

The staff member conducting the review will ensure:

- The letter has been reviewed and decided on an appropriate action (clinical review and medicines reconciliation)
- Where appropriate, a follow-up appointment has been made
- It has been verified that the patient has enough medication
- It has been determined if there is any need for an acute prescription
- The patient’s review date has been appropriately updated

If a patient requests a supply of medication before the hospital communication has been received, a copy must be requested from the hospital. The urgency placed upon this request should be guided by the duration of the patient's remaining supply and clinical need. If there is a risk that the correspondence will not be received in time, this should be referred to a doctor for review.

The staff member conducting the review or medicines reconciliation must update the patient's electronic healthcare records and complete the task by filing the hospital communication. The medicines reconciliation READ/SNOMED code should also be added to the consultation record or journal. Checks should include:

- Duplication of same drug or same drug class
- Duplication of drug by brand and generic name
- Delete medications that has been discontinued
- Appropriate dose and dosage form
- Appropriate quantity

6. Prescription Management Systems

Electronic Prescription Service (EPS)

The Electronic Prescription Service (EPS) enables prescriptions to be sent to pharmacies or appliance contractors from GP surgeries electronically, making the prescribing and dispensing process more efficient for staff and patients alike. EPS is the preferred method for transmitting prescriptions for the GP surgeries within the directorate.

Patients are able to choose the pharmacy where they would like their prescription to be sent; this is referred to as "nomination" and can be set, changed or cancelled as required.

Repeat Dispensing

Repeat Dispensing is the process by which patients can obtain supplies of their repeat medicines over a defined period of time without the need to contact their practice each time a new supply is required. The service should be provided via electronic Repeat Dispensing (e-RD).

Any patient with a long-term condition that is considered likely to remain stable for the duration of the Repeat Dispensing could be suitable for the service.

This includes but is not limited to:

- Patients on single stable therapy such as levothyroxine
- Patients with stable long term conditions
- Patients on multiple therapy such as hypertension, diabetes, asthma
- Patients who can appropriately self-manage seasonal conditions

Repeat supplies are managed by the patient's nominated pharmacy. There are a number of differences and added benefits between the repeat dispensing model and traditional repeat prescribing processes, including:

For the GP and practice:

- reduction in workload issuing and re–authorising repeat prescriptions
- reduced medicines waste
- earlier detection of medicines–related problems

For the patient:

- improved access to regular medicines
- simplified one–stop process for obtaining next supply of medicines
- regular contact with pharmacist to discuss medicines–related issues
- pharmaceutical support for self–care and the management of long–term conditions

Electronic Repeat Dispensing (e-RD)

Two-thirds of prescriptions issued in primary care are repeat prescriptions. These repeat prescriptions account for nearly 80% of NHS medicine costs for primary care.

410 million repeat prescriptions are generated every year - equivalent to an average of more than 375 per GP per week.

It is estimated that up to 330 million, or 80%, of all repeat prescriptions could eventually be replaced with e-RD, this could save 2.7 million hours of GP and practice time.

Electronic repeat dispensing is an integral part of EPS, which offers many extra benefits over paper repeat dispensing and repeat prescribing:

- It provides an efficient way to supply patients with repeat medication without the GP needing to sign repeat prescriptions each time.
- It allows the prescriber to authorise and issue a batch of repeat prescriptions at the patient's nominated pharmacy, at a specified interval until the patient needs to be reviewed. This has significant benefits to practices and patients as a time saving measure.
- The prescriber can cancel the prescription or prescription items at any time and the prescriber will know whether the prescription is 'with dispenser' or 'dispensed to patient'
- There is a full end to end audit trail from prescribing to dispensing to the patient
- e-RD provides a contemporaneous, medico legal record including the reason for prescription (item) cancellation
- Automatic cancellation of all outstanding prescriptions will occur when the Personal Demographics Service is updated with notification of death, preventing carers being notified of, or given prescription items for deceased individuals
- Patients can change their dispenser nomination at any point during the duration; subsequent issues will be available to the newly nominated dispensing site.
- Prescriptions can be tracked using the EPS tracker.

