Prescribing Policy

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This document has been produced for the sole purpose of the requirements for the PCN hub model developed by the Folkestone, Hythe and Rural PCN during the time of the pilot and will require continuous updates. It is intended to be shared only as a resource guide for this model approach and not direct application.

1 Introduction

1.1 Policy statement

The purpose of this document is to ensure that all prescribers within Coastal and Rural Health Partnership understand the requirement to maintain currency and to work within their professional boundaries[1] to deliver safe and effective clinical care.

1.2 Status

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment.

1.3 KLOE (England only)

The Care Quality Commission (CQC) would expect any primary care organisation to have a policy to support this process and this should be used as evidence of compliance against CQC Key Lines of Enquiry (KLOE)[2].

Specifically, Coastal and Rural Health Partnership will need to answer the CQC Key Questions on “Safe” and “Effective”.

By safe, we mean people are protected from abuse and avoidable harm.*

**Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse*

CQC KLOE S3	Do staff have all the information they need to deliver safe care and treatment to people?
CQC KLOE S4	How does the provider ensure the proper and safe use of medicines where the service is responsible?
CQC KLOE S6	Are lessons learned and improvements made when things go wrong?

By effective, we mean that people’s care, treatment and support achieve good outcomes, promotes a good quality of life and is based on the best available evidence

CQC KLOE E3	How does the service make sure that staff have the skills, knowledge and experience to deliver effective care, support and treatment?

[1] Good practice in prescribing and managing medicines and devices - ethical guidance summary - GMC (gmc-uk.org)
[2] KLOE

1.4 Training and support

The organisation will provide guidance and support to help those to whom it applies to understand their rights and responsibilities under this policy. Additional support will be provided to managers and supervisors to enable them to deal more effectively with matters arising from this policy.

2 Scope

2.1 Who it applies to

This document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

Furthermore, it applies to clinicians who may or may not be employed by the organisation but who are working under the Additional Roles Reimbursement Scheme (ARRS)[3] and are to follow all policies and requirements as per "Coastal and Rural Health Partnership staff".

2.2 Why and how it applies to them

This document refers to the legislative acts associated with prescribing and it explains the activities intrinsically linked to prescribing including but not limited to:

- The supply of prescription-only medicines
- The prescribing of medicines, devices and dressings
- The provision of advice to patients regarding the purchase of over-the-counter medicines

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the Equality Act 2010. Consideration has been given to the impact this policy might have regarding the individual protected characteristics of those to whom it applies.

3 Policy

3.1 Accountability

Prescribing errors are relatively common but preventable events. Most of these errors result in no harm or low-to-moderate harm; however, some result in severe harm or death. Prescribing error rates of 4.9% of all prescription items in general practice have been observed.[4] All clinicians authorised to prescribe within Coastal and Rural Health Partnership

[3] Network DES Contract specification 2022/23

[4] https://www.gmc-uk.org/-/media/about/investigatingtheprevalenceandcausesofprescribingerrorsingeneralpracticethepracticestudyreoprtmay2012.pdf?la=en&hash=62C1821CA5CCC5A4868B86A83FEDE14283686C29

are aware that it is the clinician who signs the prescription who will be held accountable should an error or incident occur. Prescriptions issued on the recommendation of a non-prescriber, i.e., a nurse or allied healthcare professional, remain the responsibility of the named, authorised prescriber.

Clinicians must only prescribe medicines, devices or dressings when they are satisfied they have sufficient knowledge of the patient's health and that they are content that the prescription is fully justified.

3.2 Guidance

All authorised prescribers are to follow the information and guidance provided in the British National Formulary (BNF), whilst also taking into consideration the guidance published by NICE (England).

Clinicians working within Coastal and Rural Health Partnership are expected to keep their knowledge of national and local guidance up to date in their area(s) of practice.

Clinical guidance updates for Primary Care Clinicians are available to be received on email from

- NICE Updates for primary care – web link to subscribe to mailing list for updates NICE newsletters and alerts | News | NICE

- GP Practice update from Kent and Medway ICB – Web link to welcome to subscribe to the mailing list. (Previous issues of the General Practice Update are available online).

Access to the local formularies and exiting local guidance is available at East Kent Prescribing Formulary (eastkentformulary.nhs.uk).
National prescribing formulary is available on BNF (British National Formulary) | NICE.

If prescribers have any uncertainty regarding strength, dosage, interactions or other elements of prescribing, they are to seek the appropriate guidance from suitably experienced colleagues, such as pharmacists and pharmacy technicians within the pharmacy team of the organisation or from Kent and Medway ICB Medicines Optimisation team (kmccg.eastkentprescribing@nhs.net).

3.3 The Medicines Act 1968

The Medicines Act 1968 regulates the licensing, supply and administration of medicines.

The Act defines three categories of medicine:

a. Prescription Only Medicines (POM) which are available only if prescribed by an appropriate practitioner

b. Pharmacy Medicines (P), available only from a pharmacy supervised by a registered pharmacist but without a prescription

c. General Sales List (GSL) which are medicines that can be obtained from shop without a prescription or not under the supervision of a pharmacist

The Act controls the supply of drugs but does not define any offence of simple possession, as possession of a POM without a prescription is only an offence if the drug is also controlled under the Misuse of Drugs Act 1971. Therefore, possession of a prescription only antibiotic without a prescription is not an offence.

The Medicines Act protects the use of how drugs can be administered and an example is that, unless instructed, the pharmacist or dispensary cannot alter the dose or change the form of a POM, for example, by crushing or opening a capsule. To do so would be a breach of the 1968 Act. Crushing or opening a capsule is also outside of the product licencing of the medication, any adverse outcomes linked to the medication that occur subsequently to the medication being administered in this way is at the liability of the clinician instructing the action. Exceptions are occasionally granted to allow pharmacies to change the product ordered on a prescription to a set alternative option drug form, as per the guidance, for sudden supply issues so as to avoid a break in therapy.

This policy both alludes and conforms to *The Medicines Act 1968 and its subsequent amendments* throughout.

3.4 Recording prescriptions

All prescriptions, where practically possible, are issued via Electronic transfer (EPS – Electronic Prescription Service) to the patients nominated pharmacy using EMIS. This information is retained in the patient's electronic healthcare record and ensures that all staff involved in the care of the patient are aware of current medications and are able to avoid prescribing any medication that may be contraindicated. Printed or handwritten routine prescriptions are not normally produced at this organisation unless circumstances dictate otherwise, i.e., power failure or other noteworthy events.

It is imperative that accurate records are maintained at all times and extant guidance stipulates that the following are to be recorded:

- Relevant clinical findings
- Advice/information given to the patient
- Planned actions and confirmation that said actions have been discussed with the patient and are agreed
- Medicines prescribed / altered / stopped

When recording the prescription on EMIS, the prescriber will ensure that the prescribed medication is recorded as acute, repeat or variable repeat.

Clinicians undertaking home visits are to take with them printed patient summaries which include details of patient medications and known allergies or an electronic device with remote access to EMIS or a mobile version of EMIS with access to the patients' records. The clinician should document in the patients record details of the consultation notes, particularly details of handwritten prescriptions. This documentation should occur at the time of the consultation if remote access possible to EMIS or at the earliest next access to EMIS on return to the practice or organisation offices. If remote access to EMIS is not possible at the time of the consultation, accurate notes may be made at the time on paper for reference

when inputting the information to EMIS later and the paper notes destroyed after as per data handling policies.

3.5 Electronic Prescription Service

The Electronic Prescription Service (EPS) enables prescriptions to be sent to pharmacies from Coastal and Rural Health Partnership or practices served by the organisation electronically, making the prescribing and dispensing process more efficient for staff and patients alike. Patients can choose the pharmacy where they would like their prescription to be sent; this is referred to as “nomination” and can be set, changed or cancelled as required. At dispensing practices, if the patient is eligible for dispensing services and chooses to have their prescriptions dispensed by the practice, then their record is noted of the choice and the prescription is dispensed in-house (not sent EPS).

