ROYAL PHARMACEUTICAL SOCIETY

RCGP RPS Repeat Prescribing Toolkit

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Foreword

This resource was commissioned by NHS England to address recommendation 7 of the National Overprescribing Review, which tasked the Royal Pharmaceutical Society (RPS) and Royal College of General Practitioners (RCGP) to develop a toolkit to help practices improve the consistency of repeat prescribing processes and support this with training resources.

The development of the Repeat Prescribing Toolkit was made possible through collaboration with a diverse group including GPs, practice pharmacists, practice managers, reception staff, community pharmacists, pharmacy technicians and patients. This partnership has resulted in a valuable resource that emphasises patient safety and active patient involvement in managing their medicines.

We recognise that primary care teams continue to face many challenges, including increasing demand, frequent medicine shortages and workload pressures. This toolkit helps practices to reassess current processes to streamline systems and services for patients.

Millions of patients in England receive their medicines through repeat prescriptions, ensuring they have access to the medications they need safely and on time. However, findings from the National Overprescribing Review along with patient feedback, highlight concerns about the lack of regular reviews for some users of long-term medicines. In some cases, patients have been exposed to harm due to inadequate monitoring or review of repeat prescriptions.

This Toolkit is the first national good practice guidance on repeat prescribing in 20 years. We welcome the collaboration between the RPS and RCGP to create this important resource.

We encourage all GP practices to work together with their local community pharmacies and to consider if their repeat prescribing systems can be improved in terms of efficiency, safety and patient care. This Toolkit provides a framework to achieve those changes.

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1 Introduction

This toolkit was commissioned and is supported by NHS England as part of the National Overprescribing Review report

1.1 Background

In 2022/23, 1.18 billion prescription items were dispensed in primary care in England, and this number increases every year.[i] The Department of Health and Social Care published the National Overprescribing Review, 'Good for you, good for us, good for everybody' in 2021. This made 20 cross-system recommendations to help reduce overprescribing in England and make patient care better and safer.[ii] Recommendation 7 asked the Royal College of General Practitioners (RCGP) and the Royal Pharmaceutical Society (RPS) to develop a national **toolkit** to help practices improve the consistency, safety and efficiency of repeat prescribing systems, and to support general practice (GP) practice reception and administration teams with training resources. This focus on repeat prescribing is important as repeat prescriptions make up around three quarters of all prescription items dispensed.

In 2023, NHS England (NHSE) commissioned the Royal Pharmaceutical Society (RPS) and the Royal College of General Practitioners (RCGP) to develop this toolkit.

1.1.1 Purpose

Repeat prescribing systems vary between individual general practices and community pharmacies. Dispensing practices will have the additional dispensing component in their repeat prescribing process. The purpose of the toolkit is to set out what should be included within a good GP practice repeat prescribing system.

In recent years, general practices have come together to form primary care networks (PCNs). In many areas, PCNs have streamlined repeat prescribing systems across several practices, but this is not universal. This repeat prescribing toolkit refers to general practice and/or PCNs.

The toolkit focuses on repeat medication only; acute medicines and appliances are not included within the scope of this work.

This toolkit is **NOT** a clinical or prescribing guideline. However, it does identify some higher-risk clinical scenarios that practices or PCNs should pay particular attention to.

The toolkit takes the form of a self-assessment process (see section 7), to enable a practice and/or a PCN to assess their local arrangements against the questions and then discuss and agree as a team where any gaps lie or where improvements can be made.

Practices may wish to undertake a full process-mapping exercise of their repeat prescribing system. Ideally, this will involve the whole team and include patients, carers and colleagues working in community pharmacy who are an essential part of the local repeat prescribing system. This is described further in section 3.

The RCGP/RPS repeat prescribing toolkit was developed with an expert working group of key stakeholders including GPs, pharmacists, pharmacy technicians, practice managers, integrated care board (ICB) medicines leads, patients and third-sector representatives. A summary of the group membership, the approach to this work and guiding principles are provided in annex A.

The scope of the work is set out in annex A, on page 67.

While it will take time to discuss and complete the repeat prescribing self-assessment and address all the actions that come from the discussions, we are hopeful that all practices will engage on some level with the toolkit and self-assessment process to understand where any current risks lie. The self-assessment process is best undertaken with a range of members of the practice team and with input from the local patient participation group (PPG) and community pharmacies. The resulting practice or PCN action plan will then shape the work to be done in the coming months. Practices are encouraged to adopt a quality improvement methodology, and support for this is described in section 3. Practices are encouraged to review recent errors, mistakes, near misses and complaints related to the repeat prescribing process and discover how and why they happened. See section 7 for the self-assessment toolkit.

Practices that have thoroughly assessed and process-mapped their activity have improved the management of their repeat prescribing and become more efficient. For further support and good practice examples, including testimonials from practices and PCNs who have already completed this type of work, see section 3 and section 6.

1.2 Current guidance and research

We conducted a background literature search (see annex B) and identified that between 2013 and 2023, there were a limited number of publications directly related to repeat prescribing processes in the UK. This work also highlighted that there is no contemporary, national guidance to inform good practice in England.

In 2004, the former National Prescribing Centre (NPC) published 'Saving time, helping patients – a good practice guide to quality repeat prescribing' which highlighted key areas of the repeat prescribing process, and suggested a model focussing on areas of production, management and clinical control that many practices adopted.[iii] However, this document was published before electronic repeat dispensing (eRD) or the electronic prescription service (EPS) were widely available.

The importance of a repeat prescribing system has since been described in paragraphs 98–102 of the current General Medical Council (GMC) guidance, 'Good practice in prescribing and managing medicines and devices' and is further iterated in their good practice standards.[iv-v]

The RPS Competency Framework for all Prescribers also advises prescribers to develop governance processes to support safe prescribing, citing repeat medicines as an example of a higher-risk clinical situation.[vi]

The Care Quality Commission Single Assessment Framework (SAF) includes a quality statement related to medicine optimisation, which sets out the safety and legal requirements expected of organisations that prescribe medicines.

In 2017, Price et al described a risk management model that uncovered 62 important safety concerns relating to repeat prescribing systems in 48 general practices.[vii] This important work included locally held educational workshops and an introduction to process mapping of the repeat prescribing process. Integrated care systems (ICS) should consider how this could be deployed locally to support practices in addressing repeat prescribing safety. For more on process mapping, see section 3.

1.3 Repeat prescribing utilisation

Repeat prescriptions can be requested and issued in several ways, but the introduction of the Electronic Prescription Service (EPS) in England has helped to streamline this for both patients and practice staff. In 2022, over 95% of all prescriptions were issued electronically. The NHS Business Services Authority (BSA) EPS and eRD utilisation dashboards provide information on rates of EPS and eRD uptake and help to visualise trends across general practice, within and between Integrated Care Systems and across England.[viii]

Patients can request repeat medication via the NHS app or directly from their practice through an online form or via a community pharmacy app which integrates with the NHS standards. If preferred, there are non-digital routes for patients and carers, including manual paper-based forms. In some areas of the country, hub systems operate where patients may phone a dedicated phoneline manned by trained call handlers. Some community pharmacies also offer a managed repeat prescription service, although such services have been reduced over recent years.

Prescriptions can be dispensed by a local community pharmacy, a dispensing practice or an online/remote pharmacy.

PRESCRIPTION DESTINATION	TOTAL NUMBER OF PRESCRIPTION ITEMS DISPENSED	% OF TOTAL PRESCRIPTION ITEMS DISPENSED
Community pharmacy	89,998,175	86.4%
Dispensing doctor	6,415,836	6.2%
Distance selling pharmacy	6,223,292	6.0%
Personally administered items	510,519	0.5%
Appliance contractor	1,026,752	1.0%
Total	**104,174,574**	**100.0%**

Table 1 shows prescription items in England and where they were dispensed in May 2024, taken from ePACT.[ix] This includes appliance contractors and items prescribed and administered within a practice.

1.4 Patient safety

A key driver behind the development of this repeat prescribing toolkit is to ensure the safety of patients receiving medicines on a repeat prescription. Medication errors can occur at different stages of the repeat prescription process; errors are usually attributed to weak systems or the impact of human factors.[x]

In 2018, the UK Department of Health funded research estimated that 237 million medication errors occur in England per year. While many have little or no potential for harm, 66 million potentially clinically significant errors occur per year and 71% of these are in primary care. Primary care prescribing accounts for 33.9% of all potentially clinically significant errors.[xi]

In 2019, the Care Quality Commission (CQC) published a report looking at common areas of risk in relation to medicines and highlighted the need for improvement in prescribing, monitoring and reviewing medicines.[xii] Case studies have shown where inadequate repeat medication processes can cause a patient harm and, in some instances, lead to patient death.[xiii] This is described further in section 2.

Example of a medication safety incident highlighted by the coroner in a Regulation 28 Prevention of Future Deaths report

In November 2018, a patient was discharged from hospital for a fractured radius. The patient was prescribed **100 mL** of oral morphine sulphate 10 mg/5 mL solution by the hospital for **acute pain relief**.

After discharge from the hospital, in addition to their routine prescriptions, the patient began to receive **300 mL** of oral morphine sulphate 10 mg/5 mL regularly on **repeat** prescription.

This continued, **unchecked** until March 2019.

Shortly after this, the patient died. Toxicology tests carried out as part of the coroner's investigation revealed a fatal level of morphine in their blood.

At the inquest, the GP surgery gave evidence that this should not have happened and that there had been no formal review of this patient between 28 November 2018 and 29 March 2019.

The coroner also raised concern that the local community pharmacy had requested repeat prescriptions without seeking the view of the patient. The coroner requested that consideration be given to providing guidance to all pharmacists in England and Wales that when making a request for a prescription to a GP they should ensure that the wishes of the patient are obtained, save in circumstances where this is not possible such as where the patient lacks capacity.

The RPS guidance on repeat medicines is published here, and the pharmacy alert published following this report is available here. (RPS members only).

1.5 Other contributory factors

In 2023, the Chief Medical Officer's annual report: 'Health in an Ageing Society' highlighted the growing impact of multiple, long-term conditions in older age people (multimorbidity) and the challenges of polypharmacy.[xiv]

Repeat prescribing systems need to adapt to meet the demands of a changing population and developments in the NHS. NHS IT systems and the opportunities provided by a growing number of non-medical prescribers working within primary care can help optimise processes to improve both safety and efficiency, **but** only with careful management, good multidisciplinary teamwork and a detailed, local-level understanding of the risks in current systems.

1.6 Co-production with patients

Listening to patients' experiences and taking the time to reflect on their individual stories is paramount to improving care and their use of medicines. Patient needs are better met when they are involved in an equal relationship, working together. Structured medication reviews provide an important opportunity to listen to and understand any issues, concerns and expectations that patients may have in relation to their medicines.

We would especially like to thank and acknowledge the patients involved in the co-production and design of the repeat prescribing toolkit.

"As a patient taking medicines long term, and along with others, I have been closely included and involved in the preparation of this information from the start through to the final version. Drawing on my experience of many conversations with patients from diverse communities I have done my best to include those views and experiences into these documents so that they help as many people as possible get the most benefit with the least harm from their medicines."

Graham Prestwich – patient representative.

1.7 Equality and impact assessment

We have carried out an equality and health inequalities impact assessment (see annex C) with our analyses and conclusions.

1.8 Roles and responsibilities

A number of different organisations have roles to play for the successful implementation of this repeat prescribing toolkit.

A summary of these suggested roles/ responsibilities is set out below:

NHSE

Promote the use of this tool via the national, regional and local networks, and ensure that PCN clinical directors are aware of its importance and context.

RCGP AND RPS

Promote the importance of this toolkit with their members and highlight the impact it is aiming for, in relation to medication safety.

Ensure links to patient organisations are used to highlight the patient partnership agreement.

ICB

Ensure that local PCNs, GP practices, Local Medical Committees and Local Pharmaceutical Committees are aware of the toolkit and encourage them to engage with and complete the self-assessment.

ICBs could consider incentivising this activity via local prescribing incentive schemes or hold local workshops to ensure PCN and practice teams and local community pharmacies are aware of the context.

PRIMARY CARE NETWORKS

Establish local meetings to work though the self-assessment and ensure that local leads for this work are appointed and supported to lead this work from self-assessment through to action and improvement.

COMMUNITY PHARMACIES

Work with your local GP practices to share local good (and poor) practice and agree what will deliver improvement in repeat prescribing.

PATIENTS AND THE PUBLIC

Be aware that patients are part of the partnership with clinicians that will deliver good outcomes from repeat medicines. Read the patient partnership agreement, only order what you need and order your repeat medicines in a timely way.

2 Medication safety

While the majority (97%) of primary care encounters are safe, recent research highlights that there are between 19,800 and 32,000 incidents of 'probably avoidable' harm in England each year. Of these, 26% are medication related.[xv]

The NHSE Patient Safety Strategy supports local best-practice through a whole-system approach to medicines harm reduction. This is important for repeat prescribing because the repeat prescribing system is managed by a team and not by one individual. A positive safety culture across general practices and pharmacies is important to make the repeat system safer and reduce avoidable harm.

For information on how to build effective teams in general practice, see The King's Fund publication, How to build effective teams in general practice.

In collaboration with the RCGP in Wales, we have developed this helpful resource, Multidisciplinary Team Working in a General Practice Setting, that supports the building of effective multidisciplinary teams in general practice, which is essential for the safe functioning of repeat prescribing systems.

The section below sets out the medication safety risks associated with repeat medicines. We hope that this will prompt a practice or PCN-level discussion about the different types of repeat medication authorisation and review defined here, when they should be deployed and how they should be recorded in the clinical notes.

Particular attention is required to address higher-risk medicines and repeat prescribing scenarios defined in box 1 and to ensure that the appropriate level of medication review is carried out with the appropriate frequency and with the appropriate level of clinical input. The frequency of review will be dictated by the nature of the medicine and dose as well as the patient scenario, such as how well they organise their repeats, if they are taking medicines with abuse potential and how well the patient is aligned with the prescribing and monitoring schedule set out by their prescriber.

BOX 1: HIGHER-RISK MEDICINES AND HIGHER-RISK REPEAT PRESCRIBING SCENARIOS

Practices are advised to discuss and agree safe arrangements for the following higher-risk medicines/situations:

HIGHER RISK BY THERAPEUTIC GROUP

Cardiovascular medicines, such as:

- Medicines affecting the renin-angiotensin system[1]
- Anticoagulants[2, 3]
- Antiplatelets[3]
- Diuretics.[3]

CNS medicines, such as:

- Antidepressants[4]
- Benzodiazepines and other hypnotics[4]
- Gabapentinoids and pregabalin[5]
- Lithium[6]
- Opioids.[4]

All antimicrobial agents (prescribed on repeat)[7]

Immunosuppressants, such as:

- Methotrexate[8]
- Azathioprine[9]
- Leflunomide.[9]

Non-steroidal anti-inflammatory drugs (NSAIDs)[3]

HIGHER-RISK THERAPEUTIC SCENARIOS

- Patients who take 10 or more medicines on repeat, especially those aged 75 and over
- Medicines prescribed in a 'shared-care' arrangement with secondary or specialist care
- Unlicensed, paediatric medicines
- Vulnerable patient groups such as those with learning difficulties and those who are house-bound and reliant on others to order and collect their repeat prescriptions
- Women of childbearing age taking teratogenic medicines[10]
- Medicines for both adults and children that may need dose adjustments based on weight.

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WHEN THINGS GO WRONG

The majority of patients access their repeat medicines safely, with regular reviews to check the ongoing appropriateness of the medication. However, medicines remain a significant cause of harm, and practices will need to consider this as they complete the repeat prescribing toolkit self-assessment.

When things do go wrong, practices and pharmacies are recommended to report patient safety incidents via the Learn from patient safety (LFPSE) reporting system. See the NHSE, Learn from patient safety events (LFPSE) service for more information.

WHERE MEDICINES AND PRESCRIBING ARE HIGHER RISK

In their report in 2019, the Care Quality Commission (CQC) highlighted that, "Some medicines are considered 'high-risk' because of the possible adverse side-effects, so patients require frequent tests (blood or other tests) and reviews, and doses may need to be adjusted to ensure they do not cause harm". Common examples of high-risk medicines included **warfarin, lithium, methotrexate, azathioprine and leflunomide**. Inspection reports gave examples of how providers did not always meet these requirements.[xii]

EXAMPLE FROM CQC INSPECTION REPORT: POOR MONITORING OF HIGH-RISK MEDICINES[xii]

On the inspection of a surgery, we saw that policies did not always match practice. For example, the policy stated that methotrexate (a medicine used to treat a range of conditions, including arthritis) would only be prescribed with regular blood tests. Regular blood tests are important to ensure that patients do not experience side-effects that can result in harm. When inspectors checked records at this practice, they found that blood tests were either not carried out consistently or the results not checked before repeat prescriptions were authorised. Inspectors also found inconsistencies in prescribing three other high-risk medicines, including for one patient who had not had blood tests recorded for 12 months and others who had no blood tests recorded at all.

In 2007, a systematic review looked at which drugs cause preventable admissions to hospital and identified that the majority of preventable drug-related admissions involved **antiplatelets, diuretics, NSAIDs or anticoagulants.**[xvi]

Observational studies have also identified polypharmacy as a key driver of adverse drug reactions causing hospitalisation. Drugs commonly implicated in unplanned hospital admissions in adults included **diuretics, anticoagulants and antiplatelets, proton pump inhibitors, chemotherapeutic agents and antihypertensives.**[xvii]

In addition to particular higher-risk medicines, practices are advised to think about their arrangements for **higher-risk prescribing scenarios for more vulnerable patient groups**, such as:

- Older people taking ten or more medicines
- Repeat prescriptions of unlicensed, paediatric medicines
- Patients with learning difficulties
- Those who are house-bound and reliant on others to order and collect their medicines
- Women of child-bearing age taking teratogenic medicines such as sodium valproate.

