PRESCRIBING POLICY FOR GENERAL PRACTICES (M-027)

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Policies should be accessed via the Trust intranet to ensure the current version is used

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1. INTRODUCTION

Prescribing is an essential part of everyday NHS healthcare provision. In addition to prescriptions generated for acute conditions, repeat prescriptions accounts for about 60-75% of all prescriptions written by general practitioners (GPs), and 80% of their cost. On average, approximately half of a practice's population will be receiving repeat prescriptions. In addition to implementing medicine optimisation principles, the presence of efficient acute and repeat prescribing systems are also recognised by General Medical Service (GMS) Contract as proxy quality marker for care delivered by general practice. Benefits of implementing and regularly reviewing a robust prescribing system to patients and GP practices include:

Benefits to patients

- Improve patient access to their medication
- Assurance that medicines are used in a safe, effective and appropriate manner
- Improved patient safety and quality of prescribing
- Increased patient involvement and responsibility

Benefits to GP practices

- Promote high quality, safe prescribing
- Improve efficiency and allow a more manageable workload
- Ensure appropriate and efficient use of professional and practice staff time and skills
- Ensure greater understanding of the process by everyone involved, including roles responsibilities and timelines
- allow earlier recognition of problems, reduce potential for 'near misses' and adverse incidents and reduce the risk of patient harm
- minimise patient complaints and potential litigation

Although acute and repeat prescriptions provide convenience for both patients and general practices, the presence of robust prescribing system is essential to minimise associated risks such as inability to promptly detect changes in a patient's medical condition and side-effects, continued treatment beyond the necessary period, continued use of ineffective treatments, polypharmacy as well as potential drug wastage. As an organisation, Humber Teaching NHS Foundation Trust recognises the importance of operating robust repeat prescribing system across all Trust general practices. This policy serves to provide guidance and standardise acute and repeat prescribing processes as well as ensuring governance framework are in place. This document also details the roles and responsibilities of practice staff involved in the repeat prescribing process both clinical and non-clinical.

2. SCOPE

This policy sets out the framework for the management of acute and repeat prescribing throughout all general practices within the Humber Teaching NHS Foundation Trust. It concerns all staff involved in the prescribing processes in general practice including receptionists, administrative staff, practice managers, general practitioners, practice nurses, clinical pharmacists and all non- medical prescribers (NMP), be this on a permanent or temporary basis. It also applies to locums, bank, agency, independent contractors and their staff. This policy must be adhered by all practice staff to ensure patient safety and the promotion of good prescribing practice, improving service delivery and patient access to medicines.

3. POLICY STATEMENT

Acute and repeat prescribing requires a robust infrastructure and the provision of a safe process in order to ensure the effective delivery of patient centred care. This document details clear, written procedure for the repeat prescribing process, describing the roles of each person involved in the
production of prescriptions. A system should be in place to record that all practice staff involved in the repeat prescribing processes have read the procedures and that ensure it is included in the induction program for new staff.

This policy should be used in conjunction with other relevant supporting Trust policies and procedures including (but not exhaustive) the Trust Formulary, Prescription Security Policy and Non-Medical Prescribing Policy. This policy also outlines the administrative and procedural steps required for acute and repeat prescribing in general practice. It should be noted that all prescribing should be in line with Hull and East Riding Prescribing Committee (HERPC) formulary and the
associated joint primary/secondary care guidelines. The HERPC guidelines for primary care can be found on the Hull University Teaching Hospitals website: www.hey.nhs.uk/herpc.

4. DEFINITIONS

Prescribing is used to describe many related activities, including supply of prescription only medicines, appliances, 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.

4.1. Acute Prescribing

Acute prescription is usually a prescription issued on a one-off basis for conditions that are often short lived for example pain following an operation. Normally the independent prescriber is responsible for issuing an acute prescription following a consultation with a patient. However, patients will also request an acute prescription online or by telephone, and hospital letters may also require the issue of an acute prescription.

4.2. Repeat Prescribing

Repeat Prescribing is a partnership between patients and prescriber that allows the prescriber to authorise a prescription so it can be repeatedly issued at agreed intervals, without the patient having to consult the prescriber at each prescription request, thereby reducing unnecessary consultations.

The repeat prescribing process can be divided into eight stages:

1. Authorising repeat prescriptions
2. Requesting repeat prescriptions
3. Issuing repeat prescriptions
4. Signing repeat prescriptions
5. Medication review
6. Collection repeat prescriptions
7. Using the medication
8. Quality assurance and risk management

Please refer to Appendix 1: Repeat Prescribing Protocol for a flowchart detailing pertinent steps at each stage for practice staff and GPs/independent prescribers.

The prescriber should retain an active involvement throughout both acute and repeat

prescribing process; they should not delegate any entire part of the process to ancillary practice staff. Those stages in above are entirely the **responsibility of the prescriber**. An essential component of the repeat prescribing process is that the authorising prescriber ensures 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.

5. PROCEDURES RELATING TO THE POLICY

5.1. Acute Prescriptions

Taking Acute Prescriptions Requests

When taking requests for acute prescription from patient or their representative, where possible, practice administrative staff should ask all of the following questions (remember the WWHAM rule):

W – Who is it for? (Name, address, DOB, telephone number) W – What are your symptoms?
H – How long have you had these symptoms for?
A – Allergies (i.e. are you allergic to any medications?)
M – Medications (tried anything already - over-the-counter medicines? Taking any homeopathic medicines? Had anything before from the doctor?)

All information provided by the patient should be recorded in the task list and assigned to duty GPs or independent prescribers. Patients should be reminded that the GP/independent prescriber may decide to:

- Write a prescription
- Leave advice on how to manage symptoms without a prescription
- Telephone the patient for more specific information
- Ask to see the patient for face-to-face consultation

Acute Prescriptions Authorisation

All prescriptions for acute conditions are to be authorised by GPs or independent prescribers only. Generally, acute prescriptions should be limited to a maximum of seven days treatment except in exceptional cases where the GP or independent prescriber feels different treatment duration is more appropriate. If it is not appropriate for a prescription to be written in response to the given symptoms then the GP or independent prescriber should either:

- Contact the patient for more detail
- Request that the patient come to surgery
- Leave a note explaining how to manage the symptoms without a prescription (copies of patient information leaflets for some conditions/prescribing policies are in each surgery)
- If the request is for a regular acute prescription, then the prescriber should consider adding the acute item to the repeat list if appropriate

5.2. Repeat Prescriptions Authorisation

The decision to transfer a drug from an acute prescription to a repeat prescription will always be made by the prescriber after careful consideration of whether the drug has been effective, well tolerated and is required long term. The patient should ideally be seen, or at least spoken to, at this stage, to ascertain the above and to check compliance. It is the duty of the prescriber at this stage to ensure that the patient understands the repeat prescribing process and what is required of them. When initiating repeat prescriptions for a patient, it is considered good clinical practice for prescribers 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.
- Exercise care to ensure the repeat record is accurate, quantities for each drug are synchronised where possible and review dates are entered. See Appendix 2: Synchronisation Form which may be handed to the patient to complete. All repeat medications should be linked to documented clinical indication as appropriate.
- Ensure all repeat prescriptions should be computer generated to avoid misinterpretation of handwritten items/directions and to ensure the medication record is complete. Handwritten prescriptions may be generated on domiciliary visits; however, this information should be transferred to the practice computer clinical record at the earliest possible opportunity with notes to record that repeat prescription was issued "by hand".
- Follow the clear arrangements for setting up repeat prescriptions for new patients, following home visits, after outpatient visits and discharge from hospital. Care must be taken to check the discharge form/hospital letter for dose changes, drugs stopped and started.
- Initial prescription for a new medication should be minimal (usually 28-day pack) to avoid wastage should the patients experience side effects/intolerance of the drug prove to be ineffective for the individual patient. Newly prescribed treatments and those with frequent alterations should be set up as an acute prescription. This may be for example, a trial of a new medication for a chronic condition, or treatment for an acute condition, an antibiotic or short course of pain relief. It is prudent to prescribe smaller quantities in these situations.
- If an item is prescribed as a replacement for an existing repeat medication, the old item must be removed from the repeat prescribing template to prevent unintended duplication.

Prescribers would also need to consider patients who may be unsuitable for repeat prescribing, for example, registered drug addict, patients detained in prison or when patient is clinically unstable.

Note Repeat Prescribing is **not** routinely accepted as practice for non-medical prescribers with bank or agency contracts, however, exceptions can be made but this must be approved via the Non-Medical Prescribing Lead. Please email Julie Moore at julie.moore28@nhs.net for more information.

5.3. Recommended Repeat Prescribing Intervals

Long-term conditions place a substantial burden on primary care services, with drug therapy being a core aspect of clinical management. However, the ideal frequency for issuing repeat prescriptions for these medications is unknown. Previous studies in the UK and abroad have shown significant savings and a reduction in waste with 28-day prescribing. The latest systematic review published in British Journal of General Practice in March 2018 concluded current recommendations to issue shorter 28-day prescriptions have been based on a lack of sound scientific evidence.