Further information regarding the EPS is available via NHS Digital. Any questions relating to EPS can be directed to enquiries@nhsdigital.nhs.uk

Patients may be given the token number of the EPS prescription as a printed token or as the number only. This number allows the individual EPS prescription to be identified and tracked, and also pulled down for dispensing by a pharmacy. Advice on tracking of EPS prescriptions is available from Coastal and Rural Health Partnership Pharmacy team.

To obtain the EPS token number after a prescription has been issued in EMIS highlight the required medication in the medication page, using a right click over the drug name, select “Drug History”, expand the view of the prescription issue in question by clicking on the white arrow at the side of the date and then select View. The EPS token is displayed in brackets after “EPS – Direct to Main Pharmacy”.

EPS issued prescriptions can be tracked to identify the stage the prescription has reached in the prescribing and supply chain. This link takes you to the NHS Spine Spine - NHS Digital where the EPS tracker is located. An NHS Smart card must be used to login and access the information.

3.6 Repeat prescribing

The purpose of a repeat prescription is to authorise the repeated issue of medicines at agreed intervals, without the patient attending a consultation with the prescriber. As previously stated, the clinician signing the prescription is accountable for that prescription; this includes repeat prescriptions for medications initiated by a colleague.

A prescribing clinician can authorise the transfer of medication from an acute prescription to a repeat prescription. The decision to do so will take into consideration:

- The effectiveness of the medication
- How well the patient has tolerated the medication
- If the medication is required on a long-term basis

The prescriber will only prescribe evidence-based medicines so long as they have adequate knowledge of the patient’s health and are satisfied that they meet the patient’s needs. The prescriber will also determine the number of repeat authorisations before a review is required; this may be every 3, 6 or 12 months.

Prior to transferring from acute to repeat prescriptions, the prescriber is to recall the patient and review the factors stated above, whilst informing the patient about the repeat prescribing process at the practice serviced by Coastal and Rural Health Partnership.

To maintain effective control over repeat prescribing, when adding a medication as a repeat, an appropriate coded reason must be given. Clinicians are to make certain that the repeat record is correct, quantities are synchronised (to minimise wastage) and review dates are entered.

3.7 Prescribing and safeguarding

Consideration must be given to safeguarding concerns with both children and vulnerable adults when prescribing.

Firstly, the prescriber is to consider capacity and as to whether the patient can understand the instructions needed for the medication to be taken safely. When a person is found to lack capacity, the best interests of the patient must be considered and a decision must be reached to also include supporting those who are relevant to the patient, such as families and carers as well as other professionals. To whatever extent possible, the person must also be involved, with genuine value placed on their wishes and beliefs.

If the individual has made an Advance Decision to refuse treatment directly relevant to the medication suggested or has a Lasting Power of Attorney (POA) for Health or Court appointed Deputyship (CAD), then the decisions afforded through these legal mechanisms must be respected as the person's voice.

If there are concerns the Advance Decision or the decisions of a POA/CAD is putting an individual at significant risk, then further advice is to be sought. Additionally, a referral may be made to appoint an Independent Mental Capacity Advocate (IMCA) who can represent the patient.

To further support this subject, this link from the Royal Pharmaceutical Council (RPC) provides some case studies as to how they are committed to supporting this area. Further useful links can also be found in this document.

Furthermore, if covert administration is to be considered, refer to Section 6.25.

3.8 Electronic Repeat Dispensing (e-RD)

Electronic Repeat Dispensing (e-RD) was introduced in July 2009 as a non-compulsory method of dispensing prescriptions electronically. From April 2019, as stated in the GP contract, e-RD became a contractual obligation for all patients where it is clinically appropriate and the patient consents.

e-RD is a process that allows a patient to obtain repeated supplies of their medication or appliances without the need for the prescriber to hand sign authorised repeat prescriptions each at each issue. This allows the prescriber to authorise and issue a batch of repeat prescriptions until the patient needs to be reviewed. The prescriptions are then available for dispensing at the specified interval by a patient's nominated dispenser.

Who is suitable for e-RD?

Any patient suitable for a repeat prescription could be suitable for e-RD. Factors considered in assessment of suitability for e-RD include but are not limited to:

- Patients on stable therapy
- Patients with long term conditions
- Patients on multiple therapy e.g., hypertension, diabetes, asthma etc.
- Patients who can appropriately self-manage seasonal conditions

Whilst all the above patient groups may be considered suitable for electronic repeat dispensing, the additional functionality allows the patient suitability to be broadened based upon clinical assessment.

e-RD requires the patient to consent to the introduction of two-way sharing of their information between the dispensing and prescribing site.[5] The patient should be asked to consent, which may be verbal consent documented in their records as written consent is not required.

A patient must have their dispensing site nomination recorded for any prescription to be sent electronically.[6]

Resources available to support e-RD implementation are available including:

- e-RD Handbook
- Electronic Repeat Prescribing (e-RD): An Overview – video
- e-RD guidance
- e-RD e-learning course
- What e-RD means for patients – video
- Electronic Repeat Dispensing in Response to COVID-19 slideshow
- GDPR roles and responsibilities guidance document
- Benefits of e-RD
- e-RD patient suitability guide
- e-RD cancelling and synching prescriptions
- e-RD patient pathway
- Key messages for patients
- Key messages for dispensers
- e-RD patient flyer
- e-RD patient poster – COVID-19 version
- Waiting room slides
- Content for your website or bulletin
- Patient letter template
- Patient email message content
- Patient text message content
- Social media content

[5] www.england.nhs.uk
[6] systems.hscic.gov.uk

e-RD advice during the COVID-19 outbreak

As part of the preparations to prioritise work and help to manage an increased pressure on the health service, NHS England and NHS Improvement advised that organisations should consider putting all suitable patients on electronic repeat dispensing as soon as possible.

This allowed the following benefits during the pandemic situation:

- Reducing footfall to the primary care sites and to the pharmacy to support social distancing
- Reducing workload for prescribers allowing better prioritisation of resources
- Controlled management of the supply chain reducing the number of temporarily unavailable medicines

It has always been the case that patients need to individually consent to receiving their medication through e-RD. However, using the powers granted by the National Health Service (Amendments Relating to the Provision of Primary Care Services During a Pandemic etc.) Regulations 2020, NHS England and NHS Improvement agreed with the Secretary of State that, in certain circumstances, this requirement could be temporarily suspended.

Organisations in England may transfer any clinically suitable patient onto e-RD if they are already receiving, or have agreed to receive, electronic prescriptions. This means any patient that meets any of the following criteria:

- They have previously had medication dispensed by means of the electronic prescription service (EPS)
- They have recorded a nominated pharmacy either via the primary care organisation, pharmacy or NHS App
- They are registered with an organisation that is live with EPS Phase 4

Further reading can be sought from NHS BSA document titled e-RD information for patients.

Due to return now to normal working practices of NHS services, Coastal and Rural Health Partnership Staff are instructed to gain patient consent before transferring repeat medication prescribing to e-RD as per best practice.

3.9 Requesting a repeat prescription

Coastal and Rural Health Partnership Staff or individuals providing ARRS services within GP practices should adhere to the repeat prescription policies for the practice they are working in at the time.

The following usually are permitted to request repeat prescriptions:

- Patients
- Nominated representatives, i.e., carers
- District nurses and/or specialist nurses
- Pharmacists (after checking with the patient which medications are required)
- Care home staff

It is imperative that confidentiality is always maintained; therefore, all staff must ensure that:

- They do not divulge information unnecessarily
- The request is appropriate and genuine
- The person requesting the repeat prescription is authorised to do so

Patients or their representative may be able to request repeat prescriptions in the following ways (dependent on the practice's policy):

- Online
- Via email
- In writing
- Using the prescription counterfoil (usually the right-hand side of the prescription) and returning to the organisation

Requests via email, if allowed by the practice, must include the following information in the email:

- Clinical number
- Date of birth
- Medication required
- Collection method

Emails are usually to be sent to the patients practice email address and comply with the following. In the subject heading, patients are to state: "Repeat Prescription Request". An automatically generated reply is usually sent to patients from the mailbox. Email repeat requests are normally processed in the same way as written/counterfoil requests and within the same time frame.

