APPENDIX B

NHS
Luton
Clinical Commissioning Group

Repeat Prescribing Best Practice Guide

Medicines Optimisation Team
July 2015

Foreword

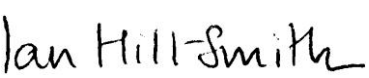
Safe and efficient repeat prescribing is a core function of providing high quality primary care. Patients need their medications on time and in a way that minimises the risk of interactions or duplications. Hitherto, automated systems from third parties to request repeat prescriptions on behalf of patients may seem attractive to an individual patient, freeing them from a responsibility to remember to request their prescription on time, but there are hidden dangers of providing medicines that are no longer appropriate to the patient, both in terms of clinical safety and wastage of resources that could have been used to much greater benefit.

We have taken a bold step in Luton by asking practices to change their systems to ensure that the patient is always at the heart of any request of a prescription. The CCG have done this on behalf of all patients and practices following the results of an extensive audit of repeat prescribing locally.

In practice, very little changes from a GP perspective. A GP would never issue a prescription for several items when a patient only requests one or two. Nor would a GP issue a prescription solely on the basis that it is time for a repeat. Yet by accepting requests that do not involve the patient directly, we are in effect extending our repeat prescribing process to allow such risks of over-prescribing and wastage to occur.

The change initiated by Luton CCG is simple yet profound. It will help to ensure safer medication for patients and prevent considerable waste of crucial resources that could enhance the health of the people of Luton across all sectors. We acknowledge that there will be a small minority of people for whom third party requests for prescriptions may remain the best option and this needs identification and facilitation, but for the overwhelming majority, requests are best coming from the patient. We recommend this change to you as a way to achieve higher quality care for patients and improve efficiency for all health care in Luton.

Dr Ian Hill-Smith



Chair, Luton Primary Care Prescribing Committee

Dr Nina Pearson

Chair, Luton CCG

July 2015

CONTENTS

1. INTRODUCTION

What is repeat prescribing?

Repeat prescribing can be defined as:

> 'a partnership between the patient 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 issue.'[1]

What are the aims of this guidance?

This guidance is designed to be a resource which will help with the provision of high quality, safe and effective repeat prescribing. It provides tools to help practices and should be used as a working document. This means that you decide which sections are the most relevant at a particular point and then use the tools provided to make improvements to your systems.

Repeat prescription ordering services have changed in Luton. The majority of people who are on repeatable prescriptions now order their repeat prescriptions directly from their GP surgery. This ensures that patients are always involved in the request for a repeat prescription.

Whilst changing repeat prescription ordering arrangements will go some way to improving the quality of care for patients, repeat prescribing is a complex system involving a number of stages with risks at each stage. Changing prescription ordering systems provides an ideal opportunity to review the entire repeat prescribing system in your practice and make improvements which benefits patients and clinicians in primary care.

Why do we need it?

Repeat prescribing is a complete system involving many people and processes with many opportunities for things to go wrong or for potential 'near misses'. The entire system needs to be reviewed regularly with input from those integral to the process, to help practices assure the quality of their service and minimise the risks of inefficient and unsafe systems. The benefits of a well-managed repeat prescribing system include:

- Improved patient safety by minimising risk of errors and harm, complaints and potential for litigation
- Improved quality of prescribing
- Better patient experience and access to the medicines they need
- Better and more appropriate use of relevant professional and practice staff skills and time
- Decreased practice workload once change is implemented
- Optimal efficiency in the processes involved benefiting both health professionals and patients
- Less wastage of medication and better use of NHS resources

Who is the guidance for?

This document is targeted at all individuals in the practice with responsibility for repeat prescribing – including prescribers, practice administrative staff and practice managers. See appendix 1 for summary of individual responsibilities. Community pharmacists and CCG practice support pharmacists may also find the guidance a useful resource.

Patients have a key role and good communication to patients is essential. A separate guide has been developed for patients on repeat medicines to support them to get the most from their medicines. The medicines optimisation team will distribute printed copies of 'The Patient Guide to Repeat Medicines' to practices for a limited period of time. An electronic version of the guide is included as appendix 2 of this guide.

How should I use the guidance?

The person responsible for the repeat prescribing system and the prescribing lead GP should use this guide to help analyse and make improvements. This guide is made up of chapters each of which is designed to explore a certain part of the repeat prescribing process. The end of each chapter contains useful action points that you can decide to take forward. You may choose to review one or more aspect of your repeat prescribing system at any particular time, for example reviewing and updating your repeat prescribing policy, and raising awareness of community pharmacy services and utilising the referral template.

This needn't take up a lot of time. By focussing on the key issues and 'bottlenecks' in the system it is possible to simplify the process of making improvements.

For more advice and support, please contact your designated practice pharmacist or contact the medicines optimisation team on LutonCCG.Prescribing@nhs.net or telephone 01582 532002.

Repeat prescribing systems differ in the way they operate to meet the needs of those providing and receiving care. Clearly, there is not one 'best model' or 'quick-fix' but there are principles for good practice that should be common to all systems which this guidance aims to bring together.

2. REPEAT PRESCRIBING – ADMINISTRATIVE RESPONSIBILITIES

2.1 Practice manager

The overall management of repeat prescribing is the responsibility of the practice manager but everyone in the practice has a role. See appendix 1 for summary of individual roles and responsibilities. Practices should agree and write their own repeat prescribing policy based on good practice principles. A repeat prescribing policy template handbook[1] is available for practices to review and is attached in appendix 3 (this template was issued to all delegates attending the Repeat Prescribing course in 2013).

You may want to include reference to relevant CCG policies and guidance within your policy. These include, for example;

- Luton CCG Prescribing Duration Guidance
- Luton NHS Patient Travelling Aboard Policy
- Luton NHS to Private Care Policy
- Position Statement on MDS and 7 day prescribing

All current CCG policies are available to view and download from the CCG intranet site Gelifish.

The practice should ensure that all staff involved in the repeat prescribing process are aware of the practice policy and their own roles within it. It is important that all staff have appropriate training and are competent in the tasks they undertake.

2.2 Other administrative staff

Prescribing clerks, or named administrative staff are often delegated the day to day task of generating repeat prescriptions. See appendix 1 for summary of individual roles and responsibilities. The table overleaf summarises key points for administrative staff.