2.1 Preventing avoidable harm

Regulation 28, Prevention of Future Deaths (PFD) reports (commonly known as coroners' letters) are issued to an organisation or individuals where the coroner believes that action should be taken to prevent further deaths. Approximately half of all deaths in England and Wales are referred to HM Coroner. Since 1984, it has been a statutory duty to report about deaths with a view to preventing future deaths.[xiii]

In April 2023, a study was published looking at the preventable deaths involving medicines. This work reviewed coroners' reports from 2013–2022.[xviii] One in five coroner-reported, preventable deaths involved medicines. It identified that medicines cause over 1,700 preventable deaths annually in England and of the 704 PFD reports, the most common medicines involved were:

- **Opioids (22%)**
- **Antidepressants (9.7%)**
- **Hypnotics (9.2%).**

Coroners expressed concerns around the major themes of patient safety and communication, including minor themes of monitoring and communication between organisations.

For these reasons, general practice and community pharmacies are asked to ensure that all high-risk medicines and particularly **opioids, antidepressants and hypnotic medicines** are treated very carefully where they are to be prescribed as a repeat medication. The practice, the pharmacy and the patient all need to be clear about the arrangements for ordering and monitoring such medicines as well as frequency of and purpose of a thorough, structured medication review.

Published reports are available via the Courts and Tribunals Judiciary website.

Clear themes in all the reports reviewed include:

- Antidepressants, opioids for chronic, non-cancer pain and benzodiazepines were prescribed 'on repeat' but review of the ongoing need for these high-risk repeat medicines was limited
- Practices were not always aware of how much medicine was being ordered and so patients were able to gain access to large quantities of, and/or request very frequently, these higher-risk repeat medicines relatively easily
- Opioids and antidepressants were prescribed to vulnerable patients where the risk of intentional or unintentional overdose was high.

Practices are asked to think carefully about their arrangements for repeat prescribing of these classes of medicines when they complete the repeat prescribing self-assessment.

Patients should be afforded regular and very careful review of their medicines and the decision to repeat prescribe these high-risk medicines may need to be considered on an individual basis. Some patients may benefit from a written agreement with the practice to help support safety, and a clear review timeline, e.g., three monthly.

Practices and local pharmacies are encouraged to discuss and agree how concerns about suspected over ordering of these medicines (especially for vulnerable people) are to be communicated and how these concerns will be acted upon.

To help PCNs to assess the consistency of their opioid prescribing, the Health Innovation Wessex opioid checklist for PCNs is included in section 6, good practice examples.

THE RISK OF NOT SUPPLYING

Sadly, there have also been reports of deaths caused when rigid adherence to an agreed repeat medicine process has led to patients being unable to access their highly essential medicines; practices will wish to consider how teams will assess and respond to individual requests for high risk, highly essential medicines, to ensure that the risk of not supplying is balanced against the risk of on-going supply.

2.2 Antimicrobials on repeat prescription

Antimicrobial resistance (AMR) currently poses one of the biggest threats to healthcare as we know it. Overuse of antibiotics drives AMR, which is associated with over 35,000 deaths each year in the United Kingdom.[xix] The cost impact of avoidable antibiotic exposure for respiratory tract infection in primary care in the UK, due to adverse events and re-consultations, has been estimated at £238 million annually.[xx]

In general practices in England, 10% of antibiotics are prescribed for 0.5% of registered patients, equating to 10 or more prescriptions per year for this vulnerable patient cohort experiencing recurrent infection.[xxi]

Prescribing data indicate large variations across general practices in England in the proportion of patients repeatedly exposed to antibiotics, indicating a potential opportunity for improvement. Evidence-based resources for healthcare professionals have been developed to facilitate structured medication reviews (SMR) with patients to promote interventions to reduce future risk of recurrent infection.

Antimicrobials need to be thought of as high-risk medicines in relation to being repeated. Repeated courses of antibiotics, although common practice, may have limited benefit and can increase the risk of:

- Antimicrobial resistance
- Hospitalisation.

Research from the University of Manchester showed that patients who have had nine or more antibiotic prescriptions for common infections in the previous three years are 2.26 times more likely to go to hospital with another infection in three or more months.[xxii]

Older patients and those with multiple long-term conditions and morbidities are at a higher risk of repeat antimicrobial prescribing. Chronic obstructive pulmonary disease and urinary tract infections have been highlighted as the most common conditions linked to repeat antimicrobial prescribing.[xxiii] Patients who do have a clinical need for the long-term use of an antimicrobial should have a clear indication for this in their notes and their ongoing need for the antimicrobial thoroughly assessed on a regular basis. For example, the NICE guideline for recurrent urinary tract infection recommends a 6-monthly review of the ongoing need for the antimicrobial.

Practices are asked to think carefully about their arrangements for repeat prescribing of antibiotics and ensure a clear indication is recorded in the notes where ongoing supply is deemed appropriate, with a specified review date.

The RCGP have produced the Target Toolkit Hub to support more responsible use of antimicrobials.

Good-practice examples in relation to antimicrobial prescribing are included in section 6.

2.3 Multiple medicines (polypharmacy)

Over a million people in England receive 10 or more medicines on repeat prescription.[xxiv] Evidence shows that up to 16.5% of admissions to hospital can be caused by adverse drug reactions (ADR) with polypharmacy and multimorbidity important factors contributing to this. Reducing inappropriate polypharmacy should be a major aim for preventing ADR.[xvii]

The RPS has previously produced guidance on polypharmacy.

When a new medicine is prescribed for a person already taking other medicines on repeat, a thorough check is needed to ensure any side effects, interactions and contra-indications have been considered. There are digital solutions to help with this in the GP clinical record system, but they can be overlooked. General practices and/or PCNs are encouraged to discuss how these warning and alert systems are used, including those suggesting over or under use of repeat medicines. This is convered in the self assessment questions.

Practices are advised to make use of the nationally commissioned new medicines service (NMS) from their local community pharmacies.

An SMR, defined on page 17 is the best tested intervention to reduce polypharmacy. Practices and PCNs should have systems in place to identify patients taking multiple medicines, and high-risk repeat medication, and have a process to invite them for a structured medication review with a healthcare professional. It is vital that shared decision making is incorporated into the SMR to ensure that patients are fully engaged with the process and are able to express any issues, concerns and expectations related to their medicines.

See section 5.3 for evidence-based materials, available in a range of languages, to help to engage patients with the SMR process. These materials have been co-designed with patients and have been shown to increase the uptake of SMRs and reduce the number of patients who do not attend their SMR.

2.4 Medication reviews

Millions of people have the experience of receiving a repeat medication, and each year they receive a form of medication review to check that their repeat medication(s) are still appropriate and safe. However, some patients have reported that they don't have **any** checks to their repeat medication and this, rightly, worries them. In addition, there is still much confusion, even in primary care about the term 'medication review' and exactly what this should comprise. The generic term 'medication review' means different things to different people – for example, must the patient be present, how often should they happen, how detailed should it be, how long should be allocated for the appointment?

To try to address this, we have built on existing definitions and set out three broad terms for the different levels of medication review and how we think they should happen.

SIMPLE REPEAT MEDICATION CHECK (CLINICAL RE-AUTHORISATION)

- A check that the medication(s) for a single condition (e.g., asthma) or multiple allied conditions (e.g., cardiovascular diseases) were clinically checked and authorised as suitable repeat medication(s), and for how long
- The medication(s) would have ideally been clinically checked within a patient consultation or via a desktop review
- The authorisation for each medication should be either time-limited by setting the date of the next authorisation (e.g., a maximum of 12 months) or limited by the number of repeats allowed. The quantity of medication should be synchronised with the number of days issued (e.g., 56 tablets if prescribed one tablet twice a day and on a 28-day cycle) or made clear it is for use as required (e.g., 60 sachets for PRN use if repeat medication is needed)
- This review should be clearly visible within the repeat medication section of the clinical record system.

MEDICATION REVIEW

- A holistic, clinical review of all medications for all of a patient's conditions, ensuring any long-term condition/ Quality and Outcomes Frameworks (QOF) reviews and/or relevant blood tests for safe prescribing have been undertaken or are scheduled at the required intervals
- This can be undertaken as desk-based review but ideally should be face to face or via a telephone or video consultation
- All the repeat medication should be time-limited by setting the date of the next repeat authorisation or limited by setting the number of repeats allowed
- The review should be clearly visible within the repeat medication section of the clinical record system and ideally all authorisation durations should be synchronised to coincide with the next medication review
- A systematized nomenclature of medicine clinical terms (SNOMED CT/read code) for a medication review should be recorded in the clinical record and include a clear date when the next medication review is due.

STRUCTURED MEDICATION REVIEW (SMR)

- An SMR is defined by NICE as a critical examination of a patient's medicines with the objective of reaching an agreement with the patient (or their carer) as part of a shared decision-making process about treatment, optimising the impact of medicines, minimising the number of medication-related problems and reducing waste[xxv]
- Ideally an SMR should be undertaken face to face with the patient but can be via telephone or video call
- All the repeat medication should be time-limited by setting the date of the next repeat authorisation or limited by setting the number of repeats allowed
- This review should be visible within the repeat medication section of the clinical record system and ideally all authorisation durations should be synchronised to coincide with the next medication review
- A SNOMED CT (read code) for a structured medication review should be recorded in the clinical record allowing visibility for all and including a clear date when the next SMR is due (SNOMED code 1239511000000100 SystmOne Read Code Y282b).

2.5 Suggested questions for practices to consider in relation to higher-risk medicines or higher-risk patient scenarios

HIGHER-RISK REPEAT MEDICINES

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)
2. How is the repeat process for higher-risk medicines managed? Is it different to that for lower-risk medicines?
3. 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?
4. 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?
5. 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?
6. 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?
7. 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

8. Is there a practice process to identify and monitor patients taking high-risk medicines on repeat?
9. 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)?

3 Process mapping – how to understand the repeat prescribing system

There are many benefits of a robust repeat prescribing system.[iii]

BENEFITS TO PATIENTS AND CARERS:

- The process is convenient, and patients can access the medicines they need in a timely manner
- There is a clear understanding and appreciation of the process
- Patients have confidence that they are receiving their medicines safely
- Patients are familiar with the purpose and importance of having a regular medication review and take the opportunity to share any issues, concerns and expectations related to their repeat medicines
- Patients are familiar with the purpose and importance of attending the practice for any required monitoring related to their repeat medication
- Patients are involved in decisions about their medicines and their care.

BENEFITS TO PRACTICES:

- More streamlined, manageable workloads
- Reduced 'failure demand' through fewer queries and anomalous situations*
- Risks and safety issues can be better mitigated or managed
- More appropriate and efficient use of professional and practice staff time and skills
- Greater understanding of the process by everyone involved, including roles and responsibilities
- Improved communication and working relationships with other healthcare professionals, e.g. community pharmacy
- Easier implementation of other initiatives which can further reduce work burden and improve quality of care, e.g. eRD (see section 9)
- Reassurance and confidence for prescribers that the processes behind their clinical responsibilities are well organised and robust.

*Failure demand is the demand caused by a failure to do something or to do something right for the customer.[xxvi] In a healthcare setting, failure demand describes the failure to get it right for the patient first time. Patients then come back, making further demands to resolve the issue and thereby unnecessarily consuming practice or community pharmacy resources because the service they received was ineffective.

BENEFITS TO THE WIDER NHS:

- Assurance that medicines are used in a safe, effective and appropriate manner
- More efficient use of resources (including workforce) within the NHS
- Reduced medicines waste
- Reduced potential for adverse incidents and harm to patients
- Reduced potential for abuse of the repeat prescribing system.

Process mapping is a technique to visually map workflows and processes. It is a useful tool to enable practices to understand their own repeat prescribing process, which can be made of many separate procedures happening at the same time.

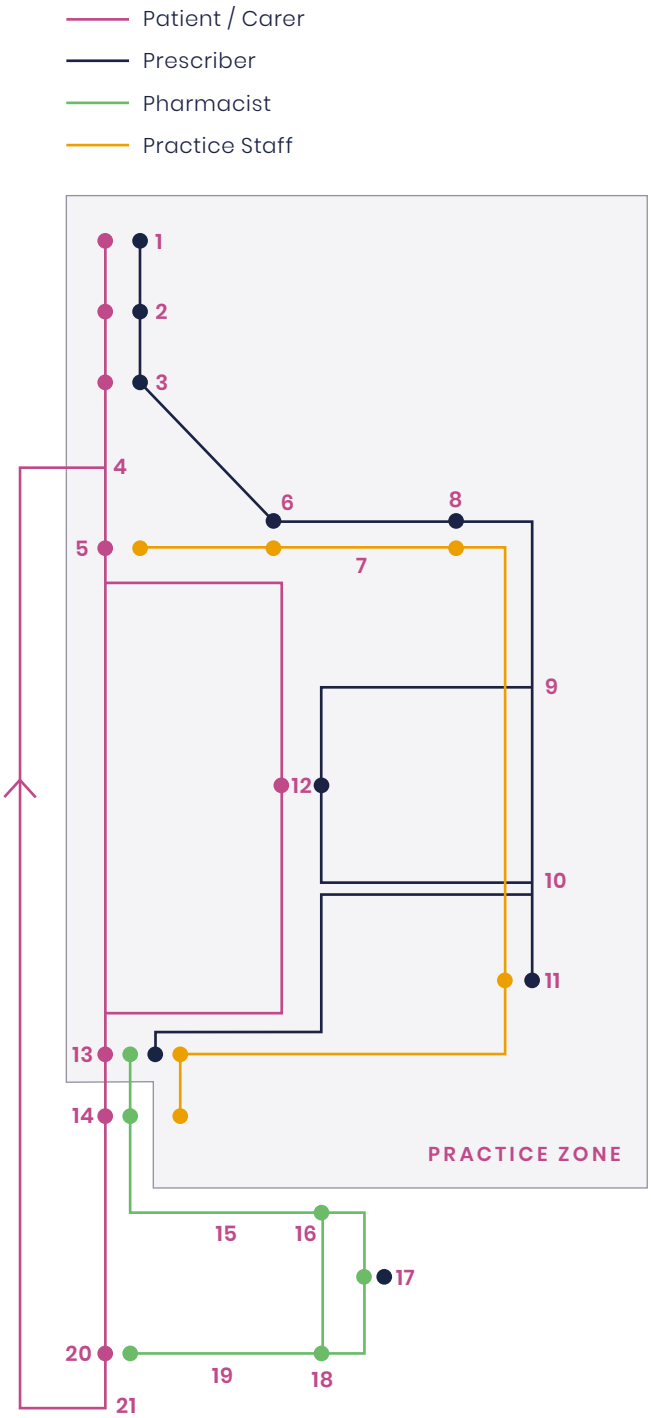
This concept was defined nationally in the 2004 National Prescribing Centre guidance and included a **generalised** repeat prescribing process map, illustrated in Figure 1.[iii] This resembles an underground rail network with a station marking each step, and some stations are common to different lines. This process map was published before the EPS or eRD were introduced.

It is important that each practice maps out their own local processes and overall system, ideally using protected learning time to do this as a collective group, with all members of the practice team represented and engaged – clinical, administrative and technical. Figure 2 shows some of the steps you may wish to include.

WHEN UNDERTAKING PROCESS MAPPING, IT IS IMPORTANT TO IDENTIFY:

- Steps that are working well and you want to keep
- Steps that are not adding value (or not improving safety) as these could be designed out of the new process
- Steps that could work better with a better process design. These could improve efficiency, safety or just make things simpler
- Where there are gaps in the process
- How escalation routes work, e.g., if requests need to move to a clinician
- Where a digital solution or clinical system functionality can be used to automate or simplify the step process
- Which role in the practice has the responsibility for completing each step, and consider if that is the most appropriate role.

A MAP OF THE MAIN ELEMENTS OF THE REPEAT PRESCRIBING PROCESS



1 Patient sees prescriber
2 Need for repeat medication identified
3 Repeat medication authorised
4 Patient decides to reorder medication
5 Request for repeat submitted
6 Check whether repeat allowable (administrative check)
7 Prescription produced
8 Prescription presented for signature
9 Check whether repeat appropriate
10 Prescription signed
11 Prescription returned to practice staff
12 Medication review, and prescription issued / given to patient (if prescription not given to patient, it is then returned to practice staff)
13 Prescription collected / given to patient or representative
14 Prescription received by pharmacy
15 Professional check
16 Patient medication record checked
17 Prescription checked with prescriber / prescriber records — as necessary
18 Items dispensed / accuracy check
19 Medication put out for collection
20 Medication received by patient
21 Medication used

Practice Zone — quality assurance

Figure 1 – NPC. 'Saving time, helping patients – a good practice guide to quality repeat prescribing' 2004 (archived) (reproduced with permission from NICE).

3.1 Process-mapping case studies

These case studies, available on the NHSE website (general practice case studies) showcase where process mapping and redesign have improved efficiency, reduced clinician and practice team time spent on repeats and improved patient satisfaction and safety.

CASE STUDY SUMMARY – 168 GP APPOINTMENTS RELEASED A MONTH AFTER REDESIGNING THE REPEAT PRESCRIPTION AND MEDICATION REVIEW PROCESS

A practice in Staffordshire with a patient population of over 11,800 carried out a process-mapping exercise of the different steps it took for the practice to deal with medication requests and reviews. They involved the whole practice team to ensure accurate and complete input.