Where patients are have been identified as suitable for repeat dispensing, directorate encourages the use of e-RD as much as possible.

e-RD requires the patient to consent to the introduction of two-way sharing of their information between the dispensing and prescribing site. The patient should be asked to consent but written consent is not required.

A patient must have their dispensing site nomination recorded for any prescription to be sent electronically.

Reduce Prescribing of Over-The-Counter (OTC) items

The directorate aims to reduce prescribing of Over-The-Counter (OTC) items that are used to treat minor illnesses that are often self-limiting and may be treated through self-care. Such medicines should not be prescribed on repeat prescriptions.

These prescriptions include items for a condition:

- That is considered to be **self-limiting** and so does not need treatment as it will heal of its own accord;
- Which lends itself to **self-care**, i.e., that the person suffering does not normally need to seek medical care but may decide to seek help with symptom relief from a local pharmacy and use an over-the-counter medicine.

This advice does not apply to:

- people with long-term or more complex conditions who will continue to get their usual prescriptions.
- patients where the clinician considers that their ability to self-care is compromised as a consequence of medical, mental health or significant social vulnerability; these patients will continue to receive prescriptions for over-the-counter items subject to the item being clinically effective.

People who receive free prescriptions will not automatically be exempt from the guidance.

Private prescriptions

Practices are able to consider converting a previously private prescription request into an NHS prescription under certain conditions including:

- The private consultant has written to the practice confirming this request
- Confirmation that the medication requested has been stabilised and likely be required on a longer term /chronic basis
- The medication requested is available under NHS prescribing regulations and meet national or local guidelines of appropriateness and suitability
- The prescriber feels able to accept the clinical and governance responsibility for issuing the prescription

Practices will not convert private prescriptions to NHS prescriptions for acute requests or a first prescription where correspondence has not yet been received by the consultant. In these instances, the patient should be informed that they need to obtain the medications privately.

Prescription requests for Travel

Patients may request repeat medications to take with them if they are going away on holiday. Most repeat prescriptions should cover holiday periods but if a repeat is required during the trip, the practice may be able to give and early repeat (usually 1 month **and no more than 3 month's** supply).

Providing a prescription for longer than the patient's usual supply is at the prescriber's discretion. Where medications require frequent monitoring (for example blood tests, blood pressure etc), it may not be possible or appropriate to prescribe for extended periods, so the prescriber will need to make a clinical judgement.

If the patient is travelling abroad for less than 3 months, the practice will be able to provide enough medications to cover the duration of the journey. Patients returning from being abroad for less than 3 months will continue to be entitled to receive NHS treatment as before their trip.

If travelling abroad for more than 3 months, the practice will only provide the regular repeat prescription of a sufficient quantity (maximum 3 months) in order to get to the destination. The patient should be advised to register with a local doctor at the destination for continuing medication. It would be prudent for the patient to check with the manufacturer that medicines required are available in the country they are moving to / staying in.

Patients returning permanently from being abroad for more than 3 months may need to show that they are 'ordinarily resident' in the UK to receive NHS treatment, including their repeat prescriptions.

7. Safe Practice

Information for Patients

Patients should have access to written instructions on how to order repeat prescriptions on the practice website, as well as Patient Access, the NHS website and the NHS App.

Make sure patients are aware of:

- The procedure for ordering repeat prescriptions
- The time it takes to turn them around (including arrangements for weekends, bank holidays etc.)
- When they will be ready for collection
- Letting the practice know if they have stopped taking anything on the prescription
- Asking the doctor, nurse or pharmacist if they are unsure about any of their medicine
- A practice repeat prescribing leaflet should be available, located at the point where repeat prescriptions are collected

- The message section of the counterfoil should be used to inform the patient of the repeat prescribing policy.

Prescription security

A prescription form should be considered an asset that has a financial value; it is in effect a blank check open to potential misuse. The theft of prescription forms and their resulting fraudulent misuse, potentially involving third parties, is a serious concern.

Blank prescriptions must never be signed by a prescriber for later completion by practice staff. Unused space should be cancelled out under the last drug by a computerised mechanism or by the prescriber deleting the space manually.

