PharmacyVoice

Speaking up for community pharmacy

Prescription interventions

Practice-based Audit 2014/15

June 2015

Pharmacy Voice
4 Bloomsbury Square
London
WC1A 2RP

T 020 3405 2810
E info@pharmacyvoice.com
www.pharmacyvoice.com

Executive Summary

- Prescribing is the most common patient-level intervention in the NHS**. Over 1 billion prescription items were supplied in primary care in England during 2014**, the vast majority of which were supplied by community pharmacies.[1]

- Working from high street, local and rural locations, community pharmacy teams ensure that medicines are correctly and safely supplied, together with information and advice. These core members of the healthcare community act as an **essential safety barrier** aiding in the prevention of issues with prescriptions from reaching patients.

- The audit data presented here sought to quantify the number of prescribing incidents and queries received by pharmacies and establish the volume of these which may have resulted in a serious patient incident where moderate or severe harm, or even death, could have been caused.

- **Data were collated from 5,198 pharmacies**, including national and regional multiples as well as independents. These pharmacies recorded a total of 113,471 interventions during a two week period. Based on an estimated figure of 3,131 as the average number of items that a community pharmacy dispenses over a two week period, this suggests an intervention rate of 0.70% or 7 interventions per 1000 items. Cautious extrapolation of these figures suggests that **community pharmacy teams in England intervene on a possible 6.6 million prescription items every year**.

- The most common types of interventions on prescriptions related to supply/availability problems (20.49%), unsigned prescriptions (18.07%), problems with the medicine form (7.86%), quantity (6.79%) or drug item/brand (6.70%) prescribed.

- The audit found that, for the interventions where potential level of harm prevented was recorded, one in ten of the issues encountered with prescriptions could have resulted in a serious incident if it had not been for the pharmacist's intervention. There is however a degree of subjectivity in recording potential harm levels prevented, even with the definitions provided by the NRLS. Because of this, combined with the fact that in nearly half of the cases the level of potential harm was not recorded at all, it is difficult to draw firm conclusions about the overall levels of harm prevented by pharmacist interventions. A cautious conclusion from the data collected is that somewhere between 5 and 10% of the interventions made by pharmacists every day prevent moderate or severe harm from being caused.

- The audit has provided further evidence that **medicines shortages are still widespread** and that this persists as a growing problem for patients and the public, highlighting the need for action on this issue. Pharmacy Voice will continue to work closely with the British Generic Manufacturers Association (BGMA), British Association of Pharmaceutical Wholesalers (BAPW), Association of the British Pharmaceutical Industry (ABPI) and others to contribute to the work of the Department of Health Supply Chain Group on medicines shortages, in order to ensure that a rapid resolution is found for patients and pharmacy teams.

- The management of these interventions necessitates a considerable time pressure for all members of the primary care team. Therefore, steps taken to reduce the need for interventions will improve efficiency and patient safety. Pharmacy Voice continues to advocate strongly for greater **joint working between GPs and pharmacy teams** to reduce errors, increase learning, improve the patient journey, drive efficiency and reduce delays in patients safely receiving their medicines.

- Pharmacy Voice recognises the value that providing **access to patient records** for pharmacists can bring and welcomes the Department of Health announcement that NHS Summary Care Records will be rolled out to all community pharmacies. On the basis of the findings presented here, Pharmacy Voice will continue to advocate for 'read and write' access to the patient record for all community pharmacists.

[1] Health and Social Care Information Centre (2015) Prescription Cost Analysis, England – 2014. Available at: http://www.hscic.gov.uk/catalogue/PUB17274/pres-cost-anal-eng-2014-rep.pdf

Background

Prescribing is the most common patient-level intervention in the NHS. There has been a marked increase over the last decade in the number of items prescribed in primary care in England, from around 450 million items in 2004 to over 1 billion items in 2014.[2] Most of these prescription items are dispensed by community pharmacies; in 2013-14, 948.2 million of the 1.3 billion items prescribed were dispensed from community pharmacies.[3]

Community pharmacies check and dispense prescriptions every day as a fundamental part of their regular practice; dispensing is Essential Service 1 of the NHS Community Pharmacy Contractual Framework and is offered by all pharmacy contractors. Working from high street, local and rural pharmacies, community pharmacy teams ensure that medicines ordered, or bought over the counter, are correctly and safely supplied, together with information and advice. As experts in medicines, pharmacy teams act as an essential safety barrier, ideally placed to help prevent any issues with prescribed medicines from reaching patients.

