Lancashire & South Cumbria Medicines Management Group

NHS

Guidelines for Good Prescribing in Primary Care

DRAFT FOR CONSULTATION Version 0.24 – October 2024

Please note that this is a draft document for consultation. If you wish to feedback, please follow the link and complete the Microsoft Form by 21st February 2025 - https://forms.office.com/e/yfhUSbngP8

Contents

1. INTRODUCTION AND BACKGROUND

The purpose of this guidance is to outline recommendations for prescribing within primary care in Lancashire and South Cumbria. It is intended to provide information on current best practice including providing advice on prescribing situations which are not always clear to ensure a consistent approach by primary care prescribers. All prescribers are encouraged to follow this guide.

Suitably trained and registered nurses, pharmacists, physiotherapists, podiatrists, optometrists, radiographers, and paramedics are now eligible to prescribe within their competencies either as supplementary prescribers, prescribing in partnership with a doctor, or as independent prescribers.

2. PRESCRIBING WITHIN THE 'COMPETENCY FRAMEWORK FOR ALL PRESCRIBERS'

To support all prescribers in prescribing safely and effectively, a single prescribing competency framework was published by the National Prescribing Centre/National Institute for Health and Care Excellence (NICE) in 2012. Based on earlier profession-specific prescribing competency frameworks the 2012 single prescribing competency framework was developed because it became clear that a common set of competencies should underpin prescribing, regardless of professional background.

The full document, which included the full list of behaviours and actions, can be found at:

https://www.rpharms.com/resources/frameworks/prescribing-competency-framework/competency-framework#purpose

3. RESPONSIBILITY FOR PRESCRIBING

Medicines may only be prescribed by registered doctors, dentists or non-medical prescribers. The person issuing the prescription is **clinically responsible** for the intervention. Medicines should be prescribed when they are necessary, and in all cases the benefit of the medicine should be considered in relation to the risk involved.

Special care should be taken with patients who have disabilities, those for whom English is a second language, or have religious or cultural beliefs that may be a barrier to understanding or taking their medication. Measures should be undertaken to address any barriers for

example supplying information in different formats or supplying mediation in appropriate forms.

4. SHARING INFORMATION WITH COLLEAGUES

4.1 General information on transfer of care

You should contribute to the safe transfer of patients between healthcare providers and between health and social care providers: [3] [4]

- You should share all relevant information with colleagues, including information about the patient's current and recent use of medicines, other conditions, allergies, and previous adverse reactions to medicines.
- Provide relevant information with the patient or as soon as possible on admission to hospital whether an emergency or not.
- Check the completeness and accuracy of the information accompanying a referral.
- After an episode of care is complete, the patient's GP should be informed of any changes to patient's medicines (existing medicines changed or stopped and new medicines started), with reasons; length of intended treatment; monitoring requirements; any new allergies or adverse reactions identifies, unless the patient objects or if privacy concerns override the duty, for example in sexual health clinics.
- Consider whether the information you have is sufficient and reliable enough to prescribe safely.
- Ensure that a patient's medicines following discharge are reviewed and quickly incorporated into the patient's records and checked by a clinician.

It is important that, when patients are transferred from hospital to general practice on a medicine that is not frequently prescribed in primary care, this should only take place with full local agreement and the dissemination of sufficient information to individual GPs. This could take the form of an agreed shared care management guideline. Clear processes and good communication are pivotal to effective shared care and GPs will need to be aware of their responsibilities when writing prescriptions for specialist medicines. Legal responsibility for prescribing lies with the doctor who signs the prescription. This is a particularly important consideration if a GP is intending, or has been asked to prescribe an unlicensed medicine or a licensed medicine either for an off-label indication or a dose outside that recommended in the Summary of Product Characteristics. (See advice from MHRA in section 7). Local commissioners could be asked to pursue any specific difficulties.

4.2 Shared Care of Medicines

Responsibilities for continuing care or treatment should be based on the patient's best interests. All parties including the patient should agree to this. Effective communication of all relevant information and continuing liaison are essential. [3] [5]

Shared Care Agreements (sometimes called Shared Care Guidelines) are developed when complex treatments that were initiated in secondary care are then transferred for prescribing to a GP. All LSCMMG new medicines reviews that are agreed for use with a RAG status of: 'Amber1' or 'Amber2' should have an associated shared care agreement in place and available for use on the LSCMMG website and the Lancashire and South Cumbria Formulary. GPs are not obliged to enter into a shared care agreement where one exists.

Successful shared care arrangements enable the combination of the best of both primary and secondary care for the benefit of the patient. They allow the seamless transfer of patient treatment from the secondary care sector to general practice. Effective shared care relies on Effective Shared Care Agreements including the following aspects:

- Individual, patient-by-patient arrangements - Effective Shared Care Agreements should be patient specific and encompass all aspects relevant to that particular patient.

- A reasonably predictable clinical situation - Clinical responsibility should be considered for transfer to primary care **only** where it is agreed that the patient's clinical condition is stable or predictable.

- Willing and informed consent of all parties - This includes patients, carers, and doctors. Consenting parties must have sufficient, accurate and timely information in an understandable form. Consent must be given voluntarily.

- A clear definition of responsibility - The shared care arrangement should identify the areas of care for which each partner has responsibility and where, if appropriate, the specialist resources are available to the GP. This should be patient specific.

- A communication network - Agreed communication should include a telephone contact number for use when problems arise, and an email address if appropriate. Progress reports should be produced to an agreed time-scale with regular review.

- A clinical summary - This should include a brief overview of the disease and more detailed information on the treatment being transferred for which each partner has managerial and clinical responsibility. At a minimum, it should identify the product's licensed indications, therapeutic classification, dose, route of administration and duration of treatment, adverse effects (their identification, management, importance

and incidence), monitoring requirements and responsibilities, clinically relevant drug interactions and their management, storage and reconstitution of product, peer-reviewed references for product use, and contacts for more detailed information.

- Emergency support - Contact numbers should include those for out-of-hours queries.
- Training - Any training required by GPs and their staff should be identified and provided to a satisfactory standard by the specialist department seeking the shared care arrangement.

The issue of patient safety is always paramount.

4.3 Traffic Light Scheme /RAG Scheme/Colour Classification for medicines

Colour classification for medicines

Medicines across Lancashire and South Cumbria are classified by colour which depicts whether a medicine is funded or not and if funded where the prescribing responsibility lies across the whole health economy. The LSCMMG consider individual new medicines or new indications for licensed medicines taking into account the safety and monitoring requirements of a medicine before assigning its colour classification:

GREEN Medicines		
Appropriate for initiation and on-going prescribing in both primary and secondary care. Generally, little, or no routine drug monitoring is required.		
GREEN (Restricted) Medicines		
Appropriate for initiation and ongoing prescribing in both primary and secondary care provided: ○ Additional criteria specific to the medicine or device are met, or ○ The medicine or device is used following the failure of other therapies as defined by the relevant LSCMMG pathway. Generally, little, or no routine drug monitoring is required.		
AMBER Medicines		
Amber0	**Amber1**	**Amber2**
Suitable for prescribing in primary care following recommendation or initiation by a specialist. Little or no specific monitoring required. Specialists should fully discuss the recommended treatment with the patient, including: rationale, side effects and monitoring. Patient may need a regular review, but this would not exceed that required for other medicines routinely prescribed in primary care. Brief prescribing document or information sheet may be required.	Suitable for prescribing in primary care following recommendation or initiation by a specialist. Minimal monitoring required. Specialists should fully discuss the recommended treatment with the patient, including: rationale, side effects and monitoring. Patient may need a regular review, but this would not exceed that required for other medicines routinely prescribed in primary care. Full prior agreement about patient's on-going care must be reached under the Shared Care Agreement (or Shared Care Guideline).	Initiated by specialist and transferred to primary care following a successful initiation period and stabilisation of dose. Significant monitoring required on an on-going basis. Specialists should fully discuss the recommended treatment with the patient, including: rationale, side effects and monitoring. Full prior agreement about patient's on-going care must be reached under the Shared Care Agreement. Amber Level 2 medicines require significant monitoring for which an enhanced service may be suitable.

