An evaluation of the role of community pharmacists in optimising safe and appropriate medicines use in response to patient requests for emergency supplies

Emergency Supply of Prescription-only Medicines (ESoPoMs)

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EXECUTIVE SUMMARY

In this study, the term ‘emergency supply’ refers to the supply of medicines made by community pharmacists without a prescription, including situations where a charge is paid by the patient, as well as those where medicines are loaned prior to an NHS prescription being obtained.

The overarching purpose of this study was to explore and inform best practice regarding the delivery of an emergency supply service of prescription-only medicines in community pharmacies. The study was also designed to explore the support required by pharmacists in providing this service, and to identify how it may be integrated into established health and social care provision to help maximise adherence. The study’s primary aim was to explore the operation of the emergency supply service undertaken by community pharmacists (CPs), whilst the secondary aim was to engage community pharmacists and enhance their involvement in, and experience of, pharmacy practice research.

METHODS

This study used a mixed methods approach, with data collection being undertaken by practising community pharmacists who were trained in research techniques as part of the study (known as Pharmacist Researchers – PRs). The evaluation was based on data from four phases:

1. Prospective audit of emergency supply requests for prescribed medicines;
2. Interviews with community pharmacist service providers;
3. Follow-up interviews with service users who received emergency supplies;
4. Interactive feedback sessions with medical practice teams.

Triangulation of the data from all study phases provides an understanding of the service from multiple perspectives, enhancing the validity and reliability of the study outcomes. A regional pharmacy stakeholder workshop took place towards the end of the study to invite comment on our preliminary findings and to help us to formulate our recommendations.

SUMMARY FINDINGS

Emergency supplies were a routine aspect of community pharmacy practice and arose for multiple reasons, including problems relating to patients obtaining supplies of repeat-prescribed medicines. These supplies created additional, hidden, workload for pharmacists, which was neither currently recognised nor remunerated as the majority of these supplies were made as a loan, in anticipation of an NHS prescription. Supplies made in this way helped to maintain access to medicines and supported patients in adhering with prescribed treatment plans. Pharmacists faced some challenging situations in responding to requests, but good relationships with local medical practices and robust policies and procedures helped to alleviate problems. Pharmacists recognized the potential for problems arising from inappropriate supplies being made and exercised caution when making the decision to supply. There was no formal mechanism for reporting emergency supplies back to the patient’s GP and this was something that was widely considered to be necessary to reduce risk of misuse or further clinical problems arising. In some cases, emergency supplies triggered interventions by pharmacists, from provision of advice around adherence through to full Medicines Use Reviews. Many participants felt that provision of emergency supplies helped to reduce unnecessary burden on out-of-hours and urgent care services including walk in centres, Out-of-Hours GP services and Accident and Emergency departments.
Pharmacist researchers were effective members of the research team and contributed to the collection of high quality, robust evidence from their practice, their peers, their patients and fellow health professionals. Incorporating PRs into research is potentially a highly useful mechanism to building the evidence base for primary care practice in community pharmacy.

**RECOMMENDATIONS FOR PRACTICE**

The recommendations below reflect the study data and comments on our preliminary findings from a pharmacy stakeholder workshop. They relate to the safe and effective provision of emergency supplies of prescription-only medicines made through community pharmacies and arise directly from the key findings of the study. Recommendations outline how such supplies could be better integrated and form a more coordinated component of health and social care pathways, thus ensuring that patients benefit from being able to maintain adherence to their prescribed medicines regime.

Key recommendations for practice are as follows:

1. An NHS-funded service should be commissioned nationally that will allow pharmacists to supply regularly prescribed medicines to NHS patients under the existing criteria as laid out in the Medicines Act and subsequent Regulations. Such a service should include additional features around supporting patients in managing their medicines effectively and might include a facility to enable pharmacists to synchronise supplies of multiple medications or address other technical issues around the supply of repeat medication. Furthermore, incorporating Medicines Use Reviews into the service would also allow further review of patients with more complex issues. This approach would help to reduce the hidden workload of emergency supplies arising from multiple loaned supplies and allow the community pharmacy team to continue to reduce unnecessary burden on the wider NHS.

2. Pharmacists should have read-only access to electronic patient medical records to inform their decision-making regarding emergency supplies. In addition, having write access to add information regarding emergency supplies made would also ensure that the patient’s medical practitioner was fully informed regarding adherence to treatment.

3. Continued rollout of, and improvements to, the Electronic Transfer of Prescriptions (ETP) service may help to reduce the turnaround time of prescriptions and provide further mechanisms for handling emergency situations. In addition, better use of technology by community pharmacies, such as automatic reminders to patients to order their prescription in sufficient time, could further alleviate problems. Some pharmacy software providers are already developing such systems and these reminders could be via text, email or telephone.

4. A review of the current systems for ordering and supply of prescribed medicines should be undertaken locally by medical practice teams, in consultation with local community pharmacies and patient representatives to help streamline the process for patient benefit and to reduce unnecessary burden on out-of-hours and urgent care services. Such a review might involve considering wider use of the existing Repeat Dispensing Service for medicines for long term conditions, which has potential to quickly reduce the current burden on medical practices. Medium term, a review may look towards a more multidisciplinary approach to the ordering and authorisation process once electronic transfer of prescriptions and the sharing of medical records becomes more widespread.
RECOMMENDATIONS FOR RESEARCH
Further research, including economic modelling to estimate the cost-effectiveness of a funded NHS emergency supply service, is required to assess its feasibility and its potential to be a cost effective mechanism to reduce demand on out-of-hours services.
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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency department</td>
</tr>
<tr>
<td>BNF</td>
<td>British National Formulary</td>
</tr>
<tr>
<td>CATC</td>
<td>‘Care at the Chemist’ minor ailments service</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CD</td>
<td>Controlled Drug</td>
</tr>
<tr>
<td>CP</td>
<td>Community pharmacist/pharmacy</td>
</tr>
<tr>
<td>CRN</td>
<td>Clinical Research Network</td>
</tr>
<tr>
<td>EPS</td>
<td>Electronic Prescription Service</td>
</tr>
<tr>
<td>ETP</td>
<td>Electronic Transfer of Prescriptions</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>GPhC</td>
<td>General Pharmaceutical Council</td>
</tr>
<tr>
<td>HCA</td>
<td>Health Care Assistant</td>
</tr>
<tr>
<td>HENW</td>
<td>Health Education North West</td>
</tr>
<tr>
<td>HSCIC</td>
<td>Health and Social Care Information Centre</td>
</tr>
<tr>
<td>LPC</td>
<td>Local Pharmaceutical Committee</td>
</tr>
<tr>
<td>LPN</td>
<td>Local Professional Network</td>
</tr>
<tr>
<td>MEP</td>
<td>Medicines, Ethics and Practice guide</td>
</tr>
<tr>
<td>MP</td>
<td>Medical Practice</td>
</tr>
<tr>
<td>MUR</td>
<td>Medicines Use Review</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute for Health and Care Excellence</td>
</tr>
<tr>
<td>NIHR</td>
<td>National Institute for Health Research</td>
</tr>
<tr>
<td>NPA</td>
<td>National Pharmacy Association</td>
</tr>
<tr>
<td>NRES</td>
<td>National Research Ethics Service</td>
</tr>
<tr>
<td>OOH</td>
<td>Out-of-Hours (GP service)</td>
</tr>
<tr>
<td>OTC</td>
<td>Over-the-Counter (medicine)</td>
</tr>
<tr>
<td>PCRN</td>
<td>Primary Care Research Network</td>
</tr>
<tr>
<td>PGD</td>
<td>Patient Group Direction</td>
</tr>
</tbody>
</table>
Presentation of the Data in the following chapters

In Chapters 4-9, data are presented from different phases in order to show the triangulation of findings in this mixed-methods study. The direct quotes from participants are prefixed as follows, to identify what type of participant they were:

(PXX) e.g. (P20) refers to a community pharmacist interviewed in Phase 2.

(CPX-PtX) e.g. (CP3-Pt1) refers to a patient from a community pharmacy interviewed in Phase 3.

(MPX, [type of professional]) e.g. (MP1, GP) indicates a quote from a GP in a medical practice from the Phase 4 feedback sessions.

(SX) e.g. S8 indicates a stakeholder at the regional pharmacy stakeholder workshop.
1 BACKGROUND

1.1 POLICY BACKGROUND

The Medicines Act 1968, and latterly the Human Medicines Regulations 2012, permit community pharmacists to supply prescription-only medicines without a prescription, in an emergency when requested by either a prescriber or the patient. This enables pharmacists to use their professional judgement to ensure patients’ medicine(s) supply is not disrupted. Under this provision, pharmacists must ensure there is an ‘immediate need’ for the requested medicine, whilst also considering the well-being of the patient and the consequences of not supplying.

Conditions that apply to emergency supplies made at the request of the patient also consider available evidence of previous treatment, knowledge of dose and availability for the pharmacist to interview the patient. Guidelines for length of treatment, record keeping and labelling, and possible reasons for refusal are also provided. Circumstances in which an emergency supply can be made at the request of a patient and legislative requirements (Human Medicines Regulation 225) are detailed in Box 1.

**Box 1: Emergency supply at the request of a patient**

**Interview:** the pharmacist must interview the patient, preferably face-to-face.

**Immediate need:** the pharmacist must be satisfied that there is an immediate need for the POM (prescription-only medicine) and that it is not practical for the patient to obtain a prescription without undue delay.

**Previous treatment:** the POM requested must previously have been used as a treatment and prescribed by a relevant prescriber.

**Dose:** the pharmacist must be satisfied of knowing the dose that the patient needs to take.

**Not for controlled drugs, except phenobarbital:** medicinal products cannot be supplied if they consist of or contain any schedule 1, 2 or 3 controlled drugs; phenobarbital can be supplied to patients of UK-registered prescribers for the purpose of treating epilepsy.

**Length of treatment:** if the emergency supply is for a controlled drug (i.e. phenobarbital or schedule 4 or 5 controlled drug), the maximum quantity that can be supplied is for five days’ treatment. For any other POM, no more than 30 days can be supplied except:

- if the POM is insulin, an ointment, a cream, or an inhaler for asthma (i.e. The packs cannot be broken), the smallest pack available in the pharmacy should be supplied.
- if the POM is an oral contraceptive, a full treatment cycle should be supplied.
- if the POM is an antibiotic in liquid form for oral administration, the smallest quantity that will provide a full course of treatment should be supplied.

**Records kept:** an entry must be made in the POM register on the day of the supply (or, if impractical, on the following day). The entry needs to include: date supplied; name (including strength and form where appropriate) and quantity of medicine supplied; name and address of patient; information on nature of emergency.

**Labelling:** in addition to standard labelling requirements, the words “Emergency Supply” need to be added to the dispensing label.

For loans in anticipation of a future NHS prescription, the additional work undertaken by the pharmacists is not remunerated, either by the patient or the NHS. For an emergency supply, a charge may be made to the patient to cover the medicine costs, and a discretionay small amount for administration.
1.2 **Definition of Emergency Supply**

For the purposes of this study, *emergency supply* includes both the supply of medicines where a charge is made as well as the loan of medication, where no charge is made and the supply is reconciled against a future NHS prescription. Emergency supplies made at the request of a prescriber were not included in this research.

1.3 **Previous Research**

A literature search indicated few studies specifically exploring emergency supplies and none less than ten years old. A 1998 survey of 243 pharmacists in South East England by O’Neill *et al.* examined frequency and characteristics of emergency supply, as well as pharmacists’ views of the process. The survey found that emergency supply requests by patients at each pharmacy ranged from none in the last 12 months to one or more per day. Approximately two-thirds of respondents reported receiving requests at least monthly, and a third of these respondents at least weekly. ‘Loans’, where no payment is taken for the medicine but a future prescription is anticipated, were considered separately in this survey. When loans were included request rates rose to at least monthly for three-quarters of respondents, at least weekly for half and at least daily for 1 in 10. Respondents gave multiple reasons for refusal of emergency supplies, but three-quarters reported that failure to establish an immediate need was a primary factor. Respondents perceived emergency supplies as an important service, but over three-quarters felt it was open to misuse.

The use of pharmacy patient medication records (PMRs) to facilitate the emergency supply process was documented by Rogers *et al.* in 1994 during an 18-month study of reporting in patient records of clinical interventions made by community pharmacists. Pharmacists described legal and ethical dilemmas relating to emergency supplies in interviews by Hibbert *et al.* in 2000: for instance, there was an example of a patient who was having an asthma attack in which a community pharmacist discussed ‘side-stepping’ the law to make an emergency supply in order to avoid causing potential harm, demonstrating the conflict between duty of care and adhering to legal aspects. This has been confirmed in more recent studies. Several pharmacists interviewed by Cooper *et al.* in 2007 identified further examples related to emergency supplies which involved them balancing patient welfare with legal or procedural concerns; specifically requests made by a representative of the patient - rather than the patient themselves - or where pharmacists suspected that a patient expected a supply to be made. Focus group discussions, used by Deans in 2010 to develop an understanding of pharmacists’ attitudes towards ethics in their practice, also highlighted emergency supplies as causing dilemmas. An instance of ‘breaking the rules’ to supply medication without prescription to a patient who had run out of her medicine was cited, with recognition of the importance of professional autonomy/judgement in these ‘emergency’ cases.

Active threads on pharmacy-related web networks (e.g. Locum Voice) suggest that this remains a challenge. Indeed, the *Chemist and Druggist* has recently included three scenarios relating to emergency supply in its ‘Ethical Dilemmas’ feature. One such dilemma presented for comment concerned an emergency supply request for a salbutamol inhaler made by a regular customer on a Sunday morning; this was a second emergency request for the same item, leading the pharmacist to suspect the patient may be using the pharmacy to get his supply instead of obtaining a prescription.

Despite the fact that the majority of emergency supplies relate to medicines prescribed under the NHS, this service has - since its inception via the Medicines Act - fallen outside the NHS
suite of services offered by community pharmacy. At the initiation of this research, no national NHS service was in place in England to deal with emergency supply requests, although some local services existed. In Cornwall and the Isles of Scilly, a funded emergency supply service was established for NHS patients via a Patient Group Direction (PGD)\textsuperscript{9} in 2008. Local commissioners have reported positive experiences of this service, in that GPs are routinely informed about supplies made and patients do not have to pay for medicines where they are entitled to free NHS prescriptions, ensuring equity of access\textsuperscript{10}.

1.4 **Practitioner involvement in research**

Building research capacity in community pharmacy and advancing the research agenda continues to be an important development area within the profession both nationally and internationally. In 2013, the Royal Pharmaceutical Society (RPS)/Pharmacy Research UK (PRUK) reported on work to develop systems and tools to enhance the relationship between project investigators, the RPS/PRUK research team and practising community pharmacists (CPs)\textsuperscript{11}. This ‘Research Ready’ initiative has utilised similar accreditation from general practice, adapting this for the needs of community pharmacists through consultation with frontline CP pharmacist volunteers and other stakeholders. Translation of interest in, and sign-up to, participation in such research initiatives and training into active engagement of community pharmacists as research partners/co-researchers remains a key objective for improvement.

This project was developed by Workgroup 2 of the NW Primary Care Pharmacy Research Group, which was facilitated by the former NW Primary Care Research Network (PCRN). This workgroup is actively involved in building research capacity among community pharmacists in the Region. The steering group includes academic members from the Region’s three Schools of Pharmacy (Liverpool John Moores University, the University of Manchester and the University of Central Lancashire), as well as practising community pharmacists, and a primary care trust pharmacist.

1.5 **Structure of the Report**

Chapter 2 provides an overview of the research design, with the methods used in this multi-phase study described in detail in the following chapter (Chapter 3). The subsequent chapters of this report explore the emergent themes from the triangulation of the data from each of the study phases. Chapter 4 outlines the frequency and characteristics of emergency supply requests being made at community pharmacies, drawn largely from quantitative data from the clinical audit. Chapters 5 to 8 compare and contrast the emergent themes from the remaining qualitative phases of the study:

- Pharmacist actions and challenging issues (Chapter 5);
- Patient experience and impact on medicines adherence (Chapter 6);
- Position of emergency supply in health and social care pathways (Chapter 7);
- Recommendations regarding current emergency supply system (Chapter 8).

Chapter 9 considers the implications of this research for pharmacy practice and policy regarding emergency supply of prescription-only medicines at community pharmacies in England, as discussed at the wider stakeholder workshop. Finally, key recommendations are made as to how the emergency supply system might operate most effectively as an integral and coordinated component of health and social care pathways, thus ensuring that patients benefit from being able to maintain adherence to their prescribed medicines regime.
2 RESEARCH DESIGN

2.1 OVERVIEW OF RESEARCH DESIGN
The overarching purpose of this study was to explore and inform best practice regarding the delivery of an emergency supply service of prescription-only medicines in community pharmacies. The study was also designed to explore the support required by pharmacists in providing this service, and to identify how it may be integrated into established health and social care provision to help maximise adherence. The study had primary and secondary aims.

Primary aim - To explore the operation of the emergency supply service undertaken by community pharmacists (CPs).

Objectives associated with the primary aim were:
- To describe and analyse emergency supply activity, in terms of;
  - The frequency and characteristics of requests;
  - The views and attitudes of service providers, including the incidence and resolution of dilemmas;
  - The views of service users and other stakeholders, including general practitioners.
- To explore how this convenient, patient-focused service does, and could, form an integral and coordinated component of health and social care pathways.

Secondary aim - To engage community pharmacists and enhance their involvement in, and experience of, pharmacy practice research.

The objectives associated with the secondary aim were:
- To become familiar with the relevant aspects of research methodology;
- To become adept at data collection techniques relevant to each study phase.

