COMMUNITY PHARMACY CHESHIRE & WIRRAL

Pharmacy First: Getting to know the service and preparation to provide

Pharmacy First event overview

- 7.30pm: Welcome, Introduction, Venue Details
- 7.35pm: High Level Overview of PF
- 7.45pm: The clinical pathways and PGDs – focus on UTIs and Sore Throats.
- 8.00pm: Otoscope focus
- 8.30pm: Dermatology focus
- 8.50pm: Table discussions and peer support on implementation
- 9.15pm: Roaming Q&A
- 9.30pm: Close

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Thank you

- Thank you to Teva for helping us put on these events and for covering the catering costs.

- Thank you also to the pharmacy team at Cheshire & Merseyside ICB for the partnership way of working which will continue through the implementation and developments of the service.

NHS
Cheshire and Merseyside

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Community Support

- Thank you to anyone generous enough to contribute towards our community drive by donating non-perishable food items, hygiene products, or any other contribution. We will be making these donations as follows:

- Monday 15 January – Cheshire West & Chester - West Cheshire Foodbank
- Wednesday 17 January – Warrington - Warrington Foodbank
- Monday 22 January – Wirral - Wirral ARK
- Tuesday 23 January – Cheshire East - Mid Cheshire Foodbank

The Pharmacy First service

- Community Pharmacy England submitted proposals for a Pharmacy First service to DHSC and NHSE in March 2022
- This was followed up with a comms and lobbying campaign
- On 9th May 2023, DHSC and NHSE published the Delivery plan for recovering access to primary care
- This included a commitment to commission a Pharmacy First service, allowing the treatment of seven conditions
- The **start date** is **31st January 2024** (subject to IT support being available)

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The Pharmacy First service

- Pharmacy First will be a new Advanced service that will include **seven new clinical pathways** and will **replace** the Community Pharmacist Consultation Service (CPCS)
- The service will consist of **three elements**:

Clinical pathway consultations

- new element

Urgent supply of repeat meds and appliances

- previously part of CPCS

Referrals for minor illness consultations

- previously part of CPCS

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What are the seven conditions?

Sinusitis

12 years and over

Sore throat

5 years and over

Acute otitis media

1 to 17 years

Infected insect bite

1 year and over

Impetigo

1 year and over

Shingles

18 years and over

Uncomplicated UTI

Women 16 to 64 years

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The Pharmacy First service

Pharmacies opting-in must provide **all three elements** of the new service

Patients can **present to the pharmacy** for clinical pathways consultations **(only)**

Clinical pathways consultations can be provided **remotely**, except for the acute otitis media pathway (otoscope required)

Remote consultations **must** be **via high-quality video link**

DSPs can **only** provide clinical pathways consultations **remotely** (due to the link to Essential services)

They cannot provide the acute otitis media pathway (otoscope required)

There are no changes to the former CPCS elements of the service, e.g. referrals are still required and telephone consultations are still possible, where clinically appropriate

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What does this mean for CPCS?

- CPCS will end on 30th January 2024 and the Urgent supply of repeat meds and Referrals for minor illness consultations with a pharmacist elements of CPCS will become part of the Pharmacy First service from 31st January 2024
  - General practices **can still formally refer patients** for Referrals for minor illness consultations with a pharmacist, not the Urgent supply of repeat meds element (as is the case with CPCS) – **referrals must be sent via a secure digital route, verbal/telephone referrals are not allowed**
  - Patients will not be able to walk-in to a pharmacy and access these parts of the service (self-refer); needs to be a referral from an authorised organisation
    - Therefore, **general practice will still need to make formal referrals** for patients who present at their practice but are then referred to the pharmacy for a Minor illness consultation with a pharmacist

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GP Slides: Why formal referrals are required

- **Ensures patient has a private discussion with the pharmacist**
  - If signposted, the patient may be seen by another member of the team in the pharmacy area and treated under the Self-care Essential service
- **Reassures patients that their concern has been taken seriously and the pharmacist will be expecting the patient**
  - If signposted, the patient may feel they are being fobbed off and be unsatisfied with the service provided by the GP practice and the pharmacy as they won't be expecting the patient
- **Patient will be sent to a pharmacy providing the service**
  - If signposted, patients may have to figure out themselves who is providing the service (the referral route should provide a more joined-up patient journey)

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GP Slides: Why formal referrals are required

- **There is an auditable trail of referral and clinical treatment, including consultation outcome**
  - If signposted and treated under the Self-care Essential service, no records are made or sent back to the GP practice
- **If the patient does not contact the pharmacy, the pharmacy team will follow up with the patient and the GP practice will be made aware of the outcome**
  - If signposted, this will not happen as the pharmacy won't be aware that the patient was meant to visit the pharmacy
- **The pharmacy team can proactively contact the patient upon receipt of referral to arrange a time for the patient to speak to the pharmacist – beneficial to patient and pharmacy workload**
  - If signposted, the patient may present at a time that means they may have to wait to be seen by the pharmacist

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GP Slides: Why formal referrals are required

- **The pharmacy will receive patient information on the referral therefore ensuring they are informed of the presenting condition**
  - If signposted, the patient will have to talk through their presenting condition, provide other information again, which may be frustrating for the patient and does not present a joined-up patient journey
- **Referral data can show that patients are being actively supported to access appropriate treatment, evidencing that GP practices are meeting other PCARP requirements**
  - If signposted, this data is not captured
- **Ensures pharmacies are paid for the service they are providing which helps your local pharmacies stay in business**
  - If signposted and patients do not meet the gateway point for the Clinical pathways consultation, the pharmacy will receive no payment for the Pharmacy First service

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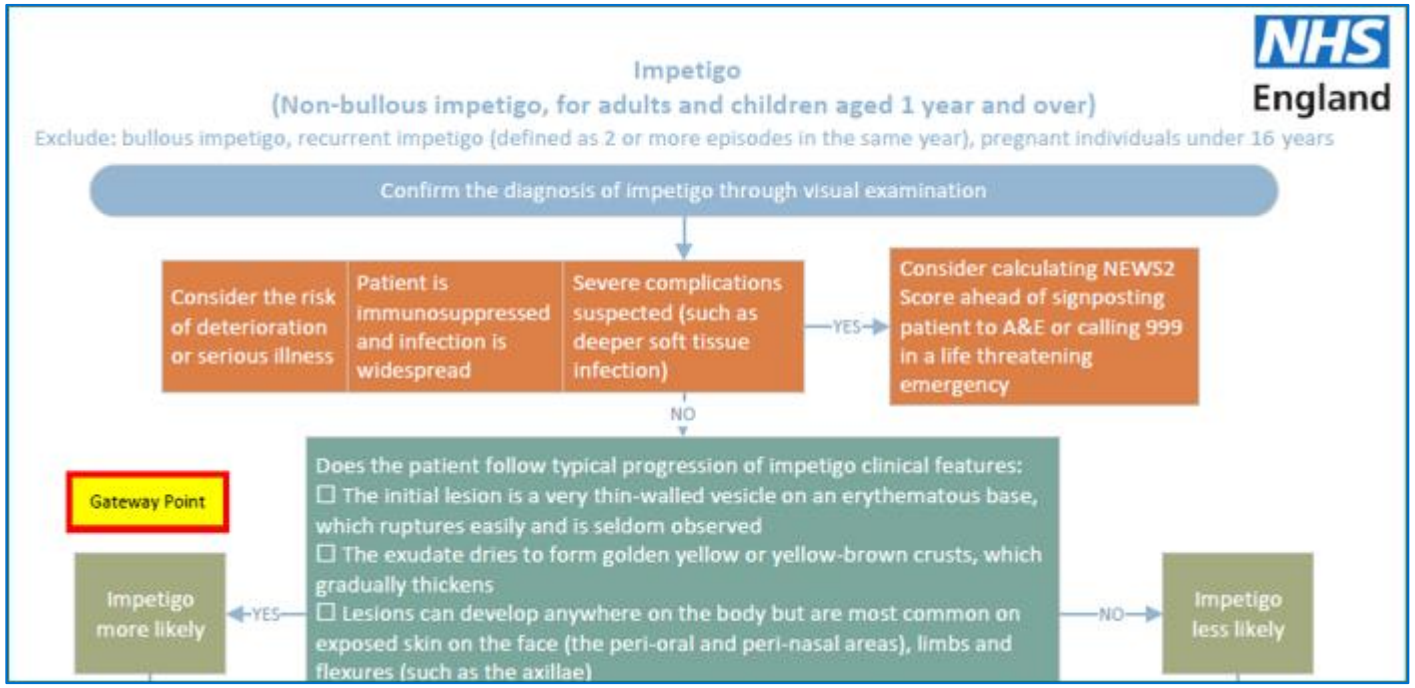
Summary of the service requirements

Clinical pathways consultations

- Service spec and seven clinical pathways developed
- 23 associated PGDs and one clinical protocol (P med)
- The clinical pathways contain one or more Gateway points
- For a patient to be eligible to receive a clinical pathways consultation, a Gateway point must be passed



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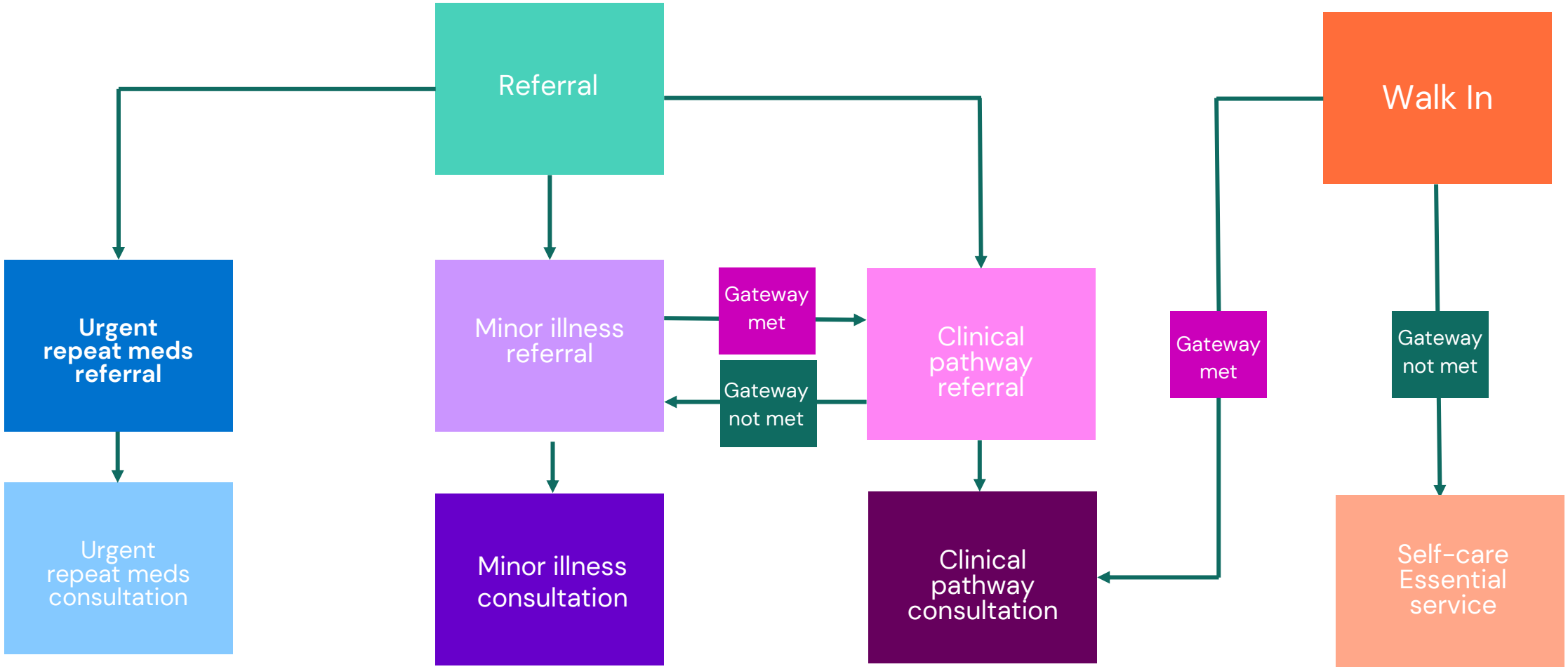
High-level service overview



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A more detailed service pathway diagram can be found in Annex A of the service spec

The service requirements

- Complying with Terms of Service requirements for Essential services and clinical governance
- Have a consultation room meeting the ToS requirements, with access to IT equipment for record keeping
- Equipment – otoscope – see buying advice in Annex C
- Standard operating procedure, including the process for escalation
- Competency and training requirements
- Have an NHS-assured clinical IT system
- Sign-up to provide the service on MYS
- Where supplies of an NHS medicine are made, the normal prescription charge rules apply

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Funding

- Funding for the clinical pathways consultations comes from the additional **£645m** provided to support the recovery plan
- Initial fixed payment of **£2,000**
  - Must sign-up to provide the service on MYS **by 11.59pm on 30th January 2024**
  - Claims submitted **by 11.59pm on 31st Dec 2023** will be paid on **1st February 2024**
  - Claims submitted **by 11.59pm on 30th Jan 2024** will be paid on **1st March 2024**
  - The payment will be **reclaimed** if **5** clinical pathways consultations are not provided **by the end of March 2024**
- £15 fee per completed consultation (also applies to CPCS consultations from 1st Jan 2024)

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Funding

- A **monthly** fixed payment of **£1,000** where the pharmacy meets a **minimum number** of clinical pathways consultations:
- From April 2024, an initial cap of 3,000 consultations per month per pharmacy will be put in place
- From October 2024, new caps will be introduced based on actual provision of clinical pathway consultations, designed to deliver 3 million consultations per quarter

Month	Minimum number of clinical pathways consultations
February 2024	1
March 2024	5
April 2024	5
May 2024	10
June 2024	10
July 2024	10
August 2024	20
September 2024	20
October 2024 onwards	30

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The clinical pathways and PGDs

Clinical pathway consultations

- The clinical pathways element will enable the management of common infections by community pharmacies through offering **self-care**, **safety netting advice**, and only if appropriate, supplying a **restricted set of medicines** to complete episodes of care for seven common conditions
- NHSE commissioned SPS to develop patient group directions (PGDs) and a protocol for the Pharmacy First service
- The final PGDs and protocol, published on the NHS England website, have received national approval from the National Medical Director, Chief Pharmaceutical Officer and National Clinical Director for IPC & AMR

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Specialist Pharmacy Service

Development of clinical pathways

Multi-professional expert working group to develop robust clinical pathways for each of the 7 conditions

Adherence to NICE guidelines

National template for PGDs developed by SPS

Pharmacy Quality Scheme antimicrobial stewardship foundation

AMR Programme Board Oversight National Medical Director and Chief Medical Officer for England

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Monitoring and surveillance

- NHSE will closely monitor the Pharmacy First service post-launch to allow for robust oversight and monitor for any potential impact on antimicrobial resistance so that any needed mitigations can be quickly actioned
- NHSE is working with NHSBSA to enable pharmacy reimbursement and functionality for PGD supply to be recorded via ePACT2 data, or in a parallel dashboard
- NIHR will commission an evaluation of Pharmacy First services considering implications for antimicrobial resistance

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Clinical Record Keeping

- The clinical IT systems will send messages containing a summary of the consultation to the patients general practice.
- Ensure your consultation notes include what happened, information and findings, any justification/background for decisions and include written or verbal information given to the person – including safety netting, return visits and products recommended/sold
- These records may be visible by patients depending on the access/IT arrangements the practice has with the NHS App – be aware of potential poor choices in language that may cause offense and avoid these

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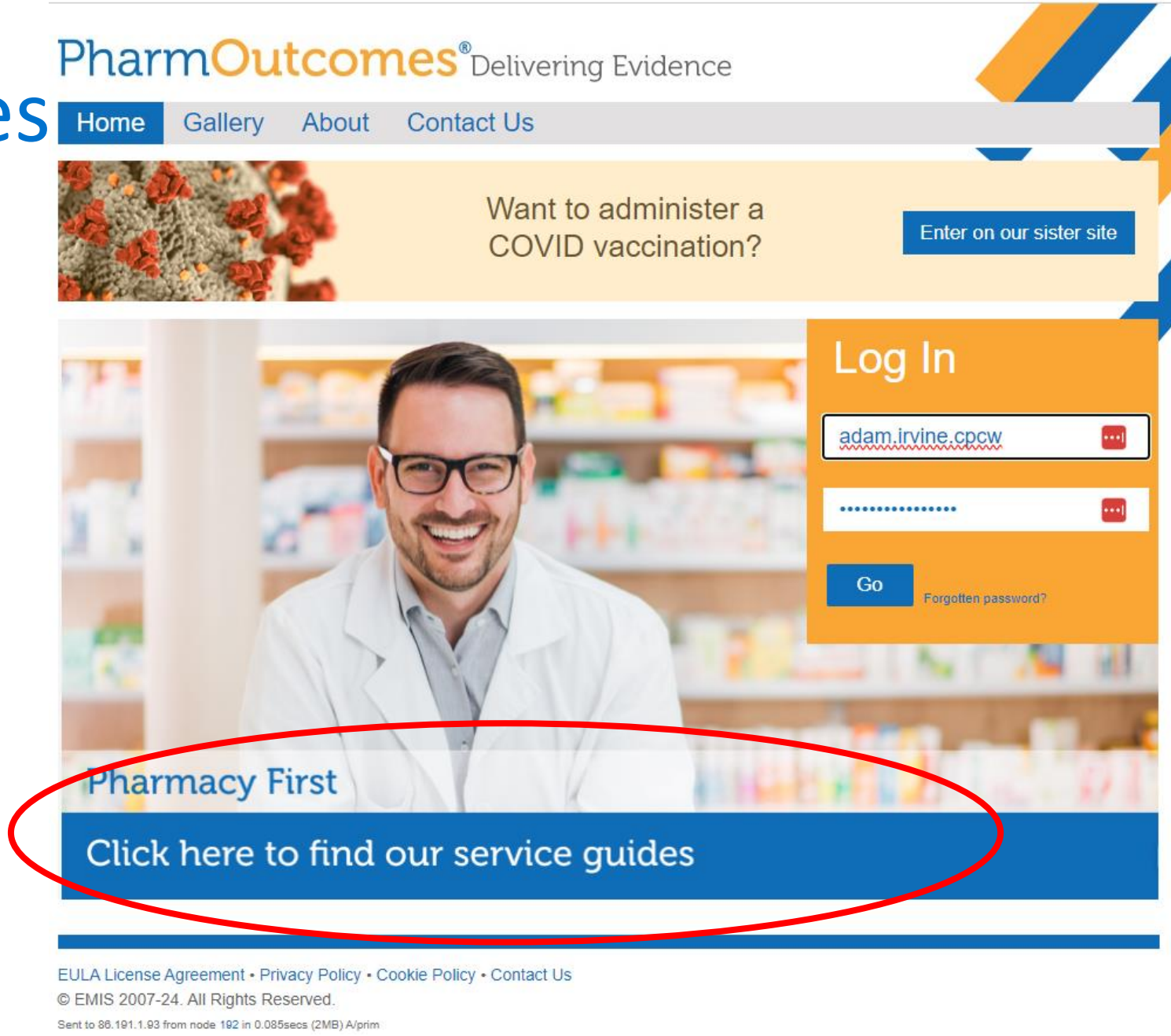
PharmOutcomes