Primary care prescribers must be familiar with the drug to take on prescribing responsibility or must receive the required information from specialist colleagues where necessary. When recommending or transferring care of amber0 classified medicines, specialists should ask primary care prescribers to take over prescribing responsibility, and if agreed, should give information about the indication, dose, whether use is off-label and instruction on any necessary dose adjustments to allow them to prescribe with confidence.	Primary care prescribers are advised not to take on prescribing of these medicines unless they have been adequately informed by letter of their responsibilities with regards monitoring, side effects and interactions and are happy to take on the prescribing responsibility. A copy of locally approved Shared Care Guidelines should accompany the letter that outlines these responsibilities. Primary care prescribers should reply to specialist colleagues as soon as possible by letter so that arrangements can be made for the transfer of care.	(Subject to local commissioning arrangements). These medicines are considered suitable for GP prescribing following specialist initiation and stabilisation of therapy, according to a locally agreed Shared Care Agreement which will be provided with the written request to prescribe. On-going communication between the primary care prescriber and specialist is expected.
RED Medicines		
Medicine is prescribed by the specialist service for the duration of the treatment course. Primary care initiation or continuation of treatment is not recommended unless exceptional circumstances exist such as a specialist GP. Red medicines are those where primary care prescribing is not recommended. These treatments should be initiated by specialists only and prescribing retained within specialist services. They require specialist knowledge, intensive monitoring, specific dose adjustments or further evaluation in use. If, however, a primary care prescriber has had particular recognised formal training in the specialist area and has specialist knowledge in prescribing such a drug, it would not always be appropriate for them to expect to transfer that prescribing responsibility back to a secondary care specialist service. There should be a specific reason, and a specific risk agreement, protocol and service set up to support this. Primary care prescribers may prescribe RED medicines in exceptional circumstances to patients to ensure continuity of supply while arrangements are made to obtain on going supplies from the specialist service. However, it is important to remember that many RED drugs are not commissioned by the ICB and are the responsibility of NHS England. It is important to ascertain the commissioning responsibilities before undertaking the prescribing. Many of the RED drugs would also present a significant cost pressure on GP prescribing budgets.		
DNP Medicines		
NOT recommended for use by the NHS in Lancashire and South Cumbria. Includes medicines that NICE has not recommended for use and NICE terminated Technology Appraisals. Includes medicines for which there is insufficient evidence of their effectiveness.		
GREY Medicines		
Medicines which have not yet been reviewed or are under the review process. GPs and specialists are recommended not to prescribe these drugs. This category includes drugs where funding has not yet been agreed.		

The Lancashire and South Cumbria medicines formulary is available at: https://www.lancashireandsouthcumbriaformulary.nhs.uk/default.asp.

4.4 Multiple prescribers prescribing concurrently for a patient

Some medicines, described under the colour classification system above as red drugs, are prescribed, and issued or administered solely by specialist services. These medicines may not appear on the GP prescribing system. Prescribers must be aware of any “RED” medicines

being prescribed for a patient to avoid drug interactions or contraindications and potential patient harm e.g. patients prescribed and given biologics by specialist rheumatology services being called for or given a live vaccine such as shingles vaccine. Healthcare professionals providing a medicine under a Patient Group Direction also need to be aware of any “red” classified medicines that the patient may be taking or receiving.

4.5 Medicines as Part of a Hospital Trust initiated Clinical Trial

Prescribing of medicines as part of a hospital trust initiated clinical trial or the continuance of a hospital initiated clinical trial should remain with the hospital. The hospital should have a clear exit strategy for patients being treated in a clinical trial. Continued prescribing will not be taken over by primary care clinicians unless formal approval of the drug has been made through local decision-making processes.

4.6 High-Cost Medicines

Prescribers also need to be aware that high-cost medicines prescribed by secondary or tertiary care specialist services that are not included in the Payment by Results tariff may be funded by another funding stream other than primary care, such as NHS England or Cancer Drugs Fund.

Secondary care prescribers initiating high-cost medicines should ensure that an ICB or national position (e.g. NICE TA) has been agreed before initiating treatment. Where high-cost drugs have been approved for use the provider trust must ensure a ‘Blueteq’ form has been completed where available.

5. MEDICINES AND HOSPITAL ADMISSION

5.1 Medicines Before and During Hospital Admission

One Stop dispensing requires patients to take all their current medicines with them on admission to hospital. Where appropriate, patients continue on their own medicines during their in-patient stay, and any new medicines are dispensed and labelled for that patient as an original pack and ready for discharge. Usually, a month’s supply is dispensed. This supply is used whilst they are an in-patient, and the remainder taken home on discharge when ordered on the discharge prescription.

By operating these systems, confusion is hopefully avoided as:

- Patients continue with the medicines with which they are familiar,
- Wastage is reduced, and

- Unnecessary duplication of medicines on discharge is avoided.

Please ensure that patients know to take their medicines into hospital with them for planned admissions.

5.2 Medicines for Discharge

Whichever system for discharge medicines is operated, hospitals should ensure that patients have sufficient medication to take home at discharge which allows the patient enough time to organise a new prescription from their GP. Time allowed needs to take into consideration the time taken for: the GP to receive the discharge note, the patient to arrange an appointment with the GP or to obtain a prescription via the GP process, and time to enable dispensing particularly for items that are not commonly available. This should also include a time allowance for weekends.

The minimum number of days on discharge should be agreed with the ICB. Evidence and research show that this time frame and thus number of days of medication on discharge should be 14 days, however care should be taken in some clinical areas e.g. suicide risk. If medication is required to be dispensed on discharge, it should ideally be in original packs labelled for discharge as this both saves time and ensures that the dispensing complies with national directives.

5.3 Medicines Reconciliation

Medicines reconciliation is defined by The Institute for Healthcare Improvement (IHI) as “being the process of identifying the most accurate list of a patient’s current medicines – including the name, dosage, frequency and route – and comparing them to the current list in use, recognising discrepancies, and documenting any changes, thus resulting in a complete list of medications, accurately communicated”. The term 'medicines' also includes over-the-counter or complementary medicines, and any discrepancies should be resolved. The medicines reconciliation process will vary depending on the care setting that the person has just moved into – for example, from primary care into hospital, or from hospital to a care home. [7]

Medicines reconciliation following hospital admission or specialist appointment requires clinical judgement and should only be undertaken by competent health care staff. The level of therapeutic knowledge required would normally be achieved by prescribers, pharmacists or suitably experienced pharmacy technicians or nurses. [7]

Non-clinical staff should only undertake administrative aspects of reconciliation and good checking processes by those with clinical knowledge should always be in place.