Researchers from RAND Europe in Cambridge conducted a systematic review of evidence dating back to 1993 that compared the impact of shorter (28 days) and longer (two to four months) prescriptions on clinical and health service outcomes. All of the studies were randomised controlled trials in primary care settings in middle- and high-income countries that involved participants with relatively stable chronic conditions, including hypothyroidism, diabetes, cardiovascular disease and depression. They also found six studies that suggested shorter prescriptions may be associated with less wastage,

although these studies were considered to be 'very low quality'. The researchers found nine studies that suggested longer prescriptions were associated with better medication adherence. Given the latest systematic review of primary care studies, Humber Teaching NHS Foundation Trust has reconsidered current recommendations for 28-day prescription lengths for patients with stable chronic conditions.

Humber Teaching NHS Foundation Trust now endorses 56-day repeat prescribing intervals for most patients with stable chronic conditions; with a maximum of 84 days in exceptional cases in order to ensure equity across all Trust GP Practices.

The Trust recognises that a 56-day repeat prescribing interval makes the best possible balance between patient convenience and minimal drug wastage. Longer prescription intervals to lead to important potential benefits by improving patients' adherence and thus the effectiveness of the drugs, lessening workload for health care professionals, and reducing inconvenience and costs to patients.

The Trust also acknowledges the statement from British Medical Association that "Prescribing intervals should be in line with the medically appropriate needs of the patient, taking into account the need to safeguard NHS resources, patient convenience, and the dangers of excess drugs in the home". The ultimate decision on the duration of prescribing intervals is at the **discretion** of the **individual** prescriber in partnership with their patients. Prescribers should consider the stability of their patients' medical conditions, expected duration of treatment, likelihood of medication changes and clinical monitoring requirements. In certain clinical circumstances, the prescriber may decide it is appropriate to issue prescriptions at shorter prescribing intervals.

The benefits of continuing 28-day prescribing for certain patient cohort include:

- Reducing the amount of medicine which is currently wasted when the prescriber alters or discontinue medication. This also reduces the potential for error when patient's medication is changed during 28-day supply cycle of repeat prescription issues.
- Increased safety as patient will not have multiple containers of the same medicine and likely to reduce the number of mistakes made by, for example, elderly patients, and it also reduce the risk of potential poisoning of young children.
- Many medicines are supplied in 28-day 'calendar packs' that show the day of the week on the packaging, this allows patient to check medication compliance. Patients can start and finish the container of each medicine on the same day of the week, it makes it more transparent for your prescribers to review all of the repeat medicines patient are taking and check for non-compliance.
- Many patients have to make several visits each month to their surgery because they have run out of their medicines at different times. With 28-day prescribing all patients' repeat medications can be synchronised at the same time, reducing surgery visit once a month to collect your repeat prescriptions. It will also reduce the likelihood of patient needing to make an emergency request they run out of medicines.

5.4. Dosage Instruction

All repeat prescriptions should include clear, concise dosage instructions to facilitate appropriate administration of medication by patients and compliance checks by practice staff. All repeat medicines must have a dose specified by the prescriber, e.g. 'one puff twice daily' not 'use twice daily'. Use of the term 'as directed' should not be used routinely,

except when prescribing variable medication, e.g. reducing dosage of steroids.

When prescribing repeat medications with directions for variable dose and 'when required' dosing, patient should be supplemented with information when and how to take or use the medicine. As part of good clinical practice, patient should be supplied written dosage instructions including the maximum amount to be taken in a day and how long the medicine should be used, as appropriate. This is particularly important for psychotropic drugs.

5.5. Drugs needing Special Consideration

Prescribers should exercise clinical judgement for the appropriateness of initiating the following types of medications or devices on repeat prescribing template: High Risk drugs, controlled drugs, antibiotics, benzodiazepines, dressings, dietary supplements and topical corticosteroids.

'High risk drugs' that are highlighted by National Patient Safety Agency that requires specific monitoring, e.g. warfarin, lithium, methotrexate, immunosuppressant. This includes those that are toxic and require unusual dosing and those that require monitoring under a shared care agreement. The patient's notes and/or computer record must be available to the Prescriber for all high-risk drugs which are as follows:

Methotrexate

- For reasons of patient safety, prescriptions for Methotrexate should **only** be issued as 2.5mg tablets. Methotrexate should only have a dosage regime of once weekly with the day of the week specified on the prescription.
- Item authorisation should be limited to one issue to ensure that prescriptions for Methotrexate are actively reviewed at each issue by a prescriber. This may be by reviewing the notes for new letters etc. and does not necessarily mean seeing the patient each time.
- Results of biochemical monitoring at the specified intervals must be available to the Prescriber and be within normal limits before issue of the prescription. Patients who have not attended for monitoring or whose results are outside normal limits should not be issued with a prescription unless it can be justified. Either action should be fully documented in the patient records.
- Initiation of, and dose alteration to the computer prescription record should only be made by a Prescriber with the appropriate drug knowledge base.

Warfarin

This section also applies to other anticoagulants such as nicoumalone, phenindione or acenocoumarol although they are rarely prescribed:

- Prescriptions for warfarin tablets should only be for 1mg and 3mg tablets because of the risk of confusion between 1mg tablets (brown) and 5mg tablets (pink). These colours may be difficult to differentiate for a person with poor vision. However, in exceptional circumstances 5mg tablets may be used but the 0.5mg tablets should be avoided because of their white colour.
- Evidence of monitoring must be available to the prescriber before a repeat prescription is issued. This can be obtained from the "yellow booklet" held by the patient and the information required includes the dose, the INR target range, last INR result, date of last result and date of next appointment. The latest result should not be more than three months old. It is best practice to photocopy the relevant page of the yellow book, returning the book immediately to the patient. It is important to record the patient's name and date onto the photocopy.
- Item authorisation should be limited to one issue to ensure that prescriptions are

actively reviewed by the Prescriber. This may be extended to three issues if the patient is stable and on a three-month anticoagulation monitoring appointment and has **not** been prescribed any interacting drugs during this period.

Lithium

- Prescribing of lithium will come under Shared Care Agreement and enhanced services within the GMS contract
- Item authorisation should be limited to three issues to ensure that prescriptions are actively reviewed by the prescriber
- Evidence of monitoring must be available to the prescriber before a repeat prescription is re-authorised

5.6. Drugs requiring Monitoring under Shared Care Agreements

- Prescribing of HERPC AMBER drugs will come under Shared Care Agreement requiring monitoring under enhanced services within the GMS contract.
- Item authorisation should be limited to number of issues relating to the frequency of required monitoring to ensure that prescriptions are actively reviewed by the prescriber. Responsibility to define the issue number lies with the prescriber.
- Evidence of monitoring must be available to the prescriber before a repeat prescription is reauthorised.

5.7. Requests for Antibiotics

- Patients requesting antibiotics for an acute condition over the telephone should be offered and appointment to discuss with clinician. This includes topical antibiotics +/- steroids.
- Prescriptions for patients with conditions requiring the long-term use of antibiotics may be authorised for repeat and should be treated in the same way as other requests for repeat prescriptions.

5.8. Prescribing of Topical Corticosteroids

- Care should be taken in prescribing topical steroids due to risk of local and systemic side effects, particularly with more potent preparations, and in children.
- When setting up a repeat prescription, document discussion of detailed instructions and side-effect warnings in the patient's record. Clear prescribing instructions should be entered on the repeat prescription including area to be treated, quantity, frequency of application and duration of treatment.
- Potent topical steroids for use on the face should not be prescribed on repeat prescription.
- Repeat prescriptions for all topical steroids should be limited to 12 weeks before review occurs, and wherever possible work out appropriate quantities to be given, and use the "minimum number of days before issue" function on the prescription. Detailed guidance on prescribing steroids is available in the BNF.

5.9. Generic Prescribing

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. 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.

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) (as described in the British National Formulary (BNF) and not specify the manufacturer or supplier.

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
- 'Biosimilar' 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

See Appendix 6 for Medicines Unsuitable for Generic Prescribing for examples of drugs/preparations which are **not** recommended for generic prescribing. This list is for guidance only, please refer to the BNF or contact your general practice clinical pharmacist for more information.

Reauthorisation
Reauthorisation of repeat prescriptions must be by prescriber only and under their clinical control, this process should not be over-ridden by receptionists. When reauthorising repeat prescriptions, the prescriber needs to consider the number of authorisation after which the medications must be reviewed, e.g. three, six or 12 months. If poor compliance is suspected, repeat medications should be re-authorised for short periods and review regularly.

