North Street Medical Care

REPEATED PRESCRIBING POLICY

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Contents

1. Policy Statement

1.1 Repeat prescribing enables patients to obtain further supplies of medicines without routinely having to see the Prescriber, thereby reducing unnecessary consultations. It is an essential part of everyday health care within the NHS, and accounts for about 60-75% of all prescriptions written by general practitioners (GPs), and 80% of their cost. Approximately half of a practice's population will be receiving repeat prescriptions.

1.2 The presence of a robust repeat prescribing system is a proxy quality marker for general practice care. This is recognised within the General Medical Services (GMS) Contract by the inclusion of several quality indicators related to medicines management. Benefits of a well-managed system include:

- *Improved quality of prescribing*
- *Improved patient convenience and access to the medicines they need*
- *Improved patient safety*
- *Better and more appropriate use of relevant professional and practice staff skills and time*
- *Decreased GP workload*
- *Optimal efficiency in the processes involved*
- *Increased patient / carer involvement and responsibility*
- *Better use of NHS resources*

2. Scope of this policy

2.1 This policy is applicable to all staff employed by North Street Medical Care including locum / independent contractors (and their staff) who may work at the practice.

3. Definitions

3.1 Prescribing is used to describe many related activities, including supply of prescription only medicines, prescribing medicines, devices and dressings on the NHS and advising patients on the purchase of over the counter medicines and other remedies. It may also be used to describe written information provided for patients (information prescriptions) or advice given. (General Medial Council. Good practice in prescribing and managing medicines and devices, 31 January 2013)

3.2 Repeat prescribing is an agreement between the prescriber and the patient that allows the prescriber to authorise a medicine(s) to be issued to a named patient repeatedly over an agreed period of time without the need of consultation.

3.3 Repeat prescribing process has been divided into

- *Requesting, authorising, issuing and signing repeat prescriptions*
- *Special prescribing*
- *Medication review*
- *Collection repeat prescriptions*
- *Using the medication*
- *Quality assurance and Risk management*

3.4 An essential component of this process is that the authorising prescriber ensures that arrangements are in place for any necessary monitoring of usage and effects, and for the regular assessment of the continuing need for the repeat prescription – which should be considered within the context of the clinical review of the patient.

4. Requesting Repeat Prescriptions

4.1 The patients will be given a list of drugs they are currently taking on repeat prescription as a computer-generated list (the right hand side of the prescription slip). Where possible, this should be used to request further medication.

4.2 The patient or their representatives need to retain an active role and responsibility in requesting a repeat prescription.

4.3 Requests can only be made, in writing:

- *Either using the request slip or the surgery request form & handed in directly to the surgery*
- *By post*
- *By internet (once properly registered for online-access)*
- ***Telephone / verbal requests are NOT accepted by the practice***

4.4 The community pharmacy should not initiate a repeat prescription request, except by prior written arrangement with the patient / parent / carer. A community pharmacy is expected to confirm with the patient, which repeat items are required before requesting a prescription from the practice.

4.5 The patient will be required to indicate on the repeat request slip which drugs they require when a request is made. (e.g. by ticking the drugs on the list required). If they have left the form blank and it is not obvious which medication is needed, the patient should be contacted, rather than all the medication given.

4.6 It is important for patients to understand that medications will not be removed from their repeat list because they are not ordered on every occasion.

4.7 If patients do not have the pre-printed repeat request slip, a 're-print' of the repeat prescription list can be produced for patient or the prescription request form can be completed. [Appendix I]

4.8 Requests not submitted using the repeat request slip / request form [Appendix I], including requests using empty boxes of medication previously prescribed will not be accepted and returned to the requestor to complete the proper request forms.

4.9 The practice will endeavour to process and issue ***'routine and uncomplicated'*** repeat prescription requests within 2 whole working days {excluding weekends and bank holidays) of their receipt.

4.10 Requests that require further advice from the requestor or from the practice clinical team will require more than 2 whole working days to process and are often due to

- *Incomplete / unclear details on the written request*
- *Requests for 'when required' or 'acute' medications that are not authorised on the regular / current repeat prescription (These need requesting using Appendix II)*
- *Expired medication (not issued > 6 months or longer)*
- *Medication requested that requires a 'Medication Review' before any further prescriptions can be issued*
- *Continued drugs issued by the hospital (from outpatients or discharge) where the request has been made within 2 weeks and / or the paperwork has not been received /processed.*

5. Requesting Urgent Medication

5.1 Urgent requests are those defined as being clinically necessary to be issued within 24 hours of the submitted request

5.2 The patient / representative (requestor) need to clearly indicate on the written repeat prescription request of its urgency and indicate the reason for the urgency. The practice's own request form [Appendix I] should be alternatively used and submitted if the repeat prescription form is unavailable.

5.3 Receptionists should check the medication is needed urgently that day, date stamp the request upon receipt and pass to the senior receptionist / reception clerk immediately.

5.4 The request should be processed as soon as possible that day, following normal procedure

5.5 The practice will endeavour to process and issue urgent requests on the same day.

5.6 If the request cannot be issued straight away, it will be forwarded to the appropriate clinician (usual clinician, clinical pharmacist, duty doctor) with the necessary IT tasks / paperwork / diary entries made. These requests it may take up to 1 whole working day to complete.

5.7 Patients should be advised to return back to an agreed location, after a specified time, to collect their prescription (This should be recorded within the patient's record)

5.8 Patients will be informed if an urgently requested script has been sent directly to the pharmacy (EPS) and may also contact the pharmacist to advise of its urgency.

5.9 A patient who consistently requests medication late (and advises it is urgent) when they have 'run out' should be brought to the attention of the practice Senior Management Team.

5.10 The practice will not direct patients to the community pharmacy to obtain emergency supplies. This is a facility reserved for the out-of-hours period in line with pharmaceutical regulations.

6. Requesting 'High Risk / Special' prescriptions

6.1 High risk drugs include those that are toxic and / or require unusual dosing and those that require i) monitoring under a shared care agreement or ii) more frequent monitoring to safeguard a patient's health and well-being. {e.g. mental health}

6.2 Drugs that are highlighted by the National Patient Safety Agency (NPSA) that require specific monitoring {e.g. Warfarin [Appendix II], Lithium, Methotrexate [Appendix III], Immunosuppressant's}

6.3 Antibiotics [Appendix III]; Controlled drugs [Appendix IV]; Benzodiazepines; Dietary supplements; Dressings and higher potency Topical Corticosteroids are all considered 'special / high risk' prescriptions

6.4 All the above medicines are not to be ordinarily entered onto the repeat prescribing system and are to be monitored and issued when requests are made, in writing, and usually only when having been clinically evaluated.

6.5 Some high risk drugs, by virtue of their potency or side effect profile would be appropriate to be put onto a repeat prescription but should, ordinarily be issued for up to a month only and require more frequent clinical reviews to re-assess and document clinical need.
(E.g. Mental Health medications including anti-depressants and anti-psychotics, Insulin preparations, Orlistat)

7. Requesting Homecare products / Requests from 3rd party suppliers

7.1 Supply of homecare products e.g. tube feed, stoma care, tracheostomy products, catheters are regulated by The National Health Service (Pharmaceutical services) (Appliances) (Amendment) Regulations 2009 which came into force on 1st April 2010.