General practices have various systems in place to help reduce the risks of error. In 2012, the General Medical Council published a report on the prevalence and causes of prescribing errors in general practice.[4] The report found that the vast majority of prescriptions are appropriate and effectively monitored; however, around 1 in 20 contained an error. Researchers classified most of these errors as mild or moderate, but around 1 in 550 prescription items was associated with a severe error. The report recommended a greater role for pharmacists in supporting GPs. Pharmacy Voice believes closer working between GPs and pharmacy teams would lead to huge improvements in patient experience, not just in terms of patient safety but also ensuring that people see the right person at the right time and thereby relieving pressure on GPs.

Methodological Approach

The contractual framework for pharmacy in England and Wales requires each pharmacy to complete two types of audit every year over a total combined period of 1 week. The first audit is completed at the request of NHS England and the second is a practice-based audit conducted by the pharmacy on a topic of its choosing.

Practice-based audits present an opportunity to review the systems and procedures operating in a pharmacy and, having assessed what is happening, ascertain what can be done better. Audits can be used to gain data about what is happening in a pharmacy as a prompt for working with other health professionals to improve safety, quality and the whole patient experience.

Pharmacy Voice has worked with pharmacy owners over the last few years to develop an audit that could be carried out on a large scale across a number of companies and types of community pharmacy to gather results that can be used to gain a picture of an issue at a national level. This represents the fourth audit that Pharmacy Voice has carried out in this way and its topic was determined through consultation with Pharmacy Voice members. The audit was available to all members of the Association of Independent Multiple Pharmacies, Company Chemists' Association and the National Pharmacy Association.

The purpose of the audit was to review the number of prescription interventions that pharmacists and their teams make as part of their everyday practice. Three years ago, Pharmacy Voice used its first national audit of this type to investigate prescribing interventions, and there was considerable interest in the results inside and outside of the profession. For the first time, we quantified, at scale, this particular type of activity. Three years on, we will be looking to see if these pharmacist interventions on prescriptions are increasing or decreasing, and provide further evidence of the day to day role of pharmacists in contributing to care.

[2] HSCIC (2012) Prescribing. Available at: http://www.hscic.gov.uk/prescribing.
[3] HSCIC (2014) Prescriptions Dispensed in the Community. Available at: www.hscic.gov.uk/catalogue/PUB14414
[4] Avery, T. *et al.* (2012) Investigating the prevalence and causes of prescribing errors in general practice. Available at: http://www.gmc-uk.org/Investigating_the_prevalence_and_causes_of_prescribing_errors_in_general_practice___The_PRACtICe_study_Reoprt_May_2012_48605085.pdf

The aim of the audit was to investigate the number of issues with prescriptions that each pharmacy encounters and addresses (through intervention) over a two week period. Pharmacies conducted the audit during September, October or November 2014. The objectives were:

- to quantify the number of prescribing incidents and queries received by each pharmacy
- to identify the volume of prescribing incidents which may have resulted in a serious patient incident where moderate or severe harm, or even death, could have been caused.

A data collection form and associated two-page guidance document were made available for pharmacy teams on the Pharmacy Voice website. Pharmacy teams also had an opportunity to participate by submitting details of each incident on an individual basis using an online survey.

Data were collected manually in each pharmacy. The data collection form could be downloaded and saved for filling in electronically or printed out and filled in by hand. Pharmacists were asked to use their local Standard Operating Procedures to handle any issues that arose with a prescription. Once an issue had been resolved they were then asked to record the details of the intervention made on the data collection form. This included noting the incident and/or query, the potential level of patient harm avoided by intervening and the action taken to resolve the incident or query. Data were then either shared directly with Pharmacy Voice or collated first by some of the larger multiples. The collated, anonymous data were analysed centrally and the results are reported here.

Definitions

Prescription item – Each item prescribed on a prescription form. Each prescription form may include one or more prescription items.

Clinical query or error – Any intervention where there is a clinical problem or error with the prescription, e.g. an interaction or a concern about dosing or timing of the medication. This also includes issues where the prescriber or surgery is contacted where there are problems with the supply of the medication due to it being out of stock.

Documentation error – Any intervention where there is a question about the legal validity of the prescription that requires intervention, e.g. it is unsigned or does not comply with CD regulations

Potential patient harm avoided – the potential for patient harm due to the incident or query, as defined by the National Reporting and Learning Service (NRLS) and NHS England:

No harm	Any patient safety incident where no harm would have been caused to patients receiving NHS-funded care.
Low harm	Any patient safety incident that could have required extra observation or minor treatment and could have resulted in minimal harm to one or more patients receiving NHS-funded care. Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned; nor does it include a return to surgery or readmission.
Moderate harm	Any patient safety incident that could have resulted in a moderate increase in treatment and that could have resulted in significant but not permanent harm to one or more patients receiving NHS-funded care. Moderate increase in treatment is defined as a return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident.
Severe harm	Any patient safety incident that could have resulted in permanent harm to one or more patients receiving NHS-funded care. Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiological or intellectual, including removal of the wrong limb or organ, or brain damage.
Death	Any patient safety incident that could have directly resulted in the death of one or more patients receiving NHS-funded care. The death must be related to the incident rather than to the natural course of the patient's illness or underlying condition.