[1] LCCG would like to thank Dr Ian Hill-Smith for producing and sharing this handbook

Table 1: Key Points for Safe Prescribing – administrative staff

Dealing with requests for repeat prescriptions

- Patients need to know how the practice repeat prescription system works
- Requests must be dealt with accurately, securely and within an agreed timeframe e.g. 2 working days
- With paper based systems, patients should be encouraged to use the repeat prescription request slip
- Prescription synchronisation – when items run out at different times, the patient will come back more frequently for a repeat which increases workload for the practice and inconvenience for the patient. This should be considered prospectively by the prescriber on initiation. However staff generating repeats should highlight this to prescribers

Deciding if the repeat prescription should be generated

An administrative check needs to be done to determine:

- Is the drug on the repeat prescriptions list?
- Is the drug within its review date?
- Is the request earlier (or later) than expected?
- Has the patient requested alterations e.g. 2x500g Zerobase rather than the usual 500g?

When to refer to the GP

- Item requires re-authorising
- Acute item has been requested
- Chronic disease review or medication review are overdue
- Any additional requests made by patients e.g. double issue to cover holidays etc.
- If in doubt, a clinician/qualified prescriber should be asked to make the decision about whether a prescription should be generated

Other action you can take

- Medication review or chronic disease review is due or will be due at next issue – arrange the appointment for review with the patient
- Whenever the dose of a patient's medication is increased you may be able to investigate whether the medication is available as a higher strength. E.g. 20mg strength available instead of two 10mg strength tablets. Often (but not always) the higher strength tablet is cheaper than taking two of the lower strength. Highlight this to the doctor who can authorise the change. Ask the medicines optimisation team or your practice pharmacist for further advice.
- Make sure that you are competent for the tasks you are performing and have had the necessary training.

ACTION POINTS

All practices must hold an up to date repeat prescribing policy. Is your policy up to date and used by all staff involved in the process?
Have all administrative staff received appropriate training and are competent to perform their designated tasks?

3. REPEAT PRESCRIBING – CLINICAL RESPONSIBILITIES

3.1 General guidance for GPs

Repeat prescribing brings benefits of convenience to both doctors and patients. However, repeat prescribing systems are complex and there are safety risks at various points in the process. General prescribing guidance for GPs can be found in GMC good practice in prescribing and managing medicines and devices (2013)[2], and guidance relevant to repeat prescribing is detailed in table 2.

Table 2: General Guidance for GPs

GMC prescribing guidance: repeat prescribing and prescribing with repeats
55. You are responsible for any prescriptions you sign, including repeat prescriptions for medicines initiated by colleagues, so you must make sure that any repeat prescription you sign is safe and appropriate. You should consider the benefits of prescribing with repeats to reduce the need for repeat prescribing. *NB this includes medications originally initiated by hospital colleagues*
56. As with any prescription, you should agree with the patient what medicines are appropriate and how their condition will be managed, including a date for review. You should make clear why regular reviews are important and explain to the patient what they should do if they: a. suffer side effects or adverse reactions, or b. stop taking the medicines before the agreed review date (or a set number of repeats have been issued). You must make clear records of these discussions and your reasons for repeat prescribing.
57. You must be satisfied that procedures for prescribing with repeats and generating repeat prescriptions are secure and that: a. the right patient is issued with the correct prescription b the correct dose is prescribed, particularly for patients whose dose varies during the course of treatment c. the patient's condition is monitored, taking into account of medicine usage and effects d. only staff who are competent to do so prepare repeat prescriptions for authorisation e. patients who need further examination or assessment are reviewed by an appropriate health care professional f. any changes to the patient's medicines are critically reviewed and quickly incorporated into their record.
58. At each review, you should confirm that the patient is taking their medicines as directed, and check 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. You should also consider whether requests for repeat prescriptions received earlier or later than expected may indicate poor adherence, leading to inadequate therapy or adverse effects.
59. When you issue repeat prescriptions or prescribe with repeats, you should make sure that procedures are in place to monitor whether the medicine is still safe and necessary for the patient. You should keep a record of dispensers who hold original repeat dispensing prescriptions so that you can contact them if necessary.

[2] http://www.gmc-uk.org/guidance/ethical_guidance/14325.asp

3.2 Clinical control and quality

Clinical control is the doctor's, or other qualified prescriber's' responsibility and involves TWO tasks, namely authorisation and periodic review. Some of the key points that GPs should be aware of to ensure safe repeat prescribing are outlined in table 3, more detailed guidance was published by the National Prescribing Centre in 2004 [3].

Table 3: Key Points for GPs for Safe Repeat Prescribing

Authorisation

Authorisation is the clinical decision that a repeat prescription is appropriate, the prescriber being satisfied that the drug is effective, well tolerated and still needed

Only appropriately qualified prescribers should be allowed to put medications on repeat prescription (see below for which medication may not be suitable for repeat prescriptions). When medication is first added to a repeat prescription it should be clearly noted why it was initiated. It is important to know this when reviewing medication at a future date.

An **appropriate review date** needs to be set, taking into account of the need for monitoring of therapeutic benefits and potential adverse effects. However, to allow prescribers and administrative staff time to focus on what matters, a policy that allows for long/indefinite repeats may be beneficial in order to ensure that routine 'automatic' reauthorisation does not become the norm.

Prescription quantity should be **synchronised** with existing supplies. Any change in quantity should be reviewed and authorised by a GP. However, practices may choose to delegate the task of alerting the computer record to suitable trained administrative staff.

All medication should have **full, clear and concise directions**. The use of 'as directed' are not appropriate, especially for elderly patients and people who rely on carers to administer their medication. Exceptions may be where directions are complex or may change and are documented elsewhere, e.g. warfarin dose in the yellow warfarin booklet. Other examples include blood glucose testing strips etc.

Periodic Review

This is a review of the patient and the medication to ensure that treatment is still effective, appropriate and well-tolerated. The prescriber makes an informed decision as to whether to continue, change or stop medication and whether additional monitoring e.g. blood test is required.

Medication review is an integral part of the repeat prescribing process and is covered in chapter 4 of this guidance.

It is anticipated that changes in ordering systems will lead to a reduction in the volume of repeat prescription requests. This may provide GPs with an opportunity to undertake appropriate clinical screening of all prescriptions, and in particular those items which may require additional information, such as by accessing clinical notes. Changes in medication following and outpatient appointment, inpatient stay, home visit, etc. should be reviewed by the authorising prescriber before addition or deletion from the repeat list.

