

REPEAT PRESCRIPTION REPORT

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Executive Summary

Repeat prescriptions represent a key point of contact between millions of patients, their GPs and pharmacies.

Applying historical age- and sex-specific prescribing rates to the latest detailed ONS data on the UK population gives an illustrative estimate that 32.3 million people – 46.6% of the population – receive at least one repeat medicine.^{1,2}

In England, 1.3 billion prescription items were dispensed in the community in 2025/26 at a cost of £11.6 billion, compared with 1.1 billion items and £9.2 billion in 2016, as reported in the Repeat Prescription Report in 2017.^{1,3} The historical and current cost measures are not fully harmonised, so this is not a formal like-for-like cost comparison. The direction of travel is clear: item volume is higher, as are the reported costs.

Part One of this new report examines the scale, cost and clinical mix of repeat prescriptions; how prescriptions are ordered and received; the time and cost involved in collection; where the process breaks down; and the perceptions of online pharmacies.

One of the biggest changes since the 2017 report has been the shift to digital at every stage of the repeat prescription process. Paper scripts are now largely a thing of the past, as 97% of items dispensed by community pharmacies in England were processed through the Electronic Prescription Service (EPS). In June 2026, 7.4 million repeat prescription orders were placed through the NHS App, 31% more than a year earlier. Meanwhile data from Pharmacy2U, the UK's biggest online pharmacy, shows 63% year-on-year growth in NHS prescriptions dispensed between July 2025 and July 2026.⁴

While the NHS App is now the most common ordering route for prescription managers, most people still collect the dispensed medicines from a local community pharmacy.

1.3

billion prescription items were dispensed in the community in 2025/26 at a cost of £11.6 billion.

7.4

million repeat prescription orders were placed through the NHS App in June.

Executive Summary

The findings in this report point to barriers to completing the process digitally and having medication delivered, including awareness, trust, assumptions about delivery cost, and uncertainty about how pharmacy nomination works.

Online pharmacy is well suited to planned repeat supply, reminders, tracking, delivery and support for carers, but community pharmacy remains important for urgent medicines, face-to-face advice, physical assessment, vaccination and testing.

Part Two considers what comes next. The NHS 10 Year Health Plan is organised around three shifts: hospital to community, analogue to digital, and sickness to prevention. All three are relevant to repeat prescribing: a regular prescription contact between a patient and pharmacy can be used to identify overdue monitoring, discuss side effects, support medicine-taking or direct a patient to a preventive service.

Those services need the same clinical discipline as any other part of healthcare. Digital pharmacy services must connect with the patient record and the wider care team, while telephone and face-to-face routes must remain available for people who need them.

Online and community pharmacy should be designed as connected parts of the same system rather than a binary choice. Patients should be able to decide the route that suits them best at any time without losing continuity, professional advice or access to urgent care.



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PART ONE THE REPEAT PRESCRIPTION NATION

Ordering is increasingly digital, but most prescription managers still collect repeat medicines in person.

1 Introduction

Repeat prescribing allows people with stable, long-term conditions to receive regular medicines without a new consultation for every supply. It gives patients continuity, keeps clinical workloads manageable for prescribers, and provides pharmacies with a dependable funded dispensing workstream.

Because the process is routine, its scale and complexity are easily overlooked. Repeat prescribing sits at the meeting point of population ageing, long-term conditions and multiple medicine use, general practice workload, medicine availability, community pharmacy capacity and changing expectations about digital access.

The 2017 report cited an estimate that around three-quarters (77%) of prescription items were repeats.¹ Assuming repeat prescriptions account for 77% of current expenditure, applying this proportion to the £11.6 billion cost of items dispensed in the community in England in 2025/26 gives an illustrative annual cost of about £9 billion.^{3,5}

Unlike new or acute prescriptions, which are issued following a clinical consultation, these are typically reauthorised and re-prescribed at intervals rather than reviewed at each issue, leaving more scope for outdated information to persist between review points or errors that were never caught the first time. This makes outpatient settings a key point at which patient safety depends on the design of the wider system, not just on any single prescriber's check.

A 2023 review found wide variation in reported medication-error rates across outpatient settings, with prescribing and dosing errors being the most frequently reported. Contributory factors included both active failures and underlying conditions such as gaps in knowledge, workflow and system design.⁶ The WHO 2024 review similarly treats preventable medication-related harm as a problem that requires changes to processes and systems.⁷

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The 2017 Repeat Prescription Report captured a system in transition. At the time, electronic prescriptions (the NHS EPS service) were expanding, online ordering was uncommon and paper prescriptions still played a major part.¹ Nine years later, EPS is routine, the NHS App widely used, and it's easier than ever for patients to change their nominated pharmacy online.^{8,9}

The remaining problems are less about replacing paper and more about making the whole journey reliable, convenient, and safe. Prescriptions still need authorisation, medicines still need to be available, and patients still need information about when and where they can obtain them. Some also need help to avoid running out or missing doses.

2 What are repeat prescriptions?

Electronic systems have removed many paper-based steps, but they have not removed professional judgement.

A repeat prescription allows a prescriber to authorise continuing treatment so that a medicine can be prescribed and dispensed at agreed intervals without a fresh consultation. They are widely used for the management of long-term conditions, including hypertension, diabetes, asthma, cardiovascular disease, thyroid disease, arthritis and some mental health conditions.

Behind that definition is a chain of clinical and administrative decisions. The medicine must remain appropriate; monitoring or review may be due; the request must be authorised; the prescription must reach the right pharmacy; and the item must be available, dispensed safely and collected or delivered. A problem at any point can delay the supply.

Electronic systems have removed many paper-based steps, but they have not removed professional judgement. Staff in both GP surgeries and pharmacies still deal with early requests, overdue reviews, changes made after hospital care, and items that are no longer active. Digital tools make requests more visible and easier to track, but they do not remove the need for clinical oversight.

Three terms are often used as if they mean the same thing, but describe different parts of the process:

- Online ordering is how a patient requests a prescription from the prescriber, for example through the NHS App, GP system or online pharmacy.
- The NHS Electronic Prescription Service (EPS) is the infrastructure through which a prescription is sent electronically from the prescriber to the patient's chosen pharmacy dispenser.
- Electronic repeat dispensing (eRD) allows a prescriber to issue a series of NHS repeat prescriptions in advance for a patient whose treatment is stable.

A patient may use EPS without knowing, by ordering through the NHS App and then collecting from a community pharmacy. Someone using an online pharmacy still needs the prescription to be clinically checked and authorised. Keeping these steps separate is important when judging where the system works and where patients still encounter difficulty.

Requests, prescriptions, items and patients are different units. NHS App statistics count order events and distinct users; an order event does not necessarily represent one medicine item. Once a request has been approved, each prescription shown in the NHS App may contain up to four medicines, with additional prescriptions created where more medicines are issued.

3 The scale, cost and clinical mix of repeat prescribing

In England, 1.3 billion prescription items were dispensed in the community in 2025/26 at a cost of £11.6 billion.³ Item volume rose by 3% and cost by 4% compared with the previous year.

