Crawford Street Surgery's Repeat Prescribing Policy

Revised and Updated, adapting NWL Policy

Version	V1.0
Authorised by Clinical Lead	Name: Dr Etheldreda Kong Signature:
Date Approved	24th July 2025
Review Date	24th July 2026
Target Audience (use this guidance for best practice adaptation)	Repeat prescribing process is the responsibility of all staff in the practice ▪ Prescribers and practice staff ▪ Practice nurses ▪ Non-medical independent prescribers ▪ Primary Care Network/Practice pharmacists (clinical and ARRS) ▪ Patients

Audit/review of the policy needs to be conducted annually.

Version number	Review date	Clinical Lead	Changes
V1.0	27 July 2026	Dr Etheldreda Kong	

Signature Page

Please sign to say you have read and acknowledged the Repeat Prescribing Policy:

Name (Print)	Role	Signature	Date
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Contents

Aims of policy

- To standardise repeat prescribing processes and protocols within the surgery
- To enable staff to understand their roles and responsibilities
- To provide guidance on good repeat prescribing processes and procedures
- To ensure safeguards are in place to minimise errors and reduce risks

There are five main stages in the repeat prescribing process:
1. Authorisation process
2. Requesting process
3. Processing of repeat prescriptions
4. Patient receives prescriptions
5. Medication Reviews

1.0 Authorisation process

Initiating Repeat Prescriptions

- The prescriber must be satisfied that drug treatment is appropriate, necessary and consider non-drug treatments and lifestyle interventions
- Consider an initial prescription for up to 4 weeks to check for suitability
- Patient sensitivities, allergies and significant interactions should be considered and recorded
- Take note of 'ALERTS', for example OptimiseRx or practice system alerts (only prescribers can override this)
- Prescribe generics, unless there is a valid reason not to (see Appendix 1 for examples)
- The dose and frequency must be specified. The instructions:
  - "as directed" should not be used, unless appropriate
  - "when required" should not be used alone and should have a recommended duration of treatment e.g. topical steroid creams
- Where possible prescription quantities and ordering dates should be kept 'synchronised' (so that regular ordering falls at the same time/rate) to help patients maintain a regular ordering pattern and prevent waste
- Counsel the patient on:
  - What is being prescribed and why, using shared decision making as outlined by NICE. Discuss and document 'off-label' or unlicensed medicines use
  - Common side effects from the patient information leaflet
  - How the drug(s) is administered (and demonstrated, if appropriate)
  - What actions should be taken if problems arise

Reauthorisation of Repeats

Re-authorisation is a good opportunity to check patient compliance, to align quantities and to assess whether the patient benefits from repeat medication.

- Within the practice it should be clearly stated who can add authorised medications to a patient's repeat medication list (only an appropriately qualified prescriber can authorise repeats and issue acute prescriptions e.g. GP, pharmacist, non-medical prescriber). Non-prescribing clinical staff such as clinical pharmacists or pharmacy technicians may re-authorise prescriptions depending on their level of competence and agreement with their line manager and lead GP, with suitable access to a prescriber if required
- Newly prescribed medicines requiring follow up or medication with frequent dose changes should be set up as an acute prescription until suitable to change to repeat medication
- Define the number of repeats or the period before the next review. Ensure repeat record is accurate, synchronise quantities where possible
- Before reauthorising, ensure the item is needed, effective, patient concordance, no adverse effects, interactions considered and the patient's condition is stable
- Prescribe appropriate duration of treatment and check drug name, strength, form, dose, indication, monitoring and next review date.

Clinical responsibility for re-authorisation

Practice may agree that clinical staff who are non-prescribers may extend repeat medications for one issue to prevent treatment breaks while patients wait for a review with a qualified prescriber. The patient must have an appointment booked, and must be notified their medication supply has been extended for this purpose. This should be documented in the patient's medical notes. Medications excluded from this extension are controlled drugs and any medicines defined as high risk. NHSE define high risk medicines as those with potential to cause significant harm even when used entirely correctly, but where healthcare intervention could reduce the risk of harm. Examples of high risk medicines include anticoagulants, azathioprine, leflunomide, lithium, methotrexate, steroids.
Patient must be informed that their medication cannot be extended further beyond this point until they have had their review.
Non-clinical staff must not re-authorise prescriptions and must send a query to the prescriber on the clinical system.

Items not suitable for repeat

Most prescription items will be suitable for repeat status, but there are certain medicines which are not routinely appropriate. These include: antibiotics/antifungals, hypnotics and anxiolytics, potent topical corticosteroids and dressings. Examples of medicines which should be prescribed as 'acute' can be found in Appendix 2.