[3] Saving time, helping patients. A good practice guide to quality repeat prescribing. National Prescribing Centre January 2004,

The Kings Fund research paper – The Quality of GP prescribing[4] makes recommendations and suggestions on indicators that describe high-quality prescribing. Table 4 includes those relevant to repeat prescribing.

Table 4: Indicators of High Quality Prescribing

'Repeat prescribing systems have been audited to ensure accurate and timely supply of medicines in accordance with a written repeat prescribing policy.'
'Practices demonstrate that medication review is done regularly and effectively and to a high standard. Clinical pharmacists should be involved where practicable.'
'Close co-operation between practice and community pharmacy is demonstrated'
'Extra support is provided to assess patients who need to take six or more medicines (necessary polypharmacy).'
'Reduce risk of dispensing errors by uptake of electronic transmission of prescriptions'.

3.3 Drugs appropriate for repeat prescribing

Practices should agree their own list of drugs which they consider are less suitable for repeat prescriptions. This may vary according to practice preference and systems. The following table is a list for practice discussion to highlight items that may not be appropriate or are appropriate in some circumstances.

Table 5: Medication less suitable for repeat prescriptions

Medication	Rationale
Oral antibiotics	National public health concerns with regard to antibiotic resistance. Prescribed in specific exceptional circumstances and in accordance with local antibiotics policy. e.g. anticipatory prescribing of oral antibiotics for COPD patients suffering frequent exacerbations, prophylaxis in asplenia.
Topical antibiotics/ thrush treatments	Resistance develops quickly especially to fusidic acid. If an initial course has failed, repeated issues should not be given.
Antivirals and antifungals	Long term conditions need further investigation.
Moderate to potent topical corticosteroids	Long term unsupervised use is not appropriate, especially for the more potent steroid creams. Consider short review date.
Some head lice treatments	Resistance to Malathion has been reported.
Short-term, high dose proton pump inhibitors	Reduce to lowest dose maintenance treatment.
Short course for symptom control: analgesics and anti-pyretics	Whilst acceptable for long-term conditions, e.g. paracetamol for osteoarthritis, acute illness will require changes according to need of the patient.
Dressings	Require regular assessment. Has potential for significant wastage.
Sip Feeds/ONS	Limited indications and also potential for abuse.
Benzodiazepines	Guidelines for short term use only.

[4] http://www.kingsfund.org.uk/sites/files/kf/field/field_document/quality-gp-prescribing-gp-inquiry-research-paper-mar11.pdf

3.4 Prescription Synchronisation

Unsynchronised quantities on repeat prescriptions mean that patients have to order different items at separate times. When items run out at different times, the patient will come back more frequently for a repeat which increases workload for the practice and inconvenience for the patient. There are clear benefits of prescription synchronisation for both practices and patients. Synchronising the quantities of medication prescribed so they all run out at the same time is highly desirable (recognising that some are used 'when needed' e.g. analgesics and in some cases the quantity is inexact e.g. skin preparations).

This should be considered prospectively for new prescriptions and retrospectively for existing repeats. This is the responsibility of prescribers on initiation and staff generating repeats to highlight to prescribers for authorisation to amend.

ACTION POINTS

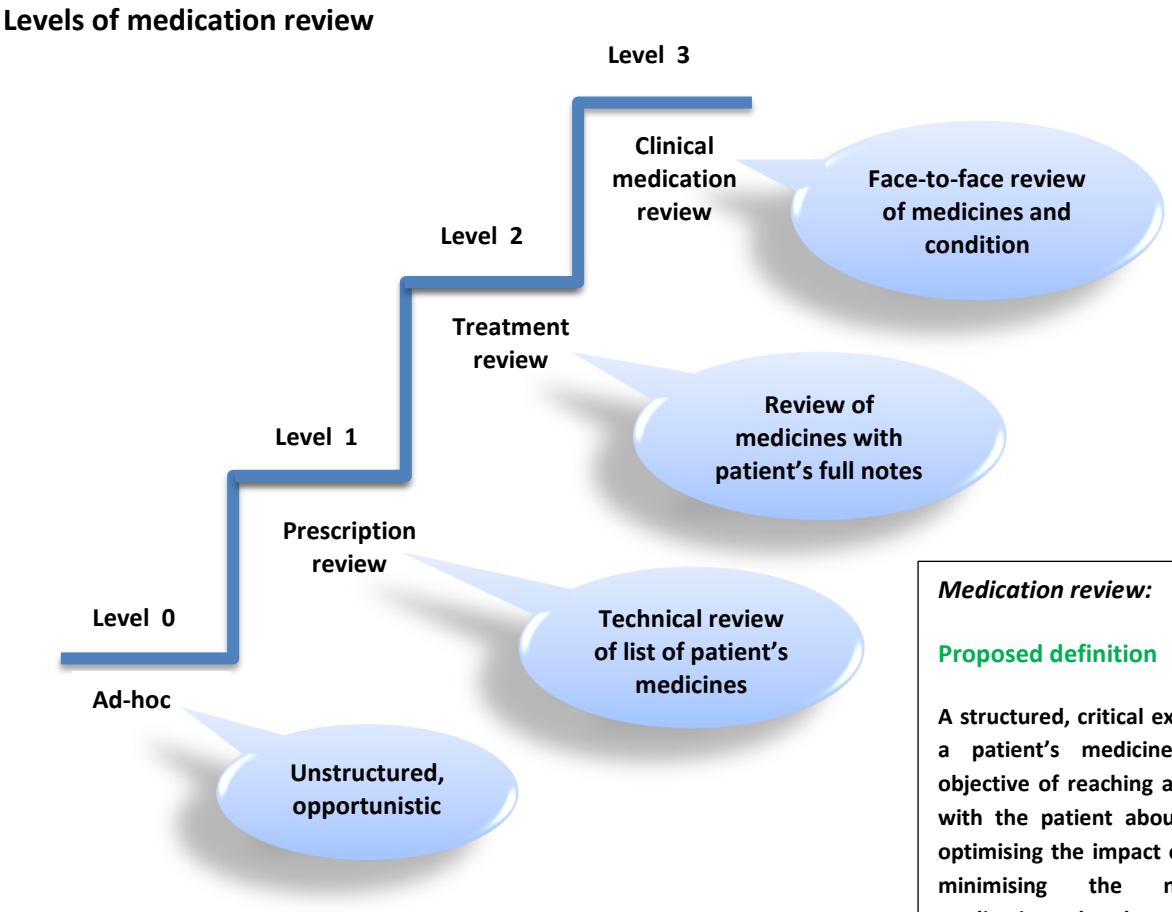
GPs retain clinical control for all prescriptions.
How do you ensure that robust systems for repeat prescriptions are in place and that GP authorisation and review are undertaken to a high standard?
Do you have a list of drugs which are unsuitable for repeat prescribing?
How do you manage prescription synchronisation?

