Halton Clinical Commissioning Group

NHS Halton CCG
Repeat Prescribing and Ordering Guidance

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INTRODUCTION

This guidance provides good practice standards to facilitate GP practices to deliver safe and efficient management of repeat medication for their patients.

The aim of this guidance is to provide practices with a description of best practice and to highlight areas of risk. This document can be used in local discussions and development of robust repeat prescribing protocols to ensure repeat prescription requests are dealt with efficiently and safely.

Prescribing is the most common patient-level intervention and it is the second highest area of spending in the NHS, after staffing costs[1]

Repeat prescriptions represent approximately 60-75% of all prescriptions written by GPs and approximately 80% of primary care prescribing costs.[2]

The General Medical Council (GMC) advises that it is the prescriber who is responsible for the prescriptions they sign, including repeat prescriptions for medicines initiated by colleagues, so they must make sure that any repeat prescription is safe and appropriate.[3]

The Care Quality Commission (CQC) requires safe management of medicines (Outcome 9). A summary of the standards is available[4].

It is essential that practices have a repeat prescribing system underpinned by a robust policy to ensure repeat prescription requests are dealt with efficiently and safely.

A robust repeat prescribing system offers many benefits[5]:

Benefits to patients and carers:

- Convenient and easy access to the medication.
- Clear understanding and appreciation of the process. Knowing when and how to request the repeat, and knowing when, and from where, it can be collected.
- Confidence that they are receiving the most appropriate medicines, tailored to their individual needs, provided through a system that conforms to good practice.
- Understanding of exactly how to take or administer medications as a result of receiving complete prescriptions with full instructions.
- An understanding of the importance and the process by which they have the opportunity to discuss their medication with a health care professional.
- Reduced potential for adverse incidents and adverse effects (through regular review).

Benefits to practices:

- Earlier recognition of problems, reducing the risk of patient harm and for potential complaints and litigation. Demonstrating that there is a properly organised system for issuing and monitoring repeat prescriptions may help to defend the prescriber from criticism, or worse, if there is an adverse event.
- More manageable workload resulting from improved efficiency.
- Fewer queries to practice staff, reduced ‘traffic’ at the reception counter and enhanced reputation of the practice.
- Appropriate and efficient use of professional and practice staff time and skills.
- Greater understanding of the process by everyone involved, including roles, responsibilities and timelines.
- Improved co-operation and working relationships with other health care professionals, such as nonmedical prescribers, nurses and community pharmacists.
- Easier implementation of new initiatives that will further reduce work burden and improve quality of care, e.g. electronic prescribing, repeat dispensing.

Benefits to the NHS:

- Assurance that medicines are used in a safe, effective and appropriate manner.
- Efficient use, with reduced waste, of resources available to the NHS.
- Appropriate use of individuals’ particular skills and knowledge, and a broadening of responsibilities.
- Reduced potential for ‘near misses’ and adverse incidents. Facilitated shared learning across the NHS to help prevent them occurring again.

Index

Standards for Repeat Prescribing and Ordering in GP Practices

These standards reflect best practice and will be aspirational in some cases.

Standard	Description	See page
1	Only prescribers should authorise repeat status. If delegated to other members of staff this should be covered by an agreement and attached to the practice's Repeat Prescribing Policy.	**8**
2	All drugs must have appropriate directions.	**10**
3	Most repeat prescriptions should be written for a maximum of 28 days' supply to minimise the potential for waste.	**8**
4	Drugs for each patient should be synchronised where possible i.e. they should all last the same length of time.	**10**
5	Variable repeats should be used for items that are needed repeatedly but not regularly e.g. salbutamol inhalers.	**10**
6	Medication changes indicated on discharge and outpatient letters should only be entered onto the system by the prescriber or other authorised person directly specified and documented by practice.	**11**
7	'Hospital Only' drugs should be entered on the practice system in the recommended way to enable prescriber awareness of any interactions with other drugs they may prescribe.	**11**
8	The prescriber should update the patient's electronic medical records with an account of any consultations outside of the practice e.g. home visits. Handwritten prescriptions should be added to the current medication screen	**11**
9	Repeat prescription requests are taken using the computer-generated counterfoil, via the Patient On-line Access webpage/app or other practice approved method.Telephone requests should not generally be accepted.	**12**
10	Repeat Prescription requests should not be accepted from 3rd parties on behalf of patients unless patient is Read coded as 'pharmacy managed repeat prescription patient', 'uses dispensed monitored dosage system' or has appliances supplied by a DAC	**13**

