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Medicines Optimisation

Model Repeat Prescribing System

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Document Summary

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Document Purpose:	A model repeat prescribing system
Document Name:	North of England Commissioning Support (NECS) MO Repeat Prescribing Process
Document Ref No.	MOPP-011
Report Owner or Sponsor:	Ian Morris
Target Audience:	GP Practice staff
Description	To demonstrate the process including detailing the roles and responsibilities
Action Required:	To note for compliance with the procedure
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Document Status

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Model Repeat Prescribing System

1. Introduction

1.1. Background

An acute prescription is one that is issued on a “one-off” basis, as the result of a consultation or transfer of care. A repeat prescription is a continuation of a previously prescribed medication that is issued without the need for a full consultation with the prescriber.

This document provides practices with practical support to design their own robust systems to enable safe and accurate repeat prescribing to take place.

Practices can use it to develop or review their own internal policies and procedures. These should be written, overseen and managed by a senior member of staff with responsibility for oversight of the repeat prescription process, with delegation to an appropriate deputy if required and cover arrangements. Policies and procedures should be reviewed every 2 years or earlier, if either new guidance becomes available or circumstances change. Practices might find it beneficial to have a specialist non-clinical member of staff or a team, to run the repeat prescribing process, e.g. medicines manager or prescribing clerk(s). In addition, all members of staff, including locum prescribers, should be trained and fully aware of how the practice repeat prescribing system works, including their individual responsibilities. Senior members of staff should have assurance of this. Practices should maintain comprehensive, up-to-date and accurate repeat prescribing information for each patient on their clinical system.

Use of electronic repeat dispensing (eRD) replaces the need for patients to order their medication regularly via the practice. This is more convenient for both the patient and practice. It has been estimated that up to 80 % (330 million) of all repeat prescriptions could potentially be processed with eRD, saving 2.7 million hours of GP and practice time, saving the NHS approximately £90m.[1] In 2010, a public survey found the average cost of medicines waste to be £5.33 per person.[2] The synchronisation of quantities and durations and the provision of medication through eRD are recommended as potential methods to try to reduce this cost of medicines waste occurring through over ordering.

[1] NHSD. Maximising electronic repeat dispensing. https://digital.nhs.uk/services/electronic-prescription-service/electronic-repeat-dispensing-for-prescribers/maximising-electronic-repeat-dispensing *Accessed 25/2/19.*

[2] York Health Economics Consortium, The School of Pharmacy, University of London. (2010). Evaluation of the Scale, Causes and Cost of medicines waste. http://discovery.ucl.ac.uk/1350234/1/Evaluation_of_NHS_Medicines_Waste__web_publication_version.pdf *Accessed 12/6/19.*

The following processes will still be relevant when initiating and re-authorising batches of eRD. ERD is not suitable for all patients and practices should ensure they meet the needs of these patients to enable them to order and take their medication. Learn more about eRD through the NHS Digital (NHSD) website. https://digital.nhs.uk/Electronic-Prescription-Service/Electronic-repeat-dispensing-for-prescribers.

Practice systems and processes are regulated by the Care Quality Commission (CQC). Practices can find other relevant information in the NECS document 'Care Quality Commission Inspections: Managing Medicines in a GP Practice'. https://medicines.necsu.nhs.uk/download/cumbria-cqc-managing-medicines-in-a-gp-practice-resource-oct-2016/?highlight=cqc

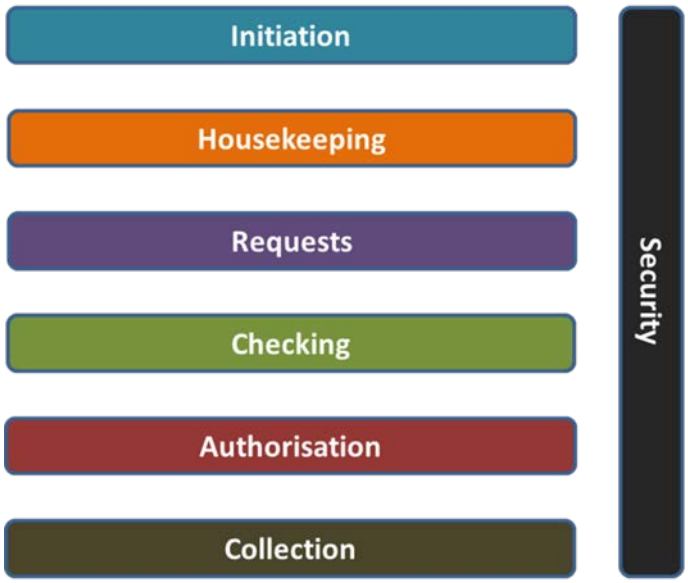
Both the practice's repeat prescribing system and the processes involved should encourage a person-centred approach to care[3], enabling all patients to order and receive their medication quickly, safely and easily. Collaboration with patient involvement groups can be helpful when reviewing the system, ensuring it is simple to use and providing efficient, seamless care that meets the needs of all patients. A well-designed system is convenient for patients, practices and community pharmacies; wrapping around other aspects of patient care e.g. tying together an annual asthma review with implementation or re-authorisation of an eRD batch. Each step should offer flexibility, particularly to support patients who are vulnerable e.g. requesting or collection processes should take into account rurality, frailty and other individual needs.

A number of case studies are included for practices to use during a review of their systems, or as educational tools during training. A checklist is available at the end of this document for review of practice prescribing systems by the nominated individual (or delegated as necessary). Regular review of the system helps to keep prescribing safe and cost-effective; it is also useful evidence during a CQC inspection.

1.2. Process stages

The process of repeat prescribing has been split into the seven stages shown below and will be described separately in the subsequent sections of this report.

[3] Royal Pharmaceutical Society (RPS). (2013) Medicines Optimisation: Helping patients to make the most of medicines. https://www.rpharms.com/Portals/0/RPS%20document%20library/Open%20access/Policy/helping-patients-make-the-most-of-their-medicines.pdf *Accessed 10/6/19.*



2. Initiation

This details the processes to ensure that repeat prescriptions are started safely; meeting best practice and guidance at both a national and local level. It might take place following a consultation or during medicines reconciliation following transfer of care from another practice or hospital. This is only a guide and does not replace clinical judgement.

2.1. Initiation – Responsibilities

Adding medication to the clinical system is the responsibility of the prescriber. For a non-medical prescriber, they should ensure they are working within their area of competence and have assessed the patient before adding the medication. Where medication is added by a non-clinical member of staff, it must be checked by a prescriber for clinical suitability and accuracy; this check should be recorded. Please see the General Medical Council (GMC) Guidance entitled 'Good practice in prescribing and managing medicines and devices'[4] for further information. This is also discussed in greater detail in Section 6.3.

2.2. Initiation – Identifying suitable medicines

The National Health Service England (NHSE) General Medical Services (GMS) contract states that eRD is to be the default position for all clinically appropriate

[4] GMC. Good practice in prescribing and managing medicines and devices https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/reviewing-medicines *Accessed 12/6/19.*

patients from April 2019.[5] Findings from a NECS eRD implementation project demonstrated that 50-60 % of prescribed medication is typically suitable for eRD.[6] When determining whether a medication should be prescribed through eRD, both medication suitability (section 2.2) and patient suitability (section 2.5) should be considered. A prescriber should add authorised medications to a patient's repeat medication list, following the steps below. The practice may wish to have an additional protocol for this process. ERD should be embedded in both the repeat prescription process and the medication review process. Practices may also find a separate protocol for eRD (in addition to embedding) beneficial, depending on the structure and approach taken to identifying suitable patients / medication.

Section 2.3.1-2.3.3 See respective paragraphs in section 2.3 Initiation; Points to note.

[5] NHSE. (2019). Investment and Evolution: A five-year framework for GP contract reform to implement the NHS long term plan. https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf *Accessed 27/2/19.*

[6] NECS. (2019). Medicines Optimisation. Electronic repeat dispensing (eRD) pilot. NHS Confidential.

2.3. Initiation – Points to note

2.3.1 Assess appropriateness of medication; examples of items generally not considered suitable for eRD include:

- Acute prescriptions
- Red drugs
- Schedule 2 or 3 controlled drug (CD)
- Drugs that require additional monitoring such as anti-coagulants, lithium or Disease Modifying Anti-Rheumatic Drugs (DMARDs), and other shared care medication.
- Low molecular weight heparins
- Appliances including:
  - Catheters and associated products*
  - Stoma bags and associated products*
  - Blood glucose test strips*
  - Pen needles*
  - Lancets*
  - Dressings
- Insulin*
- Sip feeds
- COPD Rescue packs (antibiotics and steroids)
- Adrenaline pens
- Hypnotics and anxiolytics
- As required medication (PRN)
- Seasonal medication*

*May be suitable for ‘variable use’ repeat dispensing for some patients.

2.3.2 Other areas for consideration including patient stability on medication:

- Stability of the patient’s condition and how often their clinical management is reviewed.
- The risk of side effects
- How likely it is the patient will take the medicine as intended.
- Safety considerations associated with storing the medicine in the home.
- Patient convenience including, where relevant, cost in prescription charges.
- Any monitoring required including frequency of monitoring, ensuring safety.

2.3.3 Prescribing intervals

Prescribing intervals should be agreed with the patient, taking into account the need to safeguard NHS resources (potential for wastage), patient safety and convenience, and the dangers of excess drugs in the home.

As a guide, 28 day prescribing is advised in the following:

- Newly initiated medicines (use smaller quantities where possible i.e. maximum 28 day prescribing and set up as an acute initially).
- Care homes.
- Patients requiring compliance aids such as monitored dosage systems or dosette boxes. In some cases, quantities less than 28 days may be appropriate; refer to guidance on the Equality Act 2010[7] for further information.
- High risk drugs and those that require frequent monitoring (such as DMARDS).
- Expensive items (prescribers should be aware of costs).
- Controlled drugs
- Medicines liable to abuse.
- Terminally ill patients.
- Patients who may not be taking medicines appropriately or who may struggle to manage more than 28 days stock of medicines.