Non-clinical staff should not generate acute or new repeat prescriptions and only assist in genuine repeat prescriptions working in accordance with robust policies and procedures.

6. UNLICENSED MEDICINES AND MEDICINES OFF-LABEL

Medicines prescribed should preferably be licensed and licensed for the indication for which they are prescribed. Doctors can prescribe unlicensed medicines, or licensed medicines for unlicensed uses (off-label). [3] However, when a prescriber chooses to prescribe a product outside the terms of its license, the product liability passes to the prescriber, and they are legally responsible for the medicine and any ensuing consequences. An unlicensed medicine may be prescribed on the basis of an assessment of the individual patient, for medical reasons and it is necessary to do so to meet the specific needs of the patient.

The hospital pharmacy department may be better placed to oversee continued sourcing, quality and supply of unlicensed medicines however commissioning implications do need to be taken into consideration.

Doctors may receive queries from pharmacists dispensing unlicensed or off label medicines, or other health professionals involved in the care of patients for whom they have been prescribed, to check that they have followed the above guidance. This is because they also have a duty of care around these medicines.

Advice to Prescribers from MHRA [8]

- be satisfied that an alternative, licensed medicine would not meet the patient's needs before prescribing an unlicensed medicine,
- be satisfied that such use would better serve the patient's needs than an appropriately licensed alternative before prescribing a medicine off-label,
- before prescribing an unlicensed medicine or using a medicine off-label you should:
    - be satisfied that there is sufficient evidence base and/or experience of using the medicine to show its safety and efficacy,
    - take responsibility for prescribing the medicine and for overseeing the patient's care, including monitoring and follow-up,
    - record the medicine prescribed and, where common practice is not being followed, the reasons for prescribing this medicine; you may wish to record that you have discussed the issue with the patient.

7. BASIC RULES FOR GENERATING ALL PRESCRIPTIONS

Where the patient is prescribed a drug dependant on a delivery device or piece of equipment e.g. an inhaler device or nebuliser, the patient should be instructed carefully on the use and maintenance of the device. It is important to check that the device continues to be used correctly as inadequate technique can be mistaken for a lack of response to the drug but also lead to generation of waste.

The BNF and BNF for Children chapters 'Guidance on Prescribing' provides extensive advice on prescribing and are the main source documents for the points itemised below. The GMC Good practice in prescribing and managing medicines and devices also adds useful insight. [1]

Prescriptions in any format must only be authorised by suitably qualified medical, dental, and non-medical independent (within their areas of competency) and supplementary prescribers (within the scope of an approved clinical management plan).

Ensure prescriptions, whether computer generated or in exceptional circumstances handwritten are legible, indelible, dated, state the name and address of the patient, the address of the prescriber and the type of prescriber.

In addition [3]:

1. Ensure prescriptions are authorised by the prescriber, but only after completion. DO NOT sign blank prescription forms.
2. Always complete the age box as a matter of good practice. This is a legal requirement for children under 12 years of age.
3. Ensure that the strength of each item is stated. Avoid unnecessary decimal points e.g. use 300mg NOT 0.3g. Quantities less than 1 mg should be written in micrograms, e.g. 100 micrograms, not 0.1 mg. Use of the decimal point is acceptable to express a range e.g. 0.5 to1g. In particular, strength of liquid preparations should be clearly stated (e.g. 125 mg/5 mL).
4. 'Micrograms' and 'nanograms' should not be abbreviated. Similarly, 'units' should not be abbreviated.
5. Ensure that the quantity to be dispensed is clearly stated.
6. Ensure that clear directions are given for each item prescribed. These should be in English without abbreviation. Dose and dose frequency should be stated; in the case of preparations to be taken 'as required' a minimum dose interval should be specified. Avoid "as directed."

7. Never abbreviate drug names.
8. Always prescribe generically except where there are bioavailability issues, compound preparations or specific formulations recommended by the British National Formulary (BNF) or in accordance with local formulary.
9. Avoid adding additional handwritten items to computer generated prescriptions.
10. All alterations and additions must be initialled by the prescriber. However, it is preferable to cancel the incomplete or incorrect prescription and generate a fresh accurate version.
11. Always document prescriptions on the patient's electronic records. Where this is not possible due to the environment of the prescribing, document the prescriptions on a repeat prescription card system. This will help to ensure that unnecessary duplicate repeat prescriptions are avoided and will assist in preventing drug misuse.
12. Do not include too many items on one form. The number on computer generated forms need be limited only by the ability of the printer to produce clear and well-demarcated instructions with sufficient space for each item and a spacer line before each fresh item. Practices may adjust their systems to set a limit on the number of items per prescription form e.g. three items.
13. Where an urgent prescription has been telephoned to a pharmacy, the FP10 must be with the pharmacist within 72 hours. This is a legal requirement. Controlled Drugs cannot be supplied in this way, except phenobarbital or phenobarbital sodium prescribed for epilepsy.
14. Prescribe within the limits of your professional expertise and competence.
15. Do not prescribe for yourself or for anyone with whom you have a close personal or emotional relationship, other than in an emergency. An emergency is when treatment is immediately necessary, and no other prescriber is available.
16. Each patient who requires a medicine each MUST have his or her own prescription. This is a legal and contractual requirement.
17. DRUGS NOT AVAILABLE FOR PRESCRIBING ON THE NHS: It is a breach of the Terms of Service for both doctors and pharmacists to prescribe and dispense drugs, medicines and other substances listed in Part XV111A of the Drug Tariff. Such prescriptions are disallowed for payment.

The regulatory requirements for general prescriptions are described in The Human Medicines Act 2012.

Relationship with Practice and Community Pharmacists

Foster a good working relationship with your local community pharmacist(s) and practice pharmacist or local Medicines Management team for the patient's benefit. They will be able to help you with advice about drug interactions and other pharmaceutical advice. Alternatively, the Medicines Information Services (details in the BNF) also provide independent advice.

8. GUIDELINES FOR QUANTITIES TO BE ISSUED

Practices may like to consider having a practice policy for prescribing, including quantities to be issued on prescription.

1. Acute prescription: Normally no more than one- or two-weeks supply for acute conditions, where applicable. For many infections, a short course of only 3-5 days is likely to be appropriate.
2. Repeat prescription: Normally no more than 28 days' supply of medicines for non-acute conditions. 28-day quantities are regarded as best practice pertaining to safe repeat prescribing systems.
3. The decision to provide a longer quantity has to be balanced against patient need (including financial considerations), safety and the potential for waste. Pre-payment certificates may help some patients financially and repeat dispensing may offer convenience for patients on regular stable medication.

a) Conditions where longer supplies / repeat dispensing might be considered for well stabilised patients under regular review are:

- Hypertension
- Epilepsy
- Diabetes
- Thyroid disorders
- Chronic musculoskeletal conditions
- Hormone Replacement Therapy
- Endocrine disorders
- Long term neurological conditions

N.B. CDs cannot be issued on Repeat Dispensing

b) Colostomy & surgical appliances (rubber items tend to deteriorate)

Up to 3 months' supply should be met by issuing separate prescriptions for one month at a time. Recommended quantities can be found under Stoma Prescribing Guidelines on the LSCMMG website [9]

c) For the oral contraceptive pill, prescriptions should normally be for 3 to 6 months' supply.

d) Original Pack (OP) Dispensing: Please **avoid** using the term OP in order to prevent confusion with the term Patient Packs.