Patients must be advised that requests for "all repeats" or requests with limited information are likely to result in a delay in the process. In such instances, staff will need to contact the patient to discuss their exact requirements.

The following medications are not appropriate for repeat prescribing:

- Antibiotics, antivirals and antifungals for acute infections
- Cholecalciferol (Vitamin D)
- Hypnotics
- Benzodiazepines
- Nutritional supplements
- Oral or topical corticosteroids
- Antipsychotics (in the elderly)
- Strong opioids

Patients (or their representatives) are to understand that they are responsible for requesting repeat prescriptions in a timely manner, allowing at least 48-72 hours for the request to be processed, excluding weekends and public holidays.

The opportune questioning of patients by dispensing staff and prescribers will help to minimise wastage and will reduce cost. Staff should encourage patients to inform them if they are no longer taking their medication. A relevant clinician can then discuss this with the patient and determine if the medication is still required and update the patient's healthcare record accordingly.

Prescriptions for patients in care/nursing homes should be monitored to ensure that all medicines requested are actually required, particularly when required (PRN) medicines. If PRN medicines are routinely requested, a review should be conducted to determine the actual need for these medicines.

Repeat prescriptions are not to be issued more frequently than the agreed time interval. However, there may be occasions when this might be necessary, e.g., if the patient is going on holiday; this requires prior agreement and approval from an authorised prescriber.

Schedule 2 and 3 controlled drugs (CDs) will be limited to a maximum supply of 30 days.

There may be a requirement to issue medication in Multi-dose systems (MDS) such as seven-day blister packs or dosette boxes, e.g., for those who have difficulty in managing their medication. In such instances, it is feasible for the pharmacy to issue four packs (four weeks) at any one time. When patients or patient representatives request MDS, the patient's suitability should be assessed by a suitably experienced Pharmacist or Pharmacy technician. Coastal and Rural Health Partnership Pharmacy Team will be able to advise on obtaining an assessment. The provision of MDS is a private agreement between the patient (or their representative) and the dispensing service nominated by the patient, and may incur a private charge. There is no NHS funded payment for provision of MDS.

There may be a need to restrict prescribing of medication to a maximum of seven day supply at each prescription issue. Seven day prescribing may be required when:

- There is a clear clinical need for restricting the quantity of medication that a patient holds at any one time, e.g., concerns about overdose or misuse. Please note MDS use usually does not restrict or prevent intentional overdose or misuse.

- There are frequent changes to the medication regime and using seven-day quantities will help to minimise waste because of medication changes

- To allow intensive monitoring of compliance of a particular patient.

There may be exceptions to the above supply limitations and these will be managed on a case-by-case basis and in consultation with the prescriber.

3.10 Non-medical prescriber (NMP)

A range of non-medical healthcare professionals can prescribe medicines for patients as either independent or supplementary prescribers.

Independent prescribers are practitioners responsible and accountable for the assessment of patients with previously undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing.

Supplementary prescribing is a partnership between an independent prescriber (a doctor or a dentist) and a supplementary prescriber to implement an agreed Clinical Management Plan for an individual patient with that patient's agreement[7].

This section is aligned to:

- The CQC's GP Mythbuster 95 – Non-medical prescribing
- Royal Pharmaceutical Society – A Competency Framework for all prescribers
- NICE Non-medical prescribing
- RCN Non-medical prescribers

A range of non-medical healthcare professionals are permitted to prescribe medicines for patients as an independent or supplementary prescriber.

Non-medical prescribers (NMP) can:

- Give patients quicker, more efficient access to medicines
- Make best use of healthcare professionals' skills
- Help address demand and workforce issues

In the UK, a range of non-medical healthcare professionals can qualify as NMPs. In general practice, most NMPs are pharmacists or nurses. They could also be, for example, paramedics or physiotherapists.

NMPs can be independent or supplementary prescribers.

a. Independent prescriber are practitioners responsible and accountable for

   - The clinical assessment of patients
   - Establishing a diagnosis or manage a pre-diagnosed condition
   - Decisions about the patient's clinical management
   - Prescribing

   Independent prescribers obtain their prescribing qualification within a defined scope of practice and should restrict their prescribing to be within their scope. Their scope of practice may be extended and redefined, after personal development plan reviewed against service need, appropriate training completed and competence assured.

   It should be noted that independent prescribers are recommended to prescribe generically except where this would not be clinically appropriate or where there is no approved non-proprietary name.

      i. Nurse

[7] bnf.nice.org.uk

Depending on the individual's scope of practice, Nurse independent prescribers can prescribe any medicine for any medical condition and are able to prescribe, administer and give directions for the administration of Schedule 2, 3, 4 and 5 Controlled Drugs.

This extends to diamorphine hydrochloride, dipipanone or cocaine for treating organic disease or injury but not for treating addiction. Nurse independent prescribers must work within their own level of professional competence and expertise.

ii. Pharmacist

Depending on the individual's scope of practice, Pharmacist independent prescribers can prescribe any medicine for any medical condition. This includes unlicensed medicines, subject to accepted clinical good practice.

A pharmacist independent prescriber is also able to prescribe, administer and give directions for the administration of Schedule 2, 3, 4 and 5 Controlled Drugs. This extends to diamorphine hydrochloride, dipipanone or cocaine for treating organic disease or injury but not for treating addiction.

This NMPs must work within their own level of professional competence, expertise and defined scope of practice.

It is the responsibility of the clinical directors at Coastal and Rural Health Partnership to ensure that independent prescribers have the necessary skills and knowledge to carry out the role and that their scope of practice is appropriate for the individuals expertise, training and competence.

The Royal Pharmaceutical Society (RPS) competency framework dated September 2021 sets out the following steps prior to and after issuing any prescription:

- Assess the patient
- Identify evidence-based treatment options available for clinical decision making
- Present options and reach a shared decision
- Prescribe
- Provide information
- Monitor and review

Prescribing governance is detailed as:

- Prescribe safely
- Prescribe professionally
- Improve prescribing practice
- Prescribe as part of a team

All prescribers at Coastal and Rural Health Partnership must take individual responsibility for their prescribing decisions and should recognise that there are certain areas of practice where remote prescribing is unlikely to be suitable, for

example when prescribing medicines likely to be subject to misuse or abuse or injectable cosmetic treatments.

In summary, an independent prescriber can prescribe any medicine for any condition within their scope of practice and competence.

b. A supplementary prescriber is a voluntary partnership between an independent prescriber and a supplementary prescriber. They implement an agreed clinical management plan (CMP) for a specific patient with the patient's consent.

You can only use supplementary prescribing after:

- Assessment and diagnosis by an independent prescriber. This must be a doctor or dentist.
- The independent and supplementary prescribers develop a written CMP together. The CMP lists medicines that can be prescribed for the patient.

Qualifications to become a NMP must include:

- Being registered with the relevant professional regulator
- Having their prescribing qualification annotated on the register

To gain this, NMPs must undertake an accredited non-medical prescribing programme at a higher education institution. These programmes provide the knowledge, skills and training to prescribe safely and competently.

Dos and don'ts:

- NMPs should work to the Royal Pharmaceutical Society's – A Competency Framework for All Prescribers
- NMPs should not prescribe outside their agreed scope of practice
- The organisation should have systems to make sure NMPs are working within their scope of practice and review their scope of practice at appraisal dates
- All NMPs must have adequate medical indemnity. This is part of the requirements of registration with their professional body. This indemnity should include their NMP role.

