Royal Cornwall Hospitals
NHS Trust

The Medicines Policy
Chapter 2: Standards of Practice
Prescribing

V6.0

June 2025

Table of Contents

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

1.1. This policy sets out the prescribing standards and processes that should be followed by RCHT staff when prescribing medicines in the Trust.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

To ensure that medicines are prescribed for our patients safely, legally, and effectively by RCHT staff.

3. Scope

This policy applies to all staff that are involved in the prescribing of medicines at RCHT.

Non-medical prescribers (NMPs) should also refer to the Trust's non-medical prescribing policy.

4. Definitions / Glossary

A medicinal product is any substance or combination of substances that may be used by or administered to human beings with a view to restoring, correcting, or modifying a physiological function by exerting a pharmacological, immunological, or metabolic action, or making a medical diagnosis. Medicinal products come under the jurisdiction of the MHRA. Food, nutrition, and herbal products are not classified as medicinal products.

5. Ownership and Responsibilities

5.1. Role of the Managers

5.1.1. The executive lead for medicines management is the Chief Medical Officer (CMO).

5.1.2. The chief pharmacist is responsible for ensuring the correct policies, processes and facilities are in place to enable good medicines management.

5.1.3. The CMO and Chief Nursing Officer and AHPs (CNAO) are responsible for ensuring that the doctor, nursing, pharmacist and AHP workforce are appropriately trained and managed on adherence to this policy.

5.1.4. The Chief Finance Officer (CFO) is responsible for ensuring the financial resource is available to ensure the necessary facilities are available to enable safe prescribing of medicines in line with our statutory requirements.

5.1.5. Line managers are responsible for ensuring staff are trained on safe and appropriate prescribing of medicines, that there is audit assurance of compliance and audit findings are acted upon.

5.2. Role of the Medicines Practice Committee

5.2.1. The Medicines Practice Committee is responsible for overseeing and providing assurance that this policy is correctly implemented and audited.

5.2.2. The group will review datix trends and audits relating to safe and effective prescribing of medicines and ensure the learning is escalated to the MPC to inform policy development.

5.3. Role of Individual Staff

5.3.1. All staff are responsible for creating and maintaining a safe environment in respect of medicines and informing more senior staff of any relevant issues.

5.3.2. All staff involved in the use of medicines are responsible for understanding their obligations for safe and effective prescribing of medicines as set out in this policy and escalating concerns.

6. Standards and Practice

6.1. Prescribing

6.1.1. Patient-Centred Prescribing

- Patients must be at the centre of all prescribing decisions and prescribers must ensure the medicines given are appropriate and person-centred by taking account of their:

  1) Age.

  2) Choices.

  3) Lifestyle.

  4) Cultural and religious beliefs.

  5) Allergies and intolerances.

  6) Existing medical conditions and prescriptions.

  7) Adverse drug reactions.

  8) Recommended prescribing regimes.

- Healthcare professionals should adapt their consultation style to the needs of individual patients so that all patients have the opportunity to be involved in decisions about their medicines at the level they wish.

- Establish the most effective way of communicating with each patient and, if necessary, consider ways of making information accessible and understandable (for example, using pictures, symbols, large print, different languages, an interpreter, or a patient advocate).

- Offer all patients the opportunity to be involved in making decisions about prescribed medicines.

- Establish what level of involvement in decision-making the patient would like.

- Be aware that increasing patient involvement may mean that the patient decides not to take or to stop taking a medicine. If in the healthcare professional's view this could have an adverse effect, then the information provided to the patient on risks and benefits and the patient's decision should be recorded.

- Accept that the patient has the right to decide not to take a medicine, even if you do not agree with the decision, as long as the patient has the capacity to make an informed decision and has been provided with the information needed to make such a decision.

- Be aware that patients' concerns about medicines, and whether they believe they need them, affect how and whether they take their prescribed medicines.

- Offer patients information that is relevant to their condition, possible treatments, and personal circumstances, and that is easy to understand and free from jargon.

- Recognise that non-adherence is common and that most patients are non-adherent sometimes.

- Routinely assess adherence in a non-judgemental way whenever you prescribe, dispense and review medicines.

- Be aware that although adherence can be improved, no specific intervention can be recommended for all patients. Tailor any intervention to increase adherence to the specific difficulties with adherence the patient is experiencing.

- Review patient knowledge, understanding and concerns about medicines, and a patient's view of their need for medicine at intervals agreed with the patient, because these may change over time.