Independent multiple pharmacy – In this instance, an independent multiple pharmacy was any chain with between four and sixty branches.

Multiple pharmacy – In this instance, a multiple pharmacy was any chain with over sixty branches.

Results

These audit results were collated from 5,198 pharmacies. Data were collected by eight national multiples, nine regional independent multiples (which together have over 150 stores) and 25 independent pharmacies.

According to the Health and Social Care Information Centre, there were 11,647 community pharmacies in England at 31st March 2014[5] so this sample is representative of nearly 45% of the total community pharmacy population (n=44.63%).

The average number of prescription items dispensed per month across England is 79 million (79,017,000).[6] This works out as an average of 6,784 items per month per pharmacy. Using these figures, we can estimate the average number of items that a community pharmacy dispenses over a two week period to be 3,131. Using these data, it can be estimated that during the two-week audit period over 16 million prescription items (n=16,274,938) were dispensed from the 5,198 community pharmacies involved.

Interventions

The data gathered from the pharmacies showed that the total number of prescription interventions made during the audit was 113,471. This computes to an intervention rate of 0.70% or 7 interventions made per 1000 items dispensed. Cautious extrapolation of these figures for the 948.2 million items dispensed by community pharmacies in 2013-14 suggests that in the region of 6.64 million interventions were likely to have been made by community pharmacy teams in a year.

Figure 1 - Volume of each intervention made during the two week audit across 5,198 pharmacies

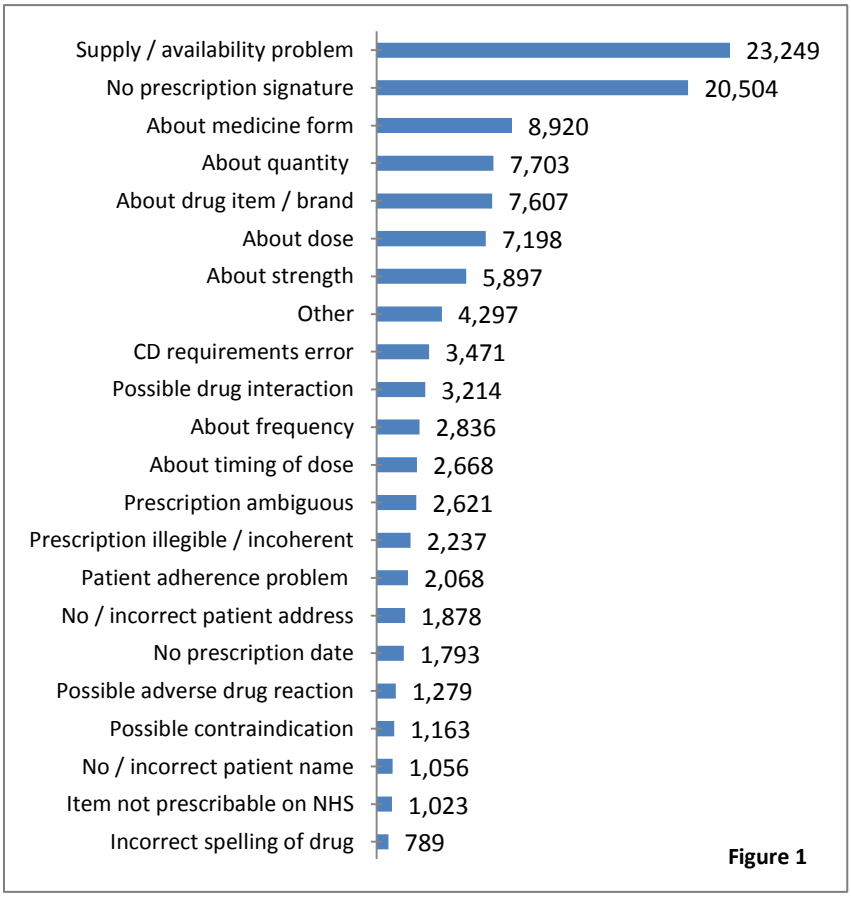


Figure 1

[5] HSCIC (19 November 2014) General Pharmaceutical Services England 2004-5 to 3013-14. Available at: http://www.hscic.gov.uk/catalogue/PUB15933/gen-pharm-eng-201314-Report.pdf
[6] *Ibid.*

As can be seen in Figure 1, issues with the supply or availability of medicines accounted for a fifth of all interventions made on prescriptions during the audit period (n=20.49%).