For items taken daily, quantities prescribed should be in multiples of 28 and the quantities and durations for individual patients should be synchronised, so they all run out at the same time. This will help to reduce medicines being stockpiled or wasted and potentially reduce the number of times the patient has to visit the surgery and the number of times a prescription has to be issued for the same patient, thus saving clinical and administration time.

The use of seven day prescriptions is not recommended unless the patient is unable to manage larger quantities or is at risk of incorrect use. In these circumstances it would be appropriate to prescribe seven days at a time. This could be done using eRD if otherwise considered to be appropriate.

2.4. Initiation – CDs

- The prescriber needs to ensure that the CD is suitable to be a repeat medication. There is currently a roll out of the functionality that enables CD schedule 2 and 3 (except liquid Methadone) to be prescribed through the Electronic prescription service release 2 (EPSr2). However, legislation

[7] Equality Act. 2010. https://www.legislation.gov.uk/ukpga/2010/15/contents

does not permit a CD schedule 2 or 3 to be prescribed on a repeatable prescription; either paper or electronic.[8]

- Schedule 2, 3 and 4 prescriptions are valid for 28 days after the appropriate date on the prescription. The appropriate date is either the signature date or any other date indicated on the prescription (by the prescriber) as a date before which the drugs should not be supplied - whichever is later. [9] The quantity should not exceed 30 days' supply (shorter intervals may be more appropriate for these medications).
- This includes temazepam (schedule 3), other benzodiazepines (schedule 4), gabapentin (schedule 3) and pregabalin (schedule 3).
- It may be useful to communicate to the community pharmacy that there is a separate CD prescription, if the other medications are prescribed by eRD. This could be done by editing the "pharmacy message" on the eRD prescription (e.g. "separate CD prescription").
- Drugs in schedule 4 and 5 may be sent electronically and via eRD.
- A list of commonly prescribed schedule 2 and 3 CDs is available on the NECS website.[10]
- A full list of CDs is available in the legislation; The Misuse of Drugs Regulations 2001 with amendments up to 2018.[11]

2.5. Initiation – Identifying suitable patients for eRD

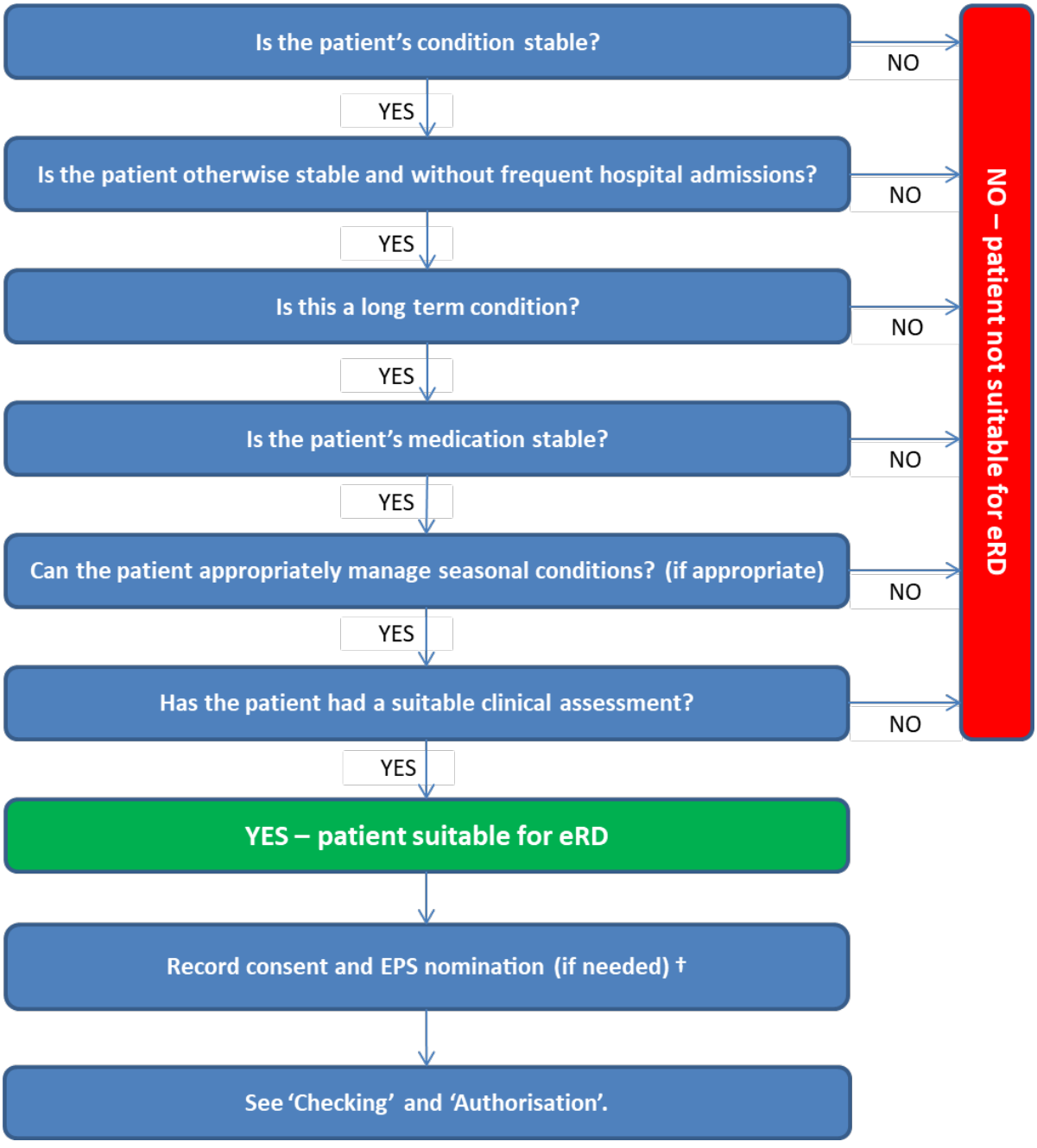
The flow chart below illustrates considerations for initiating eRD which apply to all repeat medication, whether newly added or current.[12]

In addition, as part of the initiation process, consider the following:

- Once a patient is set up on eRD, explain which items will be on eRD, and which items will need to be ordered (PRN medication).
- Ensure the patient knows how to order their PRN medication.
- Speak to the nominated community pharmacy and make sure they are aware the patient has been set up on eRD.

[8] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013, as amended. http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf
[9] RPS. (2018). Medicines, Ethics and Practice. The professional guide for pharmacists. Edition 42.
[10] NECS. Good practice guidance and tools for care homes. https://medicines.necsu.nhs.uk/necs-good-practice-guidance-and-tools-for-care-homes/ *Accessed 12/6/19.*
[11] The Misuse of drugs Regulations 2001 and as amended. https://www.legislation.gov.uk/uksi/2001/3998/contents/made
[12] NHSE. (2019). Electronic Repeat Dispensing Guidance. https://www.england.nhs.uk/publication/electronic-repeat-dispensing-guidance/ *Accessed 13/6/19.*

- Establish an in-house system to ensure patients remain on eRD after the first batch.
- If necessary, Issue an acute prescription for one month whilst a medication review is carried out. Then set up eRD until their next review if appropriate.



† see NHSE Electronic Repeat Dispensing Guidance[12] for information on consent and EPS nomination.

2.6. Initiation – Resources & References

British National Formulary (BNF). https://www.medicinescomplete.com/#/ *Accessed 12/6/19.*

GMC. (2013). Good practice in prescribing and managing medicines and devices. http://www.gmc-uk.org/guidance/ethical_guidance/14316.asp *Accessed 12/6/19.*

Medicines and Healthcare Product Regulatory Agency (MHRA). https://www.gov.uk/government/organisations/medicines-and-healthcare-products-regulatory-agency *Accessed 12/6/19.*

National Institute for Health and Care Excellence (NICE). Browse guidelines by topic. http://www.nice.org.uk/guidance/conditions-and-diseases *Accessed 12/6/19.*

NICE. (2016). Controlled drugs: safe use and management. NG46. https://www.nice.org.uk/guidance/ng46 *Accessed 12/6/19.*

NICE. (2019). Shared decision making. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making *Accessed 11/6/19.*

NICE. Clinical knowledge summaries (CKS). http://cks.nice.org.uk/ *Accessed 12/6/19.*

NECS. Regional and local guidelines and resources available. http://medicines.necsu.nhs.uk *Accessed 11/6/19.*

NECS. Guidance documents. NECS MO. Schedule 2 and 3 Controlled drugs list. http://medicines.necsu.nhs.uk/controlled-drugs/guidance-documents/ *Accessed 12/6/19.*

NHSD. Electronic repeat dispensing for prescribers. https://digital.nhs.uk/Electronic-Prescription-Service/Electronic-repeat-dispensing-for-prescribers. *Accessed 11/6/19.*

NHSD. Explaining electronic Repeat Dispensing to patients. https://digital.nhs.uk/services/electronic-prescription-service/explaining-electronic-repeat-dispensing-to-patients *Accessed 11/6/19.*

NHSD, NECS. Electronic repeat dispensing (eRD) e-learning. https://learning.necsu.nhs.uk/nhs-digital-electronic-repeat-dispensing-elearning/ *Accessed 11/6/19.*

NHSE. (2015). Electronic Repeat Dispensing Guidance. https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/06/electronic-repeat-dispensing-guidance.pdf *Accessed 11/6/19.*

Specialist Pharmacy Service (SPS), UK Medicines Information, NHS. (2017) Suggestions for Drug Monitoring in Adults in Primary Care:

https://www.sps.nhs.uk/articles/suggestions-for-therapeutic-drug-monitoring-in-adults-in-primary-care/ *Accessed 13/6/19.*

The Misuse of drugs Regulations 2001 and as amended. https://www.legislation.gov.uk/uksi/2001/3998/contents/made

3. Housekeeping

Regular housekeeping of a patient's repeat medication, for example removing old medication no longer used, as per practice protocol, will help to keep records up-to-date and accurate and can help to reduce prescribing errors and prescription waste.