Understanding where time was wasted and identifying issues with the current repeat prescribing processes helped get all staff on board to support the changes for improvement that the group put forward. All the staff engaged in understanding the problems with the current processes and proposed solutions. Patients were engaged and involved in the process.

KEY IMPACTS:

Over 28 hours of GP time released per month.

42 hours of reception team's time released per month.

Patients benefited from a streamlined approach for medication reviews, better availability of appointments and improved patient experience.

CASE STUDY SUMMARY – DISPENSARY AND ADMINISTRATION/RECEPTION TEAMS WORKING TOGETHER TO RELEASE 55 HOURS PER WEEK

A practice in Surrey working across two sites, including a dispensary, were struggling with high repeat prescription demand, and wanted to develop a more efficient process to release staff time.

Both site teams listed all the tasks involved in their repeat prescribing process and the essential steps that were frequently not completed. 35% of dispensary tasks were missed, this included tasks relating to controlled drugs. 39% of administrative/reception jobs were missed, e.g., booking appointments for patients that need a medication review. The heavy workload meant the team were in reactive mode and unable to plan a better approach.

By completing a skills matrix of current staff, this highlighted where standard operating procedures (SOPs) needed to be updated. Process mapping helped the team to objectively query every step to identify waste and value/non-value-adding work. Following testing, the teams reported back positively on the new process and the changes made.

KEY IMPACTS:

Approximately 11 hours per day of dispensary and admin/reception teams' time was released across both sites.

Time released is improving the service provided at the dispensary, including more time for face-to-face contact with patients, staff training and supervision.

The admin/reception team are now more able to work on patient and practice operational improvements including staff training, patient education and signposting.

Patients feel reassured, supported and better informed.

CASE STUDY SUMMARY – RE-DESIGNING THE ANNUAL PATIENT REVIEW PROCESS

Two practices came together under a single organisation to redesign the annual medication review process and deliver a common approach across both sites.

Staff did not have a clear understanding of the process from start to finish. Reviews took place on an ad hoc basis, often initiated/requested by the clinicians. There was a significant lack of clarity regarding responsibilities and poor communication. Clinicians were unsure of the reception team's role in the process and vice versa.

They used what was currently working well for each team along with ideas of different and more efficient ways of working and incorporated them into the new process. At every stage, there was discussion and consultation with the wider practice teams and staff were given the opportunity to feedback and contribute to the changes being considered.

A single review process is now operating across both sites.

KEY IMPACTS:

On course to achieve collective goal of over 3,100 reviews per year, leading to better patient monitoring.

Collaboration has improved understanding of others' roles and responsibilities and enhanced further joint working.

Patients are receiving a more proactive service and saving time by scheduling all relevant review appointments during one medication review appointment.

3.2 Process-mapping resources

The NHS has useful resources to support process mapping and the Primary and Community Transformation and Improvement team, which was introduced as part of the delivery plan for recovering access to primary care, can provide tailored support for practices to make changes and improvements to how they work.

Their website includes webinars, guides and other support.

The Primary Care Improvement Connect Future NHS Platform also contains a wealth of resources to support practices with quality improvement methodology and case studies.

Practical actions that general practices might consider include:

- Completing a skills matrix to map out current skills, strengths and weaknesses in the team – an example skills matrix template can be found on the improvement team website to help understand who in the team is trained to manage prescription requests and identify where further training is required
- Align patient medication review dates
- Introduce eRD where it is clinically appropriate. Benefits are particularly seen for those patients with stable conditions and medications, e.g., levothyroxine, and their medication review can be aligned to long-term condition checks. For more information on eRD, see section 9
- Work closely with local pharmacies around changes being undertaken (reducing unnecessary calls, emails, etc.)
- Seek the views of your patients via the PPG. See questions for the PPG in section 5.4.
- For patients who choose not to use the NHS app to manage their medications, look to optimise other digital channels (e.g., practice websites) to improve their ordering experience and streamline their requests in an appropriate workflow (recognising that digital solutions will not be suitable for all patients)

- Practices should discuss their arrangements for the minority of patients who are unable to use the usual repeat prescription ordering arrangements. This may be because they cannot access or use the NHS app (or other digital ordering arrangements) or because of chaotic lifestyle arrangements such as those caused when a person is homeless. Practices could consider assigning responsibility for managing these patients to a care co-ordinator (or similar) so that the arrangements support the patient and are efficient for the practice team
- Review the practice process for urgent repeat prescription requests and the reconciliation process if a request for a repeat medicine has been managed via NHS 111. See section 9.5 for emergency supply requests.

PCNs provide an opportunity for constituent practices to collaborate in a wide variety of ways, including reviewing, developing and sharing repeat prescribing protocols to support more consistent arrangements.

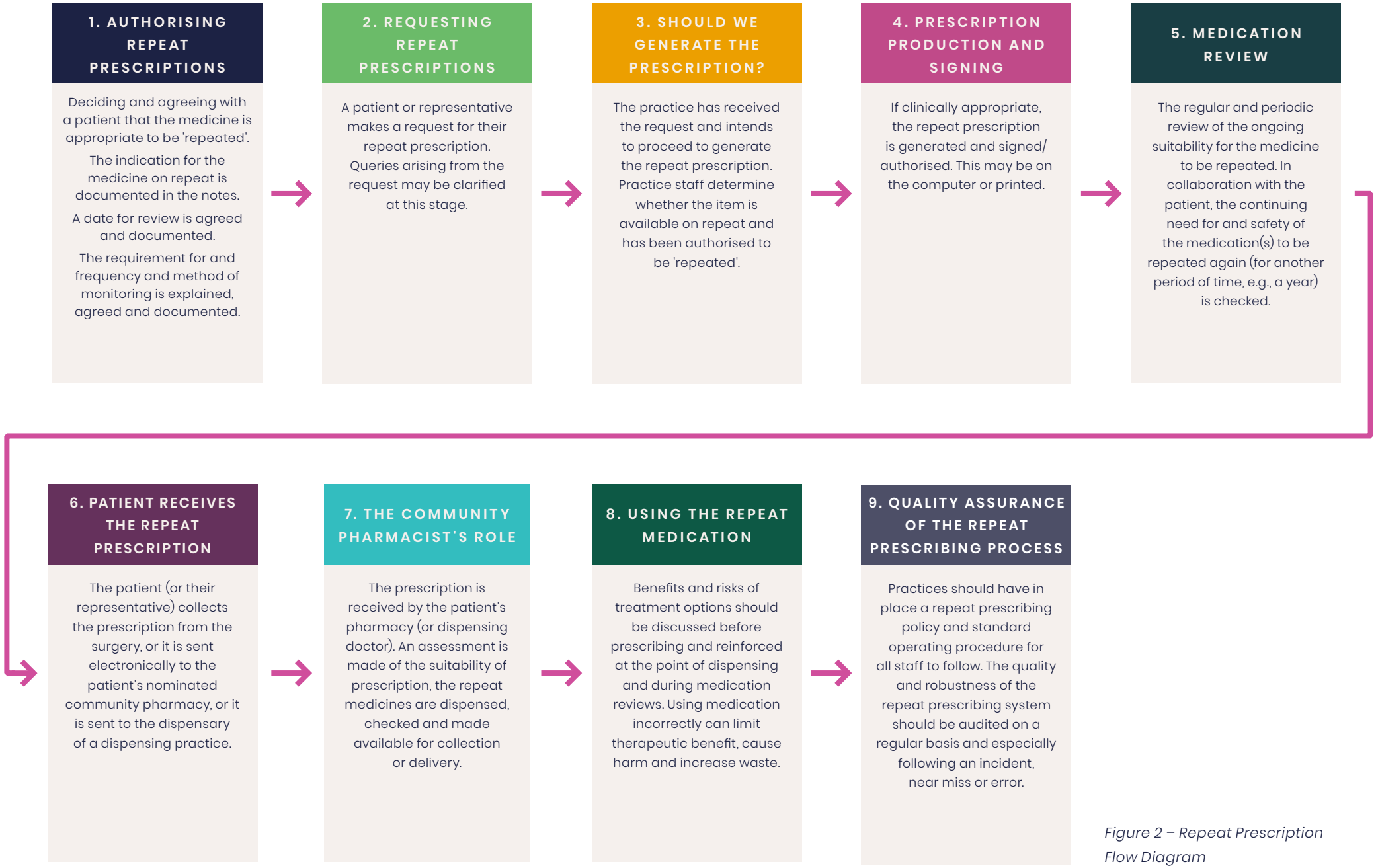


Figure 2 – Repeat Prescription Flow Diagram

4 Elements of an effective repeat prescribing system

The working group agreed that the repeat prescribing toolkit should centre around five key elements. These elements are vital to the safe and effective running of a repeat prescribing toolkit.

THE 5 ELEMENTS OF REPEAT PRESCRIBING

PATIENT / CARER

Area of the process where patients /carers fulfill 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 authorization.

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

ORGANISATIONAL CULTURE

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.

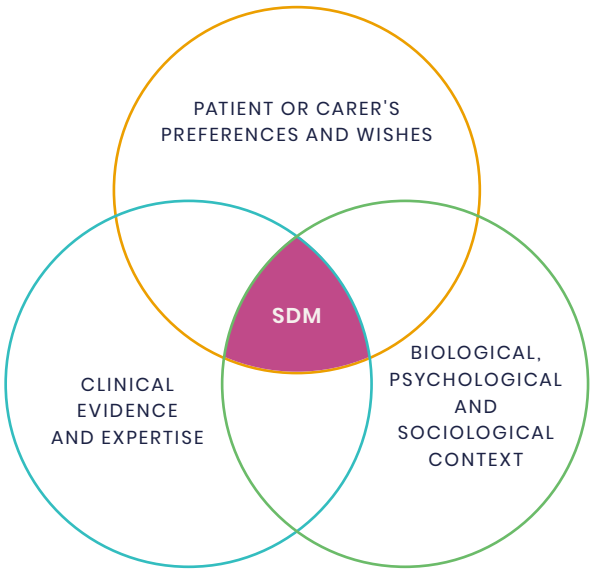
Figure 3: An outline of the five key elements of a general practice repeat prescribing process

For a detailed explanation of each of the five elements and the repeat prescribing self-assessment questions, see section 7.

5 The repeat prescribing patient partnership agreement

Many patients take medicines as repeat prescriptions to help manage their long-term conditions. But it is not uncommon for patients to express their confusion about what all the medicines are for, when they are supposed to take them and their concerns about taking medicines for long periods of time.

The prescribing and taking of medicines should be seen as a partnership between the healthcare professional and the individual; both bringing their relevant expertise and experience and agreeing the right way forward together – shared decision making (SDM).



Safe and effective healthcare is achieved through partnership between healthcare professionals and patients. The World Health Organisation encourages patients to be more actively involved in their own healthcare and use of medicines. They have a useful infographic for patients outlining the five moments for medication safety.

5.1 The NHS Constitution

To promote a good partnership between healthcare professionals and patients, it is important to recognise that patients can make a positive contribution to their own and their family's health and wellbeing. To help patients and healthcare professionals work together, the NHS Constitution says:

"Please recognise that you can make a significant contribution to your own, and your family's, good health and wellbeing, and take personal responsibility for it.

Please provide accurate information about your health condition and status.

Please follow the course of treatment which you have agreed and talk to your clinician if you find this difficult."

5.2 Supporting patients and their carers*

Prescribers and patients need to work together through shared decision-making to ensure that patients receive the right medicines for them and are engaged in the repeat prescribing process.

Below are key expectations to support patients in taking their medicines:

- Patients (or their carer, where appropriate) are at the centre of their care, especially in relation to the medicines they are prescribed
- Through shared decision-making, the benefits and risks of repeat medication need to be clearly understood
- Patients are encouraged to share what is important to them in relation to their repeat medication
- As a key partner in their healthcare, patients are supported and encouraged to take ownership and responsibility for their repeat medication. This includes the timely and safe ordering, collecting, storing and taking of medicines as prescribed
- Prescribers should confirm a patient's understanding of, and reason for taking a repeat medication and discuss any concerns and expectations
- Pharmacies (and dispensing doctors) supplying medicines to patients should do so safely and ensure that key messages around how to use the medicines safely are communicated in a way that the patient understands
- Patients are encouraged to share with their prescriber if they are not taking any of their repeat medication as intended and their reasons for that.

*Where a patient is unable to take responsibility for their medicines, it is assumed that this responsibility passes to their carer.

5.3 Useful resources

The following materials have been designed with patients and tested in primary care in England. They have been shown to help patients engage in their repeat prescribing and make the most of their structured medication review:

- I Manage My Meds
- Me and My Medicines
- Resources to support patients having a structured medication review
- Are your Medicines Working for You?

5.4 QUESTIONS FOR THE GENERAL PRACTICE PATIENT PARTICIPATION GROUP

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

5.5 Resources to help patients to understand the repeat prescribing process

The following patient partnership agreement and the patient information leaflet have been designed with patients to help GP practices and community pharmacies ensure that more patients understand the repeat prescribing process and their own roles and responsibilities within it.

WHAT CAN YOU EXPECT FROM YOUR NHS REPEAT PRESCRIBING SYSTEM?

Your prescriber

When your prescriber (e.g., GP, pharmacist or nurse) authorises that your medicine(s) can be repeated, they will set out how often you can have the medicines (e.g., monthly or every two months) and for how long (e.g., up to a year). After this time, you should receive a notification for a medication review to check how you are getting on with the medicines, if they are working for you and if you need to continue to take them.

See the Health Innovation Network's information on how to support patients having a structured medication review, which includes a helpful animation.

The practice will explain the repeat prescribing process to you and their preferred way for you to order your repeats, e.g., via the NHS app.

Your request for repeat medication will be processed carefully by the GP practice. This involves a clinician authorising that the medicine(s) is still appropriate and safe for you to take and can be re-issued. This process can take a few days to complete. If there is a query, they will contact you for more information.

See repeat prescribing flow diagram.

Your community pharmacy (or dispensing doctor)

Once your prescription has been authorised, you can either collect it or it will be digitally transferred to your nominated community pharmacy. This is known as the electronic prescription service (EPS).

If you receive your medicines from a dispensing practice, they will send the prescription directly to the dispensary.

It will take the pharmacy or dispensary time (which could be a number of days) to order your medicine(s), check that it is safe for you to take and then dispense your medicine(s) ready for you to collect.

You may be eligible for electronic repeat dispensing (eRD) where the prescription can be authorised for up to a year, enabling you to collect it from the pharmacy without ordering from the practice.

For more information, see this helpful animation.

WHAT ARE YOUR RESPONSIBILITIES TO ENSURE YOU GET YOUR REPEAT MEDICATION SAFELY?

You

Please order your medicine(s) in plenty of time to allow the GP and pharmacy to check, authorise and dispense your medicine(s) BEFORE you run out.

Please DO NOT over order medicines. Your GP practice can check the quantity of medicines that you have ordered. Over ordering is unsafe, costs more money and can result in medicine shortages. Only order what you need. See the NHS Dorset website for more information on medicines waste.

Please check your medicines as soon as you receive them to ensure you have exactly what you expected. If you have any questions or concerns, please ask. See I Manage My Meds for help and support.

Please tell your pharmacist or GP if there are any medicines you are no longer taking, or if you are taking any new over-the-counter medicines or medicines prescribed from the hospital or privately.

Please do not reorder any medicines that you have agreed to stop taking.

Some medicines require regular monitoring. This might be in the form of a regular blood test or more frequent medication reviews. If you need blood tests, please follow local guidance, and book your tests as often as is necessary. **These tests are vital to ensure that the medicine is safe for you to have on repeat.**

Most patients will be invited to take part in an **annual medication review** or **structured medication review**. This is to help ensure you still require and benefit from your medicines and to give you the opportunity to discuss with your doctor, pharmacist or nurse if you have any questions or concerns in relation to your medicines.

Medication reviews are required to keep you safe and to allow you the opportunity to speak to your doctor or pharmacist or nurse about anything you are worried or confused about.

Failure to participate in your medication review may mean that it is no longer safe for your practice to authorise your medicine(s). This could result in your prescription not being reissued until a review has been completed and it is safe to prescribe.

In certain situations, there are emergency supply routes for repeat prescriptions. Please only use these as a last resort. Abuse of such systems can present a risk to medication safety and causes increased workload for the NHS.

PLEASE return all unused medicines to the pharmacy to be disposed of safely.

Please treat all GP practice and pharmacy staff with respect. They are working hard to ensure your medicines get to you safely and on time.

An example/template patient information leaflet that practices may wish to use is included below.

THE REPEAT PRESCRIPTION REQUEST AND AUTHORISATION PROCESS – PATIENT INFORMATION (PRACTICE TO COMPLETE)

What is a repeat prescription?

Some medicines may be required to be taken on an ongoing basis to help manage your long-term condition. This is a repeat prescription.

Usually, one- or two-months' supply can be issued on a prescription and be repeated over a timeframe agreed with you before you may need another appointment or medication review.

Some medicines require closer monitoring or blood tests between appointments to make sure the medicine or the dose is effective and safe for you.

Some medicines are not issued on repeat because they require more regular reviews. Examples include strong pain killers or sleeping tablets. Your prescribing healthcare professional will discuss this with you on an individual basis.

How do I request a repeat prescription?

Ways to request your repeat medication include:

a. **Via the NHS app or NHS website – this is the fastest route as it goes straight to the practice inbox**
b. **Online via our website**
c. **In person – request forms are usually available in reception.**

Usually, requests **cannot** be taken over the telephone (to avoid errors being made).