The rest of the interventions made can be split into clinical queries and documentation errors. Of the interventions made, prescriptions with documentation errors, e.g. unsigned prescriptions or prescriptions with unfulfilled Controlled Drug requirements, accounted for a quarter (n=25.29%) of interventions made and clinical queries/errors accounted for just over half (n=54.15%) of interventions. The nature of these interventions can be seen in Figures 2 and 3.

Figure 2 – Volume of clinical queries/errors made during the two week audit across 5,198 pharmacies

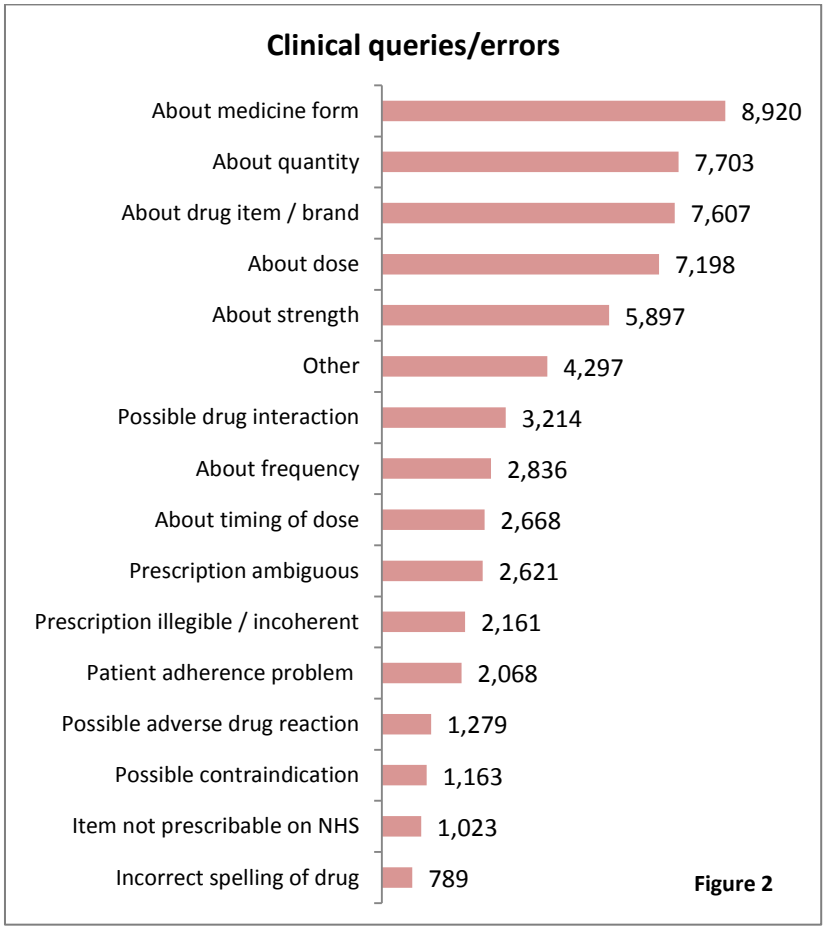
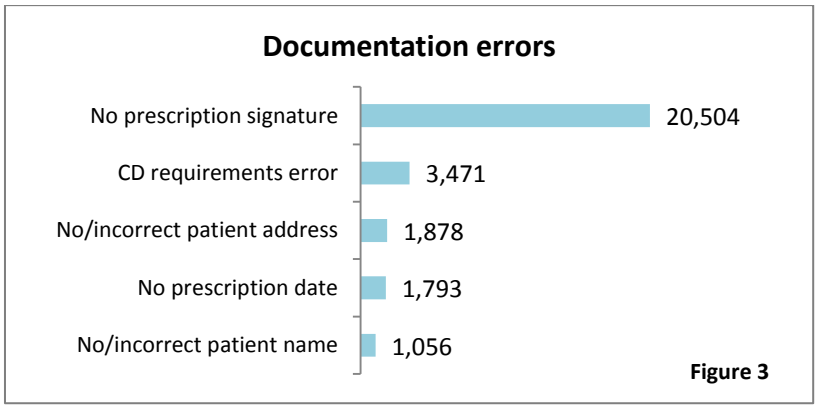


Figure 3 – Volume of documentation errors made during the two week audit across 5,198 pharmacies



Potential level of harm prevented

As it is not required by NHS England to record the level of potential harm for any errors that are detected before they reach patients, some pharmacies did not record the level of potential harm prevented for all of the interventions made during the audit. The potential level of harm avoided was noted for just over half of the total interventions recorded (n=58,763).