7.2 Patients should contact the appliance contractors to place an order, who will then contact the practice to obtain a prescription.

7.3 On receiving a request from the contractors, a prescription will be issued by a prescriber.

7.4 Upon receipt of the prescription, the contractors will dispense the products and deliver the order to patients' home.

7.5 Retrospective prescription request is in breach of terms of service by appliance contractors and may lead to medico legal issues.

7.6 This process should be agreed with patients and appliance contractor before products are put on repeat system.

7.7 It is a good practice to include order number and order date on prescription.

7.8 Appliances can also be dispensed by community pharmacy in accordance to patient preference, the practice should follow the repeat prescribing policy. This needs to be agreed and documented in the patient record.

7.9 For the purpose of this policy a Third Party is defined as a supplier other than a Dispensing Pharmacy. This is often either an appliance contractor, manufacturer or a manufacturer of supplementary feeds.

7.10 Requests by third parties such as appliance contractors or specialist food manufacturers must be processed as printed or EPS prescriptions

7.11 The patient should inform the practice in writing of any changes to their requirements (i.e.) product codes, changes in products, usage.

7.12 The patient should order the items they require in the same way as medicines, but it is advisable to allow more than 48 hours due to posting time variance to the contractor.

7.13 Prescriptions for appliances or enteral feeds, if printed, should always be on a separate prescription to other items.

7.14 Printed prescriptions will be posted to the contractor in the returns envelope provided.

7.15 EPS prescriptions ought to be sent to a nominated compliance contractor

8. Authorising Repeat Prescriptions

8.1 The decision to transfer a drug from an acute prescription to a repeat prescription must always be made by the prescriber after careful consideration of whether the drug has been effective, well-tolerated and is required long term.

8.2 It is the duty of the prescriber at this stage to ensure the patient understands the repeat prescribing process and what is required of them.

8.3 When prescribing for a patient, it is a good practice

- *to agree with the patient arrangements for appropriate follow-up and monitoring where relevant. This may include: further consultations; blood tests or other investigations; processes for adjusting the dosage of medicines, changing medicines and issuing repeat prescriptions.*
- *To inform the Medicines and Healthcare products Regulatory Agency (MHRA) of adverse reactions to medicines reported by the patients in accordance with the Yellow Card Scheme or provide patients with information about how to report suspected adverse reaction through the patient Yellow Card Scheme.*

8.4 Care should be taken to ensure the repeat record is accurate, quantities for each drug are synchronised where possible and review dates are entered.

8.5 All prescriptions should be computer generated. Handwritten prescriptions may be generated during domiciliary visits; however this information will be added to the patient's clinical record at the earliest possible opportunity.

8.6 Re-authorisation must be by the prescriber only and under their clinical control.

8.7 Re-authorisation must not be over-ridden by receptionists.

8.8 The prescriber needs to consider the number of authorisations after which the medication must be reviewed e.g. 3, 6 or 12 months.

8.9 If poor compliance is suspected, re-authorise for shorter periods and review regularly.

8.10 Quantity of medication supplied on a repeat prescription will usually be:

- *14 days: For Dossette Box preparations (Rarely more frequently for clinical need)*
- *28 days: For New repeat prescription; For patients in nursing/care home; For High Risk Medicines*
- *56 days: For most patients*
- *84 days: For medically stable patients who are compliant with monitoring requirements*
- *6-12m: Specific circumstances (e.g. stable on hormonal contraception or HRT)*

8.11 **Dosage instruction**

8.11.1 All repeat prescriptions should include clear dosage instructions to facilitate compliance

8.11.2 The instructions "as before" and "as directed" should not be used routinely, except when prescribing variable medication e.g. warfarin or reducing dosage of steroids.

8.12.2 When prescribing methotrexate, the practice should follow best practice advice to prescribe the dosage in terms of tablets and milligrams e.g. four tablets (10mg) to be taken weekly.

9. Generic Prescriptions

9.1 Many medicines are available in both generic and branded forms. However, generic medicines are, overall, much less expensive to the NHS. Their appropriate use instead of branded medicines delivers considerable cost savings and the proportion of generic medicines prescribed is used within the NHS as an indicator of efficient prescribing practice.

9.2 Generic prescribing reduces the risk of error as each drug has only one approved name, rather than many brand names. Generic prescribing allows any suitable generic (or equivalent branded product) to be dispensed, reduces the number of items to be stocked in the pharmacy and can potentially reduce delays in supplying medicines to the patient (e.g. when a particular brand is not stocked).

9.3 Except where a change to a different manufacturer's product may compromise efficacy or safety, it is good practice to prescribe drugs generically using their approved, International Non-proprietary Name [INN] (i.e.) as described in the British National Formulary [BNF] and not specify the manufacturer or supplier.

9.4 There are a few circumstances when it is appropriate to prescribe a specific manufacturer's product (branded or generic). These include:

- *drugs with a narrow therapeutic index*
- *certain modified- or controlled-release drugs*
- *certain administration devices*
- *multiple ingredient products*
- *'bio similar' medicines*
- *ensuring adherence to long-term medications, where differences in appearance between manufacturer's products might cause confusion and anxiety*
- *avoidance of intolerable product-specific excipients.*

9.5 Where a patient has documented intolerance to a generic form of a drug, the brand may be prescribed and should not be switched. This needs to be documented clearly in the patient records to avoid future generic switching.

9.6 Where there is a high risk of introducing dispensing errors by prescribing by the generic name, the Prescriber may use their judgement to consider branded medication.

9.7 Some medicines (inhalers and hormonal contraceptives) are better considered being prescribed by their generic branded names to ensure continuity when repeat prescriptions are issued.

10. Issuing Repeat prescriptions

10.1 Getting repeat prescription prepared by other members of the general practice healthcare team/staff or generated by computer can be an efficient way of meeting patients' needs, while reducing demands on clinicians' time.

10.2 Repeat dispensing may be beneficial for patients with long-term, stable conditions that need regular medicines, but whose condition is unlikely to change in the short- to medium-term. This can be set up between pharmacy and practices at the request of the patients.

10.3 Prescriptions are controlled stationery; all staff involved in preparation of repeat prescriptions should be appropriately trained in the practice protocol for repeat prescribing (Appendix V). Training will be on-going for all staff involved in the process, and is essential for new staff.

10.4 A compliance check is preferable at this stage and the computer should normally alert the user if medication appears to be over or under used. Particular attention should be paid to "as required" drugs and if problems are suspected the prescriber should be alerted. Under usage is as important as over usage e.g. asthma inhalers, blood pressure medications.

10.5 A repeat prescription would normally be issued up to seven days prior to its due date. Practices will not supply further repeat prescriptions at shorter time intervals without agreeing the reason for the early request e.g. Bank Holidays, holidays etc.

10.6 Where additions or corrections are made the prescriber signing the prescription should initial or countersign against them. The prescriber should ensure that a member of staff makes a record of any handwritten alternations to a prescription.

10.7 Prescriptions should not be generated before consulting the prescriber in the following instances:

- *The medication review date is reached or overdue*
- *Medication requested is not on the repeat record*
- *Any notes left for attention of prescriber*
- *Any handwritten alternation to a prescription*

10.8 Issuing repeat dispensing [See section 19]

10.9 Issuing post-dated prescriptions will sometimes be considered appropriate or necessary to consider and will always be at the discretion of the clinician.