If a request is received for a drug that is not authorised as a repeat item, a prescription must not be generated. The request should be referred to the prescriber as a query task on the GP clinical systems. This is to ensure an audit trail and items are followed-up.

Number of Days Supply

- Align to appropriate duration of treatment as agreed by the practice, including any exceptions e.g. contraception, HRT. The Department of Health and Social Care (DHSC) has issued strong recommendations that prescriptions for Schedule 2, 3 and 4 CDs are limited to the quantity necessary for up to 30 days' treatment. (See Appendix 3 for detailed information on Controlled Drugs Prescriptions).
- Repeat prescriptions are issued either weekly, monthly(28days) or 2 monthly(56 days). A maximum of 84 days supply is issued for patients going on holiday for three months or more. (See Appendix 4 prescription request for Travel)

2.0 Requesting process

Where a patient is capable of ordering their own medication, they should be encouraged to do so as much as possible.

Requesting a repeat prescription

When a patient first joins the practice they are made aware of the Repeat Prescribing Policy and shown how to order prescriptions. Please see 'Safe Practice: Information for patients' for more details.
The following personnel are allowed to request repeat prescriptions:

- Patient
- Carer
- District and specialist nurses
- Care Home staff
- Pharmacist *

*** By prior arrangement and only in exceptional circumstances e.g. patients who cannot request their repeat prescription and do not have a** suitable nominated person **who can request for them; Disabled patients who say that asking their community pharmacy to request their prescription is a 'reasonable adjustment' under the Equality Act 2010**
Where practices allow third party requests, ensure patient confidentiality is maintained and the correct information is accurately exchanged (and via a secure email route e.g. nhs.net email address). Patients should be contacted to confirm requests from third party ordering e.g. Dispensing Appliance Contractors.

From 26th October 2018 practice no longer accept prescription requests by pharmacists except in the following cases:

- Dosette box
- Dementia
- Housebound
- Elderly where appropriate
- Patients with mobility issues

Requests can be received by the following methods:

- Online e.g. practice website/clinical system, apps such as NHS app/S1 online/Patient Access (preferred methods)
- Other online prescription ordering apps (not encouraged)
- Repeat Prescription Medication list (tear-off counterfoil)
- Written request e.g. email, post

Verbal/telephone requests should be avoided to minimise risk of errors in medication selection except in exceptional circumstances e.g. for vulnerable patients when prescription staff have access to patient's repeat prescriptions.list of such patients is kept at the reception and will have to be authorised by Doctor to be added onto the list
A lockable box should be situated in the waiting room for patients to post their requests and should be emptied on a daily basis.
Repeat requests should be sent to the practice no earlier than 7 days in advance of supply being due except in exceptional circumstances e.g. patient going on holiday. Explanation of early supply should be documented in the patient's medical records.

The following information must be obtained before a request is processed:

- Patient's full name
- Patient's address or date of birth
- Name/strength/ form and dosage of medication(s)

Any queries arising from the request should be clarified at this stage.
N.B. It is NOT acceptable for a patient to request "all repeats" or their "orange tablets", or use a description of medication rather than specify the name (e.g."heart tablets, pain killers").

Period of notice

The prescription will usually be available at the chemist or ready to collect from the surgery after 48-72 hours from request. Patients are notified of this via the practice website/poster.

Urgent medication requests

- Aim to process within 24 hours
- The urgent request should be raised as an urgent task on the GP clinical systems to the prescriber on duty
- For patients who repeatedly request urgent requests, inform the practice manager

- When patients run out of medications and are unable to contact us, for example out of hours, they can contat NHS 111 who can advise and direct to where and how to obtain emergency supplies.