11	Only individual items that are ticked on the counterfoil should be issued. It must not be assumed patient needs all the items.	**12**
12	Practices should have a system to inform patients how to order repeat prescriptions that emphasises that patients take responsibility for ordering their own repeats whenever possible.	**13**
13	Practices should have a system to Read code patients on blister packs, in care homes or deemed 'vulnerable' and requiring pharmacy managed ordering.	**13**
14	There should be a practice protocol for the safe management of controlled drugs.	**14**
15	Practices should complete repeat prescription requests within 48 working hours.	**15**
16	Practices should have a clear protocol for processing repeat prescriptions and audit this annually.	**15**
17	Repeat prescriptions should be processed away from interruptions, by designated staffs, who have received appropriate training.	**15**
18	Practices should have a procedure in place so that the prescriber is informed when the medication review or monitoring requirements are overdue and no further repeats authorised.	**18**
19	Repeat prescription requests should be monitored for over/ under use of medication and should be highlighted to the prescriber.	**16**
20	Practices must have a procedure in place to ensure the necessary monitoring has been done and assessed before a prescription is issued for high risk drugs.	**16**
21	All prescriptions that need re-authorising need to be passed to the prescriber. There should be a system in place to ensure this is done when the last available repeat is issued.	**17**
22	All people prescribed repeat medication should receive an annual medication review. Some patients may require medication review more frequently based on clinical considerations.	**17**
23	A clear procedure should be in place to allow for the safe handing over of the correct prescription to the correct patient or representative. A clear audit trail should be in place for all CD prescriptions and should be audited annually.	**18**

REPEAT PRESCRIBING IN GP PRACTICES

1. INITIATING REPEAT PRESCRIPTIONS

1.1 Authorisation of repeats

- Repeat medications should only be set up once the patient is stable on a medication and efficacy and tolerability has been confirmed.

- Ideally only a prescriber can authorise repeat status. If setting up a repeat is delegated to other members of staff this should be covered by agreements specific to that practice and should be attached to the practice's Repeat Prescribing Policy.

- Some medication is not suitable for repeat prescribing (see Appendix 1)

1.2 Recommended formulary choices and generic prescribing

- Prescribers should follow formulary choices recommended by the Pan Mersey Area Prescribing Committee (APC) and approved by the CCG to improve prescribing quality, safety and cost effectiveness www.panmerseyapc.nhs.uk

- If the drug dictionary allows, items prescribed should be written by generic name. Exceptions to this are:

    - Drugs specified in the BNF as unsuitable for generic prescribing, highlighted by clinical system or OptimiseRx.
      A list of medication to be considered for brand-name prescribing has been produced by UK Medicines Information:
      https://www.sps.nhs.uk/articles/which-medicines-should-be-considered-for-brand-name-prescribing-in-primary-care/
    - Where a patient has proven documented intolerance to a generic form of a drug, the brand may be prescribed and should not be switched.
    - Where branded prescribing has been recommended locally to optimise cost savings i.e. branded generics.
    - Where there is a high risk of introducing dispensing errors by prescribing by the generic name, the prescriber may use their judgement, advice from the Medicines Management Team or national safety recommendations to prescribe by brand.

1.3 Number of days' supply

- Most repeat prescriptions should be written for a maximum of 28 days' supply because this repeat prescribing interval is recognised as being the best possible balance between patient convenience, good medical practice and minimal drug wastage. The number of units in total can be specified or the number of days' supply.

- GP practices that decide against adopting the default 28 day recommendation should still reduce intervals for individual patients where risks are apparent, or treatment is frequently changing and medicines waste is more likely.

- Situations where intervals of 28 days or fewer are highly recommended:

    - Drugs liable to abuse or diversion
    - Situations where risks are perceived e.g., regarding storage in the home
    - Vulnerable patients prescribed complex regimens or with frequent hospital admissions and changeable therapy.
    - Terminally ill patients receiving palliative care support
    - Sip feeds
    - Dressings for short-term use or where likely to change
    - High cost medication
    - When necessary medication
    - All patients in nursing and residential care homes
    - Patients using monitored dosage systems
    - Patients on medication that requires monthly monitoring of either effectiveness or safety
    - Medications that are recommended for short term use only, e.g. hypnotics
    - Appliances
    - Newly prescribed medication when a shorter period is appropriate to assess response / titrate dosages etc.
    - Patients utilising electronic repeat dispensing.

- Situations where intervals of more than 28 days are suitable:

    - Oral contraceptives and HRT (supplied in 3 month packs)
    - Special packs
    - Where 28 days is not equivalent to the number of doses in a special pack i.e. a 200 doses inhaler as “1 OP” (original pack)

    The patients’ other medication should still be issued at 28 day intervals where possible.

- Patients requesting medicines for longer periods than usual to take abroad should be advised that no more than 3 months is allowable, and that this may not be appropriate clinically in all cases. Further detail is provided in the Pan Mersey policy on prescribing for patients travelling abroad: http://www.panmerseyapc.nhs.uk/guidelines/documents/G4.pdf

- Acute prescriptions should be used for the first prescription until treatment stabilised, particularly for drugs with a high incidence of adverse effects.

- On rare occasions, prescriptions for 7 days may be more suitable where risks are perceived or medication is frequently changing. Community pharmacies only require weekly prescriptions if the prescriber decides weekly dispensing is appropriate, and pharmacies must not issue more than one week at a time.