5.10. Requesting Repeat Prescriptions

Patients should take responsibility for ordering their own prescriptions unless there are exceptional circumstances. These must be agreed in advance between the patient, prescriber and community pharmacist or appliance contractor, and a note made in the patient's clinical record. The patients will be given a list of drugs on the counterfoil they are currently taking on repeat prescription as a computer-generated list (the right-hand side of the prescription slip). The patient or their representatives must have an active role in requesting a repeat prescription. The community

pharmacy should not initiate a repeat prescription, except by prior written arrangement with the parent/carer. Community pharmacy is expected to confirm with the patient that items are required before requesting a prescription form the practice.

Requests can be made:

- Online
- By post
- By written request either using request slip or a letter, handed in directly to the surgery

Practices should not accept requests for prescriptions from community pharmacists unless the pharmacy is acting for a patient as part of the Repeat Medication Service (a service operated in co- operation with local prescribers). This requires the patient or carer's

request for the service to be recorded in writing and allows the pharmacist to order prescriptions on their behalf after assessing with the patient which items are required.

Requests to practices should preferably be made in writing using the repeat request slip. Email requests are acceptable if the practice is in agreement and in accordance with practice procedures. Telephone requests may be acceptable if repeat prescriptions are on a computer, otherwise the potential for error exists. For patients who are unable to access any part of this process, arrangements should be made for them or their carers to obtain repeat prescriptions without comprising safety issues.

The patient will be encouraged to indicate on the repeat request slip which drugs they require when a request is made. 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. 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. If patients do not have the counterfoil or repeat request slip, a list of repeat prescription can be produced for patient or a prescription request form can be filled in by patients.

For urgent requests (less than 48 hours) receptionists should check the medication is needed urgently that day. The request should be processed as soon as possible that day, following normal procedures.

- Patients should be advised to nominate a pharmacy for the prescription to be sent by EPS. Patients without a nominated pharmacy should be advised to call back after a specified time to collect their prescription.
- If a patient consistently requests medication late when they have “run out” of tablets, this should be brought to the practice manager’s attention.
- The practice must not routinely direct patients to the community pharmacy to obtain an emergency supply. This is a facility reserved for the out of hours’ period in line with pharmaceutical regulations.

5.11. Homecare Products

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 1 April 2010. Patients should contact the appliance contractors to place an order, who will then contact the practice to obtain a prescription.

On receiving a request from the contractors, a prescription will be issued by a prescriber. Upon receipt of the prescription, the contractors will dispense the products and deliver the order to patient’s home.

Retrospective prescription request is in breach of terms of service by appliance contractors and may lead to medico-legal issues. This process should be agreed with patients and appliance contractor before products are put on repeat system.

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

5.12. Issuing Repeat Prescriptions

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. 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.

Prescriptions are controlled stationery; all staff involved in preparation of repeat prescriptions should be appropriately trained in the practice protocol for repeat prescribing (Appendix 1). Training will be ongoing for all staff involved in the process and is essential for new staff. 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.

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. 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.

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 alteration to a prescription

Administrative staff security setting should be set so that they:

- can only issue repeat prescription but not acute prescriptions
- cannot add drugs to either the repeat or acute screen
- cannot re-issue a repeat prescription from past drugs history
- cannot issue duplicate repeat prescriptions
- Attention should be made to any messages on the repeat screen when producing the repeat prescriptions and should be acted on accordingly
- Can alert the prescriber when the number of repeats has expired or the review date has passed without the patient being formally reviewed, the requested item is not on/differs from the computer record or the request is significantly earlier or later than expected following a compliance check

5.13. Signing Repeat Prescriptions

GPs and non-medical prescribers (if within remit) must have an allocated time set aside each day for signing and reviewing repeat prescriptions. This results in less disruption in to surgeries/consultations and more timely service for patients. In order to authorise the request for repeat medication, the independent prescriber should be satisfied:

- The drug prescribed is effective (look for objective evidence)
- The patient is concordant and able to take the medication, e.g. inhaler
- Short or longer-term risk of important adverse effects
- Short or longer-term risk of interaction with other medication
- The drug prescribed is for a stable, chronic condition – other items should not enter the repeat system

The independent prescriber should check the following:

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

5.14. Date of Next Review

Repeat prescriptions should wherever possible be reviewed and signed by the GP or independent prescriber who knows the patient. The patient's medical notes should be available if needed. All drugs requested within the system should be regularly reviewed.

The production and signing of prescriptions should be systematised and monitored to reduce the risk mislaid prescriptions, consequent errors and possible theft. A system should be in place for distributing a GP's prescriptions during cases of absence.

5.15. Medication Review

Regular medication review is important and should be part of the normal everyday clinical management of patients on repeat medications. A definition of medication review is "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". The initial decision to prescribe medicines, the patient's experience of using the medicines and the patient's needs may change over time. Patient prioritised for a medication review should include those who are higher risk of side effects of medications such as elderly or frail patients on polypharmacy, residents in care homes, those on weekly dispensing and patients recently discharged from hospital.
Patients should ideally have Level 3 face-to-face medication review with prescribers every 6-12 months to cover all drugs available (including all repeat medications) and account should be taken of the various clinicians involved. For instance, a medication review by an asthma nurse may not cover all drugs prescribed and may require subsequent comprehensive medication review undertaken by GPs, independent prescribers and/or a clinical pharmacist. Where a Level 3 face-to- face medication review is not possible, (or deemed unnecessary) a thorough review of the patient's up-to-date prescription should be undertaken in conjunction with the case notes. This is a Level 2 medication review and should be conducted by a clinician. Where possible, medication review can be carried out using an electronic template/protocol to facilitate recording of what has been undertaken.

Independent prescribers and/or clinicians performing the medication review should **check**:

- the medication prescribed is appropriate for the patient's needs
- the medication is effective for the patient
- the medication is a cost-effective choice
- any required monitoring or chronic disease review has been done or arrangements are in place

Independent prescribers and/or clinicians performing the medication review should **consider**:

- drug interactions
- side effects
- compliance
- over-the-counter and complementary medicines
- lifestyle and non-medicinal interventions

- unmet need

Independent prescribers and/or clinicians performing the medication review should **record**:

- Information pertinent to any decisions made
- Read Code appropriate to the review: notes only or in person
- Proposed follow up and amend review date
- Linking medication to clinical indications(s)

The following do not constitute 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 a consultation
- Medicines Use review (MUR) or New Medicine Service (NMS) provided by community pharmacists are not acceptable to be recorded as a practice medication review as they are a predominantly a concordance check, but its findings may prompt one. It is important that the suggestions from MUR/NMS are reviewed and implemented by independent prescribers if clinically appropriate

5.16. Patients Failing to Attend for Review of Repeat Medication

The GMC in its publication 'Good Medical Practice' states that GPs and independent prescribers must only prescribe drugs or treatment including repeat prescriptions when 'you have adequate knowledge of the patient's health and are satisfied that the drugs or treatment serve the patients' needs'. Without having contact with the patient, the GP or independent prescriber cannot be assured of this and therefore attempts should be made to contact the patient or carer.

For patients who fail to attend, a number of different means of contacting the patient should be tried. It is not possible to suggest one strategy as this will vary depending on the patient but possible ideas include:

- Letter explaining the GP's obligation to ensure the welfare of the patient
- Phone call
- Visit to home
- Text message
- Using practice extended hours to offer appointments
- Email alerts
- Notifying the community pharmacist
- Reducing the quantity of repeat medication issued. However, it would be difficult to stop a patients' medication altogether because this would effectively be withholding medication knowing that the patient may suffer harm as a result

Independent prescribers, clinicians and administrative staff should check whether the patient has recently been reviewed by another health professional/organisation, e.g. secondary care/mental health team etc. Prior to contact the patient using one of the methods above, check that it is appropriate to so as it may be that the patient's carer should be contacted. All efforts should be made to check that the patient is still resident at

the registered address; it may be that the patient has moved and the practice has not been notified, for example, students and patients living abroad for the winter months. For patients that have co-morbidities, try to co-ordinate medication reviews with chronic disease review so that the attendances at the practice are reduced. All attempts to contact the patient or carer must be documented in the notes.

5.17. Collections of Repeat Prescriptions Storage

The practice stores prescriptions awaiting collection in a collection box, away from patient contact areas. All signed prescription and prescription pads/stationery will be locked away when the surgery is closed.

Posting prescriptions

Prescriptions should only be posted in exceptional cases. Note the practice should obtain and document informed consent from each patient prior to transferring prescriptions by this method. Records should be kept of all prescriptions posted and postage should be by special delivery.

- Prescription identified as "to be posted" must be posted on the same working day.
- It is important to confirm the patient's name and address with the address label before sealing envelopes and posting prescriptions.
- Make a record on patient record that a prescription has been posted to a patient.