E.g. *Dossette Box requests*
Controlled Drug prescriptions
Repeat Prescriptions due on weekends, bank holidays or just after bank holidays
Instances when the patient is unable to pick prescriptions up or attend when due

10.10 Bulk Prescribing [See section 18]

10.11 Repeat Prescriptions should not be issued to patients where there is a need for a Medication Review

11. Signing Repeat prescriptions

11.1 The practice has a routine time and procedure for prescribers to sign repeat prescriptions, where distractions are likely to be minimal. (Both for printed and EPS prescriptions)

11.2 This results in less disruption to surgeries/consultations and a more timely service for patients.

11.3 The production and signing of prescriptions should be systematic and monitored to reduce the risk of mislaid prescriptions, errors and possible theft.

11.4 Before signing the prescription, the clinician should ascertain that the medication is safe and appropriate.

11.5 All prescriptions will be presented for signature on the same day they are issued (including EPS prescriptions). The practice will endeavour to ensure prescriptions are signed on the same day of presentation.

11.6 Declined or rejected prescriptions will not be signed. The clinician will record a contemporaneous note as to the reason and the patient promptly contacted and advised accordingly by the practice.

12. Medication Review

12.1 The practice defines a medication review as "a structured, critical examination of a patient's medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste". [Room for Review, 2002]

12.2 When re-authorising, any patient not seen within the medication review due date must be recalled for a review. 1 further acute issue of a 28-day supply may be given until patient is seen and reviewed.

12.2 Patients should receive, at least, an annual face-to-face medication review.

12.3 Some patients may require more frequent medication reviews.

E.g. *The elderly, frail or vulnerable patient*
The patient on poly-pharmacy
The patient on high risk drugs
The patient with complex medical needs
The patient where compliance or adherence issues are likely or known

12.4 A medication review should always include the authorisation of future medications to remain on the repeat prescription list and the recording of the next review date

12.5 Some medication reviews (e.g. interim, non-annual) might be possible by a non-face to face consultation (e.g. by telephone). This is at the discretion of the consulting clinician.

12.6 A medication review can be carried out using an electronic template/protocol to facilitate consistent recording of what has been undertaken.

12.7 The following do not count as a full clinical medication review, but may be useful as part of the medication review process.

- *Technical check of the medication list or synchronisation of medication records (e.g. removing unrequested items from repeats or dose optimisation*
- *Switching to a formulary item*
- *'linking' medication to a problem*
- *re-authorising the repeat list or reviewing an individual medication / disease without reviewing all medication as above*
- *asking the patient "is everything else alright?" at the end of the consultation*
- *a Pharamcy Medicines Use Review [MUR] by community pharmacists*
- *a New Medicines Service [NMS] review by community pharmacists*

13. Collection / Storage of Repeat prescriptions

13.1 **Storage:** The practice stores prescriptions awaiting collection in a collection box, away from patient access and contact areas, in a safe and secure location. All signed prescription and prescription pads/stationery are safely and securely locked away when the surgery is closed.

13.2 **To be posted prescriptions:** Prescription identified as "to be posted" are posted on the same working day using a stamped addressed envelope, provided by the patient. All prescriptions sent to patents in this fashion will have all postal details checked before sealing and posting the prescriptions and a contemporaneous noted entry into the patient's notes.

13.3 **Faxed prescriptions:** Generally faxes are no longer to be used or considered 'safe' to send or receive requests for prescriptions.

13.4 **Handing to patient or representative:** It is important to confirm the patient's name and address or date of birth with the patient/representative collecting the prescription. Increasingly prescriptions are collected by community pharmacy representatives/drivers as part of a prescription collection service offered to patients. It is important that the preferred pharmacy is entered onto patient records after receiving the collection service sign up form so that the name of pharmacy will be printed on the corner of the prescription.

14. Uncollected / returned prescriptions

14.1 Staff will regularly check the prescriptions waiting for collection to identify prescriptions that have not been collected within 4 weeks of their issue date.

14.2 Any prescriptions (with the exception of controlled drug items) not collected after three months from the date of issue must be reviewed, the issue deleted from the computer and suitably recorded with the prescription put into the confidential waste..

14.3 Any controlled drug prescriptions not collected after one month from the date of issue must be reviewed, the issue deleted from the computer and suitably recorded with the prescription put into the confidential waste..

14.4 If it has not been 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.

14.5 Prescriptions returned by community pharmacists that have not been dispensed will be handled in the same way.

14.6 An investigation should be considered into prescriptions not collected to determine a reason or pattern of potential concern. Uncollected 'High risk' prescriptions or prescriptions for vulnerable patients will likely be the priority in triggering an investigation

E.g. *Controlled Drugs*
Under 16 prescribing
Inhalers
Mental Health Medication
Insulin

15. Electronic prescribing system (EPS)

15.1 The practice supports the use of and promotion of the Electronic Prescription Service [EPS]

15.2 EPS enables prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice.

15.3 The practice recognise EPS as a much quicker, efficient and more convenient prescribing and dispensing process for both patients, practice staff and community pharmacists

15.4 Practice prescribing staff will allocate EPS prescriptions, on any given day, amongst all the GPs working in the practice that day.

15.5 Urgent EPS requests will be forwarded for the attention of the usual GP who manages that patient (if they are working) or to the Duty Doctor for same-day attention.

15.6 All GPs will need their NHS Smartcard to access the EPS.

15.7 EPS prescriptions will be managed by the allocated GP on the same day as they were received.

15.8 Post-dating of prescriptions will not be considered using EPS. [See Section 10 for post-dating of prescriptions]

15.9 Repeat Dispensing can be done through EPS. [Appendix VII]

16. Multi-compartmental compliance aids (MCA's)

16.1 Multi-compartment compliance aids [MCAs] are usually a variation on the design of a box or a blister pack, divided into days of the week with several compartments per day to allow for the different timing of doses such as breakfast, lunch, teatime and bedtime. (E.g. Dossette Boxes)

16.2 The practice support the consideration of using MCAs for patients who might need some help and assistance in achieving better compliance and adherence to their individual medicines management plan.

16.3 MCAs are unsuitable for addressing intentional non-adherence.

16.4 MCA effectiveness and suitability can be determined by considering the use of an assessment tool or by working with the community pharmacist to assess a patient's need and potential benefit.

16.5 MCA prescriptions will be issued according to our policy (See Section 8.10) of either 14 or 28 day intervals.

16.6 In exceptional circumstances, and only within the discretion of the clinician, MCAs might be issued more frequently (e.g. weekly) if the patient is particularly vulnerable or at high risk of compliance or adherence concerns. Such exceptions will require full documentation within the patient's medication / review records.

16.7 The Pharmacy will usually dispense MCAs a week at a time.

17. Care Home / Domiciliary Visits (DV)

17.1 Any prescribing done during DV's or at Care Homes will need to be entered onto the patient's electronic record, either as a contemporaneous note or as soon as possible afterwards.

17.2 Medication should be added as an 'acute' item and filed as hand written, unless immediate electronic / remote prescribing was possible

18. Bulk Prescribing & Care Homes

18.1 The practice recognise that many patients in care homes are taking 'when required' medications and that this practice can lead to wastage and inefficient prescribing and confusion too when some medicines are in MCAs, others 'when required' are not

18.2 Bulk prescribing can enable commonly prescribed non-Prescription Only Medicines (POM) to be considered for use amongst multiple care home patients without the need to vary quantities on lots of individual prescriptions every month

18.3 The practice acknowledges that some non-Prescription Only Medicines are no longer considered appropriate to prescribe and the practice will continue to follow guidance issued by local CCG and National accredited bodies.

