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**The Wessex edited, summary version of the Royal College of General Practitioners (RCGP) Royal Pharmaceutical Society (RPS) repeat Prescribing Toolkit**

This edited, summary version of the RCGP RPS Repeat Prescribing Toolkit is intended to be used as a start to the complete self-assessment process. It should be delivered with a FULL understanding of the RCGP RPS toolkit.

[**https://www.rpharms.com/resources/repeat-prescribing-toolkit**](https://www.rpharms.com/resources/repeat-prescribing-toolkit)

1. **Process to follow to complete the toolkit**

**Suggested steps for GP Practices/PCNs to complete the repeat prescribing self-assessment**

**Start here**

**Appoint a lead for the repeat prescribing toolkit assessment process**

**Look at NHS BSA oversupply data**

**Convene a repeat prescribing working group**

**Highlight any wider system issues**

**Work through the action plan**

**Address any urgent medication safety issues**

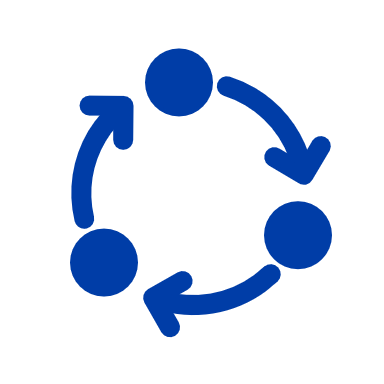
**Agree key areas to address in the action plan**

**Invite PPG and local pharmacies to be involved**

**Discuss the self-assessment questions**

* **Core**
* **Advanced**

**This process may take a number of months and require a number of PDSA (Plan Do Study Act) cycles**



1. **Suggested questions for practices to consider in relation to higher-risk medicines or higher-risk patient scenarios.**

The RCGP RPS repeat prescribing toolkit has a strong focus on medication safety. Therefore, Practices are asked (as a minimum) to engage with the higher risk, repeat medicines and higher risk patient scenarios to make sure that the practice is offering a safe and efficient process for these higher risk situations.

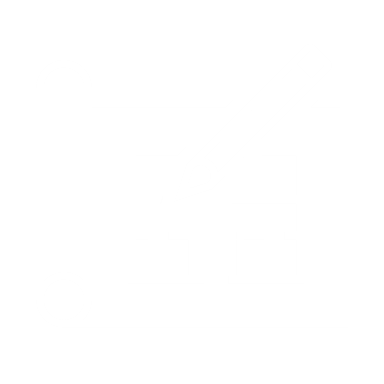
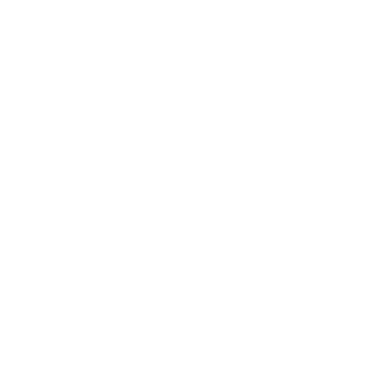
**Higher risk repeat medicines**

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| **Question** | **Response (Optional)** |
| 1. Do administrative staff have a list of medicines classed as higher risk in relation to repeat requests that they know to manage more carefully (suggestions included in [BOX 1](https://www.rpharms.com/resources/repeat-prescribing-toolkit/medication-safety#box1) |  |
| 1. How is the repeat process for higher-risk medicines managed? Is it different to that for lower-risk medicines? |  |
| 1. Careful consideration should be given before any higher-risk medicines (but especially opioids and antimicrobials) are prescribed on repeat. Is this clear in the practice procedure? |  |
| 1. Where long-term use of a moderate-risk medicine is a safety issue, how does the practice ensure that there will be regular medication reviews before repeats are issued? |  |
| 1. What is the procedure if a patient does not engage with the medication review or monitoring process? Is this clear to all members of the practice staff and locums? |  |
| 1. Is the frequency of planned medication reviews appropriate for the risk of the medicine, e.g., no longer than three months for high-dose opioids? |  |
| 1. Are there robust arrangements in place to ensure regular structured medication reviews for older people taking ten or more medicines regularly on repeat? |  |

**High-risk and vulnerable patient groups**

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| 1. Is there a practice process to identify and monitor patients taking high-risk medicines on repeat? |  |
| 1. Does the practice have an agreed process for patients or patient groups deemed to be at greater risk of harm from higher-risk repeat medicines (such as those with a history of substance abuse, the very old, patients with ‘frailty’, those prescribed ten or more medicines, those with learning difficulties and those who are reliant on others to order and collect their medicines)? |  |

**The 5 elements of repeat prescribing systems:**



**Patient / Carer**

Area of the process where patients/carers fulfil their responsibilities e.g. ordering repeats on time, being honest about over-ordering and the reasons why.