4. MEDICATION REVIEW

Medication review[5] can be regarded as a cornerstone of medicines optimisation, preventing unnecessary ill health and avoiding waste. Involving patients in prescribing decisions and supporting them in getting the best from their medicines is key to improving patient safety, health outcomes and satisfaction with health care.

4.1 Types of Medication Review

One commonly used 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' (Room for Review 2002[6]). Ideally, the review should be with the patient and their current medication to hand, but as a minimum with the full medical notes. Levels of medication review were introduced by Room for Review in 2002 – see figure below.



Reproduced from Room for Review

Medication review:

Proposed definition

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.

[5] Based on and acknowledgements to NHS Cumbria Medicines Management Team Clinical Medication Review – a practice guide February 2013

[6] Room for Review: A guide to medication review: the agenda for patients, practitioners and managers. Task Force on Medicines Partnership and the National Collaborative Medicines management Services Programme 2002

4.2 Principles of medication review

- All patients should have a chance to raise questions and highlight problems about their medicines
- The medication review seeks to improve or optimise impact of treatment for a patient
- The review is undertaken in a systematic and comprehensive way, by a competent person
- Any changes resulting from the review are agreed with the patient
- The review is documented in the patient's notes
- The impact of any change is monitored

4.3 Who to review

Room for Review and A Guide to Medication Review suggested the following target groups to prioritise medication review:

Patients at risk of medicines-related problems
Taking four or more medicines every day On a complex medication regimen or more than 12 doses in a day Recently discharged from hospital Recently transferred to a care home Frequent hospital admissions With multiple diseases Receiving medicines from more than one source e.g. specialist and GP Significant changes to the medication regimen in the past 3 months or more than 4 changes in medication in the past 12 months Taking higher risk medicines – those requiring special monitoring e.g. lithium, methotrexate; those with a wide range of side effects e.g. NSAIDs; or a narrow therapeutic range e.g. digoxin; on drugs not commonly prescribed in primary care Symptoms suggestive of an adverse drug reaction Longstanding use of psychotropic medication Where non-compliance is suspected or known High incidence of self-medication
Special needs
Older people Residents in care homes Learning difficulties End-of-life care Sensory impairment e.g. sight or hearing Physical problems e.g. arthritis, swallowing difficulties Mental states such as confusion, depression, anxiety, serious mental illness Communication difficulties Literacy or language difficulties Minority ethnic groups Refugees and asylum seekers Living alone or poor carer support Housebound Recent falls Homeless

Opportunities to improve care
New evidence or guidelines Newly diagnosed long term condition Out of date care plan Newly registered patient

Where possible, before a medication review, patients should be provided with written information about the review including what they can do to prepare for the review. See appendix 4 for an example patient leaflet that may be adapted for use in your practice.

4.4 What the review should cover

For each drug check that

The medication prescribed is appropriate for the patient's needs.
Following hospital discharge there may be unintended changes to regular medication or conversely medication may have been started that was appropriate in the hospital setting but not needed at home e.g. hypnotics, nebules.

National and local evidence based guidelines should be considered at these stage. Local guidance is available to GP clinicians on the CCG intranet Gelifish. Additionally, message alerts from point-of-prescribing software tools such as ScriptSwitch and OptimiseRx provide links to relevant documents when drugs are being prescribed and at review.

The medication is effective for the patient
This may involve objective evidence e.g. change in HbA1c or discussion with patient. In frail patients precedence may be given to drugs that provide symptomatic benefit or prevent rapid worsening of symptoms.

The medication is cost effective
Prescribing within national (NICE) and local (Bedfordshire Joint Prescribing Committee, Luton Primary Care Prescribing Committee) guidance. Medication should be prescribed generically where possible and appropriate. Exceptions include medication where a particular brand provides additional safety, such as a particular absorption rate (e.g. long-acting diltiazem), or consistent packaging and information for the patient (e.g. oral contraceptives), or where different brands are not equivalent (e.g. tacrolimus, insulin, beclometasone inhalers). Specials (unlicensed products and special formulations) are rarely cost effective but may be the only option. By preference a licensed alternative should be sought, if necessary used outside the licence. The medicines optimisation team will be able to provide advice on alternatives and additional resources are available on Gelifish.

Any required monitoring has been done or arrangements are in place
E.g. blood tests specific to medication or to monitoring.

De-prescribing options are fully considered
Consider the need to de-prescribe medication as a matter of routine. De-prescribing is the process of tapering, withdrawing, discontinuing or stopping medications to reduce polypharmacy, adverse drug effects and inappropriate or ineffective medication use by re-evaluating the ongoing reasons for, and effectiveness of medication therapy. De-

prescribing, when performed by medical professionals, can be effective in reducing medication burden in patients to improve quality of life while maintain control of long-term conditions. It must be done carefully with monitoring to avoid worsening of disease or withdrawal effects. The Kings Fund report in 2013[7] and the Drug and Therapeutics Bulletin article in 2014[8] focus on de-prescribing. They recommend:

- When reviewing medication in any setting, consider if treatment can be stopped if there is no benefit in continuing and harm is being caused
- End of life considerations apply to chronic diseases, cancer related conditions and frailty
- Prescribers need as much support, evidence and confidence to stop treatment as they do to start and maintain therapy

Additional guidance on de-prescribing can be obtained from CCG medicines optimisation team.

4.5 Documentation and communication of changes

Record any information pertinent to any decisions made. Read code appropriate to the review:

8B314/8B3S	Medication review (Level 2 Treatment review: review of medicines with patient's full notes)
8B3h.	Medication review without patient (Level 2 Treatment review)
8B3x.	Medication review with patient (Level 3: Clinical medication review- a face to face review of medicines and condition)
8B3j.	Asthma medication review
8B3k.	Coronary heart disease medication review
8B3l.	Diabetes medication review
8BIF.	Epilepsy medication review
8BI.	Other medication review
8BM0.	Mental health medication review
8BM00	Lithium annual review
8BM01	Antipsychotic medication review

The patient and/or carer must be informed of important changes and have the opportunity to discuss or be involved in the decision making. It may not be necessary to inform patients in all instances however, for example where prescription supplies have been synchronised etc.