Handing to patient or representatives

- There should be checks to ensure that the person collecting the prescriptions is authorised to do so. It is important to confirm the patient's name and address or date of birth with the patient/representative collecting the prescription.
- Children under 13 should not being allowed to collect prescriptions. Exceptions to this should only be made under authorisation from independent prescribers for exceptional circumstances, e.g. for family planning prescriptions or for treatment for STIs.
- Increasingly prescriptions are collected by third parties such as community pharmacy representatives or appliance contractors as part of a prescription collection service offered to patients. It is important that the preferred pharmacy or appliance contractor is entered onto patient records after receiving the collection service sign up form and the name of pharmacy will be printed on the corner of the prescription.
- Although there is no legal requirement, it is good practice for controlled drug prescriptions to be signed for to maintain audit trail

Electronic Transfer Prescription

The Electronic Prescription Service (EPS) enables prescribers to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.

- Practice staff needs a Smartcard to prepare an electronic prescription which can then be sent to the prescriber to review on screen and sign electronically.
- Practice staff can reassign prescriptions to a different prescriber. Prescribers can view patient details on screen before applying their electronic signature.
- Receptionists or practice nurses can instant message or add a note saying 'please sign immediately'. The GP can then sign the prescription in between consultations – this saves time and means they no longer have to wait outside the GP's door.
- Practice staff may decide to allocate one prescriber (sometimes the on-call GP) to

sign all the repeat prescriptions in one day, or you may choose to split them between all GPs in the practice.

- EPS allows you to easily view all prescriptions waiting to be signed and which prescriber they are with. If they have been signed you can see which pharmacy they have been sent to. This will help you to locate prescriptions if you are asked by either the patient or the pharmacist.

Non-collection of prescriptions

Staff will regularly check the prescriptions waiting for collection to identify scripts that have not been collected within four weeks of their issue date. An investigation should be made into every script to determine a reason for non-collection. The record of issue will then be removed from the computer and an entry made detailing the reason for the removal. The prescription will be destroyed in accordance with the practice policy.

5.18. Multi-Compartment Compliance Aids (MCAs)

Multi-compartment compliance aids 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 and MCAs are unsuitable for addressing intentional non-adherence. Please also note recommendations from the Royal Pharmaceutical Society:

1. The use of original packs of medicines with appropriate support is the preferred option of supplying medicines to patients in the absence of a specific need requiring an MCA as an adherence intervention
2. In support of independence and re-ablement, patients who can safely self-administer their medicines should be encouraged to do so and where they are unable to do so, there must be appropriate training for carers so that they are able to administer medicines from original packaging
3. Every patient identified as having medicines adherence issues should have a robust individual assessment to identify the best intervention based on their needs and the evidence currently available. This assessment should incorporate a clinical medication review, any reasons for nonadherence, medicines suitability, a consideration of all possible options to support the patient and follow up.
4. Where a patient assessment indicates an MCA is the intervention of choice, it is important that this is supported with the provision of information, appropriate counselling and follow up for the patient and that the health or social care professional is aware of the legal, professional and practice considerations. The decision to supply MCAs should only be made after taking all factors into consideration.

The provision of seven-day prescriptions remains at the discretion of the prescriber. This should be used to facilitate the most appropriate care for a patient, e.g. where there is a clinical or pharmaceutical need for medicines to be supplied every seven days and not as a method of funding MCAs. If a patient is assessed by the community pharmacist as needing MCAs under the Equality Act with no other clinical or pharmaceutical issues, MCAs should be provided by the pharmacist (free of charge to the patient) usually via 28-day scripts. Four weeks supply of MCAs should be dispensed at each interval. This applies to patients living in the community, those receiving social care support and self-medicating patients living in residential homes.

Under the terms of the Equality Act where a person has a physical or mental impairment which has a substantial long term adverse effect on his ability to carry out normal day-today activities then it may be decided that medicines be provided in a dosing system, to help the patient to overcome the aspect of their disability that prevents them using their

dispensed medicines. Having a disability does not equate with an entitlement to dosing systems – the nature of the disability must be such as to prevent the patient from being able to use their medicines, if not supplied in a dosing system. It should be noted that other interventions, e.g. change to labels and packaging may be as beneficial in some situations.

Provision of MCAs under the Equality Act falls within the Pharmacy contract and no further reimbursement is allowed. Prescriptions should usually be provided for 28 days. Community pharmacists who decide not to provide MCAs, as they either feel the patient does not meet the Equality Act criteria or that provision of an MCA is not a reasonable adjustment, should keep records clearly showing the rationale for the decision. If a patient is assessed by the community pharmacist as needing MCAs under the Equality Act, but there is a clinical or pharmaceutical issue involved requiring weekly dispensing (e.g. the medicines are only suitable for weekly dispensing; the patient is at risk of overdose or medicines regime changing frequently), MCAs should be provided by the pharmacist (free of charge to the patient) via seven-day scripts. One week of MCA will be dispensed at each interval. This applies to patients living in the community, those receiving social care support and self-medicating patients living in residential homes. N.B. repeat dispensing may be considered appropriate in these circumstances.

If a GP/independent prescriber believes that a patient would benefit from an MCA but on assessment by the community pharmacist the patient does not meet the Equality Act requirements, then the GP/independent prescriber can choose to provide seven-day scripts with the pharmacist dispensing the MCA on a weekly basis, so long as the pharmacist is happy to provide the service
in this manner. Alternatively, arrangements could be made for the patient to pay the pharmacist for providing an MCA service, or other local arrangements made.

If care homes want patients' medicines to be supplied in MCAs as part of their internal policies, then this will be outside the scope of the NHS and will be negotiated between the nursing home and the community pharmacist.

Hull City Council and East Riding of Yorkshire Council providers will provide medication assistance to patients already receiving home care support as a last resort. The health sector has an obligation to try all possible avenues of supporting patients to self-medicate first, which may include the supply of MCAs if appropriate.

5.19. Repeat Dispensing Prescriptions

Repeat dispensing was introduced as part of the new community pharmacy contract as an essential service. Humber Teaching NHS Foundation Trust support the use of NHS Repeat Dispensing Service to reduce the need for emergency supplies of medication by Humber GP practice teams and allow better workload management by community pharmacies. However, only patients on stable, long-term medicines are likely to be good candidates. Repeat Dispensing prescriptions are not suitable for patients with acute, newly diagnosed or unstable conditions. The aim of issuing repeat dispensing prescriptions is to allow patients to request and collect their medication directly from the community pharmacy of their choice. In essence the prescriber can issue a master repeat prescription, followed by a series of batch prescriptions (up to 12), with only the master prescription requiring a signature by the prescriber. The batch prescriptions are then kept by the patient or stored at the community pharmacy.

Humber Teaching NHS Foundation Trust only recommends repeat dispensing prescriptions are generated if the following eligibility criteria are met:

1. **Stable medication** – no significant changes in the last six months and no anticipated changes for the duration of the suggested batch
2. **Stable condition** – no recent unplanned hospital admissions (in the previous six months). Up to date medication monitoring – medication review completed within last six months. If not, could be considered for a telephone review
3. **Up to date disease monitoring** – initiating prescriber should review patient attendance at clinics and ensure appropriate blood tests performed/recalled and satisfactory within appropriate timescales.
4. **Exclusion criteria** includes controlled drugs (including temazepam and midazolam), Benzodiazepines, unlicensed medicines and patients with terminal illness

As part of the NHS Repeat Dispensing, consent from the patient must be taken to allow information sharing between the patent, community pharmacist and prescriber. This communication is crucial to the running of the service and patients cannot take part in the Repeat Dispensing service without giving this consent. Consent can be obtained either at the point of identification/nomination for repeat dispensing or at the point of authorisation for repeat dispensing. Consent for participation should be recorded on that patient's medication record using a written consent form (see Appendix 7).

5.20. Private Prescriptions

Humber Teaching NHS Foundation Trust should provide, free of charge, all care that NHS patients would have been entitled to have had they not chosen to have additional private care. Some treatments or consultations may not be classed as NHS care if they fall outside national guidelines or local agreements, e.g. fertility treatment where the couple do not meet the NICE guidelines.

Prescribers can only provide private prescriptions for their NHS patients in the circumstances listed below, where the item cannot be prescribed on the NHS:

1. Items included in the Drug Tariff Part XVIIIA – Drugs, Medicines and Other Substances not to be ordered under a General Medical Services Contract, also referred to as the NHS 'Black List'
2. Drugs for the prophylaxis against malaria
3. Drugs where the indication is outside those indicated on the selective list scheme (SLS – Part XVIIIB – Drugs, Medicines and Other Substances that may be ordered only in certain circumstances)
4. The product is in connection with travel and is for an anticipated condition, e.g. antibiotics for travellers' diarrhoea, acetazolamide for altitude sickness
5. Travel vaccines not included in NHS policy See extract below from guidance on NHS Choices: "Which travel vaccinations are free?" and the 'Green book'. Patients will usually have to pay for the following vaccinations for overseas travel: hepatitis B, Japanese encephalitis, meningitis ACW135Y, rabies, tick-borne encephalitis, tuberculosis, yellow fever from a designated centre

The terms of service of primary care medical services do not allow prescribers to supply private treatment to NHS patients. Therefore, issuing a private prescription for the purpose of avoiding NHS prescription charges for an item which is routinely issued on the NHS is not allowed.