Booking blood tests in preparation for a medication review

Engaging with the structured medication review process

**Administrative**

Practice administrative staff manage the process of receiving the request for a repeat medication and processing it all the way through to clinical authorisations

Processing and following up tasks related to queries about repeat prescription requests

**Clinical**

Prescriber making clinical decisions such as:

Decision to make a medicine available via “repeat”;

Prescriber setting out the duration of the repeat authorisation period;

Prescriber highlighting any parameters where the medicine should not be reissued, including lack of monitoring data;

Prescriber to check interactions with pre-existing repeat medications

**Technical**

Ensuring digital tools are deployed where possible to optimise the safety and efficiency of the repeat prescribing process and reduce staff workload.

Ensuring systems are in place for blood tests/monitoring and alerts and follow ups.

Ensure prescribing instructions are enacted. E.g. “stop after 6 months”.

Using clinical systems to highlight when repeat medications are over (or under) ordered

Follow up repeat prescription queries.

Practices will vary in their clinical, technical, and administrative capacity and capability. In the current workforce environment, it is not always possible to optimise all elements. However, by completing the self-assessment toolkit, practices will be able to identify current gaps and highlight where processes can be improved to ensure medication safety and maximise efficiency. This will require an open and honest approach from the practice and will need dedicated time to do well. Practices that have gone through such processes report that they have seen the benefits of this work, **including clinician time saved, fewer prescription queries and faster turnaround (**[**see examples in chapter 3**](https://www.rpharms.com/resources/repeat-prescribing-toolkit/process-mapping)**).**

**The five elements of repeat prescribing**

1. **Organisational culture**

A just, open and positive organisational culture will ensure that the practice operates in an environment where issues related to the safety and efficiency of the repeat prescribing system can be raised, discussed, addressed and monitored for improvement.

This is important for medication safety but can be challenging to achieve. It relates to the culture within the practice but also the relationships with local community pharmacies and the PPG, as well as the registered patient population (see [NHSE patient safety strategy](https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/)).

Part of creating a positive organisational culture includes ensuring that the general practice has ownership of creating an effective process that improves the system performance, supporting staff to carry out their work well and delivers a service that is safe and timely for the patients needing it.

1. **Patient/carer**

Patients and carers have a role to play in the safe and efficient operating of a repeat prescribing process. The roles and responsibilities needed to optimise this process are described in the repeat prescribing patient partnership agreement (see the patient partnership agreement in chapter 5).

1. **Clinical**

This is where the clinical decision to authorise the repeat prescription is made. This element will determine for how long medicines are to be repeated and how regularly they are to be reviewed, as well as any monitoring requirements.

The quality and regularity of the medication review are key to the safety of this element. Practices will need to think about their staff skill mix to ensure that the right clinicians are engaged in the medication authorisation and review processes. GMC professional standards state that ‘clinicians prescribing repeat medications should only do so with adequate knowledge of the patient’s health and are satisfied that the drugs or treatment will meet their need’.[[1]](#endnote-2)

Practices need to assess the quality of their medication reviews and if sufficient clinical input is allocated to patients receiving higher-risk medicines, in particular (see authorisation/medication review and [SMR definitions](https://www.rpharms.com/resources/repeat-prescribing-toolkit/medication-safety#2.4) Appendix 2 ).

Patients prescribed higher risk medicines on repeat described in [box 1](https://www.rpharms.com/resources/repeat-prescribing-toolkit/medication-safety) should receive a regular, structured medication review to allow for their repeat medicines to be optimised and for any issues, concerns and expectations to be addressed. This will include any non-adherence, over or under ordering and any safety or monitoring issues.

**Shared care arrangements**

Good record keeping is an essential component of any clinical system and will ensure that all members of the team are sighted on the full clinical picture. Practices should ensure that where medicines are prescribed elsewhere, that clinical records are updated in a timely way. Guidance on how to do this is available from NHSE ([Recording medicines prescribed elsewhere into the GP practice record](https://digital.nhs.uk/services/summary-care-records-scr/recording-medicines-prescribed-elsewhere-into-the-gp-practice-record)).