Figure 4 shows that of the incidents where 'potential harm prevented' was noted, the majority (n=89.54%) **would not** have resulted in a serious patient safety incident. However, around 1 in 10 of the interventions made (n=10.46%) potentially prevented moderate or severe harm, or even death, being caused.

Figure 4 – Potential level of patient harm avoided by making an intervention

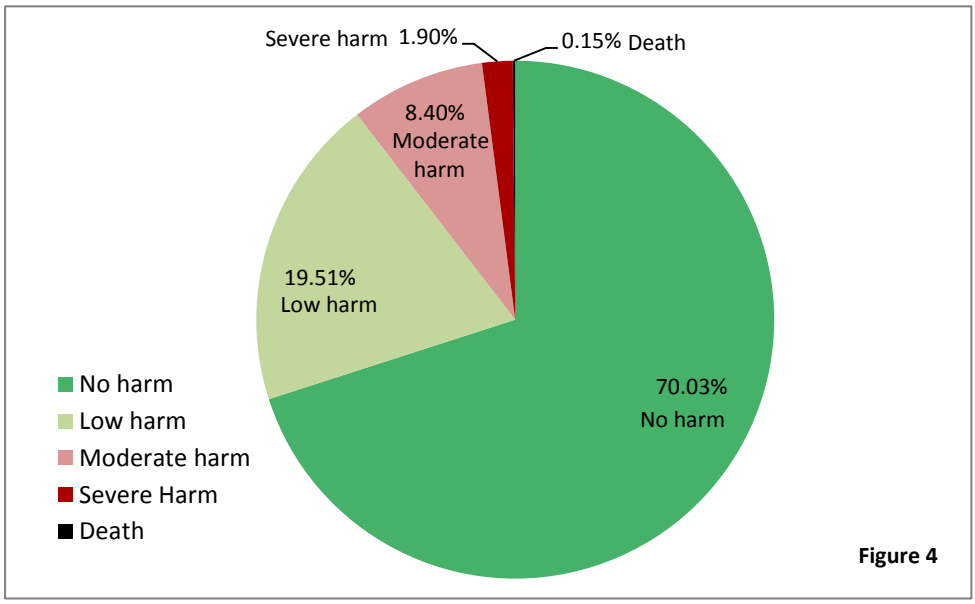


Figure 4

Resolutions

Methods of resolution were recorded for each intervention. In some cases more than one method was used. Some incidents may require a number of communications in order to reach a resolution that the pharmacist, prescriber and especially the patient are satisfied with. As shown in Figure 5, contacting the prescriber or practice staff directly (this is usually done by telephone) was the most common method for resolving problems (n=69.20%).

Figure 5 – Method of resolution

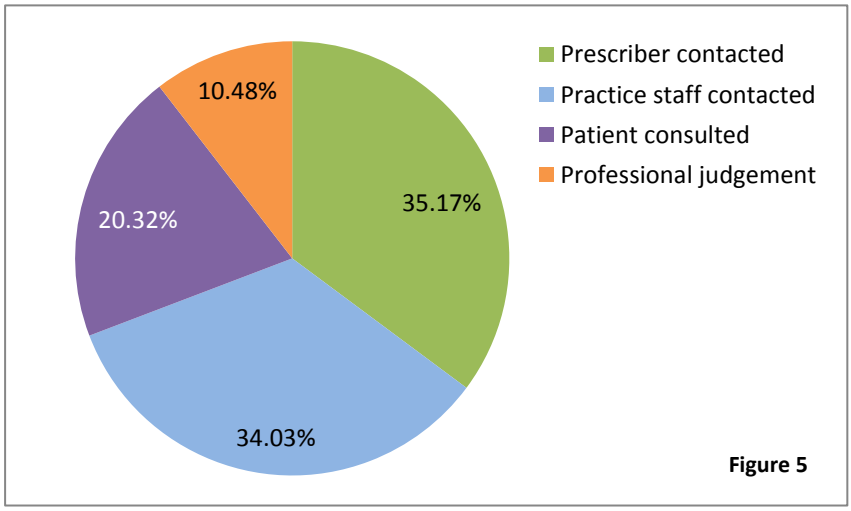


Figure 5

Discussion

Pharmacies play a vital role in ensuring patient safety when prescribed medicines are used. These data show the value of safety checks carried out in pharmacies, and the importance of information transfer between prescriber, patient and pharmacist. This audit was not undertaken to focus upon shortcomings in general practice or on the part of prescribers but rather to demonstrate multidisciplinary primary care operating well, and to identify areas for improvement in this team work. Errors can and do occur in every part of the process. This is why checks are built in, with local pharmacies working in tandem with doctors to ensure the effective and safe use of medicines by the public.