We may ask you to nominate a preferred pharmacy for your prescription to be sent to electronically. This is known as your 'nominated community pharmacy'. If you are registered at a dispensing practice, the prescription will be printed in the dispensary.

How long will it take for my prescription request to be processed?

We aim to process your prescription request within (X) working days.

This is due to the large number of requests we receive daily, and because there are several steps involved in ensuring the prescription request is safe to be authorised.

The prescription is then usually sent electronically to your chosen pharmacy or can be printed and collected. There is the option to track your prescription request using the NHS app or website.

Please be aware at particularly busy times of year, for example, around bank holidays, you will need to order earlier than usual to receive your prescription on time.

There may be delays from time to time, but we always do our best to ensure you receive your medicines safely and on time.

HOW DO REPEAT PRESCRIPTIONS WORK?

1. REQUEST

At your home, check your regular medication(s). If you have less than 10-14 days left, order a repeat prescription now:

- On the NHS App or NHS website (this is the fastest and simplest way)
- Via your GP surgery website
- In person, by completing a form at your GP surgery.

Your GP surgery may offer other ways to order medication.

Check with them which options are available.

2. REVIEW

At your GP surgery, they will always review requests, to check any medication and dose is right for you.

A member of the GP surgery team will contact you if they have any queries, e.g., if you need a blood test or review, or if there is a reason they cannot give you your medication.

Then, after your prescription is signed, it's sent to your pharmacy – or, if your GP surgery usually dispenses your prescriptions, it will be passed to them.

3. PROCESS

At the pharmacy, the pharmacist always aims to process your prescription within 24-48 hours, but this can vary at times.

Your pharmacist will also check your prescription to ensure it is correct, and contact the GP surgery if they have any queries.

Medications sometimes need to be ordered specially, but once in stock your pharmacist will dispense it, check it and bag it.

4. READY!

When your medicines are ready, your pharmacist will text you or use the NHS App to let you know. Ask your pharmacist which method(s) they prefer.

When you collect your medicines, your pharmacist might ask you how you're getting on, or give you messages from your GP, e.g., a reminder about a blood test.

There may be delays from time to time, but we do our best to ensure you receive your medicines safely and on time.

Urgent requests

Please try not to run out of your medicines. When you are running low, e.g., have two weeks' supply remaining, please request the next prescription.

If you accidentally run low or run out, we will try to process your request as quickly as possible, but please remember that the request process must be carried out thoroughly and safely and that GP practice teams are extremely busy.

Emergency supply requests for medicine can be requested from NHS 111 or 111 Online in an urgent situation. The pharmacy will check the GP record/National Care Record to ensure that they are not making duplicate supplies to ensure your safety and reduce waste.

What is a medication review and a structured medication review?

A medication review is usually arranged annually, sometimes more frequently, depending on the medication or condition being treated. A structured medication review is a more in-depth discussion between you and a GP or pharmacist. It is an opportunity to understand how you are managing with your medicines and for you to share any worries or concerns you may have. See the Health Innovation Network's helpful animation.

Medication reviews are important, even if you have been taking the same medication for a very long time. The medication review enables you to raise any questions or concerns you have with your prescriber. It is the opportunity to discuss the benefits and any unwanted effects of your medicines to ensure you are getting the best possible treatment.

Some medicines require tests to be carried out **before** your medicines can be safely re-authorised to you. For example, blood tests or blood pressure checks. If you have been asked to have any regular tests or monitoring, please book in for this **before** your medication review.

Messages on your prescriptions

Sometimes we will communicate with you via your prescription. For example, we may give you a reminder about forthcoming blood tests.

When you collect your prescription, the pharmacy will mention this. You can always ask your pharmacist to check for any messages that may have been sent with your prescription.

What is electronic repeat dispensing (eRD)?

Patients who are stable on their medication and up to date with blood tests or monitoring could have their prescription on an electronic repeat, called eRD.

eRD allows your GP or healthcare professional to authorise up to a year's supply of your repeat medication. You can collect your prescription every month or every two months from the pharmacy without having to order it. eRD is reliable, secure and confidential. Your regular prescriptions are stored securely on the NHS database, so they'll be ready at the pharmacy each time you need them.

Please speak to your healthcare professional during your next routine consultation or talk to your pharmacist about whether you might be eligible for eRD.

The NHS Business Services Authority has more eRD information for patients.

How to avoid unnecessary medicines waste

Please do not over order your medication. Once issued by your pharmacy or dispensary, medication cannot be reused and will always be destroyed when returned to the pharmacy.

If we notice you are ordering medicines too frequently, we may advise that you have a medication review and stop further prescriptions until we have spoken to you.

See the NHS Dorset website for more information on medicines waste.

IMPORTANT

All prescription-only medicines have been carefully assessed for their safety before they were licensed to be prescribed. Your prescriber and your pharmacy team will check if the medicines prescribed are safe for YOU. It is NOT safe to share your prescription-only medicines with friends, family members or colleagues.

DO NOT SHARE your prescription medicine(s). According to the Medicines and Healthcare Products Regulation Authority, anyone who shares their prescription medicines, even with a family member, is breaking the law.

The Medicines Act 1968 specifies that prescription drugs should only be supplied to the individual for whom they were prescribed.

6 Good practice examples and tools

As part of the toolkit development process, the RPS and RCGP asked our networks to submit examples of repeat prescribing good practice. In this section, we set out a number of these example to showcase how primary care teams have improved their repeat prescribing systems.

6.1 Example: Repeat medicines monitoring

Using the skill-mix across the PCN team and the searches available in it the GP clinical system, Symphony Healthcare has created a scorecard to provide a snapshot of performance across multiple indicators including high-risk medicines monitoring. A standard operating procedure for recalling patients has been developed.

This supports an approach of proactively notifying patients when monitoring tests are due and reactively reminding them when issuing prescriptions.

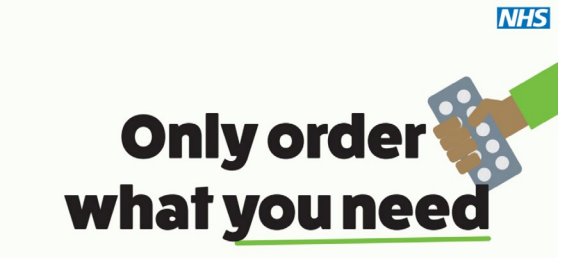
6.2 Example: Reducing waste and improving environmental sustainability

ICB MEDICINES WASTE CAMPAIGN

Medicines use accounts for 25% of the NHS' carbon footprint. NHS Dorset's Medicines Optimisation Team have created useful resources to support patients when ordering repeat medicines to reduce waste with an ICB-wide 'only order what you need' campaign.

Repeat prescription item growth decreased by over 2 .7% in the trial period, saving approximately £350–550k.

Practices that participated saw a roughly 4% reduction in repeat prescription requests.



PCN PRESCRIPTION ALIGNMENT PROJECT

Easington PCN developed a prescription alignment project to enable a reduction in patient travel and associated carbon emissions created from repeat prescribing in primary care.

The community pharmacies advertised the service and directed patients to the prescription alignment forms. The service was delivered by pharmacy technicians and allowed a review of the medication requested and escalation to pharmacists for medication review where needed.

6.3 Example: Utilising digital capability to reduce workload

ERD E-LEARNING

NECS developed an e-learning package in collaboration with NHS Digital. This learning covers eRD and how successful implementation of this can be of real benefit to GP practices, community pharmacy and patients. It also suggests a number of things to consider to enable the eRD process to be most effective, such as establishing a named lead for both the practice and the local pharmacy who will work together to overcome any issues, and the importance of starting small (patients on a stable regimen, with just one or two items on repeat) and growing the pool of target patients as confidence in the process grows.

Further resources for the implementation of eRD can be found at:

- NHSE, Electronic repeat dispensing (eRD)
- Health Innovation Wessex, Electronic repeat dispensing (eRD)

6.4 Example: QI improvement tools and case studies

A QI PROJECT UNDERTAKEN BY CITRUS HEALTH PRIMARY CARE NETWORK

A QI project revealed significant challenges in managing repeat prescription processes at one of the surgeries in a six-practice PCN, highlighting high staff turnover, increased prescribing errors and staff burnout. The practice in a deprived area faced compounded issues due to poor patient attendance for monitoring, technological barriers, and inadequate local system amendments. Implementing a new SOP and culture tailored to the practice's specific needs, alongside upskilling staff and improving communication channels, resulted in a marked reduction in errors and a substantial decrease in workload.

1. Initial challenges identified:
   - High task volumes: Q1: 9117 tasks, Q2: 10034 tasks, Q3: 9022 tasks
   - System/process errors: 73.53% of total errors
   - Significant under-reporting of prescribing errors
   - 90% of medication requests via telephone.
2. Solutions implemented:
   - New SOP and upskilling of admin staff
   - Ledger-based system for transparent task management
   - Fortnightly multidisciplinary meetings
   - Engagement with NHSBSA for eRD data
   - Switched to patient-led ordering as default system.
3. Positive outcomes achieved:
   - **Tasks reduced by 70%** in Q4 (3436 tasks completed)
   - System/process errors dropped to 0% in the second audit
   - **Clinical human errors reduced by 50%**
   - Improved staff morale and retention. 0 reception staff departures compared with 6 in the previous year

- Increased patient satisfaction with **45% reduction in complaints**
- 100% of ARRS staff report improvement in wellbeing and attitude to work.

The goodwill of staff was propping up an outdated and broken system. Since changes have been implemented, patients have increasingly embraced the NHS app and eRD and processes have been working more smoothly.

QI EXAMPLES PROVIDED BY THE PRIMARY AND COMMUNITY TRANSFORMATION AND IMPROVEMENT TEAM

Access to FutureNHS Platform is required.

- Case study on standardising medicines management: Improving management of repeat medication utilising staff within a PCN hub.

  Bellingham Green, South Lewisham Group Practice and the Jenner Practice in London, were receiving over 500 repeat prescription requests a week, some of which required a medication review. Staff were struggling to manage the reviews, with some GP appointments wasted when monitoring and test results were not synchronised with the medication review date. The PCN Pharmacy Hub stepped in to provide support and now manages most reviews across the practices.

  #### IMPACT:

  - 53 administrative hours saved per week across the three practices
  - 32 GP hours saved per week, across the three practices
  - Patients receive reviews and their medicines in a timelier manner
  - This project highlights the importance of collaboration and teamworking across a PCN.

https://future.nhs.uk/PrimaryCareImprovementCONNECT/view?objectId=33868720

https://future.nhs.uk/PrimaryCareImprovementCONNECT/view?objectId=30823952

- Future NHS – guide to increasing use of the NHS app for ordering prescriptions
- Future NHS – webinars to support process reviews: Demand and Capacity series and Safe, Reliable Process Design

6.5 Example: Supporting the safer prescribing of higher risk, repeat medicines

OPIOIDS

Health Innovation Wessex, as part of the Medicine Safety Improvement Programme (MedSIP) worked in collaboration with local ICBs and PCNs to improve consistency of opioid prescribing for chronic, non-cancer pain. The group have published a suite of resources including two PCN opioid checklists to help PCNs check if they have all elements in place to safely prescribe opioids. In response to local clinicians, they developed tools to help start discussions with patients who have been prescribed opioids long-term but who may be concerned about why their GP wishes to stop their opioid for chronic, non-cancer pain.

Joined Up Care Derbyshire have also published a number of opioid resources for patients and clinicians. Working in collaboration with Health Innovation East Midlands, they have created a practice-level opioid quality improvement toolkit and ICS minimum standards for repeat prescribing of opioids for chronic, non-cancer pain.

ANTIPSYCHOTICS IN PEOPLE WITH DEMENTIA

A toolkit has been developed by London Clinical Networks and Yorkshire and Humber Clinical Networks to support safer and more appropriate prescribing and deprescribing of antipsychotic medication.

- **NICE** has a number of decision aids to support conversations with patients and there are key examples surrounding higher risk medicines, e.g., benzodiazepine or z drugs.

ANTIMICROBIALS ON REPEAT PRESCRIPTION

The NHSE antimicrobial resistance team in the east of England have been championing a new COPD preventing exacerbations toolkit

(PET) checklist with PCNs. The toolkit stemmed from a collaboration between NHSE and UKHSA to develop "How to…?" guides for PCN staff to support structured medication review of patients experiencing recurrent infection or exposed repeatedly to antibiotics. Two 'how to' guides have been completed (COPD exacerbation and acne) and are hosted on the RCGP TARGET website. Search strategies for GP systems have also been developed to identify this patient cohort.

6.6 Example: Engaging with patients

The following materials have been designed with patients and tested in primary care in England. They have been shown to help patients engage in their repeat prescribing and make the most of their structured medication review:

- I Manage My Meds
- Me and My Medicines
- The Health Innovation Network – Resources to support patients having a Structured Medication Review
- Health Innovation North East and North Cumbria – Are your Medicines Working for You?

6.7 Supporting vulnerable patient groups

FRAILTY

Medication review in people at risk of falls is often not straight forward as people will often have multiple co-morbidities, be older and/or living with frailty, hence medicines use in this population requires a balance between the risks and benefits of multiple treatments.

The National Falls Prevention Coordination Group have produced a document for helping to review medicines of people at risk of falls.

FRAILTY AND REPEAT PRESCRIBING OF ORAL NUTRITIONAL SUPPLEMENTS (ONS)

The evidence base for frailty and malnutrition in older adults suggests limited evidence for oral nutritional supplements (ONS), with the patient group from the NIHR study stating we should 'exercise caution' in prescribing. It is acknowledged that there is oversupply, risk of overuse and subsequent discharge from hospital without full assessment. This creates a significant follow up challenge for primary care. If followed up proactively after discharge, 61% of patients discontinue ONS (Barnet MSK project 2024, unpublished data). Conversely, unintentional weight loss is frightening for patients and families and a trial of ONS may be appropriate (e.g., if awaiting diagnostic tests), with review to assess both efficacy and appropriateness. Clinical malnutrition (unintentional weight loss) can be classed as organic or psychosocial but often has elements of both and an aetiology-based approach is recommended to avoid overprescribing.

In considering if a repeat ONS prescription is necessary, it is essential to revisit the rationale for initiation, goals and adequacy of assessment and dietary advice.

Hertfordshire and West Essex ICB have some resources available and the Association of UK Dieticians has guidance around eating, drinking and ageing well.

Best prescription practice:

- A standard operating procedure within practice or medicines management team to manage repeat prescription requests, e.g., to include a process for tube-fed patients using ONS
- Use of acute prescriptions (or repeats with directions for follow up or length of prescription).

SMRS IN THOSE TAKING MULTIPLE MEDICINES

Many patients report that they are not clear about the purpose of an SMR and may not feel able to share their concerns about their repeat medicines. To address this, Bradford and Leeds universities, in collaboration with patients and the Health Innovation Network Polypharmacy Programme, have developed a range of materials to support patients with their understanding of an SMR and how to get the most out of it.

These materials have been translated into several languages and are freely available.

PEOPLE LIVING IN CARE HOMES

The care home support team across Coventry and Warwickshire have developed resources to support repeat prescribing for their care home residents. This includes support for 'proxy ordering'. Care homes are encouraged to try to use one system for ordering repeat medicines for residents who are unable to order their own medicines, where possible.

NHSE offers guidance for proxy ordering.

7 Repeat prescribing self-assessment

Over the last 20 years, a considerable burden has been placed on general practices and community pharmacies as the demand, workload and complexity of repeat prescribing and dispensing has increased.

During this time, we have also seen safety issues emerge that are related to patients being able to access repeat medicines for years without always having the recommended checks and in-depth medication reviews taking place. This is especially relevant for **opioids, antidepressants, benzodiazepines, gabapentinoids, antimicrobials, anticoagulants, lithium, methotrexate, azathioprine, leflunomide, diuretics, ACE inhibitors/A2RBs, 'shared-care medicines', teratogenic medicines for women of childbearing age and patients who take ten or more medicines. See higher risk medicines and scenarios described in Box 1.**

This RCGP/RPS repeat prescribing self-assessment tool is aimed at helping each practice or PCN look critically at both the safety and efficiency of their repeat prescribing processes and agree as a practice team where to make improvements or address issues.

7.1 Completing the repeat prescribing self-assessment tool

The repeat prescribing self-assessment tool has been designed to be discussed and completed in a practice or PCN meeting with both clinical and non-clinical staff present so that all perspectives can be heard. Where possible, local practice PPGs should also be involved. Everyone should be encouraged to be open about what is good about the current process, any gaps and where safety or efficiency in repeat prescribing can be improved and risks highlighted. In addition, practice staff are strongly encouraged speak to local community pharmacies to seek their input into areas where local arrangements cause problems or could be improved. Recent patient feedback (complaints or positive comments) should be highlighted during the discussions.

See questions for the general practice PPG in section 5.4.

There is a full appreciation of the current pressures in primary care. The first step for practices may be to discuss the self-assessment questions and be aware of issues or opportunities for improvement. If there are clear medication safety risks highlighted as part of the process, they should be addressed promptly.

However, for the majority of improvements, practices or PCNs may want to develop a repeat prescribing action plan (see section 7.6) which will be worked on over time by the whole practice team and external stakeholders, such as local community pharmacies and the PPG.

PCNs or practice pharmacists are well placed to lead this work, but improvements are most likely to happen where the whole practice team is involved in addressing any issues. Practice managers and prescribing lead GPs can play a key role in helping to keep up momentum and support any changes. **This work will need a team/PCN approach.**

There is wide variation in the way that repeat prescriptions are managed by individual practices. We appreciate that practices have very different capacity and capability challenges. To help with this, we have described 'core' questions for **ALL** practices to address and additional 'advanced' questions for practices/PCNs who wish to go further and ensure their repeat prescribing system is as robust as it can be.