5.21. Risk Management

There are considerable risks associated with both acute and repeat prescribing process. All practice staff are reminded to always check for:

- Correct patient – pay attention to patients with the same or similar names
- Check date of birth
- Correct drug name and strength – pay attention to similar sounding names, brand and generic name

It is important to record all critical incidents and "near misses" in order to ensure safer future practice. The practice should have received the necessary report forms from the Medicines Safety Officer. The aim of the anonymous reporting system is to reduce problems not to assign blame.
The practice will follow the process detailed in the Trust Reporting Adverse Incidents Policy and Procedure.

Missing prescriptions
If a prescription that has gone missing, it should not be reprinted until a thorough investigation has been carried out. If the missing prescription cannot be located, the prescription should be re- printed rather than reissued after obtaining prescriber agreement and a note with the reason for the reprint should be included in the patient record. Prescription should be marked as 'duplicate'. Care should be made to ensure patients do not run out of medication. If the prescriber or practice staff suspects that the missing prescription have been lost or stolen, then the prescriber or member of practice team must notify their Practice Manager or delegated practice staff **within one working day**. The practice manager or delegated staff must record this as a security incident on the Trust's incident reporting system, Datix (https://datix.xvictoria.nhs.uk).

Where it is suspected that claims that prescriptions have gone missing are being made in an attempt to gain excessive quantities of medicines the practice will need to put in place procedures to prevent this, e.g. record when the patient collects each prescription and reduce prescribing intervals, i.e. post-dated seven-day prescriptions. If prescriptions regularly go missing either at the practice or at a community pharmacy, the Trust Pharmacy Team should be contacted for advice on reviewing the repeat prescribing procedures.

In the event of lost or theft of prescriptions involving controlled drugs and drugs liable for misuse, they must be reported to the following agencies (in addition to Datix incident reporting):

- the designated person with overall responsibility for prescription forms in the Trust
- the Controlled Drugs Accountable Officer (CDAO) if applicable and:
  - the Police as required (by dialling 101)
  - NHS Protect should be notified of the incident by completing their notification form which should be emailed to NHS Protect at prescription@nhsprotect.gsi.gov.uk

Prescribers and practice managers should also refer to the NHS Protect security of prescriptions forms guidance.
https://cfa.nhs.uk/resources/downloads/guidance/fraud-awareness/Security_of_Prescription_forms_Updated_August_2015.pdf.

Duplicate Prescriptions
A duplicate prescription is an identical prescription reprinted as a replacement for a lost, defaced or damaged prescription. The issuing of a duplicate prescription should only occur in exceptional circumstances with authorisation from independent prescribers. The patient's clinical record will show one prescription and audit trail will show the reason for

this and that a second copy was printed. Independent prescribers should record reasons for printing a duplicate prescription in the patient's medical record. It is considered good clinical governance that regular audit should be undertaken to ensure compliance with this section of the policy.

Retrospective Prescriptions
No Prescription Only Medications should be supplied to a patient without a signed prescription or authorised PGD. Retrospective prescriptions will not be issued by the prescriber except in an emergency situation at the request of the patient/patient's carer or clinical specialist. Dispensing appliance or pharmacy contractors must not request retrospective prescriptions for items already supplied. There is no obligation for prescribers to provide a retrospective prescription and therefore prescribers should strongly consider refusing requests for retrospective prescriptions unless as a result of an emergency situation (see NHS (GMS) regulations 2004, Schedule 5, para 39 (6) and corresponding PMS regulations).

6. IMPLENTATION AND MONITORING

Quality Assurance
There should be a clear audit trail for all medicines added to or removed from a patient's repeat prescription list. Audit trails for prescription reprints, deletions, and where prescriptions have been printed and then deleted should be produced regularly. The practice computer system allows the practice to identify patients who have received repeat medication for a long time without review. Annual audit of 10-20 prescriptions should be undertaken in all practices to ensure procedures are followed. Audits are important for identifying standards of good practice and identifying areas that fall short of this. Audits may include:

- Items on the repeat list not collected for 12 months or more
- Alignment of repeat medication – do patients collect all repeats at the same time
- Registered nursing care home patients with no documented review of their medicines in the last 12 months

The repeat prescribing risk scoring tool adapted from Sandwell and West Birmingham CCG

(Appendix 3) helps practice staff to identify areas of improvement in their repeat prescribing system. Traffic light scoring system using Red, Amber, and Green (RAG) score has been devised.

Action following risk assessment needs to be implemented within one month for red areas and within three months for amber areas. Please see Appendix 4 for an example of practice-based audit tool.

Refer to Appendix 5 for a template of an action plan template to action issues identified in audits/risk assessments.

7. REFERENCE TO ANY SUPPORING DOCUMENTS

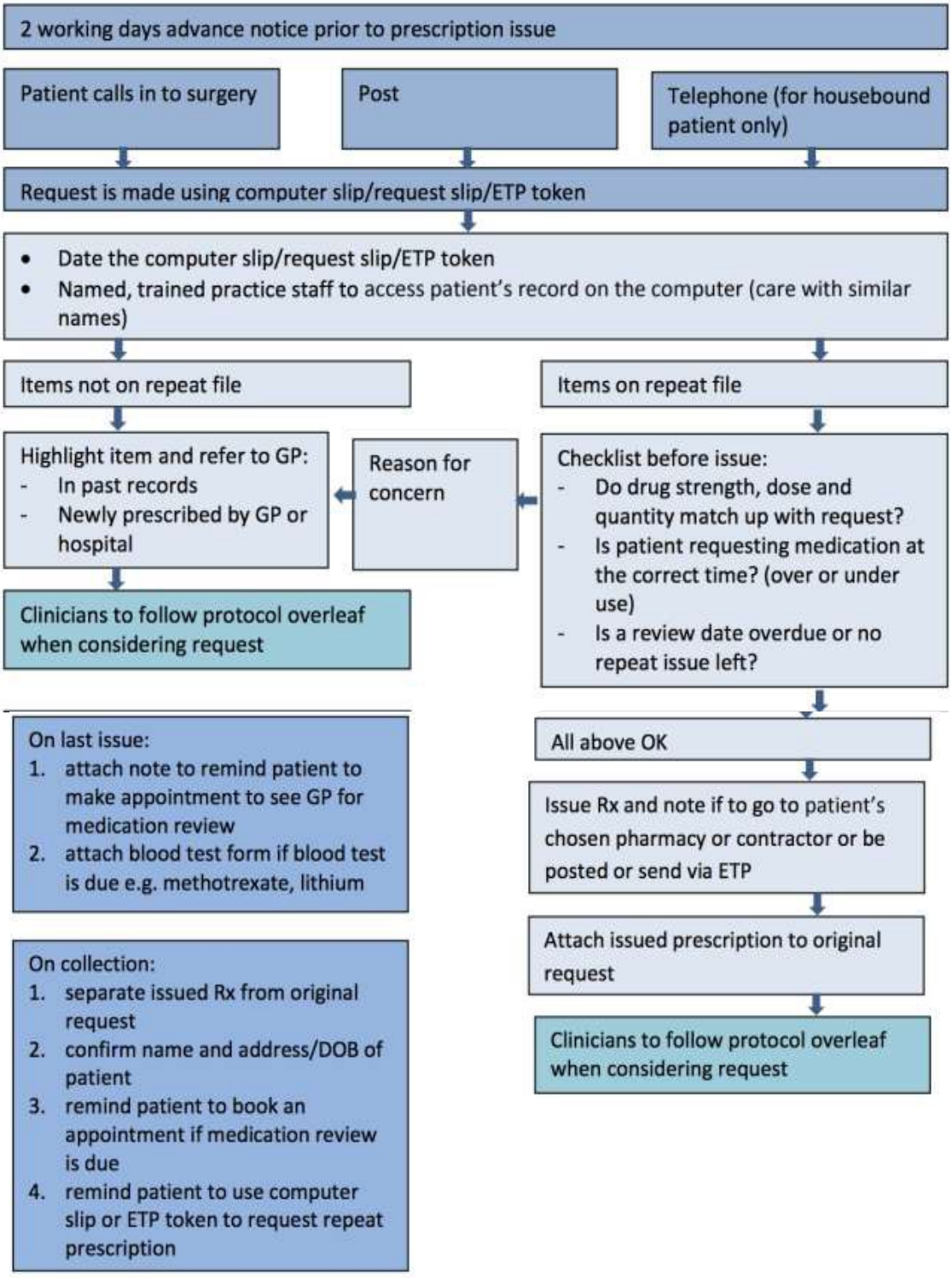
- Adapted for use from Repeat Prescribing Policy June 2013. Greenwich Clinical Commissioning Group (online). Available at http://www.valentinehealth.org.uk/website/G83067/files/CCG%20Repeat%20Prescribing%20policy. pdf (accessed 15 Feb 2018)
- Adapted for use from Repeat Prescription Synchronisation Form Dec 2013. Bexley