- Pharmacy First guides including the video now live
- Pharmoutcomes.org front page link – bottom banner on the picture
- Video is worth watching to learn how to navigate through the consultation



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Urinary Tract Infections

Inclusion/Exclusion Criteria - Urinary Tract Infections

- Inclusion Criteria:
  - **Female**
  - **Non-pregnant**
  - **Aged between 16 to 64 years inclusive**
  - Patient consent
- Exclude:
  - Males
  - Patients >65 years or under 16
  - Urinary catheter in situ
  - Recurrent UTI (2 episodes in last 6 months or 3 episodes in last 12 months)
  - Breastfeeding
  - Red flags (see pathway)
  - See pathway for other exclusions

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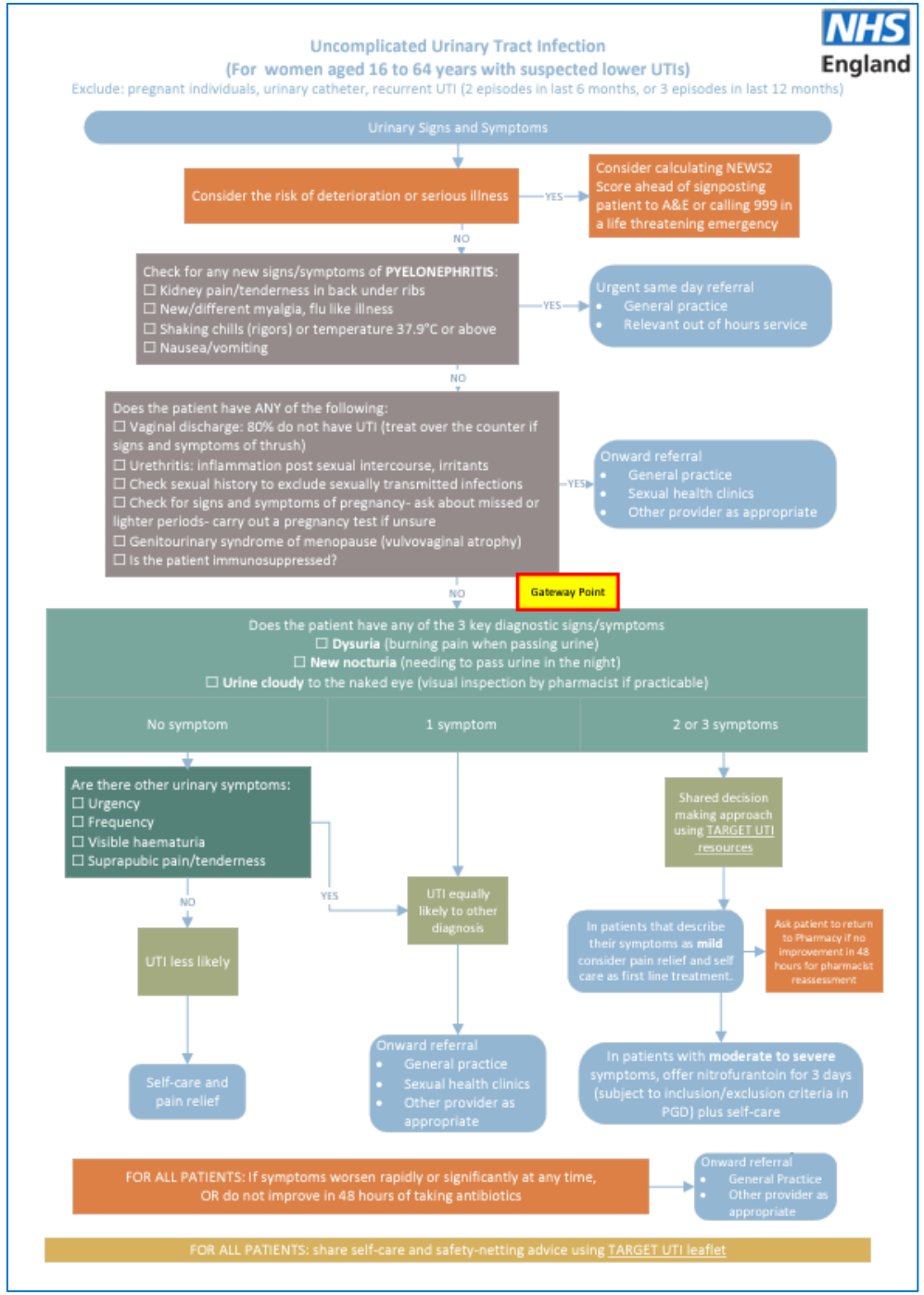

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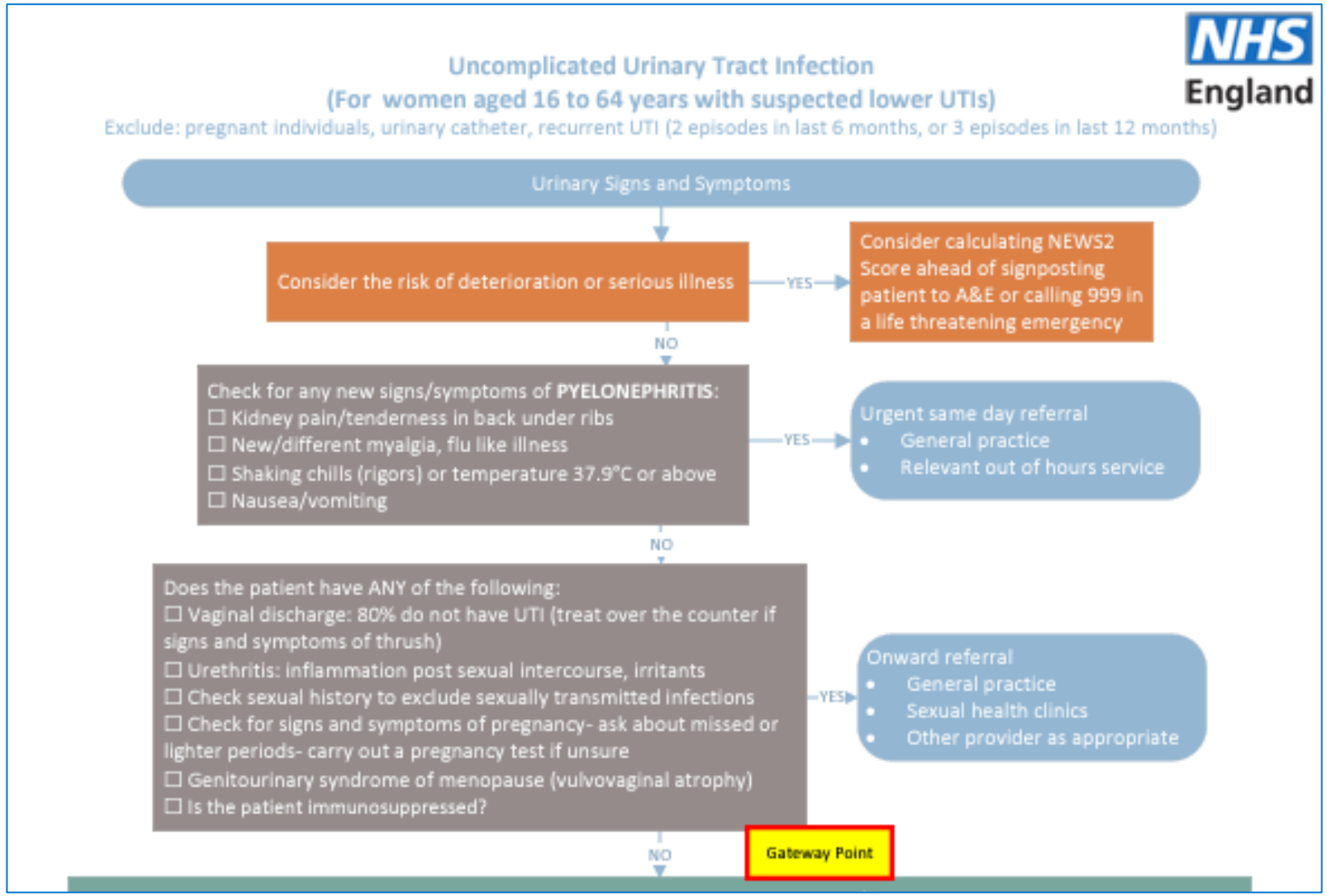

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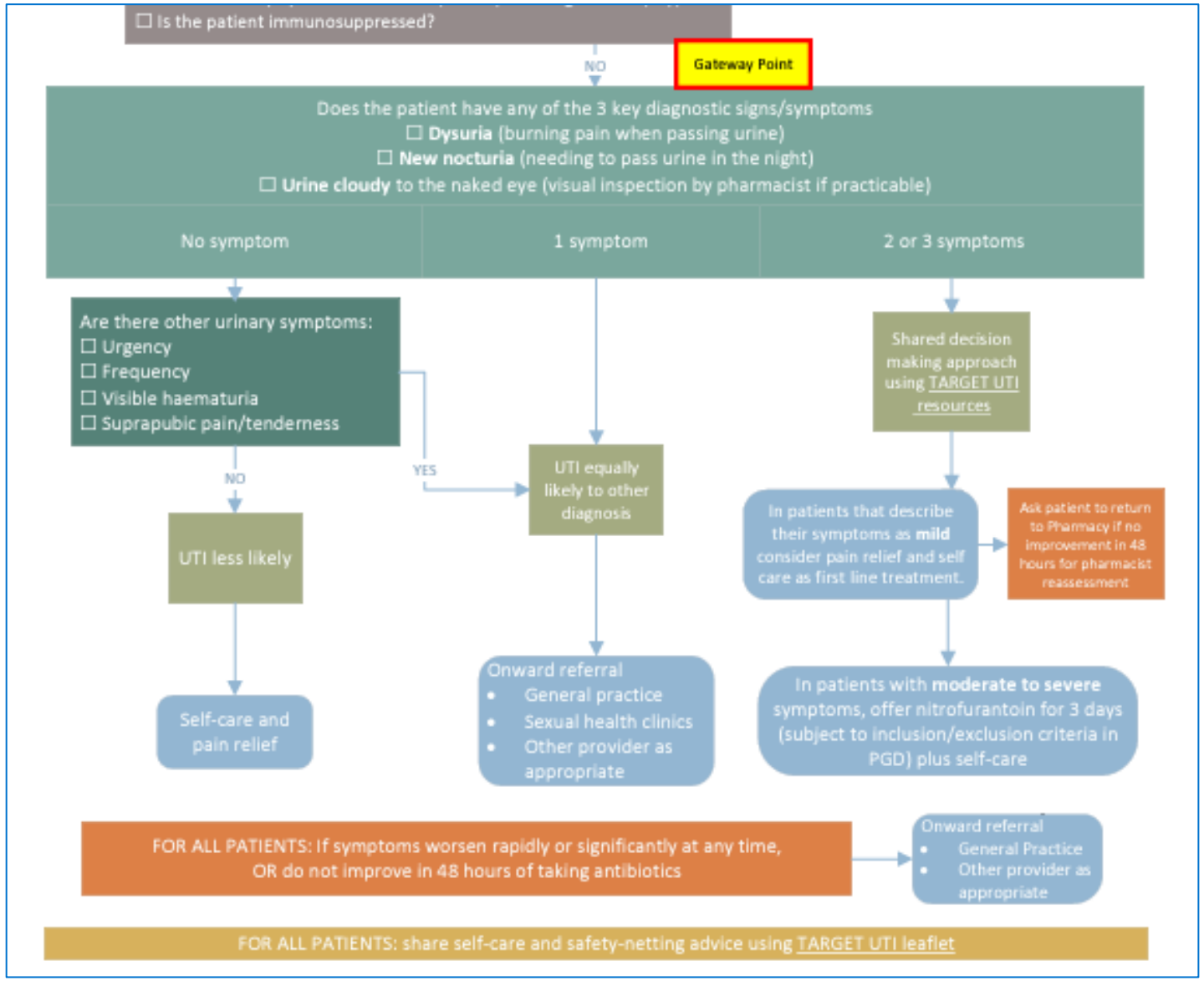

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Hints and Tips - UTIs

- No need to dip urine – pathway does include a visual inspection for cloudy urine if it's practical however
- Use the pathway to aid decision making and the target leaflet to aid explanation where supply isn't made
- Ensure counter staff can triage and refer patients to the pharmacist
- Do not be afraid to not supply antibiotics if the symptoms are mild – the patient can re-present if necessary
- If the patient is unsure of pregnancy – offer them a pregnancy test (to purchase) first or for them to go and carry one out and return afterwards
- Provide general self-care guidance irrespective of antibiotic treatment (i.e increased fluids, reduced caffeine and alcohol, pain relief, loose cotton clothing
- Know where to refer the patient to if there needs to be an onward referral

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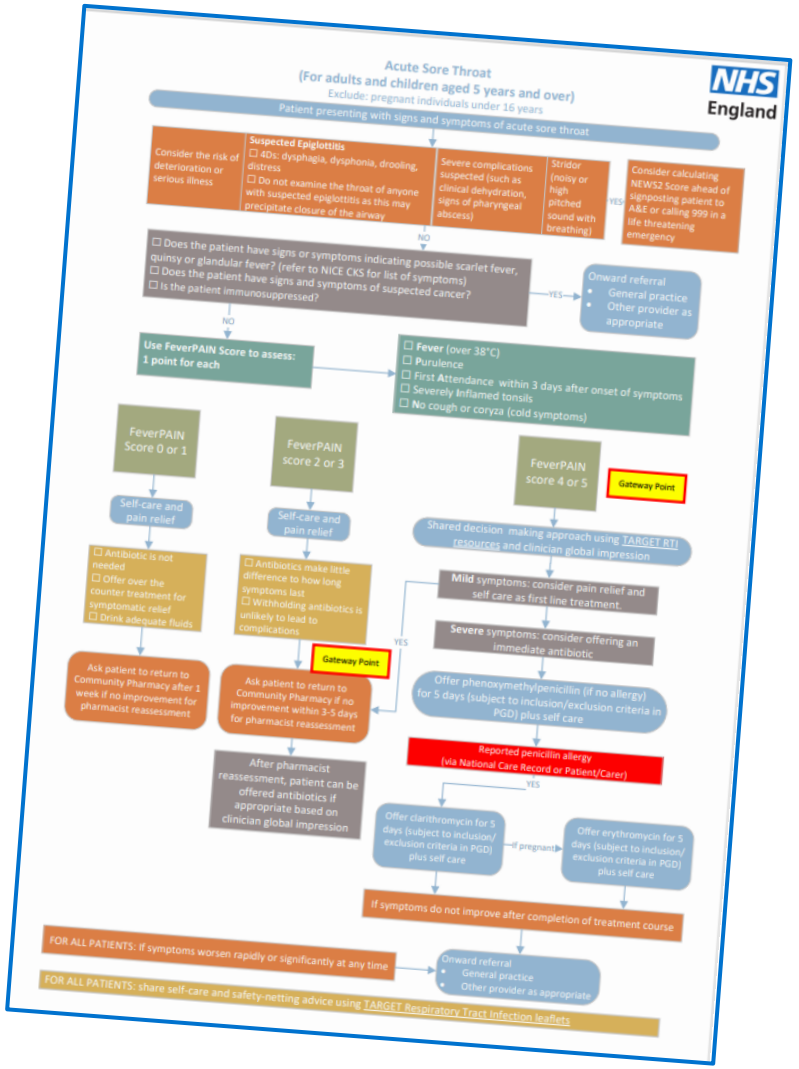
Sore Throat

Inclusion/Exclusion Criteria - Sore Throat

- Inclusion Criteria:
  - Adults and children aged 5 and over
  - Patient must have a FeverPAIN score of 4 or 5 for treatment
    - **Fever** (high temp) in last 24 hours
    - **P**urulent tonsils
    - **A**ttend rapidly (3 days or less since onset)
    - Severe tonsillar **I**nflammation
    - **N**o cough/coryza
- Exclusion Criteria:
  - FeverPAIN score of less than 4
  - Red flags (see pathway)
  - Signs of Scarlet Fever, throat cancer or glandular fever
  - Immunosupression



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Acute Sore Throat
(For adults and children aged 5 years and over)

Exclude: pregnant individuals under 16 years

NHS England

Patient presenting with signs and symptoms of acute sore throat

Consider the risk of deterioration or serious illness

Suspected Epiglottitis
- ☐ 4Ds: dysphagia, dysphonia, drooling, distress
- ☐ Do not examine the throat of anyone with suspected epiglottitis as this may precipitate closure of the airway

Severe complications suspected (such as clinical dehydration, signs of pharyngeal abscess)

Stridor (noisy or high pitched sound with breathing)

YES → Consider calculating NEWS2 Score ahead of signposting patient to A&E or calling 999 in a life threatening emergency

NO

- ☐ Does the patient have signs or symptoms indicating possible scarlet fever, quinsy or glandular fever? (refer to NICE CKS for list of symptoms)
- ☐ Does the patient have signs and symptoms of suspected cancer?
- ☐ Is the patient immunosuppressed?

YES → Onward referral
- General practice
- Other provider as appropriate

NO

Use FeverPAIN Score to assess:
1 point for each

- ☐ **Fever** (over 38°C)
- ☐ **P**urulence
- ☐ First **A**ttendance within 3 days after onset of symptoms
- ☐ Severely **I**nflamed tonsils
- ☐ **N**o cough or coryza (cold symptoms)

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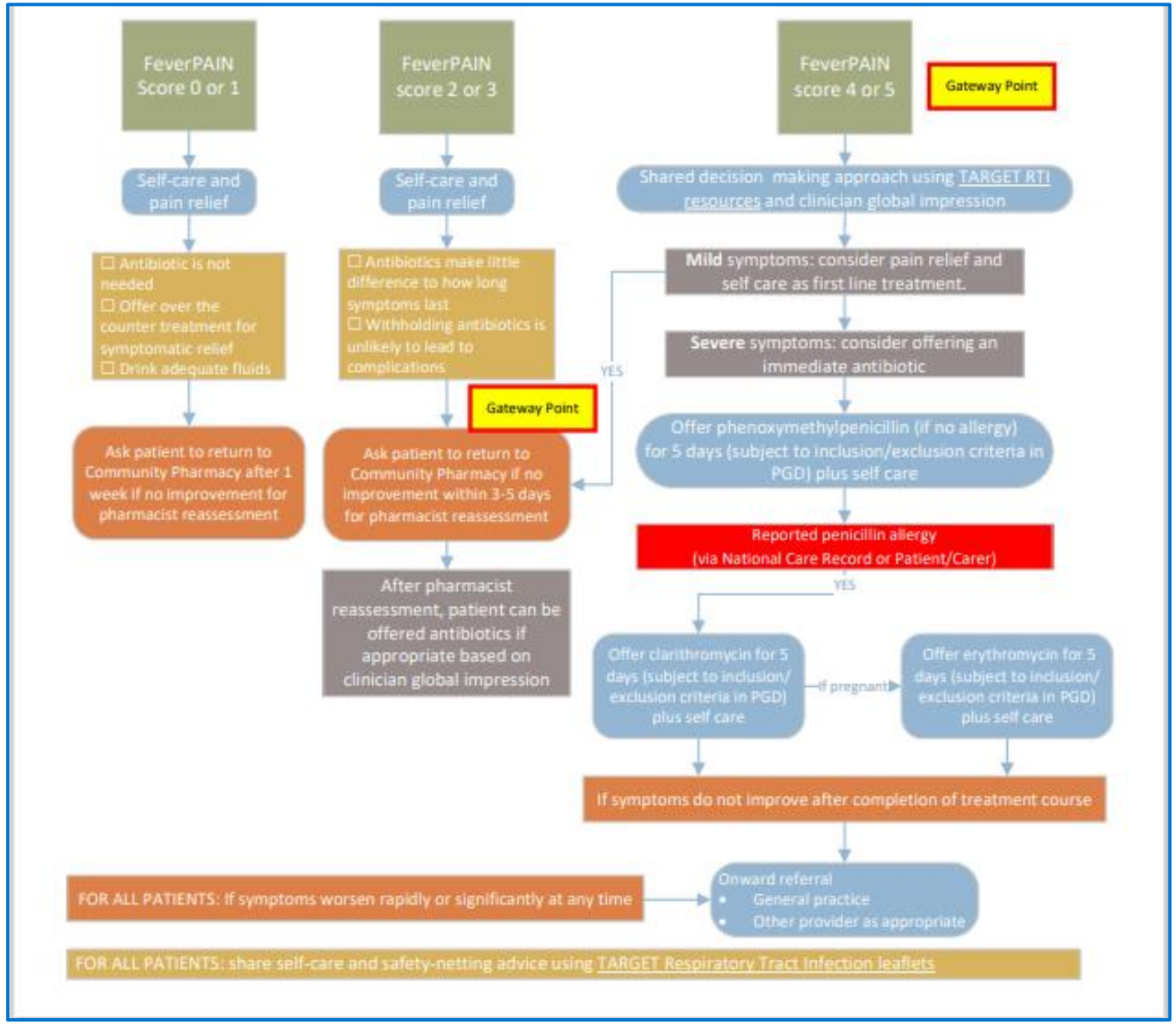

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Hints and Tips

- Use TARGET leaflet to aid decision making
- If you suspect Epiglottitis do not look down the persons throat – however you may need to check the throat for signs of purulence and severely inflamed tonsils
- Even a FeverPAIN score of 4 doesn't definitely mean this is a bacterial infection and antibiotics don't actually reduce the length of illness by very long (16 hours)
- Ensure counter staff are upskilled in order to refer to the pharmacist when needed.
- If FeverPAIN 2-3 ask them to return in 2-3 days if no improvement for reassessment to hit Gateway Point.
- Provide self-care advice e.g. Ice lollies, cold drinks, pain relief, avoidance of hot drinks/food. Avoid rough foods.

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PGDs

- Pharmacists need to read all 23 PGDs and protocol
- Final PGDs and protocol are now all published
- Pharmacists **must read and sign the final versions of the PGDs and protocol**, rather than any draft versions that may have been previously available for review
- Only fully signed final PGDs provide authorisation to supply medicines at NHS expense for the Pharmacy First service

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UTI	Shingles	Impetigo	Insect bite	Sore throat	Sinusitis	Acute otitis media
Nitrofurantoin	Aciclovir Valaciclovir	Hydrogen Peroxide Cream Fusidic acid cream Flucloxacillin Clarithromycin Erythromycin	Flucloxacillin Clarithromycin Erythromycin	Pen V Clarithromycin Erythromycin	Mometasone nasal spray Fluticasone nasal spray Pen V Clarithromycin Erythromycin Doxycycline	Phenazone & Lidocaine ear drops Amoxicillin Clarithromycin Erythromycin

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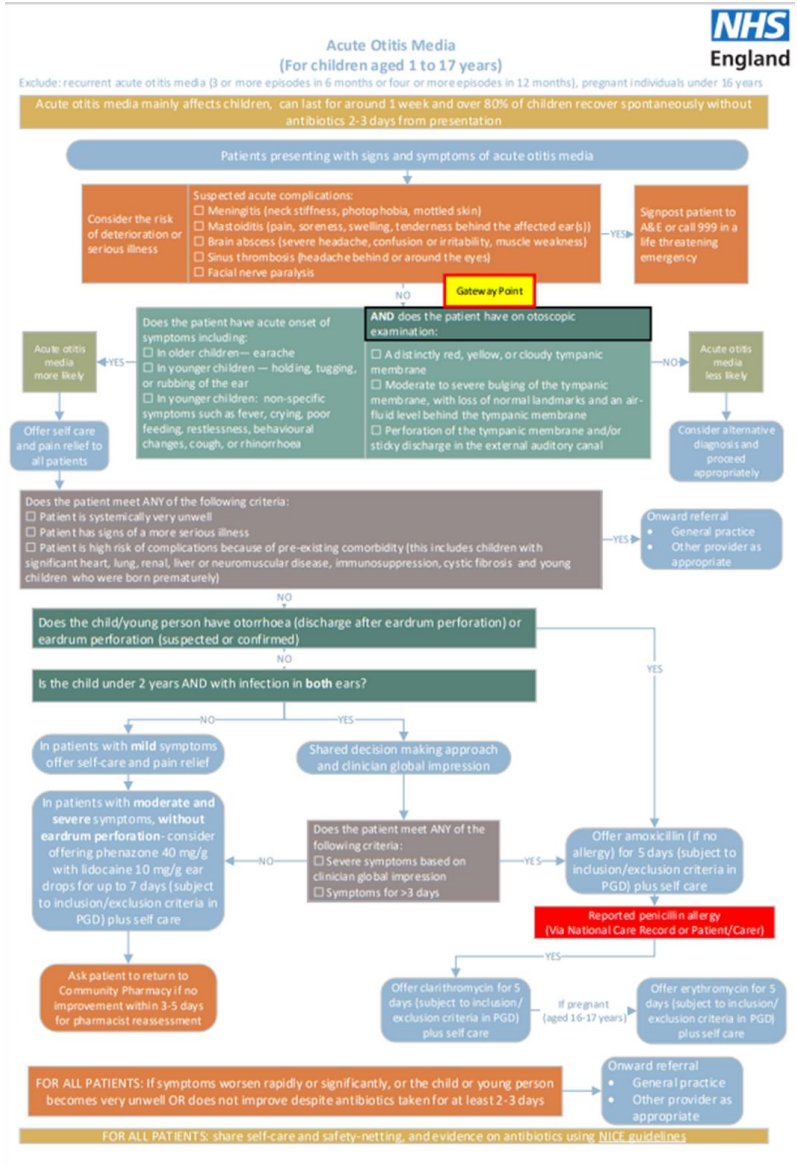
Otoscope and Dermatology

Pharmacy OTOSCOPE Talk

By Dr Lesley Hodgson MBCHB MRCGP lesley.hodgson@nhs.net

GP, GPwSI diabetes, long covid gp

Declarations – lily diabetes education


NHS England
Acute Otitis Media
(For children aged 1 to 17 years)
Exclude: recurrent acute otitis media (3 or more episodes in 6 months or four or more episodes in 12 months), pregnant individuals under 16 years
Acute otitis media mainly affects children, can last for around 1 week and over 80% of children recover spontaneously without antibiotics 2-3 days from presentation
Patients presenting with signs and symptoms of acute otitis media
Consider the risk of deterioration or serious illness
Suspected acute complications:
☐ Meningitis (neck stiffness, photophobia, mottled skin)
☐ Mastoiditis (pain, soreness, swelling, tenderness behind the affected ear(s))
☐ Brain abscess (severe headache, confusion or irritability, muscle weakness)
☐ Sinus thrombosis (headache behind or around the eyes)
☐ Facial nerve paralysis
YES
Signpost patient to A&E or call 999 in a life threatening emergency
NO
Gateway Point
Does the patient have acute onset of symptoms including:
☐ In older children— earache
☐ In younger children — holding, tugging, or rubbing of the ear
☐ In younger children: non-specific symptoms such as fever, crying, poor feeding, restlessness, behavioural changes, cough, or rhinorrhoea
YES
Acute otitis media more likely
AND does the patient have on otoscopic examination:
☐ A distinctly red, yellow, or cloudy tympanic membrane
☐ Moderate to severe bulging of the tympanic membrane, with loss of normal landmarks and an air-fluid level behind the tympanic membrane
☐ Perforation of the tympanic membrane and/or sticky discharge in the external auditory canal
NO
Acute otitis media less likely
Offer self care and pain relief to all patients
Consider alternative diagnosis and proceed appropriately
Does the patient meet ANY of the following criteria:
☐ Patient is systemically very unwell
☐ Patient has signs of a more serious illness
☐ Patient is high risk of complications because of pre-existing comorbidity (this includes children with significant heart, lung, renal, liver or neuromuscular disease, immunosuppression, cystic fibrosis and young children who were born prematurely)
YES
Onward referral
• General practice
• Other provider as appropriate
NO
Does the child/young person have otorrhoea (discharge after eardrum perforation) or eardrum perforation (suspected or confirmed)
YES
NO
Is the child under 2 years AND with infection in both ears?
NO
YES
In patients with mild symptoms offer self-care and pain relief
Shared decision making approach and clinician global impression
In patients with moderate and severe symptoms, without eardrum perforation- consider offering phenazone 40 mg/g with lidocaine 10 mg/g ear drops for up to 7 days (subject to inclusion/exclusion criteria in PGD) plus self care
Does the patient meet ANY of the following criteria:
☐ Severe symptoms based on clinician global impression
☐ Symptoms for >3 days
NO
YES
Offer amoxicillin (if no allergy) for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care
Reported penicillin allergy
(Via National Care Record or Patient/Carer)
YES
Ask patient to return to Community Pharmacy if no improvement within 3-5 days for pharmacist reassessment
Offer clarithromycin for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care
If pregnant (aged 16-17 years)
Offer erythromycin for 5 days (subject to inclusion/exclusion criteria in PGD) plus self care
FOR ALL PATIENTS: If symptoms worsen rapidly or significantly, or the child or young person becomes very unwell OR does not improve despite antibiotics taken for at least 2-3 days
Onward referral
• General practice
• Other provider as appropriate
FOR ALL PATIENTS: share self-care and safety-netting, and evidence on antibiotics using NICE guidelines

Otitis media

- See NICE guidance
- BMJ – best practice
- RCGP otitis media
- Viral vs bacterial

Annex C: Guidance on selecting an otoscope For community pharmacies

providing a minor illness service and examining both adults and children, it is important to have an otoscope that is reliable, easy to use, and compliant with MHRA safety standards

Functional Requirements:

1. Illumination: LED (preferred) or Halogen light source with adjustable brightness.

2. Magnification: At least 3x magnification lens.

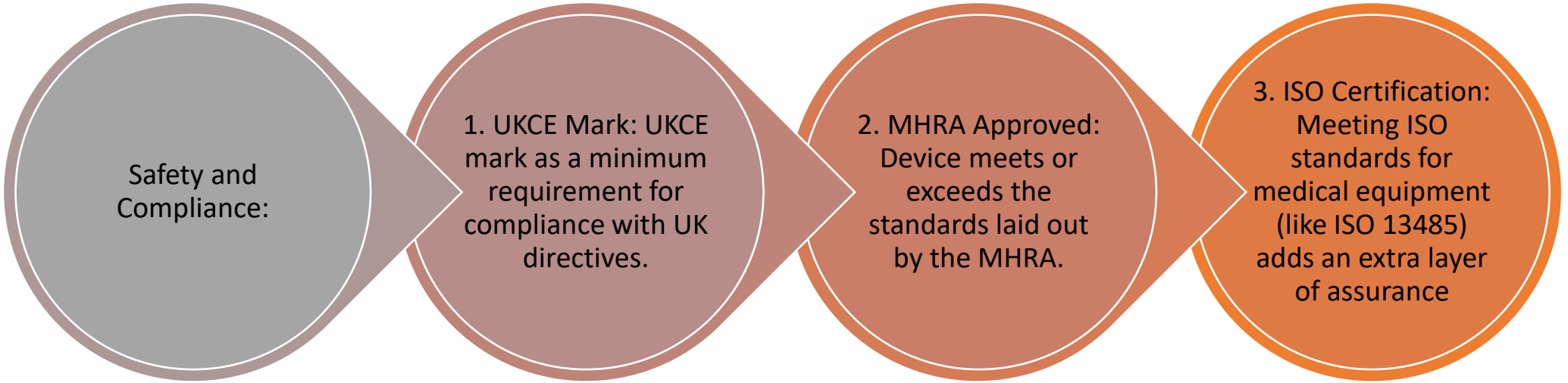
3. Field of View: Wide-angle lens to provide a broad field of view for comprehensive examination.

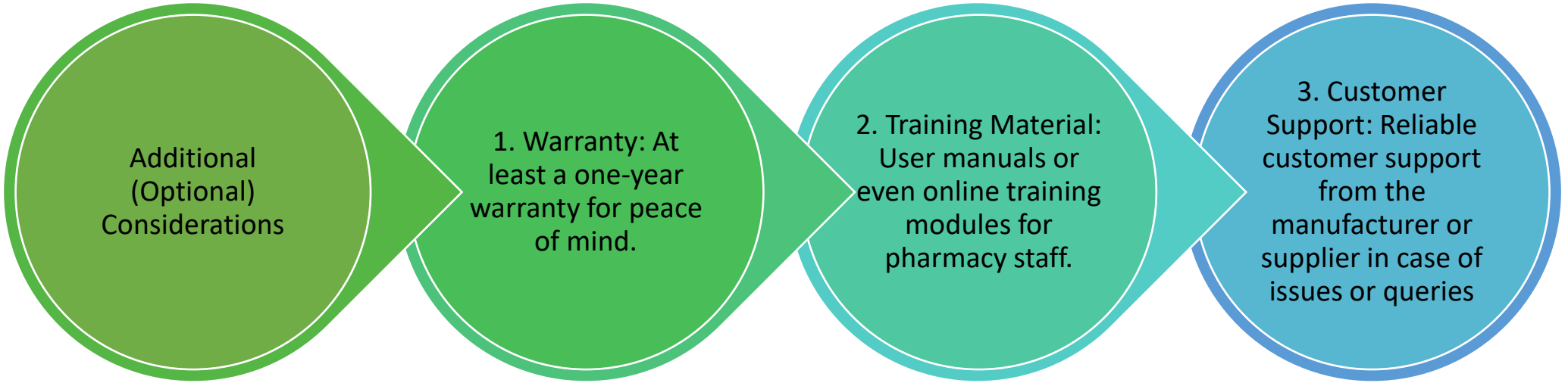
4. Tip Sizes: A range of disposable tips, from paediatric to adult sizes.

5. Focus Adjustment: Manual focus adjustment can be useful for better views.

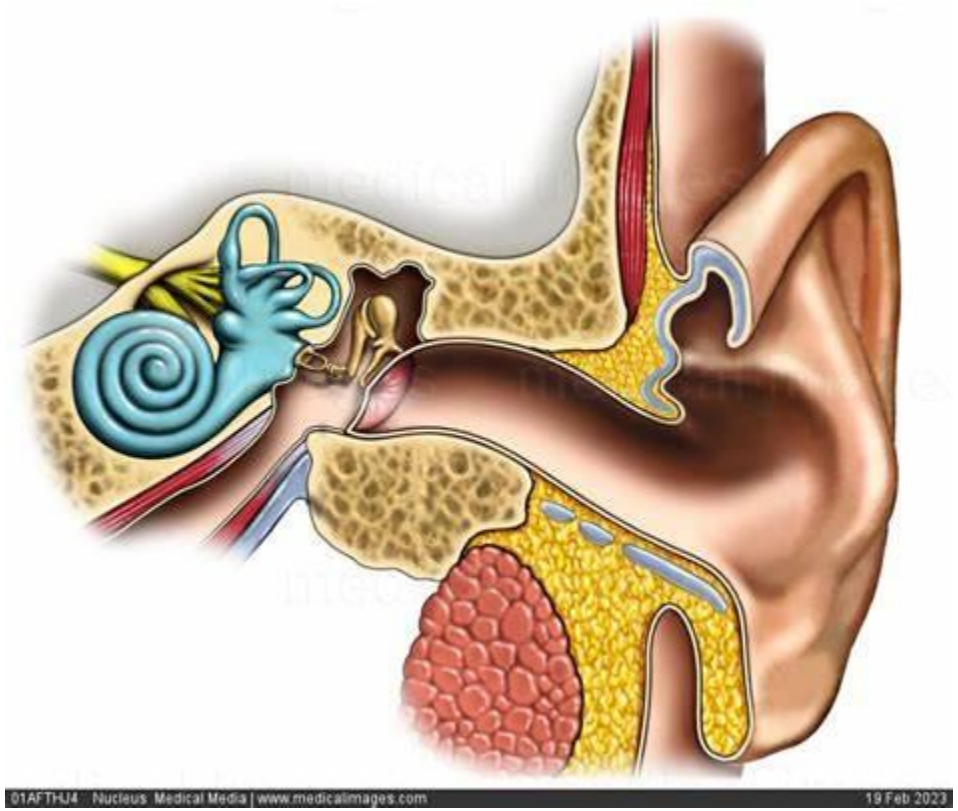
Design Requirements:

1. Ergonomics: Comfortable, non-slip handle suitable for both left and right-handed users.
2. Weight: Lightweight for ease of use, particularly for extended periods.
3. Material: Durable, medical-grade materials that can be easily cleaned.
4. Portability: Option for cordless use can be beneficial for portability.
5. Hard case for keeping at least otoscope head, handle and specula.
6. Liquid splash resistant


Safety and Compliance:
1. UKCE Mark: UKCE mark as a minimum requirement for compliance with UK directives.
2. MHRA Approved: Device meets or exceeds the standards laid out by the MHRA.
3. ISO Certification: Meeting ISO standards for medical equipment (like ISO 13485) adds an extra layer of assurance


Additional (Optional) Considerations
1. Warranty: At least a one-year warranty for peace of mind.
2. Training Material: User manuals or even online training modules for pharmacy staff.
3. Customer Support: Reliable customer support from the manufacturer or supplier in case of issues or queries

Ear canal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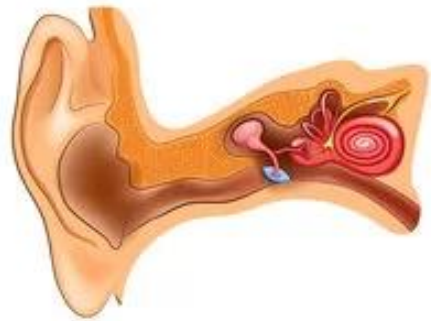
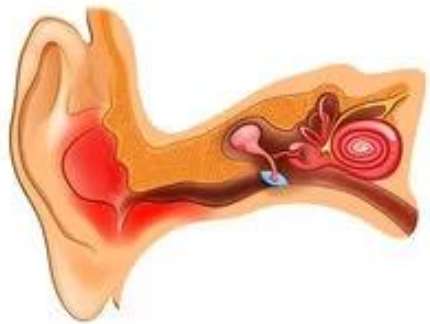
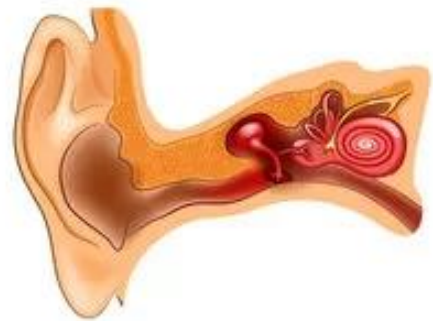
OTITISES



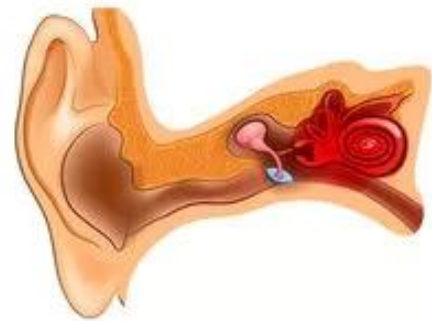
healthy ear



otitis externa

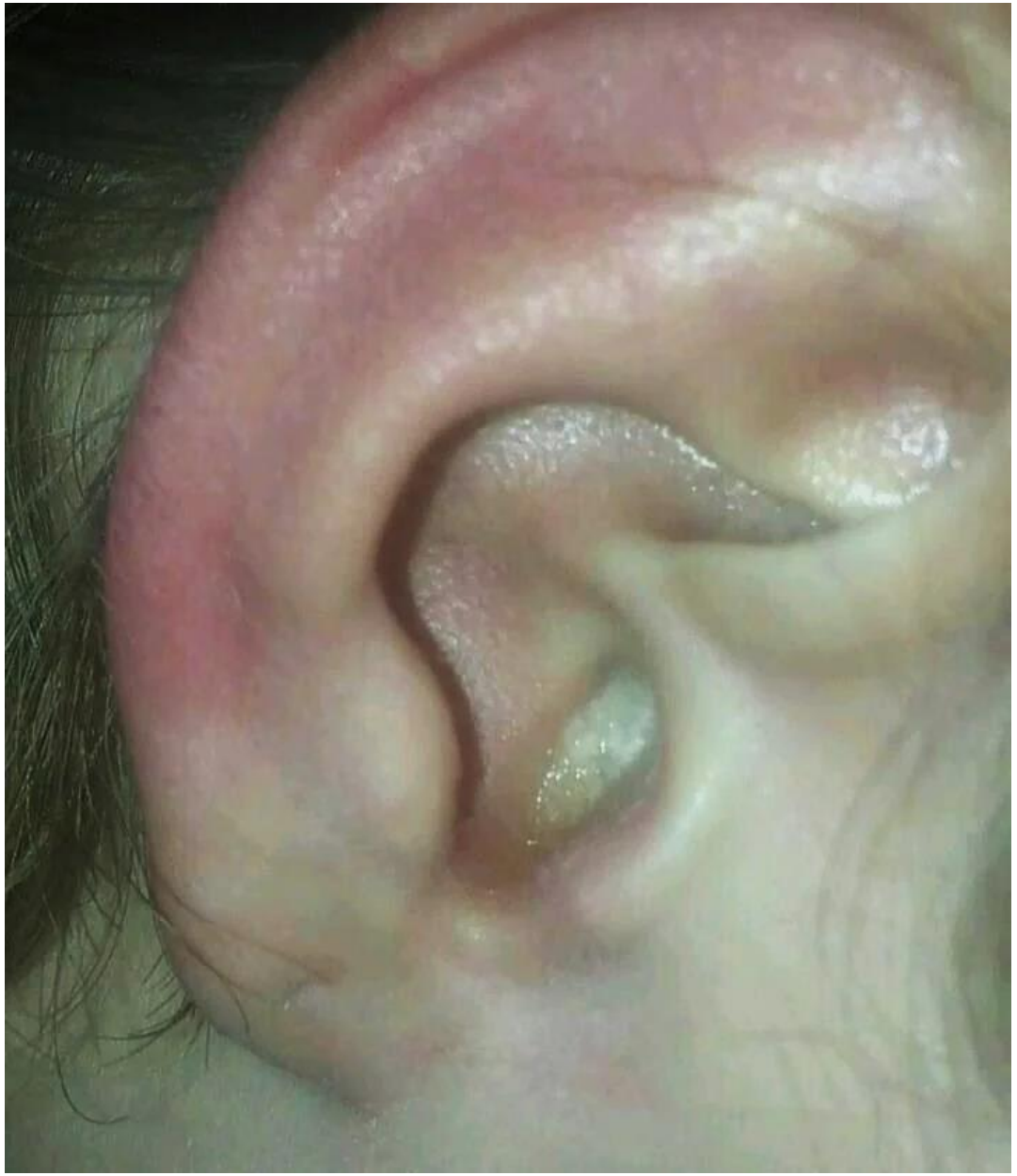


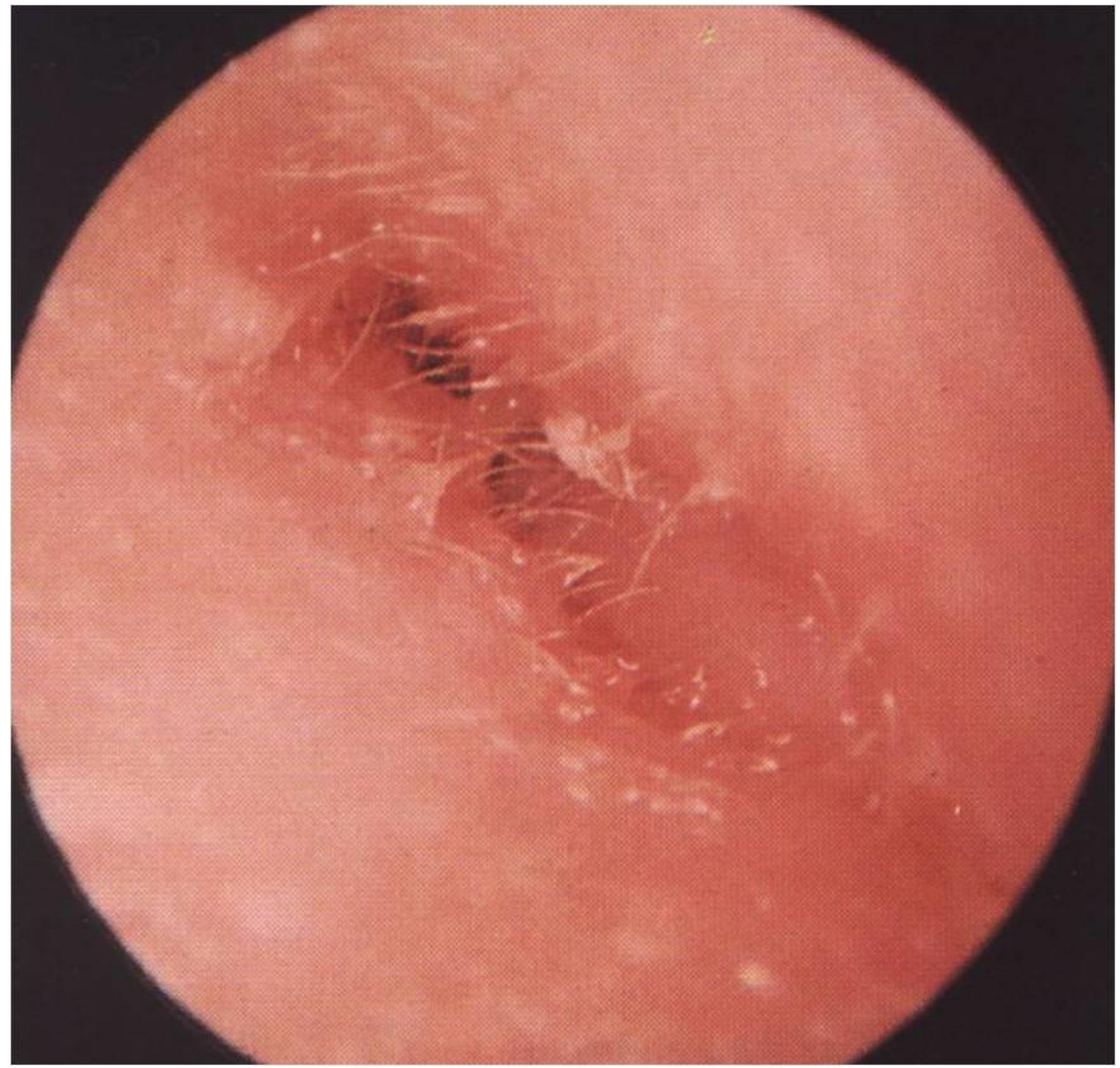
otitis media

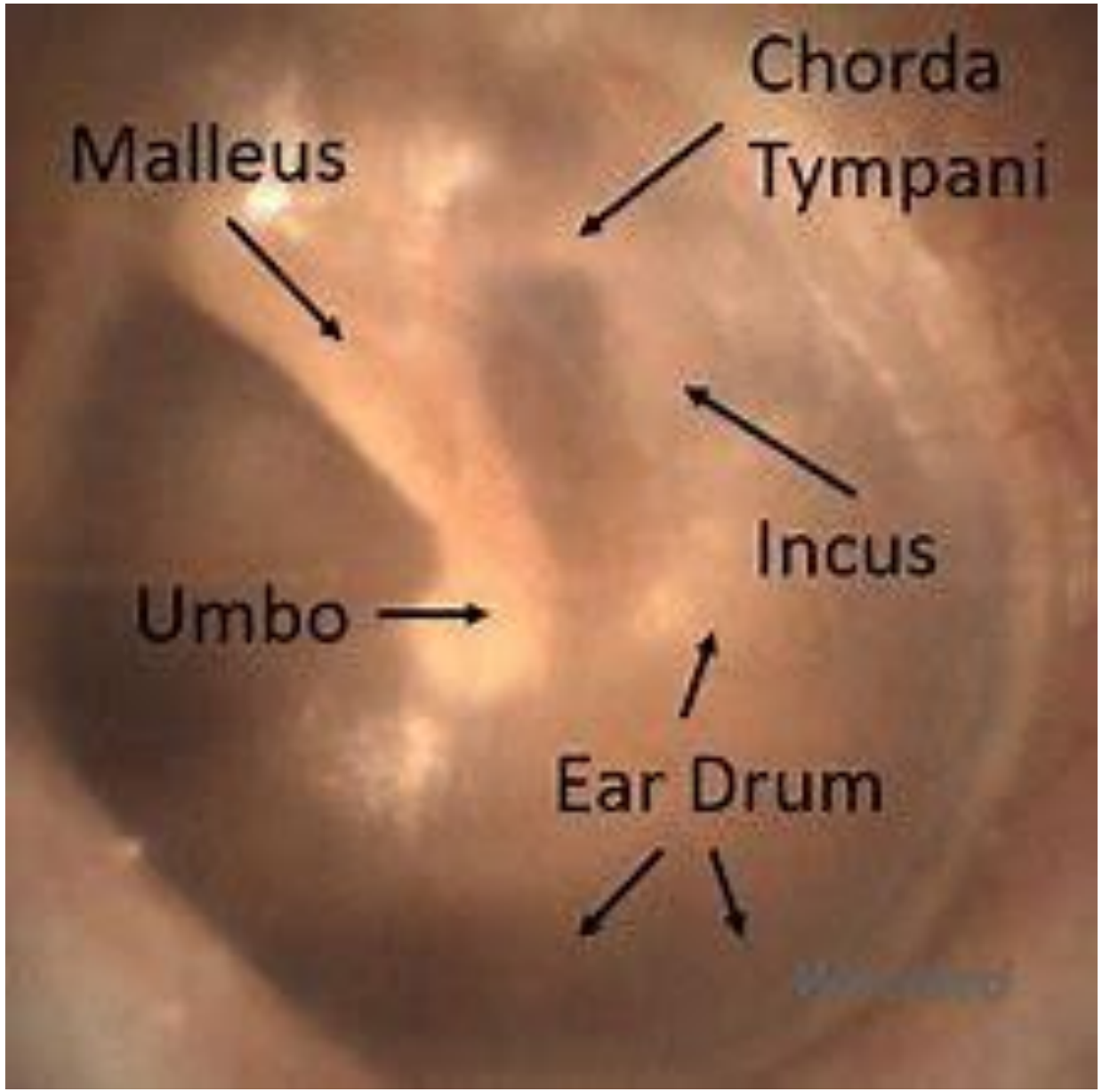


otitis interna

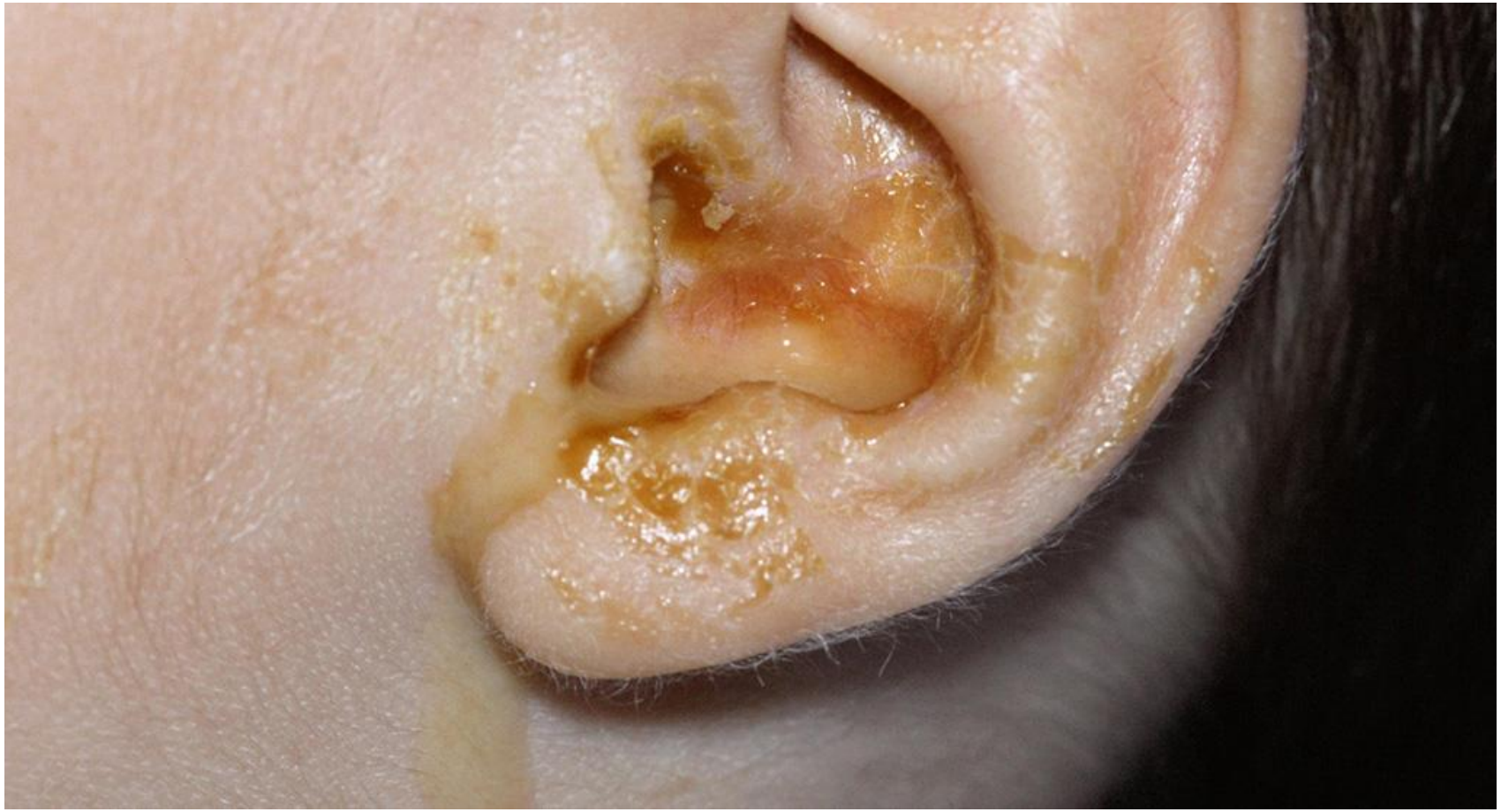
Otitis externa

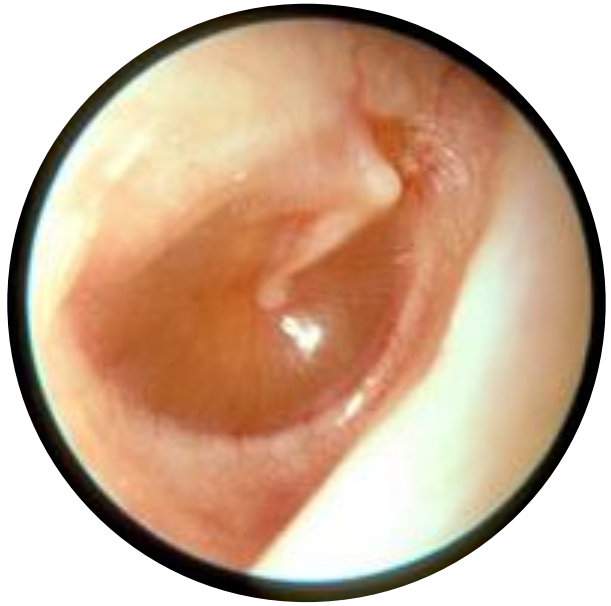




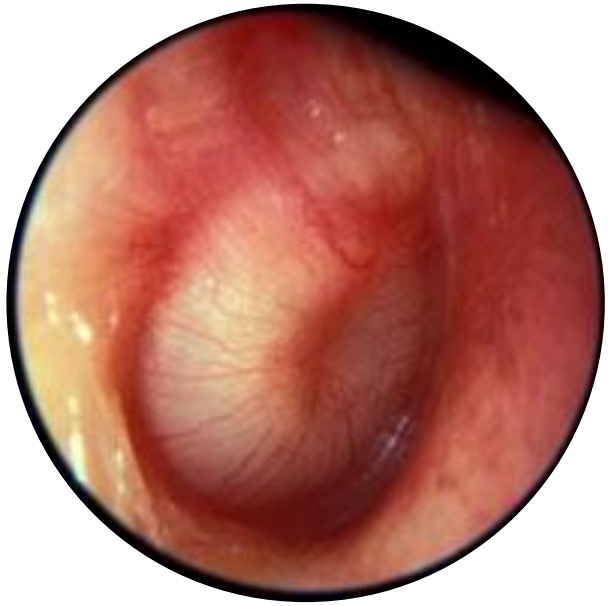

Chorda
Tympani
Malleus
Incus
Umbo
Ear Drum

Discharge from perforation

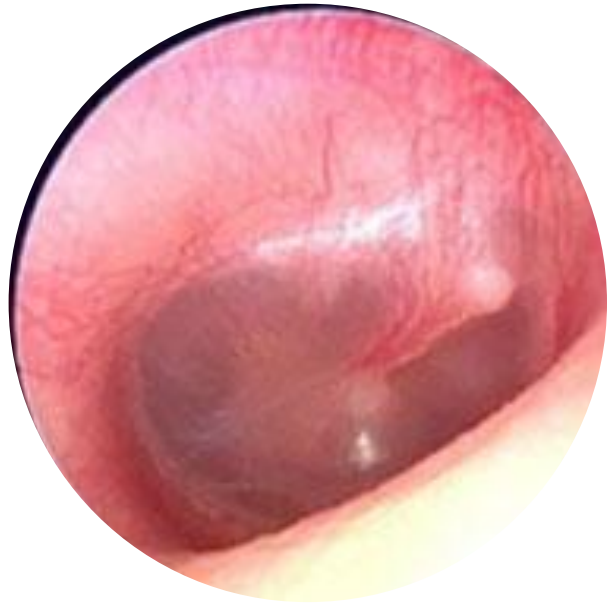




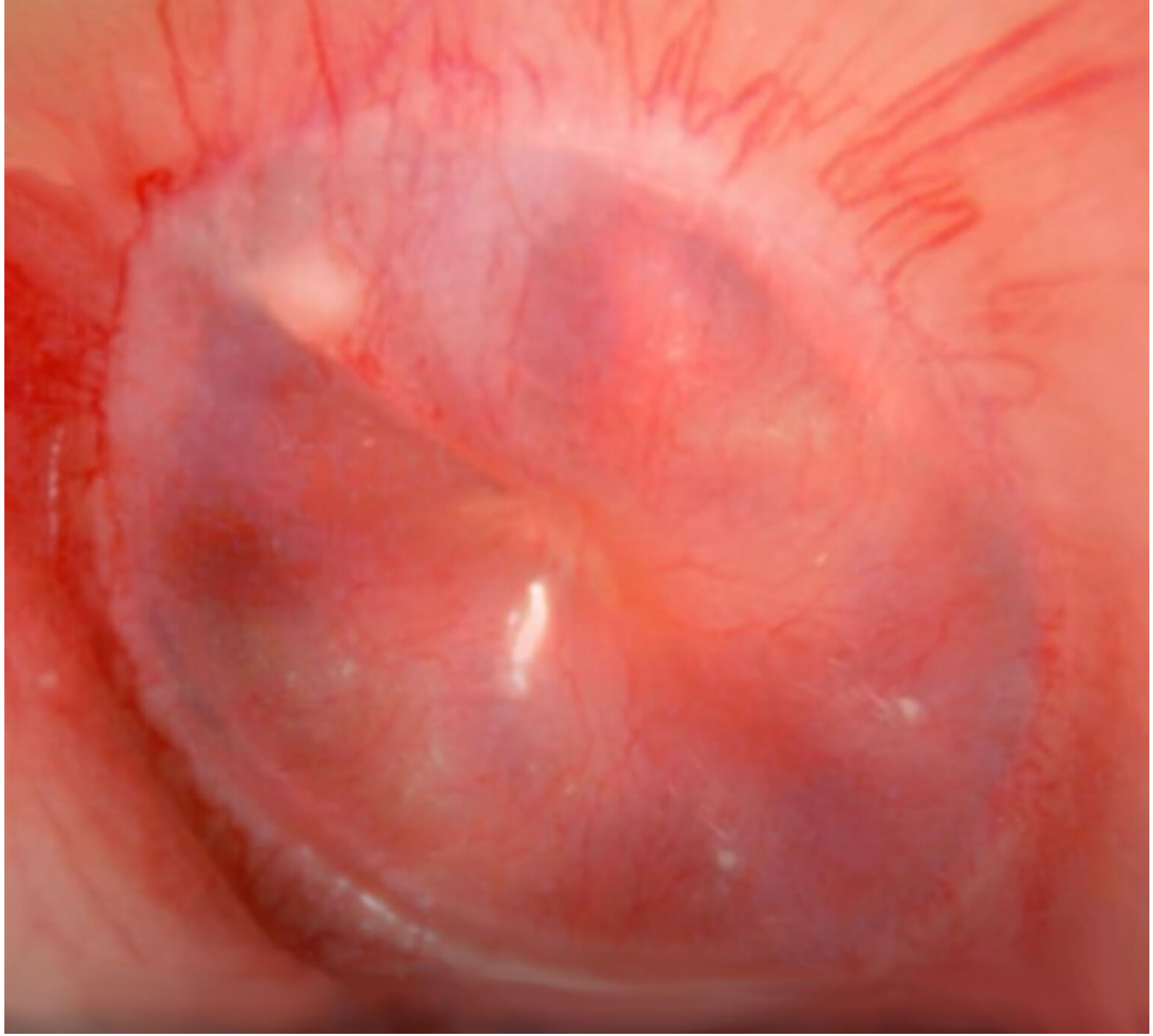
Glue ear



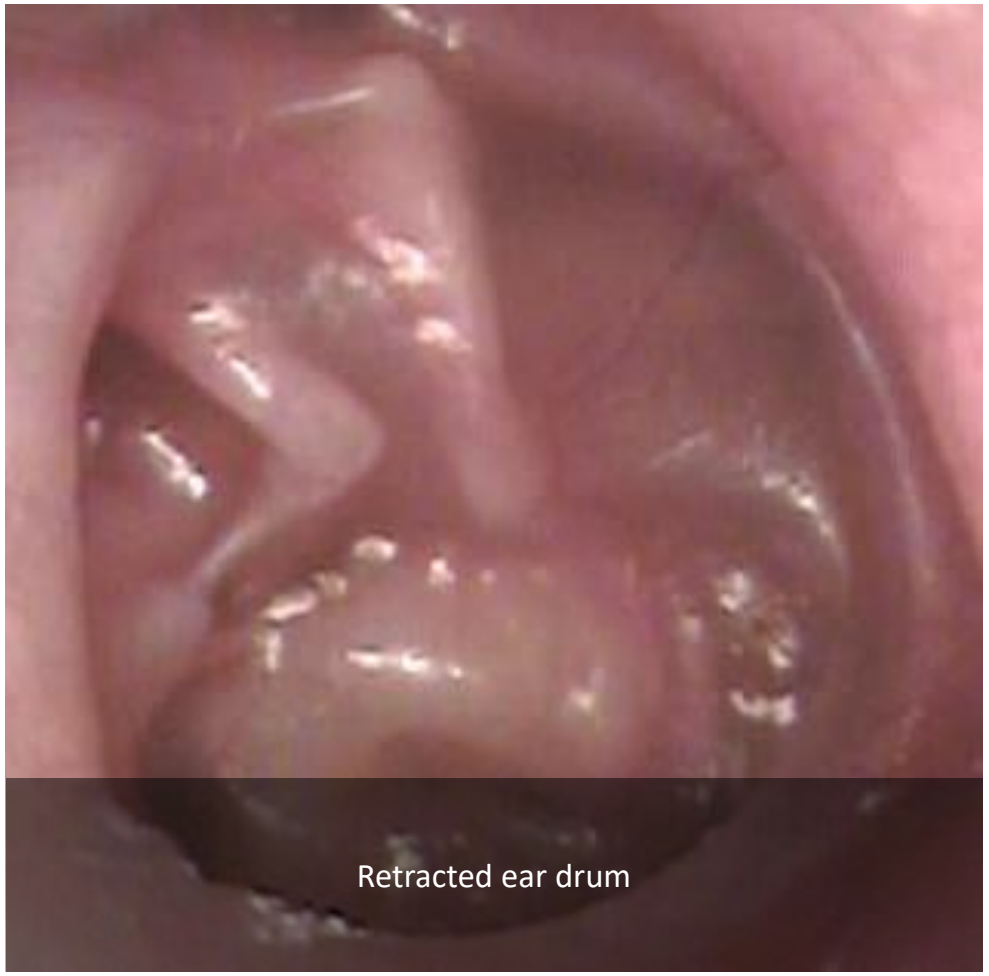
bulging



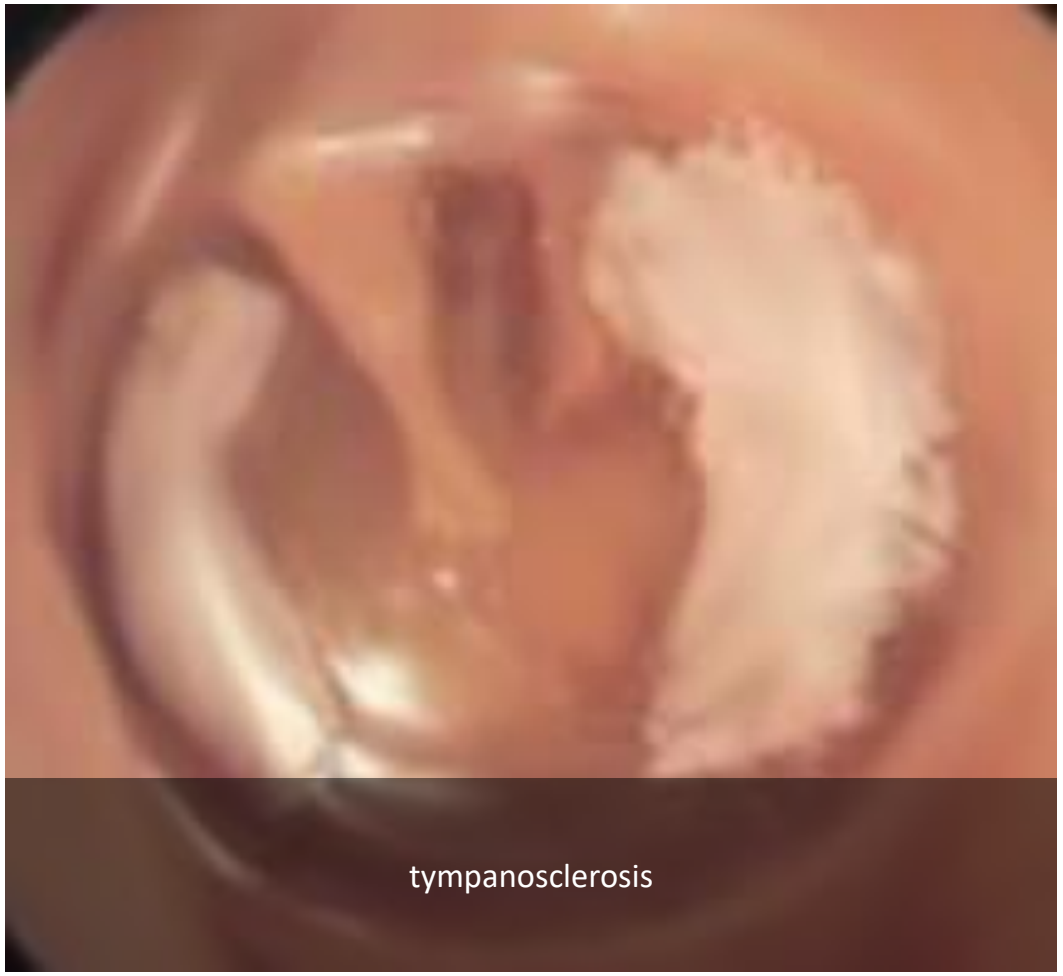
injected



Acute infection without pus



Retracted ear drum



tympanosclerosis

General examination – hints and tips

How to hold the otoscope

How to contain a child

How to straighten the canal

How deep

What to look for

What to do next

THE DERM-RELATED BITS OF PHARMACY FIRST…
(SHINGLES, IMPETIGO & INSECT BITES)

DR STEPHANIE GALLARD – DERMATOLOGY GPSI, LUFT

LPC ROLLING EDUCATIONAL PROGRAMME, JANUARY 2024

VIDEO LINK

- This section is far better viewed as a video – click here please:

https://youtu.be/WbfRgv2wKKE

JOB HISTORY AND DECLARATIONS

- Cheshire and Mersey ECP PC Derm lead
- Lots of BAD/NICE/NHSE Telederm-related hats….
- Even more Pharmacist education hats!
- PCDS Exec Committee member
- GPSI Dermatology, Liverpool ICATS
  - knows lots of Dermatology
- Salaried GP @ Speke
  - knows some Coalface GP….
- Ex-Bank family planning GP
  - surprisingly useful for Dermatology
- Registered Pharmacist
  - just insanely useful. At all times.

- Many years experience in dermatology in primary care
- Try to understand the needs of working GPs and all other primary care clinicians
- Strong interest in education and raising awareness to improve management (rather than plugging the product)
- Receive payment from Pharma for delivering educational sessions for Almirall, Aspire, Dermal, Fontus, Galderma, Janssen, LEO Pharma, LRP, Mölnlycke
- All photos are from PCDS/DermnetNZ last accessed Jan 2024 unless stated
- All slides represent my personal experience and recommendations

These slides represent my own personal advice, experience and opinions

ANOTHER DECLARATION….

Name	Designation
Dr Diane Ashiru-Oredope	Lead Pharmacist, HCAI, Fungal, AMR, AMU & Sepsis Division, UK Health Security Agency
Dr Imran Jawaid	GP and RCGP AMR representative
Dr Jeeves Wijesuriya	GP and Clinical Advisor to NHS England Primary Care Team and Vaccination and Screening Team
Dr Naomi Fleming	NHS England Regional Antimicrobial Stewardship lead for the East of England
Gill Damant	NHS England Regional Antimicrobial Stewardship lead for the North West region
Jackie Lamberty	Medicines Governance Consultant Lead Pharmacist, UK Health Security Agency
Jo Jenkins	Lead Pharmacist Patient Group Directions and Medicines Mechanisms, Medicines Use and Safety Division, Specialist Pharmacy Service
Liz Cross	Advanced Nurse Practitioner QN
Dr Michelle Toleman	Consultant Microbiologist
Temitope Odetunde	Head of Medicines Management
Kieran Reynolds (SLWG co-ordinator)	Specialist Pharmacist – Medicines Governance, Medicines Use and Safety Division, Specialist Pharmacy Service
Dr Stephanie Gallard	GP (Dermatology Special Interest)
Rob Proctor	Senior Policy and National Pharmacy Integration Lead, Primary Care, Community Services and Strategy Directorate, NHS England
Dr Mathew Donati	Consultant Medical Virologist/ Clinical Head of Virology, UK Health Security Agency

Initial PGD drafted by Alison Evans on behalf of Medicines Use and Safety Division, Specialist Pharmacy Service

USEFUL RESOURCES AND SITES

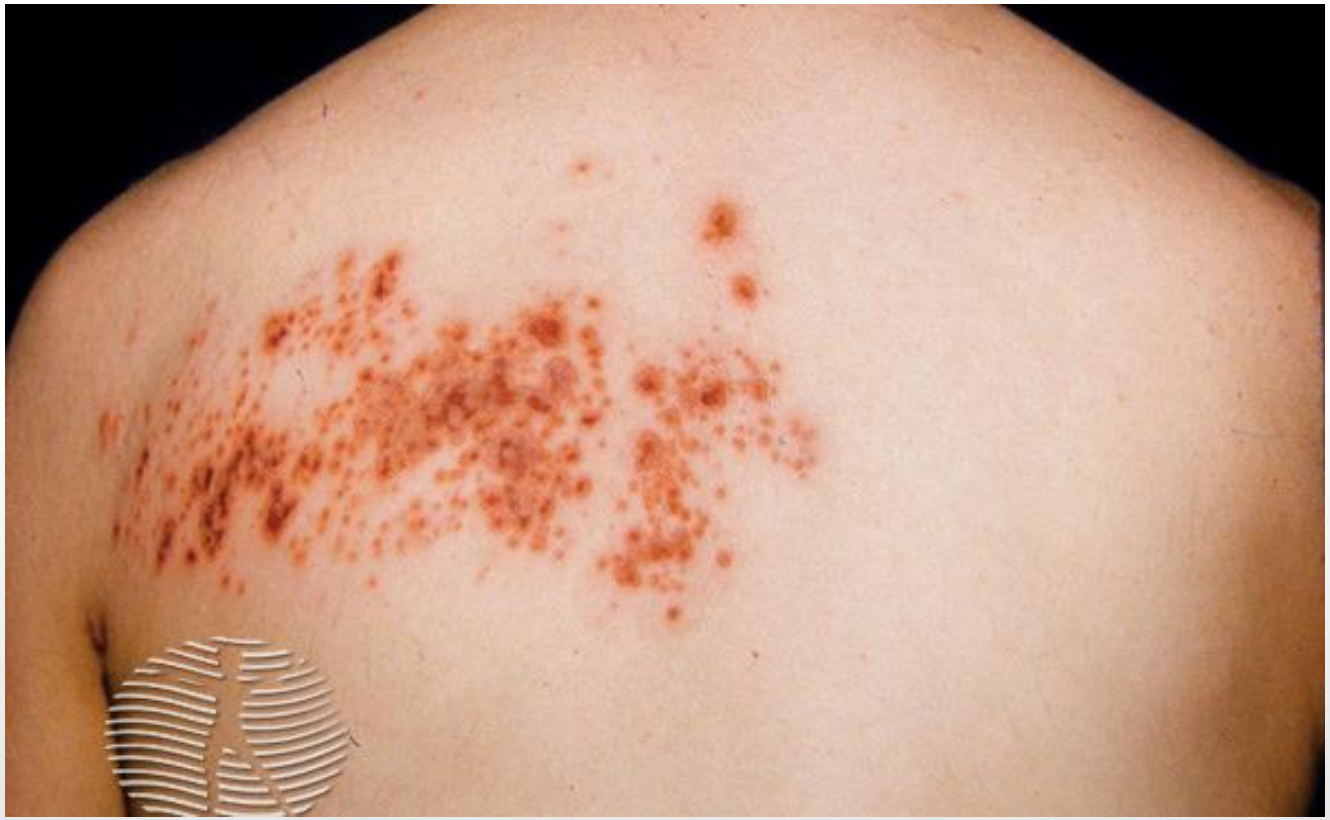
www.dermnet.org.nz

www. BAD.org.uk

www.PCDS.org.uk

HERPES ZOSTER - SHINGLES

I DON'T KNOW WHAT IT IS DOC – IT JUST FEELS FUNNY….



SHINGLES

Herpes zoster infection in childhood - chickenpox

Spots clear, virus doesn't

Lies dormant in the dorsal horn of spinal column….

Immunosuppression!

