Executive summary

- The paper presents a proposal to reduce repeat prescribing waste across North West London. The proposal anticipates a significant saving across North West London.

- Evidence for the existence and size of repeat prescribing waste is presented. There are a number of contributory factors associated with repeat prescribing waste. Some relate to current systems and processes whilst others are related to patients’ medicines-related behaviours.

- The recommended approach provides an opportunity for the majority of patients to take greater control of the re-ordering of their medicines, whilst at the same time providing flexibility for those patients who are unable to manage the re-ordering process themselves.

- It will be important to:
  - engage patients, pharmacists, prescribers and practice staff as parts of the solution
  - work in a positive and constructive manner with those professionals who will be asked to implement the recommended approach.

- In general it is sensible to:
  - Get as many patients as possible requesting their own repeat prescriptions. Actively encourage them to request their repeat prescriptions online using a computer or smartphone app, or by using repeat prescription request slips.
  - After communicating with local community pharmacies, and an appropriate transition period, stop accepting repeat prescription requests from community pharmacies except for the minority of patients who cannot request their own repeat medicines, and who do not have a friend or carer who can request for them.
  - Review how electronic repeat dispensing fits into each practice’s mix, bearing in mind the human factors that can lead to expensive waste.
  - Deploy a communications strategy and materials to ask patients to help reduce repeat prescription waste.

- Feedback about this proposed approach from the public, GPs and LMC Chairs has been positive, with 79.4% of responders (929 people) saying they would
either always or mostly be happy to order their own repeat prescription or that they ordered it already. NWL Local Pharmaceutical Committee CEOs do not support the proposed approach. Some local community pharmacists responded individually raising concerns.

- The Governing Body is asked to approve and promote adoption of the approach to repeat prescriptions outlined above and detailed on pages 4-5.

**Introduction**

- There is scope to achieve considerable savings across North West London by reducing waste associated with repeat prescribing. This view is informed by:
  - Evidence from elsewhere in London, England and Wales
  - The prevalence of non-adherence
  - Observational evidence that not every patient, prescriber and community pharmacist does everything related to repeat prescriptions perfectly.

- Evidence from elsewhere in London and other parts of the country (page 3) is that community pharmacies ordering repeat prescriptions is associated with more over-ordering (i.e. more doses ordered/prescribed than the patient needs) than when patients order their own repeat prescriptions.

- NICE’s guideline on Medicines Adherence states that between a third and a half of medicines that are prescribed for long-term conditions are not used as recommended. Consequently if everything that is prescribed is dispensed, without ascertaining precisely what the patient has and has not run out of, considerable waste would be expected.

- Human factors – a number of factors will result in waste; these are outlined on page 1 of Appendix 3.

- The aim should be simply to give patients medicines they need and intend to take, but not medicines that they don’t need or don’t intend to take. Avoidable clinical quality and safety risks exist if patients are given medicines that they do not need.

- If Governing Bodies approve the proposals, it will be sensible to view our approach positively, as a better future in which more patients take more control of their medicines; feel empowered to be truthful about what they do and don’t intend to take; are at less risk of harm; where many use phone apps or computers to quickly and easily reorder what they need, but where repeat prescription request slips can also be used by those who can’t or won’t use a phone app, tablet or other computer.

- The annual NWL CCG prescribing budget is approximately £235m. It is estimated that approximately 75-80% of prescriptions are repeat prescriptions.¹

- NWL currently has relatively high use of electronic repeat dispensing:
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<table>
<thead>
<tr>
<th>CCG</th>
<th>% of items dispensed under repeat dispensing</th>
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<tbody>
<tr>
<td>CL CCG</td>
<td>19.2</td>
</tr>
<tr>
<td>WL CCG</td>
<td>13.3</td>
</tr>
<tr>
<td>H&amp;F CCG</td>
<td>31.6</td>
</tr>
<tr>
<td>Hounslow CCG</td>
<td>32.4</td>
</tr>
<tr>
<td>Ealing CCG</td>
<td>25.9</td>
</tr>
<tr>
<td>Brent CCG</td>
<td>24.2</td>
</tr>
<tr>
<td>Harrow CCG</td>
<td>10.6</td>
</tr>
<tr>
<td>Hillingdon CCG</td>
<td>17.0</td>
</tr>
<tr>
<td>Luton CCG</td>
<td>0.67</td>
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</table>

What evidence do we have that the problem exists and about the potential savings?

1. Luton partners limited third party requests for repeat medicines and improved repeat prescribing systems. Estimated savings were 7% of the primary care prescribing budget, albeit over 2 years. Luton’s pre-intervention audit, undertaken in 18 practices, took 4 months. 1498 prescription items were assessed to calculate the number of doses requested against the number of doses prescribed over a period of time (generally 6 months).

2. Haringey used Luton’s audit methodology in late 2016. Results from 10 practices showed that patients had over-ordered by 6-17% (average 12%) and community pharmacies had over-ordered by 7-40% (average 19%). The difference in the averages was 7%.

3. The 2015 BMJ awards shortlisted a practice in Cardiff which asks patients to confirm the prescription by countersigning and dating it. Prescribing costs fell by 7.5% in the first quarter after the change was made. The GP noted that pharmacy ordering can be dangerous.

4. Initial work in Coventry reduced two practices’ cost per ASTRO PU by 8.9%.

5. SystmOne indicates that many patients have a ludicrously high numbers of salbutamol inhalers prescribed, e.g. at August 2016, 795 Hammersmith and Fulham patients had received prescriptions for 11 or more salbutamol inhalers in 12 months; 80 patients had received prescriptions for 20 or more salbutamol inhalers in 12 months. Appropriately managed patients will not need that many salbutamol inhalers; the data is consistent with over-ordering.

The similarity of the figures above from various parts of the country, including London, is striking. Local auditing would delay reduction of the waste and divert CCG staff capacity away from other money-saving work. The audits are extremely time consuming, e.g. 40-60 mins per patient prescribed 8 repeat medicines.
Proposed approach

The least wasteful approach to repeat prescriptions will involve a balanced mix of three methods:

1. Patients reordering their own repeat prescriptions
2. Electronic repeat dispensing, with prescriptions dispensed in instalments
3. For the minority of patients who cannot reorder their own repeat medicines, and who do not have a friend or carer who can order for them, community pharmacies ordering repeat prescriptions on the patient’s behalf.

A practice’s prescribers’ judgement on the optimal mix of the three methods should perhaps be informed by:

- Their judgement on how often the human factors listed on page 1 of Appendix 3 are likely to lead to waste in their area.
- The advantages and disadvantages of each of the three methods (page 2 of Appendix 3).

Each practice would be asked and supported to review its approach to repeat prescriptions, aiming to reduce waste.

In general it is sensible to:

- Get as many patients as possible requesting their own repeat prescriptions. Actively encourage them to request their repeat prescriptions online using a computer or smartphone app, or by using repeat prescription request slips (the old right hand side of the prescription, which community pharmacies should supply when they dispense repeat prescriptions, even if the prescription was electronic). It is possible for patients to give a friend or carer permission to act as their proxy to reorder their medicines using a phone app or computer.

- After communicating with local community pharmacies, and an appropriate transition period, stop accepting repeat prescription requests from community pharmacies except for the minority of patients (preferably flagged on the practice system) who cannot request their own repeat medicines, and who do not have a friend or carer who can request for them.

- Review how electronic repeat dispensing fits into their practice’s mix, bearing in mind the human factors that can lead to expensive waste.

Alongside this a communications strategy and materials would ask patients to help reduce repeat prescription waste, e.g.

- “We’d recommend that you don’t get medicines you don’t take. It’s wasted money that could be used to make sure other services continue, e.g.…….”
- “It’s your choice whether to take medicines. But please tell us if you choose not to so that we can stop prescribing them.”
- “Only ask for what you need; if the pharmacy gives you medicines or products you don’t need, please tell the practice.”
- “Take control of ordering your medicines.”
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- “Do you know you don’t have to order everything on your repeat prescription every time, if you already have enough at home.”
- “Tell your pharmacist if they give you medicines you’re no longer using or already have enough of at home.”
- “No one knows what you’re running out of better than you.”

An aim would be to change the mindset that says “I'm not going to tell my GP that I'm not taking the medicine.”

When patients ‘forget to order’, often they will not be taking the medicine, so they have no need to order.

June 2017 engagement

See appendix 1, which covers both this proposal and proposals on medicines and products that can be purchased without a prescription.

Of the 1,169 people who responded to the questions about this proposal, 79.4% (929 people) said they would either always or mostly be happy to order their own repeat prescription or that they ordered it already. 11.3% (133) said they wouldn’t want to do that.

The Chairs of NWL Local Medical Committees supported the proposal, agreeing that only the patient or carer, except in exceptional circumstances, should be able to order repeat prescriptions.

The CEOs of Middlesex Pharmaceutical Group of Local Pharmaceutical Committees and Kensington, Chelsea and Westminster LPCs commented that they had not been presented with evidence to support a statement included in an engagement document: “evidence is that community pharmacies ordering repeat prescriptions from general practices is associated with more over-ordering (i.e. more doses ordered than the patient needs) than when patients order their own repeat prescriptions”. This prohibited them from responding properly to the proposal, save to say that they dispute the assertion made and are extremely disappointed that the CCG has made these derogatory remarks about community pharmacists. Their view was that the proposal appeared to pay scant or no regard to the risk to vulnerable patient groups arising from prohibiting re-ordering of repeat prescriptions by pharmacists [but see page 4 for the precise proposal]. They do not accept the legal entitlement of GPs to refuse to accept repeat prescription requests from pharmacists, if the patient has completed a valid form of authority giving their community pharmacist legal permission to make repeat prescription requests on their behalf.

Importantly, some community pharmacists said that one aspect they were particularly concerned with was the risk that NWL CCGs and general practices would implement the proposal poorly, with large numbers of patients running out of repeat medicines and going to community pharmacies for emergency supplies. If we proceed, it will be important to implement well; high quality implementation will minimise risks for patients and maximise medium and long-term savings.
Equality and health inequalities impact assessment (EQIA)

Production of the full EQIA was commissioned from an independent provider, PHAST, a public health consultancy [www.phast.org.uk](http://www.phast.org.uk). It has written:

“PHAST assessed the impact of the proposal to reduce waste associated with repeat prescribing on equalities and health inequalities. In order to do this PHAST:

- carried out a rapid, non-systematic literature review
- obtained information on similar policy changes elsewhere
- carried out an online survey to collect information from stakeholders. The proposals on the change of policy for repeat prescriptions was included as a specific question in the survey.

Preliminary findings include:

- The proposal might have adverse impacts on people without internet access, who are likely to be older and poorer than average.
- There was a very low rate of response to this question in the online survey, limiting what can be concluded from it. However, respondents indicated that they thought it would impact negatively on the elderly, people with disabilities and with mental health issues, and that there might be particular concerns about people with co-morbidities, complex medication requirements and those with potential for poor medicine compliance.
- Many stakeholder respondents to the survey requested more time for consultation and for this to include discussions, workshops or focus groups and to give more time for them to undertake analysis to understand the potential implications before the proposals were implemented.”

If the proposal presented in this paper is approved, we will continue to listen to the public and professionals during the implementation phase. As part of this, an EQIA ‘validation session’ has been scheduled in early August. This will help us to check that any planned mitigations are appropriate and likely to be adequate.

Financial indication

The causes of repeat prescribing waste are most unlikely to be limited to over-ordering by patients and community pharmacies. It is likely that 75-80% of prescriptions are repeat prescriptions. Based on figures from other CCGs it is probably not unreasonable to aspire to save at least 5% of primary care prescribing expenditure by tightening management of repeat prescribing.

NWL CCG’s 2016-17 primary care prescribing expenditure was £235.5m. Assuming that 77% of this was on repeat prescriptions, and that 5% of that figure can be saved, would give a saving of £9m in a full year. Potential savings for each CCG are at appendix 4.
If, following engagement, the proposed recommendations and communications effort starts in August, and assuming a ramp up (0% of saving in August, 30% in September, 60% in October, 100% from November, i.e. equiv to 5.9/12 months of full year saving in 2017-18 = 0.49 of full year saving) the 2017-18 part year saving might be £4.4m.

We can be reasonably confident that multimillion pound savings are achievable, in the author’s view, but there is considerable uncertainty about the precise size of the potential saving.

### Risks and mitigation

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<tr>
<th>Risk</th>
<th>Mitigation</th>
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<tbody>
<tr>
<td>Resistance from community pharmacists</td>
<td>Continue to liaise with community pharmacists and LPCs aiming for the repeat prescriptions system to work well for patients, pharmacies and general practices; promote growth in use of MURs and the New Medicines Service, which NHSE funds from an annual global sum.</td>
</tr>
<tr>
<td>Continued growth in the use of electronic repeat dispensing, with the risk that everything on the prescription is dispensed without the dispenser checking, shortly before dispensing, what the patient actually needs</td>
<td>Increase discouragement to use electronic repeat dispensing (eRD); lobby NHS Digital and NHSE about the (probably expensive) disadvantages of eRD in reality; review the appropriateness of eRD in individual cases in line with the table in Appendix 3</td>
</tr>
<tr>
<td>Failure to increase, at pace, the number of patients who request their own repeat prescriptions using a smartphone app or computer</td>
<td>Identify reason(s) for failure and address them.</td>
</tr>
<tr>
<td>Community pharmacies do not give some/many patients the blank repeat prescription request slip when handing over dispensed medicines</td>
<td>Increase liaison with community pharmacies and LPCs to correct this.</td>
</tr>
<tr>
<td>Community pharmacies retain and submit repeat prescription request slips on patients’ behalf, with the patient’s permission</td>
<td>Whenever possible, get patients to sign and date to confirm that they have completed the request personally</td>
</tr>
<tr>
<td>Patients forget to reorder medicines they need</td>
<td>Review capability and whether the patient has a carer. Capable patients: the responsibility for reordering is rightly theirs. Often they will not be taking the medicine, so they have no need to reorder. Incapable patients with no carer: the GP may decide, with the patient, that allowing a community pharmacy to request repeat prescriptions on</td>
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</table>
their behalf is appropriate.

Monitoring progress is difficult

See below.

Implementation is rushed and inadequately executed

High quality execution will be essential. Sufficient resource should be devoted to implementation so that it is done well, as well as quickly.

Monitoring

Monitoring three parameters would provide an indication of progress:

1. Number of repeat prescriptions (or prescription items) requested electronically, divided by the practice list size
2. Primary care prescribing expenditure over time
3. Number of prescription items over time.

Recommendation

The Governing Body is asked to approve and promote adoption of the approach to repeat prescriptions detailed on pages 4-5.

Appendices

1. Summary report of the June 2017 engagement
2. Equalities and health inequalities impact assessment
3. Human factors that lead to avoidable repeat prescribing waste; advantages and disadvantages of three methods of supplying repeat medicines
4. Potential savings by CCG.

Reference