Hampshire & Isle of Wight LPC

SUPPORTING LOCAL COMMUNITY PHARMACY

Electronic Prescriptions & Repeat Dispensing
Moving the agenda forward in Hampshire & IOW

by Patrick Leppard, Community Pharmacist

The future of Community Pharmacy within the NHS lies not only with provision of care of patients with episodic needs and with long term conditions, but also with the optimisation of the use of medication. This simply cannot happen unless we embrace the technology that is now available to us. In particular, we need to master the **Repeat Dispensing** functionality within the **Electronic Prescription Service (eRD)** and our use of the **Summary Care Record**. If we can't (or choose not to) embrace this opportunity then the profession risks harming its ambition of becoming a fully integrated member of the primary healthcare team.

Immense financial resources and a significant amount of time have been invested getting us to where we are now. It is time to realise the benefits of that investment. The vision is clear; to remove the unnecessary and repetitive administrative burdens placed on general medical practice by automating as far as possible what can be automated. This will free up massive resources within practices, which will be better employed seeing and treating patients. The NHS is under considerable strain and if it is to survive it needs us all to work smarter. So called **"efficiency savings"** are part of everyday life for most of us working in the NHS and eRD fits firmly within that strategy. We should use the new technology to work much more efficiently thereby releasing substantial resources that can be redirected into patient care.

Repeat Dispensing (RD) is not new, it has been one of the **Essential Services** within the Community Pharmacy contract for more than 12 years. Its use across the country has been patchy (to say the least) but there are areas where RD has been used extensively and in these areas significant benefits to medical practice, community pharmacy and to patient care have been seen.

RD benefits surgeries because of the reduction in time and administration necessary to process repeat prescriptions and it benefits patients by making their regular medicines much more accessible, directly from their usual pharmacy. Repeat Dispensing has also been shown to reduce waste and hence prescribing costs.

RD benefits community pharmacies by allowing us to provide a more efficient and responsive service to our patients, which builds customer loyalty. It also takes us out of the daily paper chase of taking in patient prescription requests, submitting them to various surgeries, hoping prescriptions are processed in a timely manner, chasing up the ones that aren't, collecting, sorting and only then processing the medication that we could have predicted from the original request submitted several days earlier.

Repeat prescribing is slow, unresponsive, bureaucratic, labour-intensive, wasteful, unnecessarily complicated and largely pointless. It requires clinical input at every issue to confirm a prescribing decision that has already been made and which should require no further clinical consideration until the patient is next reviewed.

We have created a vast industry that shuffles bits of paper around the system just to ensure that patients can have access to the medicines that their prescriber has already decided they need. This has been made even worse by pharmacies offering ***Collection and Delivery*** **and** ***Managed Repeat*** **services**, which despite being introduced with the best of intentions (to make life easier for patients), adds yet another layer of complication to the process and probably increases medicines waste.

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A personal reflection…….

I have managed a pharmacy where **Repeat Dispensing** has been a significant part of our daily routine for more than six years. Over the last two years, more and more patients have been moved over to the electronic Repeat Dispensing service and I now process more eRD prescriptions than either paper-based RD prescriptions or indeed the more traditional repeat prescriptions that arrive from the surgery. We still dispense all three types of repeatable prescription (plus acutes), which can cause complications, but eRD prescriptions are now definitely our preferred form of prescription.

The move to **eRD** can be challenging and the system certainly isn't perfect yet, so having a good understanding of the principles behind the service, how your individual system works and what your contractual duties are in relation to eRD is essential if you are to implement it well. Having good communications, both with your local surgery(ies) and with your patients is crucial. If the eRD process is new to you, it will also be for the surgery staff and for your patients, so some mutual support and perhaps some leadership from you will benefit everyone.

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eRD automates the Repeat Prescribing process by issuing up to one year's worth of prescriptions at the same time, to be released at specified intervals (usually 28 or 56 days) in accordance with the prescriber's wishes. The prescriptions are sent from the surgery computer to the NHS messaging system known as ***The Spine***, where they are held until they are downloaded by a pharmacy. Unless there is a change to a patient's medication, the surgery need have no further input into that patient's medication supply until the next annual review, which is where the biggest savings in time and resources are derived from.

Prescriptions are normally released to the nominated pharmacy at the specified intervals, usually 7 days before they are expected to be needed. Pharmacies can download prescriptions early if, in their professional judgement, it is appropriate to do so **(for example if a patient is going away on holiday)** otherwise the next eRD prescription will appear in the dispensary system 28 or 56 days after the previous prescription.