3.0 Processing repeat prescriptions

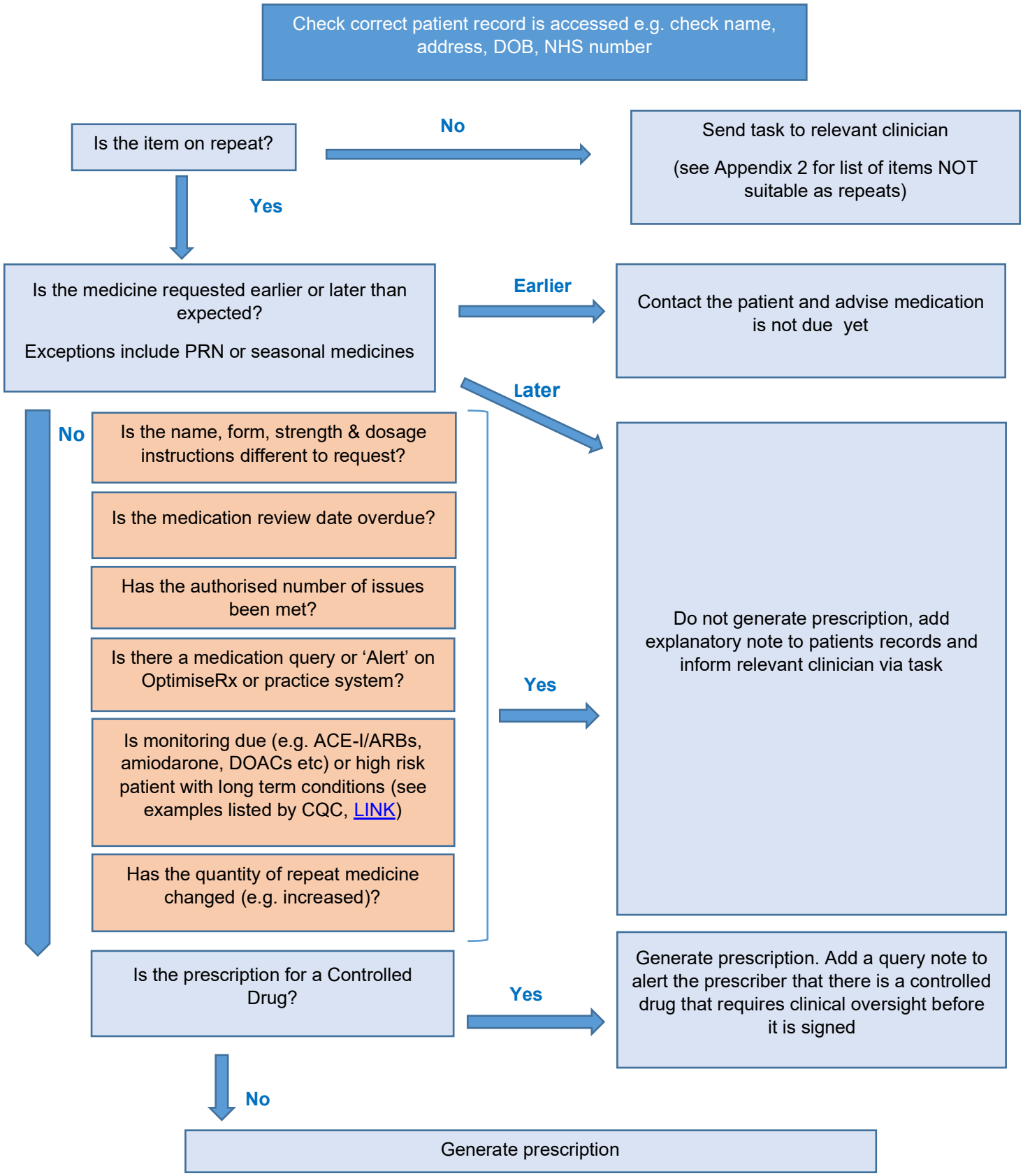
- All staff involved should be trained and understand their roles and responsibilities and the processes to be followed
- Use the Practice clinical system to generate all repeat and acute prescriptions
- A counterfoil (medication list) must be generated with every prescription (unless EPS)
- A process should be in place for dealing with care home requests e.g. proxy access
- Prescriptions should not be “directed” to any particular pharmacy or appliance contractor. Where repeat prescription collection services are in place, the pharmacy or appliance contractor used should be chosen by the patient. Practice staff should not influence the choice of pharmacy for prescriptions to be sent to.

The member of staff generating the repeat prescription is responsible for making sure these checks are made.

Any requests that do not meet the rules outlined above or raise doubt must be referred to a prescriber as a medication query. The referral should be actioned as a task on the GP clinical system to maintain an audit trail and ensure follow up.

If the prescriber decides to authorise the prescription, ensure any message from the prescriber to the patient is communicated to the patient, by informing the relevant team via a task message. In some cases, the prescriber may inform the patient directly via telephone or text message.

Flowchart showing the key questions when generating a repeat prescription:



Signing prescriptions

- The prescriber is responsible for signing prescriptions and must have allocated time set aside each day to sign and review repeat prescriptions. Non-medical prescribers may sign repeat prescriptions within their scope of practice
- All prescribers need to be appropriately linked to the practice using the appropriate prescriber code
- Before signing the repeat prescription, the prescriber should be satisfied the necessary steps have been taken during the reauthorisation process (as outlined earlier)
- A system should be in place for distributing signing of prescriptions during cases of absence.