3.1. Housekeeping – Responsibilities

Some administrative aspects of housekeeping can be carried out by non-clinical staff. Where a clinical decision is required on suitability for continued prescribing, this should be directed to a prescriber and where appropriate, involve the patient in shared decision making.

3.2. Housekeeping – Hint and Tips

3.2.1. How do you prioritise housekeeping?

Consider patients on very large numbers of repeat medicines, those who make most frequent requests for prescriptions and those who may have difficulty with medicines supplies.

3.2.2. How does the housekeeping process fit in with other patient reviews?

Housekeeping should be embedded at the beginning of the eRD implementation process as well as being embedded in the medication review, long-term condition review and repeat re-authorisation processes.

3.2.3. How do you encourage patient participation?

Invite patients to collaborate. Consider printed or online information to encourage patients and carers to let their practice or pharmacist know if they need help with their medicines e.g. a form for Medication Use Review (MUR) referrals or for patients to request that medicines are synchronised ("put in line").

3.2.4. How do you work with the local community pharmacist?

Pharmacists can promote housekeeping and synchronisation using posters, flyers and other materials to support the process via MURs. They can collect information on medicines in hand and liaise directly with patients. Providing pharmacists with copies of leaflets or forms to be handed out to selected patients may be fruitful.

3.2.5. Do you have a practice champion for repeat prescription housekeeping?

Empower relevant staff and teams to actively promote and pursue housekeeping and synchronisation.

3.2.6. How does the synchronisation process fit in with housekeeping and other practice processes?

Both the Synchronisation and Housekeeping process should be embedded in the eRD implementation process as well as linking in to both the medication review and repeat prescribing processes. There should also be a system to trigger synchronisation and housekeeping independently of these processes.

Develop local policies/procedures to guide this and empower staff. Ensure policies cover exceptions to provisions for archiving (see Section 3.3 Box 1 for examples) and processes for dealing with 'when required' medicines. Ensure out-dated or inactive repeats are removed/retired/archived (can be automated in some clinical systems, check your system specifics).

Separate 'when required' medicines and other non-standard items from regular repeats. For repeat dispensing, mark as 'variable use' in EMIS Web and as 'irregularly issued template' in SystmOne™. Other categories such as 'Hospital', 'Dental', 'Private' and 'Over The Counter (OTC)' may also be helpful. Please refer to your clinical system for specifics. Arrange for these items to be issued separately & set intervals accordingly. Where possible, align re-authorisation dates for all medicines to review dates. It may be a consideration to use birthday month as the ongoing review date to stagger workload.

3.2.7. Do you have a practice or local policy on standard prescription duration and quantities, with details of routine exceptions?

Section 3.3 Box 2 provides example exceptions to local standard supply intervals. Clearly document any ad-hoc exceptions in the patient's notes.

Use features of clinical systems to record expected duration and minimum re-order intervals. Pay particular attention to the duration set for inhalers, creams, 'when required' medicines and other non-standard items. Agree local policy (e.g. set the duration of all salbutamol inhaler prescriptions for asthma to 200 days per 200 dose pack to aid interpretation of calculated usage figures; set duration of 'when required' medication to the duration at maximum usage).

3.2.8. Do you have a practice or local policy on review and re-authorisation intervals, with details of routine exceptions?

This should specify the procedures for review and re-authorisation of repeat prescriptions.

3.2.9. Do you have a practice or local policy to support eRD?

This should also include procedures for dealing with changes mid-batch and what to do in the event of a patient or prescriber changing practice during an eRD cycle. Supporting information is available in the NHSE Electronic Repeat Dispensing Guidance.[10]

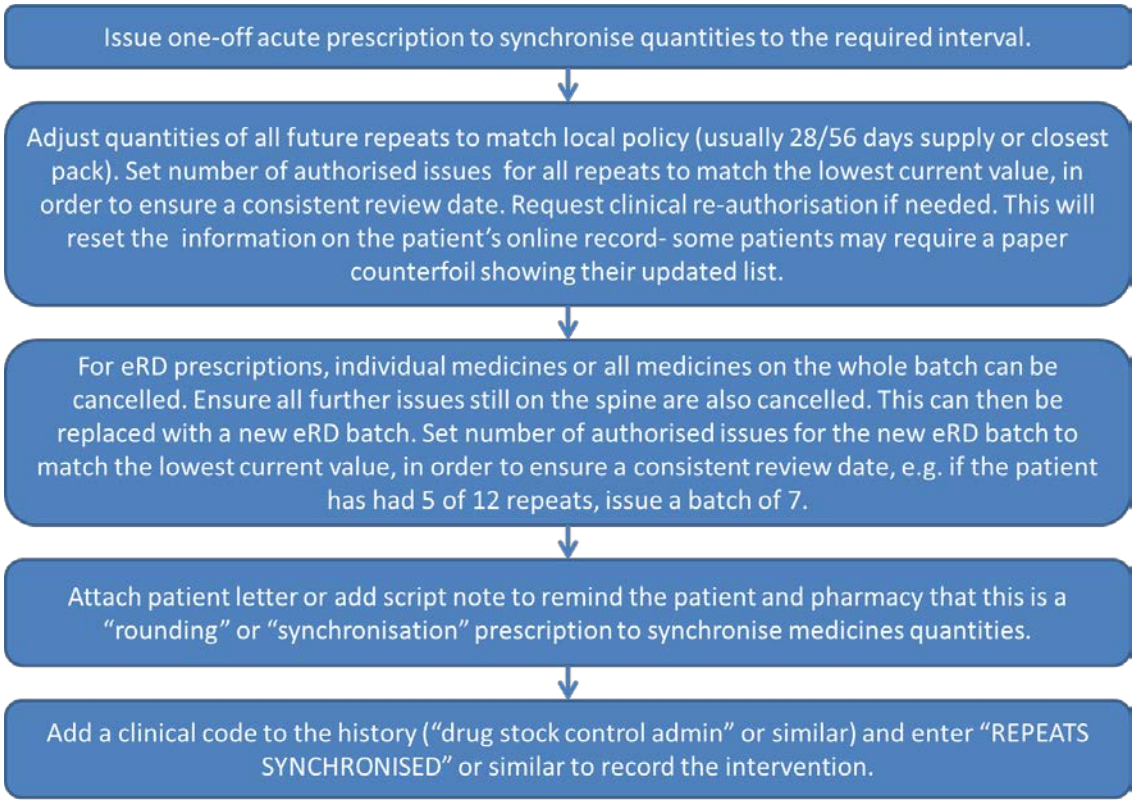
3.3. Housekeeping – Exceptions

Example exceptions – these lists are not exhaustive and practices may wish to add their own.

Box 1 Example exceptions to archiving
Medication only needed for short courses
Glyceryl trinitrate sprays or tablets
Laxatives
Topical steroids and other creams used intermittently
Seasonal medication e.g. antihistamines, allergy sprays, eye drops
Appliances such as catheters, stoma bags, etc...
Painkillers intended for intermittent use (e.g. paracetamol, co-codamol)
Aciclovir cream
Reliever inhalers
Hospital Only Medication, Dental medication and OTC medication (where appropriate) on Screen for information

Box 2 Example exceptions to local standard supply intervals
Benzodiazepines
Oral contraceptives and hormone replacement therapy
Nursing and residential homes
Individual patient agreement based on personal circumstances
Seasonal medication
CDs
Insulin
Diabetic reagent strips and other appliances
Creams
Eye drops
Inhalers
Patients receiving potentially harmful medication or where doses may be changed based on the result of regular monitoring tests e.g. warfarin, some rheumatology drugs, corticosteroids, immunosuppressants, erythropoietin, any ‘when required’ medication e.g. painkillers, glyceryl trinitrate products.

3.4. Housekeeping – Example of practical steps for local procedure



3.5. Housekeeping – Case Study

This could be carried out by a clinician with the practice, or a community pharmacist.

During their annual diabetes review, a patient has told the practice nurse that they are 'struggling a bit' with their medicines. The nurse has booked them in to see you. On their screen, you see that:

Medication	Date last ordered
56 x Metformin 500mg tabs – Two twice a day	1 week ago
28 x Lisinopril 10mg tabs – One daily	3 weeks ago
28 x Atorvastatin 20mg tabs – One daily	3 weeks ago
100 x Paracetamol 500mg tabs – two tablets when required, up to four times a day	8 months ago
500g x Emulsifying ointment – Apply when required.	4 months ago

On discussion with the patient you discover that:

- Their metformin dose has increased from 'one twice a day' to 'two twice a day', but the quantity has not changed. They are ordering these more often as a result.
- They have no problems ordering and taking lisinopril or atorvastatin.
- Paracetamol was required for knee pain, which has now resolved.
- Emulsifying ointment is used 'when required' for eczema flare-ups. The patient is not sure how often to apply it.
- The pharmacist has mentioned a 'new way of getting their medicines' but they are not really sure about it.

3.5.1. Housekeeping – Case Study: Points for consideration:

- What would you change the quantity of metformin to?
- Will you need to issue a 'rounding' prescription for any of the items, so all of their medications will run out at the same time?
- Do they still need paracetamol on repeat, or can this be archived / removed from repeat?
- Do they still need emulsifying ointment on repeat, or can this be archived / removed from repeat?
- Do the dosage instructions for emulsifying ointment need updating?
- Is the patient suitable for eRD – if so, which of their medicines will you add?