Interventions

The results presented here align with comparable studies. As previously mentioned, Pharmacy Voice conducted a similar audit in 2011/12. The 2011/12 audit found that of the 4,409 pharmacies involved, interventions were made on 44,527 potential incidents and 37,322 queries were resolved over the two week audit period. Some of the types of intervention varied from this audit. For instance, the previous audit did not specifically include interventions made due to supply/availability issues, which made up over 20% of the interventions in this audit. Supply/availability issues were included in this audit as sourcing medications and supply chain problems appear to be a growing issue, taking up a considerable amount of time for the whole primary care team.

The previous audit found a much lower rate of 2.22 incidents per 1000 items dispensed and 1.86 queries per 1000 items dispensed. This works out as an overall intervention rate of 4.08 per 1000 items compared to the 7 interventions made per 1000 items in the latest audit. The reasons for this difference are not entirely clear, and because slightly different data-sets were collected each time it is not possible to say whether this represents an overall increase in incidents. However, it is possible this is the case in the context of the growing workload for general practice and pharmacies over the past three years, as seen by increased prescriptions and repeat medications, and greater frequency of medicine shortages.

Last year's Pharmacy Voice audit also highlighted community pharmacy's essential role in the safe and effective use of medications, more specifically, repeat medications. This audit found that one in every five patients had some sort of query with their prescription that required resolution by one of the pharmacy team.[7]

Particularly comparable research to the data presented here was carried out in 2014 by Morgannwg Local Practice Forum.[8] Their audit took place in 29 pharmacies and an intervention rate of 5.5 interventions per 1000 items dispensed was found. This audit also found a high percentage (n=24%) of interventions relating to supply/availability problems. Pharmacy Voice will work with the research team from Morgannwg LPF to discuss outcomes and any joint next steps using the evidence from our recent audits.

Supply issues

With patient safety a key priority for Pharmacy Voice, shortages of medicines have been a growing concern over the past few years. Issues associated with the supply of medications in recent years have been well documented. In September 2012, Pharmacy Voice released data[9] which for the first time systematically captured the extent of patient harm caused across the UK as a result of medicine supply problems. The research found that over a quarter of pharmacies reported experiencing six or more medicine supply delays (exceeding 24 hours) in an average week.[10] The research provided a detailed audit of individual supply delays and their impact on patients. The data showed that 44% of patients

[7] Pharmacy Voice (2014) Repeat medication ordering and interventions. Available at: http://www.pharmacyvoice.com/images/resources/PV_Practice_Based_Audit_2013_FINAL.pdf
[8] Bailey, S *et al.* (2014) Keeping Patients Safe in the Community: The Evidence from Community Pharmacy Prescription Interventions. Morgannwg Local Practice Forum.
[9] Pharmacy Voice (2012) Medicine Supply Chain Survey: Assessing the impact of supply delays on patients.
[10] *Ibid.*

were inconvenienced by the interruption in their medication supply, a further 21% experienced distress and around 1 in 8 shortage incidents (12%) would have had a clinical impact for the patient.[11]

The research also found that a significant amount of pharmacy time was spent on the problem and therefore diverted pharmacy teams from patient-facing roles. This time was estimated to be at least 210,000 days of pharmacy staff time per year.[12] The All Party Pharmacy Group stated in July 2014 that "the work that pharmacists do in minimising disruption to patients is giving the impression that the issue of shortages has lessened to a low level."[13]

There have always been intermittent medicines shortages, whether caused by problems in the manufacturing process, a shortage of raw ingredients or imbalances within the supply chain between supply and demand. However, pharmacists on the front line began reporting a worsening in the supply situation approximately six years ago and it remains unsatisfactory. These audit results, in addition to the results of the Morgannwg LPF audit, clearly demonstrate that medicines shortages and supply issues continue to be a problem and need to be addressed. The priority of community pharmacies is to get medicines to patients who need them when they need them, and Pharmacy Voice is actively engaged in seeking a solution to these problems.

Pharmacy Voice will monitor the ongoing position and work with the British Generic Manufacturers Association, British Association of Pharmaceutical Wholesalers and others to contribute to the work of the Department of Health Supply Chain Group.

Prescriptions without a signature

Omitted signatures on prescriptions accounted for nearly a fifth of all interventions made during the audit (n=20,504). This is likely due to the high number of repeat prescriptions that would have been included in the prescriptions dispensed during the audit period. Repeat prescribing plays a significant part in the supply of medicines to patients in primary care. According to NHS Cumbria's Medicines Management Team, in 2011, two thirds of prescriptions generated in primary care are for patients who have requested a repeat supply of the medicines they take regularly.[14]

Most often, regular repeat prescriptions are ordered by patients through their practice and are then generated by a prescription clerk or receptionist using a patient's record. These prescriptions are often then signed by GPs in bundles. Due to the signing in bulk of these prescriptions, it is possible for some prescriptions to be omitted, resulting in a missing signature when these arrive at the pharmacy.