Clinical Commissioning Group (online). Available at http://www.bexleyccg.nhs.uk/Downloads/Medicines%20waste/Synchronisation.pdf (accessed 15 Feb 2018)

- King S, Miani C, Exley J et al.Impact of issuing longer- versus shorter – duration prescriptions: a systematic review. Br J Gen Pract 12 March 2018 (online). Available at http://bjgp.org/content/early/2018/03/12/bjgp18X695501/tab-pdf (accessed 11 Apr 2018)
- Adapted for use from Items Unsuitable for Generic Prescribing Guidance Sept 2016. *Health and Social* Care *Board. Health and Social Care in Northern Ireland* (online). Available at http://www.hscboard.hscni.net/download/PUBLICATIONS/pharmacy_and_medicines_management/prescribing_guidance/Items-unsuitable-for-generic-prescribing.pdf (accessed 15 Feb 2018)
- Good Medical Practice Guidance. General Medical Council 29 Apr 2014 (online). Available at https://www.gmc-uk.org/-/media/documents/Good_medical_practice 2018) _English_1215.pdf_51527435.pdf (accessed 2 Feb
- Improving Patient Outcomes – The better use of multi-compartment compliance aids Jun 2013. Royal Pharmaceutical Society (online)]. Available at https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Support/toolkit/ rps-mca-july-2013.pdf (accessed 15 Apr 2018)
- Adapted for use from Repeat Dispensing Handbook for Sunderland 2014. Sunderland Clinical Commissioning Group (online). Available at http://sunderlandccg.nhs.uk/wp-content/uploads/2014/05/SCCG-Repeat-Dispensing-Handbook-2014.pdf (accessed 15 Apr 2018)
- Adapted for use from A Good Practice Guide to Repeat Prescribing. Sandwell and West Birmingham Clinical Commissioning Group 15 Aug 2016 (online). Available at http://www.sandwellandwestbhamccgformulary.nhs.uk/docs/SWB%20CCG%20A%20Good%20Pra ctice%20Guide%20to%20Repeat%20Prescribing%2007.16.pdf (accessed 15 Apr 2018)

Appendix 1: Repeat Prescribing Protocol

Practice Protocol for Repeat Prescribing for Practice Staff. Adapted for our use from Repeat Prescribing Policy published by Greenwich Clinical Commissioning Group.



Practice Protocol for Repeat Prescribing for Clinicians (GPs/Independent Prescribers)

Before signing the repeat prescription, the clinician must ensure:

- Drugs that are not requested in the last 12 months are reviewed and removed if no longer required.
- Acute and repeat items are clearly marked on the clinical system (drugs that are inappropriate as repeats should be removed e.g. antibiotic issue x1).
- Hospital initiated medication is in line of interface prescribing policy.
- Drugs are listed by generic name unless there is a specific reason for brand prescribing i.e. as per BNF, intolerance to generic products
- Ensure drugs are not duplicated (e.g. brand and generic, topical and oral NSAIDs)
- Dose optimisation (e.g. 1 x 20mg versus 2 x 10mg)
- Synchronisation of quantity so that all drugs run out at the same time
- Compliance check – over or under supply
- Ensure a review date is in place or number of repeats allowed is limited to 6 months

MEDICATION REVIEW:

At least 6 monthly as a minimum with the full medical notes including a face to face review once a year

Check that

- the medication prescribed is appropriate for the patient's needs
- the medication is effective for the patient
- the medication is a cost effective choice
- any required monitoring or chronic disease review has been completed or arrangement is in place

Consider

- drug interactions
- side effects
- compliance
- over-the-counter and complementary medicines
- lifestyle and non-medicinal interventions
- unmet need

Record

- Information pertinent to any decisions made
- Read Code appropriate to the review: notes only or in person
- Proposed follow up and amend review date
- Linking medication to problem(s)

Appendix 2: Medication Synchronisation Form

Dear patient:

Synchronising your repeat medicines

We notice that on your last request for medication you only asked for some of your regular items. We are currently striving to ensure you have the same amounts of each medicine. This will have advantages for you, as you will be able to pick up all your medicines together reducing the number of times you have to order/collect your medication. This also has advantages for us, reducing the number of times we have to prepare your prescriptions. To achieve this, we want to issue a single synchronising prescription, so when your medicines are arranged so that they all run out around the same time. This means you can order all your regular medicines at the same time.

To help us with this synchronisation please complete the form below and hand it in the next time you order your repeat prescription. We will do the rest. When you next collect your prescription, you will receive different quantities of each to bring them in line. We do not plan to get it correct down to the last tablet, but in the future, you should be able to order all your regular items together
– there will be some exceptions where the dose of medication varies, i.e. painkillers, anticoagulants, insulin and cream.

Please complete the first three columns of this form and hand it in next time you order your repeat prescription, following the first example:

Name of medication	**How do you take the medication?**	**How many tablets do you have left?**	**For PRACTICE USE ONLY**	
			One month's supply =	**Supply of synchronisation prescription**
EXAMPLES: Aspirin 75mg tablets	**Once a day**	**7**	**28**	**21**

Are there any items on your repeat form that you are no longer using? YES/NO

If YES, which ones? _

If you have any questions or queries please speak to one of the reception staff.

Appendix 3: Repeat Prescribing Procedure Risk Scoring Table

Red	Action within 1 month
Amber	Action within 3 months

Question	Answer	Tick	Colour Code
Is there a written policy for repeat prescribing?	Yes		Green
	No		Red
	Do Not Know		Amber
Has this policy been reviewed in the last three years?	Yes		Green
	No		Amber
Have all staff signed to say they are aware of and understand the practice's repeat prescribing protocol?	Yes		Green
	No		Amber
	Do Not Know		Amber
Request			
Are telephone requests for housebound patients only?	Yes		Green
	No		Amber
	Do Not Know		Amber
Are all other requests taken by post / fax / email or written?	Yes		Green
	No		Amber
	Do Not Know		Amber
If the request is written is it presented on a repeat request slip?	Yes		Green
	No		Amber
	Do Not Know		Amber
Are the required items marked?	Yes		Green
	No		Amber
If the request is taken verbally which of the following is carried out?	Handwritten as request is taken then generated from computer		Amber
	If telephone request, prescription is generated from the computer as the request is taken		Green
	If face to face repeat request slip generated for patient to fill in		Green
	Do Not Know		Amber
If the request is taken verbally does the same person generate the script?	Yes		Green
	No		Amber
	Do Not Know		Amber
Does the policy specify what to do if the patient requests a repeat which needs to be re-authorised?	Yes		Green
	No		Red

Production			
Is the member of staff designated and trained?	Yes		Green
	No		Amber
	Do Not Know		Amber
Are the scripts computer generated?	Yes		Green
	No		Amber
	Do Not Know		Amber
What is the turnaround time for a repeat request?	<48 hours		Green
	>48 hours		Amber
	Do Not Know		Amber
Is there a designated time set aside for doing the repeats?	Yes		Green
	No		Amber
	Do Not Know		Amber
Is there a designated time set aside for signing?	Yes		Green
	No		Amber
	Do Not Know		Amber
Are the appropriate resources available (e.g. computer) when signing?	Yes		Green
	No		Amber
	Do Not Know		Amber
Miscellaneous			
Does the policy have specific details relating to repeat requests for high risk drugs e.g. warfarin, lithium, DMARDs?	Yes		Green
	No		Amber
Are uncollected prescriptions recorded before destruction?	Yes		Green
	No		Amber
	Do Not Know		Amber
If a prescription is reprinted, is the reason documented?	Yes		Green
	No		Amber
	Do Not Know		Amber

Authorisation			
Who authorises the repeats?	Receptionist		Red
	Nurse		Amber
	Doctor		Green
	Nurse Clinician		Green
	Pharmacist Prescriber		Green
	Do Not Know		Amber
What is the process for reauthorisation?	GP notified		Green
	GP not notified		Red
	Do Not Know		Amber
What is the process for reauthorisation?	GP notified		Green
	GP not notified		Red
	Do Not Know		Amber

How many issues are made?	0-6		Green
	6-12 (stable patients)		Green
	6-12 (unstable patients)		Amber
	More than 12		Red
	Do Not Know		Amber
Compliance			
Is compliance (days since last issue) checked before prescription issued?	Yes		Green
	No		Amber
	Do Not Know		Amber
Is there a standard written procedure for over compliance (ordering too frequently)?	Yes		Green
	No		Amber
	Do Not Know		Amber
Is there a standard written procedure for under compliance (not ordering at regular intervals)?	Yes		Green
	No		Amber
	Do Not Know		Amber
Acute Requests			
Who issues acute requests?	Receptionist		Red
	Receptionist from written protocol		Amber
	Doctor		Green
	Don Not Know		Amber