- Offer repeat information and review to patients, especially when treating long-term conditions with multiple medicines.

- Ensure that prescribing is within the Trust formulary. Any non-formulary prescribing increases the chances of patients missing doses and should be avoided. An application to the Cornwall Area Prescribing Committee should be made to have a medicine added to the formulary before any attempt to prescribe it is made.

6.1.2. Optimising Medicines and Reducing Access to Medicines as a Means of Suicide

- Self-poisoning is the second most common means of suicide, and opiates and opioids (including opioid-containing compounds, as well as prescribed and illicit drugs) are the main type of drug taken in fatal overdoses in the UK.

- The risk of suicide is markedly increased in people who have a previous self-harm episode compared with those who do not. Self-poisoning through ingestion of drugs is the most common means of self-harm.

- Evidence suggests that we can prevent suicide by optimising medicines.

- Reducing access to means of suicide may include:

  - Restricting availability of medicines for purchase, prescription and in the home.

  - Reducing stockpiling.

  - Carrying out medication reviews in line with the nice guideline on medicines optimisation.

- When making decisions about prescribing medicines consider the risks of prescribing, including dependency, overdose, and diversion.

- If a person with a common mental health disorder, in particular depression, is assessed to be at risk of suicide, take into account toxicity in overdose when choosing a medicine as well as potential interactions with other prescribed medicines. If necessary, limit the amount of medicine(s) available.

- Record your concerns and plan in the medical notes.

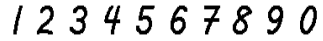
- Communicate your concerns and plan to the multidisciplinary team to ensure that nursing and pharmacy staff can ensure the plan is appropriately actioned whilst in hospital and at discharge.

- Inform the GP to ensure that any mitigating actions are continued in the community.

6.1.3. Prescription Writing Rules

Electronic prescribing systems (ePMA) are in place across the Trust. Each system has an accompanying training package. Prescribers will need to undertake this training before being given access to the relevant system. Prescribers have a responsibility to maintain their competence on these systems and should contact the relevant prescribing system support team if additional training or refresher training is required.

There remain some areas where electronic prescribing is not used or some drugs that are not able to be prescribed on ePMA. Prescribers should be aware of the inherent risks of handwritten prescriptions namely they are not always legible and unambiguous. The points made in the table below apply to all prescriptions; compliance will significantly reduce the chance of preventable medication errors and risk of patient harm.

Rule	**Rationale**
Write in BLACK or BLUE INK or otherwise so as to be indelible.	Spills happen and can easily make a previously clear prescription ambiguous. Black is specified by the RCHT policy for managing health records for all notes and notes-related documents.
Use BLOCK CAPITALS.	This is usually the most legible way of writing by hand and is least capable of misconstruction.
Use the approved numerals: 	Note particularly that there is no upstroke on the numeral one and that the numeral seven is crossed. Confusion between numerals one, two and seven is thus minimised.
Use APPROVED names for drugs except when the brand is significant (e.g. insulins, calcium-channel blockers, theophylline).	This significantly reduces the chance of error when the drug is dispensed or administered and allows the dispenser to give the most cost-effective brand when there is choice.
Never alter a prescription, always cancel it and rewrite.	Alterations frequently change a clear prescription into an ambiguous one.
Always write ‘units’ in full, never abbreviate.	Abbreviations are DANGEROUS in this case.
Write weights as G or g for grams, mg for milligrams. Write micrograms and nanograms in full.	Although in practice a thousand-fold error is unlikely to be implemented, either in the dispensary or on the ward. Never use **µg** for microgram, it is very easily confused with mg.
Write volumes as ml for millilitres.	Other units, e.g. decilitres, are uncommon in Britain and are frequently misunderstood.
Never use fractions for weights, for example ‘500mg’ not ‘0.5g’ and NEVER ‘.5g’	A range such as ‘0.5 – 1g’ is acceptable.
Write fractions of a millilitre with a leading zero: ‘0.25ml’.	Do not use microlitres, many people do not understand them, and syringes are always calibrated in millilitres.
Avoid all abbreviations other than those in Addendum 1.	Abbreviations are a form of code, what is clear to you may well mean something else entirely to the dispenser or nurse. For example, do not use QD for once a day – many professionals think this means four times a day.