Systems and processes for managing prescriptions vary between practices, and so individual practice teams would need to consider whether changes would be necessary or appropriate to reduce the numbers with signatures omitted. The signing of prescriptions is not a purely administrative task and GPs need to work closely with their whole team to ensure that this additional safety check is carried out in the most beneficial way for their patients and staff as well as their colleagues in community pharmacy. Improved systems could reduce the number of missing signatures resulting in fewer queries back to practice staff as well as a reduced workload for pharmacy teams and (potentially) reduced delays in patients receiving their medications. Joint training and awareness-raising might be useful in some cases – for example having practice staff spend some time in a pharmacy and vice versa, so that the impact of errors, omissions and queries on each others' day-to-day activities is better understood.

A better utilisation of existing systems could also help reduce delays for patients. As recommended in last year's Pharmacy Voice audit[15], if more community pharmacies were able to manage repeat dispensing services in full, this would free up resources in general practice and help ensure that pharmacy teams can continue their contribution to improving patient safety. The implementation of

[11] *Ibid.*
[12] Pharmacy Voice (2012) Medicine Supply Chain Survey: Assessing the impact of supply delays on patients.
[13] All-Party Pharmacy Group (2012) APPG inquiry into medicines shortages. Available at: http://www.appg.org.uk/downloads/
[14] NHS Cumbria Medicines Management Team (2011) Repeat prescribing: A practice guide. Available at: http://www.cumbria.nhs.uk/ProfessionalZone/MedicinesManagement/Guidelines/RepeatPrescribing-Apracticeguide2011.pdf
[15] Pharmacy Voice (2014) Repeat medication ordering and interventions. Available at: http://www.pharmacyvoice.com/images/resources/PV_Practice_Based_Audit_2013_FINAL.pdf

incentives and consistent commissioning messages for prescribers would further drive the development of repeat dispensing services in community pharmacy.

Pharmacists use their professional judgement on a daily basis to prevent inconvenience and potential harm for patients from delays in receiving medicines. These delays could be reduced through increasing the use of the Electronic Prescription Service (EPS). Increased use of EPS would help to maintain the security of prescriptions and may help reduce the time that patients spend waiting for repeat medications – especially if EPS is used in conjunction with Repeat Dispensing.

Potential harm prevented

During the audit, pharmacists were asked to record the potential level of harm that could have been caused had a pharmacist not intervened on a prescription. Community pharmacists are already familiar with the existing National Reporting and Learning Service (NRLS) harm level classifications provided as they use these to classify the alleged or actual harm resulting from incidents that actually reach patients (e.g. dispensing incidents). Since 2005, pharmacies have been required to record any dispensing incidents in an incident log and regularly report these to NHS England through the NRLS.

Community pharmacists are not however required by NHS England to report incidents to the NRLS that are detected **before** a medication is handed over to a patient or a patient's representative. These incidents which do not reach the patient are known as 'near-misses' and all of the interventions made on prescriptions during this audit fall into this category. Perhaps because it is not an existing reporting requirement, the potential level of harm avoided was only noted for just over half of the total interventions recorded during the audit (n=58,763).

The audit found that, for the interventions where potential level of harm prevented was recorded, one in ten of the issues encountered with prescriptions could have resulted in a serious incident if it had not been for the pharmacist's intervention. There is however a degree of subjectivity in recording potential harm levels prevented, even with the definitions provided by the NRLS. Because of this, combined with the fact that in nearly half of the cases the level of potential harm was not recorded at all, it is difficult to draw firm conclusions about the overall levels of harm prevented by pharmacist interventions.

One approach would be to assume that the estimated level of harm prevented for all cases is likely to be similar to that for cases where the level was recorded. This might be the case if there was no systematic reason for recording or not-recording the estimate (e.g. if this was due to reasons such as forgetting; not having time; errors completing the form). However, discussions with members of the Pharmacy Voice Pharmacy Practice Group and with companies whose branches did not record harm levels for every intervention made, suggest it may be more likely that the level of harm was not recorded when it was considered no harm would have been caused, as this is not something branches normally make a record of. This would indicate that the one in ten figure could not simply be extrapolated as an estimate to be applied to the data overall.

It should perhaps therefore be cautiously concluded that somewhere between 5 and 10%[1] of the interventions made by pharmacists every day prevent moderate or severe harm, or even death, from being caused. Whatever the true figure within this range, it is clear that the vital contribution that community pharmacy makes in preventing harm occurring further along a patient's journey is of enormous value to the NHS. In their daily practice community pharmacies are preventing harm to patients which could eventually otherwise have a serious negative impact on both patients themselves, and on the health and care system.