This study used a mixed methods approach, with a significant amount of data collection being undertaken by practising community pharmacists who were trained in research techniques as part of the study. More detail about this training is given in Chapter 3. A series of workshops were developed by the research team which are further outlined in the relevant sections below, as well as support from the Research Assistant (RA). Throughout this document these pharmacists are referred to as Pharmacist Researchers (PRs).

The evaluation had four component phases:
1. Prospective audit of emergency supply requests for prescribed medicines;
2. Interviews with community pharmacist service providers;
3. Follow-up interviews with service users;
4. Interactive feedback sessions with local medical practice teams.

Triangulation of the data from all phases of the study provides an understanding of the service from multiple perspectives, enhancing the validity and reliability of the study outcomes.

At the end of the study, a pharmacy stakeholder workshop was convened where comments were invited regarding the preliminary findings to help the research team formulate recommendations.

2.2 DATA SOURCES
The evaluation drew data from a number of sources:
1. Clinical audit data of emergency supplies in participating pharmacies across Cheshire and Merseyside, over two four-week collection periods;
2. Peer telephone interviews with community pharmacists about their views and experiences of dealing with requests for emergency supplies and loans;
3. Follow-up interviews conducted by the Research Assistant (RA) with service users who received emergency supplies or loans of prescription-only medicines from a pharmacy;
4. Qualitative interactive feedback sessions with medical practice teams.

2.3 RESEARCH ETHICS AND GOVERNANCE APPROVAL
This research project received a favourable opinion in October 2012 via the proportionate review route from the West Midlands – The Black Country NRES (National Research Ethics Service) Committee. Subsequently, approval for fieldwork was granted by the research governance departments for NHS Liverpool, NHS Knowsley, NHS Wirral, NHS Western Cheshire, NHS Sefton, and NHS Halton & St Helens.

2.4 ADOPTION TO NIHR CLINICAL RESEARCH NETWORK PORTFOLIO
The study was adopted to the National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio, a national database of high-quality clinical research studies, and was therefore eligible for support from the NIHR Clinical Research Network in England.
3 METHODS

This chapter describes the methods used in this multi-phase study. Sampling and recruitment strategies for each phase establish how participants were selected and approached to take part. Accounts of data collection and data analysis phases are also presented, including the involvement of community pharmacists throughout all stages of the research as pharmacist researchers (PR).

3.1 PHASE 1: PROSPECTIVE AUDIT OF EMERGENCY SUPPLY OF PRESCRIBED MEDICINES

This phase involved community pharmacists documenting the emergency supply of prescribed medicines to patients, in order to quantify the number and types of emergency supply being undertaken.

3.1.1 Aims and objectives

This phase addressed a primary objective: to describe and analyse emergency supply activity regarding the frequency and characteristics of requests.

3.1.2 Recruitment of pharmacies

Pharmacies were purposively sampled from a pool of interested pharmacies following a mail shot in North West England. Recruitment was undertaken by the RA in conjunction with a gatekeeper in the NW Primary Care Research Network. Local networks known by the research team were also used for recruitment. For confidentiality reasons, names and addresses of the initial mailshot sample were not supplied by the PCRN to the research team so it is not possible to calculate a response rate. The participating pharmacies were selected to provide diversity in ownership type, location and opening hours. Diversity in pharmacist experience, gender and length of time since registration was also sought.

3.1.3 Data collection tool

Over one week in March 2012, six community pharmacists piloted a data collection form developed by members of the research team. This tool was refined post-pilot and incorporated: the date of the request; patient’s age; residential status; medical practice; medicine/s requested; dose prescribed; reason for request, and action taken. These data largely comprise the information required when making an emergency supply of prescription-only medicines under the Medicines Act. No patient-identifiable information was required at any time.

3.1.4 Procedure

A prospective audit was undertaken at the participating pharmacies over two four-week periods, where details of emergency supplies of medicines were recorded using the data collection tool. Data collection for the first four-week period was staggered between sites and took place between October 2012 and February 2013. The second data collection period took place at all pharmacies from the week beginning Monday 11th March 2013, and included the Easter Bank Holiday period to permit assessment of the impact that this extended holiday period had on patient requests for emergency supplies.

In addition to the audit data, CPs logged any related issues or dilemmas that arose at the time of the supply. The RA kept in close contact with CPs through audit periods, via personal visits and telephone reminders, to maximise data quality.
3.1.5 Analysis
Data were entered into SPSS v21 statistical software; at this point, the medicines requested were coded to BNF therapeutic area categories by the RA. Descriptive statistical analysis (frequencies) was undertaken to identify trends in emergency supply characteristics, with comparative analyses (chi-square testing) exploring any associations between the frequency of requests with pharmacy variables of ownership or location. Thematic analysis of the related issues and dilemma data was also undertaken.

3.2 Phase 2: Peer Interviews with Community Pharmacist Service Providers
This phase comprised interviews with community pharmacists (CPs) undertaken by pharmacist researchers (PRs). The interview content explored the dilemmas and concerns pharmacists had faced in providing emergency supplies of medicines, including if and how these were resolved.

3.2.1 Aims and Objectives
This phase addressed the following primary and secondary objectives:

Primary Objectives:
- To describe and evaluate emergency supply activity regarding:
  - The frequency and characteristics of requests;
  - The views and attitudes of service providers, including the incidence and resolution of dilemmas.

Secondary Objectives:
- To familiarise pharmacist researchers with aspects of research methodology including:
  - Processes of obtaining informed consent;
  - Necessity of protecting the confidentiality of the data.
- To develop pharmacist researcher telephone interview skills, in particular:
  - Following the topic guide and using follow-up prompts effectively;
  - How to record the interview.

3.2.2 Procedure
Following training on telephone interview techniques by the research team (see section 3.5.1), five Pharmacist Researchers (PRs) completed recorded semi-structured peer telephone interviews with twenty-six CP peers working at pharmacies across North West England. There were two recruitment strategies: pharmacists who had been involved in phase 1 of the study were approached, and other pharmacists were recruited by the PRs through snowball sampling via their own professional networks. Questions in the interview schedule focused on interviewees’ experiences and views of providing an emergency supply service, allowing them to reflect on the dilemmas and challenges encountered in practice. This peer-to-peer interviewing approach was employed to enable effective probing of responses in order to elicit details of difficult situations through professional insight into the dilemmas described. Interviews were recorded on digital audio.

3.2.3 Analysis
Recordings were transcribed verbatim. Transcripts were thematically analysed in NVivo 10 (QSR International); a ‘directed content analysis’ approach was used. Primary attention was directed at identifying broad categories of data, followed by specific line-by-line categorisation. The study objectives provided a clear source of categories with which to organise participants’ responses, whilst allowing other themes to emerge. Analysis examined commonalities between participants as well as contrasting perceptions of the emergency supply process. Members of
the project team, and the PRs who conducted the interviews, further reviewed emergent themes to ensure robustness regarding coding and reconstruction.

3.3 Phase 3: Follow-up Interviews with Service Users
This phase comprised interviews with users of the emergency supply service at participating pharmacies about their experience and perspectives of the service.

3.3.1 Aims and objectives
This phase addressed the following primary and secondary objectives:

Primary objective:
- To describe and analyse emergency supply activity regarding the views of service users and other stakeholders, including general practitioners;

Secondary objective:
- To familiarise community pharmacists with research methodology concerning the recruitment of patients to pharmacy-based studies, including reflection upon avoiding subtle coercion by virtue of their power in providing the service.

3.3.2 Procedure
During a six-week period in April/May 2013, patients who requested an emergency supply or loan of a prescription-only medicine at participating pharmacies from Phase 1 were invited to participate in a follow-up telephone interview around two weeks after using the service. The focus of the semi-structured interviews, conducted by the RA, was patients’ views and experiences of the service, their prior knowledge of the service, their perceived impact on the continuity of their medicines’ supply, and their perceived impact on adherence.

3.3.3 Analysis
Interview recordings were transcribed and these were thematically analysed in NVivo 10. Themes were developed iteratively and with knowledge of the themes arising from Phase 2 and explored consensus between participants’ views and experiences as well as contrasting perceptions. Again, a ‘directed content analysis’ approach was employed12.

3.4 Phase 4: Interactive Feedback Sessions with Local Medical Practice Teams
This phase involved pharmacist researchers presenting a selection of interim study findings to their local medical practice team via interactive feedback sessions, which were recorded for analysis. The purpose of these sessions was to obtain the views and experiences of the local medical practice team regarding the emergency supply service and its impact on, and relevance to, their workflow and patient wellbeing.

3.4.1 Aims and objectives
This phase addressed the following primary and secondary study objectives:

Primary objective:
- To describe and analyse emergency supply activity regarding the views of stakeholders, including general practitioners;

Secondary objectives:
- To familiarise pharmacist researchers with presenting findings to a mixed audience in an accessible manner, and not over-stating results;
- To develop pharmacist researcher skills at taking feedback in order to inform recommendations of the study.
3.4.2 Procedure

The RA, in conjunction with the research team, developed a discussion guide from the findings from phases 1-3. This guide was used to give an overview of the study and the salient findings relevant to medical practice staff and included a set of prompts for the pharmacist researcher as facilitator. Pharmacist researchers contacted their local medical practice(s) by letter/email to invite them to participate in this phase. This was followed up with a telephone call to the practice manager to arrange a mutually convenient time for the meeting. Meeting attendees signed a consent form permitting the group discussion to be recorded.

Pharmacist researchers began the session by emphasising their role as a researcher rather than a community pharmacist and explaining that the findings were from multiple study sites across Cheshire and Merseyside. Therefore, while some of the data presented were local to their medical practice, many other patients, pharmacies and surgeries were also represented. The RA took field notes, provided support to the pharmacist researcher, and handed out supporting materials during the discussion. Materials included:

- An overview sheet for the session;
- Charts depicting Phase 1 results, and
- Quotes and case studies around patient adherence from Phase 3.

The discussion guide provided consistency of session format and content between multiple pharmacist researchers.

3.4.3 Analysis

Session recordings were transcribed, with the practice staff and the pharmacist researchers identified only by a unique reference code. The transcripts were thematically analysed by the RA using NVivo 10 and emergent themes identified. Themes from this phase were compared to those from previous study phases to highlight commonalities and divergence.

3.5 Secondary aim: Community Pharmacists’ involvement in the research process

The secondary aim of this study was to enhance community pharmacists’ (CPs’) involvement in pharmacy practice research and the study successfully engaged a cohort of CPs, training and supporting them as pharmacist researchers to carry out data collection across each phase. Building research capacity in community pharmacy and advancing the research agenda is an important development area within the profession both nationally\(^\text{11,13}\) and internationally\(^\text{14-17}\). Associated objectives focussed on broadening pharmacist researchers’ knowledge of research methodology, including: processes of obtaining informed consent; protection of data confidentiality; recruitment of patients; and presenting findings in an accessible manner. CPs had opportunities to become more experienced with various data collection techniques relevant to each phase of the study: consistent and complete recording of robust quantitative data; semi-structured telephone interviewing techniques; and obtaining feedback in order to inform recommendations of the study.

Insights from the PR experience was obtained and reviewed at each phase using feedback forms and one-on-one reflexive sessions. The attendees at formal training sessions were invited to complete an evaluation form for each session, and to provide free text comments. These were not, however, systematically analysed as data in their own right. Rather, they confirmed whether any participants had unmet learning needs that required addressing before they could begin.
Support from the research team through each phase was as follows:

- **Phase 1 Clinical audit**: The research assistant (RA) met with all PRs to set-up the project and kept in close contact through both data collection periods, via telephone and visits to the pharmacies, to provide encouragement, answer questions and maximise data quality.

- **Phase 2 Peer interviews with CPs**: A one-day training workshop allowed a subgroup of PRs to develop their interviewing skills. Then, early in the data collection for this phase, the RA debriefed PRs via telephone and reviewed initial transcripts to explore any challenges; possible enhancements to interview technique were suggested where appropriate.

- **Phase 3 Recruitment for interviews with service users**: The RA visited each PR to overview the recruitment procedure and answered any questions, providing any support needed by telephone.

- **Phase 4 Interactive feedback sessions with medical practice teams**: A half-day training workshop prepared PRs for presenting interim findings to medical practices and to obtain their views. The RA accompanied the PR on each visit.

### 3.5.1 Training workshops

These were conducted by Professor Morecroft, Dr Mackridge and Ms Stokes. Professor Morecroft and Dr Mackridge have extensive experience of teaching research methods to postgraduate level, and thus have developed resources for their own teaching.

**Phase 2 – Peer telephone interviewing**

Five community pharmacists attended a one-day training mentoring workshop about telephone interviews. The research team at LJMU had extensive experience of using this method. This was structured to prepare them for peer interviews about provision of the emergency supply service. Training included: discussion around differences between research interviews and healthcare consultations; instruction around the process of obtaining consent; and practical exercises to develop interviewing skills, become acquainted with recording equipment, and role play interviews. Training materials for this and following workshops were developed by the research team.

**Phase 4 – Practice feedback sessions**

Community pharmacists were recruited to conduct interactive feedback sessions with medical practice teams and volunteers attended a half-day training workshop. This included: role-play in presenting salient findings of the study; facilitation skills; and developing a discussion guide. Two workshops were run for this phase, with a total of ten attendees attending both sessions. The discussion guide for the interactive discussions was developed across these two sessions by the PRs and the research team.
3.6 **Respondents in each phase of the project**

3.6.1 **Pharmacist Researcher involvement in the study phases**

Twenty-seven CPs working at twenty-two pharmacies in North West England with diverse locations, settings, opening hours and ownership type participated as pharmacist researchers. The PRs represented all stages of career progression, including two pre-registration pharmacists. The majority of PRs undertook data collection, participated as interviewees and/or recruited patients for interview. Eleven had a more substantial role, serving as interviewers and/or conducting feedback sessions at medical practices.

3.6.2 **Participating pharmacies**

Twenty-two pharmacies were purposively sampled from a pool of interested pharmacies following a mail shot in North West England. Recruitment was undertaken by RA in conjunction with the NW Primary Care Research Network. For confidentiality reasons, names and addresses of the initial mailshot sample were not supplied by the PCRN to the research team so it is not possible to calculate a response rate. The participating pharmacies were selected to give diversity in ownership type, location and opening hours. Diversity in pharmacist experience, gender and length of time since registration was also seen. Sites were most frequently located in small parades of neighbourhood shops (9/22) or on the same/adjacent site to health centres (8/22) (Table 1). Fourteen pharmacies (63.6%) were closed at weekends, and three (13.6%) pharmacies opened for 100 hours over seven days.

Table 1: Characteristics of participating pharmacies

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number of Pharmacies</th>
<th>% of Total Pharmacies (n=22)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Pharmacy Ownership</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single independent pharmacy</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>Small group of 2 to 5 pharmacies</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Local group of more than 5 pharmacies</td>
<td>11</td>
<td>50.0</td>
</tr>
<tr>
<td>National group of over 100 pharmacies</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td><strong>Location of Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local parade of shops</td>
<td>9</td>
<td>40.5</td>
</tr>
<tr>
<td>Health Centre</td>
<td>8</td>
<td>36.4</td>
</tr>
<tr>
<td>Town centre / high street</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td><strong>Standard Days Open</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monday to Friday</td>
<td>14</td>
<td>63.6</td>
</tr>
<tr>
<td>Monday to Saturday</td>
<td>5</td>
<td>22.8</td>
</tr>
<tr>
<td>Monday to Sunday</td>
<td>3</td>
<td>13.6</td>
</tr>
</tbody>
</table>

3.6.3 **Participating Pharmacists in Phase 2**

Following training on telephone interview techniques by the research team (see section 3.5.1), five Pharmacist Researchers (PRs) completed recorded semi-structured peer telephone interviews with twenty-six CPs working at pharmacies across North West England. Interviewees
were based in pharmacies with diverse locations, settings, opening hours and ownership type i.e. independent, small/medium chain and nationwide multiple. Nineteen of the pharmacists interviewed had been involved in phase 1 of the study with the remainder being directly recruited by the PRs via professional networks.

3.6.4 Participating Patients in Phase 3
From the 191 recruitment packs distributed by 22 pharmacies, thirty responses were received from patients at nine pharmacies (16% response rate). Semi-structured interviews were completed with twenty-five respondents (2 declined to take part when contacted and 3 could not be contacted). Interviews lasted between three and nine minutes (mean five minutes).

3.6.5 Participating medical practice staff in Phase 4
Fourteen medical practice teams were invited to take part in this phase, of which six agreed. Reasons given for non-participation included: introduction of Electronic Prescription Service (EPS) occupying staff time; and a policy of refusing meetings with external parties. In some cases, practice teams appeared comfortable with meeting to hear the study findings, but were reticent about their opinions being captured, indicating that this approach may be viable as a dissemination-only strategy. The length of time made available for the meeting varied between practices with some adding the discussion to their monthly staff meeting agenda and others arranging a separate, full length discussion. Duration of the six sessions ranged from 18 to 62 minutes (mean 36 minutes).

Attendees from a range of medical practice staff categories were represented at the six interactive feedback sessions, which took place in October/November 2013. They included 5 practice managers; 25 general practitioners (GPs); 12 practice nurses; 10 reception and administration staff; 2 Health Care Assistants (HCAs); 2 District Nurses; 1 Phlebotomist; and 1 Health Visitor. Attendance ranged from 2 (the lead GP partner and Practice Manager) at one surgery to 17 team members at another.
4 FREQUENCY AND CHARACTERISTICS OF REQUESTS

This chapter characterises the emergency supply requests being made at community pharmacies, drawing predominantly on clinical audit data from Phase 1, with additional context from the interviews with CPs in Phase 2, with patients in Phase 3, and practice staff in Phase 4. Results presented include: request frequency and distribution across pharmacies and days of the week; patient demographics; medicines involved; and reasons for requests. This chapter concludes by exploring how the present study findings compare to the work from 1998 undertaken by O’Neill et al. as well as correlations with primary care prescribing data.