7.2 Suggested steps for GP practices/PCNs to complete the repeat prescribing self-assessment

1. Appoint a practice/PCN lead for the repeat prescribing self-assessment process
2. Look at the oversupply dashboard hosted in ePACT2 (NHSBSA) to understand if there is an issue with oversupply in your practice
3. Convene a 'repeat prescribing working group' to discuss the toolkit and self-assess the practice against the questions. Ideally both clinical and non-clinical staff should be invited
4. Review all responses
5. Agree the key areas of action required and document these in the RCGP/RPS repeat prescribing action plan (see section 7.6)
6. Prioritise any key medication safety issues highlighted during the process
7. Work through the practice/PCN repeat prescribing action plan with SMART objectives assigned to members of the whole practice team and timelines agreed to keep the work on track
8. Hold regular discussions to ensure actions are completed and new systems tested. See section 3 for process mapping and support to deliver quality improvement
9. Where system-wide issues are affecting the safety or effectiveness of the repeat prescribing system, e.g., poor phlebotomy services causing lack of access to timely blood test monitoring, these should be formally highlighted to the ICB
10. This process may take a number of months and require a number of PDSA (Plan Do Study Act) cycles.

Figure 4: Suggested steps for GP practices/PCNs to complete the repeat prescribing self-assessment

7.3 Elements of repeat prescribing

Research undertaken by Health Innovation East Midlands which used a 'human factors' perspective to understand opioid repeat prescribing, identified three crucial areas that have the potential to enhance the efficiency of repeat prescribing systems:

1. Improve the functionality and use of the clinical systems
2. Ensure there is an effective and embedded work procedure that is understood and accessible to all staff members and patients
3. Create a manageable cognitive load/workload for clinical and non-clinical staff.[xxvii]

These themes should be used to shape the discussions around the self-assessment.

The working group agreed that the repeat prescribing toolkit should centre around five key elements (see figure 3). These elements are important for the safe and effective running of a repeat prescribing system.

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 section 3).**

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).

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.

2. 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 section 5).

3. 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'.[xxviii]

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).

Patients prescribed higher risk medicines on repeat described in box 1 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).

Standardised shared care protocols are also available from NHSE.

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 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.

7.4 RCGP/RPS repeat prescribing practice self-assessment

ORGANISATIONAL CULTURE

CORE

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)?

2. 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?

3. Who in the practice has overall responsibility for the repeat prescribing process?

4. Who in the practice has responsibility for the day-to-day running of the repeat prescribing process?

5. Is it clear how and who in the practice will deal with an issue, incident or complaint relating to repeat prescriptions?

6. Are practice staff clear about the roles and responsibilities of all staff members involved in the repeat prescribing process?

7. 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?

8. 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?

9. What is the mechanism for the practice to discuss how the current system is working?

10. In your discussions to review the repeat prescribing system are the following included:

- The input/views of local pharmacies and or the PCN community pharmacy lead?
- How high-risk medicines and high-risk scenarios are managed and if this is working effectively?
- Any recent incidents or complaints and what can be learned for them?
- How you measure if the current system is working? This should include the NHSBSA oversupply data and any local metrics on time taken for repeats.

11. Is dedicated time allocated to clinical and non-clinical staff to manage repeats?

ADVANCED

12. Is the repeat prescribing process treated as a risk activity, e.g., is it treated as a separate task, is a dedicated room provided for administrative staff processing repeats? Is time given to clinical staff to deal with authorisation?

13. How well does the practice liaise with local community pharmacies to resolve any frequently occurring issues?

14. How has the practice learned from a recent repeat medication incident or complaint?

15. How has the practice process mapped and reviewed the workload associated with repeats? Was this for both clinical and non-clinical staff?

16. How is the practice using digital solutions to reduce workload? What else could be done? Is GP clinical system functionality optimised by **all** staff and has the practice explored the use of eRD and the NHS app?

17. 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?

18. Is the burden of the repeat prescribing system on clinical staff regularly reviewed and revised if individuals are experiencing unsafe workloads? How is this assessed? Does the practice regularly collect and review data relating to numbers of requests dealt with by admin/pharmacy team/GPs?

19. Does the practice have a member of staff who can support patients who struggle to use the usual repeat prescribing process such as those with learning difficulties, those unable to use digital processes and those where a chaotic lifestyle can make it harder to order and collect prescriptions, such as those with no fixed home address?

CLINICAL RESPONSIBILITIES

CORE

1. When a medicine is moved from acute to repeat, is this decision explicitly recorded with a duration of the repeat documented?
2. Is the indication for a repeat medication clearly documented in the GP clinical system?
3. 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?
4. Is there a separate process for higher risk repeat medicines? (see box 1)
5. How are the responsibilities around repeat medicines communicated to patients (e.g., monitoring requirements, medication reviews and when medicines will not be repeated)?
6. 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?
7. What systems are in place to monitor over ordering of repeat medicines (especially in relation to medicines with dependence-forming or overdose potential)?
8. What processes are in place to identify and manage under ordering of repeat medicines?
9. 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?
10. 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?
11. When medicines are stopped, is there a clear process to ensure they are removed from the repeat medicines list?
12. 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?

ADVANCED

13. Are terms such as ‘as directed’ or ‘when required’ avoided, especially when in relation to high-risk medicines? How is feedback provided to prescribers when clear directions are not provided?

14. Is there a clear process for dealing with prescription queries?

15. How are prescription queries monitored? Many prescription queries might indicate a process problem. The same patients querying each cycle might indicate they are unsure of the correct process. How are both scenarios addressed?

16. Have there been any serious incidents involving repeat medicines and how were lessons learned?

TECHNICAL

CORE

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?
2. How are repeat prescription requests triaged?
3. 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?
4. How are checks made around monitoring requirements, such as blood tests?
5. How does the practice ensure monitoring requirements are adhered to before repeat prescriptions are re-authorised?
6. What is the practice's process if a patient does not engage with monitoring arrangements? How is this communicated to patients?
7. How are large scale requests managed (e.g., care homes)? Is this working well?
8. 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?
9. How does the practice identify and manage over-ordering of medicines (especially those with dependence-forming or overdose potential?)
10. How does the practice identify and monitor under ordering?
11. How does the practice manage discharge letters involving requests for repeat prescriptions? How are discharge issues flagged to clinicians?
12. How are 'shared care' arrangements for prescriptions managed safely? How is this documented so that all clinicians are aware of the full clinical picture?
13. Could the practice improve efficiency in how patients request repeats and receive medication requests?

ADVANCED

14. What (digital) functions of the clinical system are used to help with the efficiency of the practice repeat prescribing system? Do all staff consistently apply these functions?

15. Is there additional system functionality that is not deployed and why?

16. What is the agreed process for interactions between the community pharmacy and the practice?

17. Is there a technical lead for repeat prescriptions who is responsible for monitoring workload, queries, system failures, inefficiencies and safety issues?

18. Does the practice regularly monitor the number of repeat requests per month and audit how the workload associated with the volume of requests falls to various team members (clinical and non-clinical)?

19. Does the practice monitor how many repeat prescription requests are made via 111? Is this excessive? ICB-level NHS 111 data is updated monthly. Could high usage of 111 indicate that there is a problem with your repeat prescribing process?

ADMINISTRATIVE

CORE

1. Who in the practice manages the day-to-day administrative duties of the repeat prescription processes?
2. 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?
3. How are administrative staff trained?
4. How are administrative staff supported in their repeat prescription roles?
5. Is there a process for dealing with queries that do not fit the usual process, and is this 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)?
6. Are administrative staff aware of the risks of circumventing the agreed practice process to expedite prescription queries?

ADVANCED

7. Are the administrative team aware of which medicines are higher risk repeat medicines, how they are to be managed and how this might differ from the usual repeat process?
8. Are administrative staff given a quiet space to process repeat prescriptions with minimal interruptions?
9. Is there a dedicated phoneline/extension for community pharmacies to contact the practice team in relation to prescription queries?
10. Does the practice regularly monitor the volume and nature of repeat 'queries', i.e., where the request or query does not follow the usual process agreed for repeats?

See patient questions in section 5.4.

7.5 Community pharmacy and dispensing practices

Community pharmacies and their local general practices need to work closely together to ensure the safe and efficient running of the repeat prescribing pathway. Both services have come under increasing pressure in recent years but should still aim to engage regularly to ensure medicines are managed effectively for patients.

Pharmacies and general practices/PCNs should aim to meet to discuss this repeat prescribing self-assessment toolkit and how any local issues can be resolved or improved. Some PCNs will have a dedicated community pharmacy lead who can support this.

Both parts of the pathway (prescribing and dispensing) are complex and hugely challenging. Both partners need to recognise the constraints experienced by the other to try to ensure that patients are provided with a safe and efficient local process.

KEY QUESTIONS FOR COMMUNITY PHARMACY TEAMS TO ASSESS THEIR REPEAT PRESCRIPTION PROVISION:

1. Is your process for receiving and dispensing repeat prescriptions clear to your patients and local general practices?
2. Is the time needed for the safe dispensing of repeat medication communicated to patients, so they are aware how far in advance to order their next supply?
3. Does your repeat prescribing process work equally well for all prescriptions from all local general practices?
4. How do you communicate urgent queries to the GP practice, and is there an audit trail in place for this?
5. How do you communicate non-urgent queries to the GP practice? Is this process effective? How do you audit this?
6. Have you worked with local GP practices to encourage the use of eRD and support implementation for patients who meet the criteria for this?
7. What role does the pharmacy play in ordering repeat medication for patients? Has this been agreed with local GP practices?
8. Is there a process for highlighting under/over ordering of medication to the GP practice?
9. How do you encourage patients to use digital solutions, such as the NHS app, to order and check on repeat prescriptions?
10. Do you have clear process of action to respond to national alerts such as national patient safety alerts of drug safety updates?

DISPENSING PRACTICES

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

1. Are there SOPs in place within the dispensary covering the processes for repeat prescribing covering roles, responsibilities and training of staff?

2. Is your process for receiving and dispensing repeat prescriptions clear to your patients?

3. Is the time for dispensing of repeat medication communicated to patients so they are aware how far in advance to order their next supply?

4. Do you encourage patients to use digital solutions such as the NHS app to order and check on repeat prescriptions?

5. What support and training are in place for dispensary staff who operate the repeat prescribing system?

6. Are all repeat prescriptions signed by the prescribing clinician before they are dispensed?

7.6 RCGP/RPS practice/PCN repeat prescribing action plan template

ACTION	STEPS TO BE TAKEN	BY WHOM	BY WHEN	COMPLETE
Organisational culture				
Clinical responsibilities				
Technical				
Administrative				
Patients				

SYSTEM ISSUES TO HIGHLIGHT TO THE ICB

ACTION	STEPS TO BE TAKEN	BY WHOM	BY WHEN	COMPLETE

PATHWAYS ISSUE TO DISCUSS WITH LOCAL PHARMACIES

ACTION	STEPS TO BE TAKEN	BY WHOM	BY WHEN	COMPLETE

8 Training resources

Part of the National Overprescribing Review recommendation 7 work was to identify current gaps in training materials, particularly for non-clinical staff who may support the repeat prescribing process. Research highlighted the importance of non-clinical staff and the level of responsibility they have when processing repeat prescriptions.[ii]

The CQC states that to deliver safe, high-quality care and treatment, practices must take reasonable steps to support staff to do their jobs. Each general practice is responsible for determining what mandatory and additional training its staff need. They are also responsible for how this is delivered.

PRESCQIPP

PrescQIPP is a non-profit NHS-funded organisation that provides evidence-based resources and tools. One of the tools they provide are e-learning materials for non-clinical staff called the **Practice medicines co-ordinators course**. This is a CPD-accredited course.

This is accessed by creating an account on PrescQIPP using an NHS email address.

It contains ten modules and should take around four hours in total to complete, using video presentations.

8.1 GP clinical system supplier training and resources

As part of the development of this repeat prescribing toolkit we met with the two major GP clinical system suppliers and requested that they provide a resource page for practices to understand how to use their system to support safer and more efficient processes for repeat prescriptions systems. These resources can be found on the TPP learning management system repeat prescribing toolkit and the EMIS Medication Resources.

8.2 Quality improvement (QI) training

NHSE – An Introduction to Quality Improvement in General Practice.

RCGP has a QI support guide for whole practice teams, training resources available for members and project case studies.

One of the future recommendations (see section 10) is for NHSE to consider a nationally available training module for general practice staff that supports the running of a safe and effective repeat prescribing process.

9 Tools to optimise repeat prescribing

To support practices and PCNs to improve the safety and efficiency in repeat prescribing systems, we are signposting to a range of tools and resources.

9.1 NHSE and NHS BSA Oversupply Dashboard

The NHS Business Services Authority (BSA) is home to all the prescribed and dispensed medicines data for England. Such detailed data allows us to understand the quality and quantity of prescribing in England and in recent years has seen a number of ground-breaking dashboards, for example those looking at the rates and type of polypharmacy in general practice.

NHSE and NHSBSA have recently developed a dashboard highlighting the scale of potential oversupply of medicines for a range of prescribing areas. This can support improvement initiatives, particularly around addressing inconsistencies with repeat prescribing processes and help to minimise avoidable waste or the risk of harm to patients. Oversupply is when more medication is dispensed that should be typically needed or wanted by the patient.

This work supports recommendation 4 of the National Overprescribing Review, namely to "improve data for feedback to clinicians and commissioners to guide prioritisation and monitor success".[ii]

The oversupply dashboard is available to all general practices and PCNs in England. The dashboard relates to a targeted number of therapeutic areas – typically those with a straightforward dosage schedule to highlight where cumulative amounts of prescribing are considered excessive for a 12-month period.

At launch, the dashboard will look at:

- Aspirin 75 mg
- Statins (solid oral)
- Glucose monitors/sensors
- Fixed dose inhalers
- Daily laxatives
- Blood glucose testing strips
- Oral nutritional supplements.

This is a list of medicines with a straightforward daily use quantity that could be indicative of an oversupply problem. It helps users to spot excessive

amounts, quantities that might not be safe, or amounts that may add up to a lot of wasted medication. This can be used to identify issues relating to specific patients or to identify practices or wider geographies with wider systemic oversupply problems. The specific patient cohorts (e.g., patients on ten or more medicines) also provide an opportunity to prioritise initiatives such as structured medication reviews.

Practices and PCNs can register for ePACT2 on the NHSBSA website, and access the oversupply dashboard.

Practices could use this data before and after completing the repeat prescribing toolkit action plan to gauge the effectiveness of any interventions.

9.2 Increasing and optimising digital functionality of the repeat prescribing system

It is recognised that different practices will be at different stages of digital maturity. However, the following principles are suggested to support the digital optimisation of the process.

REPEAT MEDICATION ORDERING

1. Use of digital/online* order requests for repeat medicines should be maximised where possible and variation in methods of accepting order requests should be minimised.

   *Digital/online refers to NHS app, NHS UK webpage, or third-party online ordering platform that delivers the request directly to the GP practice system.

RECEIPT OF REPEAT MEDICINE ORDER REQUESTS

2. IT workflows should be configured to allow timely and safe management of repeat medication order requests with mechanisms in place to identify over ordering.

PRESCRIBING REPEAT MEDICATION

3. Risk of duplicate or prescriptions issued too close together should be highlighted within clinical systems to avoid unintentional overprescribing
4. Use of EPS and prescribing IT system functionality should be optimised for prescribing repeatable medicines safely and efficiently.

9.2.1 Increasing utilisation of digital repeat prescription ordering

The number of appointments viewed or managed through the NHS app has more than doubled from 1.95 million in November 2022 to 4.1 million in November 2023.

There were 10.7 million views of patient records in the app in November 2023, compared with 5.8 million in November 2022. There has been an increase in the number of over 50s signing up for the NHS app, following the introduction of new services including vaccine bookings.

From 2023 to 2024, the number of digital repeat prescription requests in the NHS app rose by more than 45%, amounting to 3.1 million repeat prescription requests a month. A total of 77.5 million repeat prescription have been ordered through the app since the functionality was first introduced. Repeat ordering through the NHS app saves patients an average of 18 minutes with each online order and each practice an average of three minutes per order received.

As the NHS app grows in both popularity and functionality, we hope to see increasing utilisation and assurance that digital becomes one of the main routes for repeat prescription ordering. This will bring clarity about the process to most patients and a more consistent approach to managing the influx of repeat order requests for most general practices.

However, we recognise that not all patients are able to use digital tools in this way, therefore additional arrangements will need to be made locally so that patients who cannot yet use the app or other online tools are able to order their prescriptions safely and effectively.

Developments we hope to see in the NHS app in the future include:

- The ability to track prescriptions and repeat prescription requests
- Better pharmacy nomination access

- The ability to track eRD prescriptions – the number of authorisations remaining, for example
- Improved repeat medication ordering journey.

Information for patients about the NHS app can be found on the NHSE website.

Age UK have guidance for older people using the internet, including how to order prescriptions.

9.3 System suppliers

GP clinical system suppliers have a significant role to play in increasing the functionality of repeat prescribing systems and identifying over or under ordering of repeat medication by patients.

System suppliers also have a responsibility that any new functionality aimed at improving repeat prescribing efficiency DOES NOT compromise medication safety or increase the risk to patients from authorising medicines to be repeated without the appropriate clinical checks.

9.4 eRD

First introduced in 2009, eRD is a non-compulsory method of dispensing prescriptions electronically. It means that patients who regularly get the same medicine do not need to visit their GP every time they need a repeat prescription. Instead, the prescription can be sent straight to their pharmacist for dispensing.