18.4 A bulk prescription can be issued for more than 2 patients who require the same treatment, from the same institution.

18.5 A bulk prescription can only be issued if there are at least 20 persons ordinarily residing at the same address / institution where at least 10 of whom a particularly doctor is responsible.

18.6 Commonly prescribed non-Prescription Only Medicines [non-POM] that the practice might consider bulk prescribing include:-

- *Macrogols (e.g. Movicol, Laxido)*
- *Senna tablets*
- *Lactulose*
- *Paracetamol 250mg / 5mls Sugar Free*
- *Paracetamol tablets (3 x 32 tab per script)*
- *Oral rehydration sachets*
- *Dressings that don't contain a Prescription Only Medicine [POM]*
- *Sip Feeds (e.g. Complan)*

18.7 Care homes will require directions for each medicine (i.e. not 'as directed')

18.8 Creams are not suitable for bulk prescribing as they should not be shared

18.9 Providing the medicines are not POM the name on the prescription should be *'for patients under my care at …..'*

18.10 The care home will need to know which residents require the medicine, written on the MAR chart with annotation ' from bulk supply'

18.11 The individual patient records will need to indicate prescribing via bulk prescription

19. Batch Prescribing / Repeat Dispensing

19.1 The practice support Repeat Dispensing and will consider, in conjunction with the community pharmacist and patient / carer requests to convert the repeat prescribing of individual patients over to Batch prescribing / repeat dispensing

19.2 This method of prescribing provides opportunities for several prescriptions (up to 12 months worth) to be issued by the community pharmacist directly to the patient without the need for the practice to issue separate prescriptions over a determined period of time

19.3 Patients will liaise directly with the community pharmacist when requesting their medications as and when they need them

19.4 This method of prescribing is best offered to patients with stable, chronic conditions, identified and confirmed by their GP

19.5 The prescription is generated as a 'batch', up to a maximum of 12 months supply

19.6 The patient presents to their chosen pharmacy for repeat dispensing

19.7 The patient has no need to visit or contact the surgery for their repeated prescription during the repeat dispensing period.

19.8 When required (PRN) medication can be ordered as a batch of prescriptions with a longer time interval between issues [See Appendix VII]

20. Pharmacy Prescription Collection Service

20.1 The practice support the use of a Pharmacy Prescription Collection Service, where a nominated pharmacy (and their representative) acts as an agent on behalf of the patient in the ordering, collecting, dispensing and sometimes the delivering of medication to the patient.

20.2 The practice requires written permission from patients before allowing a nominated pharmacy to collect prescriptions on patients' behalf. This is normally obtained by the community pharmacy and a copy of the authorisation should be sent to the Practice. The patient's record should state the pharmacy name / location.

20.3 Pharmacy Prescription Collection Service order request will be processed by the practice in the same way as a patient putting in a request directly.

20.4 The practice will require any 'order request' to have been verified with the patient, by pharmacy, in regards to medication requirements, (including dosages and quantities), in advance of the request submitted, in writing, to the practice.

20.5 The practice will manage received written requests from the community pharmacy, within the Pharmacy Prescription Collection Service, in the way they manage other prescription requests directly from patients (See Section 4.8)

20.6 Whether a request is managed by the EPS or printed prescription process remains a decision and choice of the patient. The default will be EPS is a nominated pharmacy has been aligned within the patient record.

20.7 Non-EPS prescriptions will be kept in a safe and secure location in the practice, awaiting collection by the nominated pharmacy representative. The practice is not able to mail out or deliver prescriptions themselves.

21. Early / late requests

21.1 Reasons for Early or Late requests need to be provided by patients (at the time of presentation) and documented by practice staff to enable appropriate prioritisation and handling of such requests. Consider using Appendix Ito assist patients in giving accurate written information.

21.2 The practice will consider all early / late requests in the same way as routine or urgent requests are made (See Section 4 & 5)

21.3 Appendix I should be used and completed for the attention of the clinician / prescriber when considering early or late requests.

21.4 Early / late requests may bring to surface possible compliance and adherence issues, over or under-use concerns that may require a medication review to be performed by the practice before some or all of the medications can be safely re-issued.

21.5 The practice reserves the right to seek further information from the patient to ensure safe and effective prescribing can occur – even if this brings about a delay in the request being completed.

22. Lost prescriptions / missing medication

22.1 **Missing Prescriptions:** A repeat prescription that has gone missing should not be reprinted until a thorough investigation has been carried out; the script should be re-printed rather than re-issued and a note should be included in the patient record.

22.2 **Lost prescriptions:** Confirm that adequate steps have been taken to locate the lost prescription or medication. Also make a note of the event in the patient records and the practice incident book.

22.3 Pass request to Prescriber for consideration.

22.4 If Prescriber authorises the re-issue, mark the new prescription “duplicate”.

22.5 Patients who have lost or had stolen, prescriptions for medication liable to abuse must have notified the police and be in possession of an ‘incident number’ before a further prescription can be issued. This needs to be recorded in the patient’s notes.

23. Medication started or changed by third party health agencies

23.1 Letters from Secondary Care frequently advise on changes to patients’ treatment and it is important that they are processed with due care and attention.

23.2 All discharge summaries and hospital letters will be processed according to the practices updated workflow that will include scanned relevant medication information into the patient records and clinicians undertaking medicine reconciliations.

23.3 A medicines reconciliation process will include removing any discontinued medicines from the active / current screens.

23.4 High alert medicines such as methotrexate and sulfasalazine can only be prescribed by a Doctor.

24. Private prescriptions

24.1 The practice supports the issuing of Private Prescriptions in circumstances when it is not possible or appropriate for an NHS prescription to be issued.

E.g. Acute / short term prescriptions suggested / issued by private consultants / consultations
Certain drugs not licensed or available under NHS prescribing
Medicines for the purpose of travel (See section 25)
Medicines to be used regularly outside the UK (if > 3m away e.g.)

24.2 Private prescriptions will be processed separately to reduce the risk of error

24.3 Private prescriptions will normally be issued acutely, but at the discretion of the clinician, might be placed on repeated prescription

24.4 The practice may be entitled to make a charge for producing a private prescription for non-GMS service provision (e.g. Anti-malarial prescriptions, travel antibiotics)

24.5 The practice is unable to convert private prescriptions into NHS (FP10) prescriptions

24.6 Prescription requests / requirements arising from private consultations will be unable to be issued by the practice – even as private prescriptions. (Clinical responsibility and governance lies with the prescriber of the medication and not the original clinician who recommended it)

24.7 The practice is able to consider reverting a previously private prescription request into an NHS (FP10) prescription under certain conditions including

- The private consultant has written to the practice confirming this request
- The 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 both practice and local guidelines of appropriateness and suitability
- The practice clinician feels able to accept the clinical and governance responsibility for issuing the prescription

25. Travelling abroad - Prescription requests

25.1 If travelling abroad for less than 3 months, the practice will be able to issue medication required for pre-existing conditions to cover the duration of the journey. 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 one and no more than three months supply)

25.2 Providing a prescription for longer than the normal 28/56 days supply (see section 8.10) is at the practice / prescribers discretion.