4.1 FREQUENCY AND DISTRIBUTION

4.1.1 Number of emergency supply requests

Emergency supply requests were made for a total of 526 medicine items by 450 patients at 22 community pharmacies over the two four-week audit collection periods (Table 2). Most requests were for single items (405/450 occasions; 90%) with three or more items requested on 17 occasions (4%) (Table 3).

Table 2: Number of items requested and associated patients for each audit period

<table>
<thead>
<tr>
<th>Audit period</th>
<th>Patients</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>247</td>
<td>300</td>
</tr>
<tr>
<td>Two</td>
<td>203</td>
<td>226</td>
</tr>
<tr>
<td>Total</td>
<td>450</td>
<td>526</td>
</tr>
</tbody>
</table>

Table 3: Number of items requested per patient per visit

<table>
<thead>
<tr>
<th>Requests</th>
<th>Phase 1</th>
<th>Phase 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>219</td>
<td>186</td>
<td>405</td>
</tr>
<tr>
<td>Two</td>
<td>16</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>Three or more</td>
<td>12</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Total</td>
<td>247</td>
<td>203</td>
<td>450</td>
</tr>
</tbody>
</table>

At the feedback sessions in Phase 4, one GP commented that the low number of emergency supplies made, in relation to the total number of items supplied on prescription, was a factor for consideration when looking at resourcing a service:

‘Ninety nine per cent of patients are taking charge or responsibility for their prescriptions we are going after that one per cent. Are we going to throw so many resources at this one per cent…’ (MP1, GP)

4.1.2 Distribution across pharmacies

Location type was not a clear indicator for volume of emergency supplies (Figure 1), although staff in health centre pharmacies - where small numbers of requests were recorded - gave some suggested reasons for their low figures. These were: shared opening times between pharmacy and surgery; and good prescription collection service setup allowing an offer for Monday morning collection to patients who request emergency supplies over the weekend. Pharmacies with a high volume of requests (>30 items) were seen across the location categories.
Community pharmacists interviewed in Phase 2 described the influence of pharmacy location on the frequency of emergency supply requests; those with hospitals nearby were reported to have a higher number in comparison to those sited close to medical practices. Pharmacists working near to and/or with a good relationship with their local medical practice(s) also reported directing patients to the surgery during opening hours in response to requests, leading to lower figures, but in some cases, the good relationship/location allowed confirmation that a prescription would be provided if a loan was made. One CP, working in a health centre pharmacy, said that emergency supplies had been reduced because of an agreement that pharmacy staff could access scripts awaiting collection from surgery, even out-of-hours. Opening hours were also cited as important by pharmacist interviewees in Phase 2 with late night opening more likely to see higher requests.

There was also no clear association between request frequency and ownership type (Figure 2). However, some pharmacy companies were reported to have policies regarding emergency supplies and loans, which limit the circumstances where these are permitted (e.g. CP6 & CP12).
4.1.3 Days of the week distribution
A higher proportion of requests were recorded either side of the weekend (Mondays & Fridays), with around a quarter (123/526; 23%) being made on a Friday and a fifth (105/526; 20%) on a Monday (Figure 3). The 65 emergency supply requests made during the weekends originate from just 8 of the 22 pharmacies, with 3 open both days; 2 open all day Saturday; and 3 Saturday morning only. As such, the comparatively low number actually shows an increased rate per pharmacy in comparison to any of the weekdays.

Data from the Easter Bank Holiday period showed peaks in requests on the Thursday before the weekend (28 requests; 5%) and the following Tuesday (10 requests; 2%), mirroring the Friday/Monday peaks seen in other periods. Pharmacies open over the Bank Holiday weekend (Good Friday–Easter Monday) dealt with a further 11 requests (2%). The accompanying notes from supplies made in this period described the impact of the prolonged Bank Holiday shutdown:

'Request for anti-hypertensive at 6pm on Thursday before Bank Holiday. Surgery shut so did five days’ supply as loan to last Bank Holiday (although against official
company policy regarding not making loans, circumstances taken into account).’ (CP6)

Almost two-thirds (16/26) of community pharmacists interviewed in Phase 2 reported normally receiving requests on a daily basis, with four of these describing multiple requests per day, although request rates were often variable:

‘Probably four or five times a week […] it’s something it comes in waves: some weeks you have none and then you can have five on one day because the doctors aren't playing ball and the scripts haven't been done.’ (P1, village pharmacy serving one main medical practice)

‘Probably once a day. Probably increases through to the end of the week. We’re not open at the weekend so we have kind of a bit of a peak on Friday [with people] knowing we’re shut.’ (P3, pharmacy in residential area, closed weekends)

At the feedback sessions in Phase 4, some participants, including GPs and practice management, were surprised to find that requests were received across the week as they regarded emergency supplies as something that should only happen outside of medical practice opening times.

‘I think it’s got a role to play when GPs are closed hasn’t it? Then, definitely. I don’t know during working hours. […] Yeah. I think it should only be accessible at the weekend. Cos [the pharmacy is] shut before us anyway so they shouldn’t be asking for a loan so I think [pharmacies] should only do it on a Saturday.’ (MP1, GP)

4.2 Patient characteristics

4.2.1 Patient age distribution

Emergency supply requests in phase 1 were for patients aged from 3 months to 92 years old. Requests were made by parents/carers on behalf of thirteen (3%) children under the age of 12 (Figure 4). Although there was a trend towards more requests from older patients, a substantial number were made by young and middle-aged people.

**Figure 4: Distribution of emergency supply requests: patient age category (n=449; missing=1)**

Over two-thirds (18/26) of community pharmacist interviewees in Phase 2 highlighted older people as the most frequent client group requesting emergency supplies. While, some respondents (6/26) felt that this group had more difficulties in ordering their repeat
prescriptions on time than younger people, others (3/26) felt that this was simply related to the more frequent use of medicines in this group:

‘The elderly are not particularly er worse or better than anyone else but just because we do more scripts, then we have more of the elderly requesting it.’ (P7, single independent 100 hour pharmacy within same building as health centre)

Young and middle age groups were thought by three interviewees to request emergency supplies due to their busy schedules, particularly when working or caring for others:

‘It’s usually the workers... who have got busy lives or they've got kids to look after and they just, they just forget or they haven't got time to order it or they forget to order it and then they go to the cupboard one morning and erm there’s no tablets there.’ (P25, pharmacy in village setting)

In the feedback sessions in Phase 4, patient age distribution for emergency supplies was felt to mirror that for all prescriptions and demographics were therefore as would be expected.

4.2.2 Residential status

Almost all requests (96%) were from people who lived in their own home. However, pharmacies handled a small number of requests for people living in sheltered accommodation (10; 2%); residential care (6; 1%) and nursing homes (2; 0.5%). In the Phase 2 interviews, one pharmacist cited nursing homes as a frequent source of requests for their pharmacy, suggesting some possible medicines stewardship issues.

4.3 Medicines Characteristics

Most requests in Phase 1 were for medicines used in long-term conditions and the therapeutic areas broadly mirror the range of medicines prescribed. The main categories of medicines were cardiovascular (32%, 169/526), respiratory (13%, 70/526), endocrine (12%, 63/526) and gastro-intestinal systems (11%, 56/526) (Figure 5).
In some cases the medicines involved posed particular risk of adverse clinical implications if a supply was not provided. These included patients with a recent myocardial infarction or renal transplant, as well as oncology therapy. The wide range of medicines involved was confirmed by interviewees in Phase 2, with many stating this, although most also said that the majority of requests were for medicines for long-term conditions.

Among the 25 service users interviewed in Phase 3, anti-hypertensive (5) and analgesics (4) were most commonly requested medicines. Respiratory (3), gastro-intestinal (3), mental health (3) and thyroid (3) medications were also reported. Four individuals did not disclose the medicine involved.

4.4 REASONS FOR REQUESTS

4.4.1 Issues in ordering repeat prescriptions

Patient difficulties in renewing repeat medication were a major reason for requests recorded in Phase 1, with patients citing ‘forgot to order’ in 364 cases (n=526; 69%), with delays at the medical practice accounting for a further 16 (3%) requests. Patient interviewees in Phase 3 also reported repeat medication ordering as a cause for their emergency supply request, particularly at the end of a week where a supply was needed to cover the weekend. Some admitted this was often an oversight on their part, but others mentioned life circumstances contributing to their problems with the ordering systems:
‘What it is I’ve got erm a severely disabled husband who needs twenty four hour care and I just completely forgot about my own prescription erm I was convinced I still had a week left and I didn’t have another strip of tablets’ (CP1-Pt3, female, carer to disabled husband)

‘Because I work full time and I just have a very busy job, I’m a teacher and I just don’t I just forget basically.’ (CP3-Pt1, female, working full-time as a teacher)

Medical practice staff in Phase 4 feedback sessions recognised the issues with ordering of repeat medicines and reported patients making urgent requests for prescriptions to be issued on the same day. Staff reported feeling pressured to issue prescriptions at short notice on these occasions and this was a frustration for GPs, practice management and reception staff as handling such requests is time-consuming and interrupted other work at the medical practice:

‘I know from experience on a Friday everybody needs that medication because they can’t wait the two days till Monday so we do, you know, we know what it’s like but it’s hard for us to know what is urgent and, you know, what can wait till Monday for.’ (MP3, Receptionist)

‘The number of times we bend over backwards for patients. You tell them they can get it next door [at the pharmacy]. ‘Oh, I’m not paying for it’. So you’re supposed to leap to interrupt your surgery and do it there and then. But obviously if they are a ninety year old with dementia, you’d do anything for them. So I think it does depend a bit on the patient and how often they’re doing it.’ (MP3, GP)

A lack of patient understanding of the requirement for 48 hours’ notice was highlighted by two of the GPs and rushing the process, including checking patient records for test results, might contribute to prescribing errors. It was also felt that this was even more important with increasing numbers of medications now used in primary care:

‘I think the number of steps involved it sounds easy from the outside. The patient gives in the script and he expects it to happen like that but there is so many steps involved in it coming to the doctor and going to the pharmacist. [...] They come at three o’clock and they want a script by five o’clock before you close. So I need to drop everything what I’m doing to do the script so it puts a lot of pressure on the service. You just need two or three people to unbalance the whole thing.’ (MP1, GP)

However, patient interviews from Phase 3 revealed that most understood the need to submit repeat prescription requests with 48 hours’ notice. However, some described experiences where prescriptions had taken longer than this and an emergency supply had been necessary. In one case this was due to staff shortages, while another related to changes to electronic prescribing systems causing a backlog. Being unable to get to the surgery to collect prescriptions during GP opening hours and ordering errors at the pharmacy were also reported as causes of emergency supplies.

Other reasons around repeat prescriptions identified through the Phase 1 audit were: pharmacy errors in ordering (8; 2%); ordered items missed off prescriptions (14; 3%); and insufficient quantities prescribed (24; 5%). For example, a patient receiving levothyroxine had sufficient of one tablet strength required to make up their dose, but not the other. In a small number of audit records (7/526; 1%), requests were made owing to increases in the prescribed dose without corresponding increases in prescribed quantities.

Prescribed quantities of medicines being ‘out of sync’, sometimes with different repeat dates, led to supplies being requested in 30 (n=526; 6%) cases during Phase 1. This was also the cause for five (n=25; 20%) of the patients interviewed in Phase 3:
‘They’d sort of come in my pill box and it looked as though I’d got plenty of tablets and then when I got down to the last day I noticed oh I haven’t got that particular tablet you know.’ (CP1-Pt1, female, over 60)

4.4.2 Other reasons

Patients had also lost or misplaced medication in 26 (5%) of the requests in the Phase 1 audit and this was mirrored in the patient interviews from Phase 3. Issues included forgetting to bring medicines on holiday as well as having lost the medicines.

Two patients interviewed in Phase 3 reported that insufficient quantities of acute medicines had been prescribed for them to manage their symptoms. This included analgesia for severe migraines and nebulisers for a patient receiving palliative care.

4.5 Summary and Discussion

Results from Phases 1-4 suggest that community pharmacists are ensuring continuity of treatment by supplying medicines to patients without prescription on an occasional, but regular basis, with 526 emergency supply requests concerning 450 patients in 22 pharmacies over eight weeks. This is true irrespective of the location of the pharmacy or the ownership type of the pharmacy and is particularly prevalent around times where other health services are not available, such as around weekends and Bank Holidays. Many requests are from elderly patients and individuals with long-term conditions, but all age groups are represented and a wide range of medications involved. Extrapolation of these data across England would suggest that over 1.5 million items are supplied to over 1.35 million patients each year in England’s 11,000+ community pharmacies. In the absence of an emergency supply service, these patients would otherwise be forced to access out-of-hours and other urgent care or face not taking their medication, further adding to pressure on already stretched services.

The frequency and characteristics of emergency supply requests in this study are broadly similar to those found in 1998 study by O’Neill et al.3, although this earlier study considered emergency supplies and loans separately. Respiratory and cardiovascular medications continue to be the therapeutic categories most frequently requested and elderly patients remain the client group most likely to request emergency supplies. Comparisons with Health and Social Care Information Centre (HSCIC) data on prescriptions dispensed in the community18 show that cardiovascular, endocrine and gastro-intestinal medicines were requested in proportions that broadly reflect their prescribed usages. However, medicines for respiratory conditions were over-represented among the requests in this study, with 13% of requests being from this category, when they only account for 6% of prescribed items nationwide.

Whilst the systems in place for managing repeat medication work well for the majority of patients, there are clearly issues faced by an important minority, arising from multiple different circumstances, such as opening hours, forgetfulness, errors and competing life pressures. Community pharmacies are providing an important and under-recognised service for this group, which ensures continued treatment and reduces overall burden to the wider NHS, particularly out-of-hours and emergency care services. In the case of loans in anticipation of a future NHS prescription, the additional work undertaken by the pharmacists is not remunerated, either by the patient or the NHS.
4.6 Key findings

4(a): As many as 1.35 million emergency supply episodes could be taking place each year across England, involving 1.5 million prescription items. See Sections 4.1.1 and 4.5.

4(b): Repeat prescriptions and their associated ordering systems are a major driver for emergency supply requests. This is predominantly as a result of patients having forgotten to order their medicines, but also arises from errors and patient confusion. However, other reasons also prompt emergency supplies being needed, highlighting that simply improving repeat medicine handling would not remove the usefulness of the service. See Section 4.4.

4(c): Good relationships/communication between pharmacies and general practice helps easier resolution of emergency circumstances and supports provision of emergency supplies in the best interests of patients. See Section 4.1.2.

4(d): Company policies can be important barriers to providing emergency supplies and, in particular, loans. See Section 4.1.2.

4(e): Emergency supply requests are greatest around times when other services are not typically available – for example, around weekends and Bank Holidays. Patients who are working find accessing services particularly difficult, given the overlap of opening and working hours. See Sections 4.1.3 and 4.2.1.

4(f): Staff in medical practices are also asked for urgent prescriptions to resolve issues with repeat prescription orders, generating additional workload for practice staff and GPs and interrupting other tasks. See Section 4.4.1.

4(g): Although all medicines groups feature among the requests, many relate to management of long-term conditions and arise from older patients, which is likely to become increasingly prevalent as numbers of patients with long-term conditions continue to rise. See Sections 4.2.1 and 4.3.
5 PHARMACIST ACTIONS AND CHALLENGING ISSUES

This chapter reports actions taken by community pharmacists in response to patient requests for emergency supply of medicines. Data are from the prospective audit (Phase 1), pharmacist interviews (Phase 2) and service user interviews (Phase 3). Dilemmas and issues encountered and recorded during the audit period were explored in depth alongside data from interviews with community pharmacists, which included reflection regarding multiple instances spanning their careers to date. The similarity and diversity of dilemmas and their management is explored, with the dilemmas being presented in this chapter in the order they were most commonly raised in the data. Medical practice staff reactions to pharmacist dilemmas and resolution approaches from Phase 4 are also provided where appropriate.

5.1 PHARMACIST ACTIONS

5.1.1 Loans and standard emergency supplies

The majority (489/526; 93%) of requests recorded in Phase 1 related to medicines 'loaned' to the patient in anticipation of an NHS prescription. In the few cases (17/526; 3%) where a charge was made, this was often because the patient was on holiday and had forgotten their medicines and it would not have been practical to obtain a prescription. In all of the emergency supply requests made by the 25 service users interviewed (Phase 3), medicines had been supplied as a loan, with a subsequent NHS prescription being requested to cover the medicines cost:

‘It was on a loan because obviously I was picking my full prescription up the next day so it was just to tide me over for that one day.’ (CP2-Pt5, female who experienced delay in repeat prescription being forthcoming due to staff shortage at the GP’s surgery)

When prompted about payment, service users were largely unaware that the service was not a standard aspect of the NHS supply service and, in many cases, described their prescription levy exemption as the reason why they should not pay.

In the Phase 4 feedback sessions, staff considered loans as the more appropriate mechanism (rather than charging the patient), since the majority of requests related to repeat medication from the patient’s regular pharmacy. However, one GP commented that charging patients may act as a deterrent to the patient making a future emergency supply request, suggesting that some individuals may use the loan mechanism in preference to the standard procedure.