Examples of conditions where **no more than** one month's supply should be prescribed:

- Controlled Drugs – see below.
- Psychotropic Drugs
- Most Initial Prescriptions

Prepayment certificates are the most economical way of paying for prescriptions when more than one regular prescription item is required each month. Prepayment certificates are available at https://www.nhsbsa.nhs.uk/help-nhs-prescription-costs/nhs-prescription-prepayment-certificate-ppc

9. REPEAT PRESCRIBING AND REPEAT DISPENSING

9.1 Repeat Prescribing

EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. [10]

The prescriber is responsible for any prescription they authorise for electronic transfer or sign, including repeat prescriptions for medicines initiated by colleagues, and so should make sure that any repeat prescription they authorise or sign is safe and appropriate, agreeing with the patient how their condition will be managed, including recording the reason for repeat prescribing and date of review. Patients should be informed what to do if they suffer side effects or adverse reactions or stop taking their medicines before the review date.

Secure procedures must be in place for prescribing with repeats and generating repeat prescriptions. Ensure that:

- The right patient is issued with the correct prescription.
- The correct dose is prescribed, particularly for patients whose dose varies during the course of their treatment.
- The patient's condition is monitored, taking account of medicine usage and effects.
- Only staff who are competent to do so prepare repeat prescriptions for authorisation.

- Patients who need further examination or assessment are reviewed by an appropriate health professional.
- Medicines are monitored and still safe and necessary for the patient.

No regulation of repeat prescribing can prove effective unless all members of practice staff are aware of the importance of a review regime, and the reason for it. A method of limiting the number of prescriptions the computer will issue without further authorisation should be used. Patients should be given ample warning of when a review will be necessary, to avoid inconvenience.
Automatic generation of prescriptions should be avoided.

In addition, practices should review their management of repeat prescribing with regard to:

- Volume of drugs prescribed particularly if prescribed on a 'prn' basis.
- Duration of prescription cycle.
- Relevance of repeat prescribing – is the medication regime stable.
- Relevance of original pack size – does it match to the quantity required.
- Non-equivalence of quantities of different drugs prescribed on the same FP10 to cover the same period of time.
- Frequency of patient review.
- Method of ensuring regular review.
- Practice staff familiarity with the review requirements.
- Ensuring all members of staff are fully aware of the repeat prescribing system and their responsibilities.

To avoid misunderstandings and improve compliance, it may be valuable to issue written guidance on these issues to all members of staff. This may also be helpful in explaining any changes of policy to patients.

Careful audit of prescriptions issued to care homes can show substantial savings of prescribing costs when repeat prescriptions are tailored to the same time cycle, ideally 28 days. Special care needs to be taken with amounts for those medicines which are to be taken when required i.e. "prn".

NB repeat prescription requests should be instigated by the person in charge of the home or their deputy, not the community pharmacist.

Prescribing with repeats (repeat dispensing) may reduce the need for repeat prescribing. [3]

9.2 Prescribing with Repeats or Repeat Dispensing

Repeat dispensing [10] is the process by which patients can obtain supplies of their repeat medicines over a defined period of time, without the need to contact their GP practice on each occasion a new supply is required. People with chronic conditions that are likely to remain stable for the duration of the repeatable prescription are most likely to benefit from repeat dispensing services. The decision whether to use a repeat dispensing service is a matter for the prescriber's clinical judgement and mutual agreement between the prescriber, the patient and, ideally, the pharmacist.

The potential benefits include:

- Greater choice for patients who require repeat prescriptions for the medicines they need.
- Reduced workload for GP practices.
- More efficient use of practice staff time.
- More opportunities for early interventions to identify medicines-related problems through improved patient contact.
- Fewer prescriptions for medicines no longer needed.
- Greater involvement and better use of the skills of community pharmacists.

Repeat dispensing will not be suitable for all patients, nor is it an overnight ‘quick fix’ for longstanding supply problems. It requires commitment and support from all those involved to realise all the potential benefits.

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

eRD stores all issues of the eRD prescriptions securely on the NHS Spine and automatically downloads them to the patient's nominated community pharmacy at intervals set by the prescriber.

Patients are required to give their consent for repeat dispensing. This can be verbal and formal written consent is not required.

eRD allows the cancellation at item or whole prescription level, which will cancel all subsequent issues on the Spine.

PRN or 'when required' medication can be prescribed using eRD (it is advised that PRN items are set up as a separate eRD batch as they may have a different interval to the patient's other eRD batches). The prescriber can set the specified intervals based on the patient's usage history to predict the number of uses/doses. If the patient runs out, the subsequent issue can be downloaded in advance - based on clinical assessment by the dispenser. This may mean an extra prescription is needed to ensure the patient has enough medication to last until their

next review. Some prescribing systems have a variable prescription type, which helps with this.

eRD simplifies the repeat prescribing process and offers a range of benefits, including:

- prescribers can authorise a batch of repeat prescriptions for up to 12 months with just one digital signature. Dispensing interval can be stipulated (for example weekly, monthly, quarterly).
- a simpler repeat dispensing process, particularly in terms of volume of paper used.
- dispensers are mandated to ask patients if they require all items on their prescription before each issue, to avoid medicines wastage.
- eRD puts the prescriber in control rather than allowing the patient or dispenser to continue re-ordering unnecessary items - which leads to oversupply and stockpiling.
- reduced footfall at the GP practice and fewer telephone calls as patients do not need to collect or order repeat prescriptions for the duration of their eRD batch.

9.3 Medication Review

Structured Medicine Reviews (SMRs) are an evidence-based and comprehensive review of a patient's medication, taking into consideration all aspects of their health. In a structured medication review clinicians and patients work as equal partners to understand the balance between the benefits and risks of and alternatives of taking medicines. The shared decision-making conversation being led by the patient's individual needs, preferences, and circumstances. [14]

The number of patients to be offered a SMR will depend upon the PCN's clinical pharmacist capacity. Further information on the expectations of PCNs and more detailed clinical guidance, for example from the Royal Pharmaceutical Society and NHS Scotland can be found in the Network Contract DES SMR guidance. [14]

9.4 Emergency supplies and Retrospective Prescriptions

No prescription only medicine or appliance should be supplied to a patient without an authorised prescription. However, the Human Medicines Regulations 2012 allow exemptions from the Prescription Only requirements for emergency supplies to be made by a person lawfully conducting a retail pharmacy business at the request of either the prescriber or the patient so long as certain qualifying criteria are met – see BNF· emergency supply of medicines. [16]

When making a decision whether to provide an emergency supply or not, the Royal Pharmaceutical Society's guidelines state that the pharmacist should consider the medical

consequences of not supplying a medicine in an emergency; and if the pharmacist is unable to make an emergency supply of a medicine the pharmacist should advise the patient how to obtain essential medical care.