MISSING PRESCRIPTIONS

The use of electronic prescriptions is preferred to minimise the risk of missing prescriptions.

Repeat prescriptions that have been reported as lost or missing should not automatically be reproduced. The loss is to be reported immediately to the prescriber who signed that prescription.

If unable to locate, the practice manager must be informed for investigation to ensure that the reported loss is genuine and not an attempt to commit prescription fraud.

The practice manager will record the following details in the patient's electronic healthcare record:

- Date and time of loss (if known)
- Date and time the incident was reported
- Location or locations where the loss may have occurred

If the lost prescription was for a controlled drug, the Trust Controlled Drugs Accountable Officer (CDAO) is to be informed and extra security precautions taken, such as ensuring that the local pharmacies are made aware of this, thereby preventing the lost prescription from being used.

A risk assessment should be undertaken prior to replacing the prescription; the lost prescription should be deleted from the patient's electronic prescription record with an explanatory note, and a new prescription printed. If there is a problem with an electronic prescription print a token, do not generate a new prescription.

All prescription losses must be reported on Datix.

Refer to 'Prescription Security Protocol' which covers the safe and secure storage and handling of prescriptions.

Prevention of misuse

Regular reviews will help to prevent the misuse of repeat prescriptions and patients need to be monitored to ensure that repeat requests are appropriate. Any requests deemed to be either over or underused will be referred to the doctor or clinical pharmacist.

Staff should be aware of the following non-specific signs that may indicate misuse:

- Taking higher doses than prescribed or running out of prescribed medication before expected
- Continually "losing" medication so more prescriptions have to be written
- Seeking prescriptions from more than one healthcare professional, e.g., doctor, nurse, non-medical prescriber or from more than one practice
- Requesting a specific drug claiming that other medications "don't work" or that he/she is allergic to them
- Stealing, forging or diverting prescriptions
- Appearing to be intoxicated, sedated or experiencing withdrawal
- Excessive mood swings or hostility
- Increase or decrease in sleep
- Evidence of craving or other signs of dependence

Staff may also bring to the attention of the prescriber any concerns or uncertainties they have about a patient and their repeat prescription.

Clinical staff must also be aware of the specific signs that may indicate misuse of certain drugs such as opioids, hypnotics, anxiolytics and stimulants.

Patient safety incidents

GP practices should report all patient safety incidents identified relating to prescribing and the practice repeat prescribing system onto Datix.

The report will be sent to all the relevant parties within the primary care directorate, including the practice manager, lead GP, and lead pharmacist. The incidents will be shared at the directorate Quality and Improvement Group (QAG) for shared learning.

Non-medical prescribing

A range of non-medical healthcare professionals can prescribe medicines for patients as either independent or supplementary prescribers.

Independent prescribers are practitioners responsible and accountable for the assessment of patients with previously undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.

Supplementary prescribing is a partnership between an independent prescriber (a doctor or a dentist) and a supplementary prescriber to implement an agreed Clinical Management Plan for an individual patient with that patient's agreement.

A range of non-medical healthcare professionals are permitted to prescribe medicines for patients as an independent or supplementary prescriber. In general practice, most NMPs are pharmacists or nurses, but they could also be paramedics or physiotherapists.

Non-medical prescribers can:

- Give patients quicker, more efficient access to medicines
- Make best use of healthcare professionals' skills
- Help address demand and workforce issues

The NMP must work within their own level of professional competence and expertise.

It is the responsibility of the primary care directorate to ensure that independent prescribers working in our GP surgeries have the necessary skills and knowledge to carry out the role.

All non-medical prescribers must take individual responsibility for their prescribing decisions, and they must prescribe within their clinical competence.

The Clinical Negligence Scheme for General Practice in England and Wales covers everyone providing NHS services for general practice and includes NMPs although this does not cover non-NHS work. It does not provide legal representation for inquests and disciplinary investigations.

Please see the Trust 'Non-Medical Prescribing Policy' for further information

Roles and Responsibilities

Each member of staff involved in the repeat prescribing process has an important part to play, and everyone has a responsibility to following practice policy and protocols for repeat prescribing.