#### **4. Technical**

Technical processes should be in place BEFORE a repeat medication is reauthorised to ensure that routine monitoring and follow up actions are highlighted and completed. Use digital systems to optimise the repeat prescribing process.

The technical element of the repeat prescribing system should include alerts to prescribers to highlight under or over ordering and should ensure that medicines that have been deprescribed cannot inadvertently be restarted without a clinician’s input. Technical optimisation, with respect to repeat prescribing, will ensure that all digital and technical systems are deployed and precious clinical and administrative staff are not carrying out routine tasks that can be safely automated (see [section 8.2](https://www.rpharms.com/resources/repeat-prescribing-toolkit/training-resources#8.2) for SystmOne and EMIS examples).

The technical element of repeat prescribing also highlights the opportunity that wider deployment of technical staff, which may include pharmacy technicians, can offer to ensure that clinical staff resources are used sensibly.

#### **5. Administrative**

Administrative staff play a significant role in the day-to-day operation of the repeat prescribing system. They are at the forefront of managing queries and problems and often have oversight of the whole process. They need time for training in how to manage repeat prescriptions safely as well as a thorough induction of how the practice operates the process. They need to work closely with community pharmacy colleagues.

Support and training are not provided to all administrative staff working on repeat medication and yet this is a high-risk component of their role as well as a high-risk element of the process for the practice.

[Standardised shared care protocols](https://www.england.nhs.uk/medicines-2/regional-medicines-optimisation-committees-advice/shared-care-protocols/) are also available from NHSE.

**Dorset ICB summary repeat prescribing practice self-assessment questions\*:**

\*Action plan template to be submitted to the ICB. Answers provided within the self-assessment tool do not need to be submitted to the ICB. However, please retain responses for CQC records.

**Organisational culture**

**CORE**

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| **Question** | **Response (Optional)** |
| 1. Is there a written policy/standard operating procedure (SOP) to describe the planned process for repeat prescribing and medication reviews in the practice (is it fit for purpose, easy to access and easy to use)? |  |
| 1. Is there training for all staff involved in the repeat prescribing process (administrative and clinical) to ensure they are aware of the policy/SOP and understand the practice/PCN repeat prescribing process? What about locum staff? |  |
| 1. Who in the practice has overall responsibility for the repeat prescribing process? |  |
| 1. Who in the practice has responsibility for the day-to-day running of the repeat prescribing process? |  |
| 1. Is it clear how and who in the practice will deal with an issue, incident or complaint relating to repeat prescriptions? |  |
| 1. Are practice staff clear about the roles and responsibilities of all staff members involved in the repeat prescribing process? |  |
| 1. If any member of staff has a concern about the repeat prescribing process, is it clear how to raise issues and offer solutions, and is that effective? |  |
| 1. Is the repeat prescribing process and how it works (including time associated within the practice and the community pharmacy), clearly communicated to patients and are all patients clear about how they are to engage with it? |  |
| 1. What is the mechanism for the practice to discuss how the current system is working? |  |
| 1. Are SMRs embedded in the culture of the practice and given the space and time required to undertake them? Are patients at higher risk of medicines-related harm prioritised for an SMR? |  |

**Clinical responsibilities**

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| **Question** | **Response (Optional)** |
| 1. When a medicine is moved from acute to repeat, is this decision explicitly recorded with a duration of the repeat documented? |  |
| 1. Is the indication for a repeat medication clearly documented in the GP clinical system? |  |
| 1. How are patients informed about any risks of longer-term use of the medicine(s) and the expected length of the prescription at initiation? Is this clearly documented in the notes? |  |
| 1. Is there a separate process for higher risk repeat medicines (see box 1)? |  |
| 1. How are the responsibilities around repeat medicines communicated to patients (e.g., monitoring requirements, medication reviews and when medicines will **not** be repeated)? |  |
| 1. How can community pharmacies speak to a member of the clinical practice team to ask questions about a repeat prescription from a clinical or safety perspective? Is this working well? |  |
| 1. What systems are in place to monitor over ordering of repeat medicines (especially in relation to medicines with dependence-forming or overdose potential)? |  |
| 1. What processes are in place to identify and manage under ordering of repeat medicines? |  |
| 1. How are re-authorisations/medication reviews/SMRs (see definitions on page 16) incorporated into the repeat prescribing process and what happens if the patient does not participate? |  |
| 1. When medicines are recommended by secondary care, is there a clear and safe clinical authorisation process for discharge letters to be interpreted and medicines clinically authorised for repeat? |  |
| 1. When medicines are stopped, is there a clear process to ensure they are removed from the repeat medicines list? |  |
| 1. Is there a clear process of action for the Practice to respond to national medication alerts such as national patient safety alerts or drug safety alerts that relate to medicines prescribed on repeat? |  |