Using eRD, GPs can issue up to 12 months' worth of regular prescriptions, which can be stored securely on the NHS database, so they are ready at the pharmacy each time a patient needs them.

eRD was rolled out nationally in April 2019 as part of the GP contract. Within three months, nearly 700,000 patients were using the repeat dispensing process and today, over 1.2 million patients benefit from this service. It is estimated that eRD has helped manage increased pressure of the health service and saved over 90,000 hours of GP practice time – time that can be reinvested in patient care.

Practices can access data from the NHS BSA to identify patients who have taken the same medicines for 10 out of the previous 12 months and therefore may be suitable for eRD. This data can be requested from the NHSBSA on the 'requesting eRD data' page.

Health Innovation Wessex have published a range of tools and guidance to help practices successfully deploy eRD.

9.5 Proxy ordering

Proxy access was developed to allow someone other than the patient to access and manage parts of their GP online services account. The proxy is given their own online access account (rather than using the patient's login details). It is usually used by the parents of young children and recognised carers of adults. It can also to support CQC registered care homes and GP practices and pharmacists to work together to allow care home staff to order online repeat medication on behalf of residents.

Proxy ordering guidance can be found on the NHSE website.

9.6 Emergency supply requests

Emergency supply requests for medicine can be requested from NHS 111 or 111 Online where the patient is unable to receive a prescription for their regular repeat medication in a timely manner. NICE Emergency Supply of Medicine guidance should be followed.

Where appropriate, the pharmacist will advise the patient or their representative on the importance of ordering prescriptions in a timely manner from their GP practice and prevent the future need for emergency supplies. If an urgent supply is needed, the pharmacy should check the GP record/National Care Record to ensure that they are not making duplicate supplies to ensure patient safety and reduce waste.

9.7 Patient information leaflet

Further patient information is available in section 5 and Figure 3: the 5 elements of repeat prescribing.

10 Suggestions to improve repeat prescribing in the future

This toolkit has been designed to encourage and support general practice and community pharmacies to reflect on their repeat prescribing systems so that improvements in medication safety and efficiencies can be made wherever possible.

However, some areas were outside of the scope of this working group to address. Examples include changes in commissioning responsibilities or regulatory arrangements.

To ensure the continued safety and efficiency of repeat prescribing systems, we make the following suggestions to improve repeat prescribing in the future:

1. Commissioners are encouraged to consider incentivisation for practices/PCNs and community pharmacies to engage with this work and complete the repeat prescribing self-assessment and action plan.

2. GP and pharmacy system suppliers are asked to provide greater functionality to help to recognise the oversupply and over ordering of repeat medication, particularly for higher-risk medicines, and help practices and pharmacies to identify and address it.

3. We encourage the NHSBSA and NHSE to further develop the oversupply tool to increase functionality to measure the oversupply of higher-risk medicines such as opioids, antidepressants, benzodiazepines and antimicrobials (see box 1).

4. The terms of service for NHS community pharmacies and the Community Pharmacy Contractual Framework could formally enable pharmacy teams to support patients to discuss how they are taking their medicines and raise any concerns with their community pharmacist at the point of dispensing. The development and commissioning of a community pharmacy service to help people who are struggling or unable to manage their repeat prescriptions effectively could be explored. Such a 'repeat prescription review service' could meet the needs of the large number of patients who express confusion about what medicines they have been asked to take and how to take them safely. Such a service could be tested to explore its impact on adherence and reducing the ordering of medicines that the patients are no longer taking.

5. eRD requires urgent modernisation to ensure it works smoothly and resolve some of the well-known challenges. In particular, the ability to amend doses in EPS (rather than having to cancel that item) would be a welcome improvement both in efficiency and safety. The improved functionality of the NHS app in relation to eRD tracking and monitoring would be a significant development. More broadly, the improved medicines and prescriptions functionality in the NHS app, especially but not solely in relation to eRD to optimise user experience and safety would be very welcome.

6. A national and accredited course is needed for non-clinical staff who are essential in supporting the repeat prescribing process and support given to GP practices to enable reception staff to have the time to complete such training.

7. There is a significant need for greater information to inform the public of, and raise awareness of medication safety, medicines waste and the environmental impact of medicines. A national, public awareness campaign could address this and we ask that this is considered by national organisations and royal colleges.

8. NHS England are encouraged to expedite digital solutions to allow hospital discharge information relating to medicines to link into the patient record to create a digital audit trail of any medication changes.

9. Secondary care and specialist services are asked to make very clear to primary care on discharge of a patient from hospital, the reasons for medicines to be prescribed on repeat, the indication and the intended duration of therapy. Any medicines stopped need to also be clearly documented with a reason for the cessation of therapy. Utilisation of the Discharge Medicines Service (DMS) in England is currently not fully optimised. The DMS enables hospitals to digitally share information about medication changes with the patient's usual community pharmacy and has been shown to reduce re-admission rates at 30, 60 and 90 days. Trusts and Community Pharmacies should make the most of this opportunity to reduce avoidable harm.[xxix]

10. A clinical guideline is needed to pull together, in one place, recommendations on the frequency of medication reviews for all higher risk, repeat medications. This could be a role for NICE or Specialist Pharmacy Services.

11. Commissioners are asked to explore the formalisation and contractualization of protected time to allow for discussion between general practice and community pharmacy. This needs to be set out nationally in relation to the repeat prescription pathway, to ensure that all parties are clear about their responsibilities.

12. The issue of 'bulk authorisation' of repeat prescriptions requires a more in-depth, national review. The functionality to bulk authorise repeat medicines has been developed by some but not all of the GP system suppliers. However, the full medico-legal impact and risk of this development is unclear. A minimum set of standards and a risk assessment process for GP practices are urgently needed to ensure that the safety of authorisation of repeat medicines is maintained.

11 Glossary

Repeat prescription: Repeat prescriptions are medicines taken by patients on a regular basis and are authorised to be prescribed repeatedly for a specified length of time. This is a partnership between the patient and the prescriber. The patient does not have to consult the prescriber at each repeat request.

Repeat medication check (authorisation): A check that the medication(s) for a single condition (e.g., asthma) or multiple allied conditions (e.g., cardiovascular diseases) were clinically checked and authorised as suitable repeat medication(s), and for how long.

The medication(s) would have ideally been clinically checked within a patient consultation or via a desktop review.

The authorisation for each medication should be either time-limited by setting the date of the next authorisation (e.g., a maximum of 12 months) or limited by the number of repeats allowed. The quantity of medication should be synchronised with the number of days issued (e.g., 56 tablets if prescribed one tablet twice a day and on a 28-day cycle) or made clear it is for use as required (e.g., 60 sachets for PRN use if repeat medication is needed).

This review should be clearly visible within the repeat medication section of the clinical record system.

Repeat prescribing system: This is the process via which the practice operates their repeat prescribing functions.

Repeat prescribing processes: In a repeat prescribing system, there are many separate processes that make up the prescription journey from request to collection. These are further defined in section 2 but may include:

- Requesting a repeat prescription
- Generating a repeat prescription
- Prescription review
- Authorising a repeat prescription
- Prescription signing
- Prescription being sent to nominated community pharmacy
- Nominated pharmacy dispensing the prescription

- Person receiving or collecting the prescription
- Ongoing monitoring and medication review, medication adherence.

Medication review: A holistic, clinical review of all medications for all of a patient's conditions, ensuring any long-term condition/Quality and Outcomes Frameworks (QOF) reviews and/or relevant blood tests for safe prescribing have been undertaken or are scheduled at the required intervals.

This can be undertaken as desk-based review but ideally should be face to face or via a telephone or video consultation.

All the repeat medication should be time-limited by setting the date of the next repeat authorisation or limited by setting the number of repeats allowed.

The review should be clearly visible within the repeat medication section of the clinical record system and ideally all authorisation durations should be synchronised to coincide with the next medication review.

A systematized nomenclature of medicine clinical terms (SNOMED CT/read code) for a medication review should be recorded in the clinical record and include a clear date when the next medication review is due.

Structured medication review (SMR): An SMR has been defined by NICE as a structured, holistic, and personalised review of a patient's medicines with the objective of reaching an agreement with the patient (or their advocate) about treatment; optimising the impact of medicines; minimising the number of medication-related problems and reducing waste.

It is an evidence-based review of the person medicines that would normally be carried out by a clinical pharmacist or doctor taking into account all aspects of their patient's health.

SMRs were introduced as part of the 2020/21 Network Contract Direct Enhanced Service (DES) Specification for PCNs to deliver to key, priority groups of patients.

Ideally an SMR should be undertaken face to face with the patient but can be via telephone or video call.

All the repeat medication should be time limited by setting the date of the next repeat authorisation, or by setting the number of repeats allowed.

This review should be visible within the repeat medication section of the clinical record system and ideally all authorisation durations should be synchronised to coincide with the next medication review.

A SNOMED CT (read code) for a structured medication review should be recorded in the clinical record allowing visibility for all and including a clear date when the next SMR is due (SNOMED code 1239511000000100 SystmOne Read Code Y282b).

Synchronisation: Synchronising the quantities of medicines on a prescription with the aim of ensuring that they all run out at the same time.

Electronic repeat dispensing (eRD): eRD allows a prescriber to authorise and issue a batch of repeatable prescriptions for up to 12 months with just one digital signature.

Electronic prescription service (EPS):
The EPS allows prescribers to send prescriptions electronically to a dispenser, such as a pharmacy, nominated by the patient.

This makes the prescribing and dispensing process more efficient and convenient.

EPS is already widely used in primary care with over 95% of all prescriptions now being produced electronically.

Dispensing practice: A practice, often rural in nature, whose patients are allowed to request that their medications are dispensed from the practice, as they live too remotely from a community pharmacy.

Annex A

WORKING GROUP MEMBERSHIP AND APPROACH

The working group was formed of experts, interested professionals and third sector representatives and patients.

Four workshops were held between June 2023 and February 2024.

The working group defined the guiding principles and scope of the toolkit.

The working group defined the five main themes and suggested content for the toolkit.

We would like to thank the chairs and participants for giving their time and for their expert advice.

NAME	TITLE
Iramnaaz Adam	Medicines Commissioning Pharmacist, Lancashire and South Cumbria ICB
Professor Tony Avery	National Clinical Director for Prescribing (NHS England)
Shamma Baig	APTUK Equality, Diversity and Inclusion Executive
Wasim Baqir	Senior Pharmacist, National Pharmacy Integration, NHS England
Mike Barstow	Director and Vice-chair, Dispensing Doctor Association
Donna Bartlett	Former APTUK Professional Lead for England
Hazel Baxter	Interim Head of Medicines Optimisation, NHS Derby and Derbyshire ICB
Gill Boast	Practice Nurse facilitator and training programme lead, Staffordshire and Stoke-on-Trent ICB
Emdadh Bokth	Clinical Pharmacist, Tower Hamlets GP Care Group
Lawrence Brad	RCGP representative

Rebecca Bunton	NMP, ANP Hampshire and Isle of Wight
Mary Collier	CQC Regional Medicines Manager
James Davies	Director for England, RPS
Yvonne Dennington	Business Manager England, RPS
Jaz Dhillon	Clinical Pharmacist Interface and Governance, NHS Shropshire
Lisa Drake	Director, Quality and Improvement, Redmoor Health
Manjit Dulay	National Pharmacy Integration Lead, NHS England
Deborah Duval	Managing editor, Kidney Care UK
Richard Fieldhouse	Chairman, National Association of Sessional GPs
Laura Forbes	Pharmacy Technician Newton Drive Health Centre, Blackpool
Rachel Freeman	Age UK representative
Tracey Galt	Lead Medicines optimisation Pharmacy Technician, Nottingham & Nottinghamshire ICB
Gill Gookey	Medicines Safety Lead Pharmacist, Health Innovation East Midlands
Liz Hallett	Community Pharmacy Expert Advisory Group, RPS
Ghulam Haydar	Senior Pharmacist, National Pharmacy Integration Fund NHS England
Heather Holmes	Medicines Policy Lead, NHS England Medicines Value and Access
Clare Howard	Clinical lead, Co-chair, FRPharmS and Fellow of the Royal Pharmaceutical Society

Sundus Jawad	Lead Medicines Optimisation Care Homes Pharmacist, NHS Frimley ICB
Paul Jenks	Community Pharmacy Expert Advisory Group, RPS
Brendon Jiang	Senior Clinical Pharmacist, North Oxfordshire PCN
David Kelly	Lead Pharmacist, Highfield Surgery
Sajida Khatri	Director of Medicines Optimisation, PrescQIPP
Graeme Kirkpatrick	Head of Patient Safety (Advice and Guidance) NHS England
Sheetal Kotecha	Lead Pharmacist Arden PCN, Advanced Clinical Practitioner
Pauline Lockey	Patient Safety Clinical Lead (Medication Safety) NHS England
Anika Mandla	Senior Clinical Policy Officer, RCGP
Michael Mullholland	Co-chair, Honorary Secretary of Royal College of General Practitioners
Nishali Patel	Clinical Lead, Digital Medicines, NHS England
Rebecca Perkins	Clinical Lead NHS 111
Graham Prestwich	Patient representative
Carol Roberts	Chief Executive, PrescQIPP
Elizabeth Rushforth	POD manager NHS Bath and NE Somerset, Swindon & Wiltshire ICB
Claudia Snudden	GP Registrar, National Medical Director's Clinical Fellow, 2023–24
Graham Stretch	PCPA President and Chief Pharmacist Argyle Group

Clare Thomson	Chief Pharmaceutical Officer's Clinical Fellow, RPS 2023-24
Stacey Thomson	Programme Manager, Redmoor Health
Sati Ubhi	Director of Medicines Optimisation & Pharmacy (Chief Pharmacist), Cambridge and Peterborough ICB
Jonathan Underhill	Former Medicines Consultant Clinical Adviser, Medicines Optimisation team, NICE
Kuldeep Virdee	CQC pharmacist specialist
Steve Williams	Lead Clinical Pharmacist, Poole Bay & Bournemouth PCN
Paul Woodgate	Patient representative
Heidi Wright	Policy and Practice Lead (England), RPS

GUIDING PRINCIPLES

A good repeat prescribing system is essential to ensure the safe, efficient and convenient dispensing of prescription medications to patients who require ongoing treatment. There is no current national guidance that sets out the requirements of a good repeat prescribing system for primary care teams.

- The RCGP/RPS repeat prescribing toolkit will therefore aim to:
- Set the expected standard but allow for flexible local arrangements
- Demonstrate best practice
- Be positive not punitive
- Be safe
- Be efficient
- Facilitate patient access to repeat medication in a timely manner.

OVER-ARCHING PRINCIPLES:

- All recommendations made in the toolkit will be developed by a working group, which includes patients taking repeat medication and primary care teams involved in operational roles around repeat prescribing
- Recommendations made will **empower and support patients** to access medicines that have been authorised as a repeat prescription
- Repeat prescribing systems will be made safer, more efficient and less open to abuse
- Repeat prescribing systems should minimise the risk of over-prescribing
- The toolkit will distinguish between the clinical, technical and administrative functions as well as the elements of repeat prescribing that the patients/carers have a role in
- The toolkit will set out good practice standards but remain flexible in its framing to enable local

systems to engage with it and work out how to meet these standards within the context of their local situation (patient demographics, workforce capacity and capability, etc.)

- Elements of these recommendations will be developed in collaboration with patients and should be clearly communicated to patients on publication
    - The patient communication work will include the promotion of an equal partnership between patient, prescriber and dispenser so that all roles and responsibilities are clear and rooted in the principles of good, shared decision making.
- The toolkit will take account of the different needs of different patient groups, such as older patients, patients with frailty, those in care homes, the needs of carers, those living in deprived populations, those living in rural areas and those significantly underserved by general practice or community pharmacy
- Where possible, digital solutions that have proven to be safe and effective should be prioritised over manual processes. However, the toolkit must recognise that not all patients are digitally literate
- The toolkit will take account of the needs of different care settings such as care homes and the different levels of care support that patients receive in the community.

The scope was further defined according to the table below:

In scope	Out of scope
Describe what a good repeat prescribing system looks like	Monitored dosage systems
Include baseline data and measurement	Appliances and acute prescriptions
Provide a process map of the pathway	Original pack dispensing
Describe the right people for the right job, at the right part of the process	Mandates about the length of repeat prescriptions – 28- vs 56-day supply
Describe a training matrix for staff involved in repeat medication processes (needs to be flexible for local capacity and capability)	Mandates about the use of digital pathways as the only option for patients and carers
Ensure it is applicable for different settings and support this with good practice examples	Detailed guidance for specific medicines
Ensure there are links to community pharmacy (making the most of contractual opportunities)	Guidance about specific timing of monitoring requirements for high-risk medicine or medicines with a monitoring requirement
Signpost to other resources and e-learning materials	Exacting standards that are unachievable in the current climate
Produce a patient/carer partnership framework	Guidance in relation to 'bulk authorisation' of repeat medicines
Outline a general practice self-assessment tool	Medicines shortages

SUMMARY OF CONSULTATION AND ENGAGEMENT

The professional and patient engagement activity included:

- Members of the working group over four workshops with defined aims and objectives
- Examples of good practice: over 30 submissions received from different professional groups
- Meetings with stakeholders
- Webinars held with stakeholder groups
- Workshop with RPS conference attendees
- Consultation and final recommendations received from:
  - Members of the RCGP/RPS repeat prescribing toolkit working group
  - RCGP clinical advisers' network
  - RPS primary care expert advisory group
  - RPS community pharmacy expert advisory group
  - RPS digital pharmacy expert advisory group
  - RCGP prescribing advisory group
  - Patient representative groups – National Voices, Age UK
  - NHSE stakeholders.

