Integrated Care System
Shropshire, Telford and Wrekin

NHS
Shropshire, Telford and Wrekin

Guide to Writing a Repeat Prescribing Policy

Recommendation

All practices must have a clear, written repeat prescribing policy that outlines the roles and responsibilities of staff involved in the process. The policy should be developed by the practice team, regularly reviewed, and aligned with national guidance. It must support safe, consistent prescribing and be accessible to all relevant staff, with appropriate training in place.

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Overview and Key Principles

Repeat prescribing enables patients to obtain further supplies of prescribed medicines without needing a consultation each time. This accounts for approximately 70% of all prescriptions issued in general practice. A robust, safe, and well-managed repeat prescribing system is essential to ensure high-quality, cost-effective prescribing and to reduce medicines waste. A repeat prescribing process should begin with the clinician's decision to initiate ongoing treatment and conclude when the patient receives the prescribed medication.

Key Considerations for Developing a Practice Repeat Prescribing Process

- **Preferred Method for Requests**
  Repeat medication requests should be made via digital means wherever possible (e.g. NHS App, practice website). Verbal requests should be limited to patients without internet access or those unable to use digital services, including those lacking a proxy to order on their behalf.
- **Linking Medicines to Conditions**
  At the time of initiation, medicines should be linked to a clinical indication, and a defined repeat authorisation period should be recorded.
- **Roles and Limitations of Non-Clinical Staff**
  Repeat prescription clerks may make non-clinical amendments (e.g. quantity changes for synchronisation) but must not reauthorise or restart medication. Only a clinician can initiate or clinically approve prescriptions.
- **Reviewing Orders Before Issue**
  All repeat requests should be checked for last issue date and adherence patterns. Any concerns—such as underuse, overuse, or inappropriate frequency (e.g. inhalers or 'prn' items)—should be flagged to the prescriber, especially when ordered by carers or third parties.
- **Clinical Responsibility of the Prescriber**
  The prescriber who signs the prescription retains full clinical responsibility and must ensure the medication is still appropriate, with all required monitoring and safety checks up to date. Non-medical prescribers should only prescribe within their assessed and documented scope of competence and must not sign prescriptions issued under another prescriber's name.
- **Link to Structured Medication Review**
  Repeat prescribing processes should be closely integrated with high-quality medication reviews to ensure ongoing clinical appropriateness and safety.
- **Incident Recording and Audit**
  Practices must record incidents such as delays, lost prescriptions, and prescribing errors. These should be reviewed for learning and improvement. A formal audit of the repeat prescribing system should take place at least twice a year.
- **Training and Governance**
  All staff involved in the repeat prescribing process must be appropriately trained and understand their defined responsibilities and the procedures to follow.

Introduction

Repeat prescribing refers to the issue of regular prescriptions, without the need for a consultation at each issue.

Repeat prescribing plays a significant part in the supply of medicines to patients in primary care. Two thirds of prescriptions generated in primary care are for patients needing repeat supplies of regular medicines and these account for nearly 80% of medicines costs in primary care. Furthermore, previous cases have highlighted inadequate repeat prescribing can result in medication-related harm and mortality. A well-managed repeat prescribing system improves efficiency for clinicians, staff, and patients. Other benefits include improved quality of prescribing, improved patient safety and better use of NHS resources.

The legal responsibility for prescribing lies with the prescriber who signs the prescription and is the same whether it is the initial or final repeat prescription. Therefore, before authorising a repeat prescription, the prescriber must be satisfied that it is safe and appropriate to do so, the medication is still indicated and that procedures are in place to ensure that patients are regularly reviewed.

Purpose

The aim of this document is to outline the key elements required of a **repeat** prescribing policy, to illustrate repeat prescribing processes that are safe, transparent, auditable, and support the development of local repeat prescribing policies that meet the needs of patients, prescribers and practice teams.

This guide does not cover the prescribing of **acute** medications or **appliances**.

Repeat prescribing should preferably be managed digitally (where possible) using Electronic Prescribing Systems (EPS) for audit purposes. As all practices are different, it would be impossible to produce a universal repeat prescribing policy. This document is therefore a guide to support practices in developing and updating their own policy.

1. Development and Implementation of a Practice Policy for Managing Repeat Prescriptions

Practices must have a clear, written policy for the repeat prescribing process. The policy should describe the roles and responsibilities (see example - Table 1) of those involved in the production of repeat prescriptions. It should be written by the practice and reviewed regularly, especially following any near misses, incidents or medication errors.

A data log is advised to record any members of staff involved in any element of repeat prescribing and its management and signed to ensure that they have read and understood the policy. Practice staff involved with repeat prescriptions should be appropriately trained and the repeat prescribing policy should be included in the induction programme for new staff. Consideration should be given to involving all relevant staff in a review or update of the policy.

Table 1 – Example: Key Roles and Responsibilities in the Repeat Prescribing Process

