

Integrating Community Pharmacy into Urgent and Emergency Care (UEC) Pathways

Report on Community Pharmacy UEC management across Kent, Surrey and Sussex



Executive Summary, November 2017



*Each pharmacy in Kent, Surrey and Sussex is undertaking, on average, 13 urgent care consultations per week. Of these, 70% are managed by the pharmacy and at least half prevent referral to another NHS service. Scaled up across the region, this represents over 11,500 urgent care consultations **per week**, 8050 of which are managed independently by pharmacies, preventing approximately 5400 other NHS encounters.*

Executive summary of key findings

Background

Increasingly high demand for urgent care services (NHS 111, GP out of hours, and Accident and Emergency, A&E) is a national concern which is leading to pressures within secondary care and delayed treatment for patients. Streamlining of UEC services will help support people with urgent care needs to obtain appropriate and timely advice outside secondary care. Community pharmacy teams have been identified as an under-utilised, accessible resource, with a wealth of expertise to support demands for urgent care. The Health Education Kent Surrey and Sussex Emergency Care Board commissioned Medway School of Pharmacy (MSoP) to investigate community pharmacy involvement in UEC, to provide insight into what pharmacists are currently doing to support the UEC agenda and what future training requirements would facilitate the optimisation of urgent care management in this setting.

Evaluation Process

The evaluation was in 3 phases spanning a 20-month period from November 2015 to June 2017. Phase one involved an exploration of community pharmacists' views and experiences of UEC services, together with an evaluation of the impact of a recently locally distributed CPPE training package on UEC. The second phase of work, which started in June 2016, was an analysis of the UEC practices of 17 pharmacies, documenting in detail all UEC requests received in the pharmacy over a 2-week period, the first time that such an investigation has been undertaken. The final phase, which began in October 2016, informed by the results of phase one, evaluated a novel respiratory resource pack designed to support pharmacists in delivering UEC services, and the re-issue of the CPPE UEC pack.

Findings on community pharmacy UEC management in Kent, Surrey and Sussex region

Most pharmacists in Kent Surrey and Sussex (KSS) estimate they manage up to five urgent care requests in an average four-hour work shift. Detailed analysis in phase 2 suggested 13 such consultations per week. However, qualitative elements of phase 3 suggested these numbers could be considerably higher as many urgent conditions may be dealt with by counter staff.

In the detailed analysis of the UEC requests received by 17 pharmacies across KSS in phase 2, 70% of consultations were dealt with by the pharmacist in-house. Of the 30% of consultations which resulted in referrals, just over 50% were to a GP practice. Only 7% of consultations were to A&E. 73% of all consultations were for the person who made the urgent care request.

Over half of all UEC requests were for symptom management, with skin problems the most common (38% of all symptoms presented). Other common symptoms related to eye problems, musculoskeletal issues, upper respiratory tract infections (URTIs) and wounds.

In 27% of all consultations the pharmacist provided advice alone to manage the UEC request and in 42% of all consultations the pharmacist provided advice (oral/written) together with a sale of an over-the-counter product.

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Most pharmacists (71%) expressed willingness to provide an emergency supply of medicines if all legal requirements were met. Emergency supplies of regular prescription medicines were made in 17% of consultations in phase 2.

Pharmacists were asked to rate their perception of the urgency of patient requests. 47% of consultations managed in-house were given an urgency rating which by definition meant pharmacy management 'averted the need for other NHS services'. There was correlation between degree of urgency and likelihood of referral. Infection or suspected infection constituted 35% of the total number of referrals to other UEC providers.

A panel of health care professionals experienced in urgent care agreed with the pharmacists' rating of urgency in around two-thirds of consultations and also agreed that the management decisions in terms of referral/non-referral were appropriate in 90% of the consultations the panel assessed. The difference was explained, in part, by pharmacists perceiving requests for emergency supplies as more urgent, which may be associated with the presence of the patient in the pharmacy. The other discrepancy related to a small number of incidences of minor ailments in patients with long term conditions where the panel rated the request as more urgent. This may represent an area for more training for pharmacists in future.