**Technical**

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| **Question** | **Response (Optional)** |
| 1. What is the process for requests for repeat prescriptions? How many ways can patients request repeats? Is this manageable for the practice? Is it safe and clear to patients? |  |
| 1. How are repeat prescription requests triaged? |  |
| 1. Is there a clear medicine resupply practice policy for support staff, e.g., it is within the medication review date documented on the system or it has a specified number of authorisations that are still within a valid time period? |  |
| 1. How are checks made around monitoring requirements, such as blood tests? |  |
| 1. How does the practice ensure monitoring requirements are adhered to before repeat prescriptions are re-authorised? |  |
| 1. What is the practice’s process if a patient does not engage with monitoring arrangements? How is this communicated to patients? |  |
| 1. How are large scale requests managed (e.g., care homes)? Is this working well? |  |
| 1. How are dose changes that are needed mid prescription-authorisation cycle made, so that the patient receives the new dose, and the clinical notes are updated to prevent older dosing schedules being prescribed inadvertently? |  |
| 1. How does the practice identify and manage over-ordering of medicines (especially those with dependence-forming or overdose potential?) |  |
| 1. How does the practice identify and monitor under ordering? |  |

**Administrative**

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| **Question** | **Response (Optional)** |
| 1. Who in the practice manages the day-to-day administrative duties of the repeat prescription processes? |  |
| 1. Is there a very clear process where all relevant members of the administrative team understand their roles and their limits of what they are authorised to do? |  |
| 1. How are administrative staff trained? |  |
| 1. How are administrative staff supported in their repeat prescription roles? |  |
| 1. Is the process for dealing with queries that do not fit the usual process clear to administrative staff (e.g., ordered too early, essential blood tests not available, patient hasn’t had the medicine for a number of months or over ordering)? |  |
| 1. Are administrative staff aware of the risks of circumventing the agreed practice process to expedite prescription queries? |  |

**Questions for the general practice patient participation group**

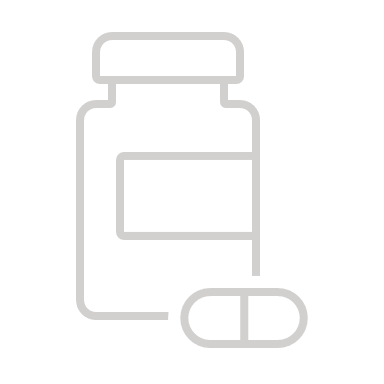
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| **Question** | **Response (Optional)** |
| 1. Do you think the practice repeat prescribing process is clear and understood by most patients registered with this practice? |  |
| 1. Would you describe the process as timely, safe and effective? |  |
| 1. Are there any parts of the repeat prescribing process that patients think could be improved? |  |

**Dispensing practices**

General practices in more rural areas offering a dispensing service should consider the following questions:

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| **Question** | **Response (Optional)** |
| 1. Are there SOPs in place within the dispensary covering the processes for repeat prescribing covering roles, responsibilities and training of staff? |  |
| 1. Is your process for receiving and dispensing repeat prescriptions clear to your patients? |  |
| 1. Is the time for dispensing of repeat medication communicated to patients so they are aware how far in advance to order their next supply? |  |
| 1. Do you encourage patients to use digital solutions such as the NHS app to order and check on repeat prescriptions? |  |
| 1. What support and training are in place for dispensary staff who operate the repeat prescribing system? |  |
| 1. Are all repeat prescriptions signed by the prescribing clinician before they are dispensed. |  |

<https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice/domain-1-knowledge--skills-and-development>



**RCGP/RPS practice / PCN repeat prescribing action plan template, to be submitted to the NHS Dorset medicines value team via:** [**medicine.quaestion@nhsdorset.nhs.uk**](mailto:medicine.quaestion@nhsdorset.nhs.uk)

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| **Action** | **Steps to be taken** | **By whom** | **By when** | **Complete** | **Comments** |
| Organisational culture | | | | | |
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| Clinical responsibilities | | | | | |
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**System issues to highlight to the ICB**

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| **Action** | **Steps to be taken** | **By whom** | **By when** | **Complete** | **Comments** |
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**Pathways issue to discuss with local pharmacies**

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| **Action** | **Steps to be taken** | **By whom** | **By when** | **Complete** | **Comments** |
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1. [↑](#endnote-ref-2)