

Community pharmacy management of minor conditions — the “Care at the chemist” scheme

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AIM • To describe community pharmacy management of minor conditions after referral from one general practice.

DESIGN • A single-centre, 26-week feasibility study in which all patients seeking GP appointments or telephone request for a prescription for 12 self-limiting conditions were offered a consultation with a community pharmacist. Pharmacists prescribed from a formulary with patients charged or exempt from charges, as for normal NHS prescriptions.

SUBJECTS AND SETTINGS • Patients from one general practice were managed in eight local community pharmacies in Merseyside.

OUTCOME MEASURES • Level of transfer to pharmacy management for the 12 conditions. Patient management within the pharmacies, including prescribing outcomes, referral back to the practice and reconsultation rates.

RESULTS • Over the study period, 576 patients used the pharmacy scheme out of a total of 1,522 who contacted the practice with one of the 12 conditions. The conditions most frequently managed in the pharmacies were head lice, vaginal thrush and upper respiratory tract infections. These three conditions accounted for 79% of all referrals. Most patients (89%) were managed with advice and treatment prescribed from the formulary. Only 21 patients were referred back to the practice and 33 patients reconsulted for the same minor condition within 14 days.

CONCLUSIONS • The scheme enabled the transfer of over one third of the workload for 12 minor conditions from one general practice to eight community pharmacies, but most of the consultations were for three of the conditions. The pharmacists were successfully able to manage a range of conditions from within a specifically designed formulary, and few patients required referral back to the practice. Further, reconsultation rates for the same condition were low.

Self-care is a common response to minor conditions.¹⁻³ This has been supported by a number of policy developments, for example, the movement of medicines to pharmacy or general sale list status⁴ and, more recently, the introduction of NHS Direct.⁵ However, it is still widely perceived that high levels of self-treatable conditions are being managed within the formal primary care services. It has been estimated that 100 to 150 million general practitioner (GP) consultations per year are for conditions that are potentially self-treatable.⁶ One study suggests that self-medication for certain minor conditions would reduce a GP's workload by 16 consultations a day.⁷ Research suggests that many patients exempt from National Health Service prescription charges, while able to self-treat or seek alternative sources of advice, are unwilling to do so because of the financial disincentive.⁸⁻¹⁰

There have been a number of initiatives aimed at reducing GP workload for minor condition consultations. Many of these have involved the use of other health professionals within the GP practice. Studies have explored the use of nurses^{11,12} and pharmacists¹³ in the GP practice to manage minor conditions. Although these studies indicate that nurse or pharmacist management is both effective and acceptable for patients, GP involvement is still required when a pre-

scription is needed. This approach also means that the patient still has to visit the GP practice, hence perpetuating the “medicalisation” of minor conditions. NHS Direct, although offering advice on self-medication, cannot provide the prescription that many exempt patients are looking for. These initiatives involve the creation of new services rather than building on existing areas of service provision. Community pharmacists are well qualified to offer advice and treatment for minor conditions and have the advantages of accessibility and convenience, as appointments are not required.¹⁴⁻¹⁶ Recent initiatives in Nottingham¹⁷ and Sunderland¹⁸ have looked at the free supply of head lice treatment in community pharmacies.

The aim of this paper is to describe the

community pharmacy management of patients with minor conditions referred from one general practice. Under a specifically designed scheme, community pharmacists could prescribe medicines to patients consulting for a range of minor conditions under the same terms as a NHS prescription.

METHOD

The study involved one general practice in a deprived area of Merseyside and eight local community pharmacies. The practice had four full-time GPs and one part-time nurse practitioner (for the first three months of the study only). The number of consultations per week was approximately 550. The approximate wait for a routine appointment was three days and the practice offered an open access clinic each morning. This service gave patients the option of waiting an unspecified period to see a GP or the nurse practitioner.

In 1998, health authority data for the area indicated that 93 per cent of prescription items were exempt from charges. The practice serves a population of over 8,000 patients, with four full-time GPs. In August, 1999, the “Care at the chemist” scheme was introduced, whereby doctors' receptionists offered patients requesting consultations or prescriptions for 12 minor conditions a consultation with a pharmacist at one of the

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eight community pharmacies. The 12 minor conditions chosen were constipation, cough, diarrhoea, dyspepsia, earache, hay fever, head lice, headache, nasal symptoms, sore throat, high temperature and vaginal thrush. They were chosen because they met three criteria: high presentation rates in the practice, GPs were willing to transfer their management, and over-the-counter (OTC), non-blacklisted medicines were available for their treatment. The receptionists did not triage the patients but they were able to inform patients about the scheme and give an indication of the likely wait for an open access appointment.

All patients participating in the scheme had a consultation with the pharmacist. When designing the scheme, the health authority pharmaceutical adviser wanted named community pharmacists to be responsible for the consultations. Observation work carried out in the pharmacies indicated that this was not usual practice, and most OTC sales and requests for advice were dealt with by the medicines counter assistants, with referral to the pharmacist when necessary. The pharmacists could prescribe from a formulary, offer advice on self-care or refer the patient back to the practice. Medicines were provided under the same terms as an NHS prescription, so medicines continued to be free for patients exempt from charges. It was important from a research perspective that the community pharmacists used a formulary so that the study outcomes could be attributed as far as possible to the change in service access, rather than a change in medicines prescribed. The formulary was compiled after examining both GP prescribing data and OTC sales in the pharmacies for each of the 12 conditions and after consultation with the health authority pharmaceutical adviser, the GPs and community pharmacists. Exclusion criteria were also included in the formulary; for example, a child under one year old with a cough was not suitable for inclusion.

If the patient accepted the pharmacy referral, a form was completed by the reception staff and faxed to the pharmacy selected by the patient. This form identified the condition for which the patient was seeking advice or medication and was necessary for monitoring and limiting the scheme to those patients registered with the study practice. The pharmacist recorded details of the consultation using a form designed for the study ("Community pharmacy professional advice" form), based on the FP10 form. This form detailed the minor condition(s) dealt with, the patient's name and unique patient number from the practice, whether a prescription was dispensed with item and quantity, whether an OTC product was purchased or whether the patient was referred back to the practice. As with the FP10, patients completed the reverse of the form, indicating whether they were exempt from prescription charges and the reason for their exemption.

The health authority reimbursed the pharmacists for the cost of the drugs, provided they adhered to the formulary and the

usual discounts and container allowances applied. They also received a fee of £1.50 for their professional input to each consultation, whether a medicine was provided or not. This fee was adopted in order to run this feasibility study without prejudice to any future negotiations to any future service provision. Separate payments were also made by the university evaluation team for data collection within the pharmacies.

Following the introduction of the scheme, data on pharmacy referrals were collected from the community pharmacy professional advice form for six months and were analysed using Statistical Package for Social Sciences. Other data were collected from the GP computer system in order to ascertain whether patients reconsulted the GP following a pharmacist consultation. Reconsulting was defined as those reconsultations for the same minor condition that occurred within 14 days. It was considered that reconsultations after 14 days probably reflect a new episode. All the community pharmacists involved in the scheme were interviewed at the end of the six-month period to ascertain their experiences and views of the scheme.

RESULTS

The "Care at the chemist" scheme was introduced in August, 1999, and data on its use were collected for 26 weeks. During this time, 576 patients used the pharmacy scheme out of a possible 1,522 who contacted the GP practice either by telephone or in person with one of the 12 minor conditions. This represents a 37.8 per cent take-up rate.

Almost three-quarters (73.4 per cent) of patients who used the scheme were female and almost two-thirds (65.3 per cent) were aged under 16 years (Table 1). Most of the patients (n=510; 92.9 per cent) who consulted a community pharmacist were exempt from prescription charges. Nine patients were not exempt from prescription charges. Of these, eight bought products over the counter and one was prescribed Diflucan and paid the prescription charge. Exemption status was unknown for those patients (n=30) who were referred to the GP or who received advice only.

The minor conditions seen most frequently in the community pharmacy were head lice, vaginal thrush and upper respiratory tract infection (Table 2). These three conditions accounted for over three-quarters (79.0 per cent) of the referrals. Table 2 also shows the prescribing rate for each of the 12 conditions and the available formulary items. The average number of items prescribed per referral was one, except for the treatment of upper respiratory tract infection where 67.5 per cent of patients received two or more items. Most of the patients referred to the community pharmacy (n=511; 88.7 per cent) received advice and treatment prescribed from the formulary (Table 3). Nine patients received advice only; of these, seven were consulting with head lice. Twenty-seven patients (4.7 per cent) who were referred did not visit the

TABLE 1: AGE AND GENDER OF SCHEME USERS

Age (years)	Male	Female
Under 4	40	58
5-16	77	201
17-24	10	22
25-34	7	72
35-44	6	39
45-54	3	12
55-64	7	10
65-74	2	2
75 and over	1	7

nominated pharmacy. None of these patients subsequently saw a GP for treatment of the same or a similar condition within the next 14 days.

As part of the scheme, the community pharmacists could refer patients back to the practice using a "rapid referral" form. Twenty-one patients (3.6 per cent) were referred back to the practice using this method. Among these patients the most common conditions were head lice (n=9) and earache (n=3). For head lice, the referrals back to the practice were mostly because the patient demanded a non-formulary product. On rare occasions the pharmacist, having assessed the patient, perceived the need for a non-formulary product and noted this on the rapid referral form.

Data collected from the practice indicated that only 15 of the 21 "rapid referral" patients were recorded as subsequently consulting a GP with the same minor condition. Of these, 11 were prescribed a product not available on the formulary (predominantly antibiotics), three did not have a prescription issued and one received a prescription for a product available under the scheme. The other six patients might have chosen not to consult the GP following their referral by the pharmacist or the GP did not record the subsequent consultation as a minor condition.

The community pharmacists commented that they had experienced problems in dealing with referrals from the practice for earache, headache and head lice. Some problems were related to the formulary, in that for headache and earache the patients had usually tried to self-treat with the products available on the formulary. Occasionally, the pharmacists had no further formulary options available or perceived the need for an antibiotic and referred the patient back to the GP.

Thirty-three patients (5.7 per cent of all referrals) who consulted a community pharmacist reconsulted for the same minor condition within 14 days (Table 4). Over half (n=19) of these patients chose to reconsult the community pharmacist rather than the GP. The most common minor conditions that patients reconsulted about were head lice (n=18), cough (n=4), upper respiratory tract infection (n=3) and constipation (n=3). Table 4 describes the type of reconsultation and how long after the original consultation it took place. The data also revealed high levels of reuse of the scheme, with 146 patients using the scheme more than once over the six-month study period.

TABLE 2: LEVEL OF REFERRAL AND MANAGEMENT OF THE 12 MINOR CONDITIONS AND A SPECIALLY CREATED CATEGORY OF UPPER RESPIRATORY TRACT INFECTION

Minor condition	No of referrals (n=576*)	Average no of items prescribed per referral	Products on formulary
Constipation	10	0.8	Senna tablets Fybogel
Cough	33	1.0	Simple linctus Pholcodine linctus
Diarrhoea	15	1.0	Ammonia and ipecacuanha mixture Dioralyte sachets Loperamide capsules
Dyspepsia	4	0.8	Maalox suspension Magnesium trisilicate mixture Gaviscon Kolanticon gel
Earache	14	0.9	Paracetamol Ibuprofen
Hay fever	1	0	Chlorpheniramine Loratadine tablets Opticrom Allergy eye-drops Beclomethasone nasal spray
Head lice	328	0.9	Suleo M alcoholic lotion Derbac M aqueous liquid
Headache	2	0	Paracetamol Ibuprofen
High temperature	8	1.3	Paracetamol Ibuprofen
Nasal symptoms	6	1.3	Menthol and eucalyptus inhalation Sodium chloride nasal drops Xylometazoline nasal drops Pseudoephedrine tablets
Sore throat	24	1.0	Aspirin Paracetamol AAA spray
Vaginal thrush	50	1.0	Canesten 1 pessary Canesten Combi Diflucan-1
†URTI	77	1.8	(See footnote)

*The column total is 572. The four missing referrals were classified as "other". This includes combinations of minor conditions not covered by the URTI definition.

†URTI = upper respiratory tract infection. This separate category was created to include combinations of cough, sore throat and nasal symptoms with temperature or headache or both. In this case, the products available in the formulary include all those available for the individual minor conditions.

TABLE 4: RECONSULTATIONS AFTER PHARMACY VISIT

Type of reconsultation	Within 3 days	Within 7 days	Within 14 days	Total
CP to CP	4	6	9	19
CP to GP	5	4	5	14
Total	9	10	14	33

CP = community pharmacist; GP = general practitioner

In the interviews, the community pharmacists were generally supportive of the scheme and felt that it enabled them further to use their skills and knowledge to manage minor conditions.

They also recognised that they offered greater accessibility through not being appointment-based and open for longer hours than GP practices. A number of changes to the scheme were suggested, most relating to the extension of specific sections of the formulary.

Although the evaluation only examined data collected for the six-month study period, the "Care at the chemist" scheme has continued to operate. For the period from February to July, 2000, there were a total of 393 referrals. This represents an average of 15 per week, a reduction on the 22 referrals per week during the evaluation phase.

DISCUSSION

The "Care at the chemist" scheme enabled the transfer of over one third of the workload for 12 self-limiting conditions from one general practice to eight community pharmacies. The study demonstrated that community pharmacists could successfully manage a range of minor conditions within this scheme, but most community pharmacist consultations were for head lice, vaginal thrush and upper respiratory tract infection. The results also indicate a high level of reuse of the scheme, suggesting patient satisfaction with the new service arrangement. Reconsultation rates were low, with many patients choosing to reconsult the community pharmacist rather than a GP. The referral criteria and formulary were on the whole successful as "rapid referrals" to the GP

TABLE 3: OUTCOMES OF "CARE THE CHEMIST" REFERRALS (N=576)

Outcome	Frequency	%
Saw CP and received advice and formulary medicine	511	88.7
Referred to CP but did not attend	27	4.7
Saw CP and "rapid referred" to GP	21	3.6
Saw CP and received advice only	9	1.6
Saw CP and bought OTC medicine	8	1.4

CP = community pharmacist

were few and in many cases were due to patient demand for a particular product rather than the community pharmacist being unable to manage the condition.

Because the "Care at the chemist" scheme was essentially a feasibility study, necessitating careful monitoring, a number of restrictions needed to be "artificially" placed on the running of the scheme. The referral process used for the scheme was necessary to create a paper trail for the gathering of patient data. The practice receptionists played an important role in the scheme as they were the referring agents. Observation in the practice suggests that the number of referrals was adversely affected when the practice was particularly busy, with receptionists less likely to offer patients a community pharmacy consultation. As the "Care at the chemist" scheme was only operating in one GP practice, it was important to ensure that only patients from that practice had access to it. This meant that promotion of the scheme was practice-based, with posters and leaflets in the reception and waiting areas. This limited scope for publicity might have meant that many patients were not aware of the scheme until they attended the practice for an appointment. Schemes across larger patient populations could use a more wide-ranging advertising campaign to publicise the service more extensively and increase uptake.

Recent policy developments point to a wider recognition of the community pharmacist's expertise, with new payment mechanisms and services being proposed in the NHS plan.¹⁹ Following the Crown review, the introduction of patient group directions (PGDs)²⁰ opened the way for community pharmacist prescribing of prescription only medicines. Indeed, towards the end of this study the need to develop and gain approval for a PGD was identified. This was needed to ensure that patients consulting with hay fever were not disadvantaged by the restrictions in over-the-counter pack sizes for antihistamines and nasal corticosteroids in comparison with the quantities usually ordered on a prescription. Although there were few presentations of hay fever during the study, the PGD continues to operate within these pharmacies. It is also worthy of note that the participating pharmacists did not receive any training in the management of these 12 conditions. All stakeholders involved in the study, including the GPs, felt that this was only an extension of what the

pharmacists were already doing in their everyday practice rather than taking on new clinical responsibilities. Indeed, interviews with all participating practitioners at the end of the study did not reveal any training needs.

ACKNOWLEDGMENTS We thank all the community pharmacists and members of general practice staff who took part in this study and Peter Johnson, who was the practice pharmacist during the early stages of this study.

Funding to evaluate the "Care at the chemist" scheme was provided by the Community Pharmacy Research Consortium and the NHS Executive. Sefton health authority met the service development costs of the intervention.

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THE SOCIETY'S SPECIAL INTEREST GROUPS

The Royal Pharmaceutical Society has established special interest groups for community pharmacists, for veterinary pharmacists, for industrial, regulatory and technical pharmacists, for hospital pharmacists, for pharmaceutical scientists and for pharmacy academic staff.

The groups hold meetings to consider topics of interest within their own fields of practice and they provide a source of advice to the Society's Council on specialist matters.

Each group is administered by a committee, most of whose members are elected by the group, the remainder being members of the Council.

Details of the groups can be obtained from the Royal Pharmaceutical Society, 1 Lambeth High Street, London SE1 7JN (tel 020 7735 9141). The name of the appropriate contact person is given after each entry below.

Community Pharmacists Group The Community Pharmacists Group, formed at the beginning of 1994, is open to all pharmacists engaged in the practice of community pharmacy. The group committee has the discretion to grant membership to pharmacists who are not engaged in community pharmacy practice but who have a

direct involvement or demonstrable interest in that aspect of pharmacy. Contact: Ms Emma Richards (practice division).

Veterinary Pharmacists Group The Veterinary Pharmacists Group is open to all pharmacists who are engaged in, or actively considering engaging in, the preparation or supply of agricultural chemicals, veterinary medicines and allied products. Other pharmacists may be granted membership at the discretion of the group committee. Contact: Miss Liz Griffiths (practice division).

Industrial Pharmacists Group The Industrial Pharmacists Group is for pharmacists who are engaged in industrial practice, those who act as consultants to industry, those whose work is concerned substantially with questions of industrial pharmaceutical practice and those whose work concerns, or who have an interest in, industrial, regulatory or technical matters affecting pharmacy. Contact: Ms Emma Richards (practice division).

Hospital Pharmacists Groups The Hospital Pharmacists Group is for pharmacists who work in National Health Service, private or armed forces hospitals and those

employed by, or acting as consultants to, NHS health authorities, health boards and trusts. Also eligible are pharmacists working in the prison service, community pharmacists seconded to provide a service within a private hospital and other pharmacists whose work is significantly concerned with matters relating to the practice of hospital pharmacy. Contact: Miss Liz Griffiths (practice division).

Academy of Pharmaceutical Sciences The Academy of Pharmaceutical Sciences of Great Britain is open to all those with a professional interest in the pharmaceutical sciences. The academy committee organises the science component of the annual British Pharmaceutical Conference and arranges symposia, meetings and courses throughout the year. Contact: Dr John Clements (scientific and technical services).

Academic Pharmacy Group The Academic Pharmacy Group is open to pharmacists and other academic staff who make a significant contribution to pharmacy teaching and research in a United Kingdom school of pharmacy or a recognised pharmacy academic practice unit. Contact: Miss Rachel Ollerearnshaw (education division).