6.2. Methods of Inpatient and Discharge Prescribing

6.2.1. Inpatient Prescribing and Additional Treatment Sheets

- All inpatient areas are live on electronic prescribing and administration (ePMA).
- The general wards are using the ePMA system.
- Critical Care is using the CareVue prescribing system.
- Chemotherapy regimens are prescribed on the Aria system (available on Lowen ward) for adults and Chemocare for paediatrics.
- Some specialty areas have their own bespoke systems including Medisoft in ophthalmology and Vital Data in the renal unit for dialysis.
- There are some elements of prescribing that have not moved over to the general ePMA system and additional treatment sheets remain in existence for these e.g. infusions and insulin sliding scales. Using infusions as an example, the prescribers should prescribe 'infusion chart' on the ePMA system and write the details on the additional treatment sheet.
- There is an available form on all wards for the prescribing and administration of urgent medicines. This is to be used in exceptional circumstances only, such as for business continuity during downtime when a medication is required urgently.
- At times of ePMA downtime a paper copy of the ePMA record will be printed off for each patient. These printouts should be used as regular paper drug charts, remembering to update the ePMA system with any changes once it is back on-line. These business continuity arrangements are co-ordinated though the site team and the digital medicines team.
- The drug charts must always show a complete record of all drug treatment for the patient, either by containing the prescription and administration record or by making clear reference to the existence of other forms (see below).
- At times of prolonged ePMA down time, the Trust will resort back to the paper drug chart form CHA2827. Pharmacy holds contingency stock of these charts. Full details of how to complete drug chart CHA 2827 can be found in Appendix 10.

6.2.2. Discharge prescriptions (TTOs)

- All discharge prescriptions must be written using the Trust's ePMA TTO system.
- This information then feeds through into the eDischarge letter that goes to the patient on discharge and is automatically sent to their GP.

- The eDischarge is used to inform the patient and their GP about the admission and about changes in drug therapy that have been initiated during admission, drugs given on discharge, drugs stopped during admission and to give advice on continuation therapy. Up to a maximum of 28 days' supply may be prescribed. In exceptional circumstance more than 28 days may be supplied and in such cases the prescriber must make a note of the reason on the prescription record.

- The eDischarge will usually be the first indication to a GP that their patient has been in hospital. Therefore it is very important that it has been completed fully, accurately, and legibly and should include a list of all medicines taken, not just those started while in hospital, any reasons for changes to medication and any follow-up required by the GP.

- An abridged version of the eDischarge is permitted on the medical admissions unit where a patient has been in for less than 24 hours.

- If ePMA is unavailable prescribers should use the discharge prescription form CHA2592.

6.2.2.1. Prescribing and Dispensing TTOs Out of hours

This section sets out the actions to be taken when medicines are to be supplied to patients to take home directly from ward stock, at a time when the pharmacy cannot make a supply. These instances should be exceptional, and every effort should be made to ensure that clinical workflows allow TTOs to be written well in advance of a patient discharge and in core pharmacy opening hours.

Such out of hour supplies may only be made by a doctor and she/he takes full responsibility for all aspects of the supply notwithstanding that s/he may have delegated part of the procedure set out below:

- The doctor must complete the TTO on ePMA and print it out.

- The doctor must check whether the patient already has sufficient, correctly labelled supplies of their own medications brought in on admission to last until their next supply or has a supply at home or awaiting collection at their community pharmacy. If the patient has, relevant items should be clearly marked ‘own drugs’ on the TTO so that a duplicate supply is not dispensed.

- Wherever possible, items shall be prescribed and dispensed using the range of ready-made discharge medicines (“pre-packs”) available in the relevant emergency cupboard.

- The emergency cupboard (located by the main pharmacy department) also contains a supply of empty containers and blank labels to allow items not held as pre-packs to be dispensed, in this case using stock held on the ward. The minimum quantity – 14 days supply – should be dispensed.

- Labels on pre-packs must be completed to show dose size, frequency, patient's name, ward name and date of dispensing.

- A second healthcare professional e.g. another Doctor or a nurse, should provide a double check to confirm the accuracy of the dispensing and sign the TTO to reflect this.

- The doctor must sign at the bottom of the TTO to indicate that he/she has dispensed the medication and handed it to the patient.

- The relevant ward or department manager must ensure that the completed TTO comes to pharmacy when it next opens so that the stock of pre-packs, empty containers and labels can be replenished.