There may be overlap in responsibilities between groups of staff. The following defines the roles and responsibilities of staff within this process.

In practices where prescription clerks are not employed, specific members of the reception team may undertake the prescription clerk role:

Doctor

- Responsible for overall clinical control and accountability
- Signing prescriptions, ensuring all legal requirements for prescription writing are met
- When signing prescriptions:
    - Ensuring an appropriate drug is chosen (in line with any clinical guidelines, local formulary
    - The drug is written generically (or branded where appropriate)
    - Checking possible interactions with other medications are taken into account
    - Appropriate quantities are prescribed
    - The most appropriate strength is prescribed (dose optimisation)
    - Clear instructions are given on the prescription
- Deciding when medicine is to be transferred to repeat status. When undertaking this task:
    - Ensuring a suitable number of authorisations are set before a review is needed
    - Not granting repeat status to medicines that are suitable for acute prescribing only
    - Where possible the amount given is synchronised with other medicines on repeat
    - Allowing the patients have the opportunity to discuss the likelihood of benefit & risks of harm of the therapy
- Re-authorising repeat medicines when appropriate to do. When undertaking this task:

    - Ensuring medication is still effective and required
    - All monitoring and chronic disease reviews have been completed
- Routine signing of repeat prescriptions
- Perform an annual full clinical medication review, follow-up reviews and SMRs
- Act on any tasks/referrals from clinical or non-clinical staff relating to medication queries – for example when a patient under or over-ordering of prescriptions
- Responsible for updating records from hospital correspondence; additions, deletions and other changes to prescriptions
- Report and investigate medication related safety incidents
- Be a point for escalation for clinical referrals that cannot be dealt with by other members of staff – for example when prescribing in outside the scope of competence of a non-medical prescriber

Clinical Pharmacist (also see below for non-medical prescriber)

- Supporting the doctor workload in:
    - Performing annual full clinical medication review, follow-up reviews and SMRs
    - Acting on any tasks/referrals from clinical or non-clinical staff relating to medication queries – for example when a patient under or over-ordering of prescriptions
- Re-authorising repeat medicines when appropriate to do. When undertaking this task:
    - Ensuring medication is still effective and required
    - All monitoring and chronic disease reviews have been completed
- Responsible for updating records from hospital correspondence; additions, deletions and other changes to prescriptions
- Allowing the patients have the opportunity to discuss the likelihood of benefit & risks of harm of the therapy
- Report and investigate medication related safety incidents
- Be a point for escalation for medication queries that cannot be dealt with by other members of staff

Pharmacy Technician

- Supporting the doctor and pharmacist workload in:
    - Performing annual full clinical medication review, and follow-up reviews
    - Acting on any tasks/referrals from clinical or non-clinical staff relating to medication queries – for example when a patient under or over-ordering of prescriptions
- Re-authorising repeat medicines (within their competence) when appropriate to do. When undertaking this task:
    - Ensuring medication is still effective and required
    - All monitoring and chronic disease reviews have been completed
- Responsible for updating records from hospital correspondence; additions, deletions and other changes to prescriptions
- Allowing the patients have the opportunity to discuss the likelihood of benefit & risks of harm of the therapy
- Report medication related safety incidents

Non-medical prescriber

- Supporting the doctor workload in prescribing for clinical conditions within their scope of practice
- Responsible for clinical control and accountability for the prescriptions they sign
- Signing prescriptions, ensuring all legal requirements for prescription writing are met

- When signing prescriptions:
    - Ensuring an appropriate drug is chosen (in line with any clinical guidelines, local formulary
    - The drug is written generically (or branded where appropriate)
    - Checking possible interactions with other medications are taken into account
    - Appropriate quantities are prescribed
    - The most appropriate strength is prescribed (dose optimisation)
    - Clear instructions are given on the prescription
- Deciding when medicine is to be transferred to repeat status. When undertaking this task:
    - Ensuring a suitable number of authorisations are set before a review is needed
    - Not granting repeat status to medicines that are suitable for acute prescribing only
    - Where possible the amount given is synchronised with other medicines on repeat
    - Allowing the patients have the opportunity to discuss the likelihood of benefit & risks of harm of the therapy
- Re-authorising repeat medicines when appropriate to do. When undertaking this task:
    - Ensuring medication is still effective and required
    - All monitoring and chronic disease reviews have been completed
- Perform an annual full clinical medication review, follow-up reviews and SMRs
- Act on any tasks/referrals from clinical or non-clinical staff relating to medication queries – for example when a patient under or over-ordering of prescriptions
- Clinical pharmacist NMP are responsible for updating records from hospital correspondence; additions, deletions and other changes to prescriptions
- Report and investigate medication related safety incidents