Where the pharmacy is supplying medication in monitored dosage systems, 7 day prescriptions are not required unless the prescriber intends these to be dispensed and issued to the patient at 7 day intervals.

- The Misuse of Drugs Regulations makes a strong recommendation that 30 day intervals should be implemented for all schedule 2, 3 and 4 controlled drugs. A shorter interval may also be appropriate.

- A one-off synchronisation prescription is recommended where regular, stable items run out at varying times during the month. The time invested to synchronise medication will reduce wasted medication and staff time in dealing with the same patient several times a month.

- Where practice clinical systems have facilities for variable repeats, these should be used for items that are needed repeatedly but not regularly (e.g. salbutamol inhalers, analgesics for occasional painful conditions).

1.4 Dosage instructions

- All new drugs added to the computer system must include clear dosage instructions. This includes liquid feeds, creams, dressings, nasal sprays, drops and all other external products. An absence of dosage instructions or "as directed" is not sufficient information for patients to use items appropriately and leads to problems for carers and care homes.

- Exceptions to specific directions may include gluten free foods, and drugs requiring regular dose adjustments, particularly warfarin. For these the use of standard wording is advised.

1.5 The number of repeats to authorise

- The number of repeats authorised or the next regime review date set is a clinical decision and an important part of the repeat prescribing process. Repeat medications should only be set up once the patient is stable on a medication and compliance, monitoring requirements and chronic disease reviews should be taken into account.

- The number of days' supply should be set on the clinical system where possible, as this enables monitoring of early requests and over-use.

- Items not suitable for long-term use should only be authorised on repeat for short periods e.g. steroid creams. Procedures must be in place to ensure that excessive prescribing does not occur.

1.6 Authorising repeats for new patients

- There should be a system to ensure that information on previous medication is obtained before the first prescription is issued e.g., asking the patient for a current counterfoil from the previous GP, contacting the previous practice for clarification, inviting the patient for a consultation. It is often more appropriate to initially issue an acute prescription.

1.7 Medication initiated by hospitals and other agencies

- There should be a system for dealing with requests to start medication from other agencies e.g. hospital discharge notifications, outpatient appointments.

- All such notifications should be reviewed by a prescriber who has access to the clinical record, before adding to the clinical system. Management systems should be in place to ensure these are dealt with efficiently and consistently and involve a prescriber. The prescriber should also ensure that any discontinued medication is removed from the screen and the reason documented in the patients notes. There is a significant risk of errors occurring if this guidance is not followed.

- Responsibility for prescribing in some cases should remain with secondary care. Refer to Pan Mersey formulary and guidance (http://www.panmerseyapc.nhs.uk/) for the RAG status as well as Optimise Rx messages to identify where prescribing should remain with secondary care or responsibility should be shared.

- If prescribing is to remain with secondary care, details of these 'Hospital Only' drugs should still be included on the practice system to enable prescriber awareness of any interactions with other drugs they may prescribe. Guidance is available on how this can be recorded in the clinical system at http://www.haltonccg.nhs.uk/members-practices/Prescribing%20Guidance/Hospital%20only%20drug%20recording%20guidance.pdf#search=hospital%20only

1.8 Consultations outside the practice and handwritten prescriptions

The prescriber should update the patient's electronic medical records with an account of the home/care home visit in the same way as if the patient had been seen in a consultation at the practice. If available remote access should be used to ensure that the prescriber has full access to patient details and items can be added to the system.

- If a handwritten prescriptiont is issued the medication should be added as an "acute" item and filed as a "hand written" prescription. Systems should be in place to ensure transfer to repeat if necessary. Any doses changed or medication discontinued should be added to the record.

1.9 Delegated authorisation

- Exceptions to prescriber authorisation must be by agreement within the practice and be supported by a written policy.

- With prior written agreement by a prescriber, Medicines Management pharmacists and pharmacy technicians may add or discontinue medication; amend dosage instructions and quantities; re-authorise medication; and set review dates and monitoring requirements.

- Supplementary prescribers may prescribe and authorise under an agreed clinical management plan.

- Prescribers may prescribe within their area of expertise and competence. Prescribers with expertise in specialist areas who are prescribing for patients who have other chronic disease states outside of their expertise are not authorised to prescribe for those conditions.

2. ORDERING REPEAT PRESCRIPTIONS

2.1 Repeats ordered by the patient

- Patients should order medication via the Patient Access webpage or mobile App or directly with the practices using the counterfoil or other practice approved method where individual items **MUST** be ticked. It must **not** be assumed that the patient needs all items. Where ordering is unclear, the patient must be contacted and the request remains unprocessed until this is clarified.

- When counterfoils are handed over in person there is an opportunity to discuss what medicines are required. This should be utilised to reduce waste and identify any patient concerns.

- Where requests are not handed over in person these should be collected in a locked box in reception, sent by post or ordered online. Methods should be agreed by individual practices and included in their patient information. **Telephone requests should not be accepted except for specific individual patients and this must be documented in the patient's notes.**

- Patients should be advised to order 7-10 days before running out of medication to leave enough time for surgery and pharmacy to process prescriptions.