The 2017 report recorded 1.1 billion items and a net ingredient cost of £9.2 billion in 2016.¹ The measures are not identical in every respect, so this is not a formal time series. Even so, the increase is clear: roughly 200 million more items are now dispensed each year, and the reported cost is £2.4 billion higher.

Table 1. Community prescribing and digital transfer: then and now

Measure	2016/2017 report	2025/2026 report	Change
Items dispensed in the community	1.1 billion	1.30 billion	Around +18%
Reported prescription cost	£9.2 billion	£11.6 billion	Around +26%
Share dispensed through EPS	59% (Aug 2017)	97%	Near universal

Sources: NHSBSA Prescription Cost Analysis 2025/26; NHSBSA General Pharmaceutical Services 2024/25. Periods and cost measures are not fully harmonised; Pharmacy2U Repeat Prescription Report 2017.

The medicines most often dispensed reflect the importance of long-term treatment. Atorvastatin, which lowers cholesterol and reduces cardiovascular risk, was the most frequently dispensed medicine in 2025/26, with 78 million items.³ Cardiovascular, diabetes, respiratory, antidepressant, thyroid and pain relief medicines also create recurring supply and monitoring needs.

National prescribing volume and cost show different aspects of medicine use. In 2025/26, lipid-regulating drugs were the largest group (categorised by BNF section) by volume (Table 2), followed by antidepressants, hypertension and heart failure medicines, antisecretory drugs and diabetes medicines.

1.1 billion

The 2017 report recorded 1.1 billion items and a net ingredient cost of £9.2 billion in 2016.

1.95 billion

Diabetes medicines were the highest-cost section at £1.95 billion for all prescriptions.

Diabetes medicines were the highest-cost section at £1.95 billion for all prescriptions, followed by respiratory corticosteroids at £866.9 million, oral nutrition at £512.4 million, analgesics at £444.1 million and interstitial-fluid glucose sensors at £364.2 million.³ Applying the same assumed 77% share of expenditure to diabetes medicines gives an illustrative annual repeat-prescription cost of £1.5 billion.

For context, the 2017 report recorded a cost of £82.95 million for prescription drugs used in diabetes in March 2017, equivalent to approximately £995.4 million a year assuming consistent costs throughout the year. This is approximately half the 2025/26 figure.¹

Table 2. Leading BNF sections by national community-dispensing cost, England, 2025/26

BNF section	Items (million)	Reported cost (£ million)	Average cost per item (£)
1. Drugs used in diabetes	78.8	1,949.5	24.73
2. Corticosteroids (respiratory)	26.7	866.9	32.53
3. Oral nutrition	6.9	512.4	74.19
4. Analgesics	60.1	444.1	7.38
5. Interstitial-fluid glucose sensors	4.5	364.2	81.49
6. Antiepileptic drugs	34.1	301.5	8.85
7. Hypertension and heart failure	84.5	300.5	3.56
8. Sex hormones	18.7	281.0	15.04
9. Anticoagulants and protamine	23.2	278.8	12.04
10. Vaccines and antisera	15.0	251.7	16.80
11. Bronchodilators	22.1	225.4	10.19
12. Antidepressant drugs	95.5	224.7	2.35
13. Lipid-regulating drugs	106.6	224.1	2.10
14. Antisecretory drugs and mucosal protectants	83.3	221.7	2.66
15. Catheters	1.6	213.9	136.03
16. CNS stimulants and drugs used for ADHD	4.2	187.2	44.18
17. Antibacterial drugs	35.3	182.4	5.17
18. Laxatives	21.1	172.3	8.18
19. Drugs for genito-urinary disorders	25.5	170.8	6.71
20. Nitrates, calcium-channel blockers and other antianginal drugs	63.6	163.5	2.57

Source: NHS Business Services Authority, Prescription Cost Analysis - England 2025/26

Ageing and long-term conditions

Long-term conditions become more common with age, and so does the use of regular medicines. The 2017 report estimated that around 29 million people were prescribed at least one repeat medicine.¹ Updating the population figures to mid-2024, while retaining the historical age- and sex-specific prescribing rates, gives an estimate of 32.3 million people, equivalent to 46.6% of the UK population.^{1,2}

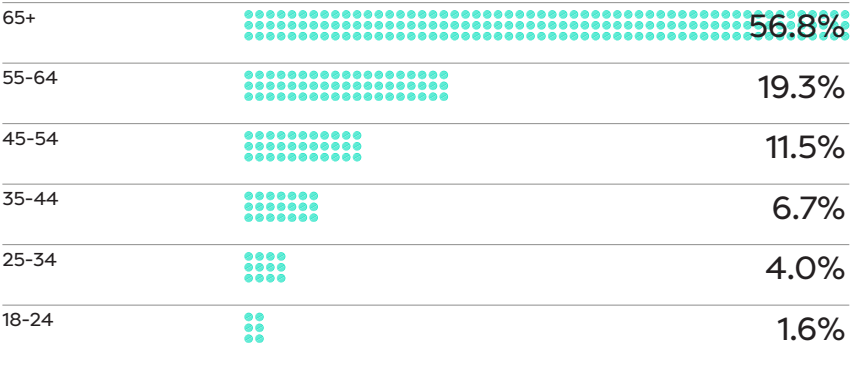
3.6 million

The population aged 85+ is projected to more than double, reaching 3.6 million by 2049.

76.2%

Adults over 55 account for more than three-quarters of prescriptions dispensed in England.

Figure 1. Age profile
Share of community-dispensed items to adults, %



Sources: NHSBSA Freedom of Information request (FOI03230), England, 2024; ONS mid-2024 population estimates. Data Warehouse, NHSBSA Copyright 2025.

NHSBSA data for England shows that people aged 55 or over accounted for more than three-quarters (76.2%) of community-dispensed prescription items attributed to adults, and almost half (49.8%) of identified adult prescription recipients (Figure 1).¹⁰ These data are not restricted to repeat prescriptions.

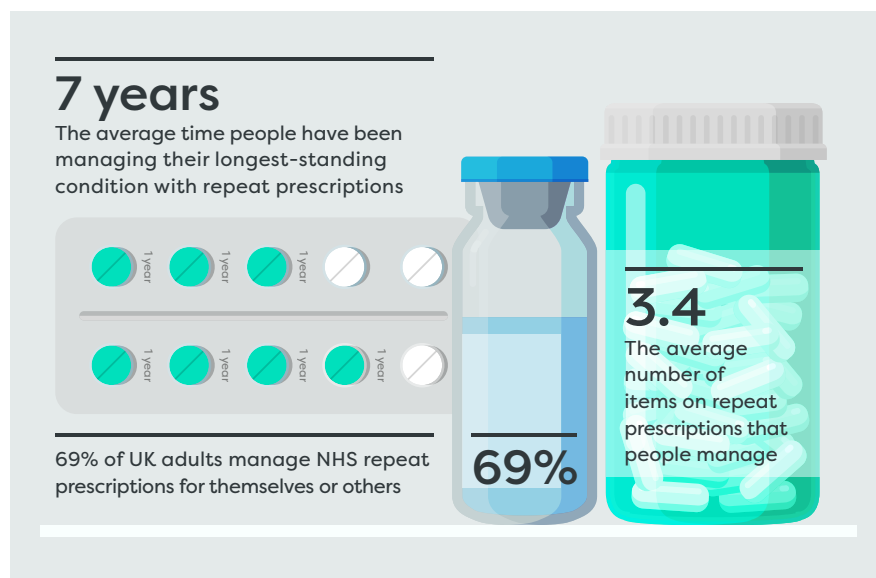
The UK population was 69.3 million in mid-2024.¹¹ Over the 25 years to mid-2049, the number of people of pensionable age is projected to increase by 23.7%, from 12.4 million to 15.3 million. The population aged 85 and over is projected to more than double, from 1.75 million to 3.6 million, over the same period.¹¹

This demographic shift not only brings more prescription items but more complex care. Older patients are more likely to receive several medicines, have treatment changed by different clinical teams, and need help with ordering, packaging, monitoring or collection. Coordination between general practice, hospitals, pharmacy, patients and carers will matter increasingly.