Patients may also present for an urgent supply of a regular medicines following access to NHS 111 (referral via the NHS Community Pharmacist Consultation Service (CPCS)).

10. CONTROLLED DRUGS

Prescriptions for Controlled Drugs that are subject to prescription requirements (all preparations in Schedules 2 and 3) must be indelible, must be *signed* by the prescriber, include the *date* on which they were signed, and specify the prescriber's *address* (must be within the UK). A computer-generated prescription is acceptable, but the prescriber's signature must be handwritten. Advanced electronic signatures can be accepted for Schedule 2 and 3 Controlled Drugs where the Electronic Prescribing Service (EPS) is used. All prescriptions for Controlled Drugs that are subject to the prescription requirements must always state:

- the name and address of the patient (use of a PO Box is acceptable);
- in the case of a preparation, the **form** (the dosage form e.g. tablets must be included on a Controlled Drugs prescription irrespective of whether it is implicit in the proprietary name e.g. MST Continus, or whether only one form is available), and, where appropriate, the **strength** of the preparation (when more than one strength of a preparation exists the strength required must be specified); to avoid ambiguity, where a prescription requests multiple strengths of a medicine, each strength should be prescribed separately (i.e. separate dose, total quantity, etc);
- for liquids, the total volume in millilitres (in both words and figures) of the preparation to be supplied; for dosage units (tablets, capsules, ampoules), state the total number (in both words and figures) of dosage units to be supplied (e.g. 10 tablets [of 10 mg] rather than 100 mg total quantity);
- the dose, which must be clearly defined (i.e. the instruction 'one as directed' constitutes a dose but 'as directed' does not); it is not necessary that the dose is stated in both words and figures;
- the words 'for dental treatment only' if issued by a dentist.

It is strongly recommended by the Department of Health that the quantity of Schedule 2, 3 and 4 Controlled Drugs prescribed should not exceed 30 days' supply. Pharmacists may legally dispense a quantity greater than 30 days. The prescriber will need to be able to justify a supply of more than 30 days on the basis of clinical need and this should be recorded on the patient's notes. No repeats are allowed on schedule 2 and 3 CDs.

A prescription for a Controlled Drug in Schedules 2, 3, or 4 is valid for 28 days after the date stated thereon (the prescriber may forward-date the prescription; the start date may also be specified in the body of the prescription). Schedule 5 prescriptions are valid for 6 months from the appropriate date.

Prescribers must use FP10 MDA prescriptions to supply daily CD instalments. It must have BOTH the dose AND the instalment amount, the total quantity, the amount of instalments and the intervals to be observed. The first instalment must be dispensed no later than 28 days after the appropriate day (i.e. date of signing unless the prescriber indicates a date before which the Controlled Drug should not be dispensed) and the remainder should be dispensed in accordance with the instructions on the prescription. The prescription must be marked with the date of each supply.

PRIVATE PRESCRIPTIONS for schedule 2 and 3 CDs (including temazepam and midazolam) must be written on specially designated forms FP10PCD. The prescription must specify *the prescriber's identification number and address*.

Pharmacists can amend the prescription if it specifies the total quantity only in words or in figures or if it contains minor typographical errors, as long as they are indelible and clearly attributable to the pharmacist (e.g. name, date, signature and GPhC registration number).

Prescribers and pharmacists dispensing drugs prone to abuse should ensure compliance with all relevant legal requirements specially when dealing with prescriptions for Controlled Drugs [17]

11. PRESCRIBING FOR CHILDREN

Children are different from adults in relation to their response to medication. Special care is needed in the neonatal period. Prescribing decisions must take into account the child's age, weight, and development stage. For detailed advice, consult the current version of the BNF for Children.

Medicines licensed for use in children in the specific age range and for specific disease must always be used if available. However, many drugs are not licensed for use in children. Thus, the informed use of unlicensed medicines or of medicines for off-label use is often unavoidable. All such use must be well documented in the patient's medical records. (See Section 6 - Unlicensed Medicines and Medicines Off-label.)

11.1 Prescriptions for Children

The consequences of errors in prescribing can be more serious in children than in adults. A common source of error is the misplacement of decimal points in dose calculations. Decimal points should be avoided where possible e.g. 500mg not 0.5g; Also "micrograms",

“nanograms” and “units” should not be shortened, and strengths of liquids should be clearly stated. All dose calculations must be double checked to ensure accuracy. Prescribers must refer to the most current version of the BNF for children for general guidance.

11.2 Adverse Drug Reactions in Children

Suspected adverse drug reactions in children and young adults under 18 years should be reported through the Yellow Card scheme at: https://yellowcard.mhra.gov.uk/. For detailed advice on adverse drug reactions in children, consult BNF for Children. MHRA 24-hour Freephone advice and information on adverse drug reactions is available on **0800 731 6789.**

11.3 Gillick competence and Fraser Guidelines

Young people (aged 16 or 17) are presumed to have sufficient capacity to decide on their own medical treatment, unless there's significant evidence to suggest otherwise.

Children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. This is known as being Gillick competent. Otherwise, someone with parental responsibility can consent for them. [20]

Any assessment of such competency must be fully documented in the patient’s medical records. Fraser guidelines apply to contraceptive products and sexual health only. [22]

12. PRESCRIBING IN THE ELDERLY

Elderly patients often receive multiple drugs for co-morbidities. This greatly increases the risk of drug interactions as well as adverse reactions and may affect compliance. The balance of benefit and harm of some medicines may be altered in the elderly e.g. increased falls risk. Therefore, elderly patients’ medicines must be reviewed regularly and medicines which are not of benefit should be stopped. Non-pharmacological measures should be considered where appropriate.

In some cases, prophylactic drugs are inappropriate if they are likely to complicate existing treatment or introduce unnecessary side effects. However, elderly patients should not be denied medicines which may help them e.g. anticoagulants, statins, osteoporosis drugs.

13. PRESCRIBING IN PALLIATIVE CARE

Palliative care is the active holistic care of patients whose disease is not responsive to curative treatment. The use of non-drug treatment options for symptom management is an important part of palliative care. Guidance on non-drug treatments for specific symptoms can be found in the Palliative Care Formulary, and the Scottish Palliative Care Guidelines (see *Useful resources*).

Although drugs can usually be administered by mouth to control the symptoms of advanced cancer, the parenteral route may sometimes be necessary.

13.1 Syringe Drivers

The use of continuous subcutaneous infusions (CSCIs) is common within palliative care in the UK, particularly for patients where swallowing medication has become increasingly difficult or impossible.

It is common practice for two or three different drugs to be mixed in a CSCI (unlicensed product), although the greater the number of drugs mixed, the greater the potential for compatibility issues. It is therefore essential to consider drug compatibility when mixing drugs in a CSCI. See the Palliative Care Formulary Syringe Driver Database on Drug Compatibility Checker, available at: https://www.medicinescomplete.com/#/compatibility,

14. PRESCRIBING MEDICINES TO PEOPLE WHO LACK CAPACITY TO CONSENT

When patients lack the mental capacity to consent to treatment, medication may still be prescribed and administered to them, provided the principles of the Mental Capacity Act 2005 are followed. Staff should also be guided by their local policy. For full details refer to The Mental Capacity Act: Code of Practice 2013 [24]

The process of assessing capacity and determining best interests must be documented in the clinical records.