- The practice must ensure that any patient sensitive data is protected.

- Patients should be encouraged to order their own repeat prescriptions in line with NHS Halton CCG guidance on patient-led repeat prescription ordering systems. However, practices should agree with pharmacies any support arrangements for patients who are unable to manage their own repeat prescriptions, which may include repeat dispensing and/or pharmacy managed repeat systems.

- Practices should have a system to inform patients how to order repeat prescriptions. This is usually done by issuing a practice information leaflet and via their website. Further information reminders may be given by use of posters in the waiting room, electronic message boards, texts and recorded messages on the answer machine/telephone. Arrangements should be made for patients with additional needs to be supported to understand and use the system.

- Although this should not be publicised surgeries should have a policy in place for dealing with urgent requests. If a patient consistently requests medication late, it should be brought to the Practice Manager's attention. The practice must not direct patients to the community pharmacy to obtain an emergency supply, as the pharmacist may legally refuse to supply.

- Practices should have systems in place to record supplies of repeat medication issued by community pharmacies providing the National Urgent Medication Supply Advanced Service (NUMSAS).

2.2 Pharmacy involvement in repeat ordering and collection

- From November 2017 NHS Halton CCG GP practices no longer accept repeat prescription ordered via third parties e.g. pharmacies behalf of patients except for:

    - Patients identified by the practice as unable to order using existing practice methods, identified by Read code 66RD 'Pharmacy managed repeat prescription patient'

    - Patients currently having their medication in blisters. Identified by Read code 8BIA0 – Uses dispensed monitored dosage system

    See Appendix 3 for a list of useful Read codes.

- GPs and practices must not direct patients to a particular pharmacy.

- In line with NPSA guidance, for medicines requiring closer monitoring, e.g., warfarin, methotrexate, lithium, ideally either a copy of the patient's record book or a copy of the latest results should be attached to the counterfoil or other method specified by the practice.

2.3 Dispensing Appliance Contractor (DAC) request

- For the purpose of this guidance a DAC is defined as a dispenser other than a pharmacy. This is often either an appliance manufacturer or a manufacturer of supplementary feeds.

- The patient should order the items they require in the same way as medicines, but it is advisable to allow more than 48 hours as the prescription usually needs to be posted to the contractor.

- Prescriptions for appliances or enteral feeds should always be on a separate prescription.

- Retrospective prescriptions should not be issued. Requests for new items from suppliers should be referred to the prescriber for a decision and confirmed by the specialist clinician involved in the patient's care.

2.4 Requests for controlled drugs (CDs)

- There should be a practice protocol for safe management of CDs.

- Careful consideration should be given before adding controlled drug to the repeat list.

- Prescribers can issue computer generated prescriptions for all controlled drugs. All details except the signature can be computer generated.

- Currently controlled drug prescriptions in schedule 2 and 3 cannot be sent via EPS and practices need to have procedures in place to ensure EPS patients receive their CD hard copy prescriptions.

- Prescriptions for schedule 2, 3 and 4 controlled drugs are only valid for 28 days. Quantities should not exceed 30 days' supply and a shorter interval may be more appropriate. It is recommended that quantities are kept to 28 rather than 30 for regular items to help keep in line with other items on repeat.

- A clear audit trail should be in place for the safe handing over of all CD prescriptions to the correct patient or representative and this should be audited annually.

- It is recommended that CD prescriptions are **not** posted and alternative arrangements are made to ensure the patient receives the medication. This can include arrangements with the patient's local pharmacy service.

2.5 Requests from nursing and residential care homes

- Patients in care homes should be identified by Read code 13FX – Lives in care home

- Nursing and residential care homes should request their regular medication every 28 days using the B-side/repeat slip "Medication Administration Record" (MAR) sheet or a form that has been agreed between the GP practice and the care home.

- Care home providers must retain responsibility for ordering medicines from the GP practice and must not delegate this task to the supplying pharmacy.

- Twenty-eight days' supply ONLY should be given. Any requests for increased quantities should be referred to the prescriber.

- Where possible repeat medicines should be synchronised to ensure that medicines are not missed or ordered mid-month. For medicines started during the cycle this may require a single synchronising form.

- Items required that month should be clearly indicated by the care home and only those should be processed. If over-ordering is suspected, the prescriber should be alerted.

- Requests for dressings should be for current wound care that has been authorised by the prescriber and documented on the patient's records. These do not usually require repeat prescriptions. Practices should enforce arrangements so homes have to order dressings on the dedicated form, as this requires a reason for non-formulary choices and highlights this to the prescriber to check.

- Prescriptions produced by the surgery must be checked against the prescription request, by the care home, before it is sent to the community pharmacy to ensure there are no discrepancies. If the prescription is sent via EPS to the pharmacy there needs to be a process to manage this, either the practice provides copies of the prescriptions or the pharmacy prints off the dispensing tokens for the care home to check.