5.1.2 Other reported actions

Other actions in addition, or as an alternative, to supply were reasonably infrequent (Phase 1). These included: completion of pharmaceutical intervention documentation; recommending compliance aids; and referrals to the GP for a medication review or additional support. In some circumstances, the item requested was available over-the-counter (OTC) and the medicine was either sold directly to the patient or, where appropriate, supplied through the Care at the Chemist (CATC) minor ailments service (an NHS-funded service for over-the-counter medication).
5.2 CHALLENGING ISSUES

5.2.1 Repeated requests for emergency supplies from individual patients

Nearly two-thirds of community pharmacist (16/26) interviewees (Phase 2) discussed dilemmas relating to repeated requests from individual patients. Pharmacists were frustrated that such patients might be exploiting the system and three pharmacists used the term ‘frequent/repeat offender’ to describe these individuals. There was speculation that knowledge of the emergency supply service, usually through use in a genuine emergency, might lead to complacency about ordering on time. However, pharmacists also recognised that repeated use may be related to personal circumstances beyond the patient’s control:

‘When they’re genuine it’s, it’s fine but when it’s the same people over and over again because they just can’t be bothered (laughs) to organise themselves you get a little bit frustrated but I suppose we shouldn’t really because I mean sometimes these people are ill and it’s that causing them to forget, you know.’ (P1)

Some pharmacists reported using patient medication records (PMRs) to track repeated emergency supply requests with some having a trigger point (e.g. two requests in three months or more than once), where action would be taken to prevent further repeat requests. Such action included: directing the patient back to the GP; offering to handle the repeat prescription for the patient; or providing aides-memoires for ordering. One pharmacist (P17) described monthly meetings with their local medical practice team where such cases are jointly reviewed.

In the Phase 4 feedback sessions, participants also expressed frustration at patient forgetfulness to order repeat prescriptions, particularly in the case of repeated requests for emergency supplies:

‘Just as an individual not a health care practitioner, but somebody who takes long term medication, if the chemist has cocked up, you know, okay [I’d] expect them to lend me some but if I’ve just forgotten to get my prescription, you do without until you get your next one, you know, because I wouldn’t have dreamed of coming demanding ‘I’ve forgotten to order my drugs, give me them.’ It’s almost doing that isn’t it?’ (MP3, practice nurse)

However, empathy for patient circumstances was also evident in these sessions, with some participants commenting that the medical practice was a service provider and that the service should be accessible to its users:

‘We are here to provide a service. I know we do but society now it’s all about, you know, providing a service that is accessible to everybody and you know twenty four seven isn’t it? That’s the way society is moving so I’m not saying it’s right but …’ (MP3, GP)

5.2.2 Concerns regarding the details or appropriateness of supply

In some cases recorded in the Phase 1 audit, pharmacists sought dosage verification from the medical practice, including one scenario where items on the repeat prescription did not permit the prescribed dosage to be taken without cutting tablets (levothyroxine), which was not practical. Pharmacists also recorded circumstances where short-term supplies had been given ahead of a scheduled GP review to avoid a break in treatment.

One quarter (7/26) of pharmacists interviewed in Phase 2 referred to instances where the correct dose was not clear and they were uncertain about making the emergency supply. Such circumstances related to: requests that differed from PMR records; where there was a suggestion that the dose might have changed; and where patients had recently started a new
Pharmacists often sought clarification from the patient’s GP. In one example, the pharmacist reported that, through confirming the details of an emergency supply, they uncovered an issue with the patient’s understanding of their dose:

‘I’ve had a dilemma fairly recently on someone wanting an emergency supply and a dose different from, she was taking something differently from what was recorded on the computer. [...] It was lucky the surgery was open so I could, I could get in touch with the surgery. She was taking, erm sertraline [anti-depressant medication] and she was taking two times 100 milligrams where in fact it had been reduced. She did initially take that but it had been reduced but she kind of got a bit confused…..’. (P3)

Pharmacist interviewees also commented that informing a GP that a supply had been made might provide an opportunity to invite the patient for a medication review where appropriate.

### 5.2.3 Difficulties with prescription issue from medical practices

Around two-fifths of pharmacists interviewed (11/26) indicated that difficulties around prescriptions being issued by the medical practice had prompted dilemmas. These included circumstances encouraging supply - for example, where a prescription appeared to have been delayed, but would arrive soon - and those prompting refusal, where the pharmacist was unsure whether the prescriber had decided not to issue the prescription for a clinical reason:

‘So I think sometimes that can, you know, sway your decision as well if the patient comes in expecting the medication ready [and...] unfortunately, you know, through no fault of our own [it isn’t]. I do think that can be swayed because you do feel, you know, partly responsible for it not being back.’ (P24)

Interviewees often loaned the item requested in such circumstances, particularly in cases where the pharmacy had ordered the prescription and they felt partly to blame. In some cases, pharmacists reported calling the medical practice to verify the details of the medicine(s) request and that the script would be following. However, it was felt that medical practice teams required a greater understanding of the emergency supply service, particularly reception staff, when such calls were made.

### 5.2.4 Manner of request

Dilemmas can arise owing to the manner in which an emergency supply request is made; for example, when someone other than the patient requests a supply on their behalf (e.g. a parent or carer) or the request is made over the telephone. Emergency supply regulations stipulate that the pharmacist must interview the patient themselves. Such circumstances were described in the audit data from Phase 1: one example was a relative making a request for a patient with chronic obstructive pulmonary disease (COPD), who was reported to be extremely breathless; and a parent requesting an extra dose of prednisolone for their nine-month-old baby who had vomited.

In the Phase 2 interviews, five CPs spontaneously commented that they had experienced requests on behalf of the patients and stated that, in such cases, they sought to verify the details of the medicine and the corresponding level of need before making a decision whether to supply or not.

Of the twenty-five service user interviews in Phase 3, six involved requests on behalf of someone else: two for children by their mothers; two for elderly parents for whom the individuals interviewed had caring responsibilities; one for a spouse; and another made by staff at a supported living home for a tenant with learning disabilities.
5.3 DECIDING NOT TO SUPPLY

5.3.1 Request for Controlled Drugs or other medicines associated with abuse

Dilemmas recorded in the Phase 1 audit arose in relation to the specific medicines requested, particularly analgesics and mental health medicines. These dilemmas were somewhat reduced where the request was made by regular patients whose personal circumstances were well known. In one case, circumstances to protect the patient from harm (weekly prescriptions) actually contributed to the need for an emergency supply:

‘A patient suffering from depression had not picked up his weekly prescription from the surgery, something which the pharmacist reported was a recurrent problem as he finds it hard to manage his medication but goes into withdrawal without it, hence an emergency supply of antidepressant medication, Mirtazapine 15mg, was provided.’ (CP3)

Although one Phase 2 interviewee indicated that he treated all requests in the same way, irrespective of the medicines involved, nearly three-quarters (19/26) said they had or would refuse to supply Controlled Drugs (CDs) or other medications where they suspected abuse. Particular medicines and groups with which such concerns were associated were: codeine (including co-codamol); dihydrocodeine (including co-dydramol); tramadol; diazepam; nitrazepam (P7), temazepam (P22) and zopiclone (P24, P26). Antidepressants were also considered to pose particular risks.

In the Phase 4 feedback interviews, participants stated that they would not like pharmacists to provide CDs as emergency supplies, unless in circumstances agreed with the prescriber or for a regular patient:

‘I've had it where in a previous surgery they’d [the pharmacist] issued controlled medication when we were trying to get the patient off controlled medication and so we had to speak to the pharmacy about that. I wasn't happy about that. So I think things like that I wouldn't like them to be giving, you know, morphine based medicines I guess unless it was, you know, I suppose we'd already discussed with the pharmacy, this was a palliative patient or whatever.’ (MP6, GP)

Concern was also expressed regarding the length of supply of antidepressant medications, with GPs being comfortable with a few days’ supply of antidepressant medication being given to a regular patient, particularly where there was a risk of withdrawal symptoms, but they were not comfortable with larger quantities because of the possible risk of an overdose:

‘Particularly with those types of medications [antidepressants] obviously we’re concerned about, you know, the, would you be less likely to give a months’ supply of those would you be more likely to give a week’s supply?’ (MP6, GP)

Overall, participants in medical practice team feedback sessions appeared reassured by the level of caution applied by community pharmacists when considering the types of medications being requested.

5.3.2 Insufficient information available

Strategies were described in the Phase 2 interviews in relation to decision making for emergency supply requests; for example, checking the PMR for details of previous supplies of the item. Where no previous records were available, pharmacists were more likely to refuse an emergency request owing to uncertainty regarding the patient or the details of the medicines needed:
'When it’s somebody who just maybe doesn’t come to this pharmacy, maybe trying to chance their arm a bit coming here looking for stuff. They may maybe have a repeat script but if they don’t normally come, if that’s somebody I don’t know kind of personally then I would probably say refer them to the doctors.’ (P12)

‘I refused emergency supply when I haven’t been convinced that the patient is actually currently on that medication. It might be that at one time they have been, you know, if they bring in an inhaler and it’s got erm a dispense date that’s twelve months [ago]. I’ve had one of those.’ (P25)

However, a lack of PMR history was not an automatic block to making a supply, and pharmacists reported contacting the patient’s medical practice to verify details during surgery opening hours but this is not usually possible in the evenings or at weekends.

‘It’s great during the week if you can contact the surgery - that’s somewhere else that you can clarify that they are on that, if they haven’t got the repeat prescription slip with them or an empty box.’ (P11)

Other sources of confirmation described were: repeat prescription order slips; empty boxes; and hospital discharge letters. However sometimes, despite trying all of these avenues for clarification, the pharmacists reported being unable to confirm important details and would refuse the supply, signposting the patient to alternative services.

5.3.3 Medication review required

Around a fifth (5/26) of pharmacists interviewed in Phase 2 cited occasions when they had refused an emergency supply where the patient was overdue for a medication review with their GP. Pharmacists refused supplies in these instances, since doses may be altered when reviewed by the doctor. However, two of these pharmacists expressed frustration regarding details of review dates as sometimes it can be unclear when a patient is due a review and this can cause delays in the issue of the script beyond the expected 48 hours.

Over half (14/26) of the CPs interviewed referred to identifying a need for medication reviews in response to an emergency supply request. In some cases, a Medicines Use Review (MUR) was undertaken, enabling the pharmacist to discuss issues around ordering repeat prescription and adherence. On other occasions, patients were referred to their GP, practice nurse, or practice pharmacist to align ‘out of sync’ medicines; deal with lost medicines; resolve dosage queries; or provide further information about using the medicines correctly. Overuse of inhalers was a particular problem that four CPs highlighted as prompting a referral to GPs:

‘I had a guy the other day who was way, way overusing his Airomir (salbutamol) inhaler. He was going through like one every two weeks and I was like, “You shouldn’t be using that much” because, you know, I can tell by looking at him he’s not that ill in a sense, you know, he’s in his fifties but, you know, he wasn’t sort of erm collapsing on the floor with breathing difficulties or anything. Erm so I ended up phoning the doctors and they actually got him in to see the nurse and erm he just wasn’t using either of his inhalers properly so they gave him a base set.’ (P1)

GPs in the Phase 4 feedback sessions reported out of sync medication to also be a challenge from their perspective, with the increased risk of issues occurring when changes were made midway through a repeat prescription cycle. Participants in the feedback sessions felt that communication from the community pharmacist to alert the GP of unsynchronised medicines would be helpful.
5.3.4 Supply requested is not an emergency

A number of cases from the audit (Phase 1) included notes stating that the request was not viewed as an emergency, with reasons for refusal or alternative action being given. One of these circumstances related to a patient that had been refused an urgent prescription for their statin therapy by the medical practice and loans were not permitted at the pharmacy due to company policy. The pharmacist felt that the patient was unlikely to come to harm through missing a few days of treatment, and the pharmacist reassured the patient of this fact. However, this type of scenario was discussed in the pharmacist interviews (Phase 2), where it was felt that while refusing to supply was unlikely to result in a clinical impact on the patient, it may provide mixed messages regarding the importance of adherence:

‘If they want say something like a statin and I know personally it’s not going to do them any harm if they don’t have them for a few days but then if they get a bit anxious about not complying with their medication sometimes I think, ‘oh, it’s just easier to give it to them’. So I do find that a bit of a dilemma, you know, making sure people take their medication and then other times it’s saying, “Do you know what it wouldn’t matter if you didn’t take it.” So it kind of gives them mixed messages I think. […] So it’s knowing, you know, when it’s important that they should continue or when it would be appropriate to say, “Oh a few days without these is no problem.”’ (P3)

Pharmacists also made a distinction between requests by someone in genuine need, where the non-provision of a supply may have clinical implications, versus those for the patient’s convenience:

‘GTN spray having an attack: great, I have no trouble with that; a diabetic who’s got who’s come up from Wales and lost his insulin today, you’ve got some records you can find, you know, if they’ve dropped a vial or something, yeah fine you know - something that’s going to save a life. Just because they can’t be bothered ordering the scripts, ordering it or just collecting the scripts, that’s not an emergency really.’ (P6)

Half (13/26) of the pharmacists interviewed felt that requests during medical practice opening hours where there was no perceived emergency could easily be directed to prescribers. This was particularly apparent where the pharmacist worked in or close to a health centre. However, it was noted that referring someone to the surgery may not always allow them to obtain a prescription that day.

Participants in the GP feedback sessions (Phase 4) also felt it was appropriate that pharmacists refuse to supply items which it was possible to buy over the counter or where it was simply for the convenience of the patient. This appeared to be influenced by their own frustration at being asked for emergency scripts for such items, as one GP explained:

‘I think erm what you’re saying about exclusions in terms of drugs you can just buy it seems very sensible to me. […] We get those on the day requests for paracetamol that the patients could have gone to Asda and bought a box for sixteen. Er it just seems ridiculous to be using an, like an acute service here [at the medical practice] or, or with yourselves to get something that’s freely, cheaply available.’ (MP6, GP)

5.3.5 Communicating refusal to the patient & signposting

Around two-thirds of pharmacists interviewed in Phase 2 (17/26) described how they communicated refusals to patients and/or the reactions they received to refusal. Respondents described the importance of a clear explanation of the reasons guiding their decision (legality issues or company policy; insufficient information; inability to contact the GP), together with an emphasis that the decision had been made for patient safety reasons. In the majority of cases,
patients understood the decision and the need for them to obtain a prescription for the medicine(s) elsewhere (GP, Out-of-Hours service, walk-in centre etc.). However, around a third (9/26) of the pharmacists reported incidents of threatening, abusive or confrontational behaviour from a minority of patients in response to a refusal.

5.4 SUPPORT AND ADVICE FOR MAKING EMERGENCY SUPPLIES

5.4.1 Sources utilised

Most CPs interviewed in Phase 2 felt comfortable using their own professional judgement to make decisions regarding emergency supplies, but they cited advice from colleagues or the Superintendent’s office as potentially useful where advice was needed. However, it was recognised that even where advice was given, the final responsibility as to whether to supply or not rested with the pharmacist making the supply. The need for support was more likely when the pharmacist was newly qualified and required reassurance that their planned course of action was appropriate. Around a fifth of pharmacists interviewed (5/26) referred to colleagues, predominantly former pre-registration students and newly qualified pharmacists, having contacted them for advice:

‘Er no, I suppose I’m old hat at this. I get a lot, I get a lot of newly qualifieds ringing me up and saying I’m in this position. […] a couple of pre-regs over the years who, who just keep, you know, ringing up, just want a bit of reassurance that’s all and I just say, “Well, listen if it was me in that situation, this is what I’d do.”’ (P6, 24 years’ experience of working in community pharmacy)

Three respondents referred to the Medicines, Ethics and Practice (MEP) guide2 (a professional/legal guide issued by the Royal Pharmaceutical Society; RPS). Two pharmacists reported having contacted national professional bodies (RPS & National Pharmacy Association; NPA) for advice.

5.5 FURTHER SUPPORT NEEDED

Around a fifth (5/26) of pharmacists interviewed felt that no additional support was needed. However, others cited a lack of support from nationwide pharmaceutical organisations such as the RPS or General Pharmaceutical Council (GPhC); or local primary care commissioners. Development of clear, national or local, guidance for emergency supplies might be useful in creating a more consistent service, which would be beneficial to both pharmacists and patients:

‘Emergency supplies are always at the discretion of the pharmacist but I think that erm how one pharmacist operates erm can be totally different to another. So from a patient’s point of view, depending on which pharmacist is on duty, erm they get a different answer. […] Some guidance [from the local primary care commissioners] of what constitutes an emergency supply would be useful.’ (P23)

‘I think we need a bit more structure on what we’re doing so we can be a bit more of a service rather than just reacting occasionally one way or another.’ (P7, Owner Pharmacist of single independent pharmacy)

Additionally around a third (8/26) indicated that they would welcome GPs issuing prescriptions, rather than reception staff referring patients to the pharmacy when their script is not ready on time or a late request is received.
5.6 ADDITIONAL CHALLENGES

5.6.1 Impact of company guidelines

Five CP interviewees (Phase 2) discussed the impact of company guidelines on decision making when an emergency supply or loan is requested, which was also reflected within the audit data. The variability of practice at several companies was also highlighted by a locum pharmacist. In one national pharmacy company, the policy does not permit loans of medicines in any circumstances and a patient charge must always be levied, severely restricting the potential to support patients. One local pharmacy group also restricted loans, but this was regarded as positive in some respects:

‘That [a loan] would be frowned upon. […] According to the SOPs [Standard Operating Procedures] anyway, classes it as a non-refundable charge erm so (laughs) as I take it, it’s in order to cover the cost of the extra labelling and the dispensing.’ (P13)

‘I worked in a [local group with more than 5 pharmacies] and they’re, they’re the only ones I’ve actively seen put memos round and put a board by the computer, like a notice board: loans, lends, borrowing do not exist. They’re not part of the Medicines Act, it doesn’t happen. It’s got to be an emergency supply handled within the correct fashion. They’re the only people I’ve seen with an active one on that, er, you know, to prompt locums.’ (P6)

Those working for smaller pharmacy groups had more flexibility and in some cases encouragement to make loans to regular customers. However, pressure to follow company guidelines was sometimes seen as a threat to the pharmacist’s autonomy, further contributing to dilemmas around emergency supplies.