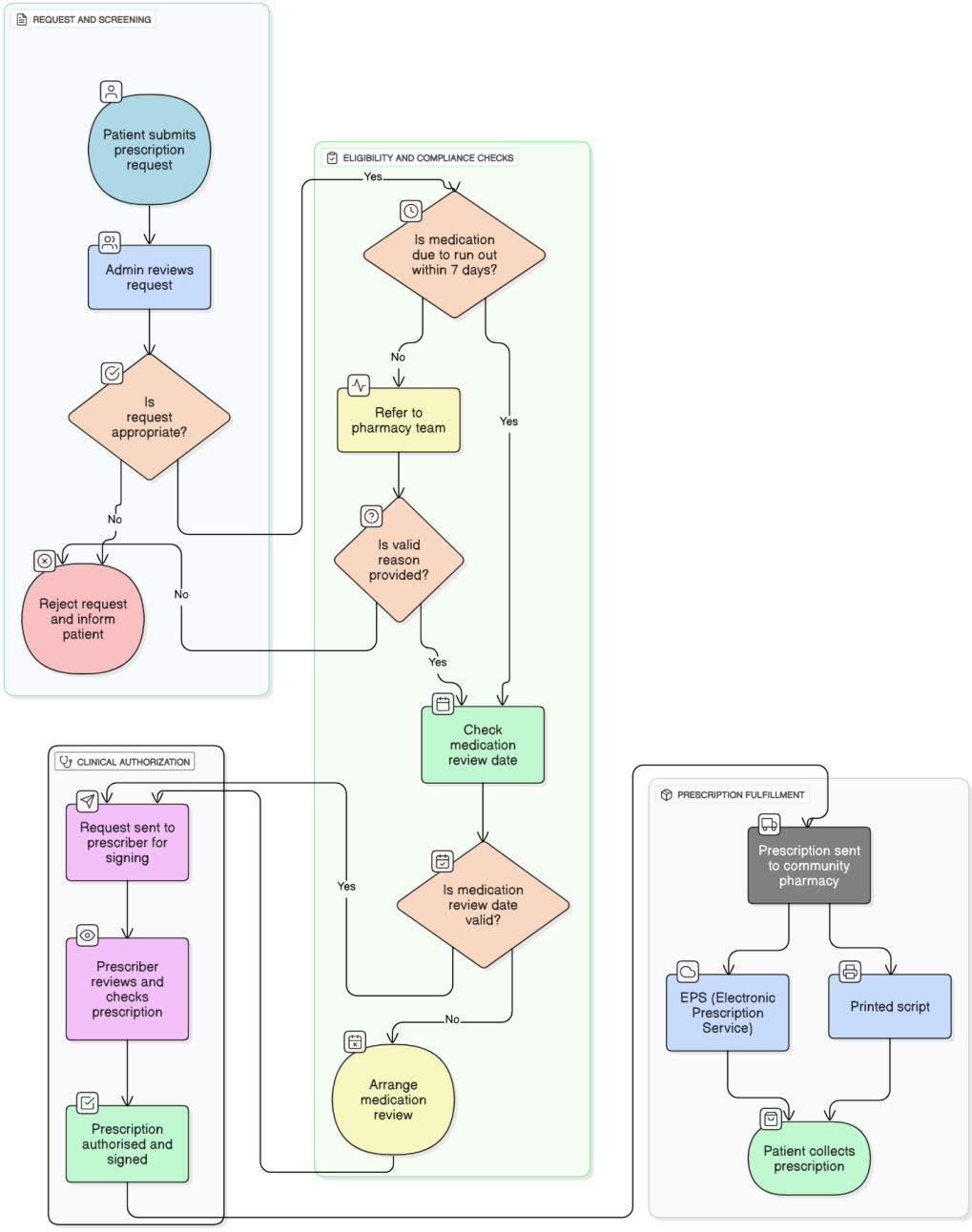
Role	Responsibilities
GP / Independent Prescriber	• Authorise new repeats (with specified duration) • Review medications for side effects/interactions/suitability • Manage complex prescribing
Practice Pharmacist / Technician	• Re-authorisation of repeat prescriptions • Structured medications reviews (SMRs) • Repeat prescription monitoring • Respond to repeat prescription queries
Prescriptions Clerk / Receptionist	• Process repeat prescription requests, • Identify medication queries and escalate if needed • Check repeat prescription synchronisation and highlight to pharmacy team if needed
Practice Manager	• Oversee repeat prescription policy implementation • Staff training and updates • Regular review of repeat prescribing policy and processes
Patient	• Order repeat prescriptions on time • Provide a valid reason for early or urgent requests • Engage with repeat medication monitoring/reviews

2. Repeat Prescribing Process Mapping

A repeat prescribing policy should incorporate process mapping (see below example – Figure 1) to clearly define each stage of the prescribing pathway in a chronological, step-by-step format. This visual representation supports safe, efficient, and consistent implementation of the policy across the practice. It ensures that all staff are aware of their roles and responsibilities, facilitates effective training and auditing, and provides a foundation for continuous quality improvement in repeat prescribing practices.

The example repeat prescribing process map is intended as a general guide and may not reflect the exact workflow of every organisation. For example, dispensing practices will have an added 'dispensing' step within their repeat prescribing process. Individual practices should adapt the process to align with their local systems, staffing structure and patient population needs, while maintaining compliance with national prescribing standards and safety requirements.

Figure 1 – Example Process Map Highlighting an Example Workflow for a Repeat Prescribing Policy



Created using Eraser DiagramGPT

Disclaimer: *This flowchart is for illustrative purposes only and may not reflect the procedures followed by all healthcare practices. Local policies and clinical judgment should always guide prescription processes.*

3. Initiating Repeat Prescriptions

3.1 Authorisation to Repeat

There are **three** main methods for authorising repeat prescriptions

- Newly initiated repeat prescription following a new diagnosis
- An acute prescription is changed to a repeat prescription following review and/or confirmed suitability of the medication.
    - The decision to transfer a drug from an acute prescription to a repeat prescription must always be made by the prescriber after careful consideration of whether the drug has been taken by the patient (compliance check), has been effective and well-tolerated, and is required long term. It is the duty of the prescriber at this stage to ensure the patient understands the repeat prescribing process and what is required of them.
- New repeat prescription following medicines reconciliation (initiated in another care setting)

To meet the GMC requirement to ensure the patient is issued with the correct prescription the repeat prescribing policy should detail:

- **Authorised Prescribers for Repeat Medications**
  Only healthcare professionals with appropriate prescribing qualifications may issue repeat prescriptions. This includes doctors and non-medical prescribers such as nurse practitioners and pharmacists, provided they are acting within their scope of competence. Non-prescribing clinicians may initiate medication requests within their clinical remit and in accordance with agreed protocols; however, such requests must be reviewed and authorised by a qualified prescriber prior to issuing. All prescribing activity must comply with current clinical guidelines and be clearly documented in the patient's record.