[7] Duerden M et al. Polypharmacy and medicines optimisation: making it safe and sound. King's Fund Report 2013.

[8] Anon. Describing de-prescribing. DTB March 2014; 52 (3): 25.

4.6 Follow up

The practice repeat prescribing policy should state the mechanism for follow up e.g. by defining amended medication as ‘acute’ or resetting medication review diary dates for one month, six months or a year.

4.7 Optimising Resources

Although a clinical medication review with a patient is seen as the ideal form of review, they will be the most resource intensive form of review. This can be mediated by:

- Deploying the skills of a range of personnel to fulfil different elements of the review – or to supplement periodic clinical medication review with other forms of review e.g. through MURs (see section 7)
- Focussing in the first instance on patients in greatest need – typically elderly patients on polypharmacy or those recently discharge from hospital
- Following a clear structure as described in the overview.

ACTION POINTS

Medication Review is a CORE clinical prescribing activity. Do you have a clear plan for medication review, have you targeted any groups and do you audit regularly?
Do you have evidence to support this (for example for CQC inspections)?

5. Electronic Prescribing System (EPS) and Repeat Dispensing (RD)

EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (usually a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.

Repeat dispensing is an alternative model for prescribing and dispensing regular medicines to patients on stable long–term treatment, where repeat supplies are managed by the patient's pharmacy of choice. In some areas repeat dispensing is known as 'batch prescribing'. EPS and RD can operate separately or in tandem.

5.1 Why use EPS?

Table 6 below summarises the benefits of EPS.

Table 6: Benefits of EPS

Less time signing prescriptions Sign individual or multiple prescriptions electronically, there is no need to sign by hand
Greater control of the prescription Prescriptions can be cancelled at any time until they have been dispensed, replacements can be sent electronically
Less time dealing with prescription queries • Standardised prescription information will reduce queries from dispensers • Improved prescription accuracy leads to a reduction in the likelihood of patients receiving the wrong medication • Electronic prescriptions cannot be lost, reducing the risk of duplicate prescriptions being generated
Process repeat prescriptions more efficiently • No need to issue, sort and file prescriptions into pigeon holes for prescribers to hand sign as they are allocated and signed electronically • Moving patients on to electronic repeat dispensing will further reduce workload associated with issuing and re-authorising repeat prescriptions • Electronic prescriptions are sent straight to the dispenser of the patient's choice. This will result in a reduction in footfall in reception as patients won't be visiting to collect prescriptions • No need to post prescriptions, saving time and eliminating the risk of prescriptions being lost in the post • No need to record events to do with paper prescriptions (e.g. printer problems, posting, lost etc.) on the clinical computer system as all EPS activity is automatically recorded
Less time preparing for prescription collection services • No need to prepare and sort prescriptions ready for pharmacies to collect • Less chance of prescriptions going to the wrong dispenser due to sorting errors
Greater flexibility • Send prescriptions straight to the patient's nominated dispenser following a telephone or video consultation • No need to fax urgent or replacement prescriptions. These can be sent electronically by the prescriber

5.2 When is EPS unsuitable?

Although EPS offers many advantages for GPs, patients and dispensers, there are circumstances where EPS may not be suitable:

- If patients use different pharmacies then they may prefer not to nominate a specific pharmacy.
- If treatment is likely to be subject to frequent changes or where the patient has frequent hospital admissions then the risks will outweigh any benefit.

From 1 July 2015, legislation came into force allowing schedule 2 and 3 controlled drugs to be prescribed and dispensed using EPS release 2. All prescribing and dispensing suppliers have been provided with the new requirements that their systems need to meet, in order to allow schedule 2 and 3 controlled drugs to be sent electronically. All suppliers must complete assurance and testing against these requirements before controlled drugs prescribing, using EPS, can be implemented across England.

NHS England, through its area team, is responsible for authorising GP practices to use EPS, implementing the Standard Deployment Model, provision of dispensing tokens, monitoring nomination and provision of registration authority services (smart cards).

For more information on EPS see HSCIC website http://systems.hscic.gov.uk/eps or contact your practice pharmacist.

5.3 Repeat Dispensing

Repeat dispensing, also known as dispensing with repeats, means patients having medicines dispensed in several episodes direct from the pharmacy, rather than going back to their GP each time. Repeat dispensing is included in the Community Pharmacy Contractual Framework as an essential service and so ALL NHS community pharmacies are able to dispense a repeatable prescription if one is presented to them.

5.4 Benefits of Repeat Dispensing

There are a number of differences and added benefits between the repeat dispensing model and traditional repeat prescribing processes, including:

- The prescriber produces a repeatable prescription and a set of identical ‘batch’ forms – the number required is equal to the number of times the prescription is to be repeated and this is to be indicated on the form, for example, 1 of x, 2 of x
- Each repeatable prescription can be dispensed at regular intervals, for example, monthly for a period of up to 12 months
- Patients will call at their chosen pharmacy for their continued supply of medicines without the need to reorder prescriptions during the life of the repeatable prescription
- The outstanding repeats left on the prescription can be cancelled and the remaining batch issues destroyed as and when required, to respond to changes in medicines, clinical condition or patient circumstances

- National guidance states that the batch forms can be stored securely at the pharmacy or retained by the patient. Locally, it is preferred that the batch forms be secured at the pharmacy.
- The duration of the repeatable prescription can be aligned to a patient review, monitoring procedure or other clinical and administrative functions of the practice
- At the point of dispensing each instalment, the pharmacist will be responsible for checking patient adherence and other clinical factors that are relevant to the appropriateness of the continued supply, for example, whether there are any problems the patient may be encountering with their medicines, whether the patient has recently been in hospital or had changes made to their medication regimen. Any issues of concern to the pharmacist will be reported to the practice.