The Clinical Negligence Scheme for General Practice in England and Wales covers everyone providing NHS services for general practice and includes NMPs although this does not cover non-NHS work. It does not provide legal representation for inquests and disciplinary investigations. NMPs may wish to also obtain "top up" insurance cover, which is a personal decision and not essential for practice.

Who can prescribe what?

The Pharmaceutical Services Negotiating Committee (PSNC) has provided a guidance document titled Who can prescribe what. This document provides a useful list showing the level of prescribing ability specific to each healthcare professional.

3.11 Generic prescribing

Medicines are available in both generic and branded forms, yet in general generic medicines are much less expensive to the NHS. Generic prescribing lessens the risk of error as each drug has only one agreed name. At Coastal and Rural Health Partnership, all drugs are to be prescribed generically using their approved name as specified in the BNF, unless the following apply.

A specific manufacturer's product could be either branded or generic and should be prescribed in the following circumstances:

1. **Where there is a difference in bioavailability** between brands of the same medicine, particularly if the medicine has a narrow therapeutic index. In these circumstances, lack of clarity over which preparation is intended when prescribing can lead to the patient receiving a subtherapeutic or toxic dose. Examples include ciclosporin, lithium and CFC-free beclometasone metered dose inhalers.
2. **Where there are important differences in formulation** between brands of the same medicine. For example, Fentanyl patches are available as matrix and reservoir formulations. Although neither should be cut, cutting reservoir patches can lead to leaking and overdose so if the prescriber intends the patch to be cut, the prescription must specify a brand of matrix formulation patch. This also includes certain modified or extended-release products, whereby the drug release and bioavailability profiles may differ considerably, primarily because different formulation approaches have been taken by manufacturers. For example modified-release nifedipine.
3. **Certain drug administration devices**. Technique may be an important component of drug delivery, and brand name prescribing is appropriate where administration devices, such as metered dose inhalers, have different instructions for use and patient familiarity with the same product is important. For example salbutamol dry powder inhalers and adrenaline prefilled syringes.
4. **Multiple ingredient products**. Generic titles may not always exist for many multiple ingredient products, and prescribing a specific brand or manufacturer's product is necessary for identification and ensuring that the correct product is dispensed. Examples include: oral contraceptives; emollient creams. Non-proprietary titles should not be invented for the purpose of prescribing generically.
5. **Where the product is a biological rather than a chemical entity**. A biological medicine is a medicine that contains one or more active substances made by or derived from a biological source. A biosimilar medicine is a biological medicine that is developed to be similar to an existing biological medicine (the 'reference medicine'). Biosimilars are not the same as generics, which have simpler chemical structures and are considered to be identical to their reference medicines. The active substance of a biosimilar and its reference medicine is fundamentally the same biological substance, though there may be minor differences due to their complex nature and production methods. Examples of biologics with available biosimilars include epoetin alfa and somatropin.
6. **Where the products contain different excipients**. Inactive formulation ingredients (excipients) may differ between products (branded and generic). Where an individual

patient has a true intolerance to an excipient, it may be reasonable to prescribe a specific brand or generic product that does not contain the troublesome component.

7. **Where there are differences in appearance**. For conditions requiring long-term medication, differences in appearance between manufacturers' products might cause confusion and anxiety, and this may affect adherence. This may be of most concern among the elderly, those with learning disabilities, mental health patients, non-English speaking patients and those with low-levels of 'health literacy'. Where it is not possible to allay patients' concerns effectively, it may be appropriate for a specific brand or manufacturer's generic to be prescribed. Recommendations about how healthcare professionals can support patients to adhere to their prescribed medicine can be found in NICE clinical guideline 76.
8. **Differences in licensed indications**. Product licences list the indications for which the particular product has gained its licence for use within. The indications listed in the licencing of individual products which contain the same drug, can be different. Prescribing a product for use in a condition not listed in the product licence is prescribing unlicensed and has legal implications for responsibility of any adverse events encountered with patent and the medication (see section 3.12 Prescribing Unlicensed medicines).
9. **Anti-epileptics** (where used in epilepsy only). The MHRA has written to healthcare professionals to provide information about switching between different manufacturers' products of antiepileptic drugs (AEDs). This includes switching between branded products and generic products, and between different generic products of a particular drug, following a review of the available evidence and consideration of the bioavailability and pharmacokinetic characteristics of the different drugs. See BNF and SPC for detailed information.

3.12 Prescribing unlicensed medicines

In relation to the prescribing of unlicensed medicine, the following GMC guidance is to be adhered to.[8]

Unlicensed medicine is a term used to describe medicines which are not licensed in the UK or are outside the terms of their UK licence. They are commonly used in areas of medicine such as paediatrics, psychiatry and palliative care. Clinicians at Coastal and Rural Health Partnership may prescribe unlicensed medicines where, based on an assessment of the patient, they conclude, for medical reasons, that it is necessary to do so to meet the needs of the patient.

Prescribing unlicensed medicines may be necessary where:

- There is no suitably licensed medicine that will meet the patient's need. Examples include (but are not limited to) where:
    - There is no licensed medicine applicable to the particular patient. For example, if the patient is a child and a medicine licensed only for adult patients, would meet the needs of the child

[8] Prescribing unlicensed medicines - ethical guidance - GMC (gmc-uk.org)

- A medicine licensed to treat a condition or symptom in children would nonetheless not meet the specific assessed needs of the particular child patient, but a medicine licensed for the same condition or symptom in adults would do so

- The dosage specified for a licensed medicine would not meet the patient's need

- The patient needs a medicine in a formulation that is not specified in an applicable licence

- A suitably licensed medicine that would meet the patient's need is not available. This may arise when, for example, there is a temporary shortage in supply

- The prescribing forms part of a properly approved research project

When prescribing an unlicensed medicine, prescribers must:

- Be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy

- Take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring and any follow up treatment, or ensure that arrangements are made for another suitable doctor to do so

- Make a clear, accurate and legible record of all medicines prescribed and, where prescribers are not following common practice, their reasons for prescribing an unlicensed medicine

In addition to the above guidance, prescribers at Coastal and Rural Health Partnership must ensure that patients are given sufficient information about the medicines which are being prescribed. This enables them to make an informed decision.

Some medicines are routinely used outside the terms of their licence, for example in treating children. In emergencies or where there is no realistic alternative treatment and such information is likely to cause distress, it may not be practical or necessary to draw attention to the licence. In other cases, where prescribing unlicensed medicines is supported by authoritative clinical guidance, it may be sufficient to describe in general terms why the medicine is not licensed for the proposed use or patient population. Prescribers must always answer questions from patients (or their parents or carers) about medicines fully and honestly.

Any clinician intending to prescribe unlicensed medicines where that is not routine or if there are suitably licensed alternatives available, this should be explained to the patient along with the reasons for doing so.

3.13 Processing a repeat prescription request

All staff involved in the repeat-prescribing process should be suitably trained and understand their roles and responsibilities and the processes to be followed in each practice that they provide services for. To avoid any unnecessary errors, all repeat prescriptions are to be generated using EMIS and the following should be checked:

- The patient's name, date of birth and address
- That the medication requested is an authorised repeat medication
- That the drug name, strength, dose and form are identical to that on the repeat list
- That the repeat medication review date has not been exceeded

In the following situations, the repeat request must be referred to a prescribing clinician if:

- The review date has been exceeded
- The number of repeat issues has been met
- Requests are received earlier or later than indicated (this may be due to poor use by the patient)
- A repeat has not been requested for one year, the exceptions being seasonal medications
- No repeat date has been set

The process after verification is as follows:

- The prescription should be generated electronically (printed or hand written only on exception) and sent to a GP or NMP for signature (ideally the clinician who sees the patient regularly) who will:
    - Ensure that the correct patient is issued with the correct prescription
    - Ensure that the correct dose is prescribed
    - Ensure that appropriate directions for use are shown, not "as directed"
    - Review the patient's record, medicine usage and effects

- If an EPS prescription, after the prescription is signed electronically by the prescriber it will be sent electronically automatically to the patients nominated dispenser.
- If the prescription is printed or hand written, the prescriber returns the prescription to the person who generated the prescription.
    - The prescription is retained securely until it is collected
        - Storage is to be away from areas accessible to patients and, when the practice is closed, they are to be secured.
    - Staff must cross-reference the information on the prescription with the person collecting it (confirming the name, address and date of birth of the patient)
    - The prescription is given to the patient or their representative
    - Prescriptions not collected after 28 days are to be discussed with the prescribing clinician then shredded and the patient's health record updated.
    - Children under 16 are not permitted to collect prescriptions unless a prior written agreement has been arranged between the parents or guardians of the patient and the practice manager/prescriber.