3. GENERATING A REPEAT PRESCRIPTION

3.1 Period of notice

- Practices should normally complete repeat prescription requests within 48 working hours. In a normal week, a prescription ordered on a Friday will be ready on a Tuesday.

- Patients and community pharmacists should be informed of the notice needed when ordering prescriptions and when the prescription will be ready for collection. This can be via the practice information leaflet, information on the website or via a reminder notice close to the prescription request box.

3.2 Processing repeat requests

- All repeat prescriptions must be computer generated by designated staff who have received training on the processes.

- Practices should have a clear protocol for processing repeat prescriptions and review this annually as minimum, to ensure there are no gaps between protocol and operating practice. The practice protocol should ensure that:

    - Repeat prescriptions are processed away from interruptions; no other duties should be performed whilst repeat prescriptions are processed.

    - Request slips should be marked with the date processing started

- The drug name, form, strength and dosage instructions should be checked, in order to highlight any discrepancies between the request and the repeat medication list to the prescriber.

- Staff are clear about how to handle queries and documenting the query and outcome in the patient record, including requests for drugs not on repeat or re-issues from past drugs. There should be an audit trail of any communications regarding the request and therefore the clinical system functionality should be utilised to do this electronically. The Medicines Management Team can provide advice on this.

- When the medication review or monitoring requirements are overdue or there are no further repeats authorised, the prescriber should always be informed.

- Early or late requests may indicate over or under use of medication and this should be highlighted to the prescriber. Under use needs to be assessed with regard to risk of endangering the patient or others e.g., antipsychotics, asthma preventer inhalers. Over use is just as important clinically, e.g., for medication with addictive potential, or from a wasted medicines perspective. If early requests are processed, the reason should be documented in the notes.

- Items are discontinued that have not been ordered for over 6 or 12 months. Exceptions are medication required infrequently or seasonally, such as GTN spray, glucose oral gel, and hay fever medication. These items should be considered for addition to the variable repeats section on the EMIS system.

- There is a clear policy for dealing with private prescriptions to ensure these are not issued as an NHS item.

- There is a clear system for forwarding to the prescriber for signing. When the original prescriber is away there should be a system to identify who is responsible for signing and access to the clinical record is essential.

3.3 Requests for "High Risk" Drugs.

- "High risk drugs" include those that are toxic and require unusual dosing and those that require monitoring under a shared care agreement. Practices must have a procedure in place to ensure necessary monitoring has been done and is recorded on EMIS before a prescription is issued. Examples of high risk drugs are: Methotrexate, Warfarin, Lithium, DMARDs, insulin.

4. RE-AUTHORISATION OF REPEATS AND MEDICATION REVIEW

4.1 Clinical responsibility for re-authorisation

- Only the prescriber can re-authorise repeats when the number of authorised issues has been reached or the regime review date is due. When a repeat is re-authorised it is the prescriber's responsibility to ensure ongoing need, repeat prescribing remains appropriate and necessary monitoring and medication review have been carried out. This is an essential part of the repeat prescribing system.

- All prescriptions that need re-authorising need to be passed to the prescriber. There should be a system in place to ensure this is done when the last available repeat is issued.

- Post-dating prescriptions is not recommended, as on some systems this will cancel reauthorisations, affects the audit trail and cannot be cancelled until the authorisation date.

- Re-authorisation is a good opportunity to align quantities so they all run out at the same time. This will avoid medicines waste and wasted staff time if multiple prescriptions are ordered each month for different items.

- Re-authorisation is a good opportunity to assess if the patient may benefit from repeat dispensing.

4.2 Medication review

- The benefits of medication review are well documented and contribute to improving health outcomes, reducing medicines-related admissions and reducing waste.

- Medication review is an integral clinical component of the repeat prescribing system. One of the functions of medication review is to confirm that it is appropriate to continue to issue repeat prescriptions as written without further clinical intervention.

- All people prescribed repeat medication should receive an annual medication review. Some people may require medication review more frequently based on clinical considerations. The review date must be apparent on the counterfoil.

- It is important that practice staff members dealing with repeat prescriptions know when and how to refer patients to prescribers for medication review.

- Practices will receive reports of Medicine Use Reviews (MUR) conducted by Community Pharmacists. This involves a concordance review with the patient and the clinical record is not reviewed. This is not a full medication review. Read code: 8BMF MUR

- A system should be in place to recall patients for medication review and monitoring and include details of the system if patients DNA the medication review request.

5. COLLECTION AND MANAGEMENT OF PRESCRIPTIONS

5.1 Issue of prescriptions

- The issue of completed prescriptions to either the patient or the patient's representative can be by collection at reception, by post, via community pharmacy.

5.2 Collection

- A clear timetable of when prescriptions will be ready for collection should be on display to the patients.

- A clear procedure should be in place to allow for the safe handing over of the correct prescription to the correct patient. Reception staff should check the identity and address of the patient collecting the prescription. If a patient's relative or friend can demonstrate proof they are collecting a prescription and the person is unknown to the reception staff, they should be required to sign for the prescription.

