

## Warrington Place Prescription Medication Shortages Guidance

### Background

Medication shortages have become increasingly common over the last few years. There are many reasons why a medicine might go out of stock including problems with the manufacturing process, raw material shortages and regulatory issues. Some manufacturers have introduced wholesaler quotas to better manage the supply of UK medication to improve patient access; however problems in the supply chain can arise when a wholesaler has exceeded their quota. This results in varying availability between community pharmacies and confusion over overall stock availability.

Stock shortages can have a substantial negative impact on:

- **Patients** - Shortages can lead to delays in treatment, deterioration in therapy if an alternative medicine is prescribed, decreased compliance and the inconvenience of increased visits to their pharmacy and GP practice when their medication is unavailable due to supply issues.
- **Community pharmacies** - Shortages inevitably lead to increased time spent in sourcing products, discussing alternatives with prescribers and counselling patients. These factors have a major impact on increasing community pharmacy workload.
- **General Practice** – Increase in workload for reception staff dealing with sourcing pharmacies that do have stock of existing medication and/or prescribers finding alternative medication and counselling patients.
- **Medicines management teams** – Supporting patients, general practice and community pharmacy with sourcing medication, suitable alternatives and liaising with manufacturers all impact on workload.
- **NHS as a whole** - Medication shortages can be very costly to the NHS. As well as the increased costs of sourcing potentially more costly alternatives, the unavailability of a key medicine or decreased patient's compliance with their medication regimen can lead to the exacerbation of a patient's medical condition, increasing hospital admissions and treatment costs.

Shortages can have a negative impact on relationships between these key stakeholders as dealing with the shortage can cause friction between the patient and the pharmacist and the pharmacist and the prescriber.

It is important that all stakeholders work together to ensure that a shortage of a product does not cause unnecessary problems for patients, community pharmacies and prescribers. Each supply problem is different and has to be dealt with on an individual basis. However, the following suggested actions provide a general approach for pharmacy and practice staff to provide a patient centred approach:

- Guidance for Community Pharmacy (Appendix 1)
- Template form for communication between community pharmacy and general practice: medication shortages (Appendix 2)
- Guidance for general practice (Appendix 3)

### References

- Pharmaceutical Services Negotiating Committee Guidance on Supply chain and shortages  
<https://psnc.org.uk/dispensing-supply/supply-chain/>
- Medicines Supply tool (NHS email needed to register)  
<https://www.sps.nhs.uk/home/planning/medicines-supply-tool/>

## Appendix 1: Guidance for Community Pharmacy

Community pharmacists use a range of measures to ensure patients can access medicines in short supply. Pharmacies have contingency arrangements in place to source medicines where stock is unobtainable from the primary wholesaler. It is beneficial for these to be available to all of the pharmacy team, including locums.

In order to ensure that patients have access to their medicines with reasonable promptness (within 24 hours under normal circumstances) and to fulfil the requirements of the Pharmacy Contract Essential Service “Dispensing” the flowchart in Appendix 1 details a checklist of actions that could be taken when trying to source a prescribed medication.

### Assess need

- ☐ Confirm that the patient still uses or requires the medication. The patient may prefer to wait for stock to arrive if the medication is not required urgently.
- ☐ Identify the number of days’ supply of the medication that the patient has at home.
- ☐ Check if the patient has tried to obtain the medication from other pharmacies.



### Contact Suppliers

- ☐ Where stock is unavailable from a wholesaler, attempt to re-order via an alternative wholesaler(s).
- ☐ Check whether all pack sizes and all brands of the medication are out of stock with all wholesalers and take note of any alternative strengths that are in stock.
- ☐ Call the wholesalers by telephone and ask when they expect to receive stock. They may also be aware of stock that your automated ordering system did not attempt to order.
- ☐ Consider contacting the manufacturer with regards to direct supply. If manufacturers are holding stock they will usually wholesale directly to the pharmacy to meet the needs of a specific patient urgently. For further information see <https://psnc.org.uk/dispensing-supply/supply-chain/manufacturer-contingency-arrangements/>.
- ☐ Consider dispensing a branded item against a generic prescription if appropriate.