Discharges/Outpatients/Home Visits			
Who makes the decision to add/delete medication from the repeats?	Doctor		Green
	Nurse Clinician		Green
	Pharmacist prescriber		Green
	Nurse		Amber
	Receptionist		Red
	Do Not Know		Amber

Who updates the patients repeats after hospital discharge/outpatient's appointment/home visits?	Doctor		Green
	Receptionist not checked by doctor after update		Red
	Receptionist but doctor checks after update		Amber
	Do Not Know		Amber

Medication Review			
Who carries out the medication review?	Nurse		Green
	Doctor		Green
	Pharmacist		Green
	Has not been reviewed at appropriate intervals		Amber
Is there a procedure for highlighting when a medication review is due?	Yes		Green
	No		Amber
Are the notes/computer records clearly marked with date if present/future repeat medication reviews?	Yes		Green
	No		Amber
Prescription Collection			
Is there a record of prescriptions collected by pharmacies?	Yes		Green
	No		Red
Are uncollected prescriptions	Yes		Green

removed from patient's records and paper copies destroyed?	No		Red
Does the practice have a policy regarding missing scripts? Do they check with chemist, reprint?	Yes		Green
	No		Red
Prescription security			
Is there a procedure for recording serial number of prescriptions?	Yes		Green
	No		Amber
Are there appropriate storage facilities for signed prescriptions awaiting collection?	Yes		Green
	No		Red

Appendix 4: Repeat Prescribing Procedure Audit Tool

Audit Instructions

Audit ten patients per GP or 20 per practice, whichever is greater. Complete the repeat prescription (Rx) audit on page 24 for randomly selected patients.

Part 1

- Enter number of items on repeats for each patient in the relevant column (patient 1 to 10).
- Repeat the above process for each of the criteria listed under part 1.
- Add up the total of each criterion and enter number in the last column – this yields the total for each criterion (A).

Part 2

- Enter Yes (Y) or No (N) under each criterion.
- For each criterion add up the number of yes answers and enter the total number in the last column (which reads “No. of ‘Yes’ (B)).
- For seven-day prescriptions (if any selected in the random sample) – ensure you count and enter the number of seven-day script items where indicated on the table.

Transcribe the results A and B of repeat Rx audit onto the first column of Part 1 and Part 2 respectively of the ‘Summary of results from the repeat Rx’ audit form.

Part 1

- The sum of all items on repeat is referred to as D for calculation purposes on part 1 of the ‘Summary of repeat Rx audit’ form
- Calculate the percentage (%) by dividing A by D and multiplying by 100.
- Compare your practices’ percentage with the suggested standard listed in the table. This will help you identify areas for improvement.

Part 2

Divide the number of Yes (B) on repeat Rx audit by the total no. of patients audited(C) and multiply by 100 to give the practice percentage. Compare your practice’s percentage with the standard listed to help you identify areas of improvement.

For the ‘7-day prescription’ criterion, divide ‘No of 7-days scripts items issued properly (E)’ by Total no. of 7-days script items (F) and multiplying by 100 gives the practice percentage.

Appendix 5: Repeat Prescribing Procedure Audit Form

Practice:

_____

Date of audit:

_____

Repeat prescription (Rx) audit

Audit 10 patients per GP or 20 per practice, whichever is greater

NHS
Humber Teaching
NHS Foundation Trust

Criteria ↓ / Patient →	1	2	3	4	5	6	7	8	9	10	Total no. of Items(**A**)
Part 1 Enter number(no.) of items with reference to computer screens of randomly selected patients											
No. of items on repeat											**(D)**
Number of items linked to indications											
Number of drugs prescribed that should not be on repeat											
Number of items with appropriate directions (dose and frequency). Instructions PRN or MDU alone are not acceptable											
No. of items not ordered in the last 6 months (excluding seasonal medication e.g. hay fever)											
No. of PRN oral or topical analgesics including NSAIDs											

Part 2 Answer Yes(Y) or No(N)											No. of 'Yes' **(B)**
Are quantities prescribed appropriate to dose?											
Are all quantities synchronised (so they all last the same time)?											
Are all repeats authorised for a maximum of 12 months?											
Are all regular repeats (excluding PRN items) being ordered regularly?											
Are repeats being issued after the authorisation period has expired?											
Have drugs not ordered in the last year been removed from the repeat prescribing screen?											
Is there a record of a medication review in the past 12 months?											
Are there any items that are prescribed as generic that should be prescribed by brand?											
Are there any items for which dose could be optimised? (e.g. 2x 5 mg switched to 10 mg?											
Are there any duplicate items on repeat?											
Checked with patient-all items required?											
Are 7 days scripts items being issued for valid reasons?											Total no. of 7 day script items.....

Summary of the results from the repeat prescription (Rx) au

Humber Teaching NHS Foundation Trust

Practice: _____
Total no. of items on repeat sampled (**D**): _____

Part 1	Total no. of items(**A**) on repeat Rx audit	Practice % **A/D** x 100	Suggested standard
Total no. of items linked to indications			90%
No. of drugs(items) prescribed that should not be on repeat			<5%
No. of items with appropriate directions (dose and frequency). Instructions PRN or MDU alone are not acceptable			90%
No. of items not ordered in the last 6 months (excluding seasonal medication e.g. hay fever)			<10%
No. of PRN oral or topical analgesics including NSAIDs			No suggested standard-could be a practice discussion point

Part 2	No. of Yes(**B**)on repeat Rx audit	Practice % **B/C** x 100 **C**=total no. of patients audited		Suggested standard
Are quantities prescribed appropriate to dose?				90%
Are all quantities synchronised (so they all last the same time)?				100%
Are all repeats authorised for a maximum of 12 months?				90%
Are all regular repeats (excluding PRN items) being ordered regularly?				90%
Are repeats being issued after the authorisation period has expired?				10%
Have drugs not ordered in the last year been removed from the repeat prescribing screen?				90%
Is there a record of a medication review in the past 12 months?				90%
Are there any items that are prescribed as generic that should be prescribed by brand?				0%
Are there any items for which dose could be optimised? (e.g. 2x 5 mg switched to 10 mg?				10%
Are there any duplicate items on repeat?				0%
Checked with patient-all items required?				90%
	No of 7 days scripts items issued properly **(E)**	Total no. of 7 days script items(**F**)	% **E/F** x 100	Suggested standard
Are 7 days scripts being issued for valid reasons?				100%

Appendix 6: Audit Action Plan Template

Area	Issues Identified	Action	Estimated completion date	Details of Implementation For Example: • Date protocol changed • Date all staff signed updated protocol • Date audited	Date Completed

Appendix 7: Medicines Unsuitable for Generic Prescribing

The following list provides examples of drugs/preparations which would **not** be recommended for generic prescribing. This list is guidance only, please refer to the BNF or contact your general practice clinical pharmacist for more information. Please note the list of brand names given as examples **is not exhaustive**.

Medicine Category	Generic name / group	Examples	Comments
Drugs with a **narrow therapeutic index**	Aminophylline	Phyllocontin Continus®	There may be differences in the bioavailability of the preparations and / or the difference between therapeutic and toxic plasma concentrations. Therefore the brand name should be prescribed.
	Lithium	Priadel®, Camcolit®, Liskonum®	
	Theophylline	Nuelin SA®, Slo-Phyllin®, Uniphyllin Continus®	
Drugs with a narrow therapeutic index for **certain indications**, e.g. renal transplant	Ciclosporin	Neoral®, Sandimmun® Deximune®	
	Mycophenolate	CellCept®, Arzip®, Myfenax®	
	Tacrolimus	Prograf®, Advagraf®	
Anti-epileptic drugs Category 1	Phenytoin	Phenytoin Flynn hard capsules	**Anti-epileptic drugs Category 1** Ensure the patient is maintained on a specific manufacturer's product **Anti-epileptic drugs Category 2** *The need for continued supply of a particular manufacturer's product should be based on clinical judgement and consultation with patient / carer taking into account seizure frequency and treatment history. **Anti-epileptic drugs Category 3** (Levetiracetam, Lacosamide, Tiagabine, Gabapentin, Pregabalin, Ethosuximide, Vigabatrin) It is usually unnecessary to ensure that patients are maintained on a specific manufacturer's product unless there are specific reasons such as patient anxiety and risk of confusion or dosing errors.
	Carbamazepine	Tegretol®, Carbagen®, Epimaz®	
	Phenobarbital	Prescribe generic name and state manufacturer	
	Primidone	Prescribe generic name and state manufacturer	
Anti-epileptic drugs Category 2 for some patients*	Valproate, Lamotrigine, Perampanel, Retigabine, Rufinamide, Clobazam, Clonazepam, Oxcarbazepine, Eslicarbazepine, Zonisamide, Topiramate		
Certain **modified-release** preparations	Diltiazem	Angitil XL®, Zemtard®, Slozem®, Adizem XL®, Tildiem LA®	The BNF states that brand names should be specified in certain instances as different versions of these modified-release (m/r) preparations may not have the same clinical effect.
	Mesalazine	Asacol MR®, Pentasa®	
	Nifedipine	Adipine MR or XL®, Coracten SR or XL®, Adalat Retard®	
	Methylphenidate	Concerta XL®, Equasym XL®, Medikinet XL®	