- Controlled drugs must be dispensed by pharmacy in all circumstances. Similarly, if the prescription is complex, it is good practice to ask pharmacy (through the on-call pharmacist) to do the work. However, the on-call service is for emergencies only and it will be at the discretion of the on-call pharmacist whether the discharge constitutes an emergency.

- On paediatric wards, labels, containers, and a small range of pre-packs specific to children are available.

6.3. Outpatient Prescribing

6.3.1. General Principles

- Hospital prescribers should not provide treatment which is unrelated to the current episode.

- All prescribing should adhere to the CIOS Joint Formulary, which categorises medicines into three main groups: first/second choice options, specialist initiated and hospital only medicines. The Trust formulary is available via the intranet. Non-formulary prescribing may require sign off from the chief pharmacist or appointed deputy before it can be dispensed.

- Prescriptions should only be provided for new treatments and dose changes that are clinically urgent or hospital only medicines. All non-urgent treatments and dose changes should be referred back to the GP via the clinic letter.

- All repeat prescribing should be referred back to the patient's GP unless it is a 'hospital only' drug.

- A maximum of one month's medication can be prescribed for outpatients. The exception to this is home delivery patients, or where the hospital is maintaining the patient's supply, where greater quantities may be prescribed.

- Prescribers must ensure that any repeat prescribing activity for ongoing care is captured by the Trust so expenditure can be appropriately covered by contractual arrangements.

- Clinical trial drugs must be prescribed on the specific trial prescription (and/or via the Aria system for cancer prescribing).

- Where 'shared care guidelines' are to be used, the prescriber must clearly communicate this to the GP and ensure there is agreement with the GP for this shared care to be implemented.

6.3.2. Choice of Prescription Type

- The electronic outpatient prescribing system should be used as the default for prescribing.

- When a written prescription is required, prescribers must use the hospital outpatient prescription in preference to an FP10NHC prescription.

- Using the hospital form ensures the hospital is charged the NHS price for the drug, rather than a potentially more expensive price in community pharmacy (set by the drug tariff).

- Electronic Outpatient Prescribing (eOP) is deployed across the Treliske site using the ePMA system, Medisoft for ophthalmology and Aria for chemotherapy.

- The ePMA eOP system will request whether you require a hospital OP prescription, an FP10HNC or a GP referral letter. Choose accordingly.

- Please complete the ePMA eOP training package before using the system.

6.3.2.1. FP10HNCs (for dispensing in community pharmacies)

- Should only be used for initiating urgent treatment when prescribing away from the RCHT site or out of the outpatient pharmacy opening hours.

- FP10 prescriptions are at risk of being misappropriated and their safe custody must therefore be taken very seriously. Each clinic FP10 pad will come with an accompanying accountability log. Ensure this log is completed for every

FP10 issued to allow for full traceability. If this log is not completed, an investigation will need to be undertaken to account for the prescription and ultimately FP10s withdrawn from that clinic.

- Do not use FP10HNCs to prescribe 'High-Cost Drug Exclusion' drugs (see Department of Health website).

- The use of FP10HNCs to prescribe unlicensed medications is not encouraged. The patients may have difficulty sourcing these medicines in the community and the cost of these preparations is often substantially higher in the community that when procured through the RCHT contracts.

- F1 doctors may not prescribe on form FP10 (HNC).

- FP10HNC prescribing data is fed back to the Trust via the NHS Business Authority and reviewed by the pharmacy team. Unusual, inappropriate, and non-formulary prescribing will be escalated to the Care Groups as appropriate for further investigation.

- FP10HNC prescriptions must be stored in a locked cabinet, usually a controlled drug cupboard, when not in use.

6.4. Transcribing

Transcribing of medicines by pharmacists or other professional staff must only take place in accordance with a specific transcription policy or procedure for that clinical area or staff group. This must be approved by the Medicines Practice Committee.

6.5. Prescribing of Clinical Trials

All clinical trials should be prescribed on trial specific documentation or on the e-Prescribing system (provided this allows for differentiation between clinical trials and non-clinical trials). The prescriber must be named on the specific clinical trial delegation log before prescribing. For further details of prescribing in clinical trials, please refer to the Research and Development Policy available on the document library.

6.6. Prescribing Weight-Based Medicines

6.6.1. An accurate patient's weight must be used as the basis for calculating the required treatment dose for weight-based medicines such as low molecular weight heparin and chemotherapy.