- Measures to determine the identity of a representative collecting a prescription are particularly important in the case of controlled drug prescriptions, and these must be signed for.

- Collection of prescriptions by children will be at the discretion of the Practice Manager or prescriber, and will need the permission of the parent or guardian or the person for whom the prescription is being collected.

- There are a small number of patients who must collect their own prescriptions personally. These patients must have a screen message displayed on their computer record. This message should be clearly marked on the request form and transferred to the issued prescription. Staff should ensure that these prescriptions are given to no one other than the patient.

5.3 Faxing Prescriptions

- Prescriptions may be faxed to community pharmacies but ONLY in exceptional circumstances. A log should always be maintained of when and where the fax was sent and when the prescription was collected.

- Prescriptions faxed at the request of the prescriber must be given to the community pharmacy within a reasonable time. It is the responsibility of the GP practice to phone the pharmacy to let them know a prescription is being faxed.

- If a request for a prescription to be faxed is made by the community pharmacy it is their responsibility to collect the original prescription later.

- A fax does not constitute a legal prescription.

5.4 Prescriptions to be posted (Management and control of Prescription Forms – NHS Counter Fraud March 2018)

- The preferred and safest options for patients to obtain a signed prescription form from their prescriber are either face to face during the consultation or collected on their behalf by a named representative at their nominated pharmacy.

- In **exceptional circumstances** when these options are unsuitable for a patient a practice may choose to post prescription forms to patients at their home address however there is a risk that the signed prescription may not reach the patient.

- The risks of posting prescriptions are greater if the prescription is for a CD. Therefore it is recommended that CD prescriptions are **not** posted and alternative arrangements are made to ensure the patient receives the medication. This can include arrangements with the patient's local pharmacy service.

- Before posting prescriptions practices must carry out a risk assessment which includes a process with established checks to ensure, as far as possible, the prescription reaches its intended recipient. These may include, but are not limited to:

    - Checking that the patient's address is up to date.

    - Considering if there are known individuals at the patient address with substance misuse issues.

    - Keeping records of the date the prescription form was posted, name and address of recipient, expected delivery date and items prescribed/dosages/amounts. This may include but is not limited to:

        - Discreet information on external envelope/packing so that the item is not easily identified.

        - Return address if the item cannot be delivered

        - Using a postal service with tracking information.

- Getting the item signed for at point of delivery to ensure it can be traced in the event it has not been received by the intended recipient.

- Reconciliation checks to ensure that the patient did receive the prescription form.

- Escalation and reporting actions for staff in the event the patient reports non receipt of the prescription form.

- These precautions should be recorded in any practice SOP or policy and audits undertaken to ensure it is adhered to.

5.5 Uncollected/returned prescriptions

- Any prescriptions not collected after 3 months (1 month for CDs) from date of issue must be reviewed by the prescriber. Where the issue is deleted from the computer, the prescription should be shredded and disposed of in the confidential waste, in the presence of a witness. A record should be made of the serial number within the practice records. The prescription box should be checked on a monthly basis.

- If it was not possible to cancel the last issue, the serial numbers should be recorded on the patient records, and a comment to the effect that the prescription was not collected. Then the prescription should be shredded.

- Practices should have a procedure in place to deal with notifications from a community pharmacist that a prescription hasn't been collected.

5.6 Prescription Charges

- Practices should have systems in place to advise patients regarding prescription charges. The charges are set nationally, and there are a variety of schemes in place to help patients with health costs. The prepayment scheme is an effective way for patients to reduce any potential increase in cost through transition to 28 day prescribing and so the practice is encouraged to promote the scheme for those patients affected.

- Information on exemptions and prepayment certificates should be readily available in pharmacies and practices. Further information is available from the Prescription Pricing Division: http://www.nhsbsa.nhs.uk/healthcosts

6. QUALITY ASSURANCE

6.1 Repeat prescribing and ordering protocol

- Practices must have a clear, written protocol, describing the roles of each person involved in the production of prescriptions.

- This should be written by the practice and reviewed every two years.

- There should be a named person who is responsible for the policy and ensuring that all staff are adequately trained.

- All members of staff, including locum prescribers, need to be trained and fully aware of how the practice repeat prescribing system works, and are aware of their individual responsibilities.

- A system should be in place to ensure that all staff have read the procedure and it is included in the induction programme for new staff.

6.2 Improving the repeat prescribing and ordering system

- The Medicines Management Team is well placed to offer advice and share best practice from other GP practices they work in, for example, how to maximise clinical system functionality or innovative improvement strategies.

6.3 Dealing with errors

- There should be a system in place to investigate and learn from any errors. The prescriber who signs the prescription takes ultimate responsibility for the prescribing of that medication and therefore needs assurance that the system is robust. Errors should be reported e.g. via the DATIX system or Professional Concerns Template. Errors should be discussed at practice meetings.