Staff should be aware that the Mental Capacity Act 2005 includes provision for adults, who have the capacity to do so, to make advance decisions to refuse specified treatment for a time in the future when they lack capacity to consent to it. Provided it can be established that an advance decision is valid and applicable, it has the same effect as a decision made by a person with capacity, and healthcare professionals must respect this decision.

Further guidance is available from NHS England / The National Council for Palliative Care ‘Advance decisions to refuse treatment: A guide for health and social care professionals’ [26] and the GMC Decision Making and Consent Guideline November 2020 [27].

15. PRESCRIBING NEW DRUGS and VACCINES - BLACK TRIANGLE DRUGS

New drugs are intensively monitored to ensure that any new safety hazards are identified promptly. The Commission on Human Medicines (CHM) and the MHRA encourages the reporting of all suspected reactions to newer drugs and vaccines (including those to be considered not serious), which are denoted by an inverted Black Triangle symbol (▼). This symbol appears next to the name of a relevant product in the BNF, BNF for Children, MIMs, ABPI advertising material and the MHRA Drug Safety Updates. The list of these drugs is

updated monthly on the MHRA website. Reporting of adverse reactions is done using the Yellow Card Scheme. Report forms can be found in the BNF, MIMs or online.
These drugs should be used with caution and alternative drugs with a more established safety profile should be considered first line.

16. ADVERSE REACTIONS

16.1 Adverse Drug Reactions

For new drugs (denoted by ▼) ALL adverse reactions should be reported. For established drugs and vaccines (including over-the-counter and herbal medicines), report all suspected adverse reactions that you consider to be SERIOUS. They should be reported even if the effect is well recognised.

Serious reactions are those which are;

- fatal
- life-threatening
- disabling
- incapacitating
- have resulted in, or prolonged, hospitalisation
- medically significant
- congenital abnormalities.

See the BNF for full details.

16.2 Adverse reactions to medical devices

Definitions of adverse reactions to medical devices and reporting details can be found on the MHRA website.

17. PRIVATE PRESCRIBING

The 2009 department of health document ‘Guidance on NHS patients who wish to pay for additional private care’ [37] and the NHS constitution [38] define situations in which patients can access additional private care alongside their NHS care. In summary, any additional private care must be delivered separately from NHS care but can be delivered alongside NHS care. The private clinician may treat a patient privately for whom they will continue to have clinical responsibility and will personally determine the ongoing treatment for that particular condition. Once the private episode of care is completed, an NHS prescriber may consider providing an ongoing NHS prescription if required. In some limited circumstances

an NHS prescriber may consider it appropriate to enter into a shared care agreement with a private clinician (see point 3 below). [39]

Patients can transfer their care from private to NHS as per the NHS Constitution. Thus, if a patient would normally receive follow up in general practice following specialist treatment, they should receive this if they transfer from private care, whether in the UK or not.

If a patient has been seen privately by a specialist and is given a private prescription but then requests that the medicine is supplied on the NHS or a private specialist requests directly, the following should be considered:

1. If an NHS GP receives communication from a private specialist recommending a medicine that is suitable to be prescribed in primary care, then it may be appropriate for a prescription to be issued on the NHS, but only if:
    a. the GP agrees with the advice and it is within their competence to prescribe the item,
    b. the medicine to be prescribed is available on the NHS (i.e. not NHS blacklisted) and is commissioned by the ICB. If the medicine requested is not commissioned by the ICB a suitable therapeutic alternative that is commissioned should be offered,
    c. the private episode of care is completed.
2. If the private provider is CQC registered and the GP is satisfied of the professional credentials of the private clinician.
3. The decision of whether to accept a shared care agreement lies with the NHS prescriber. However, The British Medical Association does not recommend Shared Care with private providers due to the general NHS constitution principle of keeping as clear a separation as possible between private and NHS care.
   The NHS prescriber will have full medicolegal responsibility for prescribing any item commenced by a private prescriber. This is because private and NHS healthcare must be delivered as separate episodes of care to comply with Department of Health guidance and the NHS constitution.
   For further guidance NHS prescribers should consult the advice of the Regional Drug and Therapeutic Centre and All Wales Medicines Strategy Group guide to prescribing dilemmas.
4. If a GP receives communication from a private consultation recommending a medicine that is not suitable to be prescribed in primary care, then it would not be appropriate for an NHS prescription to be issued and the patient should be informed of this as soon as practicably possible. Alternatively, the GP should:
    a. obtain a full communication from the private consultant, and

b. complete a referral to an appropriate NHS specialist for the patient to receive appropriate NHS care.

If a patient is being seen as an NHS patient in a private facility, they should be provided with NHS prescriptions by the clinician responsible for their care. The patient should be referred back to the provider to be issued an NHS prescription.

17.1 Transfer of care between NHS and private providers

Transferring between private and NHS care should be carried out in a way which avoids putting patients at any unnecessary risk. The NHS and the private provider (which may be an NHS organisation) should work collaboratively to put in place protocols to ensure effective risk management, timely sharing of information, continuity of care and coordination between NHS and private care at all times.

If different clinicians are involved in each element of care, these protocols should include arrangements for the safe and effective handover of the patient between the clinician in charge of the NHS care, and the clinician in charge of the private care.

It must always be clear which clinician and which organisation are responsible for the assessment of the patient, the delivery of any care and the delivery of any follow-up care.

17.2 Private Prescriptions for NHS Patients

GPs should provide their NHS patients with any medication available to NHS patients deemed clinically appropriate on an NHS prescription. GPs may not issue private prescriptions alongside or as an alternative to NHS prescriptions.

However, GPs may write private prescriptions for patients for the following:

- Blacklisted items found in part XVIIIA of the NHS Drug Tariff.
- Malaria prophylaxis.
- Travel vaccinations that are not covered by NHS public health policy.
- SLS items prescribed outside of their specified criteria as defined by General Medical Services Contracts Regulations 2004.

18. PATIENT GROUP DIRECTIONS (PGDs) and PATIENT SPECIFIC DIRECTIONS

18.1 Patient Group Directions

PGDs provide a legal framework that allows some registered health professionals to supply and/ or administer a specified medicine(s) to a pre-defined group of patients, without them having to see a prescriber.[40] However, supplying and/or administering medicines under PGDs should be reserved for situations in which this offers an advantage for patient care, without compromising patient safety.

PGDs must be authorised only by an appropriate authorising body in line with legislation. A lead person with responsibility for managing the use of PGDs should be nominated within each GP practice and other clinical areas.

For each PGD, the commissioning and provider organisation(s) should collaborate to firmly establish local governance arrangements with clear lines of responsibility and accountability.

Health professionals supplying or administering medicines according to PGDs must sign and retain a copy of the PGD as a legal document.

Lead persons must ensure that wherever a service is provided which depends upon a PGD:

- On-going training is provided.
- Staff required to supply or administer medicines according to a PGD are adequately trained and competent.
- Records of signed copies are retained as legal documents.
- New/Agency/Locum staff are trained to used PGDs.
- Audit is carried out to ensure that PGDs are being used correctly.