5.6.2 Customer relations

One-quarter (7/26) of pharmacists interviewed described tensions between making decisions on purely clinical grounds and maintaining good customer relationships. Therefore, in some cases an emergency supply request might be fulfilled as a goodwill gesture for a regular patient:

‘I’ve worked in pharmacies where I’ve had maybe six or seven come in in a day and they’ve just said, “Oh, I need some more aspirin or I need some more, you know, atenolol”. Erm and the owner of the pharmacy builds his business up by not refusing anyone’s request.’ (P25)

All service users interviewed in Phase 3 described satisfaction with the emergency supply service and the helpful nature of the pharmacist and other pharmacy staff. Over two-thirds of the interviewees (17/25) mentioned the benefit of requesting the supply at their regular pharmacy where they were known to the pharmacist. Existing rapport allowed a better understanding of their situation and, importantly, access to the pharmacy’s PMR to clarify details:

‘I get my medication from them, my prescription dealt with from them anyhow so they know me and they know that I usually have this medication, erm, so, erm, there was no query as to whether to give me or not. […] If I were a complete stranger and, er I hadn’t had, er prescribed medication from them in the past, er they may, they might have had to make more enquiries before… So erm it was useful that I was a regular customer at the pharmacy.’ (CP10-Pt1, female who requested emergency supply of antihypertensive medication at local pharmacy which she regularly uses)
5.7 Summary and Discussion

The data support previous findings of Cooper et al. that community pharmacists face many challenges when making emergency supplies. Such challenges arise from clinical and legal aspects of scenarios, in balancing between the patient’s best interests and legal and procedural boundaries. Dilemmas were described, which included: repeated emergency supply requests from the same patient; queries about the current dosage; requests which were not seen as an emergency; medicines requested where there were concerns around misuse or harm to the patient; and requests made by a person other than patient. Pharmacists reported being confident in resolving these dilemmas and making decisions on whether to supply and gave circumstances where they would normally refuse to provide an emergency supply. These included: requests for Controlled Drugs or other medicines with potential for abuse; insufficient evidence or record of previous prescriptions; where medication reviews were needed; when requests were not considered an emergency by the pharmacist.

When making emergency supplies as loans in advance of an NHS prescription, pharmacists undertook additional work aside from the usual supply function that they are contracted to provide by the NHS, such as communication with the patient’s GP to verify prescription details. Pharmacists identified circumstances in which they would refuse to make an emergency supply on grounds of appropriateness or patient safety and instead signpost the patient to another service such as GP Out-of-Hours services or walk-in centres.

A number of tasks related to handling requests were described, including gathering and confirming information as well as supplemental or alternative actions. However, there was inconsistency in the approaches taken by different practitioners and in different settings (owing to company policies) and this may lead to additional challenges for patients and other health professionals when seeking to take advantage of the emergency supply service.

5.8 Key Findings

5(a): The vast majority of emergency supplies are handled by pharmacists as a ‘loan’ in advance of an NHS prescription and are largely seen by patients and medical practice staff as part of the NHS supply service. Where charges are levied, this is predominantly for patients who are away from home and where a prescription would not be obtained reasonably. See Section 5.1.1.

5(b): There is concern amongst pharmacists and medical practice staff around repeated requests and potential for misuse of the system – this led some pharmacists to have personal strategies for management of repeat ‘offenders’. See Section 5.2.1.

5(c): Although making emergency supplies is routine in most pharmacies, pharmacists are cautious to ensure that the details of the medicines required are correct and take steps to verify this before agreeing to a supply. See Section 5.2.2.

5(d): Communication between the pharmacy and local surgery is important to ensure safe and appropriate supplies are made and that they are not unnecessarily refused where this may have adverse consequences for the patient. See Section 5.2.3.

5(e): Pharmacists were aware of additional risks, and took great care as a consequence, around emergency supplies for medicines that had potential for abuse and this was valued by the medical practice teams. See Section 5.3.1.

5(f): Pharmacists showed appropriate restraint in making supplies where full information on the medication was not available or there was any doubt regarding the veracity of the patient’s claims. See Section 5.3.2.
5(g): Pharmacists used emergency supply requests to select patients for Medicines Use Review (MUR) and referral for more in depth medication review by medical practice staff. See Section 5.3.3.

5(h): Pharmacists did not always make supplies – particularly where they felt that they were not genuine emergencies and this approach was supported by the medical practice teams. See Section 5.3.4.

5(i): Although pharmacists were confident in making decisions about emergency supplies, there was an appetite for national guidance on emergency supplies to help standardise the service for the benefit of patients and pharmacists. This would also help to reduce the variability in provision of loans across different companies. See Section 5.5.
6 PATIENT EXPERIENCE AND IMPACT ON MEDICINES ADHERENCE

National Institute for Health and Care Excellence (NICE) guidelines define adherence to medicines as ‘the extent to which the patient’s action matches the agreed recommendations [of the prescriber]’ and non-adherence can limit the benefits of medicines, leading to a lack of improvement, or deterioration, in health\(^1\). Economic costs of non-adherence include the costs of the original provision of the medicine, as well as those arising from further treatment following therapeutic failure. This chapter explores the perceived impact of the emergency supply service on patient adherence, as viewed by patients who requested emergency supplies, community pharmacists, and medical practice staff.

6.1 HEALTH PROFESSIONALS’ VIEWS ON THE IMPACT ON ADHERENCE

Over half of the CPs interviewed in Phase 2 (15/26) described the emergency supply of medicines - as a mechanism to ensure continuity of treatment - as having a positive influence on adherence. Additionally, seven described the safety net aspect of the service and a further two described its importance where there were delays in the processing of a prescription. Some respondents also speculated that, without emergency supplies being available, some patients would simply go without their medicines for a period:

‘I think the elderly population erm, I’ve got a sneaking suspicion that rather than go and get an emergency supply […] they’ll go without their medication. [...] I think the elderly people don’t tend to want to cause any trouble which is perhaps bad with compliance obviously.’ (P25)

Four of the CPs interviewed considered the emergency supply service to have little or no impact on patient adherence, citing the fact that its use should not be a regular occurrence. Nine pharmacists expressed frustration that, whilst they saw the benefits in genuine emergencies, some patients abused the system, rather than managing their medicines properly. However, emergency supply requests were considered to provide opportunities to engage such patients over adherence via informal discussion or Medicines Use Reviews, providing support to patients on how to best manage their medicines:

‘We try and encourage them to manage their medicine repeats in a more effective manner without being condescending or critical. Often we do try and take more responsibility for the medication; put more emphasis on how important it is that they take the medicines at the correct time and don’t go without them.’ (P20)

GPs agreed that certain medicines did not need to be supplied urgently, but recognised that if emergency supplies were refused in such cases, this might give the patient mixed messages about the importance of adherence. In addition, GPs recognised that failure to supply could be interpreted as negligence on the pharmacist’s and/or GP’s part if a patient were to experience an adverse health event owing to the interruption in treatment:

‘Even though we know realistically somebody’s blood pressure isn’t going to shoot up and somebody’s not going to suddenly have a stroke, it’s psychologically trying to convince patients of that is very difficult and then this judging the risk and if something adverse did happen, they would blame the fact that they didn’t have the medication. It’s, it’s hard to get the balance right. [...] ‘You can miss it every now and then. It doesn’t matter’. Yes you’re sending a contradictory message and [...] ‘Well you can have the weekends off. Come back for it on Monday’ and then ‘why do I take it at all?’ [...] If you start saying, ‘Well that doesn’t matter that much’, people will stop taking medication regularly or might stop it altogether.’ (MP5, GP)

Medical practice staff were not surprised by the alternative actions that service users described in the phase 3 interviews, even the case of the individual who reported having borrowed
warfarin from his friend, as they recognised such behaviour as typical amongst some of their patients.

6.2 PATIENT VIEWS ON THE IMPACT ON ADHERENCE AND THEIR HEALTH CONDITION

Service users interviewed in Phase 3 were asked to reflect on the impact of this emergency supply on their management of their medicines and condition (or, in the case of requests by carers, the person for whom it was requested). Many respondents explained that they had averted disruption to taking the medicines as prescribed and a third (8/25) said that this gave them peace of mind with respect to their treatment:

‘Well it was much better because I think it was a Friday, just enabled me to keep a routine, erm yeah and it meant that there wasn’t going to be a gap within my medication.’ (CP3-Pt1, working female, who stated she would otherwise have managed without her medicines which she felt would not have been ideal)

‘I prefer having been taking this, erm, medication for so long, I don’t know what would happen if I hadn’t got it. But I’d rather have it than never have it.’ (CP19-Pt1, male, over 60, taking multiple medications)

Two-thirds of service users (16/25) emphasised the importance of an uninterrupted supply of medicines, describing the possible impact that they believed a missed dose might have:

‘She has to take it every day so it, you know, if she hadn’t of, because like I said she has brittle asthma and she’s been in the, erm, the paediatric ICU on occasion. She had been poorly and she absolutely does need it. It’s vital for her.’ (CP10-Pt2, mother who requested emergency supply of an inhaler for her daughter, aged 11)

‘This resident is dependent on this medication, erm, on a daily basis. It’s to do with her mental health issue. It was important that we made sure that she took her medication otherwise there would be relapses.’ (CP2-Pt4, member of staff at supporting living home for people with learning disabilities who requested emergency supply of medicines prescribed for a tenant’s mental health condition)

Patients also recognised that emergency supplies should not be a routine mechanism for them to obtain medicines and one respondent described how the incident had made her more vigilant about ordering medication on time to ensure she had a continuing supply.

6.3 KNOWLEDGE OF SERVICE AND REFLECTION ON ITS ROLE IN PEOPLE’S CARE

Over half of service user respondents (15/25) had used the service on a previous occasion, with some having done so several times. In many cases, a prior loan had led to an expectation that this facility would be available to them when they asked this time:

‘I know that sometimes I’ve got to the stage where I need to go and you know I’ve run out and I’ve been to my chemist and they’ve actually given me some tablets er before I’ve got the prescription which is good because then I can go and get the prescription and take it at the chemist and they then just deduct what we’ve had from them.’ (CP21-Pt1, female, who has used the service on previous occasions to avoid disruption in her routine for taking medicines to treat hypertension and use of inhalers for control of asthma)

Where it was the first emergency supply that the individual had received (10/25), most had been told it was possible by the pharmacist or another member of pharmacy staff. Two other service users had been referred to the pharmacy by the receptionist at their medical practice and a further four knew of the service due to their own or a family member’s job in healthcare.
Service users considered the provision of emergency supplies to be an important and useful service, ensuring continuity of their medical treatment, helping to reduce worries about their medicines:

‘[My] prescription was late so there's nowhere else I could have got the medication from, you know, so I think it's a vital, vitally important. [...] I was surprised that he [the pharmacist] could do that but it saved a lot of worrying, you know, so it's worth, it's worth keeping it, the service.’ (CP2-Pt7, female who received one day’s loan of her regular medication until prescription was ready)

Around two-thirds of respondents (16/25) described the service in terms of a ‘safety net’, but it was highlighted that not everyone was aware of its availability. Although two respondents expressed concern that if it were widely publicised it might be abused:

‘I didn’t think it was, erm, er, people are made aware of the opportunity or, you know, it’s not er, a common knowledge thing which, erm, isn't widely broadcast.’ (CP3-Pt3, male who knew about emergency supply service as the pharmacist had told him about it on a previous occasion)

In three cases, service users described how medication advice given by the pharmacist helped to supplement, or even avoid the need for, a subsequent appointment with their GP or another health professional regarding their medicines. Service users also described how the emergency supply had led to them using other pharmacy services which were beneficial to their medication management, for example repeat prescription ordering and delivery services. Such services received positive feedback and service users also expressed a preference for later and weekend pharmacy opening hours to help further with their management of medicines.

Service users recognised that pharmacists may face challenges with requests for emergency supplies, particularly where the individual was not known to them:

‘I can see complications about, you know, complete strangers walking in, er, asking for a prescription-only medication to be given as a matter of emergency. [...] It would be a real emergency for somebody say coming from Cornwall or somewhere like that or Scotland and have run out of medication. [...] Yes the complications of people coming from out of the area or people unknown to them, erm, there would be the need to verify er the prescription.’ (CP10-Pt1, female)

6.4 RESPONSIBILITY FOR MANAGEMENT OF MEDICINES

Of the twenty-five service users interviewed, three respondents anticipated future problems with their medicines as they were ‘out of sync’ or would run short at the end of the next month owing to the deduction of the small amount issued as an emergency supply. Two individuals described that their regular pharmacist was proactive in giving them gentle reminders to order their next prescription on time. Similarly, two other service users reported being informed of a repeat prescription service, as a consequence of their emergency supply, which they considered might help prevent similar difficulties in the future.

Participants at medical practice feedback sessions discussed the balanced roles of GPs, pharmacists and patients in managing medicines. Overall, the primary responsibility was felt to lie with the patient, though this may shift more towards the health professionals in the case of some elderly patients. The community pharmacy repeat prescription service was considered useful, along with prompting patients to order their medication. Encouraging patients to retain their repeat prescription ordering form (the right hand tear-off side of the NHS prescription) was
thought to be helpful for pharmacists to confirm current medication where emergency supplies are requested.

‘*I think the responsibility should lie with the patient other than some cases where they're elderly, frail. You know, I mean I've gone and seen patients who are diabetic and come off all medication because they didn’t bother to request.*’ (MP1, GP)

The advantages of repeat dispensing, using electronic transfer of prescriptions, were also discussed, although one GP expressed frustration that these were not yet in place at his practice. The electronic transfer aspect (as implemented in England) would permit speedy, secure exchange of prescription information to the pharmacy, reducing turnaround time for prescriptions. Using repeat dispensing, in addition, would also transfer the responsibility for monitoring the patient’s use of long-term medicines to the pharmacist. The potential impact of such technological advances is discussed further in Section 8.3:

‘*I for the life of me don’t understand why we have to spend so many hours a week writing prescriptions for things that people know that they should be on all the time. And I’ve got no understanding as to why we don’t do that through pharmacies. [...] I think pharmacies would be far better at actually monitoring the number of prescriptions that have gone through.*’ (MP5, GP)

6.5 **SUMMARY AND DISCUSSION**

Community pharmacists expressed mixed views about the potential impact of the emergency supply service on patient adherence. While some felt it was useful for patients as a safety net that supported adherence, others considered it to have little or no impact. Service users felt that, through receiving a loan of medication and avoiding disruption to their medicines regime, they were able to maintain adherence and manage their health conditions better. The interactions with patients that arise from emergency supplies provide opportunities for community pharmacists to engage patients and discuss medicines use and adherence, as well as providing support with managing medicines. Embedding approaches such as this into routine practice is recommended in guidance regarding medicines optimisation issued by the Royal Pharmaceutical Society[20]. Supporting patients is of particular importance for those taking multiple medications for long-term conditions as the present study shows that this group are likely to require emergency supplies and further support to ensure medications are synchronised and/or future ordering of medicines is done in a timely manner. More than half of service users interviewed had previously received an emergency supply on one or more occasions, leading to an expectation that the pharmacist would make future supplies. Other service users had been informed of the service by the pharmacist/pharmacy staff or signposted to the pharmacy by the reception staff at their medical practice. Overall, the emergency supply service was considered to play an important role in people’s care, ensuring continuity of supply of service users’ medicines and encouraging adherence to medical treatment. The safety net it provides for patients on occasions when they run out of prescribed medication and are unable to get a prescription from the medical practice for whatever reason was emphasised as an important factor in this.

6.6 **KEY FINDINGS**

6(a): Many pharmacists believe that emergency supplies make a positive contribution to patient adherence, although some feel that patients may abuse the system to simply make their life easier. See Section 6.1.

6(b): Even where medicines may not be needed urgently for clinical reasons, refusing to supply could send mixed messages to patients about the need to take the medicines regularly and may have wider implications for adherence. See Section 6.1.
6(c): Patients value emergency supplies in terms of supporting their adherence and avoiding possible consequences of an interruption to the supply, which they recognise as important to the therapeutic success of their treatment. See Section 6.2.

6(d): Many patients are not aware that emergency supplies are available from pharmacies and this may reduce the number of patients accessing this service when they run out of medicines. However, there was some concern amongst healthcare practitioners and patients that widespread knowledge of the service may lead to further abuse of this provision. See Section 6.3.

6(e): Pharmacists are proactive at supporting patients with managing their medicines and try to help them to avoid situations where emergency supplies may be necessary. See Section 6.4.

6(f): Shifting management of repeat medicines to pharmacies through the repeat dispensing system and/or increasing the use of electronic prescription transfer would help to reduce some of the challenges around repeat prescription management and reduce the need for emergency supplies. See Section 6.4.
7 EMERGENCY SUPPLY: ITS POSITION IN HEALTH AND SOCIAL CARE PATHWAYS

This chapter considers how the provision of emergency supplies by community pharmacies currently fits within existing health and social care pathways. Relationships between community pharmacies and their local medical practices are examined from both parties’ perspectives as well as service user perspectives on the role that the emergency supply service has in their treatment. The role that emergency supplies play in out-of-hours care is also considered within the context of local data regarding visits to GP Out-of-Hours services for repeat medicines and the recent national review of urgent care services.