3.6. Housekeeping – Resources & References

NICE. (2009). Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence. CG 76. https://www.nice.org.uk/guidance/cg76 *Accessed 11/6/19.*

NICE. (2015). Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes. NG5. https://www.nice.org.uk/guidance/ng5 *Accessed 13/6/19.*

NICE. (2019). Medicines Optimisation; Key Therapeutic Topics. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-advice/key-therapeutic-topics. *Accessed 11/6/19.*

Pharmaceutical Services Negotiating Committee (PSNC). (2019). Medicines Use Review. http://psnc.org.uk/services-commissioning/advanced-services/murs/ *Accessed 11/6/19.*

4. Requests

Practices will have a number of different request systems in order to work safely and efficiently. Regular review of prescription request systems is necessary for safety and to ensure the needs of patients are being met. Changes to the request systems should take into account the needs of patients and other stakeholders, such as care homes and community pharmacies.

4.1. Requests – Responsibilities

Requests to issue prescribed medication should be made by the patient. Vulnerable patients might require help ordering their medicines from a carer or dispenser e.g. care home or community pharmacy. Requests can be handled by a trained non-clinical member of staff, up to the point of authorisation.

4.2. Requests – Routes descriptions

4.2.1. Patient Online ordering (preferred route)

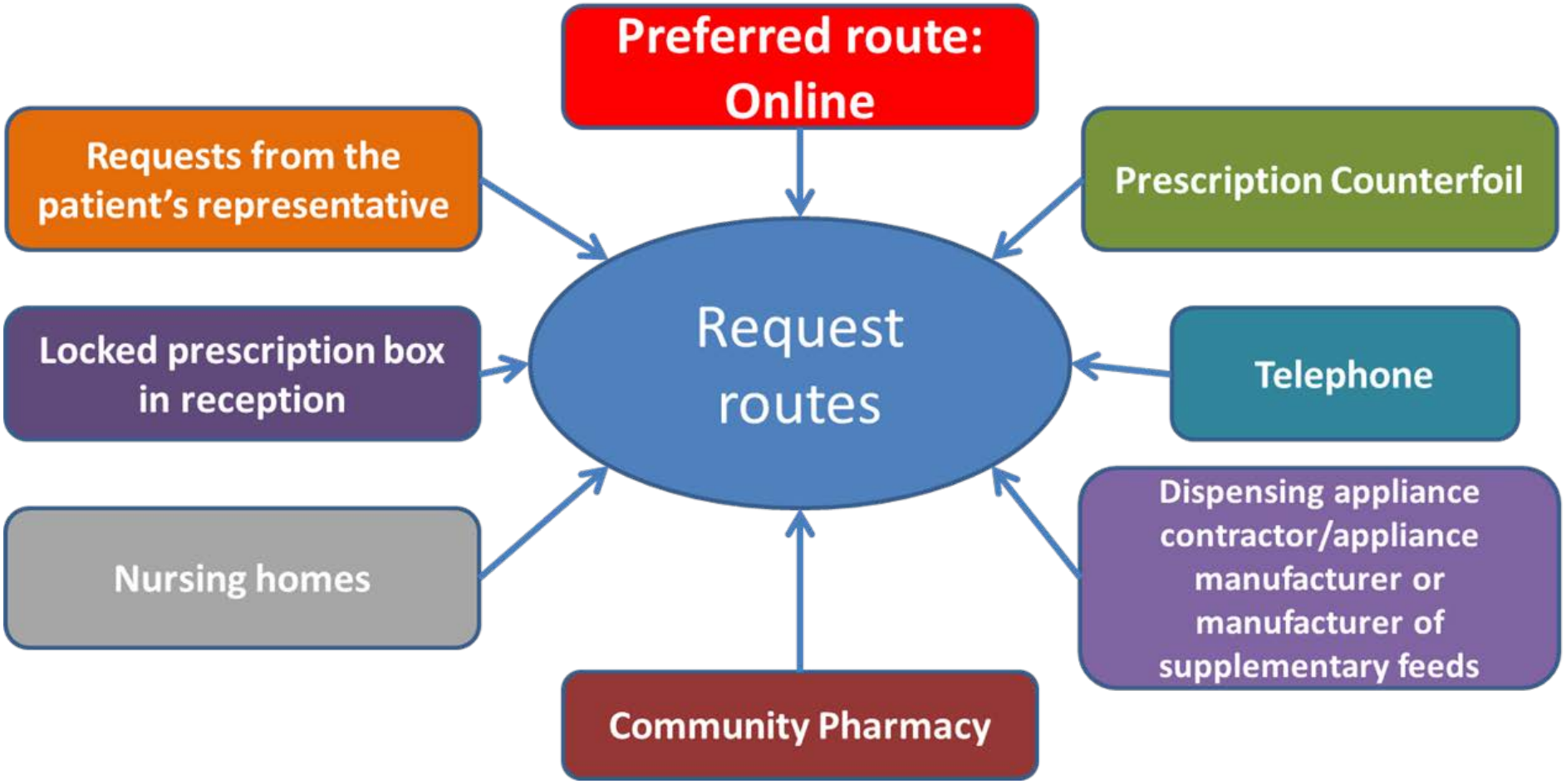
Patient Online (Online ordering) is the generic term used for online access to practice systems. Since the GMS contract of 2015/16, practices are keenly promoting Patient Online. A toolkit is available from the Royal College of General Practitioners (RCGP)[13] to support this. The benefits of Patient Online may include:

- Fewer phone calls or patient visits to practice.
- More accessible phone lines for practice.
- Receptionist time freed up for other tasks.
- Robust audit trail.
- 24/7 automated patient access via computer or mobile devices.
- Patients are able to check their list of repeat medication.
- Links to approved websites regarding potential side effects of medication (promotes self-care).
- Patients are able to check prescription status.
- Lessens the risks of repeat prescribing mistakes.
- Saves the patient time and money.
- Password protected ordering – an added layer of confidential security.
- Authorisation can be given to a proxy if required for online ordering.
- Messaging services are available to communicate with the patient if a supply is not due or an appointment is needed.
- Internet requests cannot be lost, does not allow information to be omitted and are easy to understand for both the patient and receptionist.

Supporting information and promotional help for GP surgeries can be found on the NHS England website. https://www.england.nhs.uk/gp-online-services/support/

[13] RCGP. Patient Online Toolkit. https://www.rcgp.org.uk/patientonline *Accessed 13/6/19.*

4.3. Requests – Routes



4.3.1. Counterfoil

- Patient must tick all items required.
- 'I require everything' is not allowed.
- Staff ideally should work through all items with patients to ensure waste is reduced and identify any patient concerns.
- Any ambiguity needs to be clarified with the patient.
- If there is no counterfoil, then patients should fill out a medication request form to ensure all necessary information is gathered.

4.3.2. Locked prescription box in reception

- For paper repeat requests not handed over in person to the staff and contain printed counterfoils, faxes and posted requests.
- Ensure the box and key is only accessible to authorised staff, in order to protect patient confidentiality.

4.3.3. Requests from the patient's representative

- Practice staff need to be sure that the request has come from the patient themselves and ensure the correct patient has been selected.
- This usually is done through confirming the patient's name, address and/or date of birth with the representative.
- If uncertain that the request is genuine, the practice should contact the patient directly.

4.3.4. Community Pharmacy

- Another option for **vulnerable patients**.
- Community pharmacies must have written consent from the patient to request repeat medication on behalf of a patient, which must be shown to the practice. The practice should scan this written consent into the patient's notes before issuing any prescriptions, as evidence of consent.
- The community pharmacy is responsible for checking each item required by the patient at the time that they are making the request.
- Prescription requests from community pharmacies might be marked with the pharmacy name, contact details, date and signed to demonstrate this.
- Commonly, a community pharmacy stamp is used to ensure that the practice's staff members know the destination of the prescription when filing it in to the collection box.
- Community pharmacies should remain diligent, ensuring any issues are communicated with the practice. These may include:
    - Repeat medications which are no longer being used but still appear on the counterfoil.
    - Patient compliance issues with medication.
- The practice need to ensure a process is in operation to action this feedback.

- It may be a consideration to establish a shared interface standard operating procedure (SOP) between the practice and community pharmacies to include: communication method, consent sharing, patient nomination and advice to the patient regarding the eRD process and re-ordering of medication.
- This is separate from a 'managed repeats' system.

4.3.5. Telephone

- This route is not 'best practice' and another route should be used where possible due to potential of issues with confidentiality and accuracy of information provided.
- If used, calls should be answered in a confidential location, away from public areas to protect patient sensitive data.
- Ideally telephone requests should be reserved for housebound patients unable to order medication by other means.
- Identity check questions (name, address, date of birth) need to be asked by staff before discussing confidential information.
- Given the potential for inaccuracy with this process, it is worthwhile auditing it to identify the number of people using this method and suggesting alternatives.

4.3.6. Care Homes (Nursing and / or residential care)

- A member of the nursing or managerial staff should control ordering of repeat medication. It is not the community pharmacy's responsibility, although they may be involved in the order process.
- Ordering should be undertaken using the agreed process with the care home. This may involve annotated prescription counterfoils or dispensing tokens but may also be based on the duplicate/triplicate Medication Administration Record (MAR) chart documentation provided by the community pharmacist. The MAR chart front sheet which has the administration records should not be used for re-ordering medicines. Staff again should be aware of the over-ordering potential here.
- To prescribe safely, it is important that surgery records and care home MAR charts match. Ideally there should be nominated lead(s) to act as point of contact within the practice and the care home to promote closer and more effective working relationships. Care home providers should ensure that at least 2 members of the care home staff have the training and skills to order medicines[14] (larger care homes may nominate more than one lead for different floors etc). Patient ordering should be aligned together as a single monthly process for the home. Care homes should receive 28 day supplies only of repeat medication; larger requests are referred to prescribers. Specific dosage directions are required for care

[14] NICE Guideline : Managing medicines in care homes https://www.nice.org.uk/guidance/SC1

home staff e.g. ‘as directed’ for a cream does not give enough detail to a staff member regarding frequency or area of application.