3.14 Urgent requests

Requests for urgent repeat prescriptions (less than 48 hours) are to be reviewed to ascertain if the medication is needed that same day. If this is deemed to be the case, the request is to be processed without delay.

For patients who repeatedly request urgent repeats, the practice manager is to be informed.

3.15 Emergency prescriptions

Should any patient request an "urgent or emergency prescription" then current NHS E advice is for the patient to contact their prescriber immediately to arrange a prescription.

Additionally, NHS E advises that an alternative is for the patient to attend a pharmacy in an emergency, although this is subject to the following conditions.[9]

3.15.1 Emergency supply requested by member of the public

Pharmacists are sometimes called upon by members of the public to make an emergency supply of medicines. The Human Medicines Regulations 2012 allows exemptions from the Prescription Only requirements for emergency supply to be made by a person lawfully conducting a retail pharmacy business provided:

1. that the pharmacist has interviewed the person requesting the prescription-only medicine and is satisfied:
    1. that there is immediate need for the prescription-only medicine and that it is impracticable in the circumstances to obtain a prescription without undue delay;
    2. that treatment with the prescription-only medicine has on a previous occasion been prescribed for the person requesting it;
    3. as to the dose that it would be appropriate for the person to take;
2. that no greater quantity shall be supplied than will provide 5 days' treatment of phenobarbital, *phenobarbital sodium*, or Controlled Drugs in Schedules 4 or 5 (doctors, dentists, or nurse prescribers from the European Economic Area and Switzerland, or their patients, cannot request an emergency supply of Controlled Drugs in Schedules 1, 2, or 3, or drugs that do not have a UK marketing authorisation) or 30 days' treatment for other prescription-only medicines, except when the prescription-only medicine is:
    1. insulin, an ointment or cream, or a preparation for the relief of asthma in an aerosol dispenser when the smallest pack can be supplied;
    2. an oral contraceptive when a full cycle may be supplied;
    3. an antibiotic in liquid form for oral administration when the smallest quantity that will provide a full course of treatment can be supplied;
3. that an entry shall be made by the pharmacist in the prescription book stating:
    1. the date of supply;
    2. the name, quantity and, where appropriate, the pharmaceutical form and strength;
    3. the name and address of the patient;

[9] www.nhs.uk

    4. the nature of the emergency;
4. that the container or package must be labelled to show:
    1. the date of supply;
    2. the name, quantity and, where appropriate, the pharmaceutical form and strength;
    3. the name of the patient;
    4. the name and address of the pharmacy;
    5. the words 'Emergency supply';
    6. the words 'Keep out of the reach of children' (or similar warning);
5. that the prescription-only medicine is not a substance specifically excluded from the emergency supply provision, and does not contain a Controlled Drug specified in Schedules 1, 2, or 3 to the Misuse of Drugs Regulations 2001 except for phenobarbital or *phenobarbital sodium* for the treatment of epilepsy: for details see *Medicines, Ethics and Practice,* London, Pharmaceutical Press (always consult latest edition). Doctors, dentists, or nurse prescribers from the European Economic Area and Switzerland, or their patients, cannot request an emergency supply of Controlled Drugs in Schedules 1, 2, or 3, or drugs that do not have a UK marketing authorisation.

3.15.2 Emergency supply requested by prescriber

Emergency supply of a prescription-only medicine may also be made at the request of a doctor, a dentist, a supplementary prescriber, a community practitioner nurse prescriber, a nurse, pharmacist, physiotherapist, therapeutic radiographer, optometrist, podiatrist or paramedic independent prescriber; or a doctor, dentist, or nurse prescriber, provided:

1. that the pharmacist is satisfied that the prescriber by reason of some emergency is unable to furnish a prescription immediately;
2. that the prescriber has undertaken to furnish a prescription within 72 hours;
3. that the medicine is supplied in accordance with the directions of the prescriber requesting it;
4. that the medicine is not a Controlled Drug specified in Schedules 1, 2, or 3 to the Misuse of Drugs Regulations 2001 except for phenobarbital or *phenobarbital sodium* for the treatment of epilepsy: for details see *Medicines, Ethics and Practice,* London, Pharmaceutical Press (always consult latest edition); (Doctors, dentists, or nurse prescribers from the European Economic Area and Switzerland, or their patients, cannot request an emergency supply of Controlled Drugs in Schedules 1, 2, or 3, or drugs that do not have a UK marketing authorisation).
5. that an entry shall be made in the prescription book stating:
    1. the date of supply;
    2. the name, quantity and, where appropriate, the pharmaceutical form and strength;
    3. the name and address of the practitioner requesting the emergency supply;
    4. the name and address of the patient;
    5. the date on the prescription;
    6. when the prescription is received the entry should be amended to include the date on which it is received.

Even if the pharmacist is unable to give the patient an emergency supply of a medicine, they will advise the patient how to obtain any essential medical care they may need.

3.16 Lost prescriptions

EPS prescriptions transfer electronically can be tracked by the token number allocated to the prescription generated. Section 3.5 Electronic Prescription service contains the details on how to track EPS prescriptions.

In the case of a patient stating that they have lost their printed or hand written prescription form, Coastal and Rural Health Partnership will comply with the NHS Counter Fraud Authority Management and control of prescription forms guidance issued March 2018.

The loss is to be reported immediately and the following details recorded:

- Date and time of loss (if known)
- Date and time the incident was reported
- Location or locations where the loss may have occurred

If the lost prescription was for a controlled drug, the CDAO is to be informed and extra security precautions taken, such as asking the prescriber to sign prescriptions in a specific colour, ensuring that the local pharmacies are made aware of this, thereby preventing the lost prescription from being used.

All losses are to be recorded by means of a Significant Event report.

3.17 Medication review

The review period for repeat medication rests with the prescriber. Medication reviews should be carried out at least annually or, in cases of complex repeat prescriptions, every six months.

A medication review is defined as “a structured, critical examination of a patient’s medicines with the objective of reaching an agreement with the patient about treatment, optimising the impact of medicines, minimising the number of medication related problems and reducing waste”. (Room for Review, 2002 medicines partnership (medicines-partnership.org)

There are different levels of medication review

- Level 0 – Ad Hoc – Unstructured and opportunistic
- Level 1 – Prescription Review – Technical review of list of patient’s medicines
- Level 2 – Treatment Review – review of medicines with patient’s full notes
- Level 3 – Clinical Medication Review – Medication review of medicines and conditions with the patient either Face to face or over the telephone. This includes Structured Medication Reviews (SMRs)

Structured Medicine Reviews (SMRs) are an evidence-based and comprehensive review of a patient’s medication, taking into consideration all aspects of their health. In a structured medication review clinicians and patients work as equal partners to understand the balance between the benefits and risks of and alternatives of taking medicines. The shared decision-making conversation being led by the patient’s individual needs, preferences and circumstances. SMRs can be completed by appropriately trained Pharmacists, Nurse

Practitioners or General Practice Doctors. NHS England » Structured medication reviews and medicines optimisation

Problematic polypharmacy is where, for an individual taking multiple medicines, the potential for harm outweighs any benefits from the medicines and/or they do not fully understand the implications of the medication regime they are taking. This includes:

- medicines that are no longer clinically indicated or appropriate or optimised for that person
- combination of multiple medicines has the potential to, or is actually causing harm to the person
- practicalities of using the medicines become unmanageable or are causing harm or distress.

SMRs have benefits to people taking multiple medicines:

- improved experience and quality of care through being involved in the decision-making process and having a better understanding of the medicines they take
- less risk of harm from medicines (e.g. adverse drug events, side effects, hospitalisation or addiction)
- better value for local health systems (e.g. reduced medicine waste).

Key Components of an SMR

- Shared decision-making principles should underpin the conversation
- Personalised approach – tailored to the patient
- Safety – consider the balance of benefit and risk of current treatment and starting new medicines
- Effectiveness – all medication must be effective, except where explicitly permitted in guidelines on low priority prescribing.

Across England, general practices are working together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in primary care networks (PCNs). Professionals are working together to support patients with structured medication reviews as one of the PCN service requirements which commenced during 2020/21.

From October 2020, all PCNs are required to identify patients who would benefit from a SMR, specifically those:

- in care homes;
- with complex and problematic polypharmacy, specifically those on 10 or more medications;
- on medicines commonly associated with medication errors;
- with severe frailty, who are particularly isolated or housebound or who have had recent hospital admissions and/or falls;
- using potentially addictive pain management medication.

The number of patients to be offered a SMR will depend upon the PCN's clinical pharmacist capacity. Further information on the expectations of PCNs and more detailed clinical guidance, for example from the Royal Pharmaceutical Society and NHS Scotland can be found in the Network Contract DES SMR guidance.

Coastal and Rural Health Partnership provides services to Practices within PCNs which includes SMRs. Coastal and Rural Health Partnership staff must only undertake SMRs after completion or whilst undertaking an appropriate SMR training course and being deemed competent.

3.17.1 Failure to attend for review

Attempts should be made to contact the patient to determine the reason why they have not attended their review. All communication attempts must be recorded on EMIS. There are several reasons why the patient may not have attended their review and prescribers should check that:

- The patient is still a member of the practice (they may have moved)
- The patient has not been admitted to hospital or reviewed by another clinician (possibly within secondary care)
- It is appropriate to contact the patient (it may be necessary to contact a carer)

Every attempt must be made to contact the patient and to arrange a review.

3.18 Control and monitoring

Only a qualified prescriber has the authority to issue repeat prescriptions and determine the number of repeats permitted, after which time the patient must undergo a medication review.

Clinical control is the sole responsibility of the clinician; this can also include the practice nurse for several patients (e.g., diabetes, asthma and contraception).

3.19 Patients discharged from hospital

Patients who are discharged from hospital may have been issued with additional medication or their regular medication strength/frequency may have been amended.

It is therefore essential that such patients are reviewed by their practice clinical staff and, where appropriate, an appointment made or home visit arranged. The patient's prescriber is responsible for reviewing all discharge summaries, updating the patient's repeat medication record and removing any discontinued drugs accordingly, or delegating the task to an appropriately experience staff member. Furthermore, they are also to verify that the patient has sufficient medication, if there is any need for an acute prescription and that the patient's review date has been appropriately updated. These duties may be delegated to Coastal and Rural Health Partnership staff by the prescriber, if the services provided to the practice cover the duty and the staff are deemed competent.

3.20 Prevention of misuse

Regular reviews will help to prevent the misuse of repeat prescriptions. Coastal ad Rural Health Partnership will comply with practice polices of the practices services are provided for, ensuring the patients are monitored so that repeat requests are appropriate. Any requests deemed to be either over or underused will be referred to the appropriate clinician.

Staff should be aware of the following non-specific signs that may indicate misuse:

- Taking higher doses than prescribed or running out of prescribed medication before expected
- Continually “losing” medication so more prescriptions have to be written
- Seeking prescriptions from more than one healthcare professional, e.g., doctor, nurse, non-medical prescriber or from more than one practice
- Requesting a specific drug claiming that other medications “don’t work” or that he/she is allergic to them
- Stealing, forging or diverting prescriptions
- Appearing to be intoxicated, sedated or experiencing withdrawal
- Excessive mood swings or hostility
- Increase or decrease in sleep
- Evidence of craving or other signs of dependence

Staff may also bring to the attention of the prescriber any concerns or uncertainties they have about a patient and their repeat prescription.

Clinical staff must also be aware of the specific signs that may indicate misuse of certain drugs such as opioids, hypnotics, anxiolytics and stimulants.

3.20.1 Timely intervention

The clinician, in all instances, will recall the patient and discuss their medication usage with them, providing guidance and assurance regarding the use of their repeat prescription medication.

Early intervention is key in potential misuse cases; it will enable the clinician to manage the patient more effectively before the situation worsens. The following actions may be taken when attempting early intervention:

- The clinician may conduct more frequent medication reviews
- Facilitate longer clinical appointments to discuss medication with the patient
- Agree with the patient the medication required for repeat prescribing
- Direct the patient to the available literature regarding their medication
- Discuss the case with a peer or specialist to determine the most appropriate management
- Consider issuing the patient with a medication record/diary to monitor usage
- Refer the patient to the relevant substance misuse specialists for support and guidance

3.20.2 Continued control

After early intervention, if patients are still considered to be misusing, Coastal and Rural Health partnership staff will discuss the issue with the patient’s practice clinicians and follow the practice policies to develop a support plan for the patient to address the issue. This may include the patient receiving, following their appointment with the clinician, a letter aimed at providing further guidance and reassurance to the patient that the team are going to continue to provide ongoing support for the patient. The letter is recommended to detail the

patient's obligations to manage their medication appropriately. The patient is required to sign and return the letter to their practice which is to be scanned into their healthcare record.

Should a patient raise a concern about their prescription, they are to be allocated an appointment to discuss their concerns with their usual clinician. At all times, the patient's usual clinician maintains responsibility for the medication prescribed.

All patients who are under formal medication reviews will have an alert added to their healthcare record, ensuring that all staff are aware in case the patient is seen by a different clinician or locum.

3.21 High risk drug monitoring

The purpose of regular monitoring for a range of drugs classified as "high risk" is to ensure patients continue to receive the appropriate dose whilst reducing the potential risk of adverse effects. There are several drugs which have potentially dangerous side effects and to maintain patient safety, they must be monitored efficiently.

GMC guidance, Good practice in prescribing and managing medicines and devices (updated April 2021), states that prescribers should only prescribe medicines when they have adequate knowledge of an individual's health and are assured that medicines remain safe and necessary for the individual. This also applies when shared care arrangements are in place and the legal responsibility to ensure safety rests with the person signing the prescription.

CQC Mythbuster No 84: Managing high risk medicines in general practice decrees that patients who are prescribed high risk medicines should be monitored in line with one or more of the following:

- Organisation protocol that reflects national guidance
- Shared care agreement specific to the patient
- Manufacturer's summary of product characteristics for the product.

Coastal and Rural Health Partnership clinical staff will follow guidance provided by Specialist Pharmacy Services (SPS) for the required baseline and regular monitoring for high-risk drugs and the monitoring frequency periods. This guidance is under constant review and staff should access the guidance directly on the SPS Drug monitoring web pages.

Practices provided with services by the organisation, will should have processes in place to call in patients for their required drug monitoring. Coastal and Rural Health Partnership clinical staff who prescribe must be satisfied that the practice processes will ensure the required monitoring is undertaken for the medication they prescribe. Further guidance can be sought from NICE document titled Safe prescribing of high-risk drugs.

3.25 Covert medication

Covert administration is when medicines are given in a disguised form without the knowledge or consent of the person receiving them. It is a complex issue. It involves a formal decision made between healthcare professionals and carers and should only take

place in people who do not have capacity to consent to treatment (as defined in the Mental Capacity Act 2005).

Covert administration should not be confused with disguising a medicine to give it against a competent patient's wishes. This would constitute a tort or civil wrong of trespass to the person.

Covert administration usually involves hiding oral medicines (tablets, capsules or liquids) in food or drink. But it can also apply to medicines by other forms of medicine administration, such as patches, injections, or medicines given by a feeding tube, if the person lacks capacity to consent and they don't know they are taking that medicine.

Every person has the right to refuse their medicine, even if that refusal appears ill-judged to staff who are caring for them.

Covert administration is only likely to be necessary or appropriate where all the points below apply:

- A person actively refuses their medicine
- That person is judged not to have the capacity to understand the consequences of their refusal. Such capacity is determined by the Mental Capacity Act 2005
- The medicine is deemed essential to the person's health and wellbeing

Covert administration of medicines should be a last resort. You must make reasonable efforts to give medicines in the normal manner. You should also consider alternative methods of administration. This could include, for example, liquid rather than solid dose forms, if the patient's refusal is on that grounds.

Administering medicines in food or drink can alter their therapeutic properties and effects. They could become unsuitable or ineffective. Always take advice from a Pharmacist to make sure that medicines are safe and effective.

Pathway of actions before medications can be administered covertly include;

1. **Assess Capacity** – Covert Administration should only take place in people who do not have capacity to consent to treatment
2. **Consider other options** – To avoid resorting to covert administration, explore and try and resolve reasons for refusal of medicines
3. **Best Interests Decision** – Any decision to administer medicines covertly needs to be formally agreed as being in the individual's best interests
4. **Best Interest Meeting** – A best interest meeting should take place to discuss and record the decision
5. **Management Plan** – Agree and document a management plan at or shortly after the best interests meeting
6. **Obtain prescriber authorisation** – A prescriber must authorise covert administration of medicines
7. **Record keeping and documentation** – good record keeping throughout the process is essential.

Clinical records must be maintained when medicines are administered covertly. This is particularly important for people with fluctuating capacity[10].

Detailed information that can support the administration of medicines covertly can be found in the Covert Administration Policy.

3.26 Prescription security

A prescription form should be considered an asset that has a financial value; it is in effect a blank check open to potential misuse. The theft of prescription forms and their resulting fraudulent misuse, potentially involving third parties, is a serious concern.

Coastal and Rural Health Partnership clinical staff who prescribe will prescribe using EPS prescription transfer and eliminate the risk of prescription loss or theft. Coastal and Rural Health Partnership do not hold paper prescription forms for printing prescriptions or handwriting prescriptions. On the rare occasion that a printed or hand written prescription is required, such as large scale IT failure or power failure, our staff will follow the security policies of the practice site within which they are working at the time.

The following security processes are required for Coastal and Rural Health Partnership staff involved in prescription processing:

- Must follow the prescription security polices in the practices within which they provide services.
- Only appropriately trained staff should be allowed to generate prescriptions
- Passwords should not be shared. Computer-generated prescriptions can be identified by an audit trail
- An annual review should be carried out to ensure that appropriate systems are in place and are being adhered to

NHS Counter Fraud Authority: management and control of prescription forms: A guide for prescribers and health organisations (March 2018) provides support on the following:

- Destroying spoiled or duplicate prescriptions
- Sending prescriptions by post
- Transferring prescriptions from one site to another (for example to a branch surgery)
- Locum access to prescriptions
- Alerts, investigations and sanctions
- Audit
- Security of computer systems
- Missing or lost prescription forms
- Forged prescriptions
- Reporting incidents

Further reading including what is expected to be compliant can be sought from CQC GP Mythbuster No 23: Security of blank prescription forms

[10] www.cqc.org.uk

3.27 Ordering, delivery, storage and issue of prescription forms

Coastal and Rural Health Partnership do not order prescription forms.

Coastal and Rural Health partnership do not receive, store or issue paper prescription forms.

Coastal and Rural Health partnership staff are expected to not be involved in the receipt or store of prescription forms for the practices in which services are being delivered.

Coastal and Rural Health partnership staff will not be using or transporting paper prescription forms when visiting patient residences.

Coastal and Rural Health partnership staff will follow the storage and issue of prescription forms policies of the practices in which they provide services.

3.28 Prescriptions issued at another UK nation

Prescriptions that are issued from one UK nation can be collected in another. The following section details the processes and differences when issued a prescription from one UK nation and the medication collected from another:

a. England

The table below shows where charges will be incurred should a Scottish, Welsh or Northern Irish prescription be presented in England.

Origin of prescription	Charges
Scotland	Collect prescription charges according to English rules, unless the patient qualifies for exemption
Wales	Collect prescription charges according to English rules, unless the patient presents a Welsh prescription charge entitlement card
Northern Ireland	No prescription charge

b. Scotland[11]

Patients who live in England but are registered with a GP practice in Scotland will not be charged for a prescription(s) presented for dispensing in Scotland. They will not require any entitlement card as they will have been issued with the Scottish prescription form (GP10).

[11] www.nhslothian.scot

If a patient presents a Scottish prescription for dispensing at a pharmacy in England, they will be required to pay the English charge unless they fall within one of the exemption categories listed in the equivalent English regulations.

Any Scottish prescription form (GP10) presented for dispensing in England will be charged at the English rate per item, unless the patient qualifies for exemption. Any Scottish prescription from presented for dispensing in Wales or Northern Ireland will be charged the rate in force at the time. Currently this is no charge.

Patients presenting prescriptions written in England will be charged at the English rate per item. The only exceptions are for Entitlement Card holders or those who qualify for exemption.

Patients presenting a prescription(s) written in Wales or Northern Ireland for dispensing in Scotland will not be charged under current arrangements.

c. Wales[12]

NHS prescriptions are free of charge if you have:

- A GP who works for NHS Wales, and;
- Your prescription is dispensed by a pharmacy which is employed by NHS Wales

If you live in England and have a GP in Wales, you can get prescriptions free of charge as long as the prescription is dispensed by a pharmacy employed by NHS Wales. If you choose to have your prescription dispensed in England, you will need to qualify for free prescriptions under the English criteria.

If you live in Wales and have a GP in England, you may still be able to get prescriptions free of charge by having an exemption card. Further information is available on the Low income scheme: help with NHS health costs | GOV.WALES.

You can apply for exemption cards to the following address:

NHS Prescription Card Exemption
NHS Wales Shared Services Partnership
Cwmbran House
Mamhilad Park Estate
Mamhilad
PONTYPOOL
NP4 0YP

If you have an NHS prescription dispensed in England, you will be charged at the rate set by the Department of Health and Social Care in England.

If you have been referred by your Local Health Board to a hospital in England, and are given an English prescription, you will have to pay the current rate set by the Department of Health and Social Care, even if you take it to a Welsh pharmacy. However, provided you are a

[12] www.england.nhs.uk

Welsh resident, you may claim this fee back from the NHS Wales Shared Services Partnership if you have proof of payment.

d. Northern Ireland[13]

Prescriptions written by GPs are dispensed free of charge in Northern Ireland. You do not need to qualify for free prescriptions.

Pharmacists in Northern Ireland will not charge patients from England, Scotland or Wales for prescriptions.

If you bring your NI issued prescription to a pharmacy in England, Scotland or Wales, the pharmacist will not charge you for dispensing.

3.29 Private prescriptions

Should any patient undergo private specialist treatment, the consultant will invariably prescribe medication and request that the patient's registered practice organises an NHS prescription to be issued for the medication. By doing it this way, will save the patient having to pay for it privately.

Alternatively, the patient may request that the GP transfers the private prescription to an NHS FP10 prescription.