Request for 'High Risk' Drugs

High risk drugs include those that have a narrow therapeutic index, require unusual dosing or closer monitoring. Please refer to the 'drug monitoring' toolkit within SPS for further information.
High risk drugs requiring regular monitoring will be reauthorised for 3 issues. Each issue will be maximum of 30 days supply

4.0 Patient receives prescription

Collection and Management of Prescriptions

Prescriptions should all be sent electronically by default, unless there are exceptions e.g. private prescriptions, instalment dispensed Controlled Drug (FP10MDA). Prescriptions signed electronically are received directly by the nominated pharmacy.

Handling of paper prescriptions

For physically signed prescriptions, the following applies:

- Once the prescription has been printed, place it into a designated pile to be signed by the prescriber (repeat prescriptions should only be signed by a prescriber who knows the patient or has direct access to the patient's clinical records)
- Once paper prescriptions have been signed, they should be returned to the receptionist for collection by the patient or patients' representative.
- The signed prescription should be stored in a secure, supervised place, out of reach of the public, as it contains confidential patient information
- Check name, address and date of birth with the person collecting the repeat prescription to confirm the identity of the patient
- Any arrangement to collect prescriptions by an outside agency (e.g. community pharmacy), will have been agreed by all relevant parties and a signed consent form in the patient's notes. Ensure that in all relevant cases a valid consent form has been received prior to allowing third party prescription collection. A signing out log 'prescription collected' is set up to complete on collection of prescriptions (noting the identity of the individual collecting the prescription)
- 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
- In exceptional circumstances when paper prescriptions are posted to the patient, this must be by recorded delivery
- If a review date is required or overdue, the patient is advised to make an appointment
- Controlled Drug prescriptions should be signed for when collected. This will facilitate any investigation should a problem or dispute arise
- Any lost or stolen prescriptions are documented on the patient's records

- Lost or stolen Schedule 2 or 3 controlled drug prescriptions are reported to the local police who provide a reference number. This number is added onto the patient's record
- Blank prescriptions must never be signed by a prescriber for later completion by practice staff. Unused space should be cancelled out under the last drug by a computerised mechanism or by the prescriber deleting the space manually

Missing prescriptions

Using electronic prescriptions minimises the risk of missing prescriptions.
Repeat prescriptions that have been reported as lost or missing should not automatically be reproduced and should be reported to the prescriber who signed that prescription.
If unable to locate, the practice manager must be informed for investigation to ensure that the reported loss is genuine and not an attempt to commit prescription fraud. Adding the following details into the patients records:

- 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, this must be reported to the NHS England London CDAO team via the Controlled Drugs Reporting Website and extra security precautions taken, such as ensuring that the local pharmacies are made aware of this, thereby preventing the lost prescription from being used.
A risk assessment should be undertaken prior to replacing the prescription; the lost prescription should be deleted from the patient's electronic prescription record with an explanatory note, and a new prescription printed. If there is a problem with an electronic prescription print a token, do not generate a new prescription.
All patient safety incidents to be reported on LFPSE.

Uncollected prescriptions

Prescriptions not collected 4 weeks after issue should be highlighted to the prescriber. They should be shredded, and the issue should be deleted from the issue record in the patient's medical notes. The SNOMED code "prescription not collected" (182894006) should be added to the patient's record.

The prescription collection "box" should be regularly cleared of uncollected prescriptions and occasional audits performed to determine the reason for non-collection.

5.0 Medication Reviews

- A "Medication Review" is the periodic review of the patient at which the continuing need for acceptability and safety of medication on the repeat prescription are considered[1]
- The aim is to optimise the use of medicines, reduce wastage and ultimately reach an agreement with the patient about what is required for their continued care
- A recall system should be in place to ensure all patients that have repeat prescriptions are reviewed periodically, including those who do not order their medication

Preparation

- A medication review requires consultation between the patient and a healthcare professional on an individual basis with respect to their illness and their medication
- The patient's medical record should be checked to identify if the patient has been reviewed by another healthcare professional; consider whether the consultation is necessary for existing co-morbidities
- If a review is necessary, the receptionist should be asked to:
  - Make an appointment or arrange a domiciliary visit within one week
  - Ensure the patient has sufficient medication; an acute prescription may be necessary

  - Request the patient brings all of their medication to the review consultation
- Where possible reviews are conducted in person, in certain circumstances, telephone/virtual consultations are acceptable.