- When visiting, clinicians should have a mobile list of patient medication. The home and community pharmacy should always be notified when medication changes are made, e.g. at review or hospital discharge. Any changes to the MAR chart, e.g. discontinued or new medications or changes to the dose, always need to be checked with the prescriber before amending the patient’s computer records.

4.3.7. Dressings

- Ensure requests for dressings are current, recorded on the patient’s notes by the prescriber, not on repeat (usually), requested on formulary template (if available).
- Ensure prescribers are aware of and justify any non-formulary requests.

4.3.8. Dispensing appliance contractor/appliance manufacturer or manufacturer of supplementary feeds

- Contractors are expected to contact patients to determine when a new prescription is required.
- For stable patients’ regimes, contractors can allow communication just once every three months.
- Contractor items are often expensive (i.e. stoma or incontinence products) therefore practice staff should check with patients to ensure need, if there is any uncertainty regarding patient contact.
- Most prescriptions are usually sent via EPS to the contractor. In circumstances where they are posted, the practice need to advise the patient 48 hours before the usual ordering time to allow for the posting process.
- These items need to be kept on separate prescriptions as they have a different destination to other repeat items.
- Retrospective prescriptions should not be used routinely. Any new items requested by contractors need to be confirmed with the GP and/or the specialist clinician involved in patient care.
- Patients can nominate a dispensing appliance contractor using EPSr2 separate to their usual prescription destination (not for sip feeds).

4.4. Requests – Points to note

- Patients using eRD will see practice clinicians for medication reviews but otherwise deal directly with their community pharmacy for their repeat medication. Patients do not need to request their prescriptions each time from the practice. This could save the practice considerable time and money to invest in clinical services.
- Each time a community pharmacy issues medication via eRD, they are contractually obliged to ensure that each repeat supply is required and

seek to ascertain that there is no reason why the patient should be referred back to their GP. This takes the form of 4 questions as below[15]:

  - Have you seen any health professionals (GP, nurse or hospital doctor), since your last repeat prescription was supplied?
  - Have you recently started taking any new medicines - either on prescription or that you have bought OTC?
  - Have you been having any problems with your medication or experiencing any side effects?
  - Are there any items on your repeat prescription that you don't need this month?

- Repeat prescription request information should be made available to the patient via an information leaflet, waiting room poster or website. This should include turnaround times for requests.
- Patients should be advised about the eRD process and how to re-order medication.
- GP practice staff must not direct patients to a particular community pharmacy; it must be left to the patient choice.

4.5 Requests – Resources & References

CQC. The fundamental standards. https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards *Accessed 13/6/19.*

CQC. Regulations for service providers and managers. https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulations-service-providers-managers *Accessed 13/6/19.*

NHSE. (2015). Electronic Repeat Dispensing Guidance. https://www.england.nhs.uk/digitaltechnology/wp-content/uploads/sites/31/2015/06/electronic-repeat-dispensing-guidance.pdf *Accessed 11/6/19.*

NHSE. Patient Online: Making the most of online appointments and repeat prescriptions. https://www.england.nhs.uk/wp-content/uploads/2015/11/po-making-the-most-online-apps.pdf *Accessed 11/6/19.*

NICE. (2017). Managing medicines for adults receiving social care in the community. NG67. https://www.nice.org.uk/guidance/ng67 *Accessed 11/6/19.*

NICE. (2014). Managing medicines in care homes. SC1. https://www.nice.org.uk/guidance/sc1 *Accessed 11/6/19.*

[15] PSNC. A new way to get your regular prescriptions. https://psnc.org.uk/wp-content/uploads/2013/07/eRepeat-Dispensing-leaflet.pdf *Accessed 13/6/19.*

RPS. Emergency supply.
https://www.rpharms.com/resources/quick-reference-guides/emergency-supply
Accessed 11/6/19.

RPS. Repeat medication management.
https://www.rpharms.com/resources/toolkits/repeat-medication-management
Accessed 11/6/19.

PSNC, NUMSAS scheme: http://psnc.org.uk/services-commissioning/urgent-medicine-supply-service/

5. Checking

This takes place prior to final authorisation by a clinician. It might be regulated by a period of time between reviews (medication or condition-based), or authorisation of a specified number of repeats. Carrying out these checks before issuing a prescription can help reduce prescription waste. It can be simplified by regular housekeeping of the prescription screen in the clinical system.

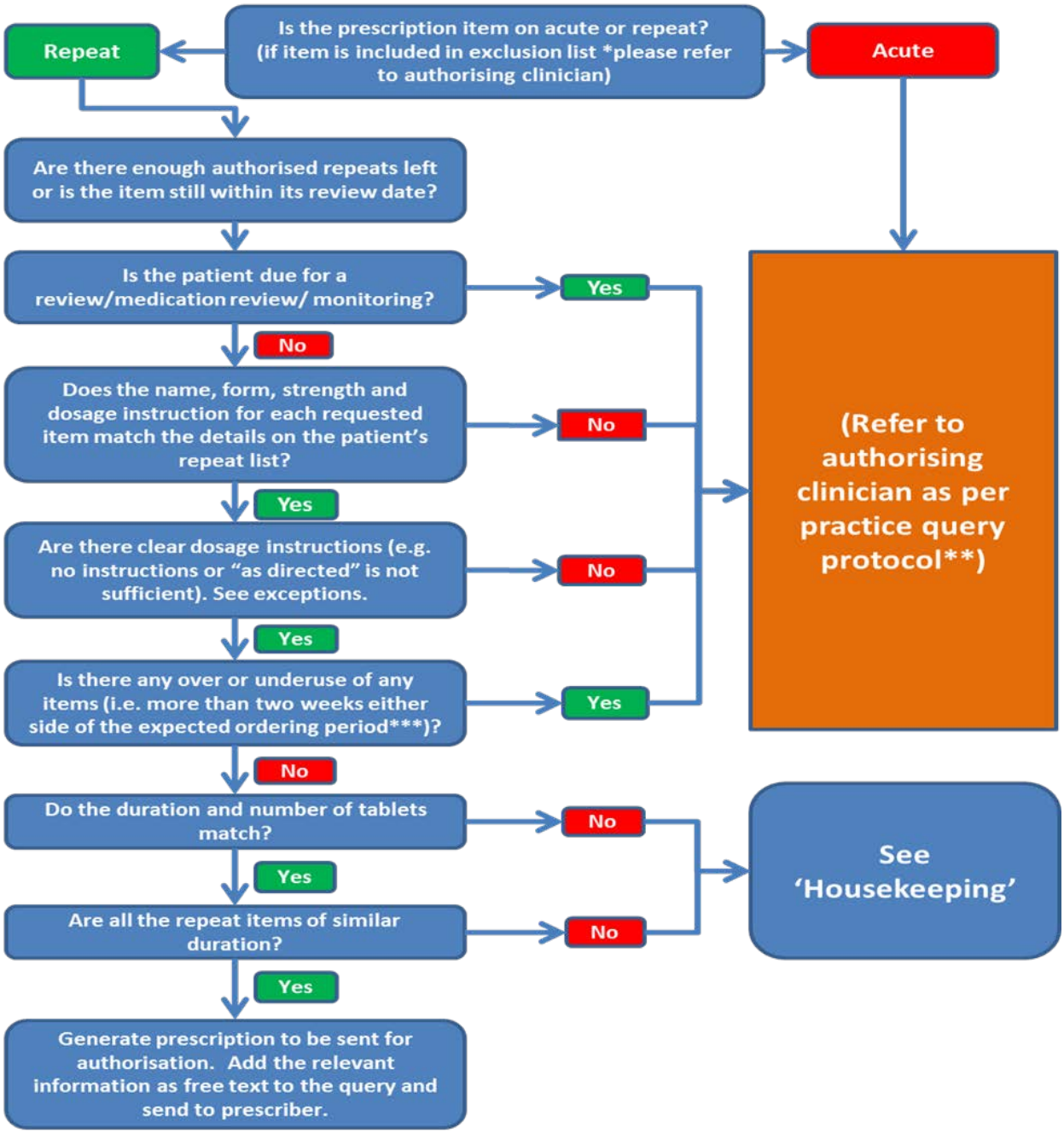
This process is not necessary each month if the medication is prescribed using eRD, but would be good practice to form part of the review process before the next batch is issued.

5.1. Checking – Responsibilities

This can be handled by the prescriber or delegated to a trained non-clinical member of staff, up to the point of authorisation. Where a clinical decision is required on suitability for continued prescribing, this should be directed to a prescriber and where appropriate, involve the patient in shared decision making.[16]

[16] NICE. (2019). Shared decision making. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making *Accessed 11/6/19*

5.2. Checking – Processing a prescription request. (See section 2.2-2.5 for appropriateness of eRD as the mode of repeat.)



***An exclusion protocol may be determined by a combination of legal and safety issues (e.g. certain CDs, high risk drugs or drugs of misuse). This should be easily available to all staff, especially those involved in the generation of prescriptions. This could include a poster, laminated sheet or via the practice intranet.

****Each practice should have a method for raising prescription queries resulting from administration checks with prescribers or suitable healthcare professionals; an electronic method would be preferred (e.g. computer tasks linked to the patient record) for audit trail purposes.

*****Medicines labelled "**To be taken when required**" or "**Use as needed**" often last longer than one month and therefore may not need to be requested every month.