Should a letter be received from a private consultation advising or suggesting a course of action, then it may be appropriate for an initial FP10 prescription and ongoing treatment to be issued following agreement from their GP. At Coastal and Rural Health Partnership staff may be asked to support GP practice staff in this type of issue. Coastal and Rural Health Partnership staff must have the understanding that as the prescriber will take clinical responsibility for monitoring, the prescriber within the practice usually senior clinician in the practice, must ensure that they are able and content to accept this responsibility. However, there may be occasions when the prescribing clinician is requested by a private consultant to prescribe medication they would **not** usually prescribe:

- **Specialist medication**

  If the medication is specialist in nature and is not a routine drug for GP prescribing, it is for the individual prescriber to decide whether to accept clinical responsibility for the prescribing and monitoring.

- **Non-formulary**

  If the medication is not part of the local joint prescribing formulary (East Kent Prescribing Formulary (eastkentformulary.nhs.uk)), it is not recommended to be transferred onto the NHS. In this instance, the prescriber may wish to offer the patient a clinically suitable formulary alternative.

- **Unlicensed or off-label**

[13] www.nidirect.gov.uk

There is greater clinical responsibility on the prescriber if prescribing unlicensed or off-label treatment. The GMC guidance titled Prescribing unlicensed medicines - ethical guidance - GMC (gmc-uk.org) provides advice on this subject and should be consulted prior to considering any transfer of prescriptions from private to NHS.

- **Drug Tariff restricted ordering under GMS contract**

  NHS Prescription Services produces the Drug Tariff on a monthly basis on behalf of the Department of Health and Social Care (Drug Tariff | NHSBSA). The Drug Tariff contains section detailing the restrictions on Drugs, medications and other substances for prescribing in primary care under General Medical Services contracting.
  - Part XVIIIA – Drugs, Medicines and other substances **not** to be ordered under a General Medical Services Contract
  - Part XVIIIB – Drugs, Medicines and other Substances that may be ordered only in certain circumstances

Furthermore, should the prescriber either:

- Believe that the medication is not clinically appropriate
- Not agree with the treatment plan
- Not have access to full written details from the private clinician

Then it would be reasonable for the Clinician to decline to prescribe.

At Coastal and Rural Health Partnership, we will follow the local East Kent formulary and prescribing guidance (East Kent Prescribing Formulary (eastkentformulary.nhs.uk)). Furthermore, will liaise with the Medicines Management Team at Kent and Medway ICB for further advice or agreement. A patient information leaflet written by The East Kent Prescribing Group is available on this link, information-on-prescriptions-issued-after-a-private-consultation-print.pdf (eastkentformulary.nhs.uk).

Further reading on prescribing private prescriptions within primary care can be sought from BMA.

3.30 Loss and theft

When undertaking services with a general Practice, Coastal and Rural Health Partnership Staff are to report immediately any identified irregularities with prescription stock to the highest manager at the practice at the time and ensure they inform the Controlled Drugs Accountable Officer (CDAO) and the police accordingly.

Any report of theft or loss must include the following details:

- Date and time of loss or theft
- Date and time the incident was reported
- Location of theft or location/s where the loss may have occurred
- Serial numbers
- Quantity

Organisation	Reporting actions
NHS England and Wales Counter Fraud Authority	Online reporting form Telephone 0800 028 4060
NHS Scotland Counter Fraud Services	Online reporting tool Telephone 0800 0151628
NHS Northern Ireland Counter Fraud and Probity Service	Reporting tool Telephone 0800 0963396

For security purposes and to prevent the lost or stolen stock being used, the prescriber to whom the stock relates is to be advised to sign prescriptions in a specific colour, ensuring that the local pharmacies are made aware of this.

Appropriate checks should first be carried out to ensure that the discrepancy is not linked to a simple error with the central stock record (such as incorrectly entered serial numbers or a prescriber having been issued with a pad but this not being recorded). If the discrepancy cannot be resolved, then the matter should be escalated.

3.31 Prescriptions lost by patients

The use of EPS prescription transfer is used in all but exceptional situations, to eliminate the risk of lost or stolen prescription orders. Should a patient report that they have lost a prescription, a risk assessment should be undertaken prior to a replacement prescription being issued. This will ensure that the reported loss is genuine and not an attempt to commit prescription fraud. Should the prescription be for CDs, the CDAO is to be informed to make certain that the medication is dispensed to the correct patient without incident.

3.32 Current and out-of-date paper prescription forms

Examples of current and out-of-date prescription paper forms can be found here. Information provided at this link is from the NHS BSA Prescription Services.

3.33 Reporting NHS prescription form incidents

When reporting an incident to the NHSCFA, as much detail as possible is to be given, this includes:

- Practice name
- Reporter's contact details
- Date and time of incident
- Where the incident occurred
- Type of prescription form

- Serial numbers
- Quantity
- Details of individual from whom forms have been stolen
- Whether the police have been notified
- Have local pharmacies and practices been notified?

Such incidents can be reported online at NHSCFA or by telephone 0800 0284060.

3.34 Reporting adverse reactions

If a patient has a serious adverse reaction to a drug, it should be reported to the MHRA and a Significant Event raised. Reactions are to be reported using the MHRA "yellow card" scheme.

3.35 Medicines optimisation

Medicines optimisation is defined as "a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines". The Royal Pharmaceutical Society has introduced four guiding principles for medicines optimisation:[14]

- Principle 1: Aim to understand the patient's experience
- Principle 2: Evidence-based choice of medicines
- Principle 3: Ensure the use of medicines is as safe as possible
- Principle 4: Make medicines optimisation part of routine practice

The goal of medicines optimisation is to help patients to:

- improve their outcomes;
- take their medicines correctly;
- avoid taking unnecessary medicines;
- reduce wastage of medicines;
- and improve medicines safety.

Further guidance can be found at: NHS England » Medicines optimisation

3.36 Controlled drugs

Detailed information that can support the management of controlled drugs can be found in the Controlled Drugs Policy.

Coastal and Rural Health Partnership do not hold any controlled drug stock or staff administer any controlled drugs during their duties.

[14] NICE Medicines Optimisation Clinical Guidelines

Coastal and Rural Health Partnership staff may issue prescription orders for patients to obtain supplies of controlled drugs (as per the prescriber's scope of practice and restrictions on the prescriber's status).

3.37 Audit

Prescribing is the most common intervention in the NHS across all sectors and, after staffing costs, it accounts for the second highest area of NHS expenditure. Prescribing makes up a large portion of a general practice's clinical care of a patient and is the most common therapeutic approach offered to patients.[15]

Clinical-based audits should include the following information:[16]

- Title
- Reason for the audit
- Criterion or criteria to be measured
- Standard/s set
- Preparation and planning
- Results and date of data collection one
- Description of change/s implemented
- Results and date of data collection two
- Reflections

Conducting a prescribing audit will enable the practice to review current prescribing performance and patterns. The benefits of a prescribing audit include, but are not limited to:

- Improving patient safety
- Reviewing clinicians' prescribing practices
- Achieving QOF
- Reducing prescribing costs
- Improving patient outcomes
- Reducing wastage
- Minimising non-compliance

Prescribing audits will be undertaken regularly on the prescribing the Coastal and Rural Health Partnership staff complete. Coastal and Rural Health Partnership Pharmacy team staff often undertake prescribing audit services for practices, to assist the practices in their compliance with targets, safety alerts and supply issues. Prescribing audits for indicators and targets at PCN discussed at Practice Manager and Core Team meetings to ensure that practice staff are aware of the audits being undertaken.

All legal and ethical guidelines should be adhered to and the confidentiality of the patient or service user, staff and health service provider should be protected at all times.[17]

[15] Prescribing Analysis and Audit
[16] RCGP Clinical Audit
[17] Clinical Audit Guidelines

4 Summary

Clinicians within Coastal and Rural Health Partnership have significant responsibility for ensuring prescribing is completed safely and competently. Accountability rests with the authorised prescriber who has signed the prescription.

Adhering to the direction provided in this policy will ensure that clinicians are fully aware of their responsibilities, reduce risk and ensure the delivery of safe and effective clinical care.