25.3 Where prescribed medications require frequent monitoring (e.g. blood tests, blood pressure etc.), it may not be possible or appropriate for the GP to prescribe for extended periods

25.4 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.

25.7 If travelling abroad for more than 3 months, patients should be advised to register with a local doctor for continuing medication (this may need to be paid for the patient). It is wise for the patient to check with the manufacturer that medicines required are available in the country they are moving to / staying in.

25.8 Patient's may require a letter stating the name of the drug and condition it is being taken for to prove medicines are for medical use to the patient. This is a non-GMS service and the practice will make a charge for this if necessary / requested.

25.9 Patients returning form being abroad for less than 3 months will continue to be entitled to receive NHS treatment as before their trip

25.10 Patients returning permanently form being abroad for more than 3 months will need to show that they are 'ordinarily resident' in the UK to receive NHS treatment, including their repeat prescriptions, on their return. Please see https://www.gov.uk/government/uploads/attachment_data/file/430967/OR_Tool_1_.pdf

25.10 The practice supports their NHS patients through provision of a travel advice and vaccination service supports advice.

25.11 For NHS registered patients, the practice does not charge any consultation fee to provide Non GMS / Private travel services / immunisations. There is however a charge for the supply and administering of any non-NHS vaccinations

E.g. - *Hepatitis B immunisation*
- *Japanese Encephalitis immunisation*
- *Yellow Fever*
- *Rabies immunisation*

or the issue of a private prescription for travel related items patients may wish to consider

E.g. - *Malaria Prophylaxis*
- *Compression Hosiery*
- *Managing Travellers diarrhoea*
- *Managing travel sickness*

26. Hospital drug / Off licence prescribing

26.1 Hospital only medicines are not to be prescribed in Primary care

26.2 The practice is not able to issue prescriptions for drugs that are listed as 'red drugs' or 'hospital only'

26.3 The practice will refer to the CCG website for details and up to date guidance on the list of Hospital only medicines. [Appendix xx]

26.4 Patients will be referred back to their Hospital Consultant for further advice and action

26.5 There maybe special or extenuating circumstances where a Hospital only Drug is being requested to be issued by the practice. In such exceptional circumstances, the decision will be considered in conjunction with the CCG Medicine's Management Team (MMT) but will remain the sole discretion of the clinician.

26.6 Some drugs maybe requested to be issued 'off license' (e.g. Sildenifil for Pulmonary Hypertension). The practice clinician has sole discretion as to whether they assume legal responsibility for the consequences of prescribing off-list and may choose to or not to.

27. Shared Care Guidelines

27.1 The practice supports the prescribing of medication under shared-care guidelines.

27.2 Shared care prescribing allows licensed medicines of a more specialist nature that originally had been commenced by a specialist to be prescribed by the practice under certain guidelines and conditions

27.3 A shared care guideline stipulates a protocol, proposed by the specialist for who takes responsibility for the diagnosis, monitoring and prescribing (including duration, name of drug, dosage) and under what circumstances responsibility for prescribing should be handed back to the specialist.

27.4 The practice follows local guidance on the current list of medicines that can be prescribed under a shared care agreement. (See CCG website)

27.5 A shared care agreement can only be considered active (live) once received, considered and signed by the practice prescriber assuming responsibility.

27.6 A Prescription cannot be issued until a shared care agreement is in place and live

28. Prescribing Formulary / NICE / Local prescribing forum

28.1 The Practice does not follow a specific practice formulary however all prescribing clinicians try to follow evidence based prescribing and best practice where possible.

28.2 The practice considers and supports generic prescribing as a safer and more effective way to provide consistent patient care

28.3 In some agreed circumstances, Branded prescribing will be considered more appropriate or effective than generic prescribing. This remains at the discretion of the clinician.[Appendix VIII]

28.3 The practice reserves the right to consider changing or re-evaluating medicines issued to any patient, at any time, in order to maintain and update high quality, consistent and evidenced based best prescribing practices

28.4 The practice continues to remain informed through the engagement and implementation of local and national networks and organisations and their respective publications and papers.

28.5 In particular, the practice follows guidance and protocols issued by

- The National Institute for Clinical Excellence (NICE) Guidelines
- The CCG Medicines Management team and prescribing advisors
- Scriptswitch for consistent, effective prescribing
- Peer lead for a (such as the Local Prescribing Forum)
- The Drug Tariff
- The British National Formulary (BNF)

28.6 The practice uses both locally and nationally benchmarked data to validate good prescribing practice, to keep it current and evidence based.

29. Staff training & competencies

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

28.2 All staff issuing prescriptions must have access to and are able to use the most recent version of the British National Formulary (BNF)

28.3 All staff involved in repeat prescribing must undertake training, both provided in-house and externally, including attendance at the local CCG Prescribing Fora

28.4 New staff should shadow a trained member of staff for at least one month.

30. References

1. Good Practice in Prescribing and Managing Medicines and Devices. General Medical Council, January 2013 http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp
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4. The Human Medicines Legislation 20125. http://www.legislation.gov.uk/uksi/2012/1916/pdfs/uksi_20121916_en.pdf
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8. *NPSA Rapid Response Report: Reducing dosing errors with opioid medicines, 4 July 2008 www.npsa.nhs.uk*
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10. BHR CCG Spending money wisely I & II
11. Repeat Prescribing Policies and Protocols. *Adapted for use by NSMC (Catherine Aigbadon, Clinical Pharmacist) from those created by Hilary Smith and Andrew White at Bolton Primary Care Trust.* Accessed: 23/04/2018.
12. Adaptation from SOP 1 : Generating Prescriptions by Trained Administration Staff. *Medicines Management Team working for NHS Eastern Cheshire CCG, NHS South Cheshire CCG and NHS Vale Royal CCG.*
13. Repeat Dispensing and EPS, May 2015. Pharmaceutical Services Negotiating Committee (PSNC). http://psnc.org.uk/services-commissioning/essential-services/repeat-dispensing/ Accessed: 29/08/2018.
14. Guidance for the Implementation of Repeat Dispensing. December 2013. *NHS Employers, PSNC, General Practitioners Committee.* www.nhsemployers.org/publications
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16. Repeat Prescribing and Ordering Guidance, *Version 1.0. NHS West Cheshire CCG & NHS Warrington CCG. Becky Birchall, Prescribing Advisor, CMCSU. Medicines Management Team. 2014.*
17. UK Medicines Information (UKMi), November 2017. Which Medicines should be considered for brand-name prescribing in Primary Care? *Specialist Pharmacy Service,* www.sps.nhs.uk
18. Barking and Dagenham, Havering & Redbridge CCG: Spend Money Wisely – Changes to what BHR CCGs will fund. *Also see: Decommissioning Products List. 29/01/2018* http://gp.haveringccg.nhs.uk/home.htm

Appendix I: Practice Repeat Request Form

PATIENT MEDICATION REQUEST

NAME	
DATE OF BIRTH	
TELEPHONE	
1ST LINE OF ADDRESS	
POSTCODE	

I am requesting the following medicines:

	DRUG NAME (In CAPITALS please)	**DOSE**	**QUANTITY**	✔ **IF URGENT**
1				
2				
3				
4				

Reason for Request: (+ if URGENT please state why)