A recurring responsibility

UK consumer research conducted by Opinionum for this report reveals that 69% of adults manage repeat prescriptions for themselves or others. Respondents reported an average of 3.4 repeat prescription items received each month for themselves or someone they help, rising to 4.2 among respondents aged 55 or over.¹² The most common conditions reported by respondents requiring repeat medication were high blood pressure, cholesterol or another heart/circulatory condition (35%); anxiety, depression or another mental health condition (29%); and asthma, COPD or another respiratory condition (16%).¹² For themselves or the person they help, respondents reported an average of 7 years managing the longest-standing condition through repeat prescriptions, rising to 9.4 years among respondents aged 55 or over.¹²

The current NHSBSA Prescription Cost Analysis does not provide a directly comparable national average for the number of distinct repeat medicines received by each repeat-prescription patient. It counts all prescription items dispensed in the community across the whole population. Its published items-per-person measures also include people who receive no regular medication.



40%
of UK adults manage prescriptions online or through an app.

4 How repeat prescriptions are ordered and received

The prescription itself is now almost entirely electronic. In 2024/25, community pharmacies and appliance contractors in England dispensed 1.13 billion NHS prescription items through EPS, equal to 97% of all the items they dispensed.⁸ EPS sends the authorised prescription from the prescriber to the patient's chosen dispenser.¹³

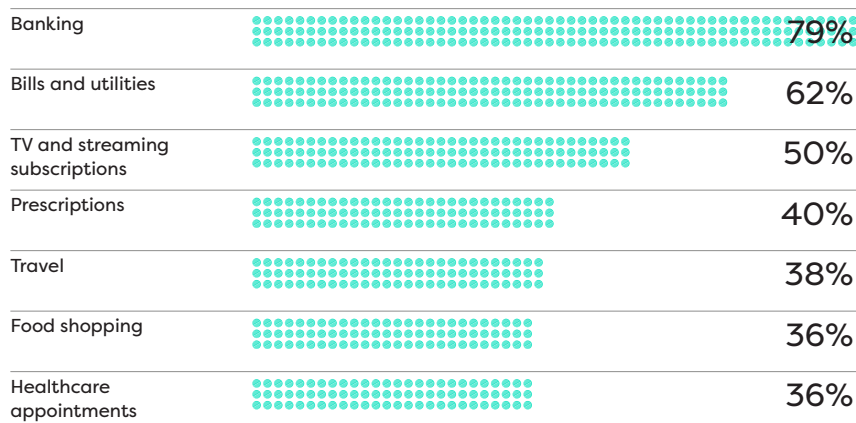
Digital prescription ordering is growing quickly. In June 2026, 7.4 million repeat prescription orders were placed through the NHS App, 31% more than in June 2025, by almost six million distinct users.⁹ NHS England estimates that an electronic repeat request saves a GP practice about three minutes compared with an offline request.¹⁴

Data supplied by Pharmacy2U, meanwhile, shows that it dispensed 5.6 million NHS prescriptions in July 2026, compared with 3.4 million in July 2025, an increase of 63%.⁴

The consumer research reflects this change (Figure 2): 40% of UK adults manage prescriptions online or through an app. That is still lower than those who manage their banking, bills and utilities, and television or streaming services online, but it is similar to the figures for travel, food shopping and healthcare appointments.¹²

Figure 2. Digital habits

Activities UK adults manage online or through an app, %

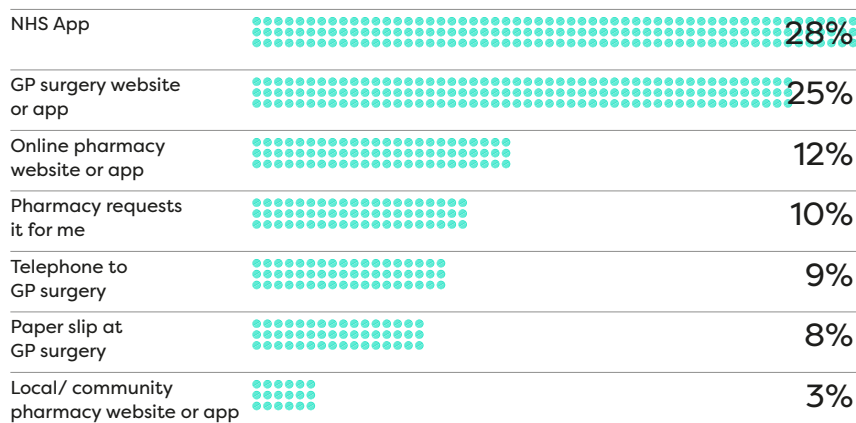


Opinium nationally representative survey of 2,000 UK adults, August 2026

Among prescription managers, the NHS App is the most common route, used most often by 28% of prescription managers (Figure 3). A further 25% use a GP website or app, while 12% use an online pharmacy's own website or app.¹²

Figure 3. Ordering

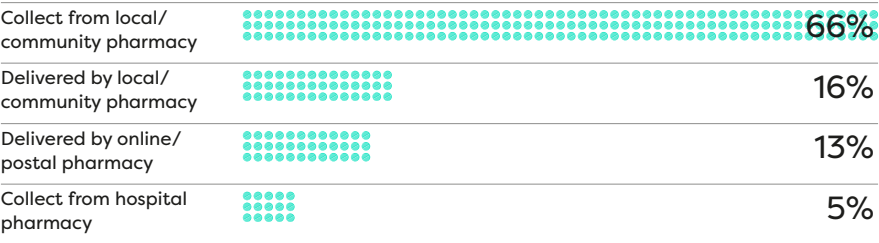
How prescription managers most often order repeat prescriptions, %



Base: 1,384 UK prescription managers, Opinium, August 2026

Most prescription managers still collect the dispensed repeat medicines from a bricks-and-mortar pharmacy in person (Figure 4). The consumer research indicates that 71% collect in person and 28% receive delivery (with 1% unsure).¹² The four main detailed responses are: 66% collect from a local or community pharmacy, 5% from a hospital pharmacy, 16% receive delivery from a local or community pharmacy, and 13% choose a delivery from an online (distance-selling) pharmacy. These percentages describe prescription managers' reported collection or delivery routes, not shares of prescription items dispensed.

