NHS England

To: Pharmacy Contractors and Community Pharmacy Teams

ACTION: Patient Safety Incident – Time critical medication not being supplied

We would like to draw attention to a patient safety incident and ask all Community Pharmacy Contractors and Community Pharmacy teams to review relevant guidance, service specifications and standard operating procedures to ensure patients receive time-critical medicines when required.

Summary of Patient Safety Incident

On Sunday 26th June 2021, Charlie Marriage died from Sudden Unexpected Death in Epilepsy (SUDEP) after he was unable to get an urgent prescription for his epilepsy medication. Following the inquest, a Prevention of future deaths report[1] stated that a lack of medication likely contributed to Charlie's death despite his efforts to obtain it over the course of two days.

Information for Community Pharmacists

NHS England's response[2] to the prevention of future deaths report included the prioritisation of actions on time critical medicines as part of the Medicines Safety Improvement Programme[3]. One of the actions is to remind front line pharmacy teams of the importance of needing certain medicines within a short timescale, particularly noting issues for medicines shortages and requests for emergency medicines supplies.

Time-critical medicines[4] (TCMs) are medicines that need to be given or taken at a specific time, where a delay in receiving the dose or an omission of the dose entirely may lead to serious patient harm.
Pharmacists should assess the patient and use their clinical judgment as to whether a medication is time critical. To support this judgment, the Royal College of Emergency Medicine[5] has suggested the MISSED mnemonic:

Movement disorders—Parkinson's / myasthenia medication
Immunomodulators including HIV meds
Sugar—diabetes medication
Steroids—Addison's & adrenal insufficiency
Epilepsy—anticonvulsants
DOACs & warfarin

NICE Guidance

The National Institute for Health and Care Excellence has also published guidance[6] for pharmacists on making an emergency supply of medication, which reinforces the guidance of the Royal Pharmaceutical Society which states: "The pharmacist should consider the medical consequences of not supplying a medicine in an emergency" and "If the pharmacist is unable to make an emergency supply of a medicine the pharmacist should advise the patient how to obtain essential medical care."

In the event of a supply issue, community pharmacies should manage the issue at an individual patient level (3.3) as detailed in the NHS England Guide to the systems and processes for managing medicines supply issues in England (3.4) [7]

- check whether supply can be arranged from other pharmacies locally, if they have stock of the product.
- liaise with prescribers regarding the availability of alternative brands, strengths or formulations of the medicine that may be clinically appropriate for the individual and arrange a new prescription to be sent to the pharmacy.
- community pharmacies should endeavour to clearly communicate to patients any supply issues and the proposed management plan. They should also counsel and support affected patients where possible.

Service Specification

We want to highlight the specific requirements in the NHS England NHS Pharmacy First Service Specification[8]:

- In cases where medication that is urgently required is not in stock at the pharmacy, that the pharmacist should, with the agreement of the patient, identify another pharmacy that provides the service and forward the electronic referral to them (4.19).
- If the patient is unable to get to the premises, the pharmacist must ensure that the patient is able to obtain the supply in a timely manner by discussing all reasonable options for accessing their medicines (4.20).

Actions for Pharmacy Contractors and Community Pharmacy Teams

1. Ensure community pharmacy teams read the guidance highlighted in this communication.
2. Ensure community pharmacy teams refresh their knowledge on the community pharmacy requirements in the NHS Pharmacy First service specifications.
3. Review and update standard operating procedures if required and ensure all staff are trained in how to apply them including any business continuity procedures at busy times.

Further useful resources:

In addition to the references shared in this note, the NHS Specialist Pharmacy Service (SPS) have recently published these resources.

Improving the safe use of time critical medicines – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

Understanding time critical medicines to support improvement – NHS SPS - Specialist Pharmacy Service – The first stop for professional medicines advice

References

1. https://www.judiciary.uk/prevention-of-future-death-reports/charlie-marriage-prevention-of-future-deaths-report/
2. https://www.judiciary.uk/wp-content/uploads/2025/01/2025-0048-Response-from-NHS-England.pdf
3. https://www.england.nhs.uk/patient-safety/patient-safety-improvement-programmes/#MedSIP
4. https://pharmaceutical-journal.com/article/feature/every-minute-counts-taking-a-national-approach-to-time-critical-medicines
5. https://rcem.ac.uk/wp-content/uploads/2023/11/Time-Critical-Medication-Safety-Flash-V8-Final-1.pdf
6. https://bnf.nice.org.uk/medicines-guidance/emergency-supply-of-medicines/#:~:text=Read%20guidance%20on%20who%20can%20request%20and%20i

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7. https://www.england.nhs.uk/long-read/a-guide-to-the-systems-and-processes-for-managing-medicines-supply-issues-in-england/#3-managing-medicines-supply-issues-in-primary-care
8. https://www.england.nhs.uk/primary-care/pharmacy/pharmacy-services/pharmacy-first/