7.1 RELATIONSHIPS BETWEEN COMMUNITY PHARMACIES AND MEDICAL PRACTICES

Over a third of community pharmacists interviewed in Phase 2 (10/26) and several GPs in Phase 4 described an established rapport with local GPs and community pharmacists respectively. Such rapport was cited as a facilitator for actions such as: verifying prescription details; checking whether a script would be issued in the case of loans; joint decisions in cases where individuals are suspected to be abusing the emergency supply service; and synchronising supplies of multiple medicines. Relationships were described to have been built up between individual practitioners over time and required proactive approaches on both sides, rather than being part of a formal network that existed locally:

‘I’ve worked in practices where there’s very often been a pharmacist like you where you get to know personally there. It’s an unwritten rule that the patients generally go on the whole to that pharmacy … and I’ve never had a problem. I’ve always thought it seems to work very well. The problem is when requests are coming for prescriptions to pay back tablets that have been lent out from a chemist that you’re not really that familiar with, and we start to wonder about what the patient’s up to.’

(MPS, GP)

Good relationships were not universally described and a third of CPs (8/26) said that they would like increased support from GPs, especially regarding the issue of prescriptions. Some pharmacists also felt that medical practice teams were not always aware of the emergency supply service, including frontline staff dealing with patients, and that educating them of the potential support that could be offered by the pharmacies in an emergency would be helpful. However, some felt that staff should not be referring patients to the pharmacy and that the existing emergency supply service is not an appropriate mechanism for resolving problems with repeat prescription systems:

‘I’ve got another surgery erm who obviously don’t have, they have a schedule to do with repeat medication ordering and if a patient goes in trying to get them get the tablets sooner than it’s ready the reception staff are telling the patient to just go to the pharmacy to get some tablets to tide them over. […] Quite a lot of the staff that work in reception, er in the surgery, I don’t think are aware that it’s, well, medication shouldn’t be supplied without a prescription anyway.’

(P13)

In the Phase 4 discussions, there was mixed awareness amongst participants about the potential for pharmacists to make emergency supplies and the difference between emergency supplies where a charge is made and loans in advance of an NHS prescription:

‘I didn’t quite understand and appreciate the difference between emergency supplies, I didn’t realise there’s a page in the BNF [British National Formulary] about it, as opposed to lending medication. I thought it was always going to be lending and you’d always need, I thought for legalistic reasons you’d need a prescription to offset it. I didn’t realise you could actually provide an emergency supply. For example you
said that you could charge the patient the cost of it, of the inhaler, say somebody was visiting from London, the generic cost of the item.’ (MP5, GP)

GP participants in Phase 4 largely appreciated the pharmacist’s position when emergency supplies were requested and trusted their professional judgement to act in the patient’s best interests. However, several stated that patient safety was paramount and the type of medication being supplied was a significant factor in this, as well as the potential for multiple supplies to be obtained by ‘pharmacy shopping’:

‘It’s not ideal but [...] you can’t leave the patient without any medication and that’s the decision you’ve got to make and it’s, I suppose, you’re put in a difficult position but what’s in the patient’s best interests, I suppose.’ (MP2, GP)

Some medical practice staff suggested that emergency supplies could provide a mechanism to bypass the medical practice and incidents were recounted where pharmacists had loaned medication, causing conflict with the surgery as they had not been entirely appropriate – although such incidents were considered to be rare:

‘The thing is I think the problem is because they can, they can actually access you and bypass us. That’s, that’s what the whole problem stems from that. If you say everything has to come through the GP and they have to come here for the repeat prescriptions that problem doesn’t arise. [...] So those incidents should not happen.’ (MP1, GP)

Medical practice staff also raised the question of clinical responsibility for any harm to the patient arising from an inappropriate supply or error and the relevance of charges in this. By making loans, and requesting an NHS prescription to cover the cost, rather than selling medicines under the emergency supply exemptions in the Medicines Act, pharmacists were effectively shifting the clinical responsibility to the prescriber – since the issuing of a prescription was a mechanism for both payment and clinical governance:

‘There’d be, number of times you could count on the fingers of one hand really where the pharmacist was saying, ‘Well I need the prescription for this’ and I’m saying, ‘Well I’m sorry but I wouldn’t have actually given that and I’m not happy to have it attached to a prescription that I’m writing.’’ (MP5, GP)

‘I’ve had some over time saying, ‘We’ve issued them with an emergency supply and can I now do a prescription for it’ and I’m thinking, ‘I wouldn’t have given that medication or there’s a very good reason why they’re not being prescribed it’. But those are the ones that come to mind about emergency prescriptions so if the pharmacist is clinically responsible for any consequence of harm then what’s our involvement?’ (MP6, GP)

7.2 IMPACT ON PATIENTS’ USE OF OTHER HEALTH SERVICES

As discussed in section 5.3, CPs in Phase 2 reported occasional refusal of emergency supplies, instead signposting the patient elsewhere to obtain a prescription for the medicine(s) required. Referrals were usually to the patient’s GP, during surgery opening hours, but at other times referrals were to the Out-of-Hours services (with the possibility of dispensing against a faxed prescription sometimes offered), walk-in centres or A&E. Clearly, in the more common circumstances where a supply was made, visits to these other services would not be necessary, saving the patient time and inconvenience as well as reducing demand for out-of-hours services, where requests were made outside of normal surgery hours:

‘It’s like sort of the emergency supplies are some sort of glue or oil that just lets the whole system work that little bit easier, erm because what if no one could get emergency supplies? “I’ve run out of medicine I need to see a doctor now.” I can
never get in to see a doctor then. You’ve got to put additional strain on the Out-of-Hours service.’ (P26)

In the service user interviews (Phase 3), participants described possible alternative actions that they would have taken in the absence of an emergency supply. Half (12/25) said they would speak to their GP or the surgery receptionist in the first instance, although some were unsure whether an appointment would be possible at short notice:

‘I think we would have had to get the tenant to make an appointment to see a doctor if they were able to fit us in as an emergency but I believe the doctors were fully booked that’s why we weren’t able to go and ask them to, you know, write a prescription for us.’ (CP2-Pt4, member of staff at supporting living home for people with learning disabilities who requested emergency supply of medicines prescribed for a tenant’s mental health condition)

Using the walk-in centre, A&E or GP Out-of-Hours service was also considered an option by four respondents:

‘I probably would have had to erm probably have gone Out-of-Hours or maybe up to A&E or drop in centre probably explain my situation from that point of view [...] erm, so yeah, erm, it would have been far more complicated and far more awkward to be able to resolve the situation, the predicament that I was in.’ (CP3-Pt3, male, who requested an emergency supply as he had left his regular medication at his holiday home after a weekend visit)

‘Well I probably would have demanded to see the doctor and then if not, I would have called the Out-of-Hours probably if I was in a mood. [...] Depends what type of mood I’m in but I really was needing them because if I haven’t had them for a few days I start getting really bad.’ (CP2-Pt8, female who requested ES of medication to control symptoms of anxiety)

Around a quarter of respondents (7/25) said that they would have just done without their medicines until their prescription was ready. In some cases, participants felt that, although this would not be ideal, it would not cause any particular harm. However, others commented that this might have a negative impact on them, for example in the case of analgesic or anxiolytic medication. Four respondents described purchasing over-the-counter medicines as a possibility although they commented that these would not be as effective as their usual medication. One service user reported having previously borrowed medicines from friends taking the same medication (warfarin) when he ran out.

Several medical practice staff in Phase 4 mentioned the large volume of prescription requests received by GP Out-of-Hours (OOH) services that they had worked at/with. Participants felt that some of these might have been better and more efficiently dealt with by the patient’s usual pharmacy as they may have more knowledge of the patient than a duty doctor. Where loans of medicines had been refused (often as a result of company policy not to make such supplies) medical practice staff felt that this was a waste of resources:

‘We do get reports from Out-of-Hours services that people present at Out-of-Hours services requesting prescriptions for inhalers or, or blood pressure or heart medications etc. and clearly that’s using out-of-hours resources which isn’t appropriate. So if the pharmacist is able to do that, then it’s going to save pressure on the Out-of-Hours services.’ (MP6, GP)
7.3 Summary and Discussion

Pharmacists and medical practice staff both identified established positive working relationships between them as being helpful in dealing with emergency requests from patients. However, such relationships take time to develop and rely on effort and will on both sides. Staff in many medical practices were aware of the availability of loans, but there was less awareness of emergency supplies. Further education on the potential for pharmacists to support patients with managing their medicines was considered to be useful amongst many participants, including pharmacists, service users and medical practice staff. If the emergency supply service had not been available at the pharmacy, many service users reported that they would access GP Out-of Hours service, walk-in centres or A & E. This is supported by data from Urgent Care 24 (UC24), a local provider of GP OOH services in the study area. In a patient population of approx. 750,000, a total of 5156 repeat medication requests out-of-hours were received by the service in the year September 2012 to September 2013. Three-quarters of these requests were made at weekends, with over half (56%) made on a Saturday. Of the requests made through the week, Monday and Friday were peak periods in comparison to other weekdays, showing similar trends to the data from Phase 1 of the present study. Suggestions by medical practice staff that OOH services making such supplies are a waste of resources fits with NHS England’s recent Urgent and Emergency Care Review, which recognised that community pharmacies are an under-used, accessible resource, particularly with respect to medication queries.

7.4 Key Findings

7(a): Positive working relationships between GPs and pharmacists help in dealing with emergency supplies and provide reassurances on both sides. However, such relationships take time to develop and require both parties to invest time and effort for them to become established. See Section 7.1.

7(b): Some pharmacists felt that better awareness of loans was needed amongst medical practice staff, although some questioned the appropriateness of loans when surgeries were open, under the current legal/practice framework. See Section 7.1.

7(c): GPs and other medical practice staff felt that emergency supplies were a useful service and they trusted pharmacists to act in the patient’s best interest. However, examples of poor practice were highlighted and patient safety was considered to be paramount. See Section 7.1.

7(d): Loans, where a future NHS prescription is used as a mechanism to cover the cost of the medicine, carried some complexities around the clinical responsibility for the supply, which some prescribers did not feel was appropriate. See Section 7.1.

7(e): Many service users described that they would use A & E, walk in centres or GP Out-of Hours services; borrow medicines from friends or family; or simply not take their medication if an emergency supply had been refused and emergency supplies made out of normal surgery hours helps to reduce unnecessary demand on out-of-hours services. See Section 7.2.
8 RECOMMENDATIONS REGARDING CURRENT EMERGENCY SUPPLY SYSTEM

This chapter considers that, while service user feedback (Phase 3) indicates satisfaction with the emergency supply service, many community pharmacists (Phase 2) and medical practice staff (Phase 4) felt that some changes to the current system might be desirable. Respondents felt that flexibility and pharmacist autonomy in decision making ought to be retained, but suggested changes to the operational structure of the service that might be useful. These suggestions are discussed further, adding views of the wider stakeholders (Phase 5), in the final chapter.

8.1 EMERGENCY SUPPLY: A FUNDED AND STRUCTURED SERVICE

Community pharmacist interviewees in Phase 2 highlighted that the loans that are presently supplied were a small, but important, facet of the existing NHS supply arrangements and structuring the service as a funded NHS service within the Community Pharmacy Contractual Framework would be helpful. It was suggested by two-fifths of respondents (11/26) that this could operate as an advanced or enhanced service, such as Medicines Use Review (MUR) or the minor ailments service in operation in the study area. If such a service were commissioned, clear and transparent terms of service and associated fees would provide recognition of the extra workload for the CP and the expertise involved:

“Well I think it should become part, should be involved in the pharmacy contract. An emergency supply really is no different from us, erm using the, what they call Care of the Chemist, the minor ailments scheme. So the minor ailments scheme attracts a fee and a consultation fee so why could we not have something similar for the emergency supply scenario?” (P20)

A national service specification would also ensure a consistent service across all pharmacies, which would be useful for patients and other health professionals in understanding/promoting the service. It would also be beneficial for all CPs who are delivering the service to be working within the same boundaries. Parallels were drawn with a similar service, which is already commissioned in Scotland23:

“It would be nice if we could package up some sort of service across particular boundaries or groups so we all work together and we don’t have the confusion for the patient really. […] Yes more structure and a more robust system that we could all adhere to which would be patient friendly.’ (P7)

“I think I’d like to see a system in line with Scotland where I understand they can make a full period supply and it’s funded by the NHS. […] It would avoid the need for the loans which create some of the difficulties.’ (P22)

Several CPs (4/26) said they would like clearer guidance stating that they were able to lend in advance of a prescription. A small number (4/26) suggested charging patients a flat fee to access the service and felt that this would result in a more responsible use of emergency supply and reduce the incidence of repeat requests:

“A minimum charge I think would, might decrease the frequency of them as well and attitude towards us where patients believe it’s their right to get the medication free all the time, where it isn’t the case and it isn’t the fault of the chemist, you know.’ (P15)

The concept of charging patients for access to an emergency supply was also supported by several GPs for the same reason, since this provision (as well as providing prescriptions at short notice at the medical practice) was viewed as a service which in many cases was resolving difficulties as a result of the individual’s inefficiency with ordering their repeat prescription.

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However, respondents did recognise that, in some cases, the patient needed the medicines through no fault of their own or as a result of difficult personal circumstances:

‘I do worry that we make life so easy for the demanding idiots who can’t be bothered and I keep saying with all of these things if they have to pay for it, they wouldn’t do it. [...] If there was any way of making a charge, even making a charge here, I would be delighted to charge people for five thirties. You know, its forty eight hours - if you want it tonight, there’d be a ten pound charge. And see them disappear.’ (MP3, GP)

8.2 FORMAL DOCUMENTATION AND FEEDBACK REGARDING EMERGENCY SUPPLIES

Currently, emergency supplies are only recorded in records held in the pharmacy making the supply (in some cases, this data may be shared with other branches, via PMR systems, but this is limited to certain larger companies). Around a quarter of the CPs interviewed (6/26) felt that there was a need to expand the information recorded regarding emergency supplies, both to promote continuity between pharmacist colleagues working on different shifts and to inform the medical practice that an emergency supply had been made including relevant messages. Some respondents identified that such a system would help to reduce abuse of the system and promote feedback from GPs about supplies, as well as helping medical practices to identify patients needing review:

‘Well there maybe should be a template where we could record what emergency supplies we’re making and maybe have a mechanism where we could report that back to the GPs to say, “Listen we are offering this service to your patient when they’re running out of their medicines, or for whatever reason. What do you think about it? Do you object to us doing it? Do you encourage us to do it? Or what’s your feedback?”’ (P20)

Mechanisms to inform the GP about emergency supplies were raised at five of the six Phase 4 feedback sessions. Participants discussed that this would be helpful for monitoring ‘repeat offenders’ to allow follow up to resolve issues such as unsynchronised medications. They also suggested that such feedback would help to warn the GP of cases where the patient was abusing medications or using more than the prescribed dose. Another useful feature would be identification of any discrepancies between the patient’s medical records (held by the GP) and the pharmacy PMR:

‘There’s some, a few who would misuse it so we need to identify those, those few patients who are misusing the service. [...] I think it, it gives you a bit more confidence doesn’t it? As a pharmacist: ‘I’ve done this, I’ve let the GP know’ and there’s a safety net somewhere that would pick up a problem if there was an issue. I think that’s not a bad idea.’ (MP1, GP)

‘If we were informed who was using the service we could explore what was the reasons and maybe reduce that.’ (MP3, practice nurse)

There was some diversity in the feedback discussions in the desired nature of feedback, with some feeling that the practice should be informed of every emergency supply, whilst others felt that this may generate extra paperwork for more ‘routine’ cases, but would be more useful where the circumstances pointed to a problem that required follow-up. Some participants suggested that feedback could be via the Medicines Use Review (MUR) mechanisms (as an emergency supply might prompt this action) and others suggested a separate form could be developed. Workload and administration for the pharmacy and medical practice staff was considered manageable with the numbers recorded in the Phase 1 audit. Practice staff favoured faxing or electronic transmission of the feedback form.
8.3 TECHNOLOGICAL ADVANCES

Around a third of pharmacist respondents (8/26) thought that technological advances such as access to electronic patient records could be useful in handling emergency supply requests. For example, this would allow clarification of the medicine(s) taken, removing uncertainty about dosages prescribed:

‘I mean it should come soon if you could check patient records […] a) they’re on it and b) it’s not going to react with anything else type of thing. Because some patients okay know what they’re on but say the wrong words, don’t know the kind, don’t know the dose. Erm so yeah if there was some way of checking that in the future electronically then that would be a lot easier.’ (P8)

The Electronic Prescription Service (EPS) was also mentioned as a possible positive step, but one respondent (P26) described teething problems and another remarked that only a limited number of medical practices were currently able to process prescriptions in this way. With increased uptake, it was hoped that EPS had the potential to streamline, and speed up, ordering processes and this was reported by staff in surgeries and community pharmacies where it had already been implemented. It was felt that this would lead to fewer emergency supply requests owing to some ordering difficulties, but it would not solve problems such as unsynchronised medicines. Repeat dispensing (pre-authorisation of multiple prescriptions) was also recognised as potentially helpful in this respect:

‘I just think the whole system could actually be changed immeasurably in favour of er the both patients, doctors and pharmacists, just by simply er making it more electronic. […] For instance, we’ve got somebody who has epilepsy we should be able I think to electronically transfer a prescription to their chosen chemist saying ‘please give this person six months prescription of this dose’ […] until the time when they’ve had six, send them back to us because they’ll need review or whatever. If that was er put through our contracts it would make a massive difference to you. It would mean that you got six monthly dispensing fees, the patient got, knows they can get hold of it. […] It comes round to an emergency prescription there should be a system which you’re involved, you’re all involved in whereby you could actually identify it and it would probably save us sort of reception wise and doctors a good three hours in total a day of work.’ (MP5, GP)