Subsequent issues within a batch of prescriptions **can only be downloaded if previous issues are completely finished.** All items within a prescription must be either dispensed or marked as not dispensed and the prescription recorded as collected/issued before the next prescription in a batch series can be downloaded. Outstanding owings on a previous prescription, for example, will prevent the successful download of a subsequent eRD prescription.

Processing eRD prescriptions for patients in **Care Homes** can prove to be challenging, particularly if the home expects to see all prescriptions before they are dispensed. If this is the case, the prescribing tokens should be printed and supplied to the Care Home for them to check before the prescriptions are dispensed.

Managing eRD prescriptions within a care home or MDS module can again cause problems but all pharmacy systems have this functionality. System suppliers are able to provide the best advice on how to mange eRD prescriptions within a care home module.

I offer some simple guidelines based on my experience of what went well and what didn't in relation to **eRD** at my pharmacy over the last few years.

- **Have** a clear process in place that is understood and followed by all members of your team. Without having clear "rules" in place, managing Repeat Dispensing can rapidly become chaotic.
  Please Note: Your Superintendent Pharmacist / Professional Services Team may have developed a standard operating procedure or framework for eRD. This LPC guidance is not meant to contradict that and we would advise you to work within your company's operating model. If in doubt, please discuss this with your Area Manager (or similar) to determine what process is right for your type of pharmacy.

- **Decide** how, when a patient asks for their prescription, you can differentiate between the various types of prescription currently in circulation; acute, repeat, repeat-dispensing, brought in by the patient, collected from surgery, received electronically, held on file or indeed, one they want you to order for them. (Patients don't easily understand the subtle differences between regular medications, repeat prescribing and repeat dispensing so using terms like batch prescriptions may help.)

- **Decide** what you are going to do with eRD prescriptions as they are received; should tokens be printed and securely stored, or left on the computer for processing when required.
  Please note RD prescriptions should not be dispensed until it has been confirmed with the patient what is needed this time.

- **Involve** the patient. Let them know what they can get directly from you and what they need to order from the surgery. You may wish to give them a token (see page 4).

NHS Electronic Prescription Service Available here

- **Encourage** patients to collect all the medicines that they will need for the (28- or 56- day) prescribing period at the same time, but not to request medicines that they have enough of already.
- **Decide** what you will do when patients only want part of a prescription to be dispensed now but may call back for the rest later.
- **Work** constructively with your surgery and explain when things don't work as smoothly as they should. It is in the surgery's interest to help you manage their repeat prescribing process effectively for them and there is much they can do to help simplify the process (see below.)
- **Use** the EPS Prescription Tracker to locate any prescription that may have gone astray before contacting the surgery. **The EPS Tracker** can also be used to see where a patient is (3 of 6, 4 of 6, etc) within a current eRD batch.
- **Use** the **Summary Care Record** (SCR) to confirm any reported or suspected changes to a patient's medications.

The Summary Care Record (SCR) is simple to use and should be set up as a quick link from your dispensary computer. It can only be used by healthcare staff qualified and registered to use it. Although still a relatively new resource for pharmacy, it has rapidly become an indispensable service that I access almost every day. From checking the legitimacy of requests for emergency supplies, to confirming changes to patients' regular medications (particularly useful for those using Repeat Dispensing), to checking interactions with OTC medications, it is an amazing resource that we should all be using to keep our patients safe.

Below is guidance that I usually promote to my surgery colleagues, which you may find helpful in discussions with yours;

- **All** repeat medications, not just some, should be moved to eRD. Patients get confused if they need to order/collect their repeat medications from different locations.
- **Print** the associated RA token and give this to the patient (via the pharmacy, if appropriate) so that they can see which items they can get directly from the pharmacy and how they are grouped together.
- **Prescribe** in dose equivalent quantities, wherever possible, so that regular medications run out at the same time.
- **Regular** medications can/should be prescribed together on the same prescription.
- **Items** prescribed for less predictable periods of time (topicals, inhalers, prns, seasonal, etc.) should be prescribed on separate prescriptions.
- **Number** of issues should be based on expected usage, i.e. if the patient had four prescriptions for their painkiller in the last 12 months, set the number of issues to four for the next 12 months, however, for regular medications that should be taken every day, set the number of issues to 13 (assuming 28-day issues.)
- **Agree** a process with your local pharmacy(ies) to rationalise individual patient's medications at the start of a Repeat Dispensing cycle, so that they run out at the same time. This ensures that the prescriptions last for the expected period of time rather than patients trying to obtain one item off the first prescription and a different one off the second, etc. which then rapidly gets through the available prescriptions. (NB: Rationalisation can take place as part of a Medicines Use Review (MUR) within the pharmacy. The pharmacy can then, as a one off supply, endorse and be reimbursed for the amount supplied to bring the medications into line rather than for the full amount prescribed.)
- **Communicate** regularly and collaborate with your local pharmacies to develop a system that works for the benefit of patients, reduces administration within surgeries, minimises the impact on pharmacies and makes the best use of NHS resources.