Other information:

- ☐ Attaching the copy of my 'yellow book' (INR values) as requesting Warfarin
- ☐ This request is for medicines **NOT** on my usual repeat slip
- ☐ This request is for medicines I have **NOT** required for > 6 months
- ☐ This request is for medicines I have **NOT** requested from you before

Signed: **Date:**

MEDICATION REQUEST – OFFICE USE ONLY

Received by:
(Date Stamped & initialled):

OFFICE USE ONLY

I have been unable to issue all the requested / indicated medications

✔	**Reason**	**1**	**2**	**3**	**4**
	Repeats have expired / require authorising				
	Been asked TCU already, not yet been seen				
	Not been issued for > 3, 6, 12 months				
	Last issued				
	Other				
	Passed onto: RJ SS RH DS SHD BQ JU Duty	CS	RR	XX	XX

Signed: **Date:**

CLINICIAN USE ONLY

I have reviewed this request and can advise as follows

✔	Clinician response	1	2	3	4
	I am able to authorise the request				
	Sent by EPS / Attached / Not issued by me				
	I am unable to authorise or issue the request				
	More information is required / incomplete request				
	Review is required before any further issues can be issued				
	Review should be F2F / Tele / Either				
	Please pass this onto Clinical Pharmacy to action / issue				
	Please issue an acute script				
	Please do a Medicine's reconciliation				
	Please put on repeat prescription & synchronise				
	Please consider BATCH prescribing along with other repeats				
	For continuity, the patient's usual Dr or the clinician who has been dealing with this issue should manage this request. Send task and leave paperwork for				
	Please consider BATCH prescribing along with other repeats				
	Other				

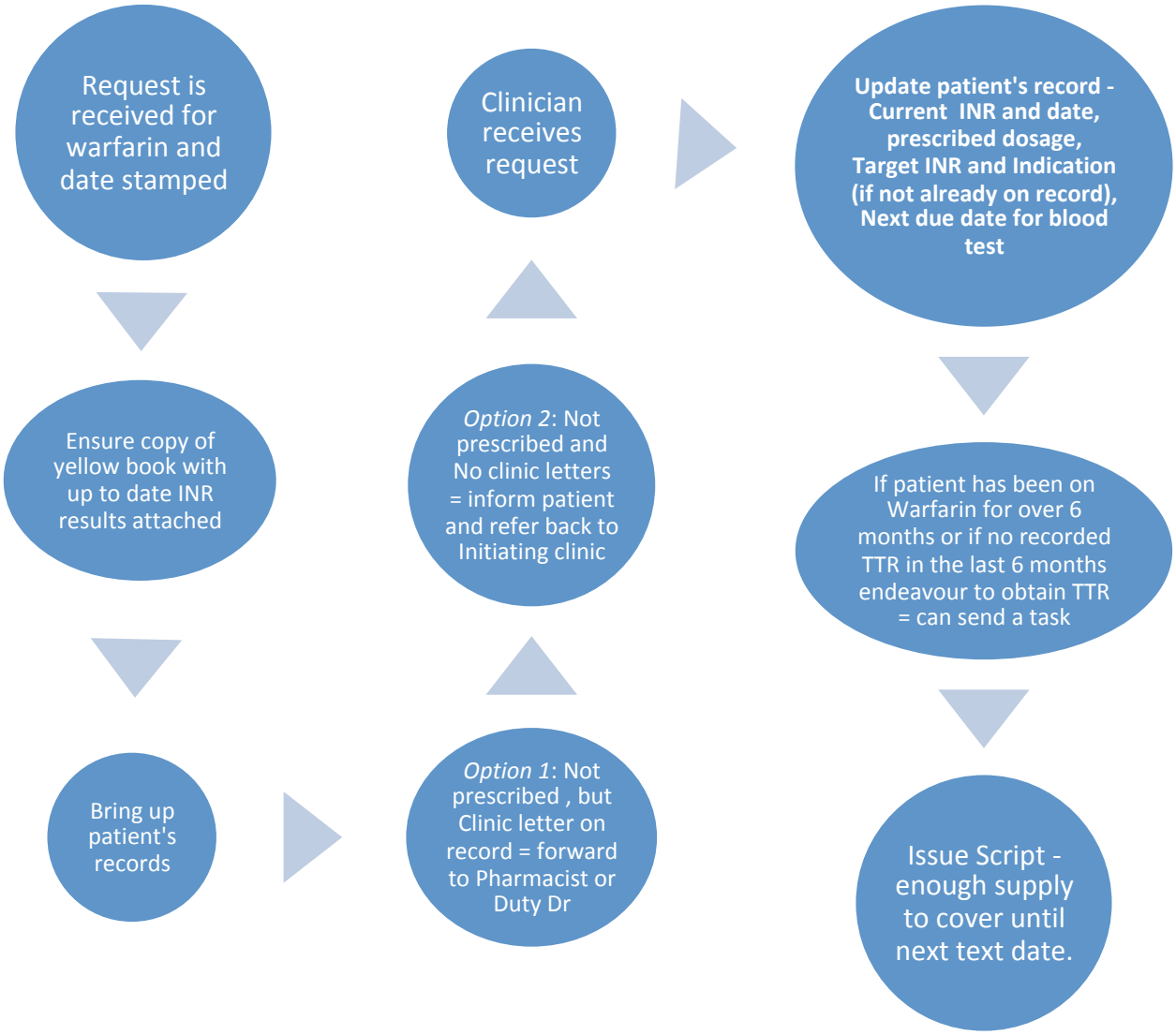
Other Instruction / follow up

- ☐ Patient needs TCU to see: Me / Usual Dr / Nurse / Clinical Pharm / Other
- ☐ Patient needs TCU for: CDM / Medication Review / Other
- ☐ Please inform Patient that no further scripts can be issued until seen as indicated above
- ☐ Please collect script – no other follow up at this time
- ☐ Other comment:

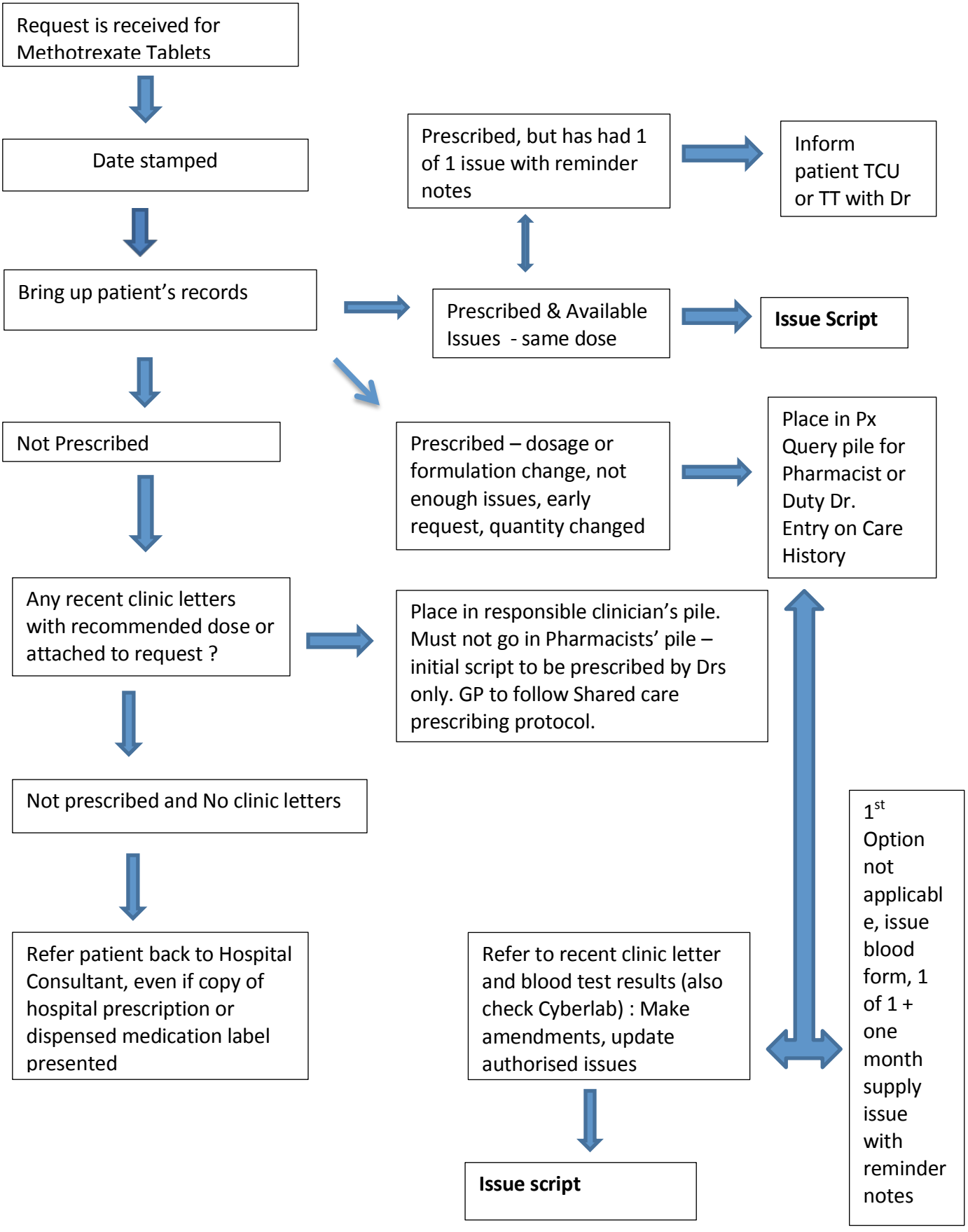
Signed: **Date:**
(Stamped / initialled)

Appendix II: Repeat Prescribing of Warfarin Requests

Clinicians – please refer to Anticoagulation Policy for more details.
Action plan for TTR <65% must be recorded on patient's record.



Appendix III: Repeat Prescribing of Methotrexate (MTX) Requests



Appendix IV: Prescribing of Antibiotics

- The Practice very closely follows the local prescribing guidelines for antimicrobials/antibiotics, bearing in mind the wider picture of the national guidelines. This is because the local guidelines takes into consideration local antimicrobial resistance and have been adapted accordingly.

- Prescribers are to refer to the relevant up to date guidance online for the management of specific infections The CCG has locally adapted Public Health England's recommendations for the management of infections guidance for primary and is available on the CCG's website.

- As a Practice, as much as is possible, broad-spectrum antibiotics such as Co-amoxiclav, Ciprofloxacin, are not prescribed except in cases where other antimicrobials are not suitable/contraindicated and sensitivity testing results have been received.

- Careful consideration is taken before prophylactic antibiotic prescribing is done, even with specialist recommendations where appropriate.

- Antibiotics are not to be prescribed on repeat, exceptions to this are frequent exacerbations of COPD at Clinician's discretions.

- If in doubt, contact the micro at the local hospital for guidance.

Appendix V: Controlled Drug Prescribing

Controlled Drugs should not be prescribed on repeat as much as it is possible. Reasons for reviewing to repeat prescription must be stated on patient's record for future reference/audit trail.

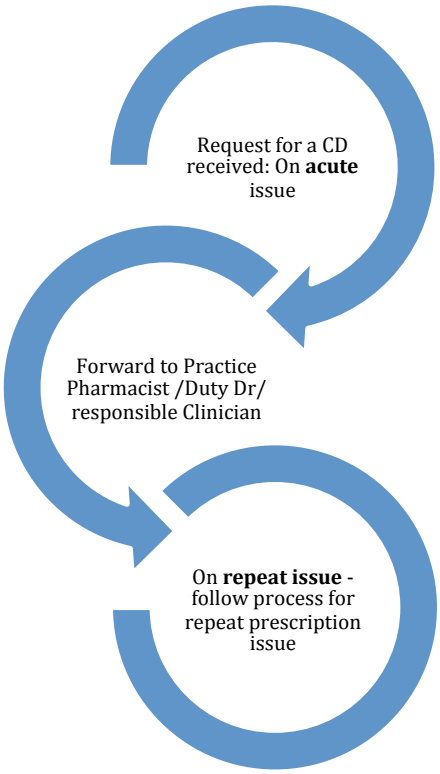
No more than 30 days supply is to be issued at any one time.

Prescriptions for Controlled Drugs are subject to enhanced prescription requirements.

They **must** be in indelible ink (or printed), be signed by the prescriber, be dated and must specify the prescriber's address.

In addition, the prescription **must** always state the following:

- The name and home address of the patient
- The formulation of the preparation
- The strength (where more than one is available)
- The dose to be taken and the directions / frequency
- The total quantity of the preparation, (or the number of dose units), in both words **and** figures



Appendix VI: Repeat Prescription Protocol

Patient communicates request to surgery – written, online, via third party

In Writing
Use either repeat slip or complete practice pro forma in full

Check the patient's name, address and date of birth against record AND date stamp request

Check that the items requested are on the patients repeat list.

If the patient requests any items not on the repeat list, refer to the GP/ pharmacist

If the item appears on the repeat list, check that name, form, strength and dosage instructions are identical to the request

If there are discrepancies refer to GP/ pharmacist.
If dosage instructions are missing they must be inserted by the GP/ pharmacist

Check medication review date has not been exceeded. If so, allow 1 x issue past review date with reminder notes or attach blood test forms

If past review date refer to GP/ pharmacist to re-authorise

Check compliance to ensure patient is not under/over-using medication. Look out for notifications on lower right hand side panel

If patient is under/over-using medication refer to GP/ pharmacist

Place request in pile: 'requests with queries' and leave for GP/ pharmacist to deal with

Write nature of problem on the pro forma and/or make entry ion Care History or send Task

Issue item on request

Place prescription into assigned GP's cubby hole for signing for forward for electronic sign off.

The name, address and date of birth must be checked with the person collecting the repeat prescription to confirm the identity of the patient. It is good practice to check the number of items the patient is expecting to receive, so any discrepancies can be dealt with immediately.