8.4 PUBLIC AWARENESS RAISING AND PATIENT EDUCATION

A third of the pharmacists interviewed in Phase 2 (9/26) felt that raising public awareness and understanding of prescription-only medicines, the emergency supply service and its appropriate use would be helpful. This was also true of staff in medical practices, where inaccurate information given to patients was found to be unhelpful. However, increasing awareness was also seen as potentially risky, in terms of encouraging inappropriate use. Difficulties around the terminology and different types of services offered by different pharmacies were also a factor in this:

‘They don’t understand actually it’s not part of an NHS service and that it’s at the discretion of the pharmacy and I think sometimes it makes people a bit, people are a bit like, “You just need to give me it!” type thing.’ […] The GPs will quite often go, “Just go and ask your pharmacist“, […] I think it needs to be a bit more educated on the part of the doctors actually, that the first port of call should be the doctor when they’ve run out and they should educate the patient that it’s not an entitlement when you ask for an emergency supply. You should have to pay for it maybe and make people aware of that.’ (P19)

‘Does anybody know it exists other than us? People think they can borrow and lend and that’s the terms that they use. They don’t realise that it’s a proper emergency supply service where you will get what you need but you will have to pay for it. […]
Whether it would be wise to go down the path of it being more easily available, I
don’t know because then who’d be monitoring who’s getting what and stuff, so it’s a
tricky one that one.’ (P8)

Appropriate patient education was also felt to be needed where it would not be detrimental to
miss a small number of doses, with consistent advice being given by pharmacists and
prescribers:

’But then you’ve got to think about the patient’s journey, you know, the patients
could be there panicking thinking ‘oh my God the pharmacist said to me I can’t
survive without these’ you know, so clearly they can erm so I take your point but I
think also about the patient and them not panicking and thinking ‘oh God what am I
going to do, oh I’d better ring out-of-hours, I’m going to the walk in centre’. I know
it’s hard.’ (MP2, GP)

Staff at several medical practices suggested drawing up a list of ‘non-urgent’ medicines, for
which they would not provide emergency, on-the-day prescriptions to patients. Community
pharmacies, it was intimated, could follow the same format, although it was acknowledged that
patient requests still had to be taken on a case by case basis:

’I think there has to be a lot of patient education going on. I certainly think as a
practice that we need to develop a list of drugs that we won’t, we won’t give as an
emergency supply on the day. […] Simvastatin, it’s a long term treatment. So any
Statins are not an emergency supply and the patients probably just need a bit of
education and reassurance that they’re not going to drop dead of a heart attack over
the weekend because they’re not taking their simvastatin. They probably don’t really
understand the long term use and the high NNTs [Number Needed to Treat] […] Just
like you’re having the issue in the pharmacies. Because if we all are saying the
same thing, it’s going to help reduce the demand for these emergency supplies both
from a GP or a pharmacist.’ (MP6, GP)

8.5 REVIEW OF AMOUNT OF MEDICINES SUPPLIED

Current legislation permits an emergency supply of up to 30 days’ treatment with the exception of:
Controlled Drugs\(^1\), where no more than 5 days treatment is permitted; where packs cannot
be broken e.g. insulin or inhaler; oral contraceptives, one cycle can be supplied; and liquid
antibiotics, where a whole pack is supplied. A maximum of five treatment days was in force until
May 2009, when adjustments were made, in part owing to the Swine Flu epidemic. However,
pharmacists had contrasting views about appropriate quantities to supply, with some (reported
by 5/25) usually only supplying sufficient medication to tide the patient over until a prescription
was available and others (5/25) usually making a full 28/30 day supply. The pharmacists who
reported only giving small supplies, felt that this:

‘Just because you can give a full month, I’m not sure I agree with that. Because
when that has happened and then when we’ve got the prescription back, the
medication has actually changed so been, you know, in a bit of a pickle that the
patient has been given a strength of drug or a drug that they’re no longer on.’ (P24)

‘I think that’s better because it makes it easier for the patients. Erm they don’t have
to come back after five, whereas it used to be five days. So I think that’s a lot easier.
You can just give them a full box now and when that runs out they do have to come
back. So I think that’s better for patient compliance.’ (P9)

\(^1\) Schedule 1, 2 and 3 Controlled Drugs cannot be supplied under these regulations with the exception of phenobarbital
when used in the treatment of epilepsy.
Two pharmacists stated that the circumstances of the emergency supply request affected their willingness to give a full month’s supply:

‘Most emergency supply I tend to charge the prescription charge for a loan item. I tend to give a bigger amount, if they’re a regular of ours erm and then I know the script is going to come to us either we’re collecting it or they’re very trustworthy, I tend to give a complete box. Erm whereas with [formal] emergency supply I’d probably give five days that would actually depend on how long they’re away from home.’ (P25)

8.6 SUMMARY AND DISCUSSION

Pharmacist and medical staff respondent groups described a number of perceived advantages of emergency supplies being handled through a formally structured NHS service. These included clarity, transparency and consistency in service provision, with all CPs working within the same boundaries, such that patients would know what to expect from the service, whichever pharmacy they accessed. CPs were also keen to see such a service agreement developed, such that the service offered and the associated extra workload and expertise involved was appropriately recognised and remunerated. Both CPs and medical practice staff agreed that charging the patient a fee for their emergency supply might engender more responsible use and reduced incidence in repeat requests from some patients. However, there was also recognition that some patients had a need for emergency supplies that arose through no fault of their own. Better communication between supplying pharmacies and the patient’s medical practice was recognised by both pharmacists and medical practice staff as desirable, along with improved communication with patients about managing repeat medications and definition of ‘emergency’.

Introduction of electronic prescribing systems had the potential to streamline the ordering process between the general practice and pharmacy, with those surgeries and community pharmacies who had already implemented these systems reporting that medicines requests were dealt with more quickly. Research by Porteous et al. indicated that patients, general practitioners and pharmacists were all generally supportive of the introduction of systems to allow the Electronic Transfer of Prescription-related information. This was supported in the present study, where improved convenience for patients and better repeat prescribing processes with reduced workload for GPs were recognised as benefits. However, concerns were expressed regarding security of patient identifiable information, sharing of information between GPs and CPs and delegation of prescription management to pharmacists. It would appear that there is still some reticence from GPs to adopt the use of electronic prescriptions, with a recent online survey indicating that of 834 GPs in England only 15% of respondents had already switched to EPS R2, while a further 25% plan to switch to electronic prescribing in 2014.

Recent government support for community pharmacy to have access to patient summary care records may facilitate the advancement of this technological agenda.

Key findings

8(a): Most pharmacists felt that a properly constituted and commissioned service, within the Community Pharmacy Contractual Framework, would be desirable. Some pharmacists and GPs felt that some of the costs of this service could be met by the patient to reduce the risk of inappropriate use. See Section 8.1.

8(b): Pharmacists and medical practice staff felt that a more robust – and inter-pharmacy – records & reporting system would be helpful for a number of reasons, including: reducing chance of abuse of the system; informing and engaging with GPs about supplies; helping to identify patients with problems; and identifying any aberrant use of medicines. Some felt that
the feedback should be limited to circumstances where the request pointed to an underlying problem. See Section 8.2.

8(c): The Electronic Prescription Service and Repeat Dispensing were seen as potentially helpful in reducing some of the problems that currently lead to emergency supply requests, however it would not solve all of the problems that patients faced. See Section 8.3.

8(d): There was diversity in the quantities that pharmacists would supply on a loan, with some favouring the minimum needed and others supplying a full month, as permitted by the law. See Section 8.5.
9 IMPLICATIONS FOR POLICY AND PRACTICE

This chapter describes the discussions held at a wider stakeholder workshop relating to implications of this research for pharmacy policy and practice. In total, eleven stakeholders attended the session, which included representatives from the Royal Pharmaceutical Society, Local Pharmaceutical Committees (LPCs) in Liverpool and Greater Manchester; Clinical Commissioning Groups (CCGs) within Merseyside; and two academic researcher members of the North West Primary Care Research Group. Other attendees held academic and superintendent pharmacist/clinical governance roles, which included representatives from independent and nationwide multiple pharmacy groups. Firstly, the challenges and barriers evident in the existing emergency supply system and its place within the current NHS landscape are summarised. Then, the potential features desired in a commissioned NHS service are considered. These reflections helped us to formulate recommendations underpinned by the data.

9.1 CHALLENGES AND BARRIERS

Practising and Superintendent Pharmacists highlighted that the nature of emergency supplies and loans, as unfunded services, added to the workload for the pharmacist. It was also highlighted that the current legislation was now outdated and needed a major overhaul to reflect the many changes in primary care prescribing since the Medicines Act was written:

'It’s the work flow thing that’s still as apparent as it was when I was practising [...] there was a little heart sink when an emergency supply came in because you knew that there was extra, you know, stuff coming with it and if you’d got, you know, pharmacies operating at quite high speed, you know, the emergency supply thing is how are we going to streamline this I guess.’ (S4)

Workshop attendees highlighted the importance of clarifying the distinction between emergency supplies - where a charge is made - and loans in advance of an NHS prescription if the service was to be taken forward as a funded NHS service. Both knowledge and practice of existing emergency supply regulations were acknowledged to vary, both within the pharmacy profession and among other healthcare professionals. The impact of company policies on decisions was highlighted as a potential source of conflict and dilemma, if making a supply would be in the patient’s best interests:

'I think there's quite a, a grey area around this which does have to be erm sort of perhaps teased out if it’s going to be integrated and we can see from it, there is an actual need.’ (S8)

Communication pathways between medical practices and community pharmacies were known to vary widely. Some GPs were perceived to be over-cautious about community pharmacy, which might prompt doubts concerning pharmacists’ competence to deliver a commissioned service. Local relationships between medical practices and community pharmacists might establish different ways to handle emergency requests from patients:

‘There will be certain surgeries that say, ‘We take forty eight erm hours to do a prescription full stop, no emergencies.’ So that very much puts the emphasis back on the pharmacy but then you get other GPs that say, ‘Actually I prefer to look after my patients and then if somebody has run out of their medication, we will sort out the prescription.’ And then where does the pharmacist stand, if they then do an emergency supply? So it’s about knowing your relationship with your local surgery as well.’ (S7)
9.2 Emergency supply within the current NHS landscape

9.2.1 Technological advances

The introduction of the Electronic Prescription Service (EPS) was thought to be potentially helpful in resolving some of the difficulties faced by patients. However, patchy implementation across medical practices and community pharmacies nationwide has not allowed these advantages to be fully realised. Similarly, community pharmacists being permitted access to electronic summary patient care records as part of an integrated primary care team was supported, but delays in this function becoming available were also reported:

‘Actually repeat EPS dispensing [...] that takes that all away doesn’t it? It’s just sat there, you’ve got the prescription. [...] At a weekend, the regular pharmacist certainly the paper version you’re stuck to that one pharmacy, on EPS you could draw down the repeat anywhere. [...] No it can happen but it’s just still  erm patchy across the country’ (S5)

‘There’s no legal reason why pharmacists can’t access community care records. It’s down to local government’s decision and we’ve started those conversations to say whether we can actually say, “Okay give us access to those records, you’ve all done your information toolkit, know who’s responsible, so why can’t we start having pharmacists... At the end of the day, everybody who’s caring for patients should have access to the records.’ (S3)

9.2.2 Inappropriate use of OOH services: prescription requests

The importance of patients accessing care in the right place (GP OOH/A&E/Community pharmacy etc.) for their needs was emphasised, and it was reported that some GP Out-Of-Hours (OOH) services had already made the decision to refuse patient requests for prescriptions where this was due to a repeat order being forgotten. Stakeholders identified the role that community pharmacists could have in removing unnecessary demand from OOH services regarding medicines supply and that this could be a driver for change to a funded emergency supply service in community pharmacies. This provision would be comparatively cost effective, directing limited NHS resources to be used in the best way:

‘I think it is about the funding as well isn’t it? [...] keeping people out of out-of-hours and going to the community pharmacies but [...] making it more standardised and making, it’s making people access the right places. It’s back to the choices isn’t it? Really, of accessing the right places for the right things.’ (S2)

Local Professional Networks (LPNs) for pharmacy were considered as potentially important in driving forward the discussion of a commissioned service through feeding into Local Clinical Commissioning Groups (CCGs) and NHS England. Urgent Care Boards within each CCG area were also recognised as important avenues to push forward this agenda in view of the impact on out-of-hours services. Emergency supply was also considered to potentially fit into the wider medicines optimisation agenda.

9.2.3 Emergency supply as a funded NHS service

A funded emergency supply service was considered desirable by stakeholder workshop attendees, with Patient Group Directions (PGDs) in Scotland and Cornwall/Isles of Scilly identified as service models shown to work in practice, overcoming some of the challenges discussed above. One LPC representative/Superintendent pharmacist referred to the draft service specification available on the PSNC website, ‘Emergency supply (at NHS expense)’28, for use to inform local discussions on service development. While such a service could now be commissioned as a local enhanced service, the wide uptake of the present service suggests that
a nationwide, advanced service could be commissioned in England. Advantages of a funded model were recognised to be the separation of the issue of payment from the supply process and increased patient safety.

Desired features of a potential service design as discussed by workshop attendees are described below:

- There should be a clear and consistent Service Level Agreement (SLA), which could be adopted by all participating pharmacies, regardless of their type or location.
- Integration with other pharmacy services, particularly Medicines Use Review (MUR), minor ailments and repeat prescription services, was recommended.
- A risk assessment should be made on the patient at the point of emergency supply request, including a discussion with the patient about reason for their request, with emphasis on setting ground rules and taking responsibility in future to ensure that this did not happen repeatedly.
- Access to summary care records/electronic patient records could address current difficulties about knowing the correct dosage. The community pharmacist would then have the full picture when making the emergency supply and be able to act in the patient’s best interests, avoiding any errors in supply.
- A facility for the pharmacist to synchronise medications in pharmacy, taking responsibility for providing the patient with the amount of medication to bring their supplies of all medicines they are taking in line, was considered to be a useful supplementary feature to allow pharmacists to solve unsynchronised medicines.
- A detailed record of the supply should be made on pharmacy PMR records and any formal documentation developed for the service, including circumstances under which supply is given with reasoning behind the decision to supply being explicit for legal reasons.
- Formalised feedback to GP, to enable any follow-up, medical investigation or review required by the GP.
- Supply of Controlled Drugs would remain outside the service specification and these cases would be dealt with in liaison with out-of-hours services.

Rather than simply advertising the availability of emergency supplies more widely, a co-ordinated approach was preferred, with all parts of the NHS (medical practices, community pharmacies, GP OOH, A&E, etc.) knowing the pathways and being able to direct patients to the appropriate service:

‘At the moment, the patient has the choice. So the patient owns where they go. The patient either goes to the pharmacy or goes to the GP or goes to the out-of-hours or goes to casualty or doesn’t do anything. But if everybody within a service was aware of what the service was and the direction and signposting, it actually wouldn’t matter where the patient had made their decision. They would be signposted to where was more appropriate to them.’ (S7)

A uniform service would also eliminate patient frustration that arises from the current individual decision-making of the community pharmacist on duty regarding whether or not an emergency supply or loan is made.

Although it was recognised that there would always be a cohort of patients who would request this type of supply, it was strongly felt that a formal service should not support patients who forgot to order repeatedly and may be considered to be abusing the system. Over time, with
continued patient education at each point of access to the service about how to avoid recurrence of emergency supply situations in the future together with action by the pharmacist/GP (e.g. synchronisation of medications, review of asthma inhaler use) to prevent this, it was hoped fewer requests would be made. Formalised feedback to the GP about the emergency supply made might also help to act as a deterrent for patients:

‘You’ll link it in with maybe an MUR a request to GP so the medication can get synched so it’s all joined up. Draw a line in the sand at that point.’ […] ‘It could be one of the questions couldn’t it that you have to why have you run out is it because you’ve not ordered your medications and that information gets driven back.’ […] ‘The principle being this should never happen again (laughs) we’ll do everything we can to try and make sure that it doesn’t happen again for you.’ (Discussion between participants showing agreement)

It was felt by many participants that some community pharmacies might need to extend their current opening hours to accommodate the expected out-of-hours demand. Whilst capacity could be found through existing 100-hour pharmacies, it was thought that patients would favour attending their local, regular pharmacy and so there would need to be good communication between all partners to organise out-of-hours’ provision. The possibility that other enhanced services could be offered (perhaps via the Healthy Living Pharmacy model), with appointments to attract those who are not available on weekdays, might also help to make longer opening hours viable. In principle, it was suggested funding which is being proposed to support wider GP opening hours should also be available to support matching community pharmacy opening, particularly in this case to back an NHS emergency supply service which might alleviate the burden on OOH GP resources and time:

‘It’s the pharmacy community having longer hours isn’t it? Not necessarily every single pharmacy but the pharmacy community and having signposting. But then that’s more difficult from an emergency supply service because then the pharmacy that isn’t a regular pharmacy doesn’t have any information.’ (S7)

9.3 SUMMARY AND DISCUSSION

The recent ‘Now or Never’ RPS report\textsuperscript{29} regarding new models of care for pharmacy has emphasised the opportunity for community pharmacy to become a first point of call for patients, thus reducing pressure on other NHS services and with any funding required for additional pharmacy services to be provided through redistribution of current spending. In this case, the business case can be made that pharmacy can meet the need of individuals to access an emergency supply of their repeat medication more cost efficiently than via out-of-hours or urgent care services. Additionally, by such patient requests being redirected to community pharmacy, OOH and urgent care services would have improved capacity to deal with emergency cases. This has been acknowledged recently with recommendations from the PSNC\textsuperscript{30}, following joint work with NHS England on how community pharmacy could support urgent care provision through winter 2014, so that where an emergency supply service is commissioned, it is done as an Enhanced service using the provision in the Human Medicines Regulations 2012\textsuperscript{1}. Commissioners are urged to recognise such opportunities to utilise pharmacists’ expertise beyond routine dispensing and supply of medicines.
10 CONCLUSION AND RECOMMENDATIONS

This concluding chapter collates the key findings and discussion points from all four study phases, with additional insights from the stakeholder workshop, in order to inform the recommendations for the safe and effective provision of emergency supplies of prescription-only medicines made through community pharmacies. Recent related developments in practice and policy provide background context and indicate how implementation of some of these recommendations may be facilitated.