- In the event that unexpected or avoidable death or severe harm of one or more patient occurs, as a result of a prescribing error, this is classed as a serious incident. All serious incidents MUST be reported on the Strategic Executive Information System (StEIS) which the CCG can access and report on. All such incidents must be reported to the relevant CCG and an investigation conducted into the circumstances of the incident.

6.4 Audit

- The repeat prescribing system is required to be audited annually in order to ensure that patients and staff are kept safe by having systems to ensure that medicines are handled safely and securely.

- The practice manager will be responsible for ensuring the audit is carried out and learning and updates to the practice's protocol or additional training are followed through.

- The Medicines Management Team can support with development of audit tools to assess practice systems.

6.5 Security of Prescriptions

- All blank and completed prescriptions must be stored in a safe and secure manner. There are a wide range of aspects the practice must consider in line with national guidance and it is recommended that the practice have a Standard Operating Procedure (SOP) for secure stationery and all staff are trained.

- All staff must be aware of the process for dealing with missing/stolen prescriptions; this should also be detailed within the SOP. Please refer to CCG website.

- Risk assessment of prescription security should be carried out on a regular basis to ensure appropriate systems are in place as per SOP.

6.6 Contingency plan for hardware failure

- The practice should have a contingency plan for power failure or system failure with degrees of time built in. They should ensure that prescriptions printed or handwritten are legible. This process should include provision to record information on the clinical system once the problem is resolved.

7. ELECTRONIC PRESCRIPTION SERVICE (EPS)

- Electronic Prescription Service (EPS) is a service that allows GPs to generate and transmit electronic prescriptions using their computer system. The prescription can then be downloaded by a pharmacy. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.

- EPS brings gains in both efficiency and safety for both patients and health professionals:
    - Improve patient safety by reducing the likelihood of dispensing errors due to unclear or illegible prescriptions.
    - Allow the instant cancellation of prescriptions thought no longer clinically appropriate.
    - Prevent the loss of prescription forms.
    - Reduce the number of fraudulent prescriptions.
    - Allows preparation of prescriptions in advance of collection, saving patient time at the dispensary, and making workflow and stock control easier for pharmacists to manage
    - Relieve patients of the need to collect prescriptions from the prescriber.
    - Eliminate the need for pharmacists to re-enter prescription information, thereby saving time and increasing dispensing accuracy.
    - For repeat dispensing, as the repeat dispensing regime is stored electronically this reduces the risk of a batch of prescriptions getting lost and improves accountability for prescriptions issued and dispensed.

- When electronic transfer of prescriptions is used it is important to remember that:
    - Prescriptions electronically sent to the NHS spine for access by the dispensing pharmacy, must be authorised by the prescriber and this is represented by the electronic signature
    - The signature must not be used by any other person than the authoriser.
- The practice must have a robust protocol for electronic issue of prescriptions which meets clinical governance and risk management issues. This protocol must comply with the latest NHS IT standards.
- Practice staff can add or change a nominated pharmacy at patient request. Verbal (does not need to be written) consent needed. Staff must document this on patients' record. Patients can request that a community pharmacy adds or changes their nomination. Nominations can be added, changed or removed at any time.

8. ELECTRONIC REPEAT DISPENSING (eRD)

- eRD offers an alternative way for patients with stable long-term conditions to access their medicines via the pharmacy without the need to contact the GP practice every time a new prescription is needed.
- Patients must have a 'nominated pharmacy' and be using the Electronic Prescription Service to receive prescriptions in this manner.
- Well managed eRD systems can reduce the time spent by GPs, and practice staff processing prescriptions, improve services to patients, reduce medicines waste and enhance the role of community pharmacies.
- eRD is not suitable for all patients. It is suited to patients with chronic conditions who are likely to remain stable on their medicines for the duration of the batch of repeat prescriptions. Patients prescribed significant numbers of items or who are likely to be hospitalised are less suited to inclusion in the repeat dispensing scheme
- Best practice housekeeping principles should be applied before starting a patient on eRD.
- Patients medication should be suitable for issuing via eRD. A list of medication that is suggested to be unsuitable is listed in Appendix 2
- Where patients are prescribed a mixture of both medications that are suitable for issuing via eRD and those which are not, a patient should be excluded from the scheme to avoid any confusion surrounding split prescriptions.

- Patients should be fully informed of the eRD process and consent obtained and documented in a patient's records before eRD is commenced.

- Patients receiving medication via eRD should be Read coded on the EMIS system appropriately.

- Only staff members trained in processing eRD prescriptions should cancel or add new eRD prescriptions.

- eRD prescriptions MUST NOT be amended, all items within the batch should be stopped, and a new batch prescribed which coincides with the date previous eRD prescriptions were due to end.

- eRD prescriptions should not be post-dated.

- eRD batch durations should not exceed 12 months.

- Patients should be reviewed before their current set of eRD prescriptions finishes to ensure patient is stull suitable to use the scheme and thus obtain further supplies without delay.

- Clear communication channels should be established between GP practices and Community Pharmacies, with GP practices regularly updating Community Pharmacies regarding new patients being added onto the scheme.