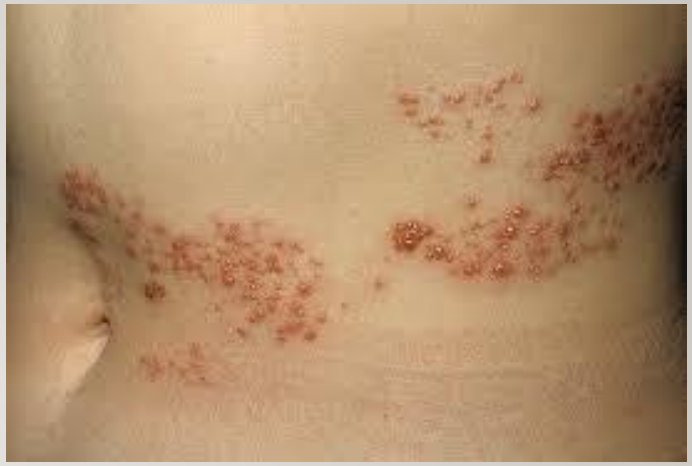
Times of stress, out it comes (for 1 in 4 of us)

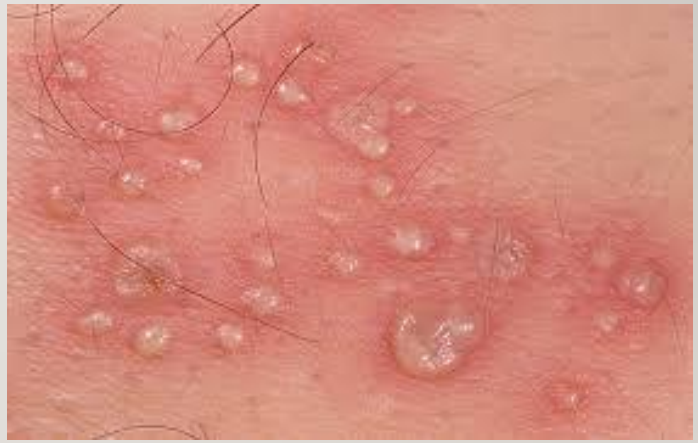
=> pain, blisters, rash

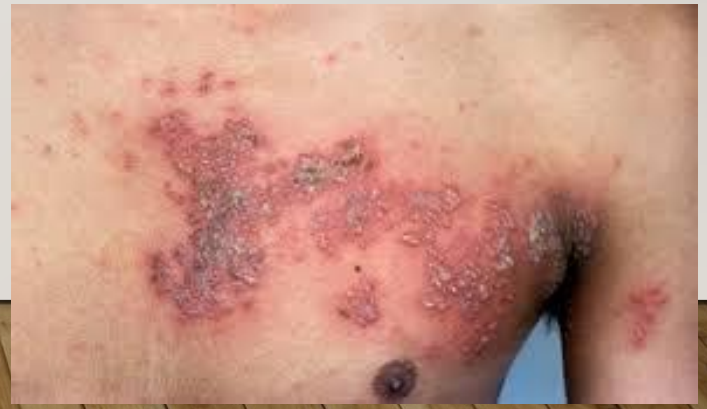
Dermatomal distribution

Unilateral nerve pathway (mostly)

Lasting 3-4 weeks

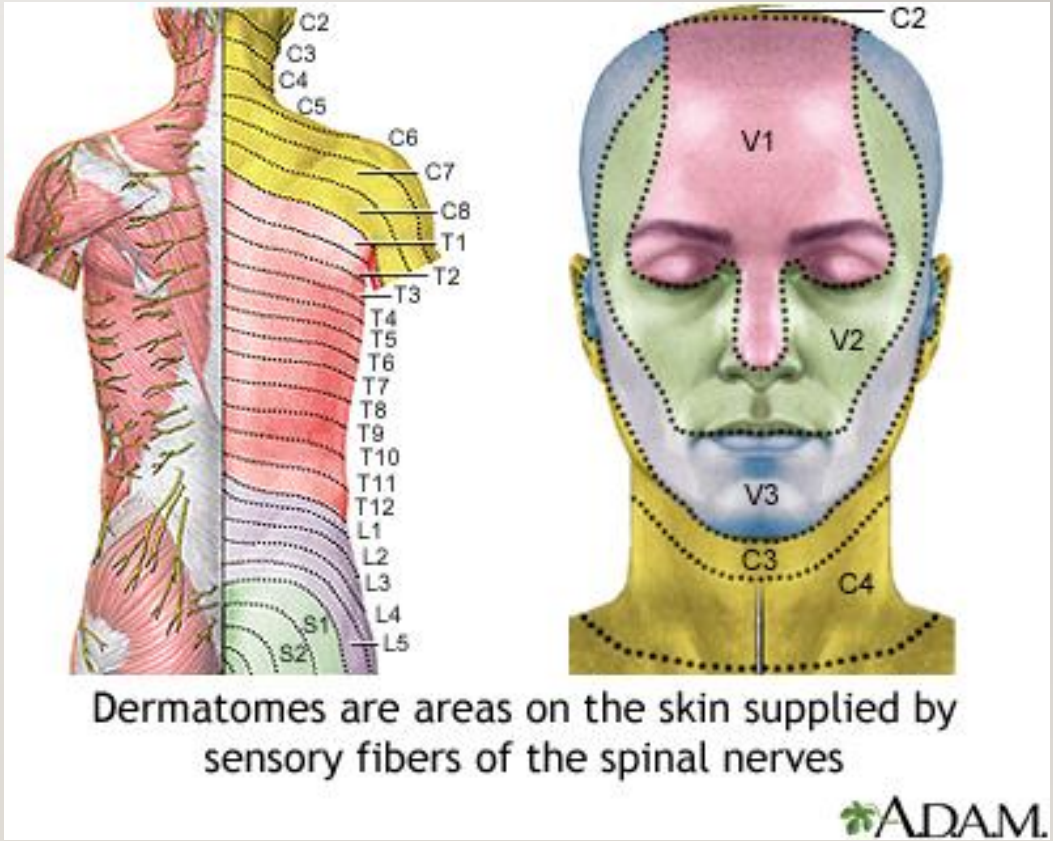






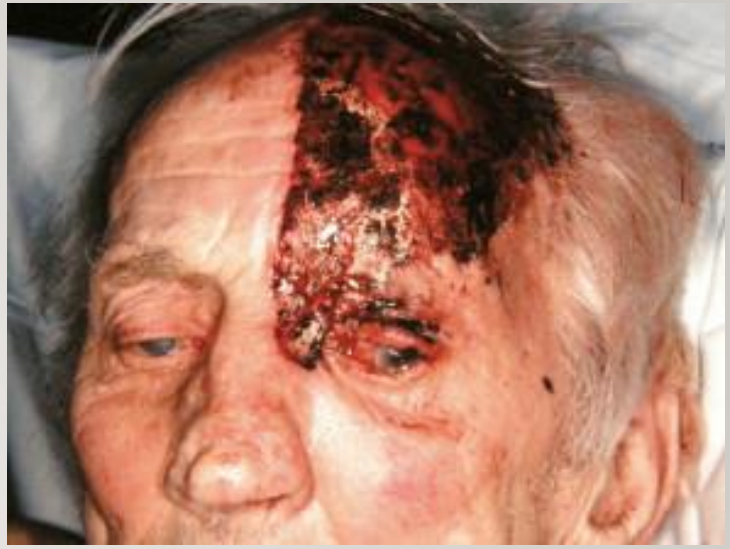
SHINGLES – A FEW POINTERS

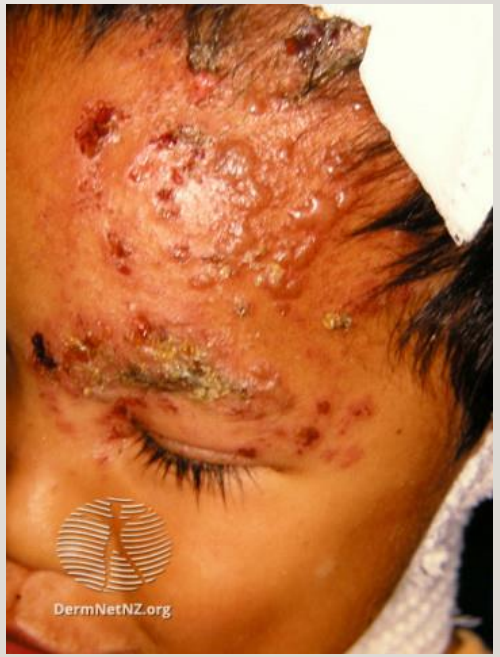
- Antivirals orally if caught early
- Pain relief
- Beware!!
  - The "itchy tingle" or the solitary blister
  - Beware secondary bacterial infection
  - BEWARE OPTHALMIC INVOLVEMENT
- Blister fluid is infectious
- YOU CANNOT CATCH SHINGLES

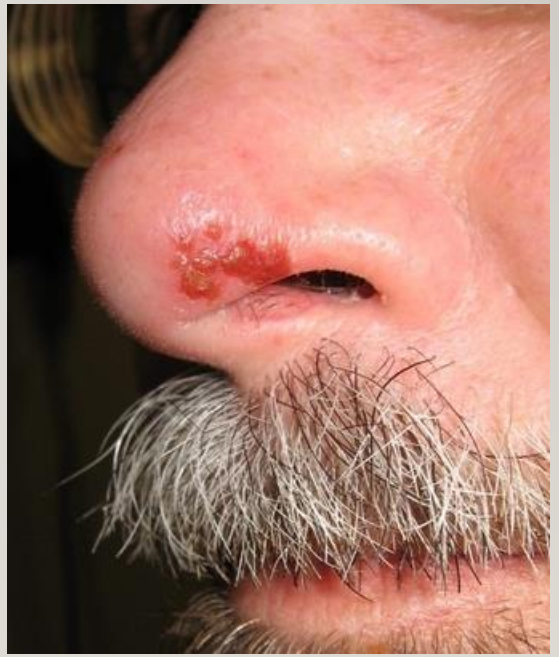


SHINGLES – WHEN AM I WORRIED ?

- Hutchinson's sign/potential of eye involvement
- Secondary bacterial infection
- Post herpetic neuralgia – complex
  - Up to 20% of sufferers
  - Esp if over 50/immunocompromised
- Recurrent attacks
- Suspect immunocompetency issues
- REFER TO PGD

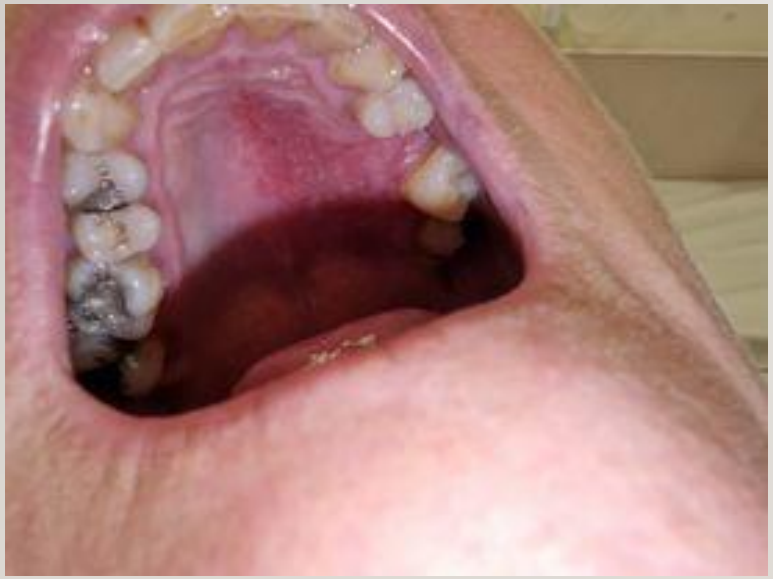






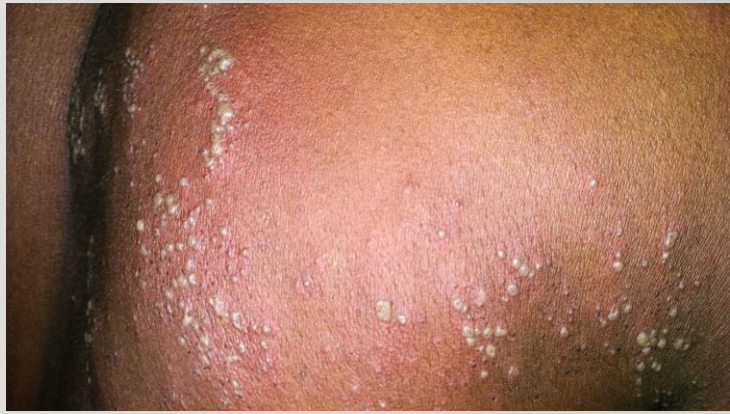
AND DON'T FORGET…

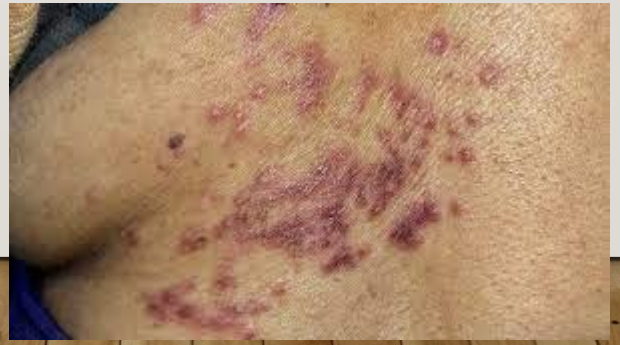
MUCOUS MEMBRANE SHINGLES

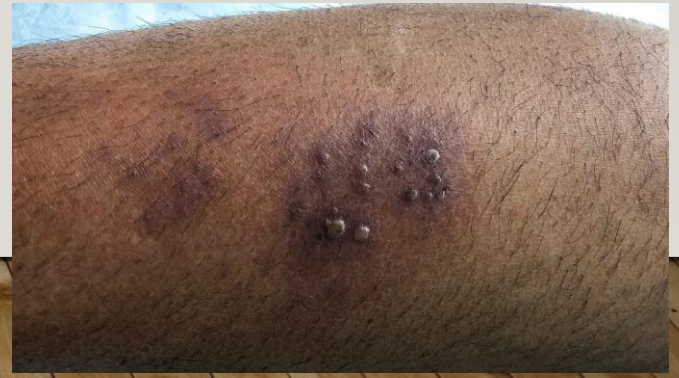


LOOK HARDER IN SKIN OF COLOUR

(LOSE ERYTHEMA => PURPLE/DARK BROWN



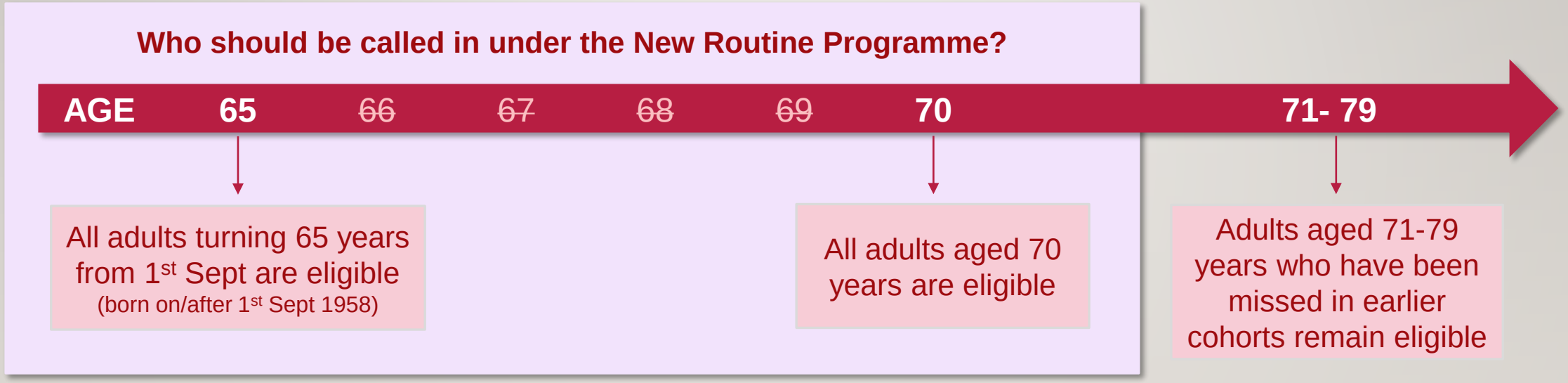




WHO'S ELIGIBLE FOR VACCINATION AGAINST SHINGLES?

From 1st September 2023, the National Immunisation Programme has expanded to provide earlier protection for:

Adults 70-79 and turning 65 years old on or after the 1st September 2023[1]

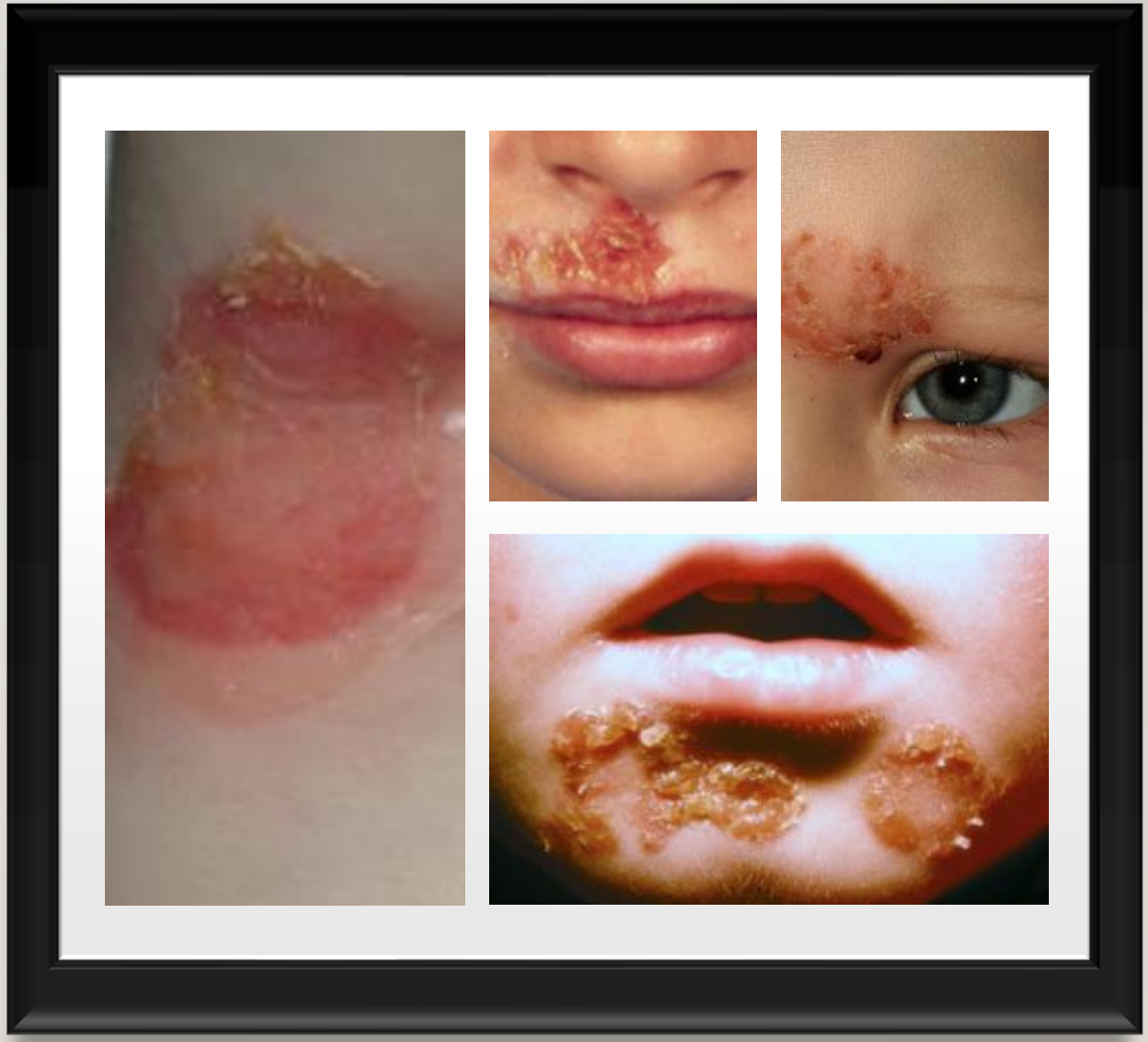


- Once an individual becomes eligible, they remain eligible until their 80th birthday
- 2nd Dose of SHINGRIX should be given in line with official recommendations

References: 1. The GreenBook chapter 28a – Shingles. July 2023

IMPETIGO

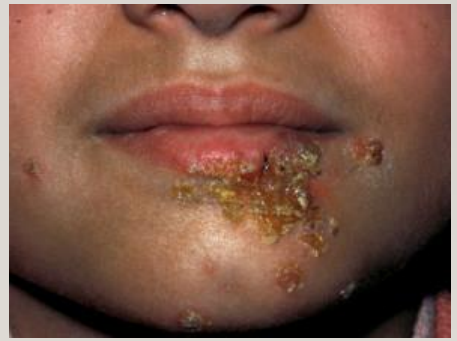
GOOD OLD STAPH AUREUS



IMPETIGO

- Staphylococcus aureus or streptococcus pyogenes infection
- Yellowy golden crust
- Often facial/around mouth
- Starts with minor skin injury
- Peak onset in summer
- Highly contagious, stay off school/nursery
- Use antimicrobial soap substitutes and moisturisers.