10.1 RECENT RELATED DEVELOPMENTS

A key principle of the 2013 NHS Constitution is ‘commitment to innovation and to the promotion, conduct and use of research to improve the current and future health and care of the population’31. This was reiterated in NHS England’s recent Call to Action32, relating to commissioning of health services, where challenges regarding the rise of long-term conditions and increasing patient expectations are highlighted. Community pharmacists are named among healthcare professionals who can support patients in managing long-term conditions in primary care. An increasing demand for online and seven-day access to health care facilities is also acknowledged. However, with increasing financial pressures, expansion of any services poses challenges.

In November 2013, a review of urgent and emergency care services in England22 highlighted community pharmacies as an under-used resource, citing that pharmacists’ knowledge and expertise could be used more effectively. Possible improvements included using pharmacists as clinical call handlers in an enhanced NHS emergency 111 service where, in response to an emergency need for supply of repeat medication, the pharmacist could access patient records, verify medications and dosage and send information to a pharmacy nearby. Following on from this review, an NHS England public awareness campaign, ‘The earlier, the better’ launched in January 2014, aims to encourage more use of the services available through community pharmacies33. This corresponds with a recent Royal Pharmaceutical Society report on future models of care for pharmacy29, which highlighted the potential of community pharmacy in out-of-hours and urgent care. The locations of community pharmacies and long opening hours were seen as advantageous, but access to integrated patient records and active engagement in local primary care partnerships and networks were seen as necessary for services to be effective, responsive and aligned to patients’ needs.

In Scotland, a service established in April 2013 funds supply of sufficient prescription-only medicines, appliances or ACBS (Advisory Committee on Borderline Substances) products, currently on repeat prescription, for up to 30 days’ treatment23. This service is restricted to circumstances where the patient’s prescriber is unavailable, the surgery is closed, or an out-of-hours system is in operation. The service operates to a standardised operating procedure, which has formalised provision and ensures consistent decision-making. Under current contractual arrangements in Scotland, community pharmacies providing NHS services are required to open for more than 30 hours per week and are remunerated for supporting unscheduled care services for patients. Joint work between NHS England and the Pharmaceutical Services Negotiating Committee (PSNC), has explored extension of pharmacy services to relieve pressure on Accident & Emergency (A&E) departments whilst maintaining standards of care30,34. Amendments to the Pharmaceutical Services (Advanced and Enhanced Services) (England)
Directions in December 2013 permit NHS England Area Teams (ATs) to commission ‘Emergency Supply at NHS expense’ as an Enhanced service from community pharmacies\(^\text{35}\). Additionally, over the past few years, the Electronic Prescription Service (EPS), a system where prescribers send prescriptions electronically directly to a pharmacy of the patient's choice, is slowly expanding across England, which has some implications for emergency supplies. As part of this, two EPS software providers, Rx Systems and EMIS undertook a pilot to integrate repeat prescribing between medical practices and community pharmacies\(^\text{36}\). Reported benefits of this pilot included community pharmacist access to a complete list of the patient's current repeat medication (as held on the GP system); improved response to patient requests; and improved communication between GPs and community pharmacies.

### 10.2 KEY STUDY FINDINGS

Our study provides a current picture of emergency supplies for prescription-only medicines being made at community pharmacies. Comprehensive stakeholder perspectives are also presented regarding how such requests are currently - and may ideally be - dealt with to support patient adherence and ease pressure on out-of-hours services. Key findings are as follows:

#### 10.2.1 Current approaches to emergency supply requests

Our study data from all 4 phases indicate that repeat prescriptions and their associated ordering systems are a major driver for emergency supply requests. This is predominantly as a result of patients having forgotten to order their medicines, but also arises from errors and patient confusion. However, other reasons also prompt emergency supplies being needed, highlighting that simply improving repeat medicine handling would not remove the usefulness of the service. The vast majority of emergency supplies are handled by pharmacists as a ‘loan’ in advance of an NHS prescription and are largely seen by patients and medical practice staff as part of the NHS supply service (note: company policies can be important barriers to providing emergency supplies and, in particular, loans.). Where charges are levied, this is predominantly for patients who are away from home and where a prescription would not be obtained reasonably. There was diversity in the quantities that pharmacists would supply on a loan, with some favouring the minimum needed and others supplying a full month, as permitted by the law.

There is concern amongst pharmacists and medical practice staff around repeated requests and potential for misuse of the system – this led some pharmacists to have personal strategies for management of repeat ‘offenders’. Staff in medical practices are also asked for urgent prescriptions to resolve issues with repeat prescription orders, generating additional workload for practice staff and GPs and interrupting other tasks. Pharmacists did not always make supplies – particularly where they felt that they were not genuine emergencies and this approach was supported by the medical practice teams.

#### 10.2.2 Requests related to management of long-term conditions

Clinical audit data, together with self-reports from pharmacists and service users about the characteristics of requests made, indicate that although all medicines groups feature among the requests, many relate to management of long-term conditions and arise from older patients. This trend is likely to become increasingly prevalent as numbers of patients with long-term conditions continue to rise\(^\text{32}\).
10.2.3 Peak periods of use when other services unavailable

Clinical audit data showed that emergency supply requests increased around times when other services are not typically available – for example, around weekends and Bank Holidays. Patients who are working find accessing services particularly difficult, given the overlap of opening and working hours. However, many patients were not aware that emergency supplies are available from pharmacies and this may reduce the number of patients accessing this service when they run out of medicines (note: there was some concern amongst healthcare practitioners and patients that widespread knowledge of the service may lead to further abuse of this provision). Service users in Phase 3 described that they would use A&E, walk-in centres or GP Out-of-Hours; borrow medicines from friends or family; or simply not take their medication if an emergency supply had been refused. Hence, emergency supplies made out of normal surgery hours may help to reduce unnecessary demand on out-of-hours services.

10.2.4 Impact on patient adherence

Many pharmacists in Phase 2 believed that emergency supplies made a positive contribution to patient adherence, although some felt that patients might abuse the system to simply make their life easier. Patients in Phase 3 reported valuing emergency supplies in terms of supporting their adherence and avoiding possible consequences of an interruption to the supply, which they recognise as important to the therapeutic success of their treatment. Pharmacists in Phase 2 and medical practice staff in Phase 4 agreed that even where medicines may not be needed urgently for clinical reasons, refusing to supply could send mixed messages to patients about the need to take the medicines regularly and may have wider implications for adherence. Pharmacists were proactive at supporting patients with managing their medicines and trying to help them to avoid situations where emergency supplies might be necessary.

10.2.5 Patient safety issues

Although making emergency supplies was reported as routine in most pharmacies, pharmacists in Phase 2 said they were cautious to ensure that the details of the medicines required were correct and took steps to verify this before agreeing to a supply. Pharmacists were aware of additional risks, and took great care as a consequence, around emergency supplies for medicines that had potential for abuse and this was valued by the medical practice teams. Pharmacists showed restraint in making supplies where full information on the medication was not available or there was any doubt regarding the veracity of the patient's claims. Loans, where a future NHS prescription is used as a mechanism to cover the cost of the medicine, carried some complexities around the clinical responsibility for the supply, which some prescribers did not feel was appropriate. Some perceptions of poor practice by pharmacists were highlighted by medical staff in Phase 4 and patient safety was considered to be paramount.

10.2.6 Relationship/communication between community pharmacy/medical practice

Positive working relationships between GPs and pharmacists seemed to help in dealing efficiently with emergency supplies in the best interests of patients, and provided reassurances on both sides that safe and appropriate supplies were made. However, such relationships take time to develop and require both parties to invest time and effort for them to become established. Some pharmacists in Phase 2 felt that better awareness of loans was needed amongst medical practice staff, and some questioned the appropriateness of loans when surgeries were open, under the current legal/practice framework. Pharmacists used emergency supply requests to select patient for Medicines Use Review (MUR) and referral for more in-depth medication review by medical practice staff. GPs and other medical practice staff in Phase 4 felt
that emergency supplies were a useful service, and they trusted pharmacists to act in the patient’s best interest.

10.2.7 Role of technological advances
Technology has an important role in both reducing demand for emergency supplies and in making them safer and more useful in the wider NHS landscape. However, pharmacists in Phase 2 reported that current patchy implementation of EPS and a lack of access to summary patient records for pharmacists were preventing these benefits from being realised. Pharmacists in Phase 2 and medical practice staff in Phase 4 felt that a more robust – and inter-pharmacy – records & reporting system would be helpful for a number of reasons, including: reducing the chance of abuse of the system; informing and engaging with GPs about supplies; helping to identify patients with problems; and identifying any aberrant use of medicines. Some felt that the feedback should be limited to circumstances where the request pointed to an underlying problem. The Electronic Prescription Service and Repeat Dispensing were seen as potentially helpful in reducing some of the problems that currently lead to emergency supply requests; however, it would not solve all of the problems that patients faced. Shifting management of repeat medicines to pharmacies through the repeat dispensing system and/or increasing the use of electronic prescription transfer would help to reduce some of the challenges around repeat prescription management and reduce the need for emergency supplies.

10.2.8 Recommended features of an emergency supply service
Current barriers to provision of emergency supplies reported by participants were the additional workload; legal and company policy issues; clarity and consistency of provision; and communication with, and support from, local GPs. Most pharmacists in Phase 2 felt that a properly constituted and commissioned service, within the Community Pharmacy Contractual Framework, would be desirable. Some pharmacists and GPs felt that some of the costs of this service could be met by the patient to reduce the risk of inappropriate use. Although pharmacists in Phase 2 reported that they felt confident in making decisions about emergency supplies, there was an appetite for national guidance on emergency supplies to help standardise the service for the benefit of patients and pharmacists. This would also help to reduce the variability in provision of loans across different companies. A clear and consistent Service Level Agreement for adoption at any community pharmacy, regardless of their type or location was preferred by pharmacy stakeholders. These stakeholders noted that for pharmacy to deliver an effective emergency supply service and have a significant impact on out-of-hours demand, longer opening hours for larger numbers of pharmacies would need to be considered.

10.3 DISCUSSION
Results from Phases 1-4 indicate that CPs are supporting continuity of medicines use by supplying them to patients without prescription on an occasional, but routine, basis. This is particularly prevalent around times where other health services are not available, such as weekends and Bank Holidays, but also happens during the week. Many requests are from elderly patients and individuals with long-term conditions, but all age groups are represented and a wide range of medications involved. Extrapolation of these data suggests that approximately 1.5 million items are supplied via this mechanism for around 1.35 million patients each year in England’s 11,000+ community pharmacies and that the vast majority of these are loaned to NHS patients in advance of a prescription. The frequency and characteristics of emergency supply requests are broadly similar to those found in the 1998 study by O’Neill et al.3. Comparisons with Health and Social Care Information Centre (HSCIC) data18 regarding
prescriptions dispensed in the community suggest that cardiovascular, endocrine and gastro-intestinal medicines were requested in proportions that broadly reflect their prescribed usages. However, medicines for respiratory conditions were over-represented among the requests, with 13% of requests being from this category, when they only account for 6% of prescribed items nationwide.

Whilst the systems in place for managing repeat medication work well for the majority of patients, there are clearly issues faced by an important minority, which are related to multiple factors. These include: opening hours; forgetfulness; process errors; and competing priorities. If patients had not accessed the emergency supply service, many would have stopped taking their medication or accessed out-of-hours and other emergency services, adding pressure to already stretched services. Non-adherence can reduce the benefits of medicines\textsuperscript{19} leading to therapeutic failure with consequential additional economic costs arising from further treatment needs. The interactions with patients that arise from emergency supplies provide opportunities for CPs to engage with patients around medicines use and adherence, as well as provide support with managing medicines. Embedding approaches such as this into routine practice is recommended in guidance regarding medicines optimisation issued by the RPS\textsuperscript{21}. The present study shows the importance of support from health professionals for those taking multiple medications for long-term conditions, as this group are most likely to require emergency supplies. A national, funded, service for emergency supply of medicines to NHS patients was supported by a wide range of stakeholders at the workshop. It was felt that such a service would have clear benefits in reducing pressure on other services, providing better structure and support for patients and supporting patients in adhering to their treatment to maximise the benefit from this. It should also include a feedback loop between the pharmacy and practice through which repeated requests, and inappropriate requests (for example, bypassing a practice medicines review by going to the pharmacy), can be discussed and joint action taken.

The findings demonstrate that community pharmacies are providing an important and under-recognised service, particularly for patients taking multiple medications for long-term conditions, which supports continuity of medicine use and a possible reduction in overall burden to the wider NHS, particularly for out-of-hours and urgent care services. The recent RPS report \textit{Now or Never}\textsuperscript{30} regarding new models of care for pharmacy has emphasised the opportunity for community pharmacy to become a first point of call for patients, thus reducing pressure on other NHS services, with funding for additional pharmacy services being provided through redistribution of current spending. In the case of emergency supplies, stakeholders felt that community pharmacy had the ability to meet the needs of individuals in accessing continued supplies of repeat-prescribed medicines with more convenience and less expense than OOH or urgent care services. They felt that redirecting such cases to community pharmacy would allow OOH and urgent care services to deal with emergency cases that cannot be handled in other settings. They wanted commissioners to be urged to recognise the opportunity to use pharmacists’ expertise via a nationally agreed, funded NHS emergency supply service, which would be advantageous for both practitioners (pharmacists and medical staff) and patients.

\section*{10.4 Benefits and Limitations of the Methods}

The methodology used in this study brought a number of benefits, and inevitable limitations. The multi-phased, mixed methods, nature of this study involved collation of data from multiple stakeholder perspectives and gives a holistic view of the provision of emergency supplies of prescription-only medicines through community pharmacies. Sufficient data were collected in all phases to reach theoretical saturation. In \textit{Phase 1}, however, data were not routinely collected regarding requests for supplies that were refused and it is not known how many patients were
referred to other services to obtain medicines. Additionally, the time of request was not recorded, so it is not possible to determine the activity in out-of-hours period other than at weekends. In Phase 2, pharmacists were self-selected and some may have known the peer whom they were interviewing. Peer-to-peer interviewing, however, has been shown to enable interviewees to be more open about issues encountered in practice, with interviewers better placed to probe answers using their professional experience\textsuperscript{37}. The response rate among patients in Phase 3 was disappointing, and it is likely that there was a self-selection bias. CPs’ existing rapport with their local medical practice team also enhanced the feedback sessions in Phase 4, with more open dialogue, giving greater understanding of the medical team perspective. In addition, CP facilitation at the stakeholder workshop was well received and their knowledge and understanding- of both practice and the study - brought additional clarity and depth to the discussions.

10.5 **Key Recommendations for practice**

The recommendations below relate to the safe and effective provision of emergency supplies of prescription-only medicines made through community pharmacies and arise directly from the key findings of the study, with input from a group of regional pharmacy stakeholders. Recommendations outline how such supplies could be better integrated and form a more coordinated component of health and social care pathways, thus ensuring that patients benefit from being able to maintain adherence to their prescribed medicines regime.

Key recommendations are as follows:

1. An NHS-funded service should be commissioned nationally that will allow pharmacists to supply regularly prescribed medicines to NHS patients under the existing criteria as laid out in the Medicines Act and subsequent Regulations. Such a service should include additional features around supporting patients in managing their medicines effectively and might include a facility to enable pharmacists to synchronise supplies of multiple medications or address other technical issues around the supply of repeat medication. Furthermore, incorporating Medicines Use Reviews into the service would also allow further review of patients with more complex issues.

2. Pharmacists should have read-only access to electronic patient medical records to inform their decision-making regarding emergency supplies. In addition, having write access to add information regarding emergency supplies made would also ensure that the patient’s medical practitioner was fully informed regarding adherence to treatment.

3. Continued roll-out of, and improvements to, the Electronic Transfer of Prescriptions (ETP) service may help to reduce the turnaround time of prescriptions and provide further mechanisms to handling emergency situations. In addition, better use of technology by community pharmacies, such as automatic reminders to patients to order their prescription in sufficient time, could further alleviate problems. Some pharmacy software providers are already developing such systems and these reminders could be via text, email or telephone.

4. A review of the current systems for ordering and supply of prescribed medicines should be undertaken locally by medical practice teams, in consultation with local community pharmacies and patient representatives to help streamline the process for patient benefit and to reduce unnecessary burden on out-of-hours and urgent care services. Such a review might involve considering wider use of the existing Repeat Dispensing Service for medicines for long term conditions, which has potential to quickly reduce the current burden on medical practices. Medium term, a review may look towards a more multidisciplinary approach to the ordering and authorisation process once electronic transfer of prescriptions and the sharing of medical records becomes more widespread.
10.6 **Key Recommendations for Research**

Further research, including economic modelling to estimate the cost-effectiveness of a funded NHS emergency supply service, is required to assess its feasibility and its potential to be a cost effective mechanism to reduce demand on out-of-hours services.
11 REFERENCES

10. Cornwall and Isles of Scilly PCT Media Centre. New Local Service Provides Urgent Repeat Medicines.