Suitable patients/situations	Unsuitable patients/situations
Patients on single, stable therapy, for example, Levothyroxine	Unstable or newly diagnosed patients
Patients with stable long-term conditions on multiple therapy for example, hypertension, diabetes, asthma	Patients requiring frequent changes to medicines
Patients that can appropriately self-manage seasonal conditions	End-of-life care

5.5 Top Ten Tips for Repeat Dispensing

Repeat dispensing has been successfully implemented in a number of GP practices. Here are the top ten tips gathered from those GPs, practice managers and pharmacists:

1. Be prepared to invest some ‘set-up’ time at the practice. This is an ‘invest to save’ process initially.
2. Start small, perhaps with a defined group of patients on a single stable therapy (e.g. levothyroxine, or up to two medications for stable diabetes or hypertension), then increase numbers and expand selection criteria as patient and practice confidence increases.
3. Improve communication between the practice and pharmacy – maximum benefits will be gained with good working relationships. Discuss the process together and understand each other’s responsibilities.
4. Identify a named lead in both the practice and pharmacy to take forward implementation and ensure regular two-way communication. Practices and pharmacists must be responsive to changes in patients’ medicines requirements and have appropriate communication channels for notification of changes, cancellation or referral back to the GP.
5. Check your clinical system or contact your system supplier to find out how to activate and use the repeat dispensing function.
6. Set patient selection criteria that will allow for easy identification and smooth running of the service. In many successful cases, patients have been identified by the pharmacy and then referred to the practice.

7. Set the total duration of the repeatable prescription to coincide with reviews or procedures and any functions that have Quality and Outcomes Framework (QoF) targets attached.
8. Ensure all staff at the practice and pharmacy are aware of the service and fully understand the processes involved.
9. Since clinical information is to be shared between the pharmacist and the prescriber, explicit patient consent is required. Your local pharmacy can help you administer the consent form.
10. Effective communication with the patient is paramount. The service will fail if patients continue to reorder their prescriptions as before or become confused.

http://www.nhsemployers.org/your-workforce/primary-care-contacts/community-pharmacy/working-with-general-practice/repeat-dispensing
http://psnc.org.uk/wp-content/uploads/2013/07/Repeat-dispensing-guide-Dec-2013.pdf
http://www.england.nhs.uk/wp-content/uploads/2015/06/electronic-repeat-dispensing-guidance.pdf

If you would like more information please contact your practice pharmacist or refer to LCCG Repeat Dispensing Guide and sample practice policy (available on Gelifish).

ACTION POINTS

Do you fully utilise EPS in your practice?
Have you identified patients suitable for Repeat Dispensing?

6. MAINTAINING SAFETY AND QUALITY

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. In 2014, CQC set out their plans for regulating, inspecting and monitoring GP practices and GP out-of-hours services[9] and was adopted on 1st October 2014. A provider handbook 'How the CQC regulates NHS GP Practices and GP out-of-hours services' describes CQC's approach, which assesses services against 5 key questions:

Are they safe? Meaning that people are protected from abuse and avoidable harm

Are they effective? Meaning that people's care. Treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Are they caring? Meaning that staff involve and treat people with compassion, kindness, dignity and respect

Are they responsive to people's needs? Meaning services are organised so that they meet people's needs

Are they well-led? Meaning that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

The consequences of poor systems can have devastating impact on patients and doctors alike. The Medical Defence Union has reported that claims made in relation to medication errors have risen over 50% between 2008 and 2012[10], although this is largely driven by an increase in workload. Any claims involve multiple allegations, but one of the main reasons cited for settled claims include problems with long term administration of medication. The claims in this category related to a failure to monitor patients on long-term repeat prescriptions which meant that they experienced harmful side-effects, including renal failure or became addicted to the drug they were taking. Drug types included NSAIDs such as diclofenac, benzodiazepines, steroids and antibiotics. The largest compensation payout made on behalf of a GP was £1.2 million to a patient who was left severely disabled after a failure to monitor levels of a long-term prescription for lithium resulting in lithium toxicity.

[9] http://www.cqc.org.uk/content/doctorsgps

[10] http://www.themdu.com/guidance-and-advice/latest-updates-and-advice/medication-error-cases-increase-by-more-than-50-per-cent-over-five-years

6.1 Risk Management Advice

We hope the following risk management advice will help you avoid the types of problem highlighted above:

1. You should be aware of current national guidance, particularly the BNF and BNF for Children, NICE guidelines and the latest GMC prescribing guidance, Good practice in prescribing and managing medicines and devices (January 2013).

2. If prescribing drugs with which you are unfamiliar, check contra-indications and side-effects and seek further advice (from a colleague, practice pharmacist or specialist) if you are unsure.

3. Check the patient's medical history and concurrent medication before prescribing any new drug, including any OTC drugs they are taking regularly such as NSAIDs.

4. Double-check you have the right drug and correct preparation and strength when selecting from a picking list. Many generic drugs have similar names and it is easy to click on the wrong one or to dispense the wrong dose.

5. Don't be complacent about the automatic drug interaction warnings on computerised prescribing systems, even if you think they are over-inclusive. Satisfy yourself that the drug is still the best prescribing option before overriding the system.

6. The GMC expects you to talk to the patient about their medication, explaining what to do in the event of a side effect or recurrence of the condition; how and when to take the medicine and how to adjust the dose if necessary; the likely duration of treatment; and arrangements for monitoring, follow-up and review.

7. GP practices are advised to have a system in place for reviewing patients on long-term medication to:

    - check compliance, dose requirements and side effects;
    - undertake appropriate examination and tests to monitor the patient’s condition and the medication;
    - ensure that the drug is still necessary.

8. It's a good idea to carry out frequent reviews for patients taking high risk drugs such as lithium, methotrexate, insulin and opioids.

9. You remain responsible for the prescriptions you sign, even if they have been produced by non-clinical members of the practice team, so be sure you are satisfied that drug and dosage are correct.

10. When care is shared between you and hospital colleagues, it is advisable to have a protocol in place setting out who is responsible for prescribing, monitoring and follow-up and to explain this to the patient. You should have all the necessary information about the patient, the condition, the required dose regime, frequency and formulation of the drug being prescribed.

11. If a patient has an adverse reaction to a drug you have prescribed, you must explain what you think has happened, what you are going to do to help them and apologise if there has been an error. Adverse reactions, including those reported in hospital discharge letters, should be noted in the patient's records as the appropriate read code and, if significant, rare or concerning a black triangle drug, reported through the MHRA yellow card system.

12. Ensure your practice learns from medication errors, perhaps through a significant event audit to minimise the risk of a repeat error. The CQC expects practices to report incidents to the National Reporting and Learning Service (NRLS) where patient safety has been or could have been compromised.