### Contact alternative pharmacy

- ☐ Contact another local pharmacy nearby to ask if they have any stock available, or can obtain stock.
- ☐ In some cases the out of stock medicine will have been prescribed on a prescription alongside other items. If the other items have already been dispensed **and handed out** to the patient the prescription cannot be taken to another pharmacy. In this case it may be more appropriate for the patient’s nominated pharmacy to carry out “Staged dispensing” (handing out some medicines and asking the patient to return at a later date for the full supply) or obtain stock from another pharmacy to fulfil the prescription.
- ☐ Consider a request for the prescriber to produce duplicate prescriptions in order for items to be available on separate prescriptions forms.



### Contact Prescriber

- ☐ Contact the prescriber to discuss potential alternative preparations if the medicine cannot be obtained. Consider using the template in Appendix 2 if appropriate. Urgent cases where the patient has a limited supply remaining may require a telephone call directly to the practice and be followed up with the information contained in the form.
- ☐ Inform the practice/prescriber if the medication is commonly prescribed and the supply issue is likely to affect multiple patients.
- ☐ It is useful to inform practice staff of the expected date that the item prescribed will be back in stock and which potential alternatives are in stock.
- ☐ **Inform the prescriber when the medicine is back in stock (where appropriate).**

## Appendix 2 - Template form for communication between community pharmacy and general practice: medication shortages

Date	
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To:

Name of prescriber	
Name of practice	

We are currently unable to supply the following medication for your patient named below.

Patient name	
Patient date of birth	
Out of stock prescription item (include name, form, strength and any other relevant details)	
Current supply issue	
Expected duration of supply problem	

The pharmacist suggests the following item as a potentially suitable alternative and the pharmacy has sufficient stock available.

Potential alternative (include name, form, strength and any other relevant details)	
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We will speak to the patient to ensure that they understand the change in medication and contact the practice when the original item is back in stock.

Thank you for your help. Please arrange for the prescription to be sent electronically where possible to (insert pharmacy name)\_\_\_\_\_ the patient has \_\_\_\_\_ days supply remaining.

Kind Regards,

Pharmacy Stamp

Contact name \_\_\_\_\_

Contact telephone number \_\_\_\_\_

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## Appendix 3 Guidance for general practice

Having strong communication links, flexibility and good relationships with community pharmacies will ensure that any medication supply issue can be addressed quickly and with minimal disruption. In order to ensure patients have access to their medicines with reasonable promptness (within 24 hours under normal circumstances) the following actions could be taken when an out of stock situation occurs.

### Pharmacy request

- Community pharmacies may contact the practice to: report a general medication supply issue, request a duplicate prescription/items split over multiple prescription forms or request a medication change for a specific patient.
- The community pharmacy could utilise the provided template in Appendix 2.



### Practice action

- Cancel electronic prescriptions, where appropriate, and provide separate prescription forms (electronic or paper) to enable a patient to obtain items from different pharmacies. In some cases the out of stock medicine will have been prescribed on a prescription alongside other items. If the other items have already been dispensed **and handed out** to the patient the prescription cannot be taken to another pharmacy. Pharmacists will attempt to obtain the out of stock medication initially without requesting additional prescriptions.
- When sending electronic prescriptions to a pharmacy other than the patient's usual nominated pharmacy (as a result of a supply issue) ensure that the nomination remains with the patient's chosen community pharmacy.
- Forward template forms and requests for medication changes to the prescriber promptly so that the changes can be made in a timely manner.



### Prescriber action

- Consider the recommendations made by the community pharmacist.
- If a medicine has been discontinued consider the ongoing need for treatment and prescribe an alternative if appropriate.
- When a medicine is temporarily unavailable and an alternative is prescribed:
  - Take into account formulation, dose, monitoring and the impact this may have on the patient.
  - Prescribe alternative medicine on "acute" initially where possible.
  - If prescribing on "repeat" make a note on the patient record that the change needs to be reviewed once the original item becomes available.
  - Consider whether quantities need to be amended to synchronise with the patient's other medication when the item is back in stock.



### Inform patient

- Inform the patient that a change has been made to their medication. Highlight any changes to the formulation, strength, dose or method of administration. Explain any additional monitoring required.
- Alternatively, it may be appropriate for the community pharmacist to counsel the patient about the changes. As messages using the EMIS / SystmOne systems do not always reliably pop up as an alert on the pharmacy PMR, a telephone call from the prescriber is preferable to agree any actions.