Process

- Standard reviews every 12 months; 6 months for patients on 10 or more medicines or for high-risk patients who may need more frequent follow up
- Ensure the patient's medication matches the intended regimen and resolve any discrepancies (advise patient to return unwanted medication to a pharmacy)
- Examine the effectiveness of each drug and consider cessation, cancellation (e.g. previously stopped but remained on patients repeat medication list), therapeutic substitution, cost-effective alternatives and dose adjustment
- Check for formulary adherence. See NW London Integrated Formulary and Red List
- Document any side effects/ allergies in the patient's record. Note actions to take if patient stops taking their medication before next agreed review date
- Archive repeat medication not ordered within the last 12 months or more, except seasonal medication
- Check all monitoring and chronic disease reviews have been completed
- Record medication prescribed elsewhere e.g. hospital only drugs
- An entry should be made in the patient's medical record at the time of medication review to indicate that it has occurred, noting any changes and update review date
- Discuss treatment adherence, understanding of their medication and any other medication taken (e.g. OTC)
- Provide the patient with an updated, printed medication list and a review date.
- Where possible align medication review to the patient's birth month or use a review date for reauthorisation rather than the number of issues.

Medication review of patient's medical notes

Some patients may have a review of their medication RECORDS after their repeats have expired following their full annual medication review.
Review of the notes is to be undertaken by non-medical prescriber (preferably a clinician who regularly treats the patient) and must be coded as "Medication review of medical notes" (93311000000106).

Below are the requirements for this form of review to occur:

- The patient's condition and medication(s) must be stable since the full annual review.
- The patient only requires basic monitoring such as a BP or simple blood test and pass the results to a clinician as part of the review. Depending on the results of the review, the prescriber will:
  - Re-authorise the prescription for further repeats and record in the patient's notes that the prescription has been re-authorised
  - Request that the patient attends a consultation if further intervention is required

All GP Practices will also have a recall system in place to ensure that patients who do not order their repeat medications are contacted and a review is arranged. This information is recorded in the patient's electronic healthcare record.

Medication reviews and mental capacity

Under the NHS constitution, patients have the right to be involved in discussions and decisions about their health and care and to be given information to allow them to do this.

Consideration should be given to potential barriers (e.g. mental health problems, lack of capacity to make decisions, hard of hearing etc.) to patients being able to take an active role in their medication review and management of their medicines.
Family members and carers could be involved in the decision-making process if appropriate and patient's views should be respected. If the patient lacks the capacity to decide who should and should not be involved, health and social care practitioners must act in the patient's best interests, taking account of the provisions in the Mental Capacity Act 2005.

Patients who fail to attend for review

If a patient misses their medication review, efforts should be made to contact them and reschedule. Various methods can be used, such as:

- Checking if the patient is still with the practice or has moved. Check their address and residency status
- Confirming if the patient is in hospital
- Sending a letter explaining the GP's duty of care
- Calling, texting, emailing, or visiting the patient
- Review issue frequency e.g. consider prescribing actuely
- Offering appointments during extended hours
- Checking if the patient has been reviewed by another professional or organisation
- Prescription message to community pharmacist to prompt patient to contact their practice for a medication review.
- Ensuring appropriate contact, including reaching out to a carer if needed

Document all contact attempts in the patient's records.

Non-compliance with medication monitoring

When a patient is identified as being overdue a blood test, identify whether they have had their monitoring done elsewhere.

If no records of monitoring can be established the following actions should be taken depending which medications are involved:

High risk medications

- The patient should be contacted and informed that their monitoring is overdue and to arrange an appointment. The amount of medications supplied should be reduced to two weeks
- If after two weeks, the patient still has not attended for their monitoring, the supply should be reduced to one week
- If the patient continues to be non-compliant with the monitoring, the patient must be discussed with the lead GP for the practice to establish an individualised strategy for the patient.

Other medications requiring monitoring

- The patient should be contacted and informed that their monitoring is overdue and to arrange an appointment. The amount of medications supplied should be reduced to four weeks.
- If patient fails to attend more than twice for their monitoring, the supply should be reduced to two weeks.
- If after this time the patient continues not to attend, the supply should be reduced to one week.
- If the patient continues to be non-compliant with the monitoring, the patient must be discussed with the lead GP for the practice to establish an individualised strategy for the patient. These patients may not be suitable for repeat prescribing.