- Further information regarding eRD can be accessed at https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/06/electronic-repeat-dispensing-guidance.pdf

References

1. Health and Social Care Information Centre. Prescribing. Accessed 21/11/2017. Available online at http://www.hscic.gov.uk/prescribing

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5. Prescqipp Repeat prescribing in primary care Bulletin 124 | March 2016 https://www.prescqipp.info/repeat-prescriptions/send/258-repeat-prescriptions/2535-bulletin-124-repeat-prescribing

6. Management and control of Prescription Forms NHS Counter Fraud (March 2018) https://cfa.nhs.uk/resources/downloads/guidance/Management%20and%20control%20of%20prescription%20forms_v1.0%20March%202018.pdf

APPENDIX 1 EXAMPLES OF ITEMS NOT SUITABLE AS REPEAT MEDICATION

Drug group	Specific drugs or groups of drugs
Antibacterials / antifungals	Oral antibiotics / antifungals Topical antibiotics / antifungals
Corticosteroids	Oral corticosteroids Very potent topical steroids
Drugs subject to misuse	Hypnotics and anxiolytics Controlled drugs Cyclizine pseudoephedrine
Drugs limited to one treatment course	Varenicline
Weight Loss treatment	Orlistat
Wound Care	Dressings

This list is not exhaustive – please consult the prescribing formulary, BNF or speak to Medicines Management Team for advice about specific drugs / preparations.

APPENDIX 2 EXAMPLES OF MEDICATION NOT SUITABLE FOR ELECTRONIC REPEAT DISPENSING

The majority of medications prescribed on a repeat template are eligible to be issued via this process, however there are exceptions.
Items to be issued via ERD must be in the dictionary of medicines and devices (dm+d)[1] . The table below lists medication which is not suitable to be issued via this method, due to its indication or monitoring requirements. Other medication can be added as per individual practice preference.

Drug group	Examples of medication
Antibacterials / antifungals short term courses	Amoxicillin, Azithromycin, Ciprofloxacin, Cefalexin, Clarithromycin, Clindamycin, Co-amoxiclav, Co-trimoxazole, Doxycycline, Erythromycin, Flucloxacillin, Lymecycline, Metronidazole, Nitrofurantoin, Ofloxacin, Oxytetracycline, Phenoxymethylpenicillin (Penicillin), Trimethoprim.
Antibiotic eye/ear drops/ ointment	Chloramphenicol, Fusidic acid, Ciprofloxacin, Otomize,
Antivirals	Aciclovir, Fluconazole, Terbinafine
Controlled Drugs Schedules 2 and 3	Temazepam, Buprenorphine, Fentanyl, Methadone, Morphine, Oxycodone (Longtec®) Pethidine, Tramadol.
Dressings	Allevyn adhesive etc.
Drugs requiring intensive monitoring:	Warfarin, Lithium, Azathioprine, Ciclosporin, Leflunomide, Methotrexate, Mycophenolate Mofetil, Sulfasalazine, Sarolimus Hydroxycarbamide, Mercaptopurine, Penicillamine, Carbimazole
Hypnotics and Anxiolytics	Nitrazepam, Temazepam, Zopiclone, Zolpidem. Buspirone, Diazepam, Lorazepam, Loprazolam, Lormetazepam. Oxazepam
Oral Nutritional Supplements	Aymes Shakes, Complan, Ensure Shake, Fortisip, Fortijuice, Forticreme all varieties.
Potent Topical Corticosteroids	Clobetasol propionate 500 micrograms/ 1 gram, (Clarelux®) (Dermovate®) Clobetasol with neomycin and nystatin Diflucortolone valerate 3 mg per 1 gram (Nerisone Forte®)
Smoking Cessation	Varenicline (Champix®) and Nicotine Replacement Products.
Topical preparations containing antimicrobials	Clotrimazole, Miconazole, Fusidic Acid, Nystatin, Timodine, Bactroban, Naseptin, Metronidazole preparations
Weight Loss treatment	Orlistat.
Additional Practice Specific Drugs	

On occasions it may be deemed clinically appropriate for exceptions to be made.
Listed below are some examples of in which scenarios this may apply.

Drug group	Examples of medication – further information
Antibacterials	Amoxicillin/Doxycycline for acute COPD exacerbation with explicit instructions, to be issued once only within a 3 issue batch of repeats.
Oral Corticosteroids	Budesonide, Fludrocortisone, Hydrocortisone, Prednisolone, only when patient stable on therapy.(have been taking same dose for 6 months)
Antidepressants	Only when patient's dose is stable and patient has a clear review date annotated in notes.
Additional Practice Specific Drugs	

APPENDIX 3 USEFUL READ CODES

Read codes used within this document

READ CODE	Definition
66RD	Pharmacy managed repeat prescription patient
8BIA0	Uses dispensed monitored dosage system
13FX	Lives in care home
8BMF	Medicines use review done by community pharmacist
R08zz	Urinary system symptoms NOS

Practice specific read codes

READ CODE	Definition