6.6.2. The weight must be accurately recorded in kilograms (kg) on the relevant ePMA system and in the clinical record.

6.6.3. Patients should be weighed at the start of therapy and, where applicable, during treatment.

6.7. Prescribing generic and biosimilar medicines

6.7.1. The basic premise is that the most cost-effective medicine should be prescribed for our patients. Medicines should be prescribed using their generic name and the pharmacy will ensure the most cost-effective medicine is supplied against that prescription.

6.7.2. There are exceptional circumstances, where MHRA guidance exists, requiring brand specific prescribing. This guidance will be adhered to and facilitated on the ePMA electronic prescribing system

6.7.3. For biosimilar medicines (the equivalent to generics for biological medicines), the most cost-effective biosimilar should be prescribed and supplied, in-line with national policy, agreed clinical pathway and contracting arrangements. Patients should be made aware when initiating biologic treatment that the brand of biologic may change over the course of their treatment. Patients should be informed when a change is planned and provided with information regarding any changes in presentation, administration or homecare arrangements.

6.7.4. Other biosimilar agents and biological agents where no biosimilar is yet available, can be prescribed provided the prescribing is in line with an agreed treatment pathway that has been approved at the Cornwall Area Prescribing Committee and commissioned.

6.7.5. In exceptional circumstances only, patients may be prescribed the branded originator product. This will be for clinical reasons only and will most commonly be due to treatment failure or significant side-effects with the biosimilar product. It should be noted all biosimilar medicines undergo strict equivalence tests as part of their licensing process by the MHRA regulator and therefore treatment failures or additional side-effects should be very rare.

6.7.6. These exceptions need to have the approval of the Chief Medical Officer and Chief Pharmacist- with exception request details being submitted to rch-tr.medicinesinformation@nhs.net

6.8. Implementing new NICE TAs

6.8.1. Commissioners have a statutory responsibility to make funding available for a drug or treatment recommended by a NICE TA or a Highly Specialised Technologies Evaluation (HST) and to begin doing so no later than 90 calendar days after the guidance is published, unless otherwise specified in the guidance. Compliance is achieved when a patient, after discussion with a clinician, is able to choose a NICE-recommended treatment without any local funding or formulary restrictions.

6.8.2. Before a prescriber implements a new NICE TA within the Trust, the Cornwall Area Prescribing Committee (CAPC) will first confirm that sufficient funding has been made available by the commissioner to allow implementation and to also confirm the Trust is commissioned to provide the service.

6.8.3. Where the CAPC or the Trust deems that insufficient funding has been made available, this should be escalated through the Care Group governance route and the NICE TA not implemented until sufficient funding is provided.

6.8.4. When NICE recommends a drug as 'an option', this is an option for the clinician and patient to consider alongside other potential treatments. This new option needs to be integrated into the existing clinical pathway, overseen by the Cornwall Area Prescribing Committee. Where the new drug is an option alongside other potential treatments, the general expectation is for the most cost-effective medicine to be used as first-line and then escalation along the treatment pathway as appropriate to the patient's response.

6.9. Prescribing for Yourself, Family Members and Members of Staff

Staff are reminded that:

- They must not take medicines from clinical areas for personal use under any circumstances as this is considered theft and may result in disciplinary action.

- They must not ask nursing or medical colleagues to give them any medicines from a clinical area for personal use unless through an agreed 'first aid' arrangement.

- Medical staff - in line with GMC good practice guidance, RCHT does not routinely allow prescribers to prescribe for themselves, members of their family, colleagues, or friends except when the consultation is part of a formal episode of care. Any members of staff requesting a prescription should be referred to the Emergency Department.

- Medical Staff wishing to self-prescribe must use a private prescription and are advised to inform their GP as soon as possible, in line with GMC good practice. (GMC - Good practice in prescribing and managing medicines and devices, 2021).

6.10. Prescribing Free of Charge Medicines

6.10.1. The Trust follows the NHSE 'Free of Charge (FOC) Medicines Schemes'. This policy can be found by searching on the internet for this title.

6.10.2. Before any patient or patient cohort is prescribed a FOC medicine the prescriber must first have ensured that the scheme has been signed off by the Cornwall Area Prescribing Committee (contact Medicines Information on x2547 for details on how to get an item added to the agenda). The prescriber and the group will confirm the FOC scheme meets the principles of the FOC policy before approving its use in the Trust.

6.10.3. If necessary, due to urgent patient need, this decision can be made outside of a formal meeting by the chair of the group but must be ratified retrospectively at the next meeting.

