

NHS Community Pharmacy Prescribing Prescription Management Guidance Draft v1.4

Background and policy context

The increasing deployment of pharmacist independent prescribers (PIPs) within NHS community pharmacy creates opportunities to improve patient access to medicines whilst reducing avoidable workload across primary care.

Patients may experience delays in treatment because of:

- medicines shortages
- prescribing errors
- omitted medicines or other prescribing-related issues

In many cases these issues currently require referral back to the original prescriber, creating unnecessary delays for patients and additional administrative burden for both general practice and community pharmacy.

Additionally, inappropriate prescribing and the supply of medicines that patients do not require or are unable to use can contribute to medicines waste. Prescribing pharmacists are ideally positioned to optimise medicines use, improving patient outcomes while reducing unnecessary waste.

Prescription management enablement provides a governance framework that allows appropriately trained NHS community pharmacist prescribers in community pharmacies to resolve suitable prescribing-related issues through prescribing, where this is clinically appropriate and, in the patient's best interests.

This enablement complements, rather than replaces, existing dispensing flexibilities and established NHS services. It should only be used when those mechanisms cannot safely resolve the problem and prescribing is required to maintain continuity of care.

1. Purpose

1.1. Prescription management allows community pharmacist prescribers deployed in community pharmacies and set up for prescribing to support safe and timely access to medicines when an NHS prescription is presented for dispensing at the pharmacy and cannot be supplied as written. In some cases, prescription management may be used to support medicines optimisation e.g. synchronising quantities or ICB led initiatives to support medicines optimisation.

1.2. Prescription management aims to:

- improve patient experience by reducing unnecessary referrals back to general practice
- support continuity of treatment, medicines safety and medicines optimisation

- reduce administrative burden on GP practices and community pharmacies
- provide a safe framework for managing prescription-related issues, including medicines shortages, prescribing errors, medicines omissions and medicines synchronisation.

1.3. This enablement allows a pharmacist prescriber to assess an NHS prescription-related issue and where appropriate, prescribe a one-off alternative medicine or make a prescribing intervention to enable continued patient care.

1.4. Prescription management should be used only where:

- the issue cannot be resolved through routine dispensing processes
- the intervention is clinically appropriate and, in the patient's best interests
- the patient has been informed and consented
- appropriate communication and governance arrangements are in place with the originating prescriber

2. Inclusion Criteria

Prescription management may be used where a patient presents with any valid NHS prescription and one of the following circumstances applies:

- A medicine is not available.
- There is a prescribing error that prevents a prescription from being dispensed.
- There is an omitted medicine.
- A medicine is no longer required.
- There is a need to synchronise prescriptions.
- Local ICB or PCN led initiatives to support medicines optimisation (e.g. switching medicines or devices).

2.1. Medicine not available

Prescription management may be used where the prescribed medicine cannot be supplied due to:

- national shortages and supply chain problems
- local stock shortages e.g. with wholesalers
- discontinuations

Actions may include:

- prescribing an alternative strength or formulation of the medicine
- prescribing a clinically appropriate therapeutic alternative (where local agreements are established, or the originating prescriber has been consulted). The patient must have been informed and consented.

Pharmacists should use existing national arrangements, including Serious Shortage Protocols before prescribing is considered. Prescription management must not be used to achieve financial benefit to the contractor.

2.2. Prescription errors

Prescription management may be used where a prescription contains an error that prevents safe supply. Examples include:

- incorrect strength
- incorrect quantity
- incorrect formulation
- incorrect dosing instructions
- other prescribing errors identified by the pharmacist prescriber

2.3. Omitted medicines

Prescription management may be used where a medicine that should have been prescribed has not been issued and interruption to treatment may occur. Principles outlined in 1.4 should be adhered to and pharmacy teams should be cognisant of situations where the patient may request medicines that the prescriber has intentionally stopped or withheld. Confirm omission was not intended (e.g. review GP patient record, contacting prescriber). The pharmacist must not rely solely on the patient's testimony.

2.4. Medicine no longer required or appropriate

A pharmacist prescriber may determine, following assessment, that supply is not clinically appropriate. Examples include:

- clinically significant interactions
- medicine previously stopped by another prescriber (e.g. by a hospital)
- medicines no longer required by the patient (e.g. patient already has enough supply)

Where supply is withheld, the pharmacist prescriber should:

- explain the decision to the patient
- inform the original prescriber

2.5. Prescription quantity synchronisation

Prescription quantities may be adjusted to align repeat prescribing cycles where this will reduce waste and improve patient experience (exclusions to be agreed locally).

2.6. Medicines optimisation initiatives

Prescription management may support medicines optimisation initiatives operating under an approved local protocol. These arrangements should:

- be approved by the ICB
- have appropriate clinical governance arrangements
- define eligible medicines and patient groups
- include communication arrangements with participating general medical practices

3. Exclusion criteria

Prescription management is for NHS primary care prescriptions where the issue cannot be resolved through routine dispensing processes and is subject to the following exclusions.