Most pharmacies, particularly if they are not used to processing RD prescriptions, will tend to dispense prescriptions as they are received and then store them awaiting collection by the patient. This is not sustainable for eRD. Once there is a large shift to Repeat Dispensing the number of prescriptions awaiting collection would swamp most pharmacies. RD prescriptions should not be dispensed until they are due and certainly not before it is known what the patient actually wants/ needs this time.

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Those of us used to **paper-based RD** will have secure filing cabinets filled with RAs and undispensed RD prescriptions, which are processed as and when they are required by the patient. In the electronic world, tokens can still be printed and stored in secure filing cabinets should you so wish, but I prefer to use the computer to store my eRD prescriptions. These can then be accessed when required by either scanning a token or by searching by patient name.

The **contractual obligations** relating to Repeat Dispensing are clear. Every time an RD prescription is issued, the patient should be asked the following questions and the pharmacist should modify their response accordingly;

- Have you seen any health professional (GP, nurse or hospital doctor) since your last repeat was supplied?
- Have you recently started taking any new medicines - either on prescription or that you have bought over the counter?
- Have you been having any problems with your medication or experiencing any side effects?
- Are there any items on your repeat prescription that you don't need this month?

If there are any doubts about the need, appropriateness or safety of supplying the medication, this should be refused and the patient should be referred back to the prescriber, if necessary.

Patients should be encouraged to collect all of the medications that are on the same prescription at the same time but they should only collect the medicines that will be needed. Attaching a **message** (see below) to a token (either prescribing or dispensing) and giving this to the patient at the start of a treatment cycle I find helpful. The patient is encouraged to bring in their token every time they need a further supply, which is then scanned to retrieve the next issue in the batch ready for dispensing.

This Repeat Dispensing Token gives you access to the regular medicines listed directly from your pharmacy every four weeks for up to one year.

When ordering from the pharmacy, try to order all the required medicines at the same time but PLEASE ONLY ORDER THE MEDICINES that will be NEEDED during the 4-week period.

DO NOT WASTE VALUABLE NHS RESOURCES.

Please note; any items not required by the patient and which won't be needed during the 28-day prescribing cycle should be deleted from the prescription as it is dispensed.

If you feel that **eRD** is about moving work out of GP surgeries and shifting it onto Community Pharmacies then, at least in part, you are probably right. It was designed to be that way. Alternatively, you could view it as the NHS recognising the skills that pharmacists bring to patient care and using eRD to further integrate Community Pharmacy into patient care pathways.

Actually, most of the Repeat Prescribing process will be automated; the repetitive and administrative parts will be done by the computerised system, which is where the major NHS savings will come from. This will not impact hugely on Community Pharmacy.

What remains for us to pick up however, will be the clever bit, the bit that can't be automated - the dialogue with the patient, the assessment of patient need, the compliance monitoring, the analysis of medication use, the highlighting of interactions and side effects, the advice and general medicines management. All of this is now delegated to pharmacy - which is where it always should have been, in my view.

If we want to continue working within the NHS we need to see the bigger picture and play our part. We need to add value to the traditional medicines supply role by making the best use of resources, reducing waste and by helping patients to get the most from their medications. We have a clear role to manage medicines supply within the NHS. We have the expertise, the access to the dispensing history and more contact with the patient than any other healthcare professional and we are therefore the ones best placed to carry out this role.

If we don't deliver on this role, if we don't add value by providing an efficient, patient-centred service, if we don't act to maximise the benefits from using medicines and reduce waste, if we don't do the clever bits and all we do is simply supply medicines without adding value to the system, we may find that the whole process becomes a target for automation and our role within it disappears. This would be tragic for our profession but even more so for the patients that we serve.