

Repeat dispensing: a solution for now

By John Wilson, pharmacist and writer from Arnold, Nottinghamshire

A question that I heard several times during a recent day at a small pharmacy where I do occasional locums was: "There's no doctor here today; what am I going to do about my prescription?" The local practice is single-handed but with another doctor doing sessions to help out, and on this day both the GP and his regular locum were ill. We did manage to ensure that no one went without essential medicines, but I was concerned at the lack of medical services, if only for a couple of days, in this small community. The situation is by no means unique. Our local primary care trust is said to be about 16 GPs short of requirements. According to the local press, Nottingham has a shortage of 21 GPs and this pattern is probably repeated across the country. Indeed, Nottinghamshire has its own "flying doctor" in the form of a South African GP who flies in regularly to do sessions.

One of the most time-consuming jobs in general practice must, surely, be the generation of repeat prescriptions. Indeed, the practice manager of the large teaching practice where my wife and I are registered once told me that operating the practice's repeat prescriptions service required 1.5 full-time equivalents of clerical staff. This was aside from the drudgery for the doctors of signing the piles of green forms.

How can pharmacy help with this? A repeat dispensing service is the obvious answer, and this is to be included in the, now fairly imminent, new contract. Already, the necessary legislation is in place to allow repeat dispensing and a number of pilot schemes are in operation. However, perhaps all is not well.

An article in *The Journal* last year (*PJ*, 8 May 2004, p567) indicated that questions have arisen over how widely repeat dispensing can be used and how quickly it can be rolled out. It seems that many GPs are resistant. "Progress has been relatively slow, mainly because of the software problems" was a comment quoted in the article. My inquiries would seem to indicate that the "master and slave" prescription system is somewhat cumbersome for the practice that initiates the prescription, as well as for the pharmacy that does the dispensing. However, it does seem to work.

What, then, of computerised transmission of prescriptions? We have heard of a number of pilot schemes for the electronic transmis-

sion of prescriptions, and this type of system would seem to be ideal for all prescribing, including repeats for those on long-term medication. Various schemes were proposed, such as the "push-down" and "pull-up" (or was it pull-down and push-up?), all of which involved extensive computer software. There have, however, been numerous reports of these systems not being reliable, and some of the original partners in the schemes have dropped out. Surely, though, the National Programme for Information Technology (NPfIT) will solve our problems? One of its functions is to be the transmission of prescriptions. However, it would be wise not to hold our breath on this one. Large government computer systems in this country have an unhappy history. Dare I mention the Passport Office, the problems with the immigration service computers, and others?

Just before Christmas, the computerised state pension system broke down. Pensioners who had new pension cards were turned away empty-handed by the post offices while those who still had the traditional, low-tech pension books could obtain their money without difficulty. At the Child Support Agency "a new £450m computer system has created a backlog of almost 250,000 cases since March 2003, involving more than £140m of arrears in child maintenance payments", according to *The Times* of 26 January. A large number of soldiers have been underpaid for several years because of a "computer glitch". Indeed, Daniel Finkelstein of *The Times* wrote on 9 February that "standards in the modern IT business are a bit like those in the 1970s British car industry".

Need I go on? And we would entrust patients' medications to such systems? Surely not. Anyway, pharmacy is traditionally the last to get any consideration, so it could be many years before repeat dispensing was made to work effectively on the NPfIT. This is, of course, assuming that doctors can be persuaded to use NPfIT in the first place. However, that is another story.

The problem of repeat dispensing is important and urgent. The present system is so unsatisfactory that something must be done, and quickly — and preferably something that requires little or no new technology. One such possibility is the repeatable FP10. This could be written in the same way as a private

prescription, with the number of repeats stated. Alternatively, the prescription could simply state "supply monthly for six months".

How would such a system work? Let us assume that our patient has a condition such as hypertension, requires long-term medication and should ideally see the doctor or practice nurse every six months for a check-up. The patient would take the prescription to the pharmacy of his or her choice as usual, and would receive one month's supply of each of the required medicines. The pharmacist's actions following dispensing would be different, but not too onerous. First, it would be necessary to stamp the bottom of the prescription with a stamp having five squares. These would be labelled "1st disp", "2nd disp", and so on. The pharmacist would put the date on the "1st disp" square, photocopy the FP10 onto plain paper, endorse the photocopy as if it were the FP10 and, finally, add a stamp certifying that "this is a true and correct copy", sign and date, and add his or her Royal Pharmaceutical Society registration number. (This would enable the pharmacist to be traced if a problem occurred, and it would also be an outward and visible sign of the pharmacist taking personal responsibility for the prescription.)

After all that, the photocopy would be submitted to the pricing bureau and the prescription filed in the pharmacy until the next month. When the last instalment has been dispensed, the original FP10 would be submitted. At this point, also, the patient could be reminded to make an appointment to see the doctor before any further medicines could be supplied. Yes, this would be a different procedure from that which we use at present, but I do not think it should present any insuperable obstacles.

A health centre pharmacy at which I work occasionally keeps the repeat prescription requests for many of the patients of the two practices in the health centre. The patients telephone the pharmacy to ask for their repeat slip to be passed to the surgery, stating what they require. At this point it is possible to remind the patients if they have not requested an important medicine or to ask if they really need yet another load of analgesics. I would expect that implementing the system that I have outlined above would not be very different.

I am no technophobe, and technology is fine so long as it works. However, the recent computer shambles has made me wonder whether we would not be better to get a simple, low-tech system of repeat dispensing working first. Computerisation could then be introduced gradually, without causing too much disruption if it does not, initially, work well.

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