Figure 4. Receipt
How prescription managers most often receive repeat medicines, %



Base: 1,384 UK prescription managers, Opinium, August 2026

Knowing when a prescription is ready

The NHS App is beginning to provide more visibility. Patients can view active repeat medicines, request items, see prescription information and change their chosen pharmacy. By the end of June 2026, 3,163 pharmacy sites were live with national prescription tracking and 2,197 with “Ready to Collect” notifications on the NHS App, covering 30% and 21% of pharmacy sites respectively.⁹

However, uncertainty among patients remains common. 38% of people who collect their dispensed medicines in person find it hard to predict how long a visit to a community pharmacy to get a repeat prescription will take, and 35% say they often wait longer than expected.¹²

Accurate status updates and ready-to-collect notifications could prevent unnecessary journeys and reduce calls to both pharmacies and GP practices.

The success of digital ordering should therefore be judged by the whole experience: fewer calls, fewer journeys, clearer information and more reliable access to medicines.

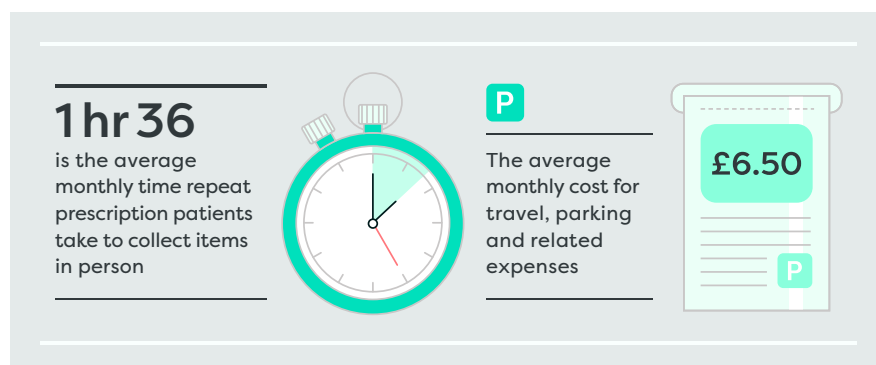
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5 The time and cost of collection

The 2017 report identified time as one of the main costs of repeat prescribing for patients. The new survey shows that this burden remains for those who collect medicines in person.

Among in-person collectors providing a time estimate, the grouped mean was about 1.6 hours per month –approximately 95 minutes – for the repeat-prescription process. This would be about 19 hours a year if the monthly pattern remained unchanged. The corresponding grouped estimate for travel, parking and related direct costs was about £6.50 per month, or approximately £78 a year on the same assumption, while 56% reported no direct collection cost.¹²

The average masks very different individual experiences. Some people live close to a pharmacy and collect at no cost; others make longer journeys, pay for parking or arrange collection around work and caring responsibilities.



Delays, repeat trips and uncertainty

53% of in-person collectors say they have had to make a second trip because a prescription was not ready. 26% had to visit multiple pharmacies to get their prescribed items dispensed, and 24% have abandoned a pharmacy visit because the queue was too long (Figure 5). 16% took time off work or rearranged their day due to collection issues, while 17% had to pay for a smaller emergency supply as their main prescription wasn't available.¹²

Figure 5. Friction in the process
Problems experienced while collecting in person, previous 12 months, %

Made second trip as prescription not ready		53%
No prescription due to GP/pharmacy mix up		34%
Experienced stress as a result of process		32%
Had to visit multiple pharmacies		26%
Gave up on trip to collect due to queue size		24%
Health problems due to pharmacy not getting item in time		17%
Paid for emergency supply as full prescription not ready		17%
Had to take time off/rearrange day to collect		16%

Base: 1,195 UK adults who collect prescriptions in person, Opinium, August 2026

17%
of prescription collectors
say they had health
problems as a result of
their local pharmacy
not getting their repeat
prescription in time.

The cause for this delay may be an outstanding authorisation, a prescription that has not reached the pharmacy, or an unavailable item. From the patient's perspective, the result is the same: the medicine is not there when expected.

34% report a mix-up between the GP practice and pharmacy which meant their repeat medicines were not available to collect when they presented, while 30% have noticed a decline in medicines being in stock during the past year. Just over a quarter of those surveyed (28%) worry that as they get older, their local pharmacy may struggle to provide the increasing number of medicines they may need to be prescribed.¹²

Among in-person collectors, 32% have experienced stress, and 17% report health problems after repeat medicines were not ready in time.¹² These are self-reported experiences and do not establish clinical causation, but they underline the importance of reliable supply.

The practice burden

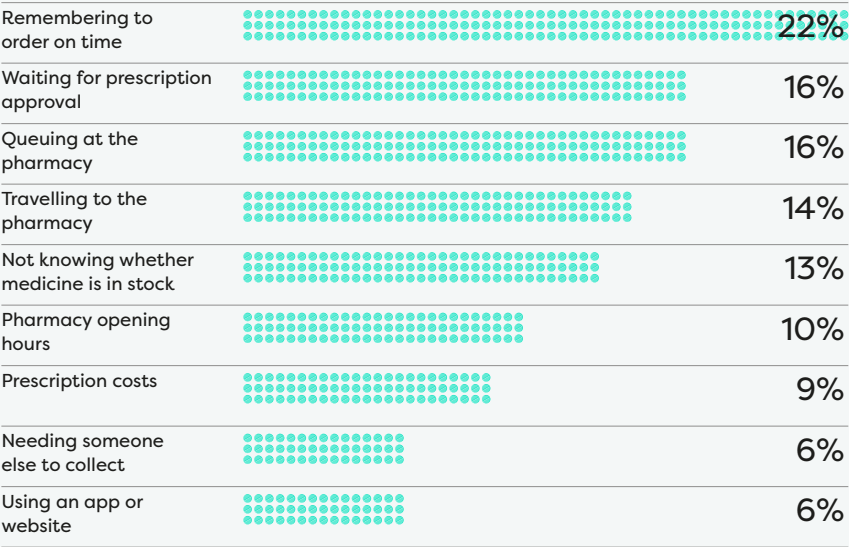
Digital prescription requests reduce manual entry, provide an audit trail and allow GP practice staff to manage exceptions within the clinical system. Applying NHS England's estimate of three minutes saved per electronic repeat-prescription request to the June 2026 order total gives an illustrative equivalent of approximately 369,000 practice hours saved. This calculation assumes that each electronic request replaces three minutes of work and is not a direct measurement of capacity released during that month.^{9,14}

However, clinical and administrative work persists. Prescription requests need authorisation, and staff must resolve early requests, overdue reviews, hospital changes, monitoring requirements and supply problems. The benefit of digital ordering is that routine work can be handled more efficiently while exceptions remain visible.

6 Where the process breaks down

Approximately three in five (58%) of prescription managers identify at least one difficulty with the repeat prescription process. Remembering to order a prescription is the most common issue, reported by 22% (Figure 6), followed by waiting for prescriber approval of the prescription, and queuing at the pharmacy, each reported by 16%. 14% find travel difficult, 13% are uncertain whether a medicine is in stock and 10% struggle with opening hours of the pharmacy.¹² During the previous 12 months, 24% had missed or delayed collection because a medicine was out of stock, and the same proportion because it was not ready at their pharmacy. 15% cited late approval by the prescriber while 14% had forgotten to order on time.¹²

Figure 6. Breakdown points
Most common difficulties in managing repeat prescriptions, %



Base: 1,384 UK prescription managers, Opinium, August 2026

58%

of prescription managers identified at least one difficulty with the repeat prescription process.