Methods of resolution

This audit did not explore the reasons for which contact with a prescriber or practice staff was necessitated; however, it is likely that these contacts were to secure further information on a patient or

[1] Our audit found that 10.46% of interventions for which the potential level of harm prevented was recorded could have resulted in moderate, severe harm or even death being caused. If the other interventions made for which a level of harm prevented was not recorded all would have resulted in no harm being caused, this figure would be 5.42%.

their condition, to enable the pharmacist to make a suitable judgement on how to proceed safely in their intervention.

The conversations with practice staff were also not timed; however, previous Pharmacy Voice research[16] suggests that the average time spent dealing with an incident is 15.41 minutes. With the suggested extrapolated figure of 6.6million interventions per year, these fifteen minutes per incident are a significant cost in both staff time and money to the pharmacy team, practice, and consequently the NHS as a whole. This time could be significantly better utilised to improve patient care.

These results demonstrate that pharmacists are sometimes resolving problems (around 3 in 10) without the requirement to contact the prescriber; this is generally through the use of records or discussions with the patient (n=30.80%). The recent announcement that all community pharmacies will be granted access to the NHS Summary Care Record will allow them to address more of these problems without interrupting prescribers. Community pharmacy access to care records has the potential to improve patient safety by supporting safer and more informed prescribing by providing timely access to accurate information.[17] The Summary Care Record also has the potential to improve the efficiency and effectiveness of patient care by reducing the time, effort and resources required to obtain information needed from a patient's GP practice. In turn this will also improve continuity of care and the patient experience.

Access to the Summary Care Record for all community pharmacies is a positive first step towards full 'read and write' access to patient records, enabling pharmacy teams to provide better patient care and help provide a more consistent primary care service.

New proposals for better working and improved liaisons between community pharmacists and GPs have recently been recommended by the Royal Pharmaceutical Society and Royal College of General Practitioners.[18] These proposals call for pharmacists to work in GP surgeries in a bid to ease current pressures in general practice. Pharmacy Voice welcomes moves for closer working between pharmacists and GPs however believes that if these proposals for practice-based pharmacists are to be taken forward by NHS England, this needs to be as part of a bigger picture of closer integration, ensuring that patients see the right person, at the right time.

Realising the potential of community pharmacy

In order for community pharmacy to be able to contribute fully to improving outcomes and safety in the NHS, it will be important to ensure the findings from this audit are effectively used and learned from. Actions to embed these findings include:

- **Pharmacies and general practices should work together openly and honestly. The sharing of best practice and learning from errors can help to reduce their reoccurrence in the future. Individual branches should discuss the results of this audit and any proposed actions with their local surgeries to improve patient care.**

- **Pharmacy Voice are working closely with the Royal Pharmaceutical Society, Royal College of General Practitioners and others, such as the National Association of Primary Care to help take forward discussions on better integration between pharmacists and general practice. http://www.pharmacyvoice.com/press/pharmacy-voice-responds-to-rcgp-and-rps-proposals-on-gp-practice-based-phar**

- **General practices should endeavour to increase the number of patients using Repeat Dispensing in order to reduce the number of prescriptions received without signatures.**

- **An increased use of the Electronic Prescription Service (EPS) would help mitigate some of the issues surrounding illegalities with prescriptions.**

[16] Pharmacy Voice (2012) Practice-based Audit: Prescription interventions.
[17] HSCIC (2014) How the Summary Care Record benefits clinical practices. Available at: http://systems.hscic.gov.uk/scr/benefits
[18] RPS, RCGP (2015) RCGP and RPS Policy Statement on GP Practice Based Pharmacists. Available at: http://www.rpharms.com/promoting-pharmacy-pdfs/rcgp-joint-statement-for-pharmacists-in-gp-surgeries-version-2.pdf

- **Building on the positive recent announcement of widespread access to the Summary Care Record for all community pharmacies, Pharmacy Voice will continue to advocate for full 'read and write' access to the patient record for community pharmacists.**

- **The commitment by wholesalers to supply pharmacies within 24 hours of an order should be recognised as a firm obligation to get medicines safely to patients.**

- **Pharmacy Voice will work closely with the British Generic Manufacturers Association (BGMA), British Association of Pharmaceutical Wholesalers (BAPW), Association of the British Pharmaceutical Industry (ABPI) and others to contribute to the work of the Department of Health Supply Chain Group on medicines shortages in order to ensure that a rapid resolution is found for patients and pharmacy teams.**

- **Pharmacy Voice's Patient Safety group will use the findings from this audit to look at how companies can improve any of their own procedures to benefit patient care and safety.**