5.3. Checking – Points to note

- Only staff who are competent to do so should prepare repeat prescriptions for authorisation.
- Explain to patients that unordered items will not be stopped. This will only happen if they are not ordered for a set length of time as determined by the practice (e.g. six months or a year) and there may be exceptions to this rule. They can always be ordered next time.
- An item must not be issued from the past medication list, as this increases the risk of an error and possible adverse incident occurring. If considered appropriate, this should only be actioned by the authorising clinician.
- The repeat prescription request should be completed clearly and correctly. If the request is not clear, then a check should be made with the patient to confirm the medicines required.
- Only issue what the patient needs. Do not automatically assume they need everything. Ask the patient to detail each individual medicine they need to reorder – **"All my medications" is not an acceptable request**.
- Be aware that some inhalers, creams, ointments and sprays can last more than a month and do not need to be requested every month.
- Encourage patients to check their prescriptions or the content of their prescription bags and return any unwanted medicines to the pharmacist whilst **still inside the community pharmacy**.
- Encourage patients to use the services of their local community pharmacy. They can offer MURs, New Medicines Service (NMS) and general advice regarding taking medication.
- If a repeat prescription is ordered by a third party, check directly with the patient if any over or under-ordering is occurring.
- For nursing and care homes, refer to any notes that accompany orders. Ring to double-check orders if necessary.
- A notice period for issuing repeat prescriptions should be 24-72 hours. Patients should be made aware of the notice period required by the practice for issuing repeat prescriptions.

5.4. Checking – Real life incident

Details of Incident	
Reporter's site/locality:	GP Practices – Locality X
Details:	Lithium patient receives monthly blister packs from community pharmacy. Patient was taken off Lithium mid-month, community pharmacy not aware that the patient had discontinued this item and requested it with other items. Concerns that a prescription for Lithium could have been issued. On speaking with the community pharmacy it was not clear that they had spoken to the patient prior to ordering the blister pack.
Cause:	Medication – other

5.4.1. Checking – Real life incident: Points for consideration

- Could this happen in your practice?
- What could be the consequences to the patient if the prescription was issued?
- How would your practice manage this problem if it happened?
- What internal procedures could you put in place to reduce the risk of it happening?
- How do you and your local community pharmacies communicate:
  - About vulnerable patients?
  - About patients on high risk medicines?
  - About repeat dispensing?

5.5. Checking – Resources & References

Specialist Pharmacy Service (SPS), UK Medicines Information, NHS. (2017) Suggestions for Drug Monitoring in Adults in Primary Care: https://www.sps.nhs.uk/articles/suggestions-for-therapeutic-drug-monitoring-in-adults-in-primary-care/ *Accessed 13/6/19.*

The Misuse of drugs Regulations 2001 and as amended. https://www.legislation.gov.uk/uksi/2001/3998/contents/made

6. Authorisation

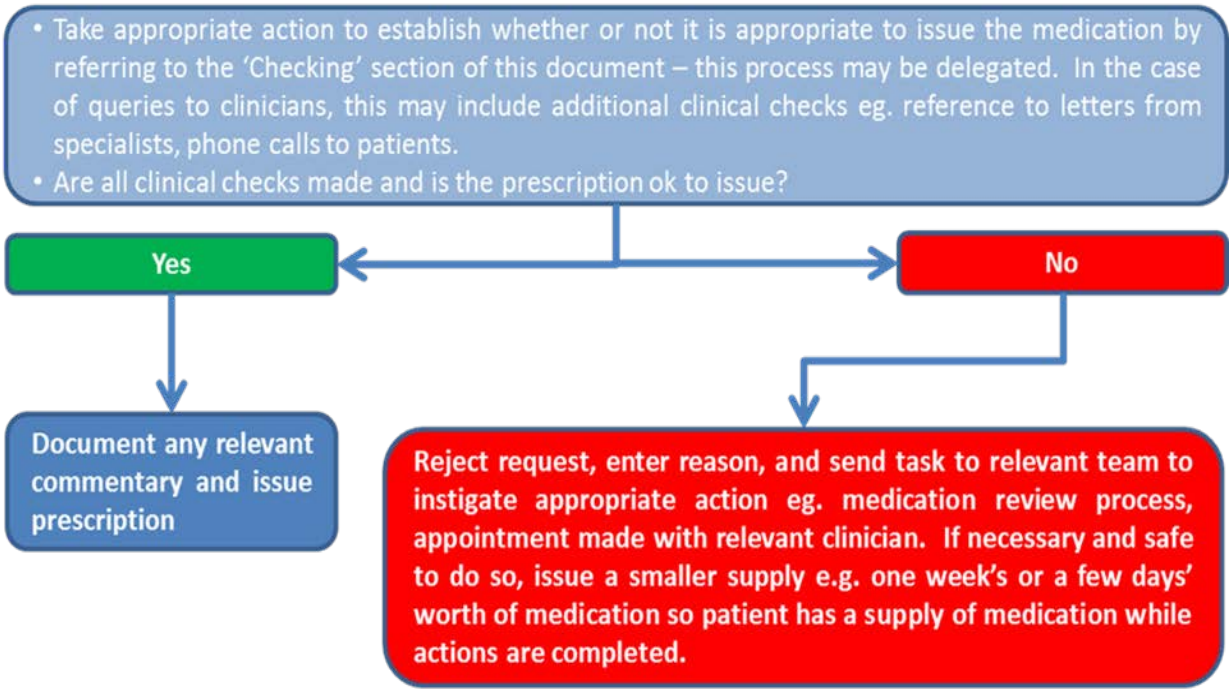
This section relates to the authorisation of a prescription or eRD batch by a clinician and may also be referred to as issuing or signing. This is only a guide and does not replace clinical judgement. EPSr2 and eRD prescriptions are authorised electronically using a smartcard.

6.1. Authorisation – Responsibilities

Practices should provide a designated time and suitable space (including full access to patient records) for prescribers to sign repeat prescriptions.

Authorising a prescription is the legal responsibility of the prescriber. For a non-medical prescriber, they should ensure they are working within their area of competency and have assessed the patient before authorising the prescription.

6.2. Authorisation – Prescriber Responsibility



6.3. Authorisation – Points to note

Prescription signing and issuing may be paper based or electronic. For eRD, the prescription only requires one authorisation at the start of the batch.

The GMC has produced guidance called "Good practice in prescribing and managing medicines and devices (2013)".[4] The guidance explains how the principles stated apply to decisions about prescribing, managing medicines and medical devices. One of the principles is "Repeat prescribing and prescribing with repeats".

- You are responsible for any prescription you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe, necessary and appropriate for the patient.
- You must be satisfied for each authorisation that:
    - The patient's condition is monitored, taking account of medicine usage and effects.

- Patients who need further examination or assessment are reviewed by an appropriate healthcare professional.
- The patient is taking the medication as directed and it has been checked that the medicines are still needed, effective and tolerated. This may be particularly important following a hospital stay or changes to medicines following a hospital or home visit.

6.4. Authorisation – Resources & References

GMC. Good practice in prescribing and managing medicines and devices https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/prescribing-and-managing-medicines-and-devices/reviewing-medicines *Accessed 12/6/19.*

7. Collection

This section applies to paper prescriptions. Following authorisation, electronic prescriptions are automatically directed by the NHS Spine to the dispenser nominated by the patient.

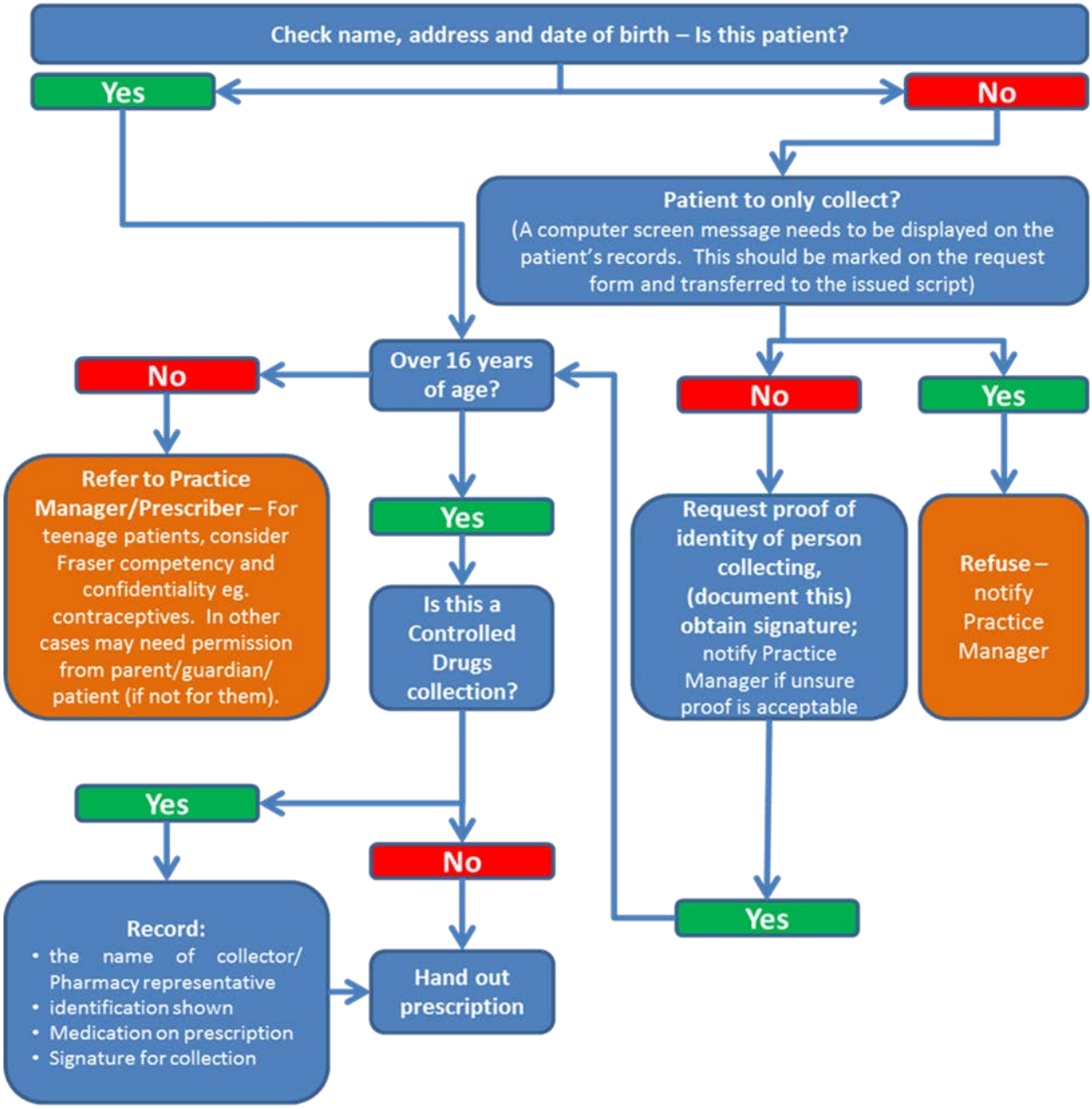
Prescriptions might be handed to patients, their representative or carer, or directly to the dispenser. In practice, the collection process is handled by a non-clinical member of staff, usually at the reception desk. Occasionally, referral to the prescriber may be necessary to resolve queries or issues.