Structured Medication Review (SMR)

An SMR is a thorough assessment of a person's medications aimed at optimising treatment, reducing medication-related problems, and minimising waste. Unlike a regular medication review, an SMR is more comprehensive and considers all aspects of the patient's health. It involves shared decision-making, with the clinician and patient working together to balance the benefits, risks, and alternatives of medications based on the patient's individual needs and preferences.
SMRs can be conducted by doctors, nurses, or clinical pharmacists and are beneficial for patients on multiple medications, those with chronic conditions, older people with frailty, and patients in care homes.

Key factors to consider during an SMR include:

- Patient's priorities
- Essential vs unnecessary drug therapy
- Effectiveness of treatment
- Risk of adverse drug reactions
- Cost-effectiveness of therapy
- Patient's ability and willingness to follow treatment

SMRs should also consider de-prescribing, which involves stopping or reducing medications to manage polypharmacy and improve patient outcomes.

Home Visits

Any alterations to a patient's medication made outside of a practice consultation (e.g. home visit), must be updated at the earliest opportunity by the prescriber.

Handwritten prescriptions must be entered onto the computer system at the earliest opportunity. This will:

- Reduce inadvertent duplication of prescribing
- Reduce the possibility of unintentional drug interactions
- Provide an audit trail.

If a patient requests a supply of medication that has been issued on a handwritten prescription, but is not on the computer record:

- Attach an explanatory note to the patient's record
- Inform the relevant clinician via sending a task on the clinical system

6.0 Safe Practice

Education & training

Practice staff involved in the preparation of repeat prescriptions should be appropriately trained in the practice protocols for repeat prescribing, their responsibilities, checking for clinical accuracy and when to refer the request for a repeat prescription to a GP.
Any members of staff involved in any element of the repeat prescribing process must read and acknowledge the repeat prescribing policy. This should be included in the induction programme for new staff, locums and doctors.
Useful staff training resources are available for both clinical and non-clinical staff on the RCGP and RPS toolkit.
New staff should shadow a trained member of staff for at least one month or until senior staff feel they are competent.

Information for patients

Patients should have access to written instructions on how to order repeat prescriptions on the practice website, NHS website and the NHS App. PrescQIPP has some useful information on how to empower patients to manage their own repeats.
Make sure patients are aware of:

- The procedure for ordering repeat prescriptions (poster displayed in reception)

- Importance of attending blood test monitoring and review appointments for safe prescribing of repeat medications
- The time it takes to turn them around (including arrangements for weekends, bank holidays etc.)
- When the prescription will be ready for collection
- Letting the practice know if they have stopped taking anything on the prescription
- Only ordering what they need to in order to reduce medicines waste
- Asking the doctor, nurse or pharmacist if they are unsure about any of their medicine

The message section of the counterfoil should be used to inform the patient of the repeat prescribing policy.

Use of screens to play adverts, touchscreen terminals, leaflets, posters and practice website useful tool to convey key messages.

Management control

This is the responsibility of the practice manager.

- Practice staff involved in the preparation of repeat prescriptions should be appropriately trained in the practice guidelines/policies for repeat prescribing.
- Staff should know what their responsibilities are. They need to be accurate in their tasks.
- Training is ongoing and prescribing is on our clinical and admin meetings agendas.
- New staff is given training as well as the policies/protocols to abide by.
- While there are rotas for tasks, admin staff should be able to cover for each other in case of absences.
- FP10s are securely stored in a locked cabinet. Access is given as needed and pad numbers written on the attached form provided.
- The practice computer system holding the repeat prescribing records is backed up daily via the clinical system provider.
- Periodical audit of repeat prescribing carried out monthly.
- The manager tests the system for safety and clinical governance issues.
- The Patient's Policy is clearly displayed in the Waiting and Reception areas as well as posted on the practice's website
- The Patient's Policy is reviewed annually, taking patients' feedback into consideration.
- The Clinical System is updated centrally where there is a new drug/dosage change or programme deficiency.
- The practice has contact details for all nearby pharmacies and liaises with them on a regular basis to inform them of individual issues as well as systemic changes.

Appendix 1: Items not suitable for generic prescribing

Examples of some medicines which should be prescribed by brand name due to differences in product formulations, for more detailed information see LINK