Appropriate records must be kept as specified within the individual PGD. Appropriate organisational records are to be maintained, stored securely and archived, in line with relevant legislation and the Department of Health's code of practice on records management.

More information can be found on the LSCMMG website:
https://www.lancsmmg.nhs.uk/lancashire-and-south-cumbria-resources/patient-group-directions-pgds/

18.2 Patient Specific Directions

A Patient Specific Direction (PSD) is the traditional written instruction, authorised by a doctor, dentist, or non-medical prescriber (hereafter referred to as “the prescriber” unless stated otherwise) for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis. This instruction may be in writing and signed or in an electronic format instruction for the practice nurse or other competently

trained health care professional to administer the medicine. The instruction may be for example:

- Primary care: a prescription or simple written or electronic instruction in the patient's notes.
- Secondary care: instructions on a patient's ward drug chart.

In practice, we know that a PSD is commonly referred to as a prescription by those who write and follow them because this indicates that it is written by a prescriber.

A PSD, signed by a qualified, registered prescriber, at a minimum should specify:

- Name of patient and/or other individual patient identifiers.
- Name, form and strength of medicine (generic or brand name where appropriate).
- Route of administration.
- Dose.
- Frequency.
- Start and finish dates.
- Signature of prescriber.

As a PSD is individually tailored to the needs of a single patient, more information may be required to enable safe supply and/or administration of some medicines and to manage identified risks such as drug interactions or contraindications. [42]

PSD do not limit those who can supply or administer the medicine. For example, a suitably trained health care assistant can do so, even though they cannot work under a PGD.
PSDs are often used in relation to the administration of vaccinations for named patients as well as some depot medications and vitamin B12.

19. TRAVEL ABROAD

Under NHS legislation, the NHS ceases to have responsibility for people when they leave the UK. The UK Global Health Insurance Card (GHIC) enables patients to get necessary state healthcare in the European Economic Area (EEA), and some other countries, on the same basis as a resident of that country. All patients should also obtain adequate holiday insurance cover. [44]

GPs are not responsible for prescribing items required for conditions which may arise while travelling e.g. travel sickness and diarrhoea. Patients should be advised to purchase these items locally prior to travel. Advice is available from community pharmacists if required. For conditions unresponsive to self-medication the patient should normally seek medical attention abroad.

To ensure continuity of care for patients on a stable medication regime, it is reasonable to provide a routine repeat prescription (usually one and no more than three months), to enable the patient to find a doctor who can continue their care in the country to which they are travelling. GPs could be in breach of the Terms of Service if they issue an NHS prescription to cover an extended absence from the country (after three months, a patient would have to re-register as their name should be removed from their list). The NHS normally will not pay for any treatment or services for patients no longer resident in the UK. This includes people who are in receipt of UK state retirement pension.

Where a patient requires a prescription for larger supplies of his/her medication because of a longer stay abroad, the patient can be given a private prescription to cover the additional period of absence; however the Doctor is clinically responsible for prescribing, and for longer periods this may be clinically inappropriate, as they are not able to monitor and care for patients.

Patients entering or leaving the UK for 3 months or more with personal medication containing a controlled drug must get a licence. Applications can be sent to dflu.ie@homeoffice.gov.uk Applications should be made at least 1 month before the patient's intended date of travel and only requests where supporting evidence is provided will be considered. Applications from overseas could take longer. Travel arrangements should not be made until the licence has been received.

Patients entering or leaving the UK for less than 3 months do not need a licence but should have a letter from their doctor with the following information.

- Patients name,
- a list of the medicine the patient has been prescribed, including doses, strength, and frequency; it must be evident that the patient is not carrying more than a 3-month supply from both the travel dates and quantities of medication listed on the letter or prescription,
- the signature of the person who prescribed the drugs and their professional registration details.

This letter may have to be shown when going through customs. [46]

19.1 Immunisation for holiday & business travel abroad

Guidance for GPs on risk assessment for travellers and appropriate advice can be found on the website of the National Travel Health Network and Centre (NaTHNac) available at https://travelhealthpro.org.uk/.

NHS England [48] advise that prescribers in primary care should not initiate the following vaccines exclusively for the purposes of travel for any NHS patient. These vaccines should continue to be recommended for travel where appropriate, but the individual traveller will need to bear the cost of the vaccination. These vaccines are:

- Hepatitis B
- Japanese Encephalitis
- Meningitis
- Yellow Fever (only available from designated centres)
- Tick-borne encephalitis
- Rabies
- Tuberculosis

The following vaccines may still be administered free on the NHS exclusively for the purposes of travel, if clinically appropriate, pending any future review:

- Cholera
- Diphtheria/Tetanus/Polio
- Hepatitis A
- Typhoid

19.2 Malaria prophylaxis

The UKHSA Advisory Committee on Malaria Prevention issues and updates guidance for malaria prevention in travellers from the UK available at: https://www.gov.uk/government/publications/malaria-prevention-guidelines-for-travellers-from-the-uk.

Medicines for the prevention of malaria are available for purchase “over the counter” at community pharmacies. Local community pharmacies have access to up-to-date advice about appropriate prophylactic regimens and can advise travellers accordingly (MIMS has updated antimalarial travel charts).

Atovaquone plus proguanil, mefloquine and doxycycline are prescription only medicines and should be prescribed on private prescription (not at NHS expense as defined by Department of Health guidance FHSL (95)7).

20. PRESCRIBING OF BORDERLINE SUBSTANCES

The BNF states that in certain conditions some foods (and toilet preparations) have characteristics of drugs, and the Advisory Committee on Borderline Substances (ACBS) advises as to the circumstances in which such substances may be regarded as drugs. GPs are reminded that the ACBS recommends products on the basis that they may be regarded

as drugs for the management of specified conditions. Doctors should satisfy themselves that the products can safely be prescribed, that patients are adequately monitored and that, where necessary, expert hospital supervision is available.

A complete list of conditions can be found in the BNF or Drug Tariff section XV.

21. VITAMINS, MINERALS, SUPPLEMENTS, HERBAL AND HOMEOPATHIC MEDICINES WITHOUT A PRODUCT LICENCE

Most food supplements (such as herbal medicines, various vitamins, and minerals) do not have a product licence (UK marketing authorisation). Products that do not have a product licence have not undergone the strict criteria laid down by the regulatory authorities to confirm the safety, quality, and efficacy of these products.

Patients may purchase these medicines to take as a complementary form of therapy but should in all cases discuss the use of them with their GP or pharmacist.

NHSE have published guidance on items which should not routinely be prescribed in primary care. [47]

22. PERSONALLY ADMINISTERED ITEMS

Personally administered items where payment **can** be claimed include:

- Vaccines, anaesthetics and injections;
- Intrauterine contraceptive devices (including drug releasing IUCDs, contraceptive caps and diaphragms);
- Pessaries which are appliances;
- Sutures (including skin closure strips) – for emergency wounds etc;
- the following diagnostic reagents: Dick Test; Schick Test; Protein Sensitisation Test Solutions; and Tuberculin Tests (i.e. Koch Test, Mantoux Test, Patch Test and Diagnostic Jelly);

Items that **cannot** be claimed as personally administered include products supplied as part of the Childhood Immunisation Programme, the Shingles Vaccine or any other product which may be centrally supplied by the Department of Health. [51]

23. CLINICIANS PRESCRIBING FOR THEMSELVES OR THOSE CLOSE TO THEM

Wherever possible, clinicians must avoid prescribing for themselves or anyone they have a close personal relationship with.