7.1. Collection – In person

Patients must be informed regarding turn-around time for prescription generation (48 to 72 hours usually). A poster or the practice website is the best way to display this information.

For electronic transfer of prescriptions, it would be up to the community pharmacy to make the decision after dispensing. This decision already takes place for collection of medication by patients or representatives.

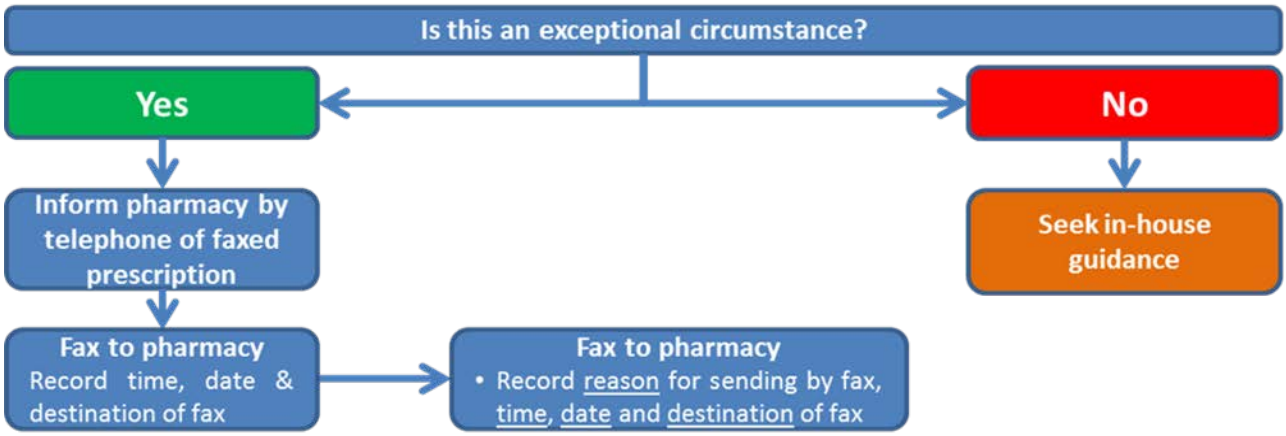
Identification should be requested, shown and recorded for collection of prescriptions for CDs and medicines liable to misuse (i.e. patient only to collect).



7.2. Collection – By fax

Electronic prescribing should be the default for sending prescriptions. Faxes should only be issued in exceptional circumstances.

- Staff must record when and where the prescription was faxed to and when the prescription was collected.
- It is the responsibility of the GP practice to inform the community pharmacy that a prescription is being faxed and that the paper prescription should be made available within a reasonable time for collection from the practice.
- If the request to fax is made by the community pharmacy then it is their responsibility to collect the prescription from the practice.



7.3 Collection – by post

- This option should only be used in exceptional circumstances following a risk assessment. There should be a SOP which includes established checks to ensure prescriptions reach the intended recipients. Please see NHS CFA guidance[17] for further detail.
- Inform patients of the longer turn-around time.
- Check the name and address of the patient on the prescription with the envelope address to ensure the correct prescription is delivered to the correct patient.
- Enter information into prescription log book – patient name, address, prescription items, date and sender name.
- It is recommended that CD prescriptions are not posted. Alternative arrangements should be made, for instance utilising the patient's local pharmacy service.[16]

7.4 Collection – uncollected prescriptions

- Check the prescription batch periodically for uncollected prescriptions (generally over four weeks old).
- Record on patient's records and review by prescriber.
- If prescription deleted from computer record then paper copy must be shredded into confidential waste with a witness present. Serial numbers of the prescriptions shredded need to be recorded by the practice in the prescription log book.
- If unable to delete the last issue on the computer records the serial numbers for the prescription should be logged on the patient's records and then the prescription shredded as previously.
- Practices should have a mechanism in place to deal with notification from a community pharmacy that a prescription has not been collected by a

[17] NHS CFA. (2018). Management and control of prescription forms. https://cfa.nhs.uk/resources/downloads/guidance/Management%20and%20control%20of%20prescription%20forms_v1.0%20March%202018.pdf *Accessed 17/6/19.*

patient. The NHS spine does not notify practices when a medication has not been dispensed. Communication between community pharmacies and practices to share this information would need to be agreed at an individual practice level.

7.5 Collection – Proof of Identity real life incident

Details of Incident	
Reporter's site/locality:	GP Practices – Locality X
Details:	Re: Prescription Collection I have been asked to report the unauthorised collection of a prescription for a patient. The prescription was for 14 Quetiapine 300mg tablets with the following directions – Two to be taken at night – WEEKLY COLLECTION. The issue date was 24th Jan 2019. The prescription had the usual community pharmacy name printed in the top left hand corner but it was collected from the practice sometime between Tuesday 24th January at 8:15am and Friday 27th January at 3:50pm. It was signed for on collection but we are unable to read the name of the signature. The patient, his mother, his grandmother and a staff member from his care team, who all collect prescriptions on his behalf, all deny collecting the prescription from the practice and claim the prescription has been collected by an unauthorised person. This has been reported to the police; if you require further information please contact the practice. With many thanks
Cause:	Administration (Medication/Prescribing etc.)

7.5.1 Collection – Proof of Identity real life incident: Points for consideration

- Could this happen in your practice?
- How would your practice manage this problem if it happened?
- What procedures could you put in place to reduce the risk of it happening?

7.6 Collection – Resources & References

NICE. (2016). Controlled drugs: safe use and management. NG46. https://www.nice.org.uk/guidance/ng46 *Accessed 12/6/19.*

The Misuse of drugs Regulations 2001 and as amended. https://www.legislation.gov.uk/uksi/2001/3998/contents/made

8. Security

Confidentiality and security of patient data is an integral part of patient care. These procedures should complement the practice's own information governance policies and comply with the NHS Act 2006[18], the Health and Social Care Act 2012[19], the Data Protection Act 2018[20] and the Human Rights Act[21]. Further information and resources on Information Governance is available through NHSE's website.[22]

EPSr2 and eRD systems provide enhanced security, reducing the risk of prescriptions being lost, going missing or being stolen. Electronic prescriptions can be traced using the NHSD Prescription Tracker: https://digital.nhs.uk/services/electronic-prescription-service/about-the-eps-prescription-tracker. The tracker may be accessed by both practices and community pharmacies. A factsheet about the tracker is available from NHSD.[23]

The practice should designate a member of staff of appropriate grade to have overall responsibility for overseeing the security process as a whole; from ordering, receipt, storage and transfer to access and overall security of prescription stationery. They should ensure appropriate security measures are implemented and maintained and that there is a designated deputy to act in their absence.[16]

8.1. Security – Responsibilities

The NHS Counter Fraud Authority (NHS CFA) has developed guidance entitled 'Management and control of Prescription Forms. A guide for prescribers and health organisations.'[16] This guidance includes information such as the ordering, delivery, storage and handling of prescription forms across a range of circumstances including home visits and transport in vehicles. In addition to considerations for an audit process, practice responsibilities and checks, processes, investigations and what to do in the event of stolen, lost or forged prescriptions are also covered. Some of the key information in relation to lost or stolen prescriptions is noted here.

All members of staff who handle patient identifiable information, such as details of medication or prescriptions, are responsible for the confidentiality and security of the information.

[18] National Health Service Act. 2006. https://www.legislation.gov.uk/ukpga/2006/41/contents
[19] Health and Social care Act. 2012. https://www.legislation.gov.uk/ukpga/2012/7/contents
[20] Data Protection Act. 2018. https://www.legislation.gov.uk/ukpga/2018/12/part/4/chapter/2/crossheading/the-data-protection-principles
[21] Human Rights Act. 1998. https://www.legislation.gov.uk/ukpga/1998/42/contents
[22] NHSE. Information Governance. https://www.england.nhs.uk/ig/ *Accessed 17/6/19.*
[23] NHSD. https://digital.nhs.uk/binaries/content/assets/legacy/pdf/5/9/eps_prescription_tracker_factsheet_sep_17_final_%28pl%29.pdf *Accessed 17/6/19.*

Practices should designate an individual to lead in the event of a lost, missing or stolen prescription, pad or smartcard. This can be a non-clinical member of staff, such as the practice manager.

Key points relating to the management and control of prescriptions forms are also available as an Aide-memoire for both prescribers [24] and practice managers [25] from the NHS CFA website.

Please see the flowcharts below for considerations for the assessment of security of paper (section 8.2) and electronic (section 8.3) prescriptions.

[24] NHS CFA. Management and control of prescription forms. Aide-memoire for prescribers. https://cfa.nhs.uk/resources/downloads/guidance/Aide-memoire%20for%20prescribers.pdf Accessed *12/6/19.*

[25] NHS CFA Management and control of prescription forms. Aide-memoire for practice managers. https://cfa.nhs.uk/resources/downloads/guidance/Aide-memoire%20for%20practice%20managers.pdf *Accessed 12/6/19.*

8.2. Security – Paper prescriptions

[26] HSC. (2015). Guidance for prescription security in primary care. http://www.medicinesgovernance.hscni.net/download/primarycare/gp_practice/Prescription%20Security/151215_PrescriptionSecurityGuidanceV9.pdf *Accessed 17/6/19.*

8.3. Security – Computer/electronic prescriptions

8.4. Security – Points to note

- Remember – the EPS provides the security necessary for confidential information and reduces the potential for prescriptions being lost or stolen. Ensure clinicians and patients are aware of this.
- Remember – when printing a prescription token, although they are not prescriptions themselves, they do contain confidential patient information and so must be kept securely if required. It may be useful to print a token during a consultation for an acute prescription, to hand to the patient.
- CCTV – could provide an idea of who collected a prescription should an investigation be required.

8.5. Security – Lost or stolen prescriptions

- NHS CFA guidance recommends that practices should have a SOP or policy for dealing with lost prescription forms reported by patients. This document should include i) incidents being recorded in the organisation's incident reporting system, ii) a risk assessment to ensure legitimacy and iii) additional requirements if the prescription was for a CD.[16]

- Local escalation and reporting procedures should be followed as lost prescriptions are likely to include practice data and the signature of an authorised prescriber.

- Fraud should be reported to the NHS CFA through either:

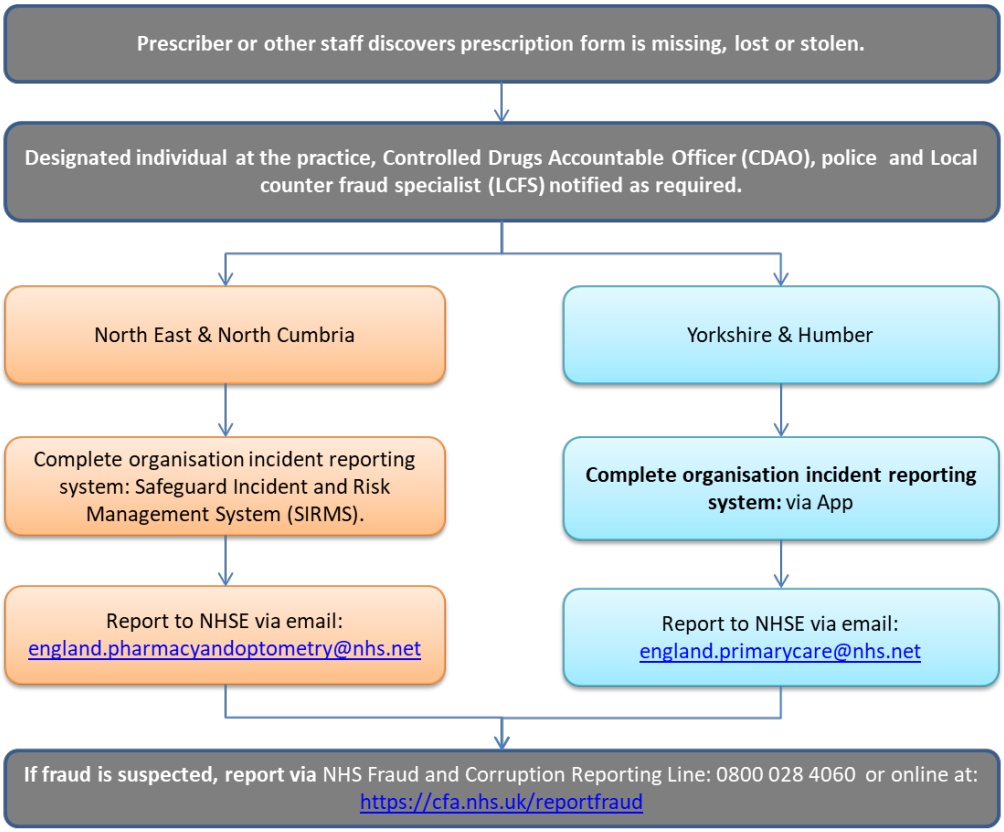
    - NHS Fraud and Corruption Reporting Line: 0800 028 4060
    - online at: https://cfa.nhs.uk/reportfraud.

8.5.1. Security – lost prescription

- There is no legislation that states lost prescriptions must be reported to the police.
- The police no longer accept lost property phone calls and any lost property is reported on the 'Report My Loss' website; this would incur a small charge. All losses reported are viewable by the police.
- In view of this charge and the fact that the prescription form contains practice and patient details, it is not necessary for patients to report lost prescriptions as these contain sufficient information to be returned, if lost.
- The practice should still report any patient lost prescriptions to NHSE (see flow chart below) for an alert to be circulated.

8.5.2. Security – stolen prescription

- Stolen prescriptions must still be reported to the police, as this is a criminal activity.



8.6. Security – Resources & References

Controlled Drugs Incident Reporting Contacts:

North Cumbria CCG:
Phil Utting, 01228 603050 england.cumbrianortheast-cds@nhs.net

Darlington, Durham Dales, Easington & Sedgefield, Hartlepool & Stockton-On-Tees, and North Durham CCGs:
Victoria Bennett, 01642 745429 england.cumbrianortheast-cds@nhs.net

Newcastle Gateshead, North Tyneside, Northumberland, South Tyneside and Sunderland CCGs:
Emma Post, 0191 217 2983 england.cumbrianortheast-cds@nhs.net

NECS MO CD (resources). http://medicines.necsu.nhs.uk/controlled-drugs/ *Accessed 12/6/19.*

NHSD. Registration authorities and smartcards. https://digital.nhs.uk/Registration-Authorities-and-Smartcards *Accessed 12/6/19.*

NHSD. About the EPS Prescription Tracker. https://digital.nhs.uk/electronic-prescription-service/rx-tracker *Accessed 12/6/19.*

NHS CFA. Contact through https://cfa.nhs.uk/nhsprotect NHS CFA. Report fraud online. https://cfa.nhs.uk/reportfraud

NHS CFA. Guidance. https://cfa.nhs.uk/fraud-prevention/fraud-guidance

NHS CFA. Management and control of prescription forms. https://cfa.nhs.uk/resources/downloads/guidance/Management%20and%20control%20of%20prescription%20forms_v1.0%20March%202018.pdf *Accessed 12/6/19.*

NHS CFA. Management and control of prescription forms. Aide-memoire for practice managers. https://cfa.nhs.uk/resources/downloads/guidance/Aide-memoire%20for%20practice%20managers.pdf *Accessed 12/6/19.*

NHS CFA. Management and control of prescription forms. Aide-memoire for prescribers. https://cfa.nhs.uk/resources/downloads/guidance/Aide-memoire%20for%20prescribers.pdf *Accessed 12/6/19.*

CQC. Nigel's surgery 23: Security of blank prescription forms. https://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-23-security-blank-prescription-forms *Accessed 12/6/19.*

GMC. Confidentiality: good practice in handling patient information. http://www.gmc-uk.org/guidance/ethical_guidance/confidentiality.asp. *Accessed 12/6/19.*

Report My Loss. Online lost property reporting service accredited by UK police. https://www.reportmyloss.com/uk. *Accessed 12/6/19.*

Appendix One: Abbreviations

Abbreviation	Definitions
BNF	British National Formulary
CD	Controlled drug
CDAO	Controlled Drugs Accountable Officer
CKS	Clinical knowledge summaries
CQC	Care Quality Commission
DMARDs	Disease-modifying anti-rheumatic drugs
EPSr2	Electronic Prescription Service
eRD	Electronic Repeat Dispensing
GMC	General Medical Council
GMS	General Medical Services
HSC	Health and Social care Board
LCFS	Local Counter Fraud Specialist
MAR	Medicines Administration Record
MHRA	Medicines and Healthcare products regulatory agency
MO	Medicines Optimisation
MUR	Medication Use Review
NECS	North of England Commissioning Support
NHS CFA	National Health Service Counter Fraud Authority
NHSD	National Health Service Digital
NHSE	National Health Service England
NICE	National Institute for Health and Care Excellence
NMS	New Medicines Service
NPSA	National Patient Safety Agency

OTC	Over The Counter
PRN	“Pro Re Nata” – As needed *or* when required
RCGP	Royal College of General Practitioners
RPS	Royal Pharmaceutical Society
SIRMS	Safeguard Incident and Risk Management System
SOP	Standard Operating Procedure

Appendix Two: Checklist

Auditing practice repeat prescribing systems

1. For each of the sections of the model system, review the following for your practice:
   - Relevant systems and policies.
   - Relevant standard operating procedures.
   - Relevant training records.
   - Checking the understanding of relevant members of staff (case studies may be useful).
   - Risk register (if used for clinical or information governance).
2. For each section, does the practice:
   - Have systems to promote eRD as the default option for repeat prescribing?
   - Have systems that work pro-actively to reduce prescribing waste?
   - Use shared decision making to involve patients in decisions about their care?
   - Use clinical codes consistently to record interventions on patient records?
   - Meet the other criteria in the relevant section of the model system?
   - Have eRD integrated in to the repeat prescription and medication review protocols?
3. If yes, sign off as complete.
4. If no, consider the following points for the section:
   - Do any systems or policies need developing or reviewing?
   - Do any standard operating procedures need developing or reviewing?
   - Does the risk register (including mitigating actions) need updating?
   - Do any of the staff need additional training? If so, how will this be provided?
   - What resources can be used to support this?
   - When does this action need to be completed by?
   - Who is the best person or people to carry this out?
   - How can patients be involved to ensure processes are simple and seamless for them to use?
5. Use the points from 4 to create a practice action plan for updating your repeat prescribing system, which can be summarised using the checklist overleaf.
6. Review progress against the action plan regularly.
7. Once complete, re-audit at regular intervals to monitor compliance.

Audit Form for practice repeat prescribing systems

Process	Page	Actions to complete	Resources to use	People to involve	Deadline	Completed name/date
Initiation						
Synchronisation						
Requests						
Checking						
Authorisation						
Collection						
Security						

Review completed by:		**Date:**		**Re-audited by:**		**Date:**	

Appendix Three: List of original contributors

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