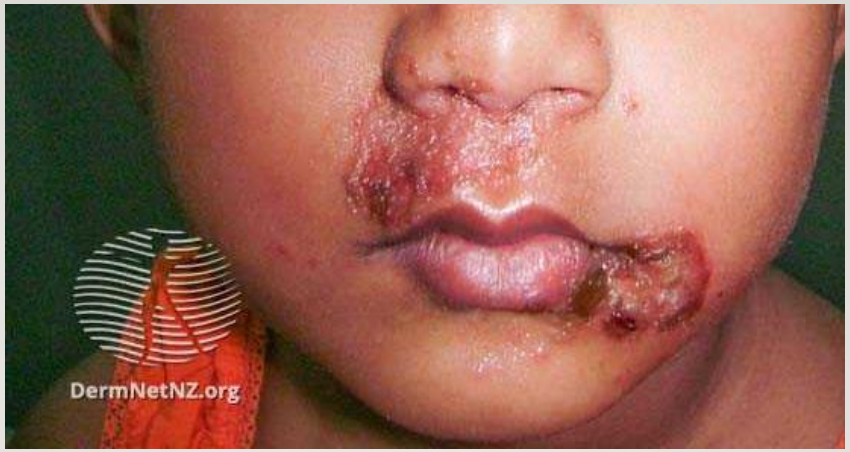
- Usually well, can see mild fever/malaise
- Gen heals without scarring
- Possible complications…
  - Bullae
  - Cellulitis
  - Osteomyelitis
  - Septic arthritis!

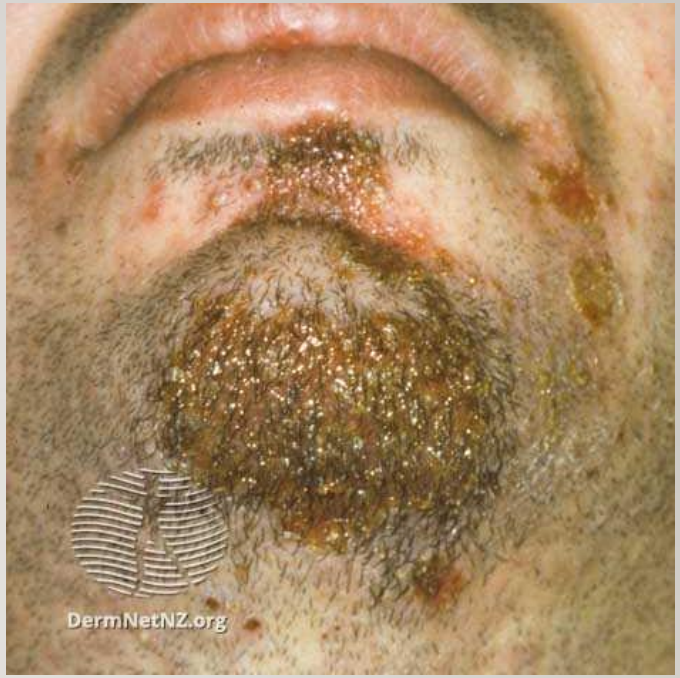


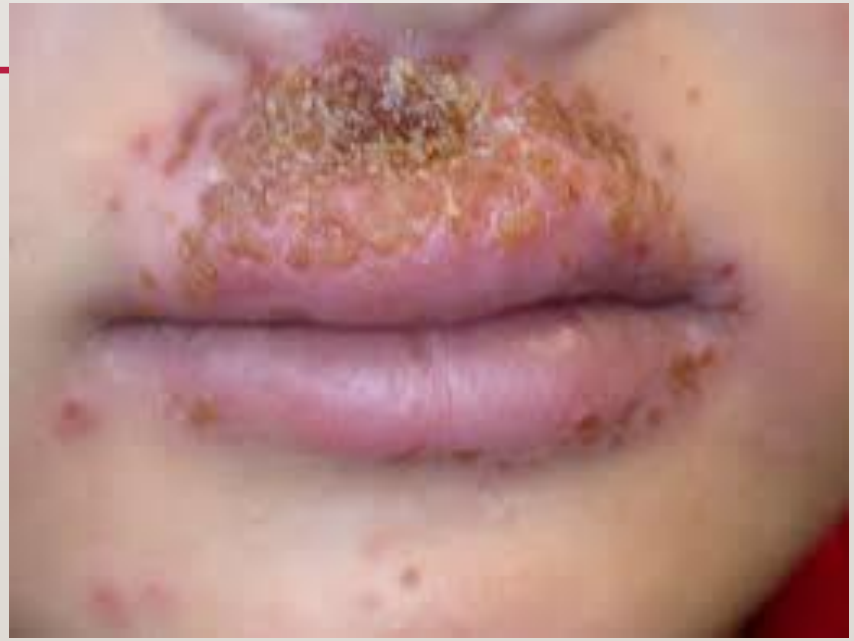
IMPETIGO- ACTIONS AND TREATMENT AS PER PGD

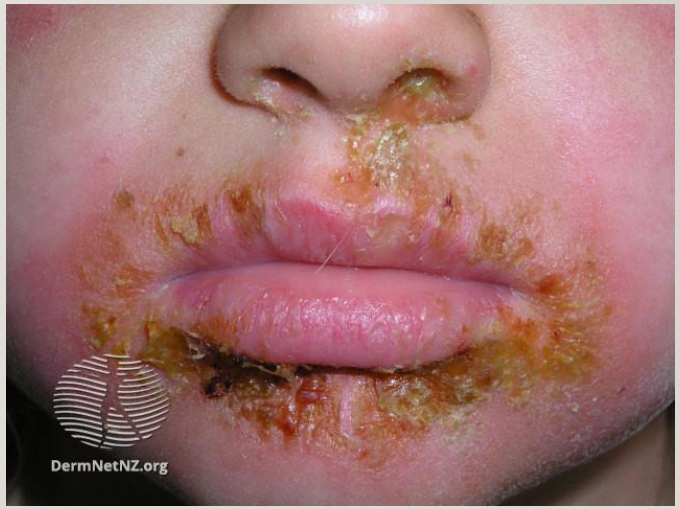
- Gentle skin cleansing BD – Dermol usually
- Topical H2O2/Fusidic acid for few lesions/small area
- Oral Flucloxacillin/Clarithromycin for more extensive area
- (MRSA - Mupirocin and oral Doxycycline)
- Separate towels and flannels - infectious
- Nasal swab for carriage status if persistent prob/resistant to tx
- If no response to topical treatments within first few days take swab
- Developing blisters/bullae/systemically unwell child => ??ADMIT
- Always consider eczema herpeticum as differential

IMPETIGO?? OR NOT?!

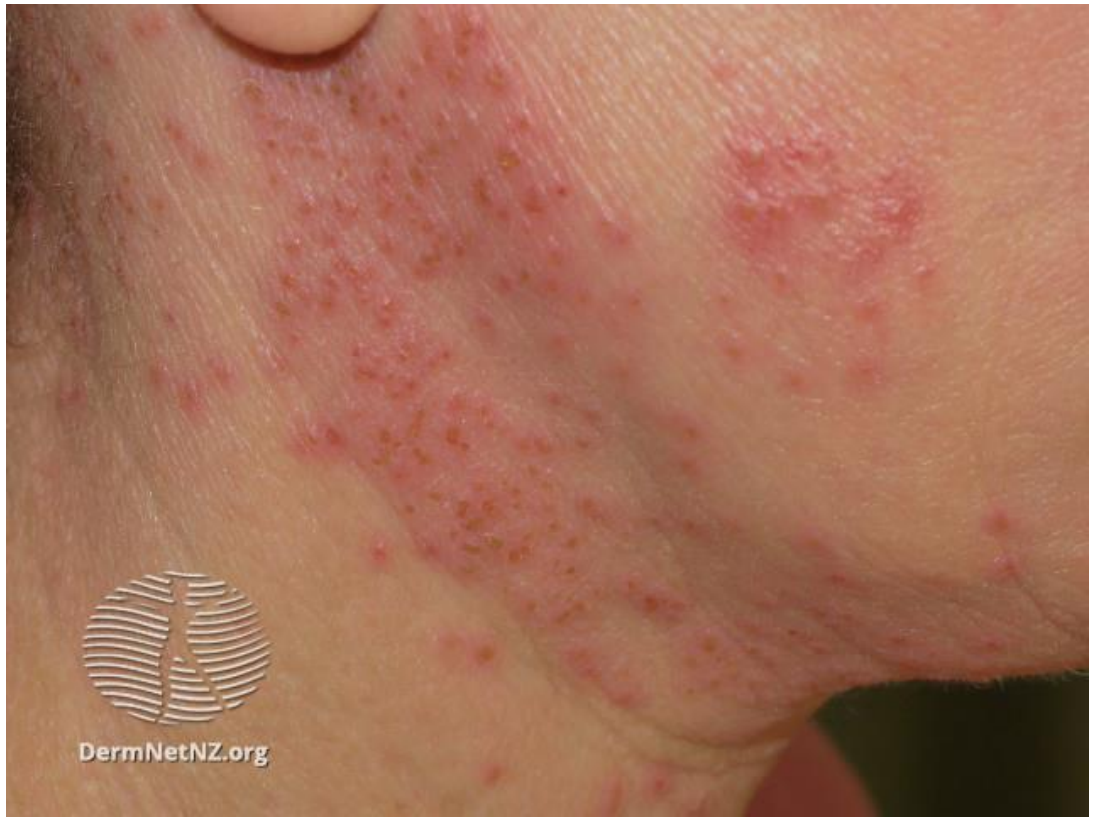






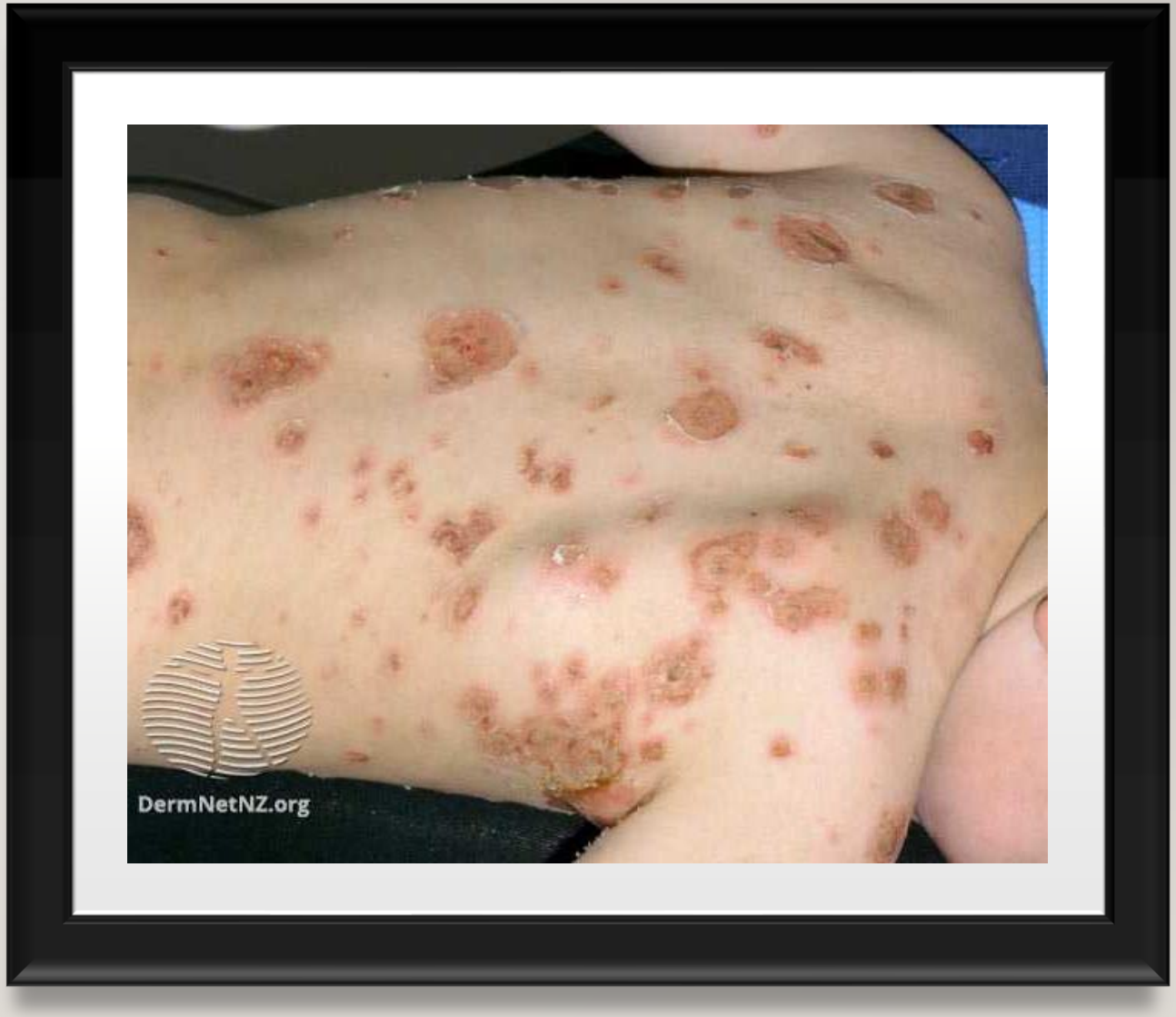


ECZEMA HERPETICUM – REFER URGENTLY



IMPETIGO: WHEN TO REFER

- Immunosuppression
- Systemic upset (fever)
- Skin pain
- *Significant* co-existing skin disease (e.g. eczema)
- Failure to improve



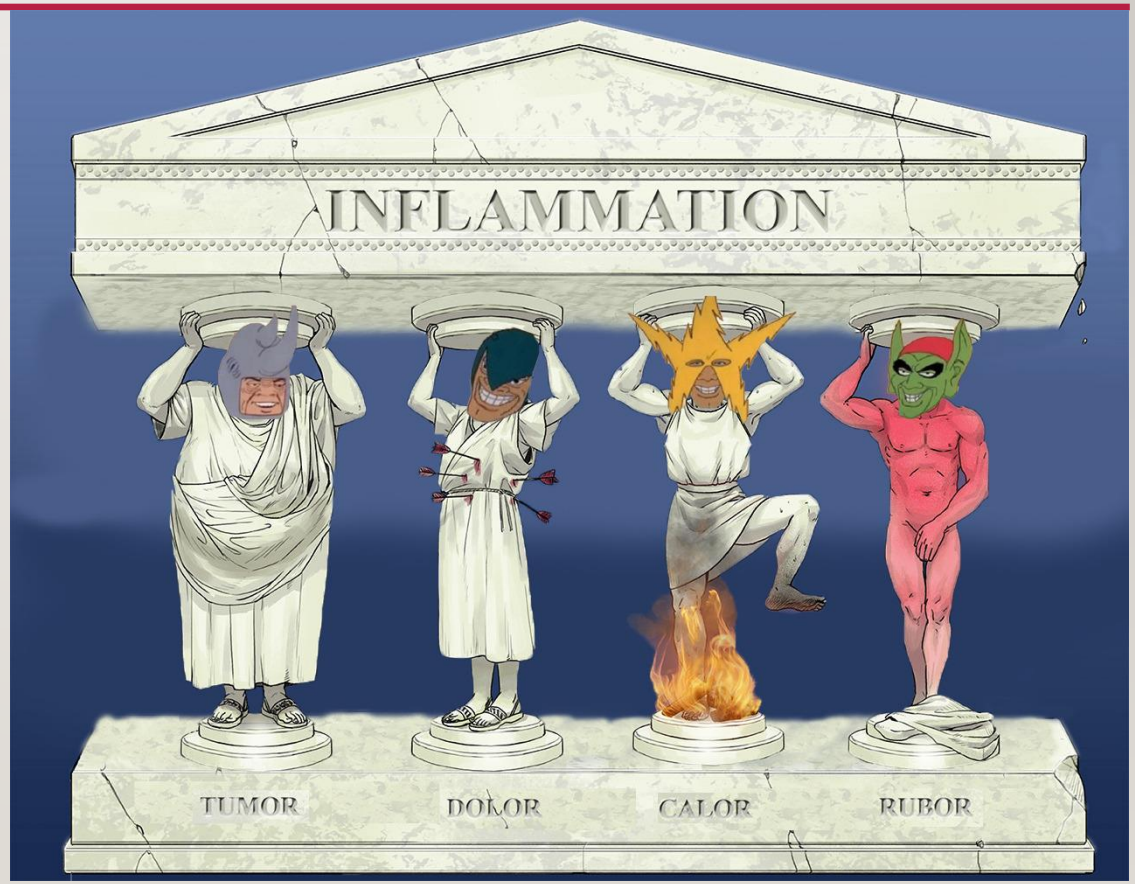
INFECTED INSECT BITES

Or not!

REMEMBER CELSUS (AD 25)

- <u>4 signs of inflammation</u>
- Calor
- Dolor
- Rubor
- Tumor

- Not necessarily infection!



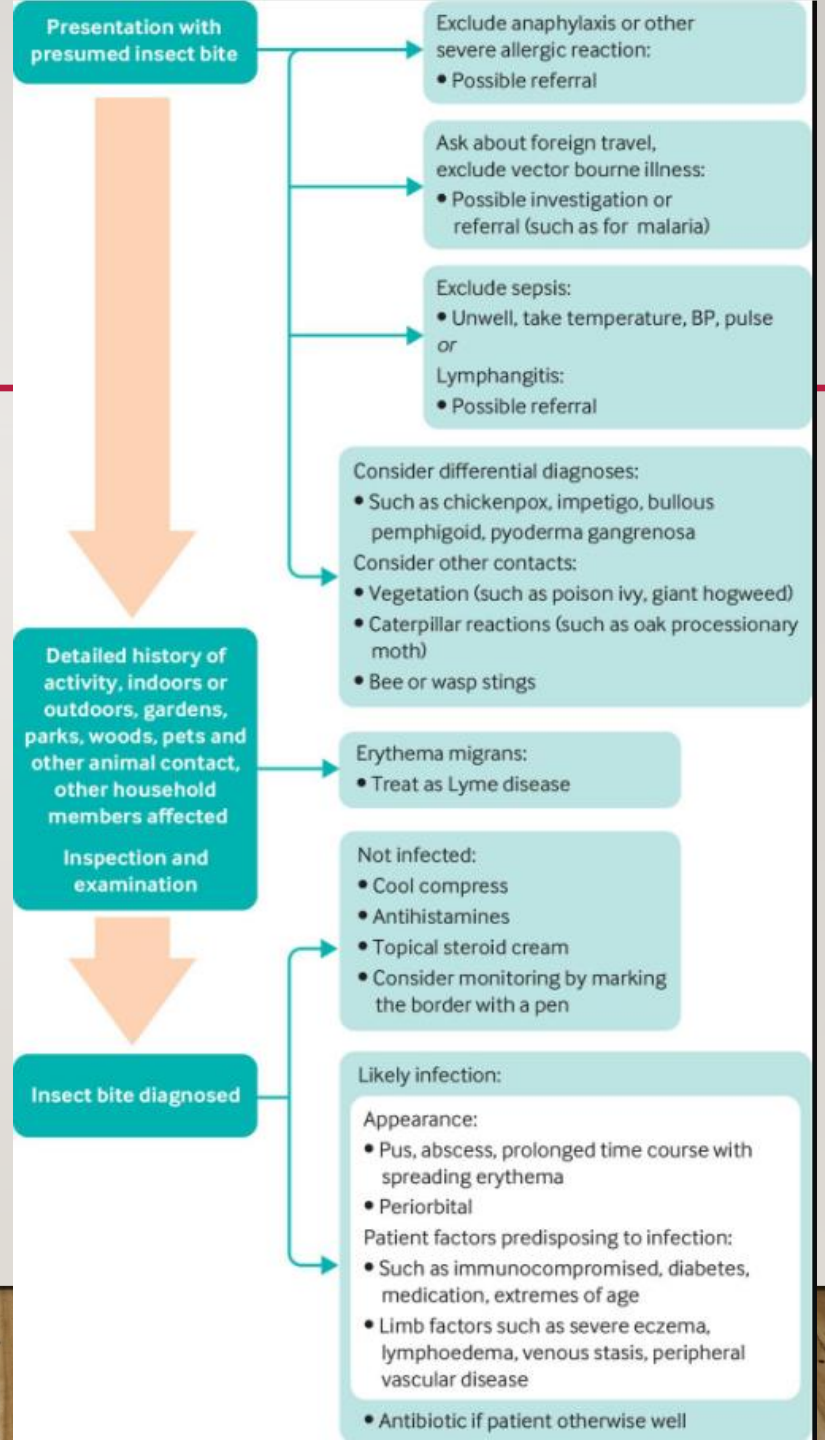
IS IT INFECTED THEN?