Case Study

A patient complaining of dyspepsia was given a prescription for a H2-receptor antagonist. The patient consulted the GP four months later with a recurrence of the problem and was prescribed a second course.

The patient received monthly repeat prescriptions of the H2-receptor antagonist for the next year. During that time the GP wrote asking him to attend surgery for a review of medication, but failed to follow this up. Eighteen months after the first visit the patient again visited the surgery with dyspepsia symptoms and was referred immediately for investigation.

An inoperable carcinoma of the stomach was diagnosed and the patient died six months later.

The ensuing complaint proceeded to a hearing (under the old complaints procedure) where the GP was found in breach of his Terms of Service. **It was recommended that the practice should review and formalise the system for repeat prescribing.**

Table 6 identifies some national and local systems which focus on safety and quality, those highlighted in bold are reviewed below. It is highly recommended that this section is reviewed by practices regularly and prior to any CQC inspections.

Table 6 Safety and Quality in Prescribing

	System	Provides evidence of[11]
National	Practice responds to patient safety alerts, rapid response reports and patient safety recommendations which require action.	SAFETY - Reliable systems, processes and practices in place to keep people safe
	Practice reports any patient safety incidents involving medication to National Reporting and Learning System (NRLS) or Medicines and Healthcare Products Regulatory Authority (MHRA) via the Yellow card scheme	SAFETY - Reliable systems, processes and practices in place to keep people safe
	Practice undertakes regular medication management audits (for example through review of this guidance)	EFFECTIVE - Treatment outcomes are monitored by undertaking clinical audits WELL-LED - Staff are clear about their roles and understand what they are accountable for
	Practice undertakes Significant Event learning Practice assists in any serious incidents (SI) investigation led by NHS England and patient	SAFETY - Lessons learned and improvements made when things go wrong SAFETY - Reliable systems, processes and practices in place to keep people safe
	Practice runs PINCER Audit Tool	SAFETY - Track records on safety demonstrated – by monitoring safety using information from a range of sources
Local/ CCG level	**Point of prescribing decision support software (ScriptSwitch or OptimiseRx) is utilised by practice**	EFFECTIVE - Treatment delivered in line with evidence based guidance
	Eclipse Live medication risk stratification tool is used by practice	EFFECTIVE - Risk stratification used to ensure that care is delivered proactively. SAFETY Track records on safety demonstrated – by monitoring safety using information from a range of sources
	Practice utilises MOT and practice pharmacists educational resources (e.g. prescribing newsletter disseminated to all clinical staff, attendance at PLT)	SAFETY- Reliable systems, processes in place to keep people safe EFFECTIVE - Staff have skills, knowledge and experience to deliver effective care and treatment

[11] Refer to CQC Provider Handbook NHS GP Practices appendices for detail

6.2 PINCER Audit Tool

The PINCER audit tool identifies at-risk patients who are being prescribed drugs that are commonly and consistently associated with medication errors so that corrective action can be taken to reduce the risk of occurrence of these errors. The PINCER audit tool is freely available to all basic and full PRIMIS Hub members[12]

This tool was developed in partnership with the PINCER Trial team at The University of Nottingham and demonstrated that the PINCER intervention is an effective method for reducing a range of clinically important and commonly made medication errors in primary care.

This audit tool runs eight queries (see below) and can help practices by:

- identifying at-risk patients
- helping prevent unnecessary harm to patients, and might also reduce the costs associated with dealing with prescribing errors, which sometimes require hospital admission

PINCER Query Library

Query 1: Patients with a history of peptic ulcer who have been prescribed a non-selective non-steroidal anti-inflammatory drug (NSAID) without co-prescription of a proton-pump inhibitor (PPI)

Query 2: Patients with a history of asthma who have been prescribed a β-blocker

Query 3: Patients aged 75 years and older who have been prescribed an angiotensin converting enzyme (ACE) inhibitor or a loop diuretic long-term who have not had a computer-recorded check of their renal function and electrolytes in the previous 15 months

Query 4: Women with a past medical history of venous or arterial thrombosis who have been prescribed combined hormonal contraceptives (CHC)

Query 5: Patients receiving methotrexate for at least three months who have not had a recorded full blood count (FBC) or liver function test (LFT) within the previous three months

Query 6: Patients receiving warfarin for at least three months who have not had a recorded check of their international normalised ratio (INR) within the previous 12 weeks

Query 7: Patients receiving lithium for at least three months who have not had a recorded check of their lithium concentrations in the previous three months

Query 8: Patients receiving amiodarone for at least six months who have not had a thyroid function test (TFT) within the previous six months

6.3 ScriptSwitch and OptimiseRx

ScriptSwitch and OptimiseRx are software tools aimed to provide prescribing decision making support to clinicians at the point of prescribing. The medicines optimisation team are moving practices from ScriptSwitch to OptimiseRx. Currently OptimiseRx is

[12] http://www.nottingham.ac.uk/primis/tools/audits/index.aspx

compatible with SystmOne so all SystmOne practices have migrated from ScriptSwitch to OptimiseRx.

OptimiseRx is a clinical support software system which is fully integrated with the patient record to enable the delivery of prescribing best practice and to optimise cost savings.

Prescribing options, alerts and prompts are based on evidence based best practice, safety and cost and support medicines optimisation. Reference messages combine national guidance and local formulary information promoting clinically effective prescribing.

Patient specific and clinically intuitive prescribing options take into account the full patient history (as coded) increasing the likelihood of clinical acceptance.

Simple access to the full solution when undertaking patient medication review and at re-authorisation of prescription, via patient snapshot button, reducing the complexity of polypharmacy with multi-morbidity patients

The messages broadly form three chapters:

Best Practice including QIPP, NICE, MHRA, Cochrane and core LTC modules;

Safety Indicators including King's Fund, PINCER, STOPP;

Cost and Value including QIPP, Therapeutic Interchanges and cost effective swaps.

The systems provide monitoring reports at practice level which indicate the acceptance rates which the practice pharmacist can prepare if requested.

6.4 Eclipse LIVE

NHS Luton CCG MO team utilise a Software system called ECLIPSE, which runs reports based on ePACT dispensing data. ECLIPSE stands for: "Electronic Checking Leading to Improved Prescribing Safety & Efficiency".

The team are trialling the advanced Eclipse "LIVE" version to undertake risk stratification enabling the running thousands of safety algorithms against all of your patients. It is aimed that this will reliably identify those patients at risk of complications /admission by generating user-friendly lists for easy management.