38%

of prescription managers with ADHD or a related condition said difficulties led to them running out of medication.

Different problems need different responses. Reminders can help with forgetting, but not with stock. Delivery removes the requirement to travel to the pharmacy but depends on reliable logistics and an urgent-supply route where needed. Tracking of the prescription approval or parcel delivery is useful only when the status is accurate. Recent reviews suggest that medication safety is more likely to improve through organisational and structural approaches – such as pharmacist-led review, multidisciplinary care and system-level monitoring – than through education or decision support alone.^{15,16} Digital reminders may improve adherence modestly, particularly when they are interactive and linked to information sharing or professional support.¹⁷

People who need more support

Among people managing repeat prescriptions for their own condition, 14% say their health makes it harder to remember when to order or collect items, 13% experience anxiety about being unable to obtain medicines, and 12% say their condition means it is more difficult to contact a GP practice or pharmacy.¹²

In the last 12 months, 16% say difficulties managing repeat prescriptions due to their condition caused them to run out of medicine, 14% to order late and 11% to miss doses. Among a smaller subgroup of those with ADHD or another neurodevelopmental condition, the reported impact was greater with 38% reporting difficulties that led them to run out of medicine, 37% to order late and 33% to miss doses.¹² These findings relate to a small subgroup and should therefore be regarded as indicative rather than definitive.

People reporting anxiety, depression or another mental health condition also reported more difficulty remembering and experiencing more anxiety about obtaining medicines. In general, younger patients were more likely to report running out, ordering late or missing doses, and they also voiced more concern about their future ability to collect medication in the face of worsening health or reduced mobility.¹²

Support therefore needs to vary. Some patients will benefit from reminders and a simple digital route; others will need telephone help, accessible packaging, authorised carer access or face-to-face advice.

Carers are part of the prescription system

17% of UK adults reported managing prescriptions for someone else; this response can overlap with managing their own prescriptions.¹² They may order, collect and organise medicines, as well as notice when a supply or treatment problem arises. Digital services should provide secure proxy access with appropriate consent and a straightforward route to contact the pharmacy team.¹⁸

7 Online pharmacy: awareness, trust and choice

52%

of all UK adults would like to order and arrange delivery entirely through an app.

Online pharmacy is familiar to many people but has not yet become the usual route for most prescription managers. The research indicates that about a quarter of respondents (24%) have used an online pharmacy.¹² Looking at the responses in more detail, 31% were aware of online pharmacies but have not used one, 13% knew of online pharmacies but did not realise they could dispense NHS prescriptions, and 12% had not heard of them.¹²

Among non-users, 36% prefer to use their local pharmacy; rising to 52% among those aged 62-80. 20% worry about delivery, 16% value face-to-face advice, and 15% are concerned about losing continuity with their GP or pharmacist. 14% did not know the service existed, and 10% did not know how to set it up.¹²

A quarter of in-person collectors would like a more convenient service but have put off switching to an online service because they are unsure how to do it or have not found the time.¹² Setup and nomination, including the patient's freedom of choice of pharmacy at all times, therefore need to be explained in plain language and supported where necessary in order to support those who may benefit.

Appetite for a more complete digital service

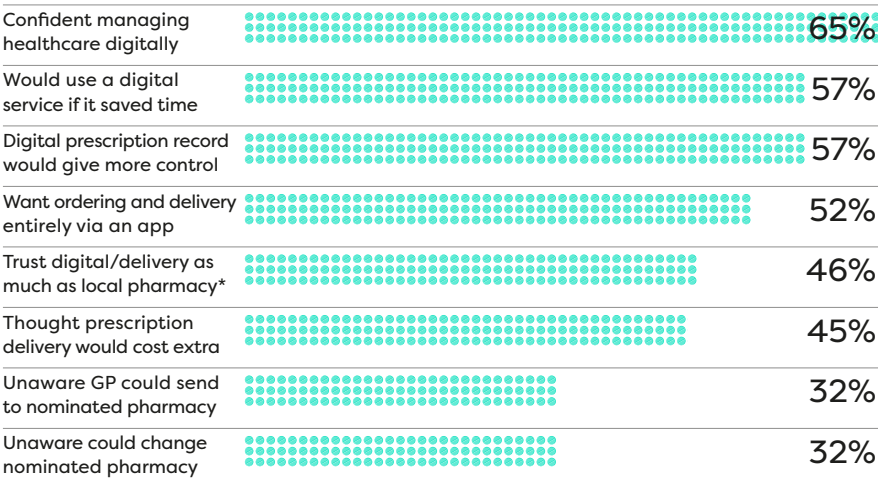
Among all UK adults, 65% feel confident managing healthcare digitally, 57% would use a digital prescription service if it saved meaningful time, and the same percentage say a complete digital prescription record would give them more control. Meanwhile, 52% would like to order and arrange delivery entirely through an app (Figure 7).¹² Separately, 24% of prescription managers have used an online pharmacy for an NHS prescription.¹²

Nearly half (46%) of prescription managers would trust a digital or delivery-based service as much as a local pharmacy, compared with 21% who said they wouldn't. However, nearly half (45%) of all UK adults assumed delivery of the dispensed medicines would cost extra, despite there being a requirement for online or distance selling pharmacies to deliver dispensed NHS medicines throughout England at no cost to the patient. A third (32%) did not know that a doctor could send a prescription directly to a nominated pharmacy, or that they could change that nomination.¹²

These findings point to a practical information gap. Patients need clear explanations of cost, regulation, safety, delivery, pharmacist access and how pharmacy nomination and choice work.

Removing friction from the process through greater digital integration could help here. For example, patients can access their Pharmacy2U account using NHS login, with their permission to share the information needed for sign-in.¹⁹

Figure 7. Digital dynamics
Attitudes to digital prescription services, %



Base: 2,000 adults, *1,384 prescription managers, Opinium, August 2026

PART TWO FROM DISPENSING TO PREVENTION

Turning routine supply into safer treatment and earlier prevention.

8 The repeat prescription as a regular care contact

The NHS 10 Year Health Plan sets out three shifts: hospital to community, analogue to digital, and sickness to prevention.²⁰ Repeat prescribing offers a practical way to support each of them.

A repeat prescription is a predictable contact with someone receiving long-term treatment. At present, that contact is mainly concerned with medicine supply. It can also prompt a check on side effects, monitoring, adherence or a relevant preventive service. Such care-related follow-up should be clinically relevant and clearly distinguished from promotional communication.

This should not turn every order into a questionnaire. Prompts need to be timely and linked to the medicine or condition. A patient taking treatment for their blood pressure might be reminded when a check is due; someone receiving inhalers could be offered an inhaler-technique review. A patient starting an eligible medicine could be invited to speak to a pharmacist after the first few weeks, as happens within the NHS New Medicine Service (NMS).²¹

Ordering patterns can suggest that support may be needed, but they do not explain why. A late order may reflect missed doses, a misunderstanding of the importance of the medicine, side effects, a hospital admission, a dose change or medicine already held at home. An early order may simply reflect travel. The appropriate response is a conversation, not an automated judgement.

Online pharmacies can provide recurring digital contact at scale. Community pharmacies can provide physical checks and face-to-face support. The greatest benefit will come when those routes are linked around the patient.

9 Medicines optimisation and safer long-term treatment

Prevention also means preventing avoidable harm from medicines and helping people obtain the intended benefit from treatment. Supplying a medicine is only one part of that task.

Medicines optimisation is the process of making sure treatment is appropriate, understood and used safely, with the patient involved in decisions.²² It becomes more important as regimens become more complex, new prescribing guidelines and evidence are published, and medicines are changed by several clinical teams.

The survey shows how access problems can affect medicine-taking. Among respondents managing prescriptions for their own health condition, 16% had run out of medicine because of condition-related difficulties, 14% had ordered later than intended and 11% had missed one or more doses during the previous 12 months.¹² Pharmacy can help at several points in this process.

A 2025 review found mobile-app interventions led to a modest improvement in medication adherence – interactive features, more advanced reminders, data sharing and pill dispensers were associated with larger effects.

Before the medicine runs out

Reminders can be linked to the expected supply and adjusted so that they are useful rather than repetitive. Tracking can show whether a prescription request is awaiting approval, if a prescription has reached the pharmacy, or is dispensed and ready to collect or deliver. Where an order appears late, the service can offer help rather than simply sending another alert.

Digital support can help, but its design matters. A 2025 review of 26 randomised trials involving 5,174 participants found that mobile-app interventions produced a modest overall improvement in medication adherence. Interactive features, more advanced reminders, data sharing and pill dispensers were associated with larger effects.¹⁷ Reminders should therefore be linked to useful information and a clear route to professional support rather than operating as repeated automated messages.

When treatment starts or changes

The NHS New Medicine Service provides structured pharmacist support after a patient starts a specified medicine for a long-term condition.²¹ More recent UK evidence supports the wider role of pharmacists in medicines optimisation. A 2024 review found that pharmacist-led primary-care interventions consistently improved prescribing-related outcomes, although the small number of high-quality studies and wide variation in interventions prevented a precise pooled estimate of effect.¹⁶ Where appropriate, online pharmacies can provide structured follow-up by telephone or video while retaining a route to face-to-face assessment if required, and communication with the prescriber.

When several medicines become difficult to manage

Structured medication reviews allow the clinician and patient to consider benefits, risks, alternatives and the person's priorities.²³ A 2025 review of 118 randomised trials, involving more than 417,000 older primary-care patients, found that interventions addressing potentially inappropriate prescribing reduced the number of medicines by the equivalent of around one medicine for every two patients. They did not produce substantial changes in hospital admission or mortality, suggesting that medication burden can be reduced safely but that wider clinical benefits should not be assumed.²⁴

Like its brick-and-mortar equivalent, an online pharmacy cannot change treatment outside its clinical scope, but it can identify concerns and refer them to the prescriber or an appropriate clinical pharmacist. The outcome may be better support, a monitoring test, a dose change, deprescribing, or a simpler regimen. The wider introduction of independent prescribing pharmacists from 2026, along with a suitable NHS service specification when published, is likely to improve the patient experience at those times when medicines can be optimised.

When the patient needs human contact

Automation of pharmacy services is useful for routine supply, but patients still need easy access to professional advice. They should know whether they are speaking to a pharmacist, a member of the pharmacy team or an automated system. A direct route to human help is particularly important where there are side effects, during pregnancy, for worsening symptoms, urgent supply needs, and with higher-risk medicines.

Performance should be judged by more than the number of items dispatched. Measures such as missed supplies, completed monitoring, resolved medicine-related problems, referrals and patient understanding are more useful indicators of care and safety.

10 Screening, monitoring and digital diagnostics

The NHS Plan places prevention and earlier diagnosis at the centre of future reform.²⁰ Pharmacy already has a wide clinical role: The NHS Pharmacy First service enables community pharmacists to complete episodes of care including the supply of prescription medicines for common conditions through defined pathways.²⁵ The NHS Community Pharmacy Blood Pressure Check service supports the identification of people at risk of undiagnosed hypertension and cardiovascular disease.²⁶ Pharmacies also provide vaccination, contraception and smoking-cessation services.

Online pharmacy can widen access to this work – many pharmacy clinical services are already being delivered remotely. Online services can also identify eligible patients, explain an offer, gather preliminary information, arrange pharmacist support, enable suitable home monitoring or direct the patient to a local service. The NHS New Medicine Service and Pharmacy Contraception Service allow remote consultations where clinically appropriate and subject to their service specifications.^{21,27} Six of the seven Pharmacy First clinical pathways can be delivered by live video consultation where the required clinical assessment can be completed remotely; acute otitis media requires an in-person examination.²⁵ Online pharmacy can therefore provide an entry and triage point, with signposting or handover when face-to-face assessment is needed.

Pharmacy2U's clinical mix supports a focused rather than indiscriminate approach. Cardiovascular medicines alone account for 34.4% of its dispensed prescription items, while diabetes and respiratory medicines are also substantial recurring groups.⁴ These categories provide a practical starting point for blood-pressure review, lipid and diabetes monitoring, inhaler support and medicines follow-up, provided each offer is clinically targeted and connected to the patient's usual care.

Online services can identify eligible patients, gather preliminary information, arrange pharmacist supports, enable home monitoring or direct them to a local service.

Where the opportunity is strongest

The most credible starting points are services with an established evidence base for improvement in patient outcomes and a clear route for follow-up:

- Blood pressure and cardiovascular risk: reminders about checks, lipid monitoring or review, with referral to NHS services where appropriate.
- Diabetes risk and monitoring: prompts for agreed reviews and tests, linked to the responsible clinical team.
- Respiratory care: inhaler-technique and adherence support, with referral when control is poor.
- Smoking cessation, weight management and vaccination: relevant, choice-based offers rather than generic marketing.
- Medicine-related monitoring: reminders for tests required for safe continuing treatment.

34.4%

Cardiovascular medicines account for more than a third of Pharmacy2U's dispensed prescription items.

Screening is a pathway, not a product

Screening is offered to people who do not have symptoms. Even a good test will produce some false-positive and false-negative results, with the potential for unnecessary anxiety, further investigation or false reassurance.²⁸

The UK National Screening Committee assesses the whole programme, not only the test, including the balance of benefits and harms, the reliability of the test, and the availability of effective follow-up or treatment.²⁹ A promising test or technology on its own is not sufficient; screening requires a defined, quality-assured pathway with appropriate follow-up.²⁸⁻³⁰

Before offering a pharmacy-led test, six questions should be considered: who is eligible; whether the test is validated; what information supports informed choice; who reviews the result; how it is recorded; and what route leads to confirmation, treatment or urgent care.

Home monitoring

NHS England's Blood Pressure @home programme provides a practical example of supported home monitoring.³¹ An eligible patient could receive a validated monitor, clear instructions and reminders, with readings reviewed under an agreed protocol and referred when necessary. Very high readings or concerning symptoms would require an urgent pathway.