Both phases 1 and 2 indicated that locum pharmacists are likely to refer more patients to other UEC services compared to the pharmacist who works regularly in that pharmacy. This was a statistically significant finding in phase 2 although there was no significant difference between locum and regular pharmacists in regard to urgency rating at the 'extremely/very urgent' level. The rate of referrals was not affected by the experience of the pharmacist. These findings suggest that locum pharmacists in particular need to be a target for training around UEC consultations.

Whilst there was no significant difference in the numbers of queries dealt with overall by multiple pharmacies (pharmacies with >20 branches nationally) and independents (<20), multiple pharmacies undertook many more consultations outside core hours compared to independents. Consultations by multiple pharmacies were more likely to be rated as 'extremely urgent' or 'very urgent' compared to independent pharmacies and perhaps, as a result, consultations to multiples were statistically more likely to result in a referral to A&E or NHS 111 than those presented to independents. Overall the number of consultations dealt with in-house without referral was not different between the two pharmacy types. These findings suggest that multiple pharmacies can play an important role in future UEC training and service delivery.

Nearly all patients surveyed as part of phase 2 (95%) expressed satisfaction with pharmacist management of urgent care queries. 72% of these patients stated they would have sought other NHS services if the pharmacist had not supplied the care and advice that they did.

IC24, an out of hours (OOH) service operating in East Kent, employs pharmacists to deal with urgent medicines related queries. Detailed records of medicine-related consultations dealt with by pharmacists working for the service over a 4-week period suggested their advice averted referral to other OOH services or IC24 doctors. The expert panel convened in this evaluation believed that two thirds of a sample of queries dealt with by IC24 could also have been managed by a community pharmacy/pharmacist.

Findings on training needs

Most pharmacists (85%) consider that they have the necessary skills and training to manage UEC requests by patients, including those for upper respiratory tract infections (URTIs). The clinical questions asked in Phase 3 of the evaluation, however indicated that some pharmacists still had training needs with respect to URTI management and the appropriate place of antibiotic therapy, despite being offered specific resources to support the provision of appropriate advice.

There was generally a low uptake of all three training resources covered by this evaluation, with, in most cases, less than half of all pharmacists surveyed remembering the mail out. The CPPE pack was

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undertaken to some degree by 11% of evaluation participants the first time and 20% on second release. The MSOP URTI resource was read or skim read by 32% of participants. The impact of all the materials was modest. On second release, the CPPE pack had changed practice for 8% and the URTI resource had changed practice for 11% of recipients.

Most pharmacists who had read the materials thought that they were relevant; however, the barriers to uptake of the distance learning provided were: time constraints; availability of other learning resources; lack of access (material sent to the pharmacy rather than an individual).

Across phases 1 and 3, pharmacists expressed a wide range of views on preferred training materials but most highlighted distance or on-line learning as being most useful to busy practitioners, particularly for knowledge-based materials. However, face to face training was preferred by some for skills acquisition such as consultation management.

Suggestions to help improve training course uptake included repeat distribution of materials, use of more visually appealing material, inclusion of more materials to display in the pharmacy to customers and training around diagnostic skills.

In Phase 1, over 70% of pharmacists supported pharmacist accreditation for provision of an urgent care service that was recognised nationally so the service could be provided by the accredited pharmacist at any location (similar to the MUR service).

Conclusions/Recommendations

Community pharmacy/pharmacists are playing a significant role in Kent, Surrey and Sussex in terms of management of UEC requests. Based on this evaluation, a conservative estimate would be that each pharmacy in KSS is undertaking on average 13 urgent care consultations per week. Of these 70% are managed by the pharmacy and approximately half prevent referral to another NHS UEC service. If this is scaled up across KSS this represents over 11,500 urgent care consultations across the patch **per week**, 8050 of which are managed independently by the pharmacies and prevent approximately 5400 other NHS urgent care encounters.

Pharmacists working in out of hours providers also make a significant contribution to avoiding unnecessary onward referrals for urgent medicines related queries.