3.1. Clinical exclusions

Prescription management must not be used:

- outside the pharmacist prescriber's area of competence (excluding quantity synchronisation). Pharmacists must always work within their competence and professional prescribing scope
- where the patient requires clinical review by another healthcare professional
- where diagnosis, indication or treatment intent is unclear
- for complex medicines, including but not limited to specialist medicines, shared-care medicines, medicines requiring ongoing monitoring, controlled drugs and other high-risk medicines unless specifically covered by local agreements and the pharmacist prescriber is competent to prescribe them. This may include, but is not limited to, clozapine, biologic medicines, methotrexate, lithium.
- Where there is uncertainty regarding diagnosis, indication or treatment intent.

3.2. Product exclusions

Subject to national and local guidance, the following may be excluded:

- items which should not be routinely prescribed in primary care¹
- dressings, appliances
- products included on local ICB "blacklists"
- products that ICBs have deemed not appropriate for community pharmacy prescribing

3.3. National restrictions

Pharmacist prescribers must not prescribe:

- products excluded under national regulations
- OTC and P medicines unless specifically permitted through a national or local service
- other products restricted within national or local NHS prescribing guidance
- branded products unless there is a clinical indication

3.4. Financial exclusions

Prescription management must not be used to:

- switch products for financial gain to the pharmacy business (including medicines or products where there are pharmacy level rebate schemes in place).
- substitute an available prescribed brand with a generic or vice-versa solely for cost reasons

Clinical need must be the sole determinant of prescribing decisions and pharmacists must not gain financial advantage from product selection. Prescription Management may achieve additional benefits e.g. supporting adherence by aligning quantities.

4. Consent and Patient Involvement

Patients should be involved in all prescribing decisions. Before making a prescribing amendment, the pharmacist prescriber must:

¹ <https://www.england.nhs.uk/medicines-2/items-which-should-not-be-routinely-prescribed>

- explain why the prescribed medicine cannot be supplied as prescribed
- discuss the available treatment options, including any proposed prescribing intervention
- explain the benefits, risks and any clinically relevant differences associated with the proposed change
- obtain informed patient consent before issuing an alternative prescription or making any prescribing amendment
- document that consent has been obtained within the clinical record along with the reason for the change
- inform the patient that the original prescriber will be contacted and informed

Where a patient declines the proposed intervention, the pharmacist should discuss alternative options, including referral to the originating prescriber where appropriate.

In situations where the patient lacks capacity, decisions should be made in accordance with the Mental Capacity Act 2005 and local safeguarding arrangements. Reasonable adjustments should be made to support communication and informed decision-making.

5. Clinical responsibility

The pharmacist prescriber assumes full professional responsibility for any prescribing decision they make under this enablement and in line with the community pharmacy Professional Assurance Framework guidance. Prescription management does not authorise amendment of another prescriber's prescription on their behalf. Rather, the pharmacist prescriber undertakes an independent clinical assessment and, where appropriate, issues their own prescription to resolve the identified prescribing issue.

Prescription management must be in partnership with the original prescriber. The originating prescriber remains responsible for the original prescribing decision. The pharmacist prescriber is responsible for any subsequent prescribing intervention they undertake.

Where changes are made, the pharmacist prescriber must ensure:

- the intervention is clinically justified and within their competence
- the rationale for the prescribing decision is documented
- the original prescriber is informed through agreed communication routes
- appropriate continuity of care is maintained

In situations where a safe decision cannot be made, as per usual business, the pharmacist should seek clarification from the originating prescriber or relevant specialist service.

Clinical Governance and Incident Reporting

Prescription management interventions should be undertaken within established local clinical governance arrangements. Any incidents, near misses or patient safety concerns should be reported through existing patient safety reporting processes such as recording on *Learn from Patient Safety Events* (LFPSE) and learning used to support continuous

improvement. Systems should undertake appropriate audit and review to provide assurance that prescribing is undertaken in accordance with this guidance and local governance requirements. This may include reviewing the numbers and types of interventions.

Professional concerns relating to the prescribing practice, competence, conduct or fitness to practise of a pharmacist independent prescriber should be managed through existing employer, contractor, commissioning and professional governance arrangements. Concerns should be investigated and escalated in line with local procedures, with referral to relevant regulatory or professional bodies where appropriate.

6. Prescribing principles (guardrails)

Annex 1 outlines the clinical decision-making process that should be used when considering a prescription management amendment. Tables 1 and 2 in Annex 2 have practical examples of how prescription management should and should not be used. Prescription amendments must always be undertaken in accordance with the following principles:

- 6.1. Patient safety and clinical benefit take precedence over operational or financial considerations.
- 6.2. Existing dispensing flexibilities should be used wherever appropriate before prescribing is considered.
- 6.3. Pharmacists must prescribe only within their competence and in accordance with applicable guidance, local pathways and governance arrangements.
- 6.4. The originating prescriber must be informed of prescribing interventions through agreed communication processes.
- 6.5. All interventions must be documented contemporaneously with an auditable clinical rationale.