Recent evidence supports digital monitoring when it remains connected to professional care. A 2025 network meta-analysis of 69 randomised trials involving 19,837 people found that healthcare professional-supported digital self-care interventions reduced blood pressure compared with usual care. Pharmacist-supported interventions produced the largest estimated reduction in systolic blood pressure, although study quality varied.³² NHS guidance also emphasises equipment quality, staff competence, governance and action on results.³³ The clinical pathway should therefore determine the technology used, rather than the other way round.

From 2028, people are expected to begin viewing their data through the NHS App, while professionals will access the information they need from one place.

The Single Patient Record

Joined-up records will be essential. The new NHS Single Patient Record programme is intended to bring health information together securely. From 2028, people are expected to begin viewing their data through the NHS App, while professionals will access the information they need from one place.³⁴

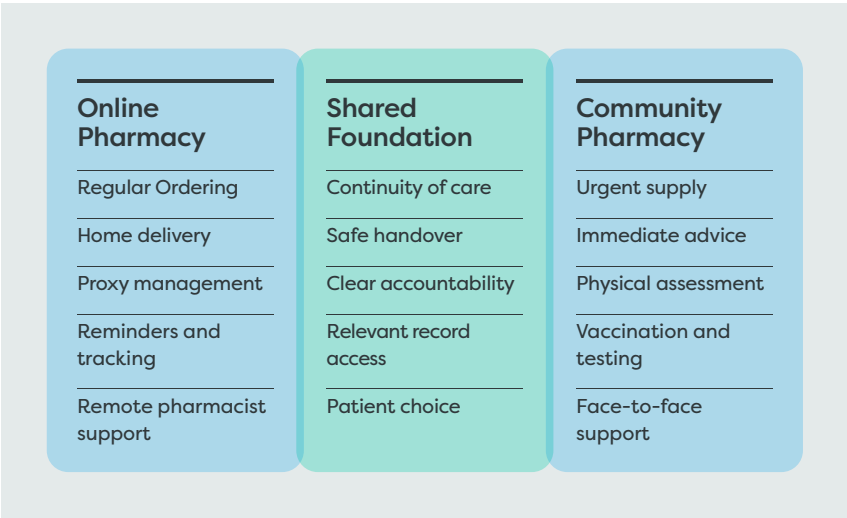
For pharmacy, this could make recent treatment changes, test results and overdue monitoring easier to see, while allowing relevant interventions to be recorded for the wider care team. Access will need to be proportionate and secure, but pharmacy care should not remain an isolated transaction.

11 Bricks and clicks: one connected pharmacy system

Online and high-street pharmacy should not be treated as competing answers to the same question. Patients use different routes for different needs, and both have clear strengths.

9,920

community pharmacies, excluding distance-selling pharmacies, were open in England as of August 2026.



Online pharmacy is well suited to planned repeat ordering, delivery, reminders, tracking, family management and remote support. It can improve access for people who are housebound, live far from a pharmacy, work irregular hours or have caring responsibilities.

Community pharmacy provides immediate access for urgent medicines, advice, vaccination, testing and face-to-face assessment. It is also important for people who prefer or need personal contact.

Many patients will use both. Someone may receive routine medicines by post but attend a local pharmacy for a blood pressure check. An online pharmacist may direct worsening symptoms to a face-to-face service. A community pharmacist may help a patient arrange delivery when mobility declines.

The test is continuity. Patients should not have to repeat the same information, and responsibility should remain clear when more than one organisation is involved. Referrals must be accepted, results shared and urgent problems handed over safely.

As of 31 August 2026, 9,920 community pharmacies, excluding distance-selling pharmacies, were open in England.³⁵ Their physical presence remains a major asset. As more routine processes are supported by digital systems and automation, pharmacists should have more time for the clinical work that depends on assessment, judgement and direct contact.

12 Trust, safety and digital inclusion

Convenience may encourage people to consider a different service, but trust will determine whether they use it.

Visible professional standards

In Great Britain, online pharmacy services are subject to the same regulatory standards as other registered pharmacy services, alongside additional guidance from the General Pharmaceutical Council (GPhC) on providing services at a distance.³⁶

A trusted service should make the following visible and easy to understand:

- the pharmacy's registration and regulatory status;
- how to access advice from a pharmacist;
- how clinical and identity checks are performed;
- how information is shared with the GP or wider care team;
- how medicines are packaged, tracked and protected in transit;
- what happens if an item is unavailable, delayed or lost;
- how urgent supply is handled;
- how the patient can complain, change pharmacy or leave the service.

Trust also depends on how the service behaves. A routine prescription order should not become a vehicle for selling unnecessary tests or treatment. Preventive offers should be relevant, evidence-based and clearly separated from promotion.

Digital inclusion

Preference for a local pharmacy should not automatically be read as a lack of digital ability. For many patients it reflects continuity, immediate access and the value of speaking to someone in person.

Digital exclusion nevertheless remains a practical concern. Barriers may include lack of a suitable device, poor connectivity, cost, disability, language, low confidence or limited health literacy. NHS England's digital inclusion framework states that digital approaches should complement non-digital services.³⁷

An inclusive online pharmacy service therefore needs more than an app. It should offer telephone support, accessible design, clear language, alternative formats, help with setup, secure proxy access and a route to face-to-face care through signposting. People should receive the same standard of care whether they use a digital service or need or prefer a non-digital route.³⁷

Cost and prescription entitlements

30% of UK adults surveyed had never heard of Prescription Prepayment Certificates (PPCs) before the survey, and 8% reported currently holding one.¹² PPCs apply in England, where an NHS prescription item costs £9.90. A certificate costs £32.05 for three months or £114.50 for 12 months. Patients in England who pay prescription charges and receive regular medicines may save money with a PPC.³⁸

Both online and community pharmacies can signpost patients to authoritative information on charges, exemptions and PPCs. This needs to be nation-specific because prescription charging differs across the UK.

13 Five priorities for the future

The evidence points to five practical priorities for community pharmacies, online pharmacies and the NHS to address in the years to come.

1. Make the whole journey visible

Patients should be able to see when a prescription request has been made, received, authorised by the prescriber, dispensed by the pharmacy, and made ready for collection or delivery. Status information should cover the complete order and explain any partial supply or delay.

2. Make switching between pharmacies simple, supported and reversible

One quarter of in-person collectors want to switch to a more convenient prescription service or pharmacy but have put it off because they are unsure how to do so or have not found the time.¹² Setup should be brief, clearly explained and accompanied by appropriate support. Patients should also be informed clearly about how to change their nominated pharmacy at any time they choose.

8%

of UK adults currently hold a Prescription Prepayment Certificate.

25%

of adults who collect prescriptions say they want to moved to a more convenient service but are unsure how or haven't found the time.

3. Design for people most likely to run out

Reminder and support systems should take account of challenges people may face managing tasks as well as mental ill health, multiple medicines, mobility limitations and caring responsibilities. Proxy access, tailored reminders and pharmacist contact should be core functions rather than optional extras.