GMC Good practice in prescribing and managing medicines and devices provides further useful advice. [3]

24. PRESCRIBING FOR VISITORS FROM OVERSEAS

Within England, free NHS hospital treatment is provided on the basis of someone being 'ordinarily resident.' Being ordinarily resident is not dependent upon nationality, payment of UK taxes, National Insurance contributions, being registered with a GP, having an NHS number, or owning property in the UK.

Those who are not ordinarily resident in the UK, including former UK residents, are overseas visitors and may be charged for NHS services.

Treatment in A&E departments and at GP surgeries remains free for all.

There are exemptions in place to protect the most vulnerable in society and for key services essential to public health. This ensures that urgent or immediately necessary treatment will always be provided, regardless of an individual's ability or willingness to pay for that treatment.

The rules are set out in the National Health Service (Charges to Overseas Visitors) Regulations 2015 (as amended) and guidance on how NHS charges for overseas visitors' healthcare are applied is available at https://www.gov.uk/government/publications/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care/how-the-nhs-charges-overseas-visitors-for-nhs-hospital-care .

25. SECURITY OF PRESCRIPTION FORMS AND CONTROLLED STATIONERY

25.1 Background

The NHS Counter Fraud Authority (NHSCFA) has issued a guide on the 'Management and control of prescription forms.' [53] Primary Care Support England (PCSE) have the responsibility for ordering prescription forms. The contact details for this service are pcse.enquiries@nhs.net or 0333 0142884.

25.2 Delivery and prescription form stock control

Xerox (UK) Ltd, the contracted secure printer for the NHS, prints the prescription forms and securely delivers them to agreed delivery points as identified by the ordering organisation.

Before the delivery driver leaves, a full check should be made against the delivery manifest that the appropriate type of prescription form and the correct number of boxes or pallets have been received.

It is important to record delivered and stored prescription stock. Two members of staff should always be in attendance when a delivery arrives, one of whom should always remain with the delivery vehicle. The delivery should be thoroughly checked against the order and delivery note and only be signed for if the packaging is sealed and unbroken.

Once the delivery has been checked, the boxes should be examined and as soon as practicable the serial numbers checked against the delivery note. Bar coding is used on all FP10SS prescription boxes. The bar code includes: the product code, quantity, box number, first and last serial number in the range. Details of the delivery should be recorded electronically and/or using paper records.

Deliveries of prescription form stock should be securely stored as soon as practicable and treated as controlled stationery. They should not be left unattended or unsupervised. As a minimum, prescription forms should be kept in a locked cabinet within a lockable room or area.

Organisations should maintain clear and unambiguous records on prescription stationery stock received and distributed. It would be preferable to use a computer system to aid reconciliation and audit. The following information should be recorded on a stock control system in organisations:

- what has been received, along with serial number data (the latter is now in bar code format and features on each box of FP10SS forms),
- where items are being stored,
- when prescription forms are issued to the authorised prescriber,
- details of who issued the forms,
- to whom prescription forms were issued, along with the serial numbers of these forms,
- the serial numbers of any unused prescription forms that have been returned,
- details of prescription forms that have been destroyed (these records should be retained in accordance with local document and retention policies).

Doctors and surgery stamps should be kept in a separate, equally secure location to prescription forms.

Records of serial numbers received and issued should be retained for at least three years.

25.3 Storage of Prescription forms

- Minimal stocks should be kept to reduce theft potential and keep stocks up to date.
- Prescribers are responsible for any forms they have, and they should be locked away when not in use.

- Prescribers should ensure that forms are never left unattended and unauthorised staff or patients should never be allowed into secure areas where forms are stored.
- Supplies of forms should never be left in care homes for GP or locum visits.
- The prescription pad must only be produced when needed and must never be left unattended. When out visiting, prescribers must keep prescription pads with them out of sight; they must never be left in the car.

25.4 Use of Prescription Forms

As a matter of best practice:

- Prescribers should keep a record of the serial numbers of prescription forms issued to them. The first and last serial numbers of pads should be recorded. It is also good practice to record the number of the first remaining prescription form in an in-use pad at the end of the working day.
- To reduce the risk of misuse, blank prescriptions should never be pre-signed. Where possible, all unused forms should be returned to stock in a (locked) secure cupboard at the end of the session or day.
- Any completed prescriptions should be stored in a locked drawer/cupboard.
- Patients, temporary staff, and visitors should never be left alone with prescription forms or allowed into secure areas where forms are stored.
- Computerised prescription forms should also be kept secure in printers in a locked room and patients should not be left unattended where they are in use. When ordering new printers consideration should be given to ordering a tray to secure the forms or locating the printer in a secure part of the building.
- Duplicate prescriptions should be securely destroyed (e.g. by shredding) before being put into confidential waste, with appropriate records kept.
- Spoiled in error prescriptions should be securely destroyed as above.
- Personalised forms which are no longer in use should be securely destroyed (e.g. by shredding) before being put into confidential waste, with appropriate records kept. The person who destroys the forms should make a record of the serial number of the forms destroyed. Best practice would be to retain these prescription forms for local auditing purposes for a short period prior to destruction. The destruction of the forms should be witnessed by another member of staff. Records of forms destroyed should be kept for at least 18 months.

25.5 Action in case of Lost or Stolen Prescription Forms

If missing prescription forms cannot be accounted for, the matter should be reported to the designated person with overall responsibility for prescription forms at the health body, the accountable officer for CDs and the police as required.

It is important that there are effective processes in place for staff to report incidents involving prescription forms and these processes are documented within a SOP or policy and widely communicated to staff. Incidents involving fraud, theft and loss of prescription forms should all be reported using the organisation's incident reporting system, which would include reporting to PCSE as required. Staff should be supported and encouraged to report and be assured that the incident will be investigated and appropriate action taken.

In reporting NHS prescription form incidents to the, it is important to include as much essential information as possible as set out by NHSCFA. The two easy ways to report fraud to the NHSCFA is through the NHS Fraud and Corruption Reporting Line 0800 028 4060 or online at: https://cfa.nhs.uk/reportfraud. [26]

The prescriber should be instructed to write and sign all prescription forms in a particular colour for a period of two months. The health body should inform all pharmacies in the area and adjacent areas of the name and address of the prescriber concerned, the approximate number of prescription forms missing or stolen, serial numbers (if known) and the period for which the prescriber will write in a specific colour.

If a patient claims to have lost their prescription, practices may consider asking the patient for a police incident number to ensure that this is legitimate before issuing a replacement script.

26. FURTHER INFORMATION ON MEDICINES

Contact your Prescribing/Medicines Optimisation Lead or Practice Pharmacist or contact North West Medicines Information, 70 Pembroke Place, Liverpool; Tel 0151 794 8113; or email nwmedinfo@nhs.net

This guidance does not override the individual responsibility of health professionals to make decisions in exercising their clinical judgement in the circumstances of the individual patient, in consultation with the patient and/or guardian or carer. For full prescribing information please refer to the BNF and SPC.

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