- Come in crops
- Intensely itchy
- Central blister
- Flea/tick/bedbug – saliva
- Bee/wasp/hornet – venom
- Often see tracking with multiple bites trapped under clothes

- At least 48 hrs – usually 72
- Spreading, tender, redness
- Leaking pus from site of bite
- Hot spoons???

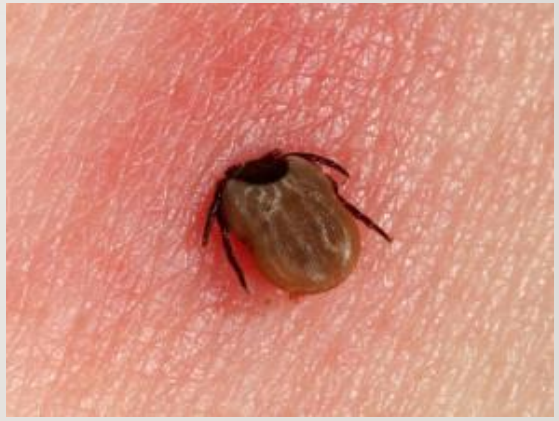
BMJ 2020;370:M2856
PRACTICE POINTER

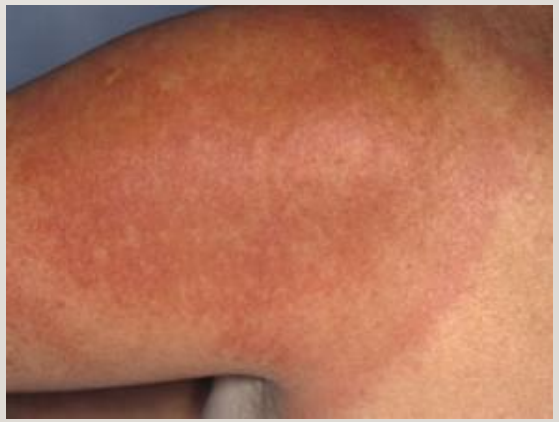
- Very little research evident
- "Secondary infection *may* be indicated by fever, systemic symptoms, and worsening reactions with spreading erythema. It can be difficult to know if mild secondary cellulitis has occurred!"

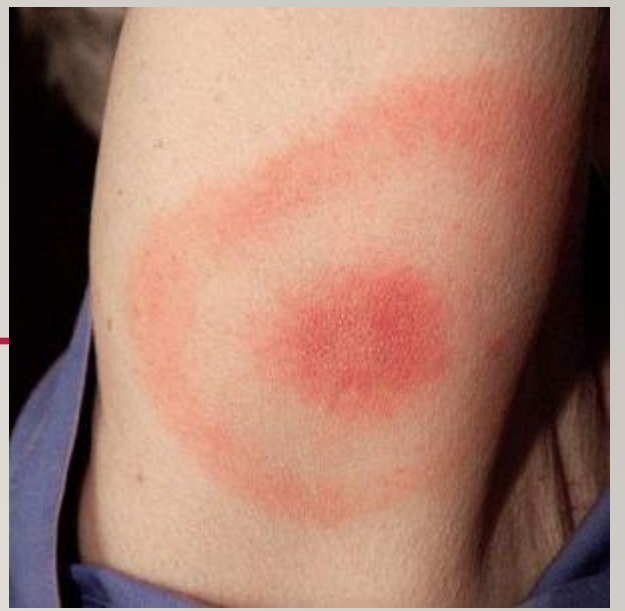


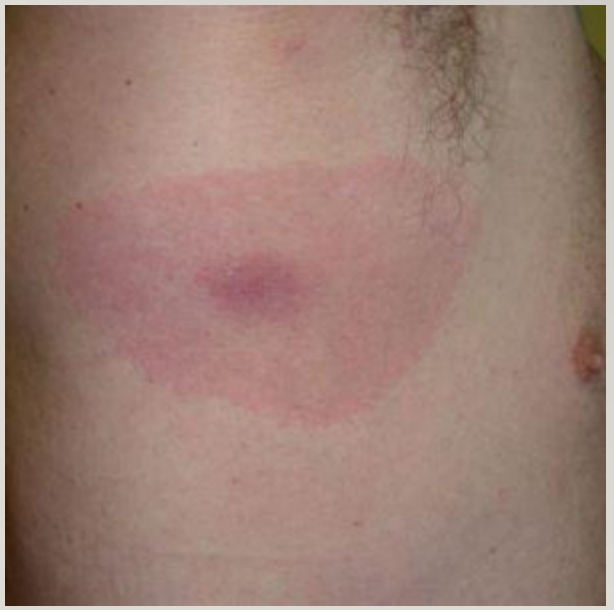
RED HERRING 1 – LYME DISEASE

- Tick bite – Borrelia Burgdorferi
- High grass, brush, woodland, leafy forest
- 3-33 days after tick or nymph bite
- Flu-like illness – low grade fever, chills , fatigue, joint pain
- Central rash, clear skin, red rash "Bulls Eye"
- Refer!! Further ix needed



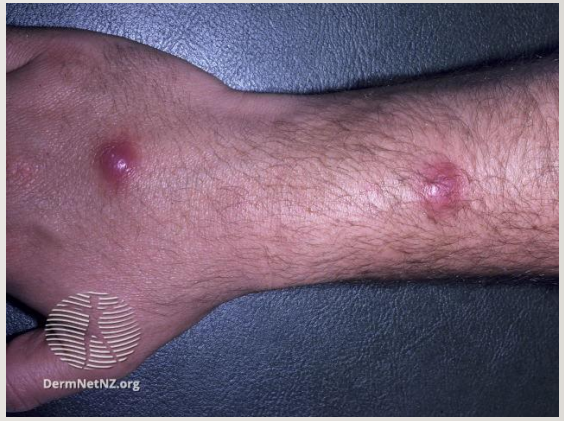


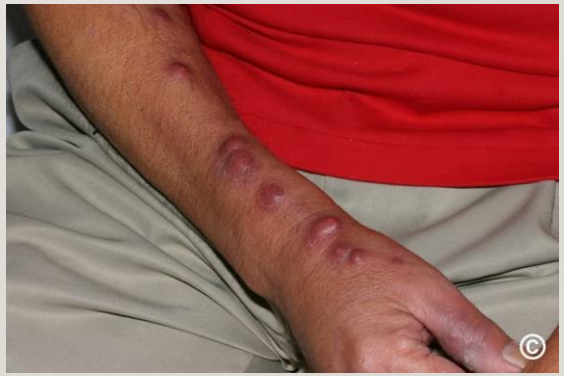


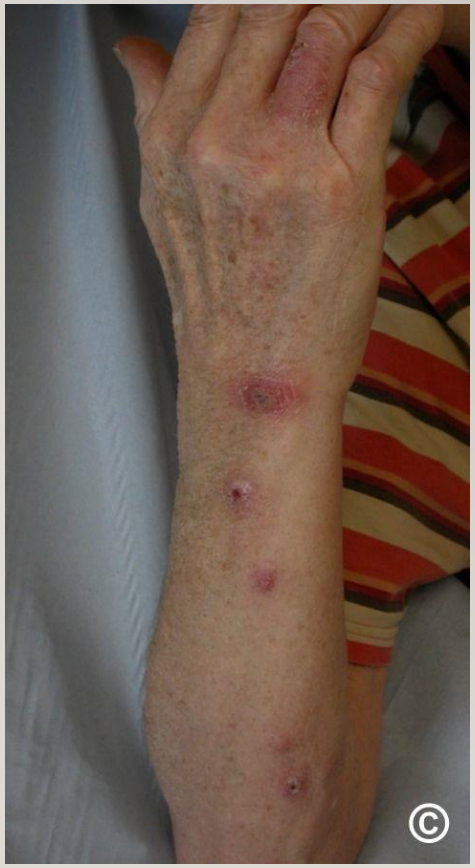


RED HERRING 2 – FISH TANK GRANULOMA

- Atypical mycobacterium (not TB/leprosy)
- Single lump/pustule => abscess
- Tracks along lymphatic drainage, usually proximally
- Common below elbow
- Wear gloves!
- REFER – 3-4/12 of doxy or clarith







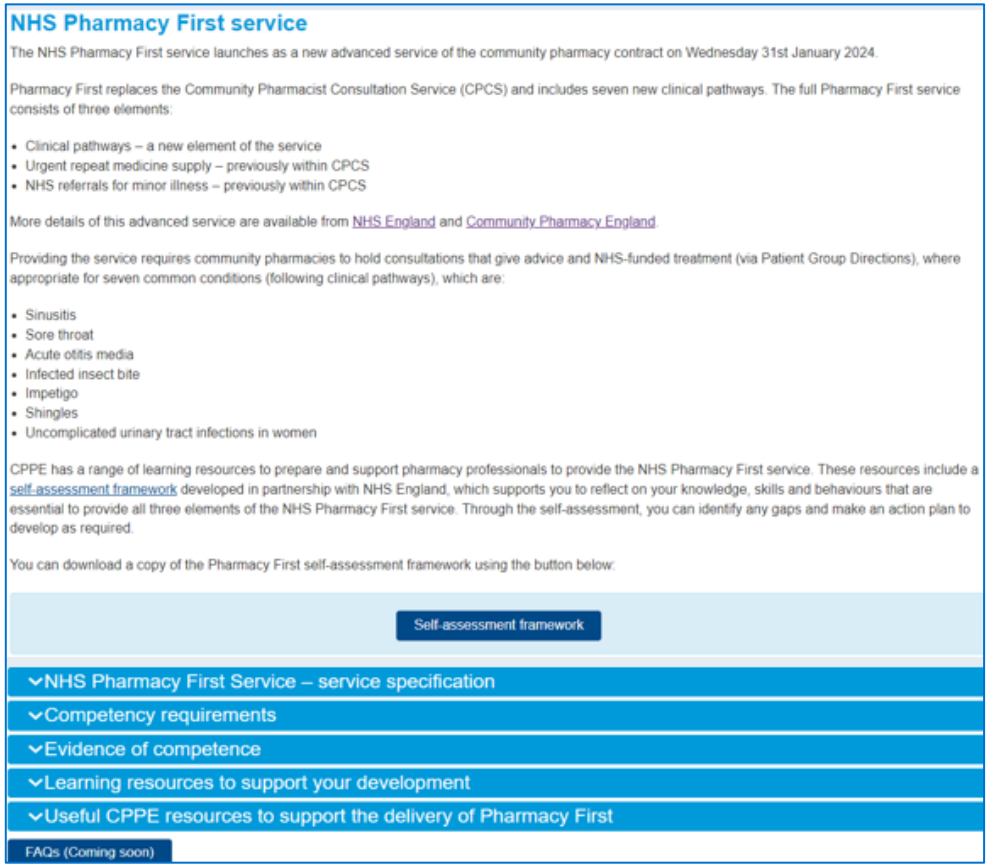
ANY QUESTIONS?

- Happy to be contacted
- Opportunity to sit in derm clinics if wanted.
- Stephanie.gallard@livgp.nhs.uk

Preparing to provide the service

Learning and development

- CPPE webpage detailing training resources
  - www.cppe.ac.uk/services/pharmacy-first/
- Pharmacy First self-assessment framework – developed by CPPE and NHSE
- Personal development action plan



NHS Pharmacy First service

The NHS Pharmacy First service launches as a new advanced service of the community pharmacy contract on Wednesday 31st January 2024.

Pharmacy First replaces the Community Pharmacist Consultation Service (CPCS) and includes seven new clinical pathways. The full Pharmacy First service consists of three elements:

- Clinical pathways – a new element of the service
- Urgent repeat medicine supply – previously within CPCS
- NHS referrals for minor illness – previously within CPCS

More details of this advanced service are available from NHS England and Community Pharmacy England.

Providing the service requires community pharmacies to hold consultations that give advice and NHS-funded treatment (via Patient Group Directions), where appropriate for seven common conditions (following clinical pathways), which are:

- Sinusitis
- Sore throat
- Acute otitis media
- Infected insect bite
- Impetigo
- Shingles
- Uncomplicated urinary tract infections in women

CPPE has a range of learning resources to prepare and support pharmacy professionals to provide the NHS Pharmacy First service. These resources include a self-assessment framework developed in partnership with NHS England, which supports you to reflect on your knowledge, skills and behaviours that are essential to provide all three elements of the NHS Pharmacy First service. Through the self-assessment, you can identify any gaps and make an action plan to develop as required.

You can download a copy of the Pharmacy First self-assessment framework using the button below:

Self-assessment framework

- NHS Pharmacy First Service – service specification
- Competency requirements
- Evidence of competence
- Learning resources to support your development
- Useful CPPE resources to support the delivery of Pharmacy First

FAQs (Coming soon)

COMMUNITY PHARMACY CHESHIRE & WIRRAL

Learning and development

- NHSE funded training by Cliniskills
  - Clinical examination skills includes e-learning and face-to-face training www.cliniskills.com/community-pharmacists/
- CPE Pharmacy First webinars:
  - **Getting to know the service** recorded version available
  - **Getting ready for launch** – 15th Jan recorded version available/available soon

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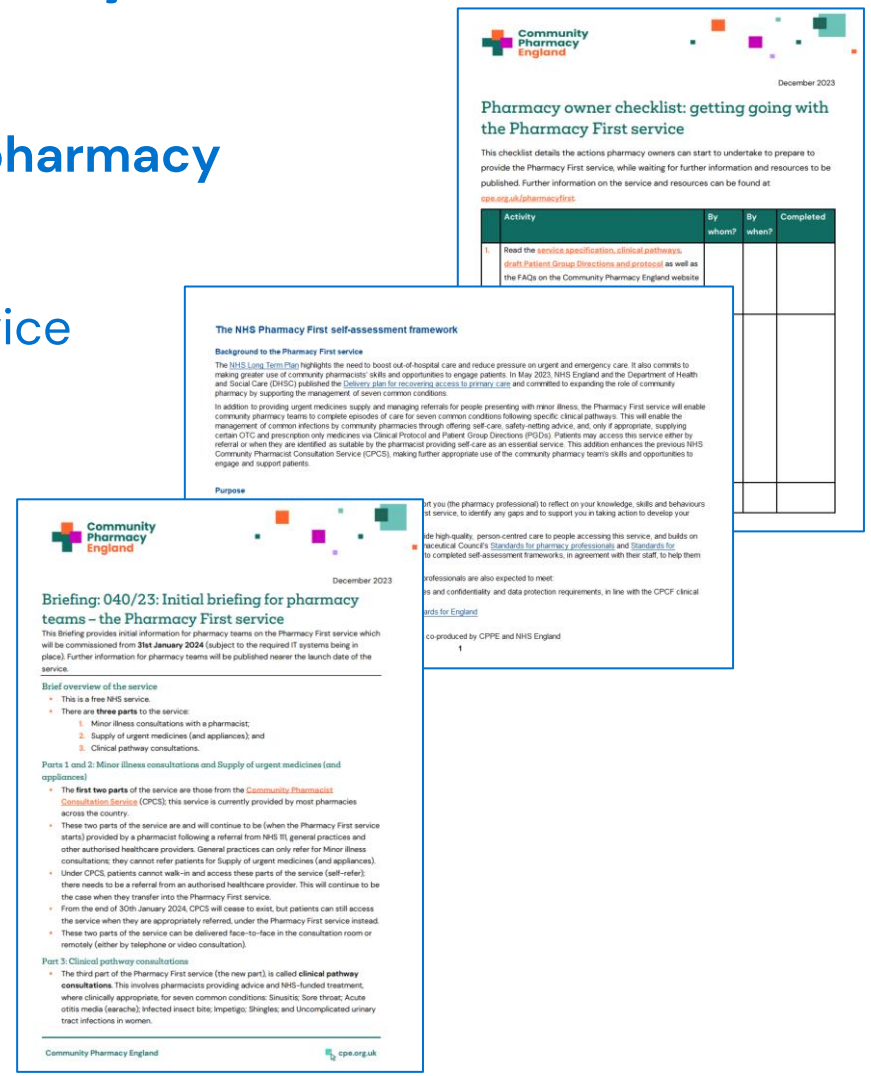
Resources to help you get ready

- Checklists of things to do to prepare for the service for **pharmacy owners** and **pharmacists**
- The **CPCS toolkit** is being updated to cover the new service
- **CPPE Pharmacy First webpage** and **self-assessment framework**
- **Cliniskills training modules** and other training options – use our training resource one pager (on tables)
- **Summary briefing** for pharmacy team members
- **VirtualOutcomes** – whole pharmacy team preparation. Seven condition modules with key points



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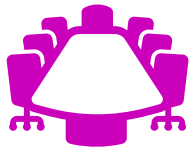
Promoting the service

- NHS England is developing a **marketing campaign** for the service
- LPCs are starting to **brief Local Medical Committees and general practices** about the service
  - A briefing for LMCs and general practice teams is available at cpe.org.uk/pharmacyfirst
- **Further resources** are being developed by Community Pharmacy England to help you and LPCs to promote the service to patients, the public and local stakeholder organisations



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Foundation (pre-reg) training is changing

New Standards

- New approach to undergraduate and foundation training
- Integration of prescribing training

Recruitment

- **ALL Recruitment must be through NHSE Oriel system**
- Open for employer registration Jan/Feb 2024

Funding

- Harmonised funding model
- Training grant claimed via MYS portal for all community pharmacy providers

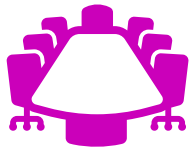
Find out more

- NHSE website
- E-mail: england.wtepharmacy.nw@nhs.net

Table Discussions

Table & Peer Discussions

- Your approach with the whole pharmacy team – how are they all being made aware to maximise recruitment? Virtual Outcomes
- Discussions with local GPs. Are there opportunities to collaborate with other pharmacies on messaging. How do you manage the pacing and volume?
- How do you encourage referrals to continue (only the clinical pathways are walk in)
- How are you going to handle locum and relief staff?
- How are you going to manage workflow and queues to help reduce waiting times for walk-in Pharmacy First patients and for those who are waiting for prescriptions/other services?
- How are you telling the public about the offering? 30 Clinical Pathway consultations / month by October to hit the minimum for the fixed payment (other PF consultations aren't counted here)



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Questions

cpe.org.uk/pharmacyfirst