4. Use repeat contact for evidence-based prevention

Begin with services that have a clear clinical pathway, such as blood pressure checks, medicine monitoring, inhaler support, smoking cessation, vaccination reminders and follow-up after a new medicine. Measure whether follow-up was completed and acted upon, not only how many invitations or tests were issued.

5. Build one bricks-and-clicks network

Online and community pharmacy should be able to refer patients to each other and share relevant information with general practice. Digital services can handle predictable supply and communication; local pharmacies can concentrate more of their time on urgent, physical and face-to-face care. Respecting a patient's choice of pharmacy is paramount, as is ensuring the system has flexibility to ensure the best possible outcomes. For those using online services, prescribers should use tools for urgent prescriptions, such as one-off nominations in the GP system. Where appropriate, non-nominated EPS "Phase 4" prescriptions can allow an urgent supply to be collected from an alternative pharmacy, including when a patient's usual nominated pharmacy is closed.³⁹

14 Conclusion

Repeat prescribing has changed considerably since 2017. Electronic transfer is now routine, and digital ordering is growing quickly. But the patient journey is only partly transformed. Most prescription managers still collect medicines in person, and many encounter uncertain waits, second journeys, direct costs and occasional gaps in treatment.

Online pharmacy can remove some of that friction, but a convenient service must also be clear, accountable and connected to the wider NHS. Community pharmacy must remain accessible for urgent and face-to-face care, and non-digital routes must continue for patients who need them.

The wider opportunity is to treat repeat prescribing and dispensing as a regular point of contact for patient care. With appropriate consent, governance and clinical pathways, it can support medicine-taking, adherence and health outcomes, monitoring and prevention as well as supply.

15 A vision of the future

In future, routine repeat prescribing and dispensing should feel dependable rather than demanding.

Patients should be able to see their regular medicines in one place, including when an item can be requested, whether a review or test is due and where and when it will be dispensed. Reminders should arrive at the right time and stop once action has been taken.

Delivery and collection should remain genuine choices. Home delivery may suit someone who works long hours, is housebound or lives far from a pharmacy, or for those who value the time saving and convenience. A local pharmacy may be better for urgent supply, immediate advice or a physical check. Patients should be able to change route without unnecessary difficulty, and it should be acknowledged that both are valid options that might suit the same patient at different times.

After a prescription order is placed, the status should be clear: awaiting approval, received by the pharmacy, ready, dispatched or delayed by a supply problem. If one item is unavailable, the patient should be told what has happened and what to do next.

Timely clinical support can be offered when relevant. A patient taking antihypertensive medicine may be reminded about blood pressure monitoring. Someone starting a new medicine may be offered a pharmacist consultation. A person managing several medicines may need help with timing, side effects or packaging. An authorised carer should be able to manage orders and raise concerns without repeated calls.

Preventive services should follow established pathways. Results need to be reviewed, recorded and acted upon. Pharmacists should be able to see the information they need and add relevant interventions to the patient record, with clear responsibility across general practice, hospitals and pharmacy.

Automation will continue to support routine preparation and communication, while pharmacists concentrate on safety, long-term conditions and prevention. Community pharmacies will remain the local point of access for urgent and face-to-face care; online pharmacies will provide delivery, scale and continuous digital contact.

A good system will offer human care and digital convenience together. The aim is simple: reliable access to medicines, earlier help when problems arise, and fewer avoidable gaps in treatment.

Research methodology and interpretation

- Pharmacy2U commissioned this report as an update to the Repeat Prescription Report published in 2017, bringing together current NHS and population statistics, peer-reviewed research, a nationally representative Opinium survey, and aggregated Pharmacy2U prescription-record data. The analysis and interpretation are those of the authors.
- In this report, a “prescription manager” is someone who manages or requests repeat prescriptions for themselves, for another person, or for both. The relevant survey base is shown where it affects interpretation.
- The consumer survey covers the whole UK. Figure 1 uses NHSBSA community prescription-item counts and identified recipient counts for England, January–December 2024. Age groups were derived as 2024 minus birth year, representing age reached during 2024 rather than age at dispensing. The six adult age groups include 1,187,960,743 items and 33,742,759 identified recipients; under-18 and unknown-birth-year records were excluded. Combined percentages were calculated from unrounded counts. The population comparison uses England’s ONS mid-2024 estimates and mid-year ages, so it is contextual rather than an exactly age-and-date-matched prevalence calculation. The NHSBSA data are not limited to repeat prescriptions.^{2,10}
- The illustrative repeat-prescription population estimate applies the rounded age- and sex-specific proportions in Table 1 of the 2017 report to the corresponding ONS mid-2024 UK population counts, using ten-year age bands through 80–89 years and a final category of 90 years and over.^{1,2} Estimated recipients were summed and divided by the total UK population. The historical proportions derive from research using November 2011 data from 29 general practices in Bradford and Airedale.⁵ The calculation assumes these local historical rates apply throughout the UK and remain unchanged over time; it does not measure subsequent changes in prescribing.
- Opinium describes an online survey of 2,000 UK adults conducted between 7 and 11 August 2026 and weighted to be nationally representative.¹²
- Pharmacy2U supplied aggregated activity data for August 2025 to July 2026 by BNF chapter, section and paragraph, age band and local authority, plus a July 2025 comparator. Results describe Pharmacy2U activity and are not national estimates of prevalence, disease burden or prescribing.⁴
- The Pharmacy2U BNF totals reconciled exactly to the age-aggregated totals for every month and BNF category. The 12-month total, age shares and BNF shares were independently recomputed. The separate July-to-July change assumes consistent definitions and criteria.⁴

- Survey percentages may not total 100% because of rounding, differences in question routing or overlapping responses. The ADHD/neurodevelopmental subgroup has a weighted base of 54 and an unweighted base of 57, so its findings are indicative rather than definitive.
- The results showing the average number of monthly items (3.4), the duration of respondents' longest repeat prescription (7 years) and the monthly time (1.6 hours) and associated costs (£6.50) are grouped estimates reconstructed from category codes, not respondent-level continuous means. The time question covers the time spent by an adult respondent getting repeat prescriptions in person for themselves or someone they help. Annual equivalents assume an unchanged monthly pattern. Where Opinium findings are compared with NHS or national survey data, comparisons are directional unless wording, geography, population, denominator and reference period align.
- Comparisons between 2016 and 2025/26 use the 2017 Pharmacy2U report and NHSBSA statistics and are not a formally harmonised series.^{1,3} The illustrative estimate of approximately one billion repeat items multiplies the rounded 2025/26 community-dispensing total for England (1.3 billion) by the historical repeat-item proportion (77%).^{1,3,5} This assumes that the historical share of issued items applies to current community-dispensed items. It is not a new measurement of repeat dispensing and does not establish the proportion of prescription costs attributable to repeats. The £9 billion and £1.5 billion cost scenarios additionally assume that repeats account for 77% of current expenditure, both overall and within diabetes medicines.
- The diabetes-cost comparison annualises the March 2017 amount of £82,950,732 by multiplying it by 12, giving £995,408,784.¹ This assumes that March is representative of a whole year and does not adjust for seasonal variation or inflation. The comparison concerns the reported costs for the BNF section "Drugs used in diabetes", not the overall cost of diabetes care or a separately measured total for repeat prescriptions.^{1,3}

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