7. Dissemination and Implementation

7.1. The document will be available on the document library

7.2. Training on the policy is part of the mandatory induction and update training as well as part of local induction.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Safe and Appropriate Prescribing of Medicines.
Lead	Pharmacy and specialty directors.
Tool	ePMA data, DEFINE, NHS benchmarking, GIRFT, datix and local audit.
Frequency	On a rolling basis as part of incident reporting and clinical audit plans.
Reporting arrangements	Results will be reported to the Pharmacy Governance Group. Medicines Value Grp and the Medicines Practice Committee and disseminated from there as appropriate.
Acting on recommendations and Lead(s)	The Medicines Practice Committee will lead on ensuring audit actions are followed up. The medication safety pharmacist and specialty lead pharmacists will act on recommendations as appropriate to their areas.
Change in practice and lessons to be shared	Via the Pharmacy Newsletter (Pharmacy Matters) and through safety huddles and safety briefs.

9. Updating and Review

9.1. This policy will be reviewed through the Medicines Practice Committee no less than every three years or shorter is guidance changes in that time.

9.2. Any revision activity will be recorded in the Version Control Table as part of the document control process.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	The Medicines Policy Chapter 2: Standards of Practice Prescribing V6.0
This document replaces (exact title of previous version):	The Medicines Policy Chapter 2: Standards of Practice Prescribing V5.0
Date Issued / Approved:	June 2025
Date Valid From:	June 2025
Date Valid To:	June 2028
Author / Owner:	Iain Davidson, Chief Pharmacist
Contact details:	01872 252593
Brief summary of contents:	Outlines the standards for prescribing of medicines at RCHT.
Suggested Keywords:	Medicines, drugs, prescribing, FP10, biosimilars, NICE
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Medicines Practice Committee. Clinical Support Governance Group.
Manager confirming approval processes:	Richard Andrzejuk
Name of Governance Lead confirming consultation and ratification:	Kevin Wright
Links to key external standards:	CQC. NHSE Hospital Pharmacy Standards.

Information Category	Detailed Information
Related Documents:	GMC- Good practice in prescribing and managing medicines and devices 2021. RPS- A Competency Framework for all Prescribers- Sept 2021. RCN and RPS Guidance on Prescribing, Dispensing, Supplying and Administration of Medicines-position statement. The Medicines Policy. Humans Medicines Regulations 2012. NICE Key therapeutic topic. Published: 1 March 2019 Suicide prevention: optimising medicines and reducing access to medicines as a means of suicide. NICE: Medicines Optimisation Clinical Guideline.
Training Need Identified:	Yes- included as mandatory training for induction and refresher.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Pharmacy

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
March 2011	V1.0	Moved from paper-based book to on-line medicines policy. Initial issue.	Iain Davidson, Chief Pharmacist
March 2014	V2.0	ePMA update and GMC guidance on prescribing for self and family.	Iain Davidson, Chief Pharmacist
February 2017	V3.0	Include information on accountability for FP10 prescriptions.	Iain Davidson, Chief Pharmacist
October 2019	V4.0	Information on reducing suicide risk. Further information on FP10 accountability. Reference to the regional medicines optimisation committee's policy on Free of Charge medicines. Full review and refresh.	Iain Davidson, Chief Pharmacist

Date	Version Number	Summary of Changes	Changes Made by
May 2023	V5.0	General review and update. No major changes. Transposed to latest accessible Trust template.	Iain Davidson, Chief pharmacist
June 25	V6.0	General review and Update. Specific section on generic and biosimilar medicines prescribing. Specific Information regards implementation of NICE TAs and HSTs	Iain Davidson, Chief pharmacist

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	The Medicines Policy Chapter 2: Standards of Practice Prescribing V6.0
Department and Service Area:	Pharmacy, Clinical Support
Is this a new or existing document?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Iain Davidson, Chief Pharmacist
Contact details:	01872 252593

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Safe and appropriate prescribing of medicines at RCHT.
2. Policy Objectives	Patient safety, minimising patient harm and improvement outcomes.
3. Policy Intended Outcomes	Outlines the standards for prescribing of medicines at RCHT.
4. How will you measure each outcome?	Audit.
5. Who is intended to benefit from the policy?	Patients and the organisation.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Medicines Practice Committee. Clinical Support Care Group.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Iain Davidson, Chief Pharmacist.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis