Step by Step Guide for the Implementation of Pharmacy First Service (including Minor Ailments) in a Practice or PCN

SECTION 1 - Getting started

Expected Outcome of Each Step	Activity, Considerations and Top Tips	Agreed Next Steps
1. Practice or PCN to understand: ▪ **the Pharmacy First Service** ▪ **the difference between referral for minor illness consultations and the clinical pathway consultations for the 7 common conditions** ▪ **the benefits of the service for the practice/PCN, patients and community pharmacy**	Depending on learning preferences, resources available: ▪ PowerPoint presentation from Devon ICB and Community Pharmacy Devon. ▪ National video detailing the service: Pharmacy First: Information for GP practice teams - Community Pharmacy England (cpe.org.uk) (2 minutes 17 seconds). ▪ Devon YouTube advert: Think Pharmacy First (youtube.com). ▪ The PCN Lead community pharmacist or someone from Community Pharmacy Devon can meet the practice or PCN Team to explain the service. A list of all PCN Lead community pharmacists in Devon, including contact details, can be found here ▪ Use the Community Pharmacy England Briefing for Local Medical Committees and General Practice.	
2. Decide how the Pharmacy First Service fits in with the practice or PCN's same day service and appreciate and decide how on the day clinical conditions and minor illness could be managed collectively across the two contractor groups	▪ How the Pharmacy First Service fits in with the practice/PCN will depend on how the practice or PCN manages its' on the day service. Pharmacy First can be programmed into some care navigation and triage systems used or can be added to an existing reception/care navigation protocol. ▪ Suggested people to involve in the discussion – clinicians and non-clinicians from the same day team, practice managers, team leaders, experienced receptionists, care navigators or care coordinators, PCN pharmacist and/or pharmacy technician, community pharmacy PCN Lead, local community pharmacists.	

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3. Understand the capacity for delivering the service through local community pharmacies	▪ Work with the PCN Lead community pharmacist to clarify the degree of readiness and the capacity for referrals per community pharmacy that will be consistently achievable Monday – Friday. ▪ When considering the capacity, take into account the number or practices referring to the community pharmacies in the locality and (if applicable) the complexity of large town/city. ▪ Highlight capacity issues with the PCN Lead community pharmacist who can feed this back to Community Pharmacy Devon to determine where practical support will help.	
4. Jointly agree to implement the Pharmacy First Service	▪ Identify the lead point of contact for the implementation of the service in the PCN, and each practice and community pharmacy (can be a senior dispenser or ops manager if pharmacy is run on locums). ▪ Determine what training is needed so practice or PCN staff feel confident in their ability to identify conditions to send as a referral to community pharmacy for minor ailments and the 7 clinical conditions and answer questions from patients – Virtual Outcomes Training is available for Practice and PCN staff free of charge: Online Event (workcast.com)	
5. Consider the information governance requirements of the service	▪ Decide whether the Practice is going to ask the patient to consent to the referral to community pharmacy. ▪ Ensure your privacy notice is updated accordingly and displayed / easily accessible to patients.	
6. Practice or PCN has a clearly documented process for the service	▪ Start building the Standard Operating Procedure (SOP) for the Pharmacy First process as questions are answered and the implementation plan is progressed, see draft SOP template.	

SECTION 2 – Making it Work

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7. Agree or confirm the communication process between the practice and pharmacy/pharmacies including the process for escalation of issues	▪ An example referral and process chart is provided for the surgery to complete with the community pharmacy. ▪ Ensure all parties are really clear about the escalation process; it is to be expected that some patients will be referred back because of symptoms found whilst being triaged by the pharmacist, or the pharmacist may recommend a non-urgent review of an existing condition. Data from Devon PCNs suggest only 1 in 10 referrals are returned by the pharmacy. ▪ How to escalate issues safely; person-to-person confirmation is an absolute requirement for anything that needs to be addressed that day, e-mails for any non-urgent escalations or DNAs. ▪ Do both practices and pharmacies have direct dial numbers to use in urgent situations? ▪ Practices must know if there is a problem delivering the service e.g., pharmacist is off sick, could MS Teams or WhatsApp be used in such circumstances?	
8. Understand the number of referrals the pharmacy can accept/receive and how to factor this into the reception schedule	▪ Understand the number of possible referrals from the practice per day (can go through same day list and identify those cases which could have been referred to get an idea of numbers). ▪ Know the capacity of each pharmacy in terms of number of referrals that can be accepted each day and identify if the practice needs to share this capacity with other practices. ▪ Consider adding the Pharmacy First appointments as a clinic. This serves as a good reminder of the service, notes can be added, appointments can be blocked if necessary and the practice knows when their referral capacity has been reached that day. Remember to remove those appointments not used at the end of the day.	

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9. Agree the details of the referral process from the practice or PCN to the pharmacy	▪ Obtain all necessary details from the pharmacies and practices, telephone numbers, the correct generic NHS mail for the referrals that will be accessed by the community pharmacy dispensary and management team and the correct generic NHS mail where the information received back will be viewed and actioned by practice/PCN staff. Your Community Pharmacy PCN Integration Lead may be able to help you collate this information. ▪ Identify the staffing groups who will be making the referral in the practice/PCN. ▪ Clarify whether the pharmacist wants to contact the patient when they receive the referral, or the patient needs to contact the pharmacy. This can be used in the referral template, tailored to the pharmacy. ▪ Discuss how no contact made by the patient/patient not contacted by the pharmacist is managed. The specification states the pharmacist can use clinical judgement whether to contact the patient and can close the referral off if the patient has not made contact/the pharmacist has not been able to reach them the next working day. What would the practice usually do in the same circumstance (as some commonality would be useful)? Would the practice want to know the patient had not made contact or the pharmacist had not contacted them? ▪ Need to ensure the pharmacy staff know what to do if referrals have been made by the practice/PCN and there is no pharmacist available to action them. This could include a referral to another pharmacy. Would the surgery want to be informed of this?	

	▪ Pharmacy and practice ensure they are checking e-mails throughout the day. What is the cut off time for the last referral to the pharmacies?	
Expected Outcome of Each Step	**Activity, Considerations and Top Tips**	**Agreed Next Steps**
9. Agree the details of the referral process from the practice or PCN to the pharmacy *continued*	▪ What is the cut off for practice/PCN staff viewing their generic e-mail for non-urgent information returned? ▪ Decide whether the practice/PCN will use EMIS refer, Ardens or Accurx. ▪ Whichever software is used to refer, ensure a code is added into the clinical system as the referral is sent (check when testing the referral system). ▪ Practice/PCN and community pharmacy to collectively decide, in addition to the patient details, the level of detail to include in the referral e.g. earache left ear, sore throat. Decide if practice / PCN staff are to add “Pharmacy first” at the start of the referral so it is easy to see on the pharmacy e-mail. ▪ Send a text to the patient to confirm they have “been referred for a consultation with an NHS pharmacist”, the details of the pharmacy and what to do, so expectations are very clear. If using Accurx, the	

	referral can be set up as an individualised template for each pharmacy the patient chooses to attend and so should include: ○ Whether the patient should contact the pharmacy, ○ Whether the patient should walk-in or telephone the pharmacy (and include the number to phone on the template), ○ Whether the pharmacist will contact them and book an appointment for them, ○ A link to the pharmacy bookable appointments (if available), ○ What to do if they have not heard from the pharmacy within 12 hrs (or another reasonable timescale agreed).	

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10. Agree the standard of information coming back to the practice and how to manage within the practice workflow	▪ Details of a community pharmacy consultation can be sent directly into the GP clinical IT system for the majority of pharmacy IT systems. If the practice has switched off GP Connect update record, the information will continue to come in via NHS mail. ▪ Consider the management of workflow, now and in the future. ▪ See TTP video: https://tpp-uk.com/pharmacy-first/ and EMIS information EMIS Web. ▪ Decide SNOMED code to use to facilitate audit of outcomes (automatic coding occurs when sent directly into the clinical system).	
11. Agree a start date	▪ Decide the condition(s) to start with. ▪ Ensure all relevant staff within each contractor group receive the appropriate training and resources and are confident to start sending referrals and managing the information being returned. ▪ All relevant practice and PCN staff to read and sign the Pharmacy First SOP.	
12. Send and track a successful test referral per GP Practice per Community Pharmacy and successfully track and receive the information back from the Pharmacy	▪ Each practice to send a test referral to each pharmacy to ensure all processes and systems are in place before proceeding, i.e., check NHS mail access / junk mail. The practices are advised to call the community pharmacies to confirm receipt of the referral. ▪ The pharmacies should then process the referral as appropriate and return the information to the practice. The pharmacies are advised to call the surgeries to confirm receipt of the information. ▪ Resolve any issues flagged via the test referral process, i.e., individual contractor leads to liaise with all engaged parties and make any necessary amendments / provide clarity for all staff involved in the referral pathway.	

SECTION 3 – Telling Everyone

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13. Communicate the 'go live' of the Pharmacy First Service to staff in the practice and pharmacy and widen the communications to patients	▪ All NHS 'Help Us Help You' pharmacy campaign resources can be downloaded, free of charge, from the Campaign Resource Centre; materials provided include a campaign toolkit with campaign messages and links to suggested social media posts to help support the national campaign and PR activity. ▪ Start advertising the service within practices and pharmacies to patients i.e., update websites, put up posters, etc. ▪ Think about advertising the 7 clinical conditions to certain groups who may particularly benefit i.e., primary and secondary school children and their families.	

SECTION 4 – Keep Going!

14. Issue resolution and patient safety-netting are actioned quickly and collectively through feedback, review and audit so Pharmacy First is a positive experience for patients, practices and pharmacies	▪ Practice(s) and community pharmacies to maintain regular contact. ▪ Arrange a review meeting between the practice(s) and pharmacies, 2 weeks after the 'go live' date so everyone has an early opportunity to report on any initial successes or challenges experienced since the launch of the service. Your Community Pharmacy PCN Integration Lead may be able to support this review meeting. ▪ Are there any types of referrals that are consistently being referred back to the practice? ▪ Arrange ongoing meetings on a regular basis to continue to embed, develop and improve the service through shared learning and open communication and consider how referral rates could continually be increased to maximise service opportunity.	