Name of medicine	Additional information
Adrenaline auto-injector devices	Prescribe by brand name to ensure patients receive an auto-injector device they have been trained to use. If switching between brands, patients should receive full training in use of the new device
Buprenorphine patches	Brand name prescribing is recommended to reduce the risk of confusion and error in dispensing and administration
Diltiazem	Different versions of diltiazem modified-release preparations containing more than 60mg may not have the same clinical effect
Epilepsy medication See MHRA for further information.	**Category 1:** Specific measures are necessary to ensure consistent supply of a particular product. These include carbamazepine, phenobarbital, phenytoin, primidone **Category 2:** The need for continued supply of a particular manufacturer's product should be based on clinical judgement and consultation with patient and/or carer. These include clobazam, clonazepam, eslicarbazepine, lamotrigine, oxcarbazepine, perampanel, retigabine, rufinamide, topiramate, valproate, zonisamide **Category 3:** Therapeutic equivalence between branded and generic products (and between generics) can be assumed for medicines in this category. They can be prescribed generically unless there are other specific reasons such as patient anxiety, confusion or risk of dosing errors. These include brivaracetam, ethosuximide, gabapentin, lacosamide, levetiracetam, pregabalin, tiagabine, vigabatrin
Fentanyl	Fentanyl transdermal patches are available as matrix and reservoir formulations.
Lithium	Lithium has a narrow therapeutic index and preparations vary widely in bioavailability. Changing the preparation requires the same precautions as initiation of treatment
Nifedipine MR preparations	Different versions of nifedipine modified-release preparations may not have the same clinical effect
Inhalers	NICE CKS asthma guidelines advise generic prescribing of inhalers should be avoided as it can lead to people with asthma being given an unfamiliar device, affecting usage and adherence
Insulin	NICE guidance recommends insulins are prescribed by brand name
Mesalazine	The BNF states there is no evidence that any one oral preparation of mesalazine is more effective than another; however, delivery characteristics of mesalazine preparations may vary. If switching between brands, advise patient to report any changes in symptoms
Morphine, oxycodone & tramadol	Available as 12-hourly and 24-hourly oral formulations. Brand-name prescribing is recommended to reduce the risk of confusion

Appendix 2: Items not suitable as repeats

Please note this is not an exhaustive list

- Antibiotics/antifungals/antivirals
- Antipsychotics in the elderly
- Dressings
- Hypnotics (other than long term existing patients, providing they have been counselled)
- Medicines requiring special monitoring for which patients have not been reviewed at the appropriate interval
- Medicines intended for short term use
- Medication used for rescue therapy e.g. steroids or antibiotics
- Medicines that are available through self-care e.g. paracetamol for acute pain, cough syrups, hay fever remedies etc.
- Schedule 2 and 3 controlled drugs
- Very potent topical steroids
- Varenicline/bupropion and nicotine replacement therapy
- HRT medications

Appendix 3: Controlled Drug Prescriptions

Schedule 2 and 3 controlled drugs (except temazepam)

CD prescriptions may be computer-generated or handwritten. Prescribers may issue computer-generated prescriptions for all CDs. Only the signature has to be in the prescriber's own handwriting.
Alterations are best avoided but if any are made, they should be clear and unambiguous. If an error is made, best practice is for the prescriber to cross out the error, initial and date the error then write the correct information.
A prescription for Schedule 2 and 3 CDs (with the exception of temazepam and preparations containing it) must contain the following details:

- Written so as to be indelible e.g. written by hand, typed or computer generated
- The patient's full name, address and where appropriate, age. An email address or PO Box is not acceptable. 'No fixed abode' is acceptable as an address for homeless people.
- The name and form of the drug, even if only one form exists
- The strength of the preparation, where appropriate (if more than one strength exists)
- The dose to be taken
- The total quantity of the preparation, or the number of dose units to be supplied both in words and figures.
  The Practice will adopt best practice and ensure that the quantity for prescriptions of Schedule 2, 3 & 4 drugs are limited to the quantity necessary for up to 30 days treatment unless there is a genuine need or exceptional circumstances where the prescriber believes a supply of more than 30 days medication is clinically indicated and would not pose an unacceptable threat to patient safety. In this event, the prescriber will:
  - Make a note of the reasons for this in the patient's notes.
  - Be ready to justify his / her decision if required.
- Signed by the prescriber with their usual signature (this must be hand written) and dated by them (the date does not have to be hand written). The date can be either the date of signing OR the date the prescriber wishes the prescription to start.
- The address of the prescriber must be stated on the prescription and must be within the UK (does not include the Channel Islands or the Isle of Man)

Temazepam and Schedule 4 and 5 controlled drugs

- Prescriptions for temazepam and for Schedule 4 and 5 CD's are exempt from the specific prescription requirements of the Misuse of Drugs Regulations 2001.
  However they must still comply with the general prescription requirements as specified under the Medicines Act.

For additional information, see LINK.

Appendix 4: Prescription Management Systems

Electronic Prescription Service (EPS)

The Electronic Prescription Service (EPS) enables prescriptions to be sent to pharmacies or appliance contractors from GP surgeries electronically.