Many thanks to contributions and case studies from:

TOPIC	AREA/ORGANISATION
QI improvement in primary care	Primary and Community Transformation and Improvement team
Me and My Medicines campaign	Leeds, supported by the Health Innovation Yorkshire and Humber
I manage my meds	University of Leeds, University of Bradford and the Yorkshire and Humber Patient Safety Translational Research Centre
SMR resources	Health Innovation Network Polypharmacy Programme

Are your medicines working for you?	Health Innovation North East and North Cumbria
Medicines waste	NHS Dorset
Medicines Monitoring	Symphony Healthcare
Prescription re-alignment	Easington Primary Care Network
QI with repeat prescriptions	Citrus Health Primary Care Network
Antimicrobial stewardship	UKHSA and NHSE teams including leads for antimicrobial stewardship in the East of England
PCN Opioid resources	Health Innovation Wessex
Opioid quality improvement	Joined up care Derbyshire and Health Innovation East Midlands
Care home resources	NHS Coventry and Warwickshire ICB
Safer prescribing of antipsychotic medication	London Clinical Networks and Yorkshire and Humber Clinical Networks
Patients at risk of falls	National Falls Prevention Coordination Group
Resources to support the implementation of eRD	Health Innovation Wessex
North of England Care System Support (NECS)	National Pharmacy Integration Lead, NHS England
Use of ONS in frailty	BDA Optimising Nutrition Prescribing Specialist Group

Annex B
Repeat Prescription Systems in England – Literature Search & Summary

SCOPE

The RPS and RCGP's proposal to address Recommendation 7 of the National Overprescribing Review proposes the production of a national toolkit to aid repeat prescribing/dispensing and reduce overprescribing. The SRT were approached to assist with a literature search on, "the best practice guidance for all repeat prescribing systems in England." The agreed scope of this literature search included the following stages:

- Conduct a literature search on relevant databases, utilising key search terms.
- Conduct a search for other relevant evidence, such as guidance documents, on repeat prescribing in the UK.
- Collate and summarise the results from the literature search in a clear format.
- Provide further guidance/advice on literature review writing if, and when, necessary.

METHODOLOGY OVERVIEW

SRT conducted searches using multiple databases (PubMed, Cochrane Library, and Google Scholar), as well as using standard search engines. Only the results published between 2013 and 2023 are included in the final reporting. Once collated, the search outputs were reviewed and filtered for relevance and quality before the final information was compiled.

OUTPUTS

The collated resources are grouped into the following categories: (a) research articles, (b) guidance and/or evaluation documents, (c) and grey literature. The documents are ordered by their original publication date, starting from the oldest and working to the most recently published resources.

RESEARCH ARTICLES

Between 2013 and 2023, there were a limited number of publications directly related to repeat prescribing processes and/or eRD in the UK. Therefore, we expanded our search to include those which discuss the repeat prescription of specific medicines and repeat prescriptions and/or eRD in other countries.

Notably, publications which discuss the appropriateness and effectiveness of long- vs. short-term prescriptions all conclude that there is not enough available evidence to support that providing short-term prescription courses improves outcomes, despite previous UK recommendations.

AUTHOR/ ORGANISATION	PUBLICATION DATE	GEOGRAPHIC LOCATION	SOURCE TYPE	MAJOR THEMES	EVIDENCE SUMMARY
Petty DR, Zermansky AG, Alldred DP	19 February 2014	UK wide	Research article	NHS, repeat prescriptions,	An investigation into the scale of repeat prescribing and to whom the medicine is prescribed to in the UK. Seeks to understand the current data and common uses as our current evidence is outdated.
Price J, et al.	31 March 2017	Lambeth, London	Research article	Patient safety, risk management	Original research investigating the efficacy of a risk management model designed to identify, measure, and reduce repeat prescription risks which result in preventable harm in primary care settings. 62 unique repeat prescription risks were identified on 505 occasions, uncovering important safety concerns in primary care.
Grosset KA, Deary E, and El-Faragy N	20 November 2017	Glasgow	Research article	Repeat prescribing, patient-centred	Quality improvement study which used the 'Always Events' concept to improve repeat prescribing in a deprived, inner-city general practice setting in Glasgow. Researchers found that the Always Event approach allowed them to elicit important feedback from patients to identify a weakness in the repeat prescribing system, which was simple to rectify and led to an improved, more efficient service. Correction following the articles' release can be found here.
Martin A, Payne R, and Wilson ECF	12 March 2018	England	Research article	Longer vs. shorter prescription durations	This study sought to estimate the cost-effectiveness of 3-month vs. 28-day repeat prescriptions from an NHS perspective. Overall, 3-month prescriptions were associated with lower costs and higher QALYs than 28-day prescriptions. However, the quality of the evidence-base on which this modelling is based is poor. Any policy rollout should be within the context of a trial such as a stepped-wedge cluster design.

King S, et al.	28 March 2018	United Kingdom	Research article	Longer vs. shorter prescription durations	This systematic review explores the existing evidence relating to the impact of differing prescription lengths on clinical and health system outcomes. Currently, there is insufficient evidence to determine whether longer vs. shorter prescription durations are preferable for improving clinical and health system outcomes; however, several studies suggest longer prescriptions may improve medical adherence. Suggests the UK recommendations to provide shorter prescriptions are not substantiated by the current evidence base.
Cardwell K, et al.	5 July 2018	Ireland	Research article	General practice pharmacists	A non-randomised pilot study that plans to use a mixed-methods approach. Four GP practices will be purposively sampled and recruited. A pharmacist will join the practice team for 6 months. They will participate in the management of repeat prescribing and undertake medication reviews (which will address high-risk prescribing and potentially inappropriate prescribing, deprescribing and cost-effective and generic prescribing) with adult patients.
Lillis S, et al.	30 September 2019	New Zealand	Research article	Repeat prescribing practice	Survey was launched to gather the opinions and insights of GPs on repeat prescribing policies and practices. This research found that patient convenience and time efficiency were the most commonly cited reasons for repeat prescribing and registrars had low awareness of their practice's policy on repeat prescribing.
Davidson S, Thomson C, Prescott G	March 2020	UK	Research article	Benzodiazepine, repeat prescription	This study aimed to investigate whether patients on repeat diazepam prescription had their prescription reviewed to reduce and to stop the repeat prescription wherever appropriate, and whether these changes were sustained at 24 months. The researchers used a minimal intervention strategy to reduce diazepam use in a semi-rural general practice. Patients with a current prescription for diazepam were invited to visit their general practitioner for a review.
Lillis S and Lack L	22 December 2020	New Zealand	Research article	Improving repeat prescribing policy	A workshop-led study designed to improve GPs' understanding of repeat prescribing policy and understand the current issues with the repeat prescribing process which may put patients at risk. The workshop identified several issues, including a lack of patient understanding of appropriateness of repeat prescribing, a lack of protected time for medicine reconciliation and the task of repeat prescribing, too many personnel and steps in the process, and a lack of clarity over responsibility for repeat prescribing.
Savickas V, et al.	10 February 2021	UK	Research article	Pharmacy services, general practice	A cross sectional study which explored services provided by all UK GPPPs (pharmacists/ pharmacy technicians), including the types of services, perceived benefits, and barriers to role development. Study was conducted using a SurveyMonkey questionnaire. Ninety-one complete responses were received (81 pharmacists; 10 technicians). Over 80% of pharmacists provided clinical services, such as medication reviews or management of long-term conditions. More pharmacists within CPGP pilot managed repeat prescribing requests. Overall, General practice pharmacy professionals deliver clinical and non-clinical services which may benefit patients, general practice, and the healthcare system.
Alghadeer S, et al.	25 September 2021	Saudi Arabia	Research article	Pharmacists' perspective on repeat prescribing	Study exploring assess pharmacists' perspectives toward the repeat prescription process and identify the issues related to repeat prescriptions in refill clinics at tertiary hospitals. Results found that the repeat prescription service might be associated with issues that lead to preventable adverse effects, especially among the elderly who are prone to such effects.

Tse Y, et al.	November 2022	UK	Research article	Complex prescriptions, repeat prescriptions, paediatrics	In the UK, medicines for chronic conditions in children and young people (CYP) are typically initiated within secondary or tertiary care, with responsibility for ongoing supply often then passed to the child's general practitioner (GP) and community pharmacist. The patient should then be reviewed in regular specialist clinics, with two-way communication for any changes in medications or clinical status undertaken between primary and secondary/ tertiary care. This arrangement allows long-term medications to be obtained close to home. This is often messy, with families regularly needing to source medicines from the GPs and others via hospitals or homecare services. In addition, these arrangements are not uniform, they vary across different areas of the UK and depend on individual GP or hospital prescriber acceptance.
Chu A, et al.	22 December 2022	England	Research article	Junior doctors, electronic prescriptions, training & resources	Mixed methods study investigating the views of junior doctors towards electronic prescribing, training, and feedback, how ready they are to receive feedback and how the prefer to receive feedback on electronic prescriptions.
Jennings AA, Guerin N, and Foley T	23 October 2023	Cork, Ireland	Research article	Antipsychotics, repeat prescribing	This study looked to use an expert consensus process to identify the key components of an antipsychotic repeat prescribing tool for use with people with dementia in a general practice setting. A modified eDelphi technique was employed. The development of repeat prescribing tool provides GPs with practical advice that is lacking in current guidelines and will help to support GPs by providing a structured format to use when reviewing antipsychotic prescriptions for people with dementia, ultimately improving patient care.

GUIDANCE AND/OR EVALUATION DOCUMENTS

Many local NHS Trusts/local authority areas have produced local guidance documents on repeat prescription and/or how to transition to electronic repeat dispensing (eRD) and Electronic Prescription Services (EPS). Although there are variations in the scope of the documents, many of the local guidance documents are similar in content. Despite the independent publication, many of the documents seem to be variations of the same guidance, with minimal changes between regions. A few nationally applicable resources are available from sources such as NHS England, NHS Digital, and GMC which some local publications are based on.

Several publications were produced in 2020 as a result of the COVID-19 pandemic and the new-found need to incorporate electronic dispensing and automated processes. Despite the additional motivation for the development of these publications, there are few differences to the pre-existing guidance documents – the context and background is different, but the overarching themes remain the same.

AUTHOR/ ORGANISATION	PUBLICATION DATE	GEOGRAPHIC LOCATION	SOURCE TYPE	MAJOR THEMES	EVIDENCE SUMMARY
NHS England	May 2015	England (national doc)	Guidance document	eRD	A comprehensive guidance document designed to enables prescriber and dispensers to use the functionality of eRD effectively.
NHS Luton Clinical	July 2015	Luton	Best practice guide	Repeat prescribing, clinical responsibilities, quality control, medication review	A resource produced to help with the provision of high quality, safe and effective repeat prescribing. It provides tools to help practices and should be used as a working document. User can decide which sections are the most relevant at a particular point and then use the tools provided to make improvements to your systems.
PrescQIPP Commissioning Group	March 2016	Not specified	Guidance Document	Repeat prescriptions, national guidance, electronic prescription service (EPS)	Guidance and advice for prescribers, practice managers, practice staff, community pharmacists and medicines management teams etc., on developing, implementing, and reviewing repeat prescribing systems. It includes information on repeat prescribing policies, managed repeat prescriptions from community pharmacies, repeat dispensing and electronic prescribing.
NHS Digital	13 November 2018	Online	eRD guidance	eRD	The EPS Team at NHS Digital have developed this toolkit to help prescribers and dispensers make the most of eRD. You can jump to different topics using the navigation above and clicking the previous and next buttons at the bottom of the screen. Throughout the toolkit you will find downloadable information which you can share, including guides for prescribers and dispensers.
NHS Shropshire Clinical Commissioning Group	26 June 2019	Shropshire	Repeat prescribing guidelines	Repeat prescriptions, GP practices	Extensive document with guidelines on the repeat prescription process, how to start repeat prescriptions, how to order/request a repeat prescription, reviewing and authorising repeat prescriptions, and risk management. Also provides guidance and advice for prescribers on how to ensure on-going good quality, safe and cost-effective repeat prescribing that minimises medicines waste. This document applies to all members of staff working at GP and includes stages in the EPS. Includes an action plan template.
NHS Yorkshire Clinical Commissioning Group, Medicines Management Team	01 May 2020	North Yorkshire	Protocol document	eRD	Protocol document developed for NY CCG employed Pharmacists and Medicines Optimisation Technicians. Designed to provide clarity about the procedures for undertaking repeat dispensing arrangements within North Yorkshire. The protocols are produced by the NY CCG MM team for use by their employed MM team members. They can be adopted for use by other healthcare staff working in GP practices across.
Wessex Academic Health Science Network	May 2020	Wessex	Handbook	eRD	A handbook designed to act as a 'quick reference guide' and a point of reference for staff in GP practices and community pharmacies to help resolve common problems and make the most of the NHS electronic Repeat Dispensing (eRD) service.

NHS England	04 June 2020	England (national)	Letter	COVID-19, eRD	Letter sent to formally notify GPs, community pharmacists and their commissioners of temporary changes to the need for patient consent (using the powers granted by the National Health Service (Amendments Relating to the Provision of Primary Care Services During a Pandemic etc.) Regulations 2020 during the COVID-19 response) to maximise use of the electronic repeat dispensing (eRD) system. Information provided on successful eRD roll out and required action at the time.
Wessex Academic Health Science Network	November 2020	Wessex	Mixed methods evaluation report	Evaluation of eRD	An evaluation of electronic repeat dispensing services in Wessex: exploring the perceptions and experiences of those working in GP, community pharmacy and people who receive medication by electronic repeat dispensing. To explore the perceptions and experiences of eRD from those working in General Practice and Community Pharmacy and people who receive their medication by eRD in Wessex. Evidence has shown the majority of reported eRD to be helpful, specifically with reference to the themes of convenience and time saving. On the other hand, respondents from the General Practice and Community Pharmacist reported challenges in using eRD.
General Medical Council	05 April 2021	N/A	Repeat prescribing and medicine and device management guide	Safe prescribing	Guidance document to help ensure the practice of safe prescribing. Covers what needs to be considered when prescribing unlicensed medicines, repeat prescribing, and when responsibility for your patient is shared. It also informs on how to work safely when you are not the patient's regular prescriber.
NHS Cheshire Clinical Commissioning Group	23 September 2021	Cheshire	Repeat prescribing guide	Patients and carers, pharmacy, GP practices	Guidance document addressing patient and carer involvement in repeat prescribing, GP practice processes and patient led ordering of repeat prescriptions, pharmacy involvement in repeat prescribing, and Care Home processes.
West of England Academic Health Science Network	December 2021	West of England	Guidance programme	eRD	An online pack of electronic Repeat Dispensing (eRD) resources to help practices and community pharmacists implement eRD. The West of England AHSN worked in partnership with South West AHSN to deliver the following webinars.
NHS Digital	15 June 2022	N/A	Guidance webpage	eRD, prescriber & patient benefits	Overview of the benefits of eRD, which could replace an estimated 80% of all repeat prescriptions. How the system works, the benefit for prescribers and patients, and several documents on how to maximise the benefits of eRD are also included in the guidance.
South West Academic Health Science Network	25 October 2022	Cornwall, Devon, Somerset	Evaluation & insight report	eRD	The report sets out findings and a set of recommendations from activities delivered by the South West AHSN to understand Electronic Repeat Dispensing and increase its usage in the region. The eRD report forms part of the South West AHSN's Technology-enabled Workforce programme, which seeks to optimise digital interactions to improve patient outcomes and workforce benefits. It is designed to be of use and interest to those involved in delivering and supporting uptake of eRD.
NHS South Yorkshire Integrated Care Board, Doncaster Place	October 2022	South Yorkshire	Guidance document	eRD, SystmOne (TPP)	Guidance document designed to provide clarity about the procedures for undertaking repeat dispensing arrangements within South Yorkshire.
South West Academic Health Science Network	01 November 2022	South West England	Report	Uptake of eRD	New report exploring the use and uptake of eRD across the South West. It is designed to be of use and interest to those involved in delivering and supporting uptake of eRD.
Pharmaceutical Services Negotiating Committee	18 November 2022	N/A	Guidance webpage	eRD background, training resources	Provides background on the origin of eRD, how it works, and shared resources for pharmacists, GPs, and patients. An FAQs section is included.

Community Pharmacy Lincolnshire	07 December 2022	Lincolnshire	Resource webpage	Repeat dispensing	Links to relevant training and resources and guidance (below) for community pharmacies in Lincolnshire to review their processes and training on eRD to ensure all teams are aware of their responsibilities.
The Barkantine	Not specified	N/A	Guidance webpage	eRD	Guide which covers eRD background, benefits for patients, and a step-by-step set-up guide.
NHS Business Services Authority	Not specified	England (national doc)	Resource & guidance document	eRD	National guidance and resources on Electronic Repeat Dispensing. Includes video developed by NHS Business Service Authority and NHS Digital for pharmacies to explain the high-level process behind eRD. Includes process for requesting eRD data, eRD reports, information for patients, pharmacies, and GP practices.
NHS Business Services Authority	Not specified	England (national doc)	Guidance dashboard	EPS, eRD	Dashboards provide information on the EPS and eRD, allowing GP practices, Integrated Care Boards (ICBs), and other bodies to: see variation in EPS and eRD prescribing across GP practices, within an ICB, and across ICBs • see trends and variations in EPS and eRD dispensing across dispensers, and within ICBs • help prioritise potential areas of activity • help monitor the impact of initiatives to increase EPS and eRD utilisation The dashboards support local interventions to drive the growth of EPS and eRD so stakeholders can understand the potential benefits of EPS and eRD.
NHS Business Services Authority	Not specified	Wessex	Guidance document	Transitioning to eRD	Report uses data from observations in 2 practices in the Wessex area to highlight the benefits of transitioning from paper-based repeats to electronic repeats, focusing on the potential benefits that moving to eRD can offer.