Whilst this work did not include an economic evaluation, it evidences that community pharmacists are helping to avert inappropriate visits to other NHS UEC services. They are also managing conditions appropriately and to the satisfaction of their patients often with just advice and/or sale of an over the counter product, avoiding prescribing costs for the NHS.

Further intervention should target the future workforce to ensure that new registrants are competent and confident to manage urgent presentations. In addition, further work is required to target the locum pharmacy workforce to improve access and uptake of training materials.

Future considerations for workforce development and associated training need to:

- Recognise that the pharmacy team is more than just the pharmacist/pharmacy manager and that locums and counter staff play an important role in UEC management. In particular, any training initiatives must target locums as they have been shown to be more likely to refer.
- Ascertain whether the management of such conditions requires ongoing professional development and if there is the need to have a system of assessment involved therein, particularly if there is a shift towards the provision of accredited services from the community pharmacy setting.
- Undertake a more detailed analysis of positive implications for workforce transformation should pharmacists be trained at scale, in particular cost saving and easing of pressure from other parts of the UEC system.

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- Ensure that training is provided within a broader structure of multi-professional systemic integration to ensure alignment with the wider aims of the NHS and minimise the risk of silo working among and between professions.
- Have support of multiple pharmacy chains at a local level, recognising the important role these organisations play and also recognising the challenges for these national businesses in supporting bespoke local projects.
- Maximise the potential of the pharmacist to identify and manage infections, using innovative service models.
- Maximise the potential of the pharmacist to identify and manage skin conditions, recognising the opportunities to improve dermatology services in primary care.

The training itself needs to:

- Be produced in multiple formats e.g. distance learning, apps, hard copy pharmacy resources, on-line resources to appeal to learners with different needs in terms of access and background – this may also help engage locums.
- Be linked to the needs of the locality and be co-ordinated through appropriate local organisations, for example the Local Pharmaceutical Committees, to avoid duplication of effort and targeting of training; not every pharmacy/pharmacist needs to upskill in every area.
- Be chunked up into smaller ‘campaigns’ and supported by promotion to the public, stressing the high satisfaction that users of pharmacies have. Services such as emergency supply could in particular be highlighted to encourage further uptake.
- Be, in some cases, delivered to a small selection of pharmacists who upskill in a particular area, for example dermatology or management of acute infections. This level of specialism could be enhanced by independent prescribing.

Report authored by:

Dr Trudy Thomas Director Taught Graduate Studies, Medway School of Pharmacy.

Mrs Linda Dodds Specialist Associate Lecturer, Medway School of Pharmacy.

Mr Atif Shamim Regional Lead, Community and Primary Care, HEE London and South East Pharmacy.

Mrs Gail Fleming Pharmacy Dean, HEE London and South East Pharmacy.

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Working definitions

Urgent - Urgent in the context of this evaluation encompassed 'any medical or health-related condition which the individual believed they need to get help with that day'.

Urgent care - covers all 'services provided for people who require same day health or social care advice, care or treatment.'

Core hours – Monday to Friday until 6pm.

Emergency care - 'services provided in emergency departments (A&E), other hospital departments, 999 and ambulances which are set up to respond to serious or life threatening emergencies.'

Locum pharmacist – Pharmacist that works temporarily to cover duties of pharmacists employed full time (also known as regular pharmacists) when absent e.g. due to sickness or annual leave.

Multiple pharmacy – chain for pharmacies with more than 20 branches nationwide.

Non-core hours (NCH) – Monday to Friday after 6pm, Saturdays after 1pm and all day Sundays.

Regular pharmacist – the pharmacist who works regularly in a pharmacy – can be full or part-time.

Saturday mornings until 1pm – Pharmacies were not classified as core or non-core based on their Saturday morning hours. Pharmacies that opened on a Saturday morning only – with no other non-core hours were classified as core hours. In pharmacies which undertook other non-core hours which also undertook to deliver services on a Saturday morning were classified as non-core.

Acronyms and Abbreviations

CH Core hours

CPPE Centre for Pharmacy Postgraduate Education

NCH Non-core hours

PGDs Patient Group Directions

PSNC Pharmaceutical Services Negotiating Committee

KSS Kent, Surrey and Sussex