Patients are able to 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.
Pharmacies must return prescriptions/items not dispensed immediately to the spine. Items not dispensed must be returned or rejected, and claiming for them would constitute fraud.

Electronic Repeat Dispensing (eRD)

Electronic Repeat Dispensing is the process by which patients can obtain supplies of their repeat medicines over a defined period of time without the need to contact their practice each time a new supply is required.
Any patient with a long-term condition that is considered likely to remain stable for the duration of the eRD could be suitable for the service.
eRD requires the patient to consent to the introduction of two-way sharing of their information between the dispensing and prescribing site. The patient should be asked to consent but written consent is not required.
A patient must have their dispensing site nomination recorded for any prescription to be sent electronically.
Schedule 2 and 3 Controlled Drugs cannot be prescribed on repeat dispensing prescriptions.

Reduce prescribing of Over-The-Counter (OTC) items

NHS England recommends to reduce the prescribing of medicines which can be brought over-the-counter.
The NHS has been spending around £136 million a year on prescriptions for medicines that can be brought from a pharmacy or supermarket. By reducing NHS spend on over-the-counter medicines, priority treatments can be given to patients with more serious conditions.
Please visit the local pharmacy first so that the pharmacist can give advice on suitable treatment for common illnesses and can refer to the GP if necessary.
Where appropriate, refer patients to the Pharmacy First service so that the pharmacist can give advice on suitable treatment for common illnesses.

Reduce prescribing of Items which should not routinely be prescribed in primary care

NHS England guidance provides recommendations for items which should not be prescribed in primary care because they are unsafe, ineffective for some or all patients, or are not cost-effective.
The policy recommends that these items:

- should not be initiated in primary care
- should be deprescribed in patients currently prescribed them.

Prescription requests for Travel

Patients may request repeat medications to take with them if they are going away on holiday. The NHS accepts responsibility for supplying ongoing medication for temporary periods abroad of up to three months. If a person is going to be abroad for more than three months, then only a sufficient supply of his/her regular medication should be provided to enable them to get to the destination and find an alternative supply. NHS prescriptions must never be obtained by relatives or friends on behalf of patients who are currently abroad, irrespective of such factors as owning a house in the UK or paying UK taxes. Patients are responsible for ensuring that any drugs they take into a country conform to local laws (BMA).
If travelling to Europe, patients can apply for a free UK Global Health Insurance Card (GHIC) or European Health Insurance Card (EHIC) which offers access to reduced-cost medical treatment. See NHS guidance for details.

Useful Links

- General Medical Council. Raising and acting on concerns about patient safety https://www.gmc-uk.org/professional-standards/the-professional-standards/raising-and-acting-on-concerns
- NHS Patient Guide: How to order a repeat prescription online https://www.nhs.uk/nhs-services/online-services/how-to-order-a-repeat-prescription/
- NHS England London CDAO team, Control Drugs Reporting werbsite https://www.cdreporting.co.uk/nhs/account/signin
- NHSE: Ordering medication using proxy access: Guidance for care homes, GP practices and community pharmacies https://www.england.nhs.uk/ourwork/clinical-policy/ordering-medication-using-proxy-access/
- NHSE: Prescribing of over the counter medicines is changing: patient leaflets https://www.england.nhs.uk/publication/prescribing-of-over-the-counter-medicines-is-changing/
- NW London Integrated Formulary & Red Drug List https://www.nwlondonicb.nhs.uk/professionals/medicines/formulary
- NW London Medicines Optimisation and Community Pharmacy Homepage https://www.nwlondonicb.nhs.uk/professionals/medicines
- NW London Prescribing/Medicines Guidance https://www.nwlondonicb.nhs.uk/professionals/medicines/Prescribing-Medicinesguidance
- PrescQIPP. Bulletin 292: Repeat prescriptions https://www.prescqipp.info/our-resources/bulletins/bulletin-292-repeat-prescriptions/
- PrescQIPP. Bulletin 325: Empowering patients to manage their repeat prescriptions. April 2023 https://www.prescqipp.info/our-resources/bulletins/bulletin-325-empowering-patients-to-manage-their-repeat-prescriptions/
- Royal College of General Practitioners and Royal Pharmaceutical Society. Repeat Prescribing Toolkit https://www.rpharms.com/resources/repeat-prescribing-toolkit
- Using Patient Access (EMIS practices)– A Guide for patients https://support.patientaccess.com/repeat-medication
- Using SystmOnline – A Guide for patients https://systmonline.tpp-uk.com/2/help/help.html