ACTION POINTS

Do you run the PINCER tool routinely?
Ask your practice pharmacist for ScriptSwitch or Optimise Rx Acceptance Report

7. SIGNPOSTING/REFERRAL TO COMMUNITY PHARMACY SERVICES

Community pharmacists provide a wide range of NHS and private pharmaceutical services. Many pharmacies choose to provide one or more advanced services under their NHS contractual framework, and these can include Medicines Use Reviews (MURs) and New Medicines Services (NMS).

The **Medicines Use Review (MUR) and Prescription Intervention Service** consists of accredited pharmacists undertaking structured **adherence-centred** reviews with patients on multiple medicines, particularly those receiving medicines for long term conditions.

The MUR process attempts to establish a picture of the patient's use of their medicines – both prescribed and non-prescribed. The review helps patients understand their therapy and it will identify any problems they are experiencing along with possible solutions. An MUR Feedback Form will be provided to the patient's GP where there is an issue for them to consider. National target groups have been agreed in order to guide the selection of patients to whom the service will be offered. From 1st January 2015 the national target groups are:

Patients taking high risk medicines (namely NSAIDs, Anticoagulants [including low molecular weight heparin] Antiplatelet agents and Diuretics)
Patients recently discharged from hospital who had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge
Patients with respiratory disease
Patients at risk of or diagnosed with cardiovascular disease and regularly being prescribed four or more medicines (from 1st January 2015).

The New Medicine Service (NMS) provides support for people with long-term conditions newly prescribed a medicine to help improve medicines adherence; it is initially focused on particular patient groups and the conditions/therapies included in the initial rollout of the service are:

Asthma and COPD
Type 2 Diabetes
Antiplatelet / anticoagulant therapy
Hypertension

For each therapy area/condition, a list of medicines has been published http://psnc.org.uk/wp-content/uploads/2013/07/NMS-medicines-list-Apr-2014.pdf

7.1 Potential benefits of the services to GPs

MURs and the NMS do not aim to duplicate work undertaken in GP practice reviews, but rather to provide additional support to patients by helping to ensure medicines are taken safely and effectively. This reduces the burden on general practice by minimising

exacerbations caused by poor adherence and preventing unnecessary repeat visits to the GP.

If a patient on your registered list is offered (and accepts) the NMS or an MUR, you may receive a feedback form from the pharmacist to inform you of any problems or other issues that you may wish to be aware of, for example if the patient is experiencing difficulty using the medicine or has stopped taking it without the prescriber's knowledge. Two national forms exist for this purpose, and were designed by the Professional Relationships Working Group which is made up of NHS Employers, Pharmaceutical Services Negotiating Committee (PSNC) and the General Practitioners Committee (GPC).

When there are no issues raised that the pharmacist feels the GP would wish to be aware of, then no form is sent (unless the GP has requested feedback when referring the patient to the service).

If a problem requiring GP review is identified, the pharmacist may refer the patient back to the GP, and if the problem is urgent they will generally telephone the practice to ensure this is handled in a timely manner.

7.2 Achieving best value from the MUR and NMS services

To gain maximum value and benefits from community pharmacy services it is important that effective communication processes exist locally between GP practices and community pharmacies. GP practices may find the following tips helpful:

- ✓ Agree referral pathways for GPs and staff to direct patients into the services. GPs are encouraged to signpost community pharmacy to patients eligible for MUR or NMS. See appendix 6 and 7 for template referral forms that can be given to the patient
- ✓ Ensure that there are procedures to manage feedback and follow-up with community pharmacies
- ✓ Where possible, timing of MURs could be coordinated with GP practice reviews to maximise beneficial outcomes and prevent duplication. If an MUR is carried out prior to the review in practice the GP would have further background information about compliance, side effects and any advice that the patient has been given

For more information on community pharmacy see http://psnc.org.uk/wp-content/uploads/2013/07/The-community-pharmacy-guide-for-GPs-and-practice-staff-July-20131.pdf and http://psnc.org.uk/wp-content/uploads/2013/07/Advanced-services-briefing-for-GPs-Aug-2013.pdf

ACTION POINT

Agree to use the Community Pharmacy Referral Form in your practice to support patients to get the most from the repeat medicines

8. FEEDBACK, MONITORING AND REVIEW

8.1 Health Care Professional Feedback and Comments

Medicines optimisation welcome feedback, comments and suggestions from all health care staff involved in repeat prescribing. In particular, we would welcome feedback on this resource. You can contact your practice pharmacist directly or send your comments to luton.prescribing@nhs.net.

8.2 Patient Information and Feedback

A patient guide to repeat medicines has been prepared to provide patients with general guidance on the medicines that they take. An electronic copy of this will be sent to all practices and pharmacies and practices will receive hard copies for distribution to patients.

Patients are able to feedback comments to their practice by a number of ways, e.g. via practice website, which practices may be able to share with the team.

8.3 Feedback opportunities at wider engagement

The Medicines optimisation team engage with practices at both individual practice and cluster level, and at Members Forum and PMFI meeting and these provide opportunity for feedback from GPs and practice managers.

Since we utilised patient participation groups (PPGs) to discuss repeat prescription ordering services, we anticipate that these groups would also provide an opportunity for patients to comment on the changes and express their views.

8.4 Monitoring and Review

Repeat prescribing is a fundamental primary care activity with significant resource implications at both practice level and more widely within the NHS locally. A review of repeat prescribing management will be made in due course following publication of the guidance. This review will examine a number of surrogate measures to identify improvements in safety and quality.

By practices – audits e.g. of medication reviews, identification of additional staff training needs etc.

By LCCG – ePACT data, EPS reports, prescribing reports, patient and healthcare professional feedback.

By Area Team/MO Dashboard –Repeat Dispensing, EPS, MUR and NMS data – trends analysis

9. APPENDICES

Appendix 1: Summary of Repeat Prescribing Key Roles and Responsibilities (separate document)

Appendix 2: Patient Guide to Repeat Medicines (separate document)

Appendix 3: Repeat Prescribing Policy Template (separate document)

Appendix 4: How to prepare for your medication review (separate document)

Appendix 5: LCCG GP Practice Cluster and Pharmacist List (separate document)

Appendix 6: Community pharmacy MUR referral form (separate document)

Appendix 7: Community pharmacy NMS referral form (separate document)