Certain **Controlled Drugs** including patches (Schedule 2 and 3)	Buprenorphine	Butec®, Butrans®, Transtec®, Bupeaze®, Hapoctasin®	Caution due to differing dosage regimes for SR and XL preparations. The BNF states that dosage should be reviewed if brand altered.
	Fentanyl (transdermal)	Mezolar®, Durogesic DTrans®, Fentalis®, Matrifen®, Tilofyl®	
	Morphine	MST®, MXL®, Zomorph®, Morphgesic SR®, Sevredol®	
	Oxycodone	Longtec®, Shortec®, Oxycontin®, Oxynorm®	
Certain **inhaler devices**	Beclometasone (+/- Formoterol)	Qvar®, Clenil®, Fostair®	Always state the type of device, e.g. accuhaler, turbohaler. This is to ensure that the patient continues to receive the device that they have been trained to use.
	Dry powder devices	Accuhaler®, Easyhaler®, Turbohaler®, Pulvinal®, Clickhaler®, Foradil®	
Multi-ingredient products	See examples →	Stalevo®	Generic prescribing may not be practical or may cause confusion due to multiple ingredients. Some combination products are appropriate for generic prescribing using an approved 'co-' prefix e.g. co-codamol, co-amilofruse, etc.
		Hormone replacement therapy	
		Oral contraceptives	
		Multi-ingredient GI preps. e.g. Peptac®, pancreatin, rehydration salts, laxatives etc.	
		Multi-ingredient ENT preparations	
		Creams, bath oils, antiseptics, liquids or gels	
		Bowel cleansing solutions	
Specific brands for **specific indications**	Duloxetine	Yentreve® or Cymbalta®	
	Denosumab	Prolia® or Xgeva®	
	Buprenorphine	Subutex® or Temgesic®	
Miscellaneous	See examples →	Antipsychotic depot injections	These should be prescribed using the brand name to avoid confusion / aid product identification. Generic prescribing for these drugs may affect clinical response or contribute to administration incidents.
		Stoma care products and appliances	
		Wound products	
		Insulin	
		Nutritional products	
		Vaccines	
		NRT	

Appendix 8: NHS Repeat Dispensing Nomination Form

Confidential

NHS Repeat Dispensing Nomination Form

Patient Details (to be completed by patient, pharmacy or GP practice)

Full Name: _____

Address: _____

Date of Birth: _____

This patient is suitable for the NHS Repeat Dispensing Scheme according to the criteria set out in the SCCG Medicines Optimisation guidance on Repeat Dispensing.

Pharmacy Details (or stamp):

Pharmacy Name: _____

Address: _____

_____

The patient has received an information leaflet and has been counselled on the use of repeat dispensing: **Yes/ No**

The patient has given verbal consent for information sharing between themselves, the pharmacy and the GP practice: **Yes/ No**

Where nominated by the pharmacy:
The patient has received a Medicines Use Review on: _____ and I am happy that no changes are required to their medication for the duration of the prescription batch I have suggested overleaf.

Where nominated within the GP practice:

Date medication review next due: _____

Form completed by (either Pharmacy or GP practice):

Full Name: _____

Designation: _____

Date: _____

Authorisation (to be completed by GP practice only):

Repeat Dispensing authorised by: _____

Repeat Dispensing READ coded added to records*: Yes/ No

Nominated pharmacy added to patients records*: Yes/ No

*as per local practice guidelines

The following is the suggested medication to be included in the batch:

Medicine details *(Name, strength, form and directions as required)*	Regular/ PRN	Quantity per issue	No. of issues	Home Stock§	Quantity for Synchronisation Prescription†

§ Complete as required

Appendix 9: Document Control Sheet

This document control sheet, when presented to an approving committee must be completed in full to provide assurance to the approving committee.

Document Type	Prescribing Policy for General Practice		
Document Purpose	The purpose is to set out the framework for the management of acute and repeat prescribing throughout all general practices within the Humber Teaching NHS Foundation Trust to ensure the safe and effective delivery of patient centred care.		
Consultation/Peer Review:	Date:	Group/Individual	
List in right hand columns consultation groups and dates	January 2022	Clinical Network	
	27 January 2022	Drugs and Therapeutics Groups	
	27 January 2022	Quality and Patient Safety Group	
Approving Committee:	Quality Committee	Date of Approval:	9 December 2020
Ratified at:	Trust Board	Date of Ratification:	27 January 2021
Training Needs Analysis: *(please indicate training required and the timescale for providing assurance to the approving committee that this has been delivered)*		Financial Resource Impact	
Equality Impact Assessment undertaken?	Yes [✓]	No [ ]	N/A [ ] Rationale:
Publication and Dissemination	Intranet [✓]	Internet [ ]	Staff Email [ ]
Master version held by:	Author [ ]	HealthAssure [✓]	
Implementation:	*Describe implementation plans below - to be delivered by the author:*		
	To be distributed to all clinical leads for discussion at their clinical meetings. A signed sheet from all clinicians in HTFT surgeries to state they have read the document. The document will be stored on the practices shared drives.		
Monitoring and Compliance:	An audit to be carried out 6 months after implementation of the policy		

Document Change History:			
Version Number/Name of procedural document this supersedes	*Type of Change, e.g., Review/Legislation*	*Date*	*Details of Change and approving group or Executive Lead (if done outside of the formal revision process)*
Version 1.0	*New document*	*Sept-20*	*New Document* *Consultation through clinical network, DTG, QPaS and approved at Quality committee 9 December 2020 with ratification at Trust Board 27 January 2021*
Version 1.1	*Review with no changes*	*Sept-21*	*Reviewed and approved through DTG and QPaS 27 January 2022*

Appendix 10: Equality Impact Assessment (EIA)

For strategies, policies, procedures, processes, guidelines, protocols, tenders, services

1. Document or process or service name: *Prescribing Policy for General Practice*
2. EIA reviewer (name, job title, base and contact details): *Marian Opoku-Fofie, Principal*
3. Is it a policy, strategy, procedure, process, tender, service or other? *Policy*

Main Aims of the Document, Process or Service		
Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma		
Equality Target Group 1. Age 2. Disability 3. Sex 4. Marriage/Civil Partnership 5. Pregnancy/Maternity 6. Race 7. Religion/Belief 8. Sexual Orientation 9. Gender Reassignment	Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed? Equality Impact Score Low = Little or No evidence or concern (Green) Medium = some evidence or concern(Amber) High = significant evidence or concern (Red)	How have you arrived at the equality impact score? a) who have you consulted with b) what have they said c) what information or data have you used d) where are the gaps in your analysis e) how will your document/process or service promote equality and diversity good practice

Equality Target Group	Definitions	Equality Impact Score	Evidence to support Equality Impact Score
Age	Including specific ages and age groups: Older people Young people Children Early years	**Low**	Review with different clinical leads, individual clinicians, pharmacy senior team and practice pharmacists took place to enable adjustments to the policy to ensure that no age group is adversely affected by this policy
Disability	Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities: Sensory Physical Learning Mental health (including cancer, HIV, multiple sclerosis)	**Low**	Review with different clinical leads, individual clinicians, pharmacy senior team and practice pharmacists took place to enable adjustments to the policy to ensure that no group with a disability is adversely affected by this policy
Sex	Men/Male Women/Female	**Low**	Review with different clinical leads, individual clinicians, pharmacy senior team and practice pharmacists took place to enable adjustments to the policy to ensure that no one is adversely affected by this policy
Marriage/Civil Partnership		**Low**	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Pregnancy/ Maternity		**Low**	Review of the policy has taken place to ensure no group is adversely affected

			by the policy.
Race	Colour Nationality Ethnic/national origins	**Low**	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Religion or Belief	All religions Including lack of religion or belief and where belief includes any religious or philosophical belief	**Low**	Review of the policy has taken place to ensure no group is adversely affected by the policy
Sexual Orientation	Lesbian Gay men Bisexual	**Low**	Review of the policy has taken place to ensure no group is adversely affected by the policy.
Gender Reassignment	Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex	**Low**	Review of the policy has taken place to ensure no group is adversely affected by the policy.

Summary

Please describe the main points/actions arising from your assessment that supports your decision above In summary, the policy is to ensure the safe and effective delivery of patient centred care to all patient groups and to support prescribers within General Practice in doing this and not	
EIA Reviewer: Marian Opoku-Fofie	
Date completed: 27 January 2022	Signature: Marian Opoku-Fofie