Prescription Clerks

- Day to day running of the repeat prescribing process

Ordering Repeats:

- Checking prescriptions box for repeat requests
- To ensure that the patient has clearly indicated what items they need. Where possible when this has not been done the patient or their representative should be contacted to confirm, rather than just providing all the items
- Only select the items the patients has requested
- To discourage patients from over ordering or hoarding medicines
- Taking requests over the telephone if required

Generating Repeats:

- Staff are responsible for making sure this is completed in a safe manner with attention to detail and must refer on any queries which they are unable or unauthorised to handle
- The last issue should always be checked before another issues is made to check for under or over ordering
- Staff must check the correct prescription reaches the correct patient by checking their name and address

Referring Problems/Potential Changes:

- Generic and inappropriate generic prescribing

- Prescriptions with no directions or as directed with no specific instructions (excludes variable dose medications e.g. Warfarin, Insulin)
- Items which are not normally allowed on long term repeat as agreed in the practice policy
- To make sure all requests for repeats are appropriate
- To consider/recommend synchronisation where appropriate in order to reduce waste
- Prescription queries raised by the community pharmacy

Review & Re-authorisation:

- Re-enforcing with the patient the need to attend regular reviews
- Flagging up certain issues and mentioned above and addressing them

Reception staff

- Referring:
    - All prescription request queries to the prescription clerk team
    - Medication related queries to the clinical pharmacist or technician
- Handling patient collections of their paper prescriptions
    - Storing signed paper prescriptions in a secure place
    - Confirming the identity of the patient with the person collecting the prescription
    - Ensuring Controlled Drug prescriptions are signed for when collected
    - Checking the prescription collection box for prescriptions that have not been collected for 4 weeks and flagging this to the doctor or clinical pharmacist

Practice Manager

- Overall management control of repeat prescribing system
- Overseeing training of practice staff
- Ensuring security and storage of prescription forms

Training

Any members of staff involved in any element of repeat prescribing process must read and acknowledge the repeat prescribing policy. It will be included in the induction programme for new staff, locums and doctors.

All staff involved in the production of repeat prescriptions must have access to and are able to use the most recent version of the British National Formulary.

All non-clinical staff involved in repeat prescribing must undertake the Prescqipp e-learning course 'Practice Medicines Coordinator training'. New staff should also shadow a trained member of staff for at least one month, or until senior staff feel they are competent.

Practice staff involved in the preparation of repeat prescriptions should be appropriately trained in the practice protocols for repeat prescribing, including their responsibilities, accuracy and when to refer the request for a repeat prescription to a GP.

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Appendix 1

Medicines Not Suitable for Repeat Prescribing

Potential medicines for consideration on the list:

- Antibiotics / antifungals / antivirals
- Medications used for rescue therapy e.g. steroids or antibiotics
- Medicines with special monitoring needs unless there is clear monitoring protocol (i.e. under shared care guidelines)
- Hospital only medicines such as oral chemotherapy e.g. cyclophosphamide chlorambucil etc and specialist drugs e.g. retinoids, clozapine
- Potent topical corticosteroids
- Varenicline / buproprion and nicotine replacement therapy
- Antipsychotics in the elderly
- Hypnotics e.g. zopiclone, temazepam and other benzodiazepines
- Pseudoephedrine
- Medicines subject to misuse e.g. strong opioids
- Medicines that are available through self-care e.g. paracetamol for acute pain, cough syrups, hayfever remedies, emollients, eye drops for mild dry eyes
- Dressings