7. Record keeping and information sharing

In line with the Prescribing Specification, contemporaneous records of any Prescription Management interventions must be kept.

- All interventions must be recorded contemporaneously.
- An auditable record of the reason for intervention, action taken and communication undertaken must be maintained.
- Records should be kept in the pharmacy and be available for clinical audit and PPV purposes
- All interventions must be communicated with the original prescriber.

8. Relationships with General Practice/ Primary Care Networks

Prescription management is intended to support collaborative working between community pharmacy, general practice/ Primary Care Network, neighbourhood teams and the ICB to improve timely access to medicines and reduce unnecessary delays in patient care. It should operate within local arrangements and in a manner that promotes professional trust, shared clinical responsibility and continuity of care. The enablement complements existing prescribing and dispensing processes and is not intended to replace engagement

between healthcare professionals where this is necessary for safe and effective patient care.

Community pharmacies, general practices and commissioners should work together to establish locally agreed processes for managing and communicating prescription management interventions. These arrangements should support timely sharing of information, maintenance of accurate patient records, effective medicines optimisation and consistent approaches to managing prescribing-related issues. Existing communication channels should be used wherever possible to minimise administrative burden and support integrated patient care.

Pharmacist prescribers should engage with the originating prescriber where additional clinical information is required, where there is uncertainty regarding diagnosis, treatment intent or ongoing management, or where there is reason to believe that a medicine may have been intentionally stopped, withheld or amended. Care should be taken in circumstances involving omitted medicines, high-risk medicines or significant changes to a patient's treatment plan.

Following any prescribing intervention, the pharmacist prescriber should ensure that the originating prescriber is informed through agreed local communication routes as soon as reasonably practicable. Communication should include the nature of the intervention, the clinical rationale, and any actions required to support ongoing patient care. This is intended to support continuity of care, maintenance of accurate prescribing records and shared understanding of the patient's treatment plan.

Effective implementation of prescription management will depend on strong local relationships between community pharmacy teams, general practices and ICBs. Systems are encouraged to develop shared approaches that support patient safety, reduce avoidable workload and foster collaborative management of prescription-related issues across primary care.

Annex 1

Clinical Decision-Making Process

The following sequence should be followed when considering a Prescription Management Amendment.



Key principle:

At every step, consider patient safety, clinical appropriateness, and local governance arrangements.

Annex 2: Practice Examples

Table 1: Permitted Interventions

Scenario	Typical Example	Permitted Action	Notes
Medicine unavailable: same medication but different strengths and formulation.	Ramipril 5mg capsules unavailable but tablets available	Prescribe an alternative equivalent formulation or strength that delivers the same treatment outcome, where BAU processes cannot address the issue (e.g. SSP). In this example, use Ramipril 5mg tablets.	
Medicine unavailable: therapeutic alternative required	Prescribed medicine subject to prolonged national shortage	Prescribe an appropriate therapeutic alternative where prior agreement exists or discussion with the originating prescriber has occurred.	Prescriber must be consulted.
Prescription error	Incorrect strength, formulation or quantity prescribed	Correct the issue through agreed local process, obtain replacement prescription, or prescribe where appropriate.	
Omitted medicine	One item omitted from a patient's repeat prescription resulting in interruption of treatment	Assess clinical appropriateness and ensure prescriber has not stopped medicine. Prescribe the omitted medicine where necessary to maintain continuity of care.	Confirm omission was not intended (e.g. review GP patient record, contacting prescriber).
Medicine no longer required	Duplicate therapy identified or medicine previously stopped remains on prescription	Do not supply where clinically appropriate and notify the original prescriber.	Ensure that the medicine is removed from the patient's primary record.
Quantity synchronisation	Patient receives medicines with multiple repeat dates causing frequent requests	Prescribe a quantity adjustment to align repeat medicines and support safer ongoing prescribing processes.	
Agreed medicines optimisation intervention	PCN/ICB agreed protocol (with agreement of general practice) to support shortages or improve prescribing efficiency	Prescribe an alternative medicine or amend therapy in accordance with agreed protocol or local arrangements.	Must operate under approved local arrangements and notification process.

For all interventions, original prescriber must be informed and where necessary consulted prior to any intervention being made. Auditable records of any communication retained. Contemporaneous and auditable consultation records must be kept.

Table 2: Interventions Not Permitted

Scenario	Reason
Switching solely to generate financial savings for the pharmacy	Prescription management must not be used for financial gain for contractors. This includes the use NHS Rebate Schemes.
Switching a prescribed brand product to generic when the prescribed brand remains available or vice versa	Not consistent with service intent.
Prescribing outside the pharmacist's competence (excluding quantity synchronisation).	All activity must remain within prescribing competence and scope of practice. Note Table 1: Therapeutic changes must be done in consultation with prescriber
Prescribing products restricted by national regulations or local exclusion lists	Must comply with national restrictions and local ICB governance arrangements.
Complex specialist medicines not covered by local agreements (see 3.1)	Requires escalation to the originating specialist or prescriber. This is a suggested operational interpretation based on the governance principles and competency requirements described in the papers.