GREY LITERATURE

There were limited number of publications or online resources discussing repeat dispensing and/or eRD.

AUTHOR/ ORGANISATION	PUBLICATION DATE	GEOGRAPHIC LOCATION	SOURCE TYPE	MAJOR THEMES	EVIDENCE SUMMARY
National Institute for Health and Care Research	14 March 2018	UK	News article	Prescription duration, economic modelling, health outcomes	Covers the British Journal of General Practice's research, and other related research, which suggests that people with long-term conditions should be able to receive prescription durations longer than 28-days.
National Institute for Health and Care Research	17 April 2018	UK	Blog post	Repeat prescriptions, patient safety, prescription length, GPs, community pharmacy	Reviews the current repeat prescription process and how to best balance patients' needs and reducing medicine waste. The pros and cons of short-term and long-term prescriptions from a patient, GP, and pharmacy perspective. The recent economic modelling exercise which showed longer prescriptions are more cost effective could impact GP practices, dispensing fees, and patient-practitioner interactions. The evidence does not align with the current 28 day prescribing policy, but it is possible that reconsidering this approach could improve patient care and prescription costs.
University of Bristol	2018	England	Research webpage	Duration of repeat prescriptions	A study commissioned by the NIHR Health Technology Assessment Programme in which researchers looked into the clinical and cost-effectiveness of longer versus shorter duration prescriptions for long-term medication, to see if there was evidence to support or change current guidance. The study included: • A cost analysis of medication wastage using GP prescribing data from across England • A cost analysis of medication wastage using GP prescribing data from across England An economic decision model, to predict the costs and effects of differing levels of adherence to medication, depending on prescription duration.
Yorkshire & Humber AHSN	Not specified	Yorkshire & Humber	Webpage	eRD	Yorkshire and Humber AHSN's electronic repeat dispensing information webpage. Includes links to resources which will support the roll out of eRD.

Annex C
Equality Impact Assessment (EqIA) Guidance

BACKGROUND

We are committed to making inclusion and diversity central to the profession by celebrating and encouraging diverse voices across pharmacy. We aim to extend this concept to encompass all RPS products and services, ensuring inclusion and diversity is at the heart of the design and delivery of our products and services in line with our RPS Inclusion and Diversity Strategy.

Equality Impact Assessments are a way to make sure the RPS does not inadvertently discriminate and encourages us to think carefully about the likely impact of our work on stakeholders including RPS members, members of the profession and members of the public.

The Equality Act 2010 provides a framework on which the Equality Impact Assessment is based on to protect individuals and advance equality of opportunity for all, protecting individuals from unfair treatment and promoting a fair and more equal society.

The Equality Impact Assessment focuses on systematically assessing and recording the likely equality impact of RPS products and services. The key purposes are to:

- Identify whether certain groups are excluded from our products and services
- Identify any direct or indirect discrimination
- Assess if there is any adverse (negative) impact on particular groups
- Address identified equality issues in our products and services
- Where possible remove or minimise disadvantages experienced by people due to their protected characteristics
- Taking the steps to meet the needs of people from protected characteristics where these are different from the needs of other people

The focus of our Equality Impact Assessments will be to assess the impact of our activities on people with the 'protected characteristics' listed in the Equality Act 2010, namely

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership

- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

In addition to these, we will also consider the impact on

- Carers
- Welsh Language
- Rurality impacts
- Different socio-economic groups

WHAT IS AN EQUALITY IMPACT ASSESSMENT (EQIA)?

An Equality Impact Assessment is an assessment to improve the work of the RPS by making sure it does not discriminate and were possible promotes equality. It focuses on systemically assessing and recording the likely impact of an activity or policy on people with 'protected characteristics'. This involves anticipating the consequences of activities on these groups and making sure that as far as possible any negative consequences are eliminated or minimised and opportunities for promoting equality are maximised.

The EqIA is carried out by drawing on available information to identify best practice with regards to equality relating to the affected product or service. This may include existing research, journal articles, direct feedback from stakeholders and internal/ external data monitoring information. Once this has been completed the findings of the EqIA should inform the development or review of the assessed product or service, including action plans which will change the delivery of a product, activity or service, with clear monitoring arrangements.

WHO IS RESPONSIBLE FOR UNDERTAKING AN EQUALITY IMPACT ASSESSMENT?

The project lead holds responsibility for ensuring an EqIA has been considered and undertaken as necessary. As the lead they will have a good understanding of the subject or product being developed. Support and advice is available from the Head of Professional Belonging.

PART 1: INITIAL SCREENING AND PRODUCT DEVELOPMENT

1. THE PURPOSE AND AIMS OF THE PRODUCT, POLICES, GUIDELINES AND EDUCATIONAL FRAMEWORKS AND CURRICULA REQUIRED

This Equality Impact Assessment (EQIA) is for the RPS/RCGP Repeat Prescribing Toolkit.

In 2021 the Department for Health and Social Care published the National Overprescribing Review, 'Good for you, good for us, good for everybody' to reduce overprescribing in England and to make patient care better and safer. Recommendation 7 asked Royal Pharmaceutical Society (RPS) and the Royal College of General Practitioners (RCGP) to develop a national toolkit to help practices improve the consistency of repeat prescribing processes and support this with training resources for GP practice receptions and administration teams.

In 2023, NHS England commissioned RPS and RCGP to develop this toolkit to help improve the consistency, safety and efficiency of repeat prescribing systems in general practices in England.

The toolkit includes a self-assessment template and series of questions that practices should ideally complete as a team, including community pharmacy and patients, to review their repeat prescribing processes.

Patients have been involved in co-production and there is also a patient partnership agreement, a patient information leaflet and infographic included as part of the publication.

2. DO YOU FORESEE ANY EQUALITY IMPACT THIS PRODUCT, POLICES, GUIDELINES AND EDUCATIONAL FRAMEWORKS AND CURRICULA AND HAVE YOU IDENTIFIED ANY SPECIFIC ACTIONS TO ADDRESS THIS DURING THE DEVELOPMENT PHASE?

An equality impact identified is that the patient material is only currently available in English, as either written information or a pictogram. We would anticipate that local ICBs, if promoting the toolkit, would adapt patient material relevant for their local population.

3. EVIDENCED USED/CONSIDERED

The purpose of the toolkit is to improve consistency of repeat prescribing processes for patients and/or their carers.

This is the first contemporary guidance reviewing repeat prescribing since 2004. There is no comparator available.

There are known inequalities within prescribing and specifically polypharmacy. As highlighted in the National Over-prescribing Review, those living in the most deprived areas are much more likely to be taking 8 or more medicines (polypharmacy), and the group with the highest proportion of those on 8 or more medicines (13.9%), are those who reported themselves as of Asian/Asian British ethnicity.

The toolkit has been developed with an expert working group of key stakeholders including GPs, pharmacists, pharmacy technicians, practice managers, integrated care board (ICB) medicines leads, CQC, patients and third-sector representatives. The group comprised of individuals with a range of protected characteristics.

The working group have sought to consider all patient groups in the development of the toolkit and there are good practice examples included.

In relation to specific protected characteristics, see table below.

4. INTERNAL IMPACT ASSESSMENT

EQUALITIES AND WELSH LANGUAGE IMPACT ASSESSMENT

PROTECTED CHARACTER-ISTIC	IMPACT: POSITIVE	IMPACT: NEGATIVE	IMPACT: NEUTRAL	REASON FOR YOUR DECISION (including evidence used). Include details of how it might impact on people from this group in eliminating direct or indirect discrimination and how opportunities to advance equality and promoting good relations have been maximised.
AGE			NEUTRAL	The working group recognised that not all options for ordering repeatable medicines should be via a digital route as this could potentially exclude certain patient groups dependent on their age. We have made it clear throughout the document that patients can continue to order their medicines by non-digital means, but digital capability within the GP practice should be maximised to account for this and to ensure equitable access to repeat medication. We have included case examples of proxy ordering within care homes – in recognition that some patients may not order their medicines themselves. In terms of rurality, we have considered that some patients receive their medicines via a dispensing surgery instead of a community pharmacy and a representative from the Dispensing Doctors Association (DDA) was an active member of the working group.

DISABILITY Disability as defined in the Equality Act 2010: Those with any physical, sensory, learning, cognitive or mental health impairment or health condition which causes individuals to face barriers to employment, equal opportunities, access to goods, facilities or services lasting or expected to last 12 months or more, or terminal.	**NEUTRAL**	All patient information needs to explicitly include carers. We have included case examples of proxy ordering within care homes – in recognition that some patients may not order their medicines themselves. Practices and PCNs must consider the need for different formats of information to meet the needs of the patient, and also consider how the information in communicated. Practices and PCNs need to consider how a review and/or patient partnership agreement may be communicated to patients e.g. neurodivergence, as this may cause some concern and anxiety. From a user perspective, there is a lot of information to navigate within the pdf document. The website design ensures this has been broken down into sections and we will ask for feedback from a range of users including those who are neurodivergent.
SEX A person's sex, including intersex people	**NEUTRAL**	
GENDER REASSIGN-MENT Internal sense of their own gender and gender expression, whether male, female or something else (for example non-binary people), which may or may not correspond to the sex assigned at birth; and aspects of how an individual expresses gender, including clothing, mannerisms and other aspects of expression.	**NEUTRAL**	Practices need to ensure that any consultations are inclusive and considerate of the needs of people who are gender non-binary, transgender or undergoing transition.

MARRIAGE OR CIVIL PARTNERSHIP	**NEUTRAL**	None identified
PREGNANCY AND MATERNITY	**NEUTRAL**	Higher risk medicines referenced in the toolkit includes those with teratogenic potential.
RACE Race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers.	**NEUTRAL**	The current patient partnership agreement, leaflet and infographic are in English. We will advise ICBs and local teams to translate these, as needed, for their local population. Practices and PCNs need to ensure the consultations are undertaken with cultural awareness, and ensure the patients understand the need for their medicines and any de-prescribing of medicines, including an awareness about how people interact with their medicines, which may impact the outcome of the consultations.
RELIGION OR BELIEF Religion includes any religion as well as lack of religion. Belief means any religious or philosophical belief.	**NEUTRAL**	Practices and PCNs need to ensure the consultations are undertaken with cultural awareness, and ensure the patients understand the need for their medicines and any de-prescribing of medicines, including an awareness about how people interact with their medicines, which may impact the outcome of the consultations.
SEXUAL ORIENTATION A person's orientation towards people of the same sex, the opposite sex or more than one gender.	**NEUTRAL**	Practices and PCNs need to be mindful of heteronormative biases and assumptions that may be made during a consultation.

CARERS A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of health condition, physical, sensory, cognitive, learning, or mental health impairment and cannot cope without their support. The care they give is unpaid.	NEUTRAL	Considerations have been given to carers throughout the document, including if they're responsible for ordering medicines, and whether they have access to digital solutions and understanding of the processes.

WELSH LANGUAGE - IN WALES, THE WELSH AND ENGLISH LANGUAGES WILL BE TREATED ON A BASIS OF EQUALITY

WELSH LANGUAGE Opportunities for persons to use the Welsh Language. Treating the Welsh language no less favourably than the English language.	**IMPACT:**	
	POSITIVE / NEGATIVE / NEUTRAL	The toolkit will not be translated into Welsh for the time being, as this was commissioned by NHS England.

IS THERE EVIDENCE OF ANY IMPACT ON OTHER GROUPS NOT COVERED BY THE PROTECTED CHARACTERISTICS? IF YES USE THE COMMENTS COLUMN TO DESCRIBE WHAT THE POTENTIAL IMPACT IS, WHAT YOU COULD DO TO REMOVE/REDUCE ANY NEGATIVE IMPACT AND WHAT YOU COULD DO TO BENEFIT FROM ANY POSITIVE IMPACT.

COMMENTS

None identified

5. EQUALITIES AND WELSH LANGUAGE IMPACT ASSESSMENT WORKSHOP

Additional recommendations, actions and conclusions captured at the Equality Impact Assessment workshop are listed below.

PROTECTED CHARACTER-ISTIC	IMPACT: POSITIVE / NEGATIVE / NEUTRAL	REASON FOR YOUR DECISION (including evidence used). Include details of how it might impact on people from this group in eliminating direct or indirect discrimination and how opportunities to advance equality and promoting good relations have been maximised.	
		ADDITIONAL RECOMMENDATIONS	EXISTING MEASURES/ MEASURES TO BE IMPLEMENTED.
AGE	NEUTRAL	Agreement on comments made in Part 2. This was also discussed from a user perspective and whether all staff in primary care will be able to access the toolkit.	It was noted that PDF version will be available in addition to a web-based toolkit
DISABILITY Disability as defined in the Equality Act 2010: Those with any physical, sensory, learning, cognitive or mental health impairment or health condition which causes individuals to face barriers to employment, equal opportunities, access to goods, facilities or services lasting or expected to last 12 months or more, or terminal.	NEUTRAL	Comments reviewed in Part 2.	A good practice example of support for patients with a disability would be best to be included in the toolkit. There may be local arrangements e.g. a dedicated staff member(s) who supports particular patient cohorts.

SEX A person's sex, including intersex people	NEUTRAL		A member of the assessment workshop wanted to ensure specifically that there is consideration of women's health and medicines that may have been prescribed inappropriately for an incorrect diagnosis are reviewed. This is outside of the scope of the toolkit but clarification will be added about ongoing indication for a medicine.
GENDER REASSIGN-MENT A Internal sense of their own gender and gender expression, whether male, female or something else (for example non-binary people), which may or may not correspond to the sex assigned at birth; and aspects of how an individual expresses gender, including clothing, mannerisms and other aspects of expression.	NEUTRAL		It is an employer's responsibility to ensure that employees receive training in that consultations are inclusive and considerate of the needs of people who are gender non-binary, transgender or undergoing transition.
MARRIAGE OR CIVIL PARTNERSHIP	NEUTRAL		
PREGNANCY AND MATERNITY	NEUTRAL	Higher risk medicines referenced in the toolkit includes those with teratogenic potential.	It will be added that this is relevant to both male and female patients.

RACE Race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	NEUTRAL	Further discussion around availability of translation services	Action: to liaise with NHS E and the health inequalities team around commonly translated patient material and what is feasible at a national or local level given the timeline for publication.
RELIGION OR BELIEF Religion includes any religion as well as lack of religion. Belief means any religious or philosophical belief	NEUTRAL	No further points raised	Action: to liaise with NHS E and the health inequalities team around materials related to awareness for certain religious practices, and whether this is relevant for the publication.
SEXUAL ORIENTATION A person's orientation towards people of the same sex, the opposite sex or more than one gender.	NEUTRAL	No further points raised	It is an employer's responsibility to ensure that employees receive training in heteronormative biases and assumptions that may be made during a consultation.
CARERS A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of health condition, physical, sensory, cognitive, learning, or mental health impairment and cannot cope without their support. The care they give is unpaid.	NEUTRAL	Discussion that the toolkit references that carers can request and order medicines via different routes.	There was a suggestion that this is added to the PPG section of the toolkit and that practices and PCNs ensure if a carer requests medicines or supports a patient with their medicines, this is formally discussed and recorded in the medical notes.

WELSH LANGUAGE - IN WALES, THE WELSH AND ENGLISH LANGUAGES WILL BE TREATED ON A BASIS OF EQUALITY			
WELSH LANGUAGE Opportunities for persons to use the Welsh Language. Treating the Welsh language no less favourably than the English language.	**IMPACT:**		
	POSITIVE NEGATIVE NEUTRAL	Not applicable as this was commissioned by NHS England	

IS THERE EVIDENCE OF ANY IMPACT ON OTHER GROUPS NOT COVERED BY THE PROTECTED CHARACTERISTICS? IF YES USE THE COMMENTS COLUMN TO DESCRIBE WHAT THE POTENTIAL IMPACT IS, WHAT YOU COULD DO TO REMOVE/REDUCE ANY NEGATIVE IMPACT AND WHAT YOU COULD DO TO BENEFIT FROM ANY POSITIVE IMPACT.

ADDITIONAL COMMENTS

Socioeconomic considerations were discussed – for those patients with no access to a phone/smart phone or laptop. It was discussed that the patient information material references different routes to request medicine, in discussion with the GP practice.

Homeless patients or those recently discharged from prison were discussed and what additional support they may require, see table added at the end of the document.

ACTIONS

Discuss with NHS E (commissioner) about the health inequalities assessment

PART 4: ACTION PLANNING

ACTION PLANNING			
ACTIONS TO BE TAKEN TO ADDRESS NEGATIVE IMPACTS AND MAXIMISE POSITIVE IMPACTS	**POTENTIAL OUTCOMES**	**LEAD**	**TIMESCALES**
A good practice example of support for patients with a disability would be best to be included in the toolkit.	Good practice example identified and being drafted		
Ensure the toolkit will be accessible with regards to format and information	Liaise with website and design leads		
To liaise with NHS E and the health inequalities team around commonly translated patient material			
To liaise with NHS E and the health inequalities team around materials related to awareness for certain religious practices.			

PART 5: MONITORING

MONITORING ARRANGEMENTS
The toolkit will be under review in 3 years' time and we suggest a further EqIA is completed at this point.
SIGNED: **DATE:** **APPROVED BY:**

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