North Street Medical Care

REPEATED PRESCRIBING POLICY

Appendix VII: Repeat Dispensing Process

Potential benefits For the GP and practice:

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

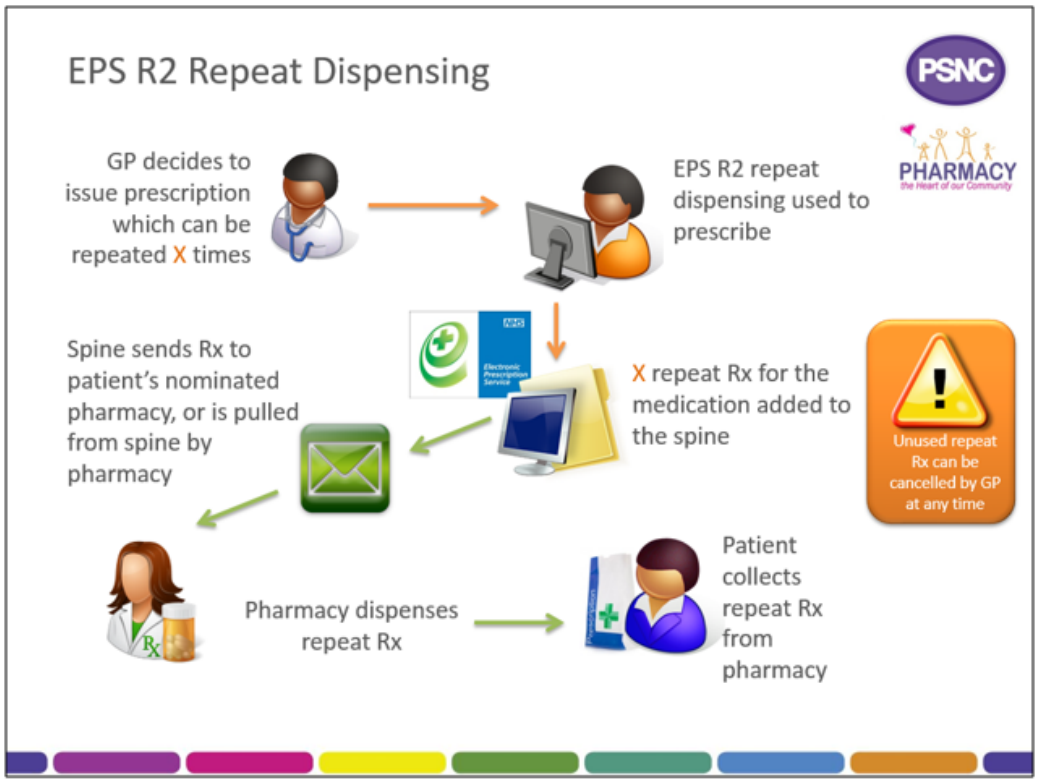
For the patient:

— 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 medication

Workflow for EPS 2 R2 Dispensing (Electronic Prescription Service, Release 2)

GP decides to issue repeat prescription which can be repeated or issued X times > EPS R2 RD used to prescribe > X repeat prescription for the medication added to spine > Spine send prescription to patient's nominated Pharmacy or is pulled from Spine by pharmacy > Pharmacy dispenses repeat prescription > Patient collects repeat prescription from Pharmacy

- Unused repeat prescription can be cancelled by the GP at any time



https://psnc.org.uk/wp-content/uploads/2013/07/Repeat-dispensing-versus-repeat-prescribing.pdf

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REPEATED PRESCRIBING POLICY

Appendix VIII: Hospital Drug List

The full, current list is available from:
http://gp.haveringccg.nhs.uk/medicines-management/hospital-only-list.htm

Appendix IX: Shared Care Guidelines

The following are a select sample of drugs, but the ones more commonly being asked, to be considered and prescribed under shared care guidelines
A full list is available from:
http://gp.haveringccg.nhs.uk/medicines-management/shared-care-guidelines.htm

Drug name	Indication
Apomorphine	Parkinson's disease
Azathioprine	Eczema
Ciclosporin oral	Eczema & Psoriasis
Colistimethate Injx / Neb	Bronchiectasis
Denosumab	Osteoporosis
Dornase Alfa	Cystic Fibrosis
Enoxaparin (Clexane®)	Anti-coagulation
Growth hormone	GH Deficiency
Hydroxycarbamide	Sickle Cell, PCV
Levofloxacin (inhaled)	Chronic pulmonary Infection
Melatonin	Sleep disorders in children
Mercaptopurine	Inflammatory bowel Disease
Methotrexate Injection / Oral	Crohn's, Psoriasis, Rheumatoid Arthritis
Midazolam	Status epilepticus, Febrile convulsions
Mycophenolate	Acute rejection
N-acetylcysteine	Mucolytic in CF

North Street Medical Care

REPEATED PRESCRIBING POLICY

Appendix X: Branded Prescribing

There are some circumstances in which continuity of the same product is important for patient safety and prescribing a specific manufacturer's product (brand or generic) is preferred. These include:

- Where there is a difference in bioavailability between brands of the same medicine, particularly if the medicine has a narrow therapeutic index.
- Where modified-release preparations are not interchangeable.
- Where there are important differences in formulation between brands of the same medicine.
- Where administration devices (e.g. inhaler or self-injection) have different instructions for use and patient familiarity with one product is important.
- Where the product is a biological rather than chemical entity.
- Where products contain multiple ingredients and brand-name prescribing aids identification.
- Where there are differences in licensed indications.

The following are a select sample of drugs (not exhaustive) of medicines considered to be prescribed by their brand-name rather than generically.

Adrenaline (epinephrine) syringes
Aminophylline MR preparations
Beclometasone dipropionate CFC inhalers
Buprenorphine patches
Carbamazepine
Ciclosporin
Diltiazem MR preparations >60mg
Dry powder inhalers (specify name too)
Fentanyl patches
Gabapentin
Insulins
Levetiracetam
Lithium preparations
Mesalazine oral preparations
Methylphenidate MR preparations
Morphine oral MR preparations
Nifedipine MR preparations
Oxycodone oral MR preparations
Phenobarbital
Phenytoin
Pregabalin
Tacrolimus
Theophylline MR preparations
Tramadol oral MR preparations

The full current list is available from:
https://www.sps.nhs.uk/wp-content/uploads/2017/12/UKMi_QA_Brand-name_prescribing_Update_Nov2017.pdf

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REPEATED PRESCRIBING POLICY

Appendix XI: Drugs of Limited Clinical Effectiveness

- Drugs of limited clinical effectiveness will not be prescribed by the Practice. These medicines include those listed under the NHS Spend Money wisely initiative or medicines for acute management of conditions that can treated and purchased over the counter under the supervision of a Community Pharmacist (Referemnce….)http://gp.haveringccg.nhs.uk/GP-Downloads/MM/Prescribing-Guidance/Decomm-Pos/Decomlist_changes.pdf

- Some of these medicines have been decommissioned by the CCG and are no longer prescribable on the NHS, while some are still available for the management of chronic long term conditions.

- Below is a list of conditions that these medicines relate to. The list is not exhaustive and position statements to support these decisions are available on the CCG's website to help management patient's requests/ expectations.

Medicine
Anti-malarial medicine
Bath oils, shower gels and shampoo
Colic remedies for babies
Cough and cold remedies
Eye vitamin supplements
Gluten-free products
Hay fever medicine
Head lice and scabies medicines
Medicines for dental conditions
Multivitamin supplements
Omega-3 and other fish oil supplements
Painkillers
Probiotics supplements
Rubefacient creams and gels
Skin rash remedies
Sleeping tablets
Soya-based formula milk
Sunscreens
Threadworm medicine
Travel sickness medicine
Travel vaccinations