- **Documentation and Clarity of Indication and Off-Label or Unlicensed Use**
  For all items issued on repeat prescription, the clinical indication should be clearly documented in the patient's medical record. Where a medication is prescribed for an off-label use or is unlicensed, this must be explicitly recorded, including the rationale for its use. Patients must be appropriately informed when a medication is being used off-label or outside its licensed indications, in accordance with GMC and MHRA guidance.

- **Management of External Healthcare Correspondence Related to Repeat Prescribing**
  A structured process must be in place for reviewing and actioning medication-related correspondence from external healthcare providers (e.g., hospital discharge summaries, outpatient clinic letters, and community services). Responsibility for implementing changes in the patient's medical record —such as initiating or discontinuing repeat medications or adjusting doses—usually rests with the clinical team.

- **Procedure of Patient Communication Following Repeat Medication Changes**
  Patients must be informed promptly and appropriately of any changes to their repeat medications to support safe and effective use. While SMS and email are the preferred methods due to their efficiency and accessibility, alternative methods—including telephone or in-person communication—should be employed, when necessary, based on the patient's preferences or communication needs. All communication must be clearly recorded in the patient's medical record to support continuity and quality of care.

  To meet the GMC requirement to prescribe safely, ensuring that the patient's condition is monitored,the repeat prescribing policy should include details of

- **Specified Duration for Initial Repeat Prescription Authorisation**
  The length of initial authorisation for repeat prescriptions should be defined and may vary depending on the medication. Clear guidance should be provided for each drug class or therapeutic category.
- **Processes to Ensure Timely Medication Reviews**
  Systems should be in place to ensure that medication reviews are scheduled and conducted prior to the documented review date. The New Medicines Service (NMS) available in community pharmacies can help facilitate and assist with reviews when initiating new repeat prescriptions.
- **Defined Criteria for Repeat Prescription Reviews**
  The policy should outline the clinical criteria used during repeat prescription reviews, including considerations such as therapeutic effectiveness, side effects, adherence, and any required monitoring. When processing repeat prescription reauthorisations, clinicians should evaluate both medication synchronisation opportunities and Repeat Dispensing (RD) eligibility.
- **Actions Required at and Beyond the Review Date**
  Clear procedures must be followed when a patient reaches or exceeds their repeat medication review date, including temporary holds (if clinically appropriate) or quantity reductions, clinical reassessment, or escalation if necessary. Various contact strategies should be utilised and tailored to individual circumstances e.g., written communication (SMS/letter) or telephone contacts. All contact attempts and clinical decisions must be comprehensively recorded in the patient record, including rationale for any prescribing adjustments.
- **Repeat Requests for Items Not on Repeat Prescription**

  The policy should outline the process for handling repeat medication requests for items not currently on a patient's repeat list - including those initiated in hospital, during clinic appointments, or listed as acute. Such items must not be added to the repeat prescribing system by non-clinical staff. All requests should be reviewed by a clinician or managed in line with an agreed practice protocol to ensure appropriate prescribing and maintain clinical oversight.

- **Named Clinical Staff for Prescribing Queries and Support**
  A list of designated clinical team members—such as GPs, pharmacists, or advanced nurse practitioners—should be maintained and made available to provide support and respond to prescribing-related queries.

- **Recording and Reporting of Prescribing Incidents**
  All incidents related to prescribing—such as lost or mislaid prescriptions, prescribing errors, or near misses—should be recorded in line with the practice's incident reporting procedures. These records should be reviewed regularly to identify trends, improve safety, and inform staff training. Serious incidents must be escalated in accordance with NHS incident management policies.
- **Audit and Continuous Improvement of the Repeat Prescribing Process**
  Practices should conduct audits of their repeat prescribing systems at least twice a year to ensure compliance with clinical guidelines, safety standards, and best practice. Audit findings should be used to inform service improvements, with actions taken to address any identified issues. Outcomes and learning should be shared with relevant staff to support a culture of continuous improvement and patient safety.

3.2 Items Not Suitable for Repeat

The policy should also include details of which items generally are not considered suitable for repeat prescribing (see example – Table 2).

For certain medications where repeat prescribing may not be appropriate—particularly those intended for use slightly beyond a short-term course—the use of post-dated acute prescriptions may be a more suitable option. This approach supports safe prescribing practices while ensuring appropriate clinical oversight and reducing unnecessary inclusion of such items on repeat.

The below list of medicines that are not routinely suitable for repeat prescribing (i.e. Table 2) is not definitive and should be reviewed regularly. Practices are advised to create similar lists in accordance with organisational prescribing preferences, formulary guidance and local/national prescribing policies.

Table 2 – Example: Medications Typically Unsuitable for Repeat Prescribing

The Following Medicines Will Not Be Added to Repeat Prescription Screens
Antibiotics, antivirals and antifungals for acute infections
Analgesia intended for short term use e.g. post-op
Benzodiazepines/Hypnotics
Cough remedies and decongestants
Dressings, dietary supplements or district nurse requested items
High-risk drugs that require specific repeated monitoring e.g. rheumatology drugs such as methotrexate
Oral contraceptives and hormone replacement therapy

3.3 Prescription Duration

A good repeat prescribing policy should detail the practice's policy on prescription duration and quantity of supply. Historically, the Department of Health has recommended a 28-day prescription duration to help reduce medication waste. However, evidence suggests that longer prescription durations may enhance medication adherence and could potentially lower overall healthcare costs when accounting for dispensing fees, clinician time, and medicine wastage.

Prescription duration should be based on individual patient needs and may vary on a patient-to-patient basis. Whilst 28-day prescribing remains the default standard, extended durations—such as 56-84-day prescribing—may be appropriate in certain circumstances (see Table 2). Prescribers must apply clinical judgement, noting that the maximum supply allowed under the NHS is three months, and that longer durations may not be appropriate for patients at higher risk of medication-related harm.

Key Considerations for Practice Policy

- **Consistency in Prescription Duration:**
  Where a change in prescription duration is deemed appropriate, prescribers should ensure that all items on a patient's repeat list are adjusted simultaneously. This avoids fragmented ordering patterns and reduces administrative workload for practice staff.
- **Patient/Carer Communication:**
  Patients and/or carers must be clearly informed when prescription durations are changed. This is essential to ensure they adjust their repeat ordering behaviour accordingly and do not unintentionally over-order medicines.
- **Policy Alignment:**
  Any decisions regarding prescription duration should align with local prescribing policies, clinical judgment, and individual patient needs, while also supporting efficiency and minimising unnecessary waste.

Table 3 – Factors That May Influence Prescription Durations

Clinical Consideration	28-Day Prescribing Recommended	Longer Duration (Up to 2–3 Months) May Be Appropriate
Clinical stability	Newly initiated medications; unstable long-term conditions; frequent medication changes.	Stable long-term conditions with minimal or no recent medication changes.
Monitoring requirements	Medicines requiring regular monitoring (e.g., warfarin, lithium).	Medicines with low risk requiring infrequent or no monitoring.
Risk of misuse or dependency	Medicines with abuse potential (e.g., opioids, benzodiazepines, gabapentinoids).	Medicines with low risk of misuse or dependency.
Risk of overdose or suicide	Patients with known or suspected risk of self-harm or overdose.	Patients with no identified risk of self-harm or overdose.
Adherence and self-management	Patients with poor adherence, cognitive impairment, or those struggling to manage medicines.	Patients with a proven history of adherence and appropriate use.
Setting	Patients in care homes; those requiring Monitored Dosage Systems (MDS) or dosette boxes.	Patients living independently without need for medication administration support.
Safety and storage at home	Where there is concern around secure storage of medication, especially controlled drugs or medicines for vulnerable people.	Patients who can safely store larger quantities of medication.
Cost and waste considerations	Expensive items or short shelf-life products to avoid wastage.	Low-cost, stable medicines where reduced dispensing frequency improves efficiency.
Palliative care	Frequent review of symptom control and titration of medication doses.	N/A
Review attendance and ordering behaviour	Patients who miss medication reviews or regularly over/under-order prescriptions.	Patients who consistently attend reviews and manage repeat requests responsibly.
Patient convenience	N/A	Patients who find frequent ordering burdensome (e.g., working adults, rural patients).

3.4 Weekly Prescription Requests

The repeat prescribing policy should clearly define the practice's position on weekly prescription requests, particularly those received from community pharmacies.

Requests for weekly prescriptions from community pharmacies should not be routinely accepted. Such requests must be clinically assessed and approved only when there is a clear and documented clinical justification, based on the prescriber's professional judgement.

Weekly prescribing may be appropriate in exceptional circumstances, such as where a patient:

- Is unable to safely manage a larger supply of medication.
- Is at risk of non-adherence, misuse or overdose.
- Requires more frequent monitoring due to clinical instability or safeguarding concerns.

In such cases, issuing medication on a weekly basis may support safer medication use and improve patient outcomes. Where clinically appropriate, the use of post-dated acute prescriptions or electronic repeat dispensing (eRD) (refer to Section 6) should be considered to manage the process effectively while maintaining clinical oversight.

All decisions to prescribe on a weekly basis must be clearly documented in the patient's medical record, including the rationale for the prescribing interval and any relevant clinical factors.

3.5 Dosage Instructions

When developing a repeat prescribing policy, practices should provide guidance and encourage clear and specific dosage instructions. This should apply to all medications and formulations added to the prescribing system including solid oral dosage forms**,** liquids, creams, sprays, and drops.

Phrases such as “take as directed” should be avoided, as they do not support safe administration—especially where medicines are given by carers or care home staff. Furthermore, medical abbreviations should not be used to prevent misinterpretation.

Exceptions to detailed directions may include:

- Blood glucose test strips
- Insulin with variable dosing
- Medical Appliances

Some medicines require more detailed prescribing, for example:

- *Topical corticosteroids*: Apply sparingly once daily
- *Warfarin*: Take as directed in the yellow book
- *Sildenafil*: Do not take more than one dose in 24 hours
- *Eye/ear/nasal drops*: Instil [number] drops [frequency] to the right/left/both [eye/ear/nostril]

Clear instructions improve safety, support adherence, and ensure consistency in prescribing practices.

3.6 Generic and Brand Prescribing

To meet GMC requirements for safe prescribing, practice repeat prescribing policies must include clear guidance on generic prescribing, in line with local and national recommendations.

Prescribers should be encouraged to prescribe generically wherever clinically appropriate, in accordance with local formulary guidance and Integrated Care Board (ICB) medicines optimisation policies, to support safety, consistency, and cost-effectiveness across the health system.

Exceptions to Generic Prescribing

Brand name prescribing may be necessary in specific situations, including:

- Medicines listed as unsuitable for generic prescribing in the BNF, or those flagged by clinical decision support tools.
    - The Specialist Pharmacy Service (SPS) provides a list of such medicines:

      SPS – Example Medicines to Prescribe by Brand Name
- Local recommendations advising branded prescribing for:
    - Supply chain considerations
    - Cost effectiveness e.g. NACSYS® compared to generic Acetylcysteine

Prescribing policies should ensure that any branded prescribing recommendations are regularly reviewed and updated, in line with current evidence and local guidance, to maintain both clinical safety and cost-effectiveness.

4. Ordering Repeat Prescriptions

4.1 Patient and Third-party Ordering of Repeat Prescriptions

An effective repeat prescribing policy should clearly outline how patients can request their repeat medications, including the approved methods of ordering and the practice's preferred channels. This information should be available through the practice website and within the practice itself.

Where patients can order their own medication, they should be encouraged to do so through digital platforms such as:

- The NHS app
- Online services (e.g. Patient Access)
- Practice websites
- Email requests - automated acknowledgement responses are advised, confirming receipt of the request

Digital ordering supports safer prescribing, reduces the risk of errors and helps decrease administrative burden associated with non-digital methods of ordering (written/telephone).

However, digital confidence and access vary across the population. Practices must ensure that the repeat prescription process remains accessible for all patients, including those who have limited digital skills or who cannot use digital tools. For patients unable to order digitally, practices should maintain appropriate non-digital ordering options, including written prescription requests and ordering through carers or via proxy access, where appropriate. Telephone requests should be minimised and used only where clinically appropriate, or when no other safe and accessible option is available, due to the increased administrative workload, lack of an audit trail and potential for errors.

The policy should set out the process for proxy access to repeat medication ordering on behalf of patients, including carers, family members, or care home staff. Practices must ensure that informed consent is obtained from the patient (or legal representative) for a named individual to order medication on their behalf, and that proxy access is set up securely and documented appropriately within the patient's medical record. Staff should follow national guidance provided by NHS England: Ordering Medication Using Proxy Access.

Ordering Medication Using Proxy Access – NHS England

Dispensing practices that offer a repeat ordering service must have additional procedures in place to ensure that explicit consent is obtained from the patient and that each item is confirmed as required before ordering. This includes reviewing the patient's recent order history, checking for any recent clinical or medication changes, and avoiding automatic reordering to reduce waste.

To support patients who may benefit from building confidence with digital tools, practices should signpost patients to existing national and local support resources. These include:

Digital Support Resources

- NHS App Help and Support
- NHS App Repeat Prescriptions Promotional Toolkit
- NHS App – How to Order Repeat Prescriptions (video)
- NHS App – General Overview for Patients (video)

Digital Literacy Resources

- Shropshire – Computer Skills for All
- Telford & Wrekin – Face-to-Face Digital Support

The repeat prescribing policy should clearly define the standard timeframe for processing repeat prescription requests from the date of request to ensure consistency, manage patient expectations, and support safe prescribing. The timeframe should provide sufficient time for administrative checks, clinical review where necessary, and authorisation by a prescriber.

The policy should highlight the practice's procedures for storage of paper prescriptions, verification of collectors and handling prescriptions that are not collected or missing to maintain confidentiality and patient safety.

Stored prescriptions should be inaccessible to patients, be kept locked when not in use, with access restricted to authorised practice staff only. Collectors should pass security checks and be able to confirm identifiable patients' data prior to handover. All reasonable efforts should be made to locate missing prescriptions and after risk assessment, a duplicate prescription may need to be issued to avoid patient harm. Non-collected prescriptions may trigger a clinical review especially for high-risk medications and may highlight medication adherence issues.

4.2 Urgent/Emergency Prescription Requests

The repeat prescribing policy must clearly define how urgent and emergency requests are processed. Urgent prescription requests can place significant strain on practice resources and must be appropriately triaged to ensure patient safety and service sustainability.

The policy should outline:

- **Timeframe** for processing urgent requests (e.g., within 24–48 hours where clinically appropriate).
- **Which medications** are eligible for urgent requests (see example – Table 3) based on clinical need.
- **Management protocols** for patients making frequent urgent requests, including review and possible clinical discussion.
- **Referral procedures** for requests deemed inappropriate or requiring further assessment.
- **Alternative options** when urgent requests are refused (e.g., referral to community pharmacy (Pharmacy First) or NHS 111).

The below list of medicines (i.e. Table 3 and 4) are not definitive and should be reviewed regularly. Practices are advised to create similar lists in accordance with organisational prescribing preferences, formulary guidance and local/national prescribing policies.

Table 4 – Example: Medications That May Be Considered for an Urgent Prescription Request

Note: This table provides general guidance. Each urgent request should be considered on an individual basis, taking into account clinical need and the reason for urgency.

Therapeutic Group	Examples of Medications	Clinical Rationale for Urgency
Adrenaline Injectors	Epipen®, Jext®, Emerade®	Essential for anaphylaxis prevention
Anti-arrhythmics	Amiodarone, Flecainide, Sotalol, Verapamil	Disruption may cause cardiac instability
Antibiotics (oral only)	Amoxicillin, Doxycycline, Nitrofurantoin, etc.	Timely treatment of infections
Anticoagulants	Warfarin, Apixaban, Edoxaban, Rivaroxaban, LMWHs (e.g. Tinzaparin)	Risk of thrombosis if omitted
Antidepressants	Sertraline, Fluoxetine, Mirtazapine, Venlafaxine	Risk of withdrawal or relapse
Antiplatelets	Clopidogrel, Ticagrelor, Dipyridamole *(excluding aspirin – available OTC)*	Prevention of clot formation
Antipsychotics	Risperidone, Aripiprazole, Quetiapine (e.g. Sondate XL®), Olanzapine	Risk of relapse or decompensation
Bipolar Disorder Treatment	Lithium (e.g. Priadel®)	Narrow therapeutic index; requires regular monitoring

Therapeutic Group	Examples of Medications	Clinical Rationale for Urgency
Diabetes – Insulin	All insulin types	Life-sustaining medication
Diabetes – Emergency	Glucagon injection, Freestyle Libre 2®, Dexcom, test strips, needles	Prevents or manages hypoglycaemia
Epilepsy Medications	Sodium Valproate, Carbamazepine, Lamotrigine, Levetiracetam, Buccal Midazolam	Seizure risk if interrupted
GTN Spray	Glyceryl Trinitrate	Used acutely for angina symptoms
Immunosuppressants	Azathioprine, Methotrexate, Ciclosporin, Mycophenolate, Sulfasalazine	Required to prevent flare or transplant rejection
Long-term Steroids	Prednisolone, Hydrocortisone, Fludrocortisone, Dexamethasone	Risk of adrenal insufficiency if stopped suddenly
Nebuliser Solutions	Salbutamol, Ipratropium	Often used during respiratory exacerbations
Oral Contraceptives	Combined oral contraceptive pills, progesterone-only pills	Avoiding missed doses to prevent pregnancy
Palliative Care Drugs	Morphine, Oxycodone, Midazolam, Levomepromazine, Hyoscine	Essential for symptom control
Parkinson's Medications	Co-careldopa (Sinemet®), Co-benedopa (Madopar®)	Precise timing needed to control symptoms
Reliever Inhalers	Salbutamol (Ventolin®), Terbutaline (Bricanyl®), Ipratropium (Atrovent®)	Acute asthma/COPD management

Table 5 – Example: Medications Generally Considered Non-Urgent

Note: The medications listed below are typically not clinically urgent. A short delay (e.g. 48–72 hours) is unlikely to result in patient harm. Each request should still be considered on an individual basis.

Therapeutic Group	Examples of Medications	Rationale
Acid Suppression	Omeprazole, Lansoprazole, Famotidine, Gaviscon	Symptom relief - short interruptions usually tolerated
Antihypertensives	Amlodipine, Ramipril, Losartan, Indapamide, Doxazosin	Minimal risk with brief interruption
Cholesterol Medications	Atorvastatin, Simvastatin, Ezetimibe	Long-term benefit; short-term omission unlikely to impact outcomes
Emollients	Diprobase, Zeroderm, Aveeno, Hydromol	Symptomatic relief; can be temporarily substituted
Eye Drops (Dry Eyes)	Hypromellose, Carbomer, Carmellose, Sodium Hyaluronate	Comfort use; low clinical risk with short delay
Iron Supplements	Ferrous sulfate, Ferrous fumarate	Minor risk if short delay
Laxatives	Lactulose, Senna, Macrogol, Fybogel	Symptomatic; alternative methods usually available
Bone Protection	Alendronic acid, Risedronate, Calcium and Vitamin D supplements	Long dosing intervals; temporary delay usually safe
Erectile Dysfunction	Sildenafil, Tadalafil, Alprostadil	Not critical to immediate health
Medications Not Recently Taken	Any drugs not taken for ≥1 week	Potential indication of non-adherence; review before reissuing
Oral Diabetes Medications	Metformin, Gliclazide, Pioglitazone, Semaglutide (Rybelsus®), SGLT-2 and DPP-4 inhibitors	Minor risk if short delay and patient not on insulin
Over the Counter (OTC)	Paracetamol, Ibuprofen, Aspirin, antihistamines	Available without prescription
Sleep Aids / Hypnotics	Zopiclone, Zolpidem, Melatonin, Temazepam, Nitrazepam	Short delay unlikely to result in harm; potential for dependency
Steroid Creams	Hydrocortisone, Betamethasone, Clobetasol	Symptomatic relief - short breaks usually tolerated
Thyroid Medication	Levothyroxine	Tolerable for a few days in most patients

4.3 Controlled Drug (CD) Requests

Repeat prescribing policies must include protocols for managing controlled drug requests, with particular attention to patient safety, regulatory compliance, and minimising the risk of misuse.

Controlled drugs carry a higher risk of dependence, withdrawal symptoms, and misuse. Therefore:

- CD prescriptions should be reviewed at regular intervals, with the frequency of review based on the individual patient's risk and clinical need.
- At each review, clinicians must:
    - Evaluate the ongoing clinical benefit versus potential risks.
    - Discuss with the patient whether to continue, reduce, or discontinue treatment.
    - Update the management plan accordingly and clearly document the date of the next scheduled review.

Prescriptions for Schedule 2, 3, and 4 CDs are legally valid for 28 days from the date on the prescription.

Department of Health and BNF guidance advises that the quantity of CDs prescribed should not exceed 30 days' supply. In exceptional clinical circumstances, a longer supply may be issued, but this must be supported by a clear clinical rationale, and the decision and justification must be documented in the patient's medical record. Requests for holiday cover must be assessed on a case-by-case basis, considering the patient's medical history and any patterns of early or repeated requests.

Preferably, Paper CD prescriptions should be signed for upon collection to enable audit and accountability. Lost prescriptions involving CDs or drugs with misuse potential must be reported promptly following local procedures and documented using systems such as Ulysses or equivalent incident reporting tools.

4.4 Requests From Nursing and Residential Care Homes

In accordance with NICE guidelines on managing medicines in care homes, practices should include specific provisions within their repeat prescribing policy to ensure safe, consistent, and efficient prescribing for care home residents.

The following principles should be embedded into the policy:

- **Responsibility for Ordering**
  Care home providers should retain responsibility for ordering medicines from the GP practice. Designated care home staff should be allocated protected time to carry out this task and to check medicines upon delivery.

- **Documentation and Record Keeping**
  Care homes must maintain clear records of all medicines ordered. On receipt, delivered items should be checked against the order record to ensure accuracy and identify any discrepancies promptly.

- **Prescribing Cycle**
  Medicines for care home residents should generally be prescribed on a **standard 28-day cycle**, in line with usual care home medication routines.

- **Synchronisation of Medicines**
  Practices should aim to synchronise all repeat medications for each resident, so that they run out at the same time. This reduces the risk of missed doses, improves ordering efficiency, and helps ensure safe medicine administration within the care home.

These measures are intended to support collaborative working between GP practice and care home staff, improve patient safety, and promote better medicines optimisation for residents.

5. ‘High Risk’ Drugs

High-risk medicines present an increased risk of significant harm if used incorrectly. This may include drugs with a narrow therapeutic index, those requiring complex dosing, or medicines that necessitate regular monitoring—often under an Integrated Care Protocol (ICP).

Practices must implement robust systems to ensure that all necessary clinical monitoring is completed and up to date prior to issuing a prescription. Prescribing without recent monitoring results can compromise patient safety and should be avoided. Examples of high-risk drugs are listed below (see examples -Table 6).

Repeat prescribing policies should:

- Clearly identify and define medicines considered high-risk.
- Specify monitoring requirements and review intervals.
- Outline the roles and responsibilities of staff in identifying, reviewing and confirming monitoring has been completed for patients prescribed ‘High Risk’ medications.
- Determine what actions are needed when monitoring requirements are not met.

Table 6 – Example: Medications Considered ‘High Risk’

This list is illustrative rather than exhaustive. Practices should regularly review their list of ‘High Risk’ medicines and consult resources such as SPS, MHRA, NICE, BNF, and local formularies to identify additional high risk medicines and update monitoring protocols accordingly.

Medicines Monitoring – SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

Drug/Drug Class	Examples
Disease-Modifying Anti-Rheumatic Drugs (DMARDs)	Methotrexate, Sulfasalazine, Leflunomide, Hydroxychloroquine, Azathioprine, Mercaptopurine
Anticoagulants	Warfarin, Apixaban, Rivaroxaban, Edoxaban, Dabigatran
Lithium	Lithium Carbonate, Lithium Citrate
Antipsychotics (long-term use)	Olanzapine, Risperidone, Quetiapine, Aripiprazole
Immunosuppressants	Azathioprine, Mycophenolate, Ciclosporin, Tacrolimus
Anti-epileptics	Sodium Valproate, Carbamazepine, Lamotrigine, Levetiracetam, Phenytoin

6. Structured Medication Review (SMR)

Incorporating SMRs into repeat prescribing policies ensures that repeat medications remain safe, effective, and clinically appropriate. They are a contractual requirement under the Network Contract Directed Enhanced Service DES. SMRs help reduce medication-related harm, support deprescribing, and improve patient outcomes—particularly for those on multiple or high-risk medicines.

An SMR is a comprehensive and clinical review of a patient's medicines, designed to support safe, effective, and evidence-based prescribing. SMRs involve shared decision-making with the patient (or their carer), focus on medicines optimisation, seek to reduce medication-related harm, and aim to minimise waste.

Who Can Conduct an SMR?

In line with the Network Contract Directed Enhanced Service (DES), only appropriately trained healthcare professionals should conduct SMRs. These clinicians must:

- Hold an independent prescribing qualification.
- Possess advanced clinical assessment and history-taking skills (or be actively working towards these).

While SMRs are primarily delivered by clinical pharmacists, General Practitioners (GPs) and Advanced Nurse Practitioners (ANPs) who meet the above criteria are also eligible to carry out these reviews.

Patient Groups Who May Benefit From an SMR

Structured Medication Reviews should be purpose-driven and targeted toward patients who are likely to benefit the most. Practices should prioritise individuals from the following groups:

- Complex and problematic polypharmacy – especially patients prescribed 10 or more regular medications.
- Adults (18+) living in care homes.
- Patients taking medications that are commonly associated with medication errors (e.g., anticoagulants, NSAIDs).
- Individuals with severe frailty who are particularly isolated or housebound or who have had recent hospital admissions or falls
- Patients prescribed potentially addictive medications, such as opioids, benzodiazepines, or gabapentinoids.

Core Components of an SMR

All SMRs must:

- Involve the patient and/or carer in the decision-making process.
- Consider the patient's values, preferences, concerns, and their understanding of their medication.
- Review all medicines, including:
    - Prescribed drugs
    - Over the counter (OTC) products

    - Complementary and alternative therapies
- Assess:
    - Clinical appropriateness and effectiveness
    - Adverse effects and interactions - any suspected adverse drug reactions should be reported using the MHRA Yellow Card Scheme, if applicable.
    - Compliance with local and national prescribing guidance
    - Any required monitoring

Deprescribing

Clinicians should actively identify opportunities for deprescribing—the process of reducing, stopping, or discontinuing medicines that may no longer be appropriate, to reduce polypharmacy, minimise harm, and improve patient outcomes.

Deprescribing considerations should include:

- Medicines with no current clinical indication or where the potential risks outweigh the benefits.
- Medicines that have not been ordered, issued, or taken for an extended period of time.
- Medicines no longer aligned with current clinical guidance.

Where a repeat medication is no longer required — clinicians should ensure that the medication is appropriately removed from the repeat prescription list, where clinically indicated. Furthermore, a clear and explicit reason for deprescribing or discontinuation is documented in the patient record. Clear documentation is essential to reduce the risk of medicines being re-ordered in error, support continuity of care and provide clarity for patients and other healthcare professionals involved in their care.

Deprescribing decisions should be made using a shared decision-making approach, considering the patient's preferences, clinical context, and overall treatment goals, with appropriate monitoring and follow-up where required.

Local training and support resources are available from:

Structured Medication Review Resources

Shropshire Telford and Wrekin (STW) ICS – Structured Medication Reviews: Best Practice Guidance for local implementation advice and clinical pathways.

7. Repeat Dispensing

Repeat Dispensing (RD) allows patients to receive supplies of their regular, repeat medication over a defined period without needing to contact their GP practice each time a new issue is required.

Eligibility and Suitability
Patients with stable, long-term conditions may be suitable for RD, including:

- Individuals prescribed a single stable therapy (e.g., levothyroxine).
- Patients with stable multi-morbidity on consistent treatment regimens (e.g., hypertension, asthma, type 2 diabetes).

The use of paper-based repeat dispensing should be phased out in favour of electronic Repeat Dispensing (eRD), as per NHS guidance.

Practice Policy Requirements
Each practice's repeat prescribing policy should include:

- A clear process for initiating and managing eRD prescriptions.
- Defined roles and responsibilities for clinical and non-clinical staff involved in eRD.
- Assurance that all relevant staff have completed appropriate training in eRD functionality, workflows, and use of the EPS tracker.
- A mechanism for identifying suitable patients for eRD through clinical review or medication review.

Training and support resources are available from NHS England and NHS Digital:
Electronic Repeat Dispensing: Information and Toolkit for Prescribers

Benefits

eRD offers a range of clinical, operational, and patient-facing benefits:

- **Enhanced Prescriber Control**
  Prescribers can cancel future prescriptions or individual items at any point. They can also see whether a prescription is with the dispenser or has been supplied to the patient.
- **Robust Audit Trail**
  eRD maintains a complete, end-to-end medico-legal record from prescribing through to dispensing, including reasons for any cancellation.
- **Automatic Cessation Following Death**
  All outstanding eRD issues are automatically cancelled when the Personal Demographics Service (PDS) is updated with a death notification, preventing inappropriate dispensing.
- **Flexible Dispenser Nomination**
  Patients can change their nominated pharmacy at any time. Remaining eRD prescriptions will be made available to the new dispenser.
- **Prescription Tracking**
  Clinicians and staff can track eRD prescriptions using the EPS Tracker, supporting safer medicines management and reducing prescription queries.

8. Incident Reporting in Repeat Prescribing

An effective and transparent incident reporting system is critical to safeguarding patient safety and maintaining quality standards in repeat prescribing. General practices must have robust procedures to ensure all prescribing-related incidents, near misses, or risks are identified, recorded, reviewed, and acted upon.

This approach aligns with the NHS England Patient Safety Incident Response Framework (PSIRF) and guidance from the National Institute for Health and Care Excellence (NICE) on medicines safety and management.

What Constitutes a Prescribing Incident?

Prescribing incidents may occur at any stage of the repeat prescribing process—from request to dispensing. These incidents should be reported, including near misses.

Table 7 – Example: Potential Prescribing Incidents Associated with Repeat Prescribing

Type of Incident	Example
Incorrect medication or dose issued	Repeat prescription generated for ramipril 10mg instead of 5mg, leading to hypotension.
Inappropriate continuation	Antibiotic or high-risk drug (e.g. methotrexate) issued repeatedly without review or monitoring.
Monitoring not completed	Lithium issued without checking renal function or recent serum levels.
Repeat item re-authorised incorrectly	Receptionist re-activates a discontinued medicine without clinician input.
Wrong patient prescribed	Prescription issued to a patient with the same name/DOB due to selection error.
Unnecessary or duplicate prescribing	Patient issued inhalers monthly despite adequate stock, resulting in overuse.
Delayed prescribing	Prescription not processed within 48 hours, leading to missed doses.
Failure to act on third-party information	Hospital letter recommends stopping medication, but prescription continues.

The repeat prescribing policy should cover the areas below to maintain patient safety and minimise risk of harm:

Reporting, Recording, and Escalation

- All incidents should be recorded using the practice's incident reporting system (e.g. Ulysses).
- Significant events (SEAs) should be discussed regularly at clinical or prescribing meetings to support learning.
- Serious safety concerns (e.g. harm from incorrect prescribing or failure to monitor high-risk drugs) must be escalated to the ICB Medicines Optimisation Team and reported through the NHS England Learning from Patient Safety Events (LFPSE) service.
- Practices must comply with Duty of Candour requirements in cases where patient harm has occurred.

Continuous Improvement and Learning

- Regular analysis of prescribing incidents should be used to identify themes, training needs, or system flaws.
- Findings should inform updates to the practice's repeat prescribing policy and staff training.
- A culture of safety and openness should be promoted where all team members, including administrative staff, are encouraged to report concerns without fear of blame.

9. Governance, Audit and Quality Assurance

To ensure patient safety, efficiency, and compliance with national standards, the repeat prescribing system should be subject to regular audit (**at least twice a year**), self-assessment, and continuous quality improvement. This process should be integrated into the practice's broader clinical governance framework.

The repeat prescribing policy should evaluate the following areas regularly to ensure quality:

Policy Development and Inclusivity
- Have all staff involved in the repeat prescribing process been consulted in the development of the policy?
- Are the roles and responsibilities of each staff member clearly defined and documented?
- Are the views of patients and/or their representatives actively sought and incorporated?

Risk Management and Review
- Has a risk assessment of the entire repeat prescribing process been conducted?
- Have appropriate interventions been implemented to mitigate identified risks?
- Is the policy subject to a scheduled review cycle (e.g. annually), and updated in line with best practice and regulatory requirements?

Incident Reporting and Learning
- Are near misses, prescribing errors, and critical incidents recorded and reviewed?
- Is learning from such incidents routinely shared with relevant team members to inform improvements?

Auditing and System Performance
- Are repeat prescribing audits conducted at least twice a year to assess safety, effectiveness, and compliance?
- Are there clear systems in place to ensure the quality, accuracy, and security of patient data?

Staff Training and Competence
- Is mandatory training on repeat prescribing systems provided to all staff, and refreshed regularly?
- Do staff understand how to use digital systems, follow protocols, and escalate concerns appropriately?

Patient-Centred Information and Inclusion
- Is accessible information available to patients and carers outlining how the repeat prescription system works?
- Are arrangements in place to support patients whose first language is not English (e.g. translation/interpreter services)?
- Is the process inclusive and free from discrimination against